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Navigating professional and prescribing boundaries: Implementing nurse prescribing in New Zealand

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ABSTRACT

Non-medical prescribing is now well established in a number of countries. Because prescribing has traditionally been viewed as a medical role, there are inevitable interprofessional boundary tensions when non-medical prescribing is introduced. In New Zealand, enabling legislation has allowed nurse practitioners to apply for prescriptive authority after undertaking appropriate educational preparation. This study explored the experiences and perspectives of one of the first cohorts of nurse prescribers and their strategies in establishing the role and negotiating the associated professional boundaries. Semi-structured interviews were undertaken with ten newly registered nurse-prescribers. Two broad categories, each comprising three themes, were identified: 'shifting professional boundaries' and 'navigating boundaries of practice'. Participants described how they were faced with the challenge of an unprepared environment as they began to prescribe and how they built trust in their prescribing practice among their colleagues and patients. They also related how they determined their personal prescribing boundaries in this new environment. They described the new professional relationship between nurse prescribers and doctors as collaborative, but with the crucial difference of it being interdependent, not dependent. The study offers insights into the challenges associated with the establishment of new professional roles such as prescribing.

1. Introduction

Health professional role extension and expansion, the introduction of new roles, and task redistribution and delegation, are common responses to contemporary health system challenges of growing demand for care as populations' age and long-term conditions increase. These responses also reflect a greater focus on primary health care and the emergence of health workforce shortages (Bosley and Dale, 2008; Cooper, 2007). One response to such challenges is the introduction of the nurse practitioner (NP) role and nurse prescribing (Niezen and Mathijssen, 2014). For Niezen and Mathijssen (2014): "Nurse practitioners (NPs) are registered nurses specially educated to take on tasks previously performed by professionals of the medical domain. This implies, that tasks are shifted from the traditional professional domain of medicine (cure) to the domain of nursing (care)" (p.51). One such medical task, and the one most likely to elicit concern and ambivalence, is prescribing.

2. Background

The Nurse Practitioner role was introduced in New Zealand (NZ) in the early 2000s. Experienced registered nurses are individually approved as Nurse Practitioners on application to the Nursing Council after completion of an approved Master's degree, and may separately apply for approval to prescribe if the required curriculum in pharmacotherapeutics has been completed. Until 2013, the only nurses in NZ permitted to prescribe were Nurse Practitioners; since then authority to prescribe has been extended to additional groups of nurses (e.g. specialist nurses in diabetes) and other health professionals (e.g. pharmacists) within designated areas of practice. As authorised prescribers, Nurse Practitioners have full access to medicines listed on the Medicines Regulations list, and are afforded the same prescribing rights as physicians and midwives (Lim et al., 2014).

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Internationally, a substantial body of research has shown that nurse prescribing is safe and acceptable (Creedon et al., 2009). The successful assimilation of nurse prescribers in primary care trusts, general practice (GP) surgeries and hospitals has been documented in a recent study from the United Kingdom (UK) (Royal College of Nursing, 2014). There has been less focus on contextual issues, including teamwork and organisational preparedness. Professional boundaries and team work issues were raised in response to the announcement of nurse prescribing by nurse practitioners in NZ; particular concerns included patient safety, negative impacts on team dynamics and confusion among patients (Mackay, 2003; Moller and Begg, 2005). Such concerns have also been voiced in Israel (Brodsky and Van Dijk, 2008), Canada (Kilpatrick et al., 2011) and the Netherlands (Kroezen et al., 2013, 2014).

Role construction and boundary setting offer a lens to explore what happens when the expansion of one profession's role encroaches on another's. Such boundaries have been negotiated historically over time and in different clinical contexts. The unique bodies of knowledge of different health professional groups are influential in boundary construction, while overlapping knowledge and practices can blur them (MacNaughton et al., 2013). Based on research in primary health teams, role construction has been conceptualised as based on structural, interpersonal and individual boundaries. For Abbott (1995), a profession has a stable core and, while boundaries serve to determine those inside the professional boundary and those outside it, the boundary edge itself is more fluid.

As the place where tasks may be shared and redistributed across professions, boundaries become a crucially important, though seldom explicit, aspect of implementing new roles. Role expansion for one member of a healthcare team, exemplified in the extension of prescribing rights to nurses, creates a challenge to implicit understandings on roles and the boundaries between professional groups and may lead to claims on the territory traditionally regarded as that of physicians (Kilpatrick et al., 2011). A focus for the negotiation of boundaries is tasks, or competencies; it is no surprise, therefore, that prescribing - a highly symbolic task until recently the domain of physicians - should provoke attempts to refute encroachment (Kilpatrick et al., 2011; Kroezen et al., 2014). Kroezen et al. (2014, p.108) observed that “investigations of workplace occupational boundaries are rare”, but such studies have noted the adaptations, adjustments and compromises contributing to boundary negotiation. One such study in Canada identified a range of dynamic actions related to micro-level boundary work starting with the need to create space for the new nurse practitioner role, a corresponding loss of functions by some members of teams as Nurse Practitioners took on the roles, and the importance of trust, interpersonal relations and time (Kilpatrick et al., 2011).

Literature provides very little detail regarding how nurses integrate prescribing in practice, however, current studies (Bowskill et al., 2012; Creedon et al., 2015; Kroezen et al., 2013) suggests that the introduction of nurse prescribing has blurred professional boundaries and affected nurse doctor relationships.

The tightly regulated introduction of the Nurse Practitioner role and nurse prescribing in NZ was the catalyst for a renegotiation of interprofessional boundaries in the health team. Against a background of physician concerns regarding the advent of nurse prescribing (e.g. Moller and Begg, 2005; Mackay, 2003), and in the context of the educational preparation in which nurses were mentored in prescribing by senior physicians in their team, the research question was: How did the first nurse prescribers enact the extended role; what were their experiences as they began to prescribe; and what actions did they take in response to issues encountered?

3. Methods

3.1. Study design and aim

A qualitative approach was selected for this study because it enabled access to context-specific knowledge that is embedded in practice. The Ethical approval to conduct the study was obtained from the university's Human Research Ethics Committee (Ref. 2007/249).

The findings reported here were part of a larger study which explored the experiences of nurses, doctors and midwives as new prescribers (involving 43 participants). The study, conducted between 2007 and 2011 (when the first Nurse Practitioners began practising), was guided by a constructivist narrative approach using a multiple case narrative strategy. The ‘multiple cases’ involved subsamples (nurse and medical students and practitioners) to capture a wide understanding of learning and practising prescribing, and an analysis procedure, based on continual stages, was followed to establish core categories and themes. Each level was constructed based on the level ‘below’ it, in a process developed by Shkedi (2005). The University of Auckland Human Participants Ethics Committee approved the study (Ref. 2007/249). Only the methods related to the nurse practitioner (NP) participants are detailed below.

3.2. Participants

Ten experienced registered nurses, recently approved as nurse practitioners and accredited to prescribe and whose names and contact details were listed on a public website, were invited to participate in the study and all agreed. It is also important to note that the nurse practitioners referred to in this study had been working as clinical nurse specialists in the same area of practice for an extended period. Their specialities and years of working experience are described in Table 1.

3.3. Data collection

Semi-structured individual interviews, of approximately one-hour duration, were conducted and audio-taped with participants' consent. The interview schedule was informed by the literature and the researchers’ experiences as academics in nursing, pharmacology and prescribing and health systems. Questions were designed to elicit responses on the following issues: Why prescribing was an important part of the role as a nurse practitioner; sources of advice in matters relating to prescribing; gaps in knowledge in relation to prescribing; influence of previous nursing experiences on prescribing decisions; influence of previous medication management experiences on prescribing decisions; factors that influence prescribing decisions and under what circumstances. In the course of the interviews, participants recounted their early experiences in prescribing and the way prescribing had consequential effects on professional relationships with patients and other members of the health care team.

3.4. Data analysis

The interviews were transcribed and analysed thematically. Data collection and analysis proceeded simultaneously in an iterative manner, so that new data further informed analysis and preliminary analysis informed interviewing. The ‘Narralizer®’ (Shkedi, 2005) software was used to generate and develop categories and also provided a tool for the researcher to link ‘bits’ of data extracted from text where thematic analysis was employed to analyse blocks of text (and not separated words) as the analysis unit.