Pharmacists and nurses as independent prescribers: exploring the patient's perspective

Rachel J Hobson*, Jenny Scott and Jane Sutton

Department of Pharmacy and Pharmacology, Claverton Down, University of Bath, Bath BA2 7AY, UK.
*Correspondence to Rachel J Hobson, NHS Wiltshire, Trust Headquarters, Southgate House, Pans Lane, Devizes, Wiltshire SN10 5EQ, UK; E-mail: rachel.hobson@wiltshire.nhs.uk

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Background. Little is known about patients’ opinions upon the development of non-medical prescribing (NMP).

Objective. To explore the opinions of patients on the development of NMP.

Methods. In-depth interviews using qualitative methodology (Interpretative Phenomological Analysis). Eighteen interviews were undertaken in Bristol (Sites 1 and 3), Swindon (Site 2) and Brighton (Site 4). [Site 1 = primary care, GP prescriber (n = 5), Site 2 = secondary care, consultant prescriber (n = 5), Site 3 = primary care (n = 5) and Site 4 = secondary care (n = 3) (both pharmacist supplementary prescribers.)] Participants (n = 18) were randomly sampled from patients under the care of the participating prescriber. Participants were aged between 42 and 81 years of age (n = 11 male and n = 7 female). Interviews took place between January and August 2006.

Results. Participants expressed concerns about clinical governance, privacy and whether sufficient space were available to provide the service in community pharmacies. Participants acknowledged the expert drug knowledge of pharmacists and their accessibility. These factors enhanced acceptability of this role for pharmacists. Nurses were highly regarded, accepted and preferred as prescribers with few concerns.

Conclusions. The results indicate support for pharmacists and nurses as prescribers, which aid successful implementation. Further research may be needed to evaluate the level of understanding that the public has of NMP and their views of the service once NMP is more widely established. Stakeholders should be mindful that the public may be hesitant regarding the professionalism, quality and clinical governance standards of clinics in community pharmacies in particular.

Keywords. Nurses, patients, pharmacists, prescriptions, qualitative research.

Introduction

Since the publication of the Review of Prescribing, Supply and Administration of Medicines Final Report1 in March 1999, non-medical prescribing (NMP) for nurses and pharmacists developed as supplementary prescribing (SP) initially (2003),2 followed by independent prescribing (IP) (2006).3

Other health professionals such as physiotherapists, radiographers and optometrists can also train to become SPs, whereas IP can only be undertaken by trained pharmacists and nurses.

NMP was developed in order to improve patient care, to provide patients with quicker and more efficient access to medicines and to make the best use of the skills of qualified health care professionals. Over time, it was also envisaged that it would help to reduce physician’s workloads.1–3

Since April 2002, following extended training, nurse prescribers were able to independently prescribe from a specific list of prescription-only medicines to treat specific conditions as ‘Extended Formulary Nurse Prescribers’ (EFNPs).4,5 The extended formulary does not now exist and these prescribers have become IPs.6

The Department of Health (DH) defines SP as a voluntary prescribing partnership between an independent prescriber and a supplementary prescriber, to implement an agreed patient-specific clinical management plan (CMP) with the patient’s agreement.
SP thus allows the medical practitioner to retain some control and supervision of the NMP by giving them permission to use recognized guidelines and specific groups of drugs as specified in a care plan.

The DH definition of IP is

Prescribing by a practitioner (e.g. doctor, dentist, nurse, and pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.

Hence, IPs are able to prescribe and diagnose without direct medical involvement or a CMP.

A thematic review of the literature from 1997 to 2007 of nurse and pharmacist prescribing examined various aspects of this development. With regards to patients and the public's perspectives, despite the patient being involved in agreeing a CMP in the case of SP, they appeared to be under-represented in research conducted during this time.

However, since nurses have had prescribing rights in various formats for longer than pharmacists, it was felt that a review of the literature might reveal perspectives of patients who have had experience of earlier forms of prescribing by nurses such as EFNP and SP.

**Patients' opinions of nurse prescribing**

Qualitative evaluation of nurse prescribing (from the Nurse Prescriber's Formulary) found that patients viewed nurse prescribing as a success. Patients reported receiving treatment more promptly and increased convenience. Positive evaluations were related to aspects of the nurse patient relationship and nurse expertise in certain therapeutic areas. Clinical outcomes such as risk and safety were not raised as an issue. The extent of patient exposure to nurse prescribing is unclear in this study.

Brooks' et al. qualitative interviews concurred with these findings. Patients suggested that nurse prescribing demonstrated more effective use of GP's and nurses' time and that nurses knew their professional limitations, when to refer and were experts in certain areas. Reported limitations included training and competency of nurse prescribers.

A systematic review was undertaken in 2002 to determine whether nurse practitioners working in primary care could provide equivalent care to doctors. Patients reported being more satisfied with care by a nurse practitioner and had longer consultation times.

An evaluation of extended formulary independent nurse prescribing in 2005 found that patients were generally positive about their experience. However, nearly half of the participants preferred to see their doctor for certain conditions and some patients preferred to see their doctor for prescriptions. There were also concerns about the consistency of information given to patients about their medicines.

**Patient opinions of pharmacist SP**

There is limited published data upon patients' opinions of pharmacist prescribing.

A qualitative evaluation of pharmacist SP interviewed 10 patients about their experiences of pharmacist SP. It was found that there was a general lack of awareness and understanding of the SP role and how it worked in practice. The patients did not understand the benefits of SP. However, some patients did admit that they felt they received more information about their medications and that the pharmacist had more time available. Similar results were also reported by patients in a study that evaluated patient's opinions of a SP pharmacist-led clinic in hypertension. These patients reported the standard of care to be better than GP clinics and that their understanding of their condition and involvement in treatment decisions improved.

**Context for undertaking this research**

The literature has shown some evidence that there is acceptance by the public of nurses as prescribers and satisfaction with their care. However, since the literature regarding pharmacists as prescribers is limited, this study focuses on the patient's perspective. Patients were also asked for their opinions of nurses as prescribers in order for them to compare the two professions.

The practice of NMP was designed to release doctors' time to enable them to concentrate on more complex cases. Patients' perception of such innovation is an important driver when GPs are considering utilizing the skills of nurses and pharmacists as prescribers.

The work reported here was part of a larger qualitative study and this paper focuses upon whether participants’ concerns were different according to the type of prescriber. The effect of experience of consulting pharmacist SP's will not be discussed in this paper.

Two areas relating to patients' perceptions are dealt with in this paper: (i) whether patients have a preference between consulting a nurse or a pharmacist IP, and if so, what is the basis of this belief? and (ii) whether patients believe that pharmacists are capable of NMP.

**Methods**

**Study design**

Qualitative semi-structured interviews were undertaken with patients in four primary and secondary care National Health Service (NHS) trusts. The four Trusts were chosen because they offered the researcher the opportunity to recruit participants from a population...
in both sectors of NHS care. This would encompass the views of patients with a variety of conditions being treated in a number of settings, e.g. general practice or hospital out-patients’ clinics.

Recruitment of participants
The recruited pharmacist prescribers practised in the therapeutic areas of hypertension and oncology. Pharmacists were included in the study primarily because they were prescribing in a practice setting. Although the therapeutic areas in which they worked were of interest to the researcher, pharmacists were not recruited specifically for this reason. The pharmacist prescribers who saw patients with hypertension prescribed prescription-only anti-hypertensive agents and the pharmacist prescriber who saw oncology patients prescribed oral capecitabine (POM). Two further sites were used to interview patients under traditional doctor care in the same clinical areas as the pharmacist prescribers. This enabled comparisons to be made by patients upon the quality of the clinical care being given by health care professionals working in the same therapeutic area.

Recruitment of sites
The four sites for recruitment of patients were as follows:

- Primary care, GP care (hypertension) Site 1,
- Secondary care, consultant care (oncology) Site 2,
- Primary care, supplementary pharmacist care (hypertension) Site 3 and
- Secondary care, supplementary pharmacist care (oncology) Site 4.

Two SP pharmacists were recruited from University of Bath graduate lists. An oncology consultant was recruited from the trust where the lead researcher was employed (Site 2). In order to recruit a GP with patients suffering from hypertension, a recruitment letter was sent to GPs in the Bristol area and as a result a GP expressed an interest in participation and was subsequently recruited to the study (Site 1).

Sampling
The prescriber at each site used a list of all patients being treated for the specified clinical condition under their care to refine a suitable list of patients for recruitment. Electronic randomization was used to select ~30 suitable patients from the list who were invited to participation. Recruitment occurred on a first-come first-served basis. The final sample size depended upon the extent to which the relevant themes had been saturated within the context of the study’s objectives. When saturation was achieved, the recruitment process finished.

The patients were interviewed at the sites where they saw their prescribers, e.g. general practice medical centre or hospital out-patients’ clinic. No other people were present at the interview other than the researcher and the participant.

Inclusion and exclusion criteria
The patients selected for possible recruitment to the study needed to be medically fit enough in the prescriber’s opinion to give informed consent and undertake an interview for up to an hour.

The principal exclusion criteria were as follows:

- Patients under 16 years of age (due to added difficulties of obtaining parental consent).
- Those suffering from dementia or mental illness that may impair capacity to consent.
- Those patients identified by the SP or doctor as being medically unfit for interview.

Consent
Immediately prior to interview, the researcher ensured that the participants understood the purposes of the research and the definition of SP and IP by discussing the patient information sheet with them. The participants were reassured that their confidentiality would be maintained and were asked to sign a consent form, on which they agreed to participate in the research and for the interview to be audio tape recorded.

Interview content
Interviews investigated (i) the background of the relationship with pharmacists and nurses and (ii) perceptions of nurses and pharmacists as prescribers.

Interview schedule development
The interview schedule was initially developed by using literature review, textbooks on qualitative interview techniques and methodology and discussion with pharmacists and other researchers experienced in using qualitative research methodology. The methodological framework for the data collection and analysis was interpretative phenomenological analysis (IPA). This is a dynamic process where themes of interest that were identified in early interviews informed the schedule in later interviews. These themes were then further explored and clarified.

Data analysis
The analytic process was both descriptive and exploratory. IPA was the methodological approach used because it acknowledges the place of the researcher’s own interpretation of the participants’ experiences and is concerned with the exploration of intrapersonal
experiences. Data analysis was undertaken concurrently with data collection and systematic efforts to check and refine developing categories of data. Analysis of individual transcripts was aided by the use of the qualitative data indexing software package, QSR NUD*IST VIVO (N-VIVO) version 2, in order to describe and interpret themes emerging from the participants’ narratives.

Results

Eighteen patients agreed to be interviewed. Details of the participants, the sites and the patients’ prescribers are found in Table 1.

The interviews took an average of 45 minutes. For ease of reading, those participants who had experienced pharmacist SP have ‘SP’ written after their participant number so that the quote can be read in context.

Do patients have a preference between consulting a nurse or a pharmacist IP, and if so, what is the basis of this belief?

Prior experience of health care professionals

Comparison of pharmacists to doctors. The majority of participants made comparisons of pharmacists and doctors in terms of knowledge, training and examination skills. The majority of participants felt that the pharmacists were inferior to doctors in this respect:

I presume a doctor gets a lot of training on what to prescribe for what a pharmacist wouldn’t get that sort of training would they? ... The doctor knows a lot more about you generally by looking at you by feeling your pulse, temperature and can know a bit more about what’s wrong with you. The chemist’s just ‘oh it sounds like you might have a heart problem or whatever’ ... (Participant 13 SP)

Comparison of nurses to doctors. Nurses were held in high regard when compared to doctors in terms of them having more time for patients and having better relationships with them.

It was recognized that in hospitals, experienced nurses support and guide junior doctors:

... now they are able to make decisions and do more for the patient, clinical as opposed to have to leave a lot of stuff to a doctor and I think it’s quite frustrating when you get the changeover of the doctors and you’ve got these young doctors which is probably their first posting they’re in Accident and Emergency or on the wards and it’s the nurses that are carrying it ... (Participant 15 SP)

The nurse was seen as the ‘central’ health care professional in a patient’s care, who saw the ‘overall picture’.

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F, female; M, male.
Comparison of pharmacists to nurses. There were mixed opinions when comparing nurses to pharmacists, but patients seemed to mostly favour nurses:

Well it is sad really, it’s difficult because you don’t think a pharmacist who is someone just behind a counter, he is set aside but I think nurses have got a little more status in my opinion . . . With the dedication to me whereas I think a pharmacist if they’re in a job, it’s just . . . Well I think nurses are usually female and they have this dedication and feeling for everyone whereas a pharmacist it varies and it’s usually men isn’t it? They are not going to have any personal contact with us. (Participant 3)

Some participants did not mind whether they saw nurses or pharmacists for prescribing services, stating that their level of training would be similar and that it would be matters such as convenience and location that would determine who they saw:

I’d go anywhere where that was quick and easy, readily accessible . . . I’d go anywhere . . . I don’t mind where I go if somebody can prescribe something quickly and easily and get it done I don’t really mind. (Participant 10)

However, some participants suggested that pharmacists might have a superior knowledge of pharmacology:

. . . the pharmacist should have more experience on drugs that are being prescribed because a nurse will not have gone through that side of it. She may see the ailments and be able to diagnose for minor ailments because she’ll have come into contact with a lot of people with minor ailments. But prescribing the drugs may be out of their area. (Participant 6)

Poor understanding of nurses and pharmacists. Pharmacist training. It was apparent that participants’ awareness of the training and knowledge of pharmacists was low, and this affects their confidence to consult a pharmacist as a prescriber:

I don’t know to be honest I don’t know a pharmacist . . . I don’t know beyond the fact that they make up prescriptions . . . I still wouldn’t have the confidence but probably I think because I really don’t know what a pharmacist’s job is. What his knowledge is really or her knowledge. (Participant 2)

Upon informing participant’s of the length of training that a pharmacist has (4 years undergraduate degree plus 1 year pre-registration training), they did concede that their knowledge must be substantial.

Nurse training. One participant thought that the acceptance of nurses as IPs would depend upon how the public perceived their status and qualifications:

I’m just thinking it all comes down to status I think the public may perceive you are just a nurse and you’re not qualified to do this. (Participant 15 SP)

Relationships. History of relationship. Participants suggested that the popularity of IP will take time to increase while patients build their relationship with their pharmacist:

For those who work in the community I think they have to I believe build up a rapport with the patients that come to them in giving advice. Because I mean, it’s a business so you have to be pleasant, you have to have the human skills and touches, good communication skills because you want those patients to build up that trust with you in return for further services. (Participant 15 SP)

Some participants stated that they would trust nurses in a prescribing role because they have an established relationship with them:

I’ve always got on well with the nurses because having your own children, my children would be born at home so you had quite a lot of contact in those days with your nurse . . . I think the nurses are in contact with the patient, whatever they need a prescription for. I think they would be involved with whoever it was. (Participant 3)

How patients feel about nurses. The following subthemes regarding nurses were identified.

Nurse positiveness. Participants overwhelmingly praised nurses. They were regarded with respect and were considered to be committed, professional and dedicated:

. . . I think they work extremely hard . . . I wouldn’t basically question their commitment or their ability or their caring really, the experience I have had has been first class. (Participant 18 SP)

Sympathy for nurses. Alongside this positive attitude held for nurses, participants also ‘felt sorry’ for nurses as they believed that they worked extremely hard, under difficult conditions for inadequate remuneration:

. . . a nurse’s job is one I have great sympathy for and I think they are poorly paid for what they do now. (Participant 5)
Some participants also held negative views about nurses, which could be detrimental towards their support as IPs:

I'm not discrediting their training, they go through a lot but I just wonder how in-depth they go into the drugs make-up itself and their knowledge of the drugs and it’s difficult to answer that question because you don't know what kind of training they would have received. Now fair enough, they may have a lot of knowledge about diabetes or whatever the condition is but with regards of the drug itself and what is the appropriate drug to give, I don’t know how in-depth at present they go into that or if they are going to be given a wider remit than what training and support they will be given to be qualified to prescribe? (Participant 15 SP)

Negative comments were made less frequently than positive ones.

Subordinate role of nurse. Participants referred to the nurse as being in a supportive role to the doctor and removing menial tasks from them. Some participants thought that nurses did not have a lot of responsibility and were always responsible to someone else:

(Asked what the role of the nurse was) Dogsbody. (Participant 17 SP)

… whatever the doctor provides for the nurses to do they do … But nurses are responsible to someone they’ve all got a boss somewhere haven’t they? (Participant 13 SP)

Nurse negativity. A few comments were made about the knowledge of nurses (questioning their ability to prescribe) and how worthwhile their role is:

You cannot say that nurses are going to get 5 years in a university. They wouldn’t be nurses after that would they; they’d be doing something a bit more worth while. (Participant 13 SP)

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Extrinsic barriers (participants did not raise these issues with regards to nurses). Lack of privacy. One of the barriers to community pharmacies developing successful pharmacist prescribing clinics was the commonly held perception that they are not private:

... also I think there is no privacy in a pharmacy is there? I don't think there is anyway ... You kind of chat over the counter for all and sundry to hear. (Participant 2)

Practicalities. Participants discussed how community pharmacies would cope with pharmacist prescribing clinics and many practical issues were raised.

Participants commented that if community pharmacies are going to become more like GP practices with a waiting area for appointments, they would have space issues. There were also concerns about the professionalism of the facilities:

... you don’t want to be put in the store room to be examined, ... the only analogy I can draw is that basically opticians these days, they are set out to do Vision Express or something like that. They are set up in a very clinical way with consulting rooms and that and the whole thing looks professional and feels professional providing it was like that, then I wouldn’t have any problem but if you were asked to sort of you know step into the broom cupboard while I sort of look in your tonsils then no, it has got to be properly licensed, I think licensed premises for consultation really so standards. There are hygiene factors and all sorts. (Participant 18 SP)

One participant commented that pharmacies would also have to recruit more pharmacists for the extra workload.

Risk management (participants did not raise these issues with regards to nurses). The participants discussed many factors that they thought necessary in order to have a safe and effective system for pharmacist prescribing.

Clinical governance. There was an expectation among participants that there would be appropriate checks in place for the new prescribing system. Participants had various ideas of ways in which this could be done, including the patient’s own role in identifying poor performance:

Well certainly I think random interviews with patients would be useful but certainly periodic examination of the patient’s medical records and progress would be important, I think that is basically the only way you could do it. You cannot have somebody sitting there watching over your shoulder all the time that is a waste of resources, but I would have thought some form of random sampling of his patients. (Participant 18 SP)

The shipman case was raised in terms of a monitoring system being needed to identify poor performers, community pharmacists working in isolation and service users being aware of monitoring systems.

Participants asked how doctors’ prescribing is monitored, and they commented that the system should have the same monitoring requirements.

One participant also commented that he thought that general public reassurance of clinical governance standards within the new system would be challenging.

Ethics. One participant commented that he did not know whether pharmacists had to conform to the same type of Hippocratic Oath as doctors do and that it may not have as much authority. Hence, it was felt that reassurance of the general public was necessary:

I suppose what many of the public may want reassurance on is whether a pharmacist is bound by the same rules of ethics and confidentiality as your doctor, so you tend to sort of assume that with the doctor you know it, but I am not sure that I would assume that a pharmacist has a patient confidentiality issue but I wouldn’t be sure and even if there was I am not quite sure that I would genuinely feel that it had the same sort of weight as a doctor ... I don’t know what pharmacists take, what oath they take ... I think that would probably need projecting in the public domain so that people are aware that there is a strict code for pharmacists. (Participant 18 SP)

Safety concerns. Concerns centred on pharmacists prescribing the wrong things for the patient, especially for what were considered to be more ‘serious’ conditions:

... to what extent the pharmacist will be aware of any issues about your health which might impact on what they prescribe. I guess there are some medicines, some medication which doesn’t necessarily go well with something that you might already be on if that’s the case, so other than asking the patient what medication are you already on then umm is there a danger that the pharmacist might find themselves in a situation where they are prescribing something which actually when it is taken in conjunction with something else that they are taking is dangerous? (Participant 5)

One participant had concerns about whether sufficient information would be available to the pharmacist in order to make safe decisions, whereas others
recognized that safety concerns are applicable to any health care professional who is prescribing. Experience was thought to reduce such risks.

Negativity about access to medical records. One participant thought that pharmacists should only have restricted access to a patient’s medical history. However, the participant did concede that it may not be safe and concluded that it was probably that pharmacists should not be treating certain conditions that were the issue:

... whether it is possible to have levels of disclosure ... I am not sure that I would like my whole history of my cancer record to be down at pharmacy level but would it be dangerous to prescribe anything without knowing that? I don’t know? ... I would have thought that certain conditions may preclude treatment by a pharmacist and again if you have got this wonderful technology you should be able to flag up that if the pharmacist is looking flags up yours records and there is a bar on it saying you know refer to GP, that would be the other issue really. (Participant 18 SP)

Medical records access in community pharmacies was particularly disagreeable for some participants as they were not confident about the security and confidentiality of their records.

Some participants had concerns as to whether there was enough information technology (IT) capability and reliability to provide medical records access in all community pharmacies and other clinic locations. IT capability issues led to concerns whether the IP would have sufficient information about the patient to safely prescribe.

Discussion

Summary of main findings

- Participants had a preference for nurses as prescribers because nurses were considered to be trustworthy, caring and from a devoted profession with which patient relationships are established.
- In terms of capability, although participants did acknowledge the expert drug knowledge that pharmacists have and their accessibility, they doubted the privacy of community pharmacies, whether they had the necessary space to provide a professional IP service and had clinical governance concerns.

Strengths and limitations of this study

As the population sample was >1000 patients for Site 1, random selection was used to produce a group of participants that represented a wide range of backgrounds. In qualitative research, purposive sampling is more commonly used to reach this objective. However, it has been stated in qualitative literature that where probability sampling is possible, it is a perfectly acceptable approach.17

For consistency, random sampling was maintained as the sampling method for all sites. This was not the most suitable sampling method for sites that had small total populations. As the purpose of qualitative research is not to generalize but to identify themes that represent the population of interest use of less desirable sampling methods is not critical.

In terms of qualitative research, the total number of participants (N = 18) is considered entirely reasonable for the methodology used.18

Patients who had been under the care of nurse SPs were not included in this study because the main focus was to investigate patients’ opinions of pharmacists as prescribers, which is a more radical development for patients. Patients were, however, asked about their opinions of nurses as prescribers in order to make comparisons.

As the order of the interview schedule started with questions about pharmacists as IPs, participants were less verbose about nurses, as they often referred back to what they had already said. In hindsight, the interview schedule could have been redesigned so that participants considered both professions concomitantly when answering questions. This may have improved the quality and richness of the data collected regarding nurses, therefore care has to be taken when interpreting this data.

Participants were interviewed from three different geographical areas. This was because the pharmacist prescribers recruited happened to run their clinics in these areas. The number of pharmacist prescribers to sample from was limited and a smaller number of pharmacist prescribers that agreed to participate, thus restricting the sampling frame further. It is recognized that interviewing patients from different geographical areas could bias the results as opinions of patients may differ according to the services they have experienced in their geographical areas.

Comparison with existing literature

Nurses versus pharmacists. Opinions of nurses as prescribers. Overall, nurse prescribing was more acceptable to the participants. Discussions of nurse IPs seemed to be based upon how they perceived nurses and felt about them on a personal level. Participants wanted nurses to be happier in their role and this desire may be fuelled by the media portrayal of nurses as underdogs who work very hard for little reward.

The support and confidence in nurses as prescribers have been reported by other researchers who have evaluated patients’ views of nurse prescribing8,9,19 with
part of this comfort with nurses’ stemming from the perception that nurses are easier to speak to and have more time to listen to patients.20–23

A qualitative study of stakeholders from one NHS trust identified that the close patient contact that nurses has would benefit them in relation to prescribing.24

The participants recognized that nurses already prescribed under certain circumstances and had experienced nurse-led clinics. Hence, the extension of the nurses’ role to a practitioner who also prescribes is not remarkable to patients. For pharmacists, this recognition does not exist. Although SP has allowed trained pharmacists to prescribe since 2004, it has been in limited numbers and hence has not reached the public psyche.

These results of this research differ from those of a quantitative study25 undertaken in Scotland in the same year (2006). In the study by Stewart et al., a questionnaire was sent to a random sample (n = 5000) of the public enquiring about awareness of NMP, levels of comfort with specific health professionals and attitudes towards pharmacist prescribing. The researchers found that comfort levels were highest for pharmacists, closely followed by nurses. More females (56.4%) compared to males responded to this survey. Whereas in this qualitative study, more males participated (61.1%), hence this could have affected opinions. However, the study by Stewart et al. did rank both nurses and pharmacists closely as the top-allied health professionals preferred as prescribers compared to other professions. The difference in findings may be attributed to the different methodologies employed by the two studies.

Opinion of pharmacists as prescribers. Participants were cautious about the fine detail of how IP would work for pharmacist prescribers. It was recognized that pharmacists have never traditionally had a ‘hands on’ role with patients and perhaps have ‘distanced’ themselves from patients by having the physical barrier of a counter between them. It was also noted that customers may not see the same pharmacist each time in a community pharmacy, which precipitates difficulties in developing a relationship.

Poor understanding of pharmacists and nurses Training. The lack of understanding that some participants illustrated when discussing the training that pharmacists have does not help to dispel intrinsic barriers.

It has been suggested in medical literature that if the department of health is to provide pharmacists with a more expansive role in public health in the UK, a campaign is needed to educate the public and the medical community about the harms of inappropriate use of medication and how pharmacists can be a potential resource for patients who take medicines.26

Participants did not comment about nurses’ background training in the same manner (which may have been due to the shortcomings of the interview schedule as discussed earlier).

Participants’ positive relations and experience of dealing with nurses meant that some participants did not consider the possibility that although nurses were socially skilled, they may be technically less sound or safe than pharmacists, given their more in-depth pharmacology training. However, only a few participants suggested that pharmacists may be more technically skilled.

Relationships
History of relationship and importance of trust. For both professions, the importance of the history of the relationship between the professional and the patient was emphasized. Experience of pharmacists in a prescribing role should dispel such concerns.

Opinion of pharmacists as prescribers
Extrinsic barriers. Practicalities and lack of privacy. The issue of community pharmacies having enough space to run prescribing clinics has been raised previously.27 Community pharmacies need to have a consulting room facility to run their clinic within the pharmacy. The creation of such a facility may be one of the biggest hurdles for some community pharmacies, considering the costs and space issues.27 The recently published study by Stewart et al.25 also found that the public had concerns with regards to lack of privacy and maintenance of confidentiality in community pharmacies.

It is due to this issue, alongside IT difficulties such as access to patients’ medical records, that the majority of pharmacist run clinics within primary care will develop within GP clinics initially. This aspect was less clear when the interview schedule was developed and the interviews undertaken. However, given the huge benefit that community pharmacy has with regards to accessibility, it is vitally important that the government supports those community pharmacies wishing to develop prescribing services, in terms of access to medical records, having clear clinical governance frameworks and financial support for development of facilities. This will then provide patients with increased choice in their health care options.

Risk management. Clinical governance. The fifth report of the Shipman Enquiry considered the issue of GPs working in single-handed practices and found that there was no good evidence that the clinical performance of single-handed GPs was inferior to that of their colleagues in group practice.28 Although this
data are not directly transferable, pharmacists working alone in community pharmacies should be mindful of the clinical governance issues that can arise from such practice and should invite scrutiny of their practice from an external professional.

This issue of clinical governance was not raised when discussing nurses as prescribers. This may indicate the higher level of trust that participants have with nurses and also the fact that the vast majority of nurses will run their prescribing clinics within NHS organizations.

Ethics/access to medical records. The current ethical code of conduct that pharmacists adhere to is contained in the ‘Medicines, Ethics and Practice’ guide. The current Government reform of the regulation of pharmacy is being undertaken to improve and enhance clinical governance in the NHS. Part of this change is to ensure that the strict ethical code adhered to by pharmacist prescribers is clearly visible to the public. Stewart et al. also found that participants in their survey had concerns regarding access to medical records and being able to record the results of consultations in the patient’s medical records.

This was not an issue for participants discussing nurse prescribing as nurses already have access to patients’ medical records and rarely run clinics in non-NHS premises.

Implications for future research and clinical practice
Further research is necessary to clearly evaluate the level of understanding that the public has of pharmacists, nurses and NMP. Based upon such data, an educational and promotional campaign could be undertaken to alleviate public anxieties.

For nurses, the results indicate support for them in this extended role. Opportunities for development of nurse NMP seem to be clear. This will be valuable in terms of the public utilizing their prescribing skills extensively in the future.

For pharmacists, the results also indicate some support for them as prescribers. However, it is recognized that there are many practicalities that need to be overcome if their prescribing skills are going to be utilized extensively in community pharmacy.

When commissioning NMP services, stakeholders ought to be aware that there are indications that the public may need more reassurance of the professionalism, quality and clinical governance standards of community pharmacy-based clinics.

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Conflict of interest: Both authors declare that the answers to the questions on your competing interest form are all no and therefore have nothing to declare.

References


