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The power to medicate.

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Fifteen countries have or are about to grant nurses prescribing rights. Marieke Kroezen traces the path to reform and asks whether the diversity in prescribing internationally will endure.

When nurse practitioners here were given the authority to prescribe medicines in 2000, Australia joined a growing number of countries that allow nurse prescribing**.** Currently, nurses in Australia, Botswana, Canada, Finland, Hong Kong, Ireland, the Netherlands, New Zealand, Sweden, Thailand, Uganda, the UK, the US and Zimbabwe have prescriptive authority, while in Spain an introduction process has been started**.**

However, a strict distinction must be drawn between nurse prescribing in industrialised nations and in lowresource settings. The differences in healthcare systems and needs make comparisons next to impossible**.**

Moreover, little is known about nurses' prescribing practices in nations with fewer resources, and the information that is available is often outdated. It is important to note that the huge umbrella term called "nurse prescribing" covers a large variety of practices, conditions and opinions. But this only makes the task of comparing and contrasting the experience of nurses around the globe all the more interesting**.**

In most Western European and Anglo-Saxon (or Western-influenced) countries nurse prescribing constitutes a relatively recent development of the past 10 to 15 years, although in some US states nurse prescribing has been around for decades. In North Carolina, for example, nurses have had prescriptive authority since 1975**.**

Some common motives for the introduction of nurse prescribing in industrialised countries are the innovation of advanced nursing roles and the objective of creating quicker and more efficient patient access to medicines, although relatively little research has been conducted to investigate the latter assertion**.**

Professional medical and nursing associations, however, differ in their views on the reasons for the introduction of nurse prescribing. This seems to have a strategic background**.**

Nursing organisations for example predominantly stress that nurse prescribing was introduced to make better use of nurses' skills, thus creating room for broad prescriptive authority**.**

Medical organisations on the other hand put more emphasis on workforce shortages in the healthcare service, which may reduce nurses' prescriptive authority to a minimum.

This would be consistent with the fact that professional medical associations in many countries largely opposed nurse prescribing. For example in Australia, as well as in the Netherlands, Spain, Sweden and the US, the introduction of nurse prescribing was met with considerable resistance by the medical profession.

In the UK on the other hand, the nursing and medical profession soon found themselves in a workable relationship. This was chiefly the result of tactics by the Royal College of Nursing. From the very beginning, the RCN took its case and arguments for nurse prescribing to the body it considered to be, at the same time, its potential ally and opponent; the British Medical Association.

After much initial opposition and a good deal of negotiating, a tacit agreement between the nursing and medical professions was reached, and they jointly mapped the road towards the introduction of nurse prescribing.

The UK is in many respects an exception to the rule. English registered nurse prescribers have much broader prescribing rights than nurses anywhere else in the world. But even though the UK is clearly an exemption, nurse prescribing practices in other Western European and Anglo-Saxon countries cannot be lumped together either.

[TABLE 1]

As I said, even though "nurse prescribing" suffices as an umbrella descriptor term, the actual practice it refers to varies considerably, both between and within countries. Nurse prescribing can either involve independent prescribing or prescribing under the strict supervision of a physician (usually called "supplementary prescribing"). Furthermore, it can involve either a limited or a broad range of medicines, a limited or broad range of medical conditions and a limited or broad range of patient groups, to name but a few.

Moreover, prescribing rights in most countries are limited to certain categories of nurses, most often nurse practitioners, and nurses' scope of practice varies considerably depending on whether protocols and/or formularies are in place and if so, how restrictive these are. It is beyond the scope of this article to go into great detail about nurses' prescriptive authority across countries, but I do want to offer some striking examples.

The country that stands out is the UK. British independent and supplementary nurse prescribers are allowed to prescribe from the entire British National Formulary for any medical condition or patient group within their clinical competence, whereas in most other countries restrictions apply.

In Sweden for example, only district nurses and nurses working in elderly care are allowed to prescribe for 60 medical conditions. In the Netherlands, on the other hand, diabetes, lung and oncology nurses will in the near future only be allowed to prescribe a limited number of medicines related to their area of expertise.

The educational and organizational requirements for nurse prescribing also vary between countries, although differences in these areas are smaller.

Again, the UK stands on its own here. In the UK as well as in Ireland, prescribing courses are offered on a stand-alone basis at bachelor degree level and require only a minimum of three years of clinical experience.

In most other countries, prescribing training is provided at master's level and is frequently incorporated into regular nursing curricula, most often the Master of Advanced Nursing Practice. However, criteria to enter prescribing courses as well as the content of the training appear to be fairly similar across countries.

Apart from the differences in legal, educational and organisational conditions, most countries have one important thing in common. Namely that despite the introduction of nurse prescribing, the jurisdiction or control over prescribing remains predominantly with the medical profession.

This was shown by two extensive international studies that we performed over the past two years, incorporating all Western-European and Anglo- Saxon countries that had introduced nurse prescribing or were in the process of doing so. This is an important conclusion, since nurse prescribing is often introduced to advance nursing roles and is seen by many professional nursing associations as a vehicle to increase nurses' professional status.

Nurse prescribing is still in the process of development, and prescriptive authority is continually being adjusted and sometimes extended. Moreover, the more countries that introduce nurse prescribing, the greater the opportunities to learn from each other will become.

With even more nurse prescribing initiatives expected, it is exciting to see how nurse prescribing will develop in the future. Will the existing international differences remain intact or will the huge "nurse prescribing" umbrella gradually shrink to smaller proportions?

TABLE

Global growth: An international timeline of nurse prescribing

Year of introduction	Country
1960s	USA
Early 1990s	Canada
1994	Sweden
1998	UK
2000	Australia
2001	New Zealand
2007	Ireland
2011	Finland
2012 Expected	Netherlands Spain

NB: Because nurse prescribing often falls under state, provincial or territorial jurisdictions in some countries, the year of introduction does not always apply nationwide.