Letters

Extended prescribing by UK nurses and pharmacists

Triumph of common sense

Editor—As a consultant neonatologist in a neonatal intensive care unit I am delighted that the Department of Health has at last seen sense with respect to nurse prescribing.[1] This now means that the neonatal nurse practitioners who form 40% of our first line "medical" team on the unit will have almost the same prescribing powers as the senior house officers who form the remaining 60%. If, in the context of a hospital, the department extended this permission to "controlled" and unlicensed drugs I would be even more pleased.

What currently stands in the way of this progress is article 12 of the Prescription Only Medicines (Human Use) Order 1997, which forbids any pharmacist from supplying any prescription only medicine except in accordance with the written directions of a doctor or dentist in the course of the business of the hospital.

PETER MENZEL/SPL

Currently a dentist or a consultant pathologist can legally prescribe drugs for the babies in our neonatal intensive care unit purely by virtue of their medical or dental qualification and despite their total lack of neonatal experience (I mean no disrespect here, I am merely using these as examples). At the same time, the neonatal nurse practitioners, each with many years of senior neonatal nurse experience followed by 12 months' nurse practitioner training and a further six months' closely supervised practical experience, cannot legally do the same.

Senior house officers joining our unit have little idea about prescribing in neonatal intensive care despite many years of medical training. The quality of their prescribing is the responsibility of those in clinical charge of the unit, who must lay down appropriate guidance. If this guidance is appropriate then prescribing will be safe and effective; if it is not it will not be.

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Competing interests: None declared.

1 Avery AJ, Pringle M. Extended prescribing by UK nurses and pharmacists. *BMJ* 2005;331:1154-5. (19 November.)

Computer systems need to incorporate nurse prescribing

Editor—In terms of the issue of nurse and pharmacist prescribing Avery and Pringle are right to raise the issue of patient safety, which must be at the heart of all we do.[1]

We have been in the forefront of nurse prescribing in our general practice and have found both good practice and some frustrations. Intrinsically we have found our extended and supplementary nurse prescribing to be safe. Nurses by their training are driven by the concept of competency, and we have found it central to the way of working to assess and prescribe only within the bounds of clear competency. The introduction of safe nurse prescribing has undoubtedly been helped by the presence of a strong and open clinical team supporting the nurses throughout their initial training and on an ongoing basis. Our frustration has been the lack of integration of nurse prescribing with our clinical computer system.

This has, as the editorial points out, removed a potential safety feature open to doctors when they prescribe. There are ways around this, but it would have been far better to encourage computer prescribing by nurses from the outset. We need a rapid roll-out of nurse prescribing software on general practitioners' and community clinical computing systems before April 2006.

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1 Avery AJ, Pringle M. Extended prescribing by UK nurses and pharmacists. *BMJ* 2005;331:1154-5. (19 November.)

Supplementary prescribing by mental health nurses seems promising

Editor—We recently conducted a qualitative evaluation study assessing the impact of mental health nurse supplementary nurse prescribing, addressing some of the issues raised by Avery and Pringle.[1]

Eleven service users, most with a diagnosis of psychosis, were interviewed about their experiences of the prescribing scheme, as were 12 consultant psychiatrist independent prescribers and 11 trained nurse prescribers. At the time of the interviews, eight of the nurse prescribers had prescribed psychiatric drugs.

The interviews for the nurses and psychiatrists focused on the quality of the training, support, and supervision; physical health care; and the experiences of providing a prescribing intervention. The service user interviews focused on their perception of involvement in treatment decisions, the management of adverse effects, and the quality of the relationship with the prescribing nurse.

Some key themes emerged from the data. Service users reported that nurse prescribers provided a greater focus on collaboration and treatment options. They thought that the nurse listened to their concerns, acknowledged difficulties associated with using psychiatric drugs, and provided information on how to minimise the risks of use. Most of the psychiatrists reported that nurse prescribing made their life easier and improved the knowledge base of the team. Both they and nurses worked in a way that was more evidence based, improving practice as a result.

The opportunity arose for improved physical health care for service users with mental health difficulties. Both nurses and psychiatrists said that this was early days in the process of the new scheme. All of the nurses interviewed, except for the nurse consultant, made comparatively straightforward decisions and prescribed for only a few service users.

The study also showed that pharmacists had not returned any prescriptions, and no prescribing mistakes had been made. Several nurse prescribers and psychiatrists identified a need to redefine roles, so that nurse prescribing practice becomes an advanced role, with the necessary support structures in place.

Nurse prescribing can lead to improvement in clinical practice, and it has clear benefits for service users. We therefore welcome the Department of Health's announcement.

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1 Avery AJ, Pringle M. Extended prescribing by UK nurses and pharmacists. *BMJ* 2005;331:1154-5. (19 November.)

Reference is interesting

EDITOR—It is interesting that Avery and Pringle are against "virtually the whole of the *BNF*" being available to pharmacist prescribers.[1] As can be seen in the book's preface, the *BNF* is written and edited by pharmacists.

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1 Avery AJ, Pringle M. Extended prescribing by UK nurses and pharmacists. *BMJ* 2005;331:1154-5. (19 November.)

Challenges of private provision in the NHS

Real story is beginning to emerge

EDITOR—Timmins's argument that the NHS has never been exclusively "public sector" is misleading.[1] It obscures the astonishing growth and concentration of corporate power in the health sector. When the NHS was created, pharmaceutical companies were in their infancy, whereas today they rank among the most powerful corporations in the world.

Throughout the NHS's history, most general practitioners have been independent contractors. However, the BMA's survey of general practitioners' opinion in 2001 showed that most doctors now see themselves as part of the NHS and do not want a greater role for private companies in primary care.[2] Even "entrepreneurial" doctors are hardly in the same league as multinational private firms.

The involvement of big business is already damaging the NHS. The private finance initiative (PFI) and its latest incarnation, local improvement finance trust (LIFT), hand over control of hospitals and surgeries to private consortia, which view them not primarily as health facilities but as opportunities to make money.

As large private companies take on more and more NHS services, they are likely to want to find additional revenue by increasing user charges. Greater private provision will come to undermine public funding through taxation. The government wants primary care trusts to become purely commissioning bodies, purchasing health care on behalf of a defined population. This makes them effectively "social insurers," and it may not be long before private insurance companies are invited to compete, perhaps justified by reference to EU trade rules.

PFI providers will increasingly link up with the private health care companies now running independent service treatment centres, creating giant monopolies, complex subcontracting chains, and deals shrouded in "commercial confidentiality." It will then be extremely difficult for the public sector to intervene, even when public safety may be at stake. The planning function of the NHS will be eroded: it will not only be fragmented but its hands will also be tied by long term, immensely complicated contracts. The *BMJ* has a responsibility to take a position on what may be the slow death of the NHS.

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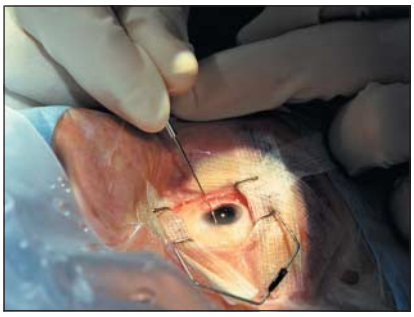
Competing interests: None declared.

1 Timmins N. Challenges of private provision in the NHS. *BMJ* 2005;331:1193-5. (19 November.)
2 National survey of GP opinion BMA 2001. www.bma.org.uk/ap.nsf/650f3eec0dfb990fca25692100069854/80256b140033ce0780256b1a004e0211/$FILE/ATT0GTSX/uk.pdf (accessed 21 Nov 2005.)

Treatment centres and their effect on surgical training

EDITOR—Timmins questions whether the benefits of using independent providers for health care outweighs the risks.[1] He notes the tendency for treatment centres to take on simpler cases, leaving the NHS to deal with complex surgery, but he brushes over the devastating effect that this is having on surgical training.[1]

Cataract surgery is the most common operation performed by treatment centres. It takes intensive training to become a good cataract surgeon. It is usually possible to predict which cataract operations are going to be difficult or high risk when the patient is seen before the procedure.[2] In our department, these complex cases are listed as "consultant to do." The remainder are listed as "any surgeon to do," and it is these patients who may be suitable for training.



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Since Netcare, a mobile treatment unit, and the Shepton Mallet treatment centre started operating in Somerset, we have noticed a dramatic reduction in training opportunities for cataract surgery. The number of "any surgeon to do" patients on each consultant list has halved from three patients per operating list in 2003 to 1.5 patients per list in 2005. Trainees are often unable to operate because of a lack of suitable cases. This will affect all ophthalmic training grades, but particularly senior house officers.

Fielder and Watson, noting that Action on Cataracts had failed to consider surgical training, made some excellent suggestions about how training could be improved.[3] Their ideas of high volume service and low volume training surgical lists, with blocks of intensive surgical training seem eminently sensible. The demand for surgery was apparently overestimated when planning treatment centres.[1] Could the NHS now use this excess capacity in the form of low volume surgical training lists? It seems very "short sighted" that, although the number of cataract operations performed in the UK is increasing, the future of cataract surgery training is under threat.

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1 Timmins N. Challenges of private provision in the NHS. *BMJ* 2005;331:1193-5. (19 November.)
2 Muhtaseb M, Kalhoro A, Ionides A. A system for preoperative stratification of cataract patients according to risk of intraoperative complications: a prospective analysis of 1441 cases. *Br J Ophthalmol* 2004;88:1242-6.
3 Fielder AR, Watson MP, Seward HC, Murray PI. Action on cataracts should influence surgical training. *BMJ* 2000;321:639.

Private health sector in India

Is private health care at the cost of public health care?

EDITOR—Sengupta and Nundy's editorial makes good reading, but I do not see any connection between the burgeoning private healthcare sector in India and the abysmal condition of the government healthcare system.[1]

To say that private healthcare is growing at the cost of public health care is unfair. While public spending on health care has been dropping, during the first half of the 1990s, India's defence budget grew at 1.5% yearly in real terms. Since 1996-7, the defence budget has been growing at 10% yearly in real terms.[2] Would it not be appropriate to say that defence spending is growing at the cost of public health care?

Patients from other countries and patients from eastern India go to south India for treatment at private institutions since these are perceived to offer better treatment than their counterparts in eastern India. The levying of a tax on hospital bills of foreign patients, to be credited to a "fund for the poor," or diverting a portion of the revenue earned from medical tourism to the government to be spent on health care would not work. Patients from eastern India should then contribute to the coffers of the state governments in south India. Also, in all probability this revenue will end being spent on defence.

Private health care in India is expensive for Indian patients: 28-30% of the project cost of a 100 bed hospital and upwards relates to recurrent expenditure on medical equipment. Maintenance costs and import duties for such equipment are high. The saying in private hospitals is: "Spend in US dollars and earn in Indian rupees."

Private health care is there for those who can afford it. Berating private health care for not assuming the government's role in providing health care to its citizens is not the solution.

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1 Sengupta A, Nundy S. The private health sector in India. *BMJ* 2005;331:1157-8. (19 November.)
2 Drieze J, Sen A. *India: Development and participation*. Oxford: Oxford University Press, 2002.

Single level health care is the only solution

Editor—The editorial by Sengupta and Nundy on the private health sector in India raises interesting issues.[1 2] People who still believe in the much discredited "trickle down" effects of money supply need to know that the Indian system rarely allows the government to collect legitimate taxes from rich and privileged people. Therefore and especially, there cannot be even the smallest hope of any public good coming of medical tourism in India, no matter how profitable it might be to the service providers.

The fact that the state medical machinery so miserably fails in India—and similar systems do only marginally better in the United Kingdom or the United States—has to do with the simple reality that the wealthy and the influential sections of the public have no interest in it. In the absence of the country's powerful folks' direct dependence on a healthy public system there can be only the dimmest hope for improvement. The opinions and self interest of the influential and the wealthy always sway government policies and priorities. The only solution is a single level, universal healthcare system with no one unqualified for it or exempt from it. If the privileged section of the population is still dissatisfied with the national arrangement, it can always buy services from commercial providers outside of the country—as many such Indians even now do.

Having lived in Canada long enough to know what it was like before our one-payer health system came into existence, I know too well what the other options are like.

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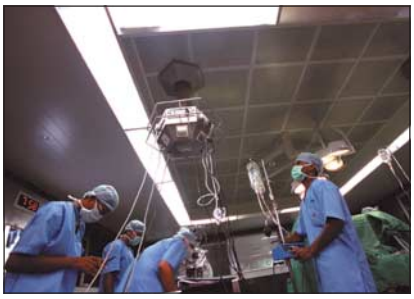
Competing interests: None declared.

1 Sengupta A, Nundy S. The private health sector in India. *BMJ* 2005;331:1157-8. (19 November.)
2 Electronic responses to Sengupta and Nundy. http://bmj.bmjjournals.com/cgi/eletters/331/7526/1157 (accessed 24 Nov 2005).

Let's not confuse the issues

Editor—Sengupta and Nundy argue that the private health sector in India is burgeoning at the expense of public health care,[1] but the two issues cannot be muddled together.

We cannot wait for potable drinking water and electricity to reach every village



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before we design and build rockets. Development in different areas should proceed simultaneously, and this should be borne in mind in the healthcare industry. Foreign exchange earned by medical tourism will certainly boost India's economy, which will in turn raise the standard of healthcare systems. What is needed is a systematic approach to make sure that a part of the funds earned is channelled to primary health care.

Raising the allocation in the budget for health is definitely called for, but not at the cost of a new source of national income.

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1 Sengupta A, Nundy S. The private health sector in India. *BMJ* 2005;331:1157-8. (19 November.)

Line between profit and profiteering is often thin

Editor—The private health sector in India undeniably suffers from many drawbacks.[1] However, if the private sector is a part of the problem, it is also a part of the solution.

The health needs of a billion people simply cannot be managed by the public sector in a country that lacks basic infrastructure. The public health sector needs a boost in investment so as to provide quality care to the patients and to preserve the morale of the staff. It is appropriate and desirable for the private sector to shoulder some of the burden of the population's health needs.

The authorities need to regulate the healthcare delivery standards expected of the private sector. The private health sector magnates must realise that the line between profit and profiteering is often thin. Much can be achieved if both the government and the private sector respect this boundary.

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1 Sengupta A, Nundy S. The private health sector in India. *BMJ* 2005;331:1157-8. (19 November.)

Reforming research in the NHS

Editor—Cole highlights some of the challenges to the proposals to reform research support from the Department of Health,[1–3] but the need to restore academic medicine does not reflect an intrinsic failure. Rather, it has been a victim of financial constraints, and clinical research has been marginalised in an increasingly citation and commercial focused academic environment.

The proposed creation of a virtual National Institute of Health Research could provide a powerful national voice for academic medicine at a time of unprecedented change, facilitate research collaboration, and build a national networked research expertise. Several fundamental consequences of the decline of clinical academic medicine, however, seem not to have been fully appreciated.

The central paradigm behind the success of academic medicine has been the two way interaction between "bench and bedside." The Department of Health proposals emphasise support for "research involving patients." This would be much too narrow a concept. The goal must be to reinforce clinical research not in isolation but as an integral limb of the totality of biomedical research and its application.

A key feature of the decline in academic medicine has been the flight of young clinicians from science.[4] The proposal to provide £100m to support new clinical academic fellowships and lectureships[2] over the next 10 years is encouraging. Clinicians appointed to this programme must be supported in undertaking creative original research, supervised by committed senior clinical academics willing to act as role models and mentors. They must also be protected from excessive service demands and offered appropriate career structures. Recent evidence of recovery of academic medicine in the United States seems to be linked to programmes addressing the specific needs of young clinicians.[5]

The proposals would create five academic medical centres selected in open competition to be re-run every seven years. However, in a scheme where "the best get more," advantage defaults to those initially successful and changes are less likely in future rounds. This may improve long term continuity of the centres selected, but the broad base of academic medicine would be squeezed by a handful of elite centres isolated by competition. The aim must surely be to raise the baseline more widely, while encouraging the best.

These Department of Health proposals are a welcome initiative to restore clinical research in the UK and have much to commend them. The objectives are ambitious, but nothing less is appropriate.

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Competing interests: None declared.

1 Department of Health. *Best research for best health: A new national health research strategy—the NHS contribution to health research in England: a consultation*. www.dh.gov.uk/Consultations/LiveConsultations/fs/en (accessed 17 Nov 2005).

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4 Council of Heads of Medical Schools. *Clinical academic staffing levels in UK medical and dental schools; data update 2004.* www.chms.ac.uk/fchms_pubs.html (accessed 30 Sep 2005)
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Diabetes and the quality and outcomes framework

Diabetes needs reintegration of primary and secondary care

EDITOR—Kenny analysed the way in which the care for people with diabetes has developed in Britain over the past 15 years or so.[1] This primary sector concern for the welfare of people with diabetes is a welcome but recent turn of events.[1] In the late 1980s, the rising prevalence of diabetes drove two major developments in hospital based diabetes care: the introduction of diabetes specialist nurses, and the creation of a countrywide network of relatively open access, hospital based, diabetes centres.

The hope was that these developments would evolve into new collaborative care networks where diabetes centres passed into the "joint ownership" of primary care, the specialist teams, and their constituencies of patients. Any aspirations of a new, patient based system were ended by the politicians, who opted for the health economists' view that the NHS could be made to work efficiently only by imposing a contestational structure on it. Primary care and hospital services were put on opposite sides of a transactional divide, and there they remain (except in Scotland, where the market has been closed down).

Simultaneously, new financial incentives were offered to general practitioners to take over the care of diabetic patients, and the response was remarkable. Primary care seemed to be rising to the diabetes challenge, largely by dint of a great expansion of practice nurse power, who were given opportunities to refresh and update their knowledge through training. Largely by enhanced nursing effort have quality standards been raised in primary care, and I hope that this will be recognised in the distribution of the financial incentivisation that Kenny considers to have been so important.

Times change. Primary care trusts now carry responsibility for commissioning hospital services. The fate and future of the diabetes centres will inevitably be influenced by their policies. I hope that in the future, the interests of diabetes patients will be the central determinants of changes in the organisation of the delivery of diabetes care and that reintegration rather than disintegration is the chosen path.

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1 Kenny C. Diabetes and the quality and outcomes framework. *BMJ* 2005;331:1097-8. (12 November.)

Integrated care is best model for diabetes

EDITOR—The Association of British Clinical Diabetologists (ABCD) welcomes Kenny's editorial on the impact of the quality and outcomes framework on diabetes management and supports his plea for supporting and strengthening secondary (specialist) care diabetes services.[1]

The implementation of the updated contract for general medical services (GMS2) has resulted in a welcome increase in the monitoring of patients, especially those with type 2 diabetes, who have been comparatively neglected in the past. However, the need to improve glycaemic control to meet the target value of 7.5% for HbA_{1c} has had some unforeseen consequences. In most specialist centres, referrals of patients treated with tablets for consideration of insulin treatment have increased, and many general practices do not feel confident with this. Simultaneously, it is not only extremely difficult for secondary care to attract additional resources, but there is actual "downsizing" of some specialist units by local primary care trusts, in line with the government's desire to transfer most, if not all, of chronic disease management from secondary to primary care.

This is one of the main reasons for the increasing frustration and discontent among diabetologists, which has led to a decline in recruitment into the specialty and many unfilled consultant posts. If as a result specialist services are lost then it will be difficult to re-create them. There is general agreement that integrated care is the best model for diabetes. However, integrated care will work only if there is something to integrate with. Without diabetologists and their multidisciplinary teams, general practitioners will be left unsupported and access to specialists for patients with complicated, diabetes related problems will be reduced. Most consultant diabetologists also provide an endocrine service and make a substantial contribution to acute general medicine. These functions cannot be devolved into the community.

ABCD therefore believes that the government and the Department of Health must rapidly reverse its present policy of downsizing hospital diabetes services if we are to avoid a serious deterioration in the quality of care for people with diabetes in the primary and secondary care sectors.

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1 Kenny C. Diabetes and the quality and outcomes framework. *BMJ* 2005;331:1097-8. (12 November.)

Soundings author apologises

EDITOR—To quote a fellow Soundings columnist from a few years back, "I'm in trouble this week, and deservedly so." Two weeks ago I tackled a sensitive issue in an insensitive way: writing—on the basis of a range of observations over the years, but no very deep scholarship—about issues that may arise for and around people in medicine with Asperger's syndrome.[1]

A series of rapid responses have made clear a number of things: that quite a few people—with and without Asperger's, within and beyond medicine—were seriously offended; that the tone of the piece—at once flippant and somewhat glacial—was a major source of the offence caused; and that anything less than appropriately professional and compassionate reference to any disability is unacceptable, in Soundings columns as elsewhere.[2] On reflection, therefore, there are no excuses: this was a column to apologise for, and I am more than happy to apologise for it.

I learnt other things too: that the sensitivities around any form of autism are such that all comment must—quite reasonably—be carefully and sensitively phrased; that there are people with Asperger's in medicine who are doing very nicely, and I am pleased to have heard from them; and that some people with Asperger's call themselves Aspies (whereas non-autistic folk are labelled, for better or worse, neurotypicals).

I find myself now not only apologetic, but interested, more sympathetic than I was, and wanting also to know more about the topic I addressed. Are there studies, and if so what do they tell us? Is career guidance available, and is it useful? And is there a support group, and if not why not? But it would have been far better to have got there without causing offence; and, for any offence I have caused along the way, once more may I say frankly that I am sorry.

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Competing interests: None declared.

1 Douglas C. Dr A will see you now. *BMJ* 2005;331:1211. (19 November.)
2 Electronic responses to Douglas. http://bmj.bmjjournals.com/cgi/eletters/331/7526/1211-a (accessed 25 Nov 2005).-