Decision making: the context of nurse prescribing

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From October 1994 qualified district nurses and health visitors from eight demonstration sites in England have been able to prescribe from a limited list of formulary items. Data collected from nurses formed only one part of the evaluation of nurse prescribing. These data highlighted a number of areas where prescribing nurses were faced with difficult decisions. A number of authors have considered how both doctors and nurses make decisions, and the factors which may influence the decision making process. With reference to the literature this paper focuses on the findings related to decision making in the context of nurse prescribing.

Keywords: nurse prescribing evaluation, community nursing, decision making, models, accountability, responsibility

BACKGROUND

Following recommendations made by a number of earlier reports (DHSS 1986, DoH 1989, 1991) nurse prescribing was introduced in England in October 1994 for community nurses at eight demonstration sites, one in each Regional Health Authority. Only qualified district nurses (DNs), health visitors (HVs), and practice nurses (PNs) who were also either a qualified DN or HV were eligible to prescribe. These nurses completed a training course which comprised an open learning pack followed by a 2-day residential course, ending with an unseen examination. Nurse prescribing is undertaken in accordance with the Nurse Prescribers’ Formulary (NPF) which consists of items from 12 chapters of the British National Formulary (BNF). In January 1995 six prescription only medicines (POMs) were added to the NPF.

In order to determine the impact of nurse prescribing in the eight demonstration sites the Department of Health (DoH) funded an evaluation study. This was undertaken

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INTRODUCTION

Historically, prescribing of drugs and dressings has been the domain of the doctor. Although community nurses have often prescribed informally and had their decision endorsed, they have not until recently been able to accept full responsibility for their decisions. It is inevitable that prescribing nurses would sometimes be faced with situations where they had to make difficult decisions about when and if to prescribe, as well as what to prescribe. Although a wealth of literature exists to suggest how nurses make decisions this does not relate directly to prescribing therefore the literature on medical decision making was also consulted.

This paper draws upon the literature relating to both nursing and medical decision making. The views of prescribing nurses interviewed as part of the evaluation of nurse prescribing are presented in so far as they relate to decisions about the types of items to prescribe, whether to prescribe or recommend an over the counter purchase, or whether to decline to prescribe at all. A number of potential influences on nurse prescribing are also considered. With increasing emphasis given to the philosophy of evidence-based practice, it is necessary to know what other factors influence decision making.

MODELS OF DECISION MAKING

The nursing and medical literature falls broadly into two models of decision making. The first is based on a scientific or analytical approach. In the case of nursing the term diagnosis is often used as a way of describing the process by which nurses identify the problems of patients through the nursing assessment of their patients (Wooley 1990, Booth 1992, Webb 1992).

The scientific or rational model of decision making involves a logical analysis, often by means of decision trees, where the probabilities of each possible outcome are assigned a numerical value. Ideally this quantitative approach to decision making requires more time and assumes that all knowledge is available to enable the correct decision or treatment to be selected (Pauker & Kassirer 1987, Miers 1990, Harbison 1991). However, it is acknowledged that not all knowledge is always available, and that some decisions will have to be made in conditions of uncertainty, and with an element of risk involved in the decision. (Kuipers et al. 1988, Miers 1990, Harbison 1991, Orme & Maggs 1993). Therefore, nurses and doctors have to decide whether the benefits outweigh the probabilities or odds of negative consequences resulting from their decision or diagnosis (Pauker & Kassirer 1987, Carson 1988, Wooley 1990).

The second model of decision making relies mainly on intuitive knowledge gained by past experience rather than on objective knowledge sources. Much credence has been given to this approach since the work of Benner (1982), who described five stages a nurse passes through from novice to expert, and suggested how decisions made depend upon the stage the nurse is at. The novice has no experience to draw upon therefore decisions or actions are based upon taught procedures and guidelines. By the time the nurse has reached the stage of expert she has a wealth of experience to draw upon and decisions are made intuitively based upon that experience. In testing this theory Watson (1994) found that 45% of nurses in his study reported finding decisions easier to make if they had prior experience of a situation.

Interestingly Hamm (1988) outlined a model which used the same five categories described by Benner (1982) but in relation to medical rather than nurse decision making. In summary it is claimed that the novice thinks analytically by working through guiding principles, whilst the expert clinician can make decisions intuitively.

Hamm (1988), rather than considering analytical and intuitive thinking as two separate strategies, instead views them as ends of a continuum, with most thinking or decision making taking place somewhere along that continuum. Hence decision making will therefore comprise both analytical and intuitive aspects, rather than being one or the other. It is proposed by Hamm that the more time and information that are available, the nearer to the analytical end of the continuum the decision will be, and vice versa.

Influences on decision making

Potential influences on the decision making of nurses have been seen to be the experience of the individual nurse (Benner 1982, Wooley 1990, Watson 1994, Bryan & McIntosh 1996), company representatives (Luker & Kenrick 1992), the patient (Jenks 1993, Radwin 1995), and the attitude of nurses themselves (Hamers et al. 1994). Jenks (1993) described how the relationship the nurse has with other colleagues, doctors and particularly patients, influenced the decision making ability of the nurse. Nurses reported feeling insecure and less certain about their ability to make appropriate decisions where good relationships did not exist. Radwin (1995) also describes how the decision making process of the nurse is influenced by how well the nurse knows the patient. She describes four strategies of decision making from ‘empathizing’, where the
nurse is less familiar with the patient and imagines how she would feel in that situation, to ‘balancing preferences with difficulties’ where more individualised interventions are given because the nurse is both more familiar with the patient, and has more time with them.

Hamers et al. (1994) considered that the attitudes of nurses influenced when, or if, they administered pain medication to children. In this study nurses delayed administering analgesics for as long as possible. Reasons given for delaying treatment included a belief that drugs were harmful or had side-effects, that other symptoms may be suppressed by the medication, or a fear that something would go wrong.

Medical decision making has been discussed in similar terms for example by looking at social factors which may influence the prescribing decisions of doctors. Some authors have looked at a wide range of factors such as the educational qualification of doctors, advertising from pharmaceutical companies, colleagues and patients, considering them to have some influence on the prescribing practice of doctors (Hemminki 1975, Eisenberg 1979). Clark et al. (1991) found social characteristics of patients, such as age, gender and class to be an important influence on doctors’ prescribing. Webb & Lloyd (1994) also reported age to be a significant factor, with elderly patients being more likely than younger patients to be given a prescription. As with some of the nursing literature, Nazareth & King (1993) discuss how doctors may feel under pressure to prescribe because of patient expectations. However, doctors were able to ‘negotiate rational prescribing’ if they knew the patient well. Clearly there are many similarities between the decision making practices of doctors and nurses. Historically doctors have been the only professionals engaged in decision concerning prescribing drugs and topical applications; this is no longer the case as the study reported here details.

THE STUDY

Sample

Data obtained from nurses formed only part of the evaluation of nurse prescribing. Data were obtained both pre- and post-prescribing from nurses, patients and carers, and community nurse managers. Single interviews were also conducted in the post-prescribing period with GPs, practice managers, FHSA advisors and community pharmacists. The methods described in this paper relate only to the post-prescribing data obtained from nurses, as the findings presented have been based upon these data. The number of nurses interviewed at each stage is presented in Table 1.

Fifty-eight nurses successfully completed the nurse prescribing training course. These nurses varied in experience, some having worked as community nurses for over 20 years whilst others were newly qualified. Details regarding the level of experience are shown in Table 2.

Although 58 nurses, of which 15 were cover nurses, successfully completed the training course to become nurse prescribers, by the end of the evaluation only 49 nurses remained in the study. The reasons for attrition were that six nurses moved post and three nurses were on maternity leave. This turnover of staff in 1 year perhaps reflects the young female workforce in the sample. Other reasons for varying sample size at each data collection point include holiday or sick leave at the time of interview.

Method

The evaluation employed multiple methods and utilized both qualitative and quantitative techniques. Data were obtained from nurses four times following the implementation of nurse prescribing at 3-monthly intervals over a 1-year period. All interviews were semi-structured, lasted between 30 minutes and 1 hour and were tape recorded. Topics covered in the interviews included those relating to the number and type of items prescribed, relationships with other colleagues and patients, how decisions were made about when and when not to prescribe. Data obtained at each stage were used to structure the format of subsequent interviews. Interviews became more structured over time in order to determine the extent to which views expressed by some nurses at one round of interviews were generally held.
Analysis

The first round of post-prescribing interviews were tape recorded and transcribed, further interviews continued to be tape recorded and were analysed using a form of thematic content analysis (Schatzman & Strauss 1973, Strauss & Corbin 1990).

FINDINGS

The findings presented in this paper are taken from the post-prescribing interview data. As the interviews were tape recorded verbatim quotes are used to illustrate the findings. The code in brackets following each quote relates to the type of nurse, a personal and site identifier. The number in subscript denotes the round of interview from which the data are drawn.

Frequency of prescribing

At the final round of interviews DNs continued to prescribe more often than HVs and PNs. More than half of the DNs reported prescribing most days, compared with only one PN and one HV. Of the 44 nurses interviewed at the end of the evaluation two had still never prescribed; both of these nurses were cover nurses. Two other cover nurses who did not participate in the final interview had also not prescribed, making a total of four nurses who had never prescribed throughout the evaluation period. The main reason for never having prescribed was that the nurse had either not provided cover, or had the opportunity to prescribe when they had been covering. Whilst all of these nurses felt that they had been kept up to date with prescribing by colleagues, all expressed some apprehension with regards to how confident they would feel when writing prescriptions in the future. This highlights the particular problem faced by cover nurses in this evaluation and raises the issue of deskilling.

Of the seven nurses who had prescribed infrequently, four were cover nurses and three were HVs. The reason given for infrequent prescribing was lack of opportunity. Two HVs, based at the same site, related the infrequency with which they prescribed to their caseload. These HVs thought that an extension to the NPF would provide them with more opportunity to prescribe, for example if items for the treatment of colic were included.

Types of items prescribed by nurses

The items most commonly prescribed by the different types of nurses remained the same throughout the evaluation, and reflect the nature of work undertaken by these nurses. District nurses most commonly prescribed wound care and catheter care products. Practice nurses also commonly prescribed wound care products and skin preparations. All but one PN had prescribed appliances and reagents for diabetes. Items most commonly prescribed by HVs were for the treatment of thrush (nystatin), nappy rash or skin conditions (barrier creams) and antipyretics (paracetamol).

At the first set of interviews, some DNs expressed a concern about prescribing enemas and laxatives. The concern was based on a fear of missing an underlying pathology given that nurses are not trained to make medical diagnoses. However, by the end of the evaluation approximately three-quarters of DNs had prescribed enemas on at least one occasion and two-thirds had prescribed laxatives, although not frequently. None of the HVs and PNs had ever prescribed enemas. Although half of the PNs had prescribed laxatives, only two of the HVs had done so. The differences between the nurse types are indicative of the differing patient populations.

Another concern related to prescribing analgesics. As with laxatives the concern appeared to be about missing a more serious problem or to do with the potential side-effects of the medication. At the final round of interviews approximately two-thirds of the HVs had prescribed paracetamol (see Table 3), usually in the form of paracetamol oral suspension for babies and children, as had half of the PNs. However, most DNs had never prescribed paracetamol. The reasons given for this were as follows: there was a lack of patients requiring this item in relation to their nursing care, because it is available over the counter (OTC), and that local policy indicates that paracetamol should not be prescribed. It is noteworthy that none of the nurses had ever prescribed aspirin.

Health visitors considered aspirin inappropriate for their client group, and other nurses claimed not to have been in a situation where it was necessary to prescribe it.

One of the benefits, mentioned mainly by HVs, was that they were able to identify symptoms when visiting for another reason, and so diagnose and treat immediately, as this nurse commented:

I went out to do a weaning visit and whilst I was there the baby had got thrush, oral and napkin thrush, and the mum hadn’t recognized it as thrush, she just thought it was nappy rash so was treating it inappropriately. So I gave her the prescription there and then and she got the medicine. (HV 420)

Table 3 Percentage of nurses prescribing enemas, laxatives and analgesics on at least one occasion

<table>
<thead>
<tr>
<th>Item</th>
<th>DN (n=22)</th>
<th>HV (n=16)</th>
<th>PN (n=6)</th>
<th>Total (n=44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enemas</td>
<td>73%</td>
<td>0</td>
<td>0</td>
<td>36%</td>
</tr>
<tr>
<td>Laxatives</td>
<td>64%</td>
<td>12%</td>
<td>50%</td>
<td>43%</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>14%</td>
<td>69%</td>
<td>50%</td>
<td>39%</td>
</tr>
<tr>
<td>Aspirin</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

A DN described a similar situation she had found herself in:

We had a lady. I was just going in to check her catheter and she had a fungal infection under a roll of skin and I was able to prescribe clotrimazole cream. And she was actually waiting for surgery, she needed a laparotomy and that could have been delayed, the surgery if I hadn’t been able to treat it quickly, because they wouldn’t have operated with an infection.

(DN 740)

In the context of topical applications the nurses appeared to feel more comfortable with the idea of diagnosis. Perhaps the risk of making an incorrect diagnosis was thought to have less serious consequences in these instances rather than when deciding whether to prescribe laxatives, enemas or analgesics.

Variations in prescribing

The first few months of prescribing data from the Prescription Pricing Authority (PPA) showed wide variation between the eight sites, with the number of items prescribed by nurses ranging from 40 at one site to 750 at another site over the same 3-month period. Therefore, at the second round of interviews nurses were asked to suggest possible factors which could account for this variation. Responses could be divided into three main categories: the characteristics of the population, characteristics of the nurses, and characteristics of the practice, including GPs.

The most common reason offered was the size and make up of the practice population:

Obviously it would depend on the area mainly... population age groups... not just their age but the type... if you go into a poor area I think you would probably be writing more scripts, and the size of the caseload obviously would make a difference.

(DN 110)

As can be seen from the above comment a number of nurses thought that the rate of prescribing would be higher if the caseload was drawn from a population of people of lower social class or with poor financial status, and vice versa. Some nurses thought that more prescriptions would be written in urban areas. Others commented on the age group of the caseload and the number of ill or dependent patients. Some nurses thought that the number of patients aware of nurse prescribing could increase demand.

The characteristics of individual nurses were also considered to be a factor, for example the confidence of prescribing nurses was mentioned as an influence. One nurse thought that the confidence of the nurse could be affected by the length of time she had been qualified. This particular nurse had been qualified for a long time and felt that it was harder for her to learn a new way of working.

The number of prescriptions issued by GPs was also thought to affect the number of nurse prescriptions issued. It was believed that where GPs had transferred workload the number of nurse prescriptions was higher than where GPs continued to prescribe NPF items, as this nurse explained:

Unless the need is brought to us we don’t prescribe, there’s quite a lot still going to the GP.

(HV 560)

However, this was not always the case since at one site GP prescribing increased for NPF items alongside nurse prescribing.

The attitude and level of control exerted by the GPs was seen to be a possible factor in the rate of prescribing. It was thought that prescribing rates could be lower at sites where GPs were putting pressure on nurses to be cost conscious. This could also be reflected in practice prescribing policies. The way in which stock was obtained, and the number and type of clinics were also seen as factors which could potentially influence prescribing. Although nurses raised these issues, their influence on prescribing is not clear.

Difficult decisions

At times nurses had to decide whether or not to write a prescription. Reasons given for declining to provide a prescription were that the item requested was not appropriate, or that the nurse believed the patient could afford to buy the item. Several nurses indicated that if the patient was exempt from prescription charges that would be sufficient reason to write a prescription. On the other hand if the patient was paying prescription charges they would look to see if the item was cheaper to buy over the counter. The financial circumstances of the patient appeared to be a major factor in the decision to prescribe or recommend OTC items.

Another factor, mentioned by each type of nurse, was the belief that if they did not write a prescription the patient may not buy the item. This was a particular concern if the item was for a child:

It was for paracetamol suspension post immunization for a family who had financial problems and that was really the main reason I wrote it, because I knew if I didn’t write it then they wouldn’t have bought it.

(HV 630)

Some nurses considered it more appropriate to give advice rather than a prescription. Some nurses indicated that they would be more likely to prescribe an item if the patient had previously obtained it on a GP prescription, or if they thought the patient would otherwise simply get the item off the doctor. As this nurse explained:

I’ve tried to encourage them to buy cream over the counter but you see people know and they say ‘well you can get me a prescrip-
tion from the doctor’. At the end of the day if they want the prescription they will go out and get it whether it’s from you or from the GP.

One PN explained why she had sometimes prescribed rather than recommend an OTC item:

Occasionally people have demanded a prescription because they feel it’s their right. I wouldn’t argue with that.

A minority of nurses commented that they were unhappy to be in a situation of making value judgements about peoples’ circumstances:

I’m a bit reluctant to be drawn into a kind of ad hoc means testing where you balance up one clients means against another ones. It’s a bit awkward if you are in a clinic situation and one person is being given prescriptions.

One HV explained why she thought she could not decline to write a prescription:

You can’t actually decline can you? If you see that their head’s running with headlice and they say they want a prescription, you can’t actually deny it, that’s a patient’s right, it’s in the charter.

The following comment shows that a PN did not have the same worry about declining a prescription:

She’d got thrush and she’d asked for Canesten. She’d had it before and I said ‘well you can go and buy it’ and she said ‘I don’t pay for my prescriptions you know’. So I said ‘it’s alright you’re still allowed to buy it’. I don’t see why I should have to prescribe it.

These comments highlight the confusion some nurses feel about whether they can actually refuse to write a prescription. Similar confusion has been voiced by GPs regarding the GPs’ Terms of Service (PAGB 1994). It suggests that this might be an area which could be clarified in the training programme for nurse prescribers.

A number of potential influences on the prescribing decisions of nurses were considered. It had been anticipated that pressure from pharmaceutical representatives would be a problem for nurse prescribers to contend with. Following an initial influx of samples and phone calls when the demonstration sites were announced, there was very little change in the amount of contact nurses had with pharmaceutical representatives. A small number of DNs commented that they were disappointed at the lack of interest shown by pharmaceutical representatives, as this nurse commented:

I would have liked more input from reps., particularly on the laxatives side of things and on the cream side of things.

This finding suggests that DNs may value contact with pharmaceutical representatives as a form of clinical update.

At the second round of interviews 19 of the 50 nurses interviewed reported that their prescribing practice was influenced by their nursing colleagues. In general this appeared to occur as a result of discussion and exchange of ideas. For example:

We discuss it, and if one of us finds that something is just as good then we’ve come back and said to each other... so we have influenced each other.

The majority of nurses (n = 35), did not feel that GPs had greatly influenced their prescribing practice. Of those nurses who had been influenced this seemed to have occurred through discussing issues with GPs or exchanging ideas. The other way GPs influenced nurse prescribing was by making known their particular preferences for example, the circumstances in which paracetamol should be prescribed, or the preferred treatment for thrush.

Almost half of the nurses thought they were influenced by patients to some extent when prescribing, although fewer HVs thought this was the case. The main way patients were seen to influence prescribing nurses was if they had a preference for certain products:

They say what they like and what they don’t like, what works and what doesn’t work, for example bandaging.

In some cases it was thought that patients may not comply with treatment if their view or preference was not taken into account.

At the second round of interviews nurses were asked if they felt more confident in their decision making if they had known the patient for a long time. Although HVs were evenly divided on this, the majority of DNs and PNs reported that they did feel more confident in their decision making if they had known the patient for a long time. The main reason given for this increased confidence related to the nurse’s increased knowledge of the patient’s medical history, allergies and suitability of items, as this nurse explained:

You know them and their medical conditions, what works for them and what doesn’t, if they’ve got a dressing that suits, what you’ve tried before...

Responsibility and accountability

The main concern voiced by nurses related to the initial anxiety they felt when writing the first few prescriptions. These worries were a combination of fear of writing the prescription incorrectly, assuming responsibility pre-
DISCUSSION

Although the evaluation of nurse prescribing had not sought specifically to investigate the decision making processes of prescribing nurses, from the data it was possible to identify certain areas which did cause anxiety or where decisions about what or whether to prescribe were more difficult than others. These seemed to be areas where an element of uncertainty about the diagnosis existed. As many nurses described situations pre-prescribing where they had initiated treatments, and there had been much discussion about nurse prescribing merely legitimizing existing practices (Carlisle 1989, Nursing Standard 1990, Smith 1990), it was perhaps surprising that the issue of diagnosis and uncertainty was such a concern. However, nurses appeared to feel more comfortable when prescribing in areas where they were perceived as the ‘expert’, for example DNs and PNs had no concerns about prescribing items for wound care, but were more anxious about prescribing laxatives and analgesics.

Another way of expressing this could be that DNs were more comfortable prescribing items which went on their patients rather than in them. Interestingly this was a view supported by patients when asked what items they thought appropriate for nurses to prescribe. On the other hand HVs prescribed paracetamol on a frequent basis, which may reflect their training where they appreciate that the consequences of a high temperature following immunizations, may be more serious than the likely side-effects of paracetamol. If the NPF were to be extended, more pharmacological training would be required by prescribing nurses, a view expressed by many of the nurses involved in the evaluation.

Although some authors have considered that nurses often make decisions about patient care under conditions of uncertainty (Miers 1990, Harbison 1991, Orme & Maggs 1993), Miers acknowledges that traditionally much of this uncertainty has been removed by doctors who make treatment decisions. Uncertainty can be a difficult concept to deal with, yet it is something that doctors have learnt to tolerate (Fox 1979).

Several authors have considered the uncertainty faced by the medical profession, viewing it as an inevitable part of life as a doctor (Williamson 1975, Grol et al. 1990, Bradley 1991, RCGP 1996). Fox (1979) claims that the problem of uncertainty is a particular problem for doctors because of the consequences decisions have on patients. He discusses two types of uncertainty, the first a result of incomplete knowledge and the second a result of limitations in current medical knowledge. Fox claims that medical students through their training and through contact with professionals who do not always have the correct answer, learn to tolerate uncertainty.

One way proposed to reduce uncertainty is through the development of evidence-based medicine (Evidence Based Medicine Working Group 1992, Rosenberg & Donald 1995). However, Eddy (1988) argues that some element of uncertainty will always exist, due to the way in which different doctors will interpret signs and symptoms. In the case of nursing Watson (1994) suggested that when nurses have to make decisions about direct care they are then held responsible and accountable for the outcome of those decisions. Nurses need to feel comfortable with being held accountable in order to make effective decisions (Orme & Maggs 1993), and prescribing as a new skill is no exception to this.

Doctors could play an important part in helping nurses to cope with the concept of uncertainty, as could the further development of evidence based practice. Although there is a move towards evidence-based practice, it still seems that most practices of both nurses and doctors are based on experiential knowledge rather than research-based knowledge (Luker & Kenrick 1992, Maynard 1994). One possible explanation for this could be that in many situations faced by GPs and community nurses incomplete knowledge is available. Although nurses expressed a desire to ‘keep up to date’ with research it would appear that many of the nurses felt more competent to prescribe in situations where they had more experience, or knowledge of the patient.

However, for doctors to help with building the confidence of prescribing nurses they need to feel that there is no threat to their professional role. Webb (1992) describes the backlash nurses encountered from doctors when the idea of nursing diagnosis was introduced in the USA. Doctors feared that nurses were encroaching upon traditional medical responsibilities and some may feel similarly about nurse prescribing.

Carson (1988) claims that when taking risks there is a tendency to highlight the things that may go wrong rather than to emphasize the potential benefits. In Sweden, community nurses have been able to prescribe from a limited
formulary for a number of years. However, in 1994 further additions were made to the formulary and community nurses can now prescribe 230 brands of products for 60 specific indications (David & Brown 1995). Criticisms of the extended prescribing rights of nurses made by Swedish doctors centred around the problem of diagnosis. There was a fear that more serious conditions would be missed, or masked by incorrect diagnosis and treatment (Enkat Om Distriktsskoterskors Forsrhinningsratt 1994). The Swedish doctors often highlighted very rare cases, for example: acknowledging that discomfort around the anus is usually harmless, but stressing the possibility of cancer of the rectum. Interestingly the fears expressed by the Swedish doctors were also expressed by nurses in this nurse prescribing initiative, and by paediatric nurses in the study by Hamers et al. (1994).

Nurses’ tendency to focus on what may go wrong may be explained in a number of ways. It could simply be an echo of doctors’ concerns, or it could be a reflection of the nurses’ own knowledge base. Whatever the explanation it is necessary to be cautious in our interpretation since nurse prescribing is a new innovation and needs time to become embedded as everyday practice before drawing firm conclusions.

The social factors suggested by nurses as possible explanations for the variation in prescribing across the eight demonstration sites, and as actual influences on their prescribing throughout the evaluation, are also remarkably similar to many of those mentioned in the literature explaining influences on the prescribing practices of doctors. Eisenberg (1979) even defined similar categories of ‘characteristics of the patient’, characteristics of the physician’, and ‘physician’s interaction with his profession’.

It may have been assumed that doctors would prefer the scientific approach to making treatment decisions, with the emphasis on knowing the condition, and nurses would be more comfortable with the intuitive model which relies on knowing the patient. However, there is much overlap. The nursing literature is leaning heavily towards encouraging an analytical model of decision making for nurses, presumably in a bid for more evidence based practice. On the other hand, in the case of general practitioners, medical literature emphasizes social factors and the experience of the practitioner as most influential on prescribing decisions.

In our study, the patient seemed to be a major influence on prescribing, either through their expectation of a prescription, or the nurses’ knowledge of the poor financial circumstances of the patient. Nurses did decline to write prescriptions if they thought the item was not appropriate by clinicians. They may have been more comfortable with the intuitive model which relies on knowing the patient well. Community nurses are in a unique position to prescribe because they often have a closer relationship with their patients, and see them more frequently than the GP. As more nurses become qualified to prescribe these could be areas of further interest and investigation. Nurse prescribing has enabled nurses to make decisions about treatment in areas previously the remit of doctors. For the nurses involved, the actual signing of the prescription has meant an extra responsibility, which has brought with it a deeper understanding of the prescribing role of GPs, and has provided further insight into the decisions made by health care professionals.

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