

RNs seek broader prescribing powers in quest for more autonomy

In a bid to increase autonomy for specially educated RNs, nursing associations in Ontario and Alberta are seeking extended prescriptive authority and the Canadian Nurses Association is asking Health Canada to allow these nurses to prescribe many controlled medications. "Prescriptive authority is a logical part of the [extended practice] role," says Sandra MacDonald-Rencz, the CNA's director of policy and research. "These nurses are educated to function in autonomous positions."

Specially educated nurses in parts of 3 provinces are already authorized to prescribe certain drugs; meanwhile, RNs in remote parts of Canada have been prescribing for years but the practice is situational and standards are inconsistent.

The CNA says new regulations would provide that consistency. They would also allow physicians to know what their nursing colleagues are qualified to do and reduce the need to delegate prescriptive authority, which can carry legal risks.

In Alberta, Newfoundland and Ontario, extended-practice nurses have already received authority from their provincial regulatory body to diagnose, manage illness and prescribe in certain circumstances. Ontario's 400 RN(EC)s [extended class] have been performing these duties since February 1998 and are allowed to prescribe some antibiotics, nonsteroidal anti-inflammatory drugs (NSAIDs), contraceptives and other drugs. These nurses have a degree in nursing, a minimum of 2 years' primary care experience and have completed a 13-month postgraduate program.



On the east coast, Newfoundland's 24 nurse practitioners prescribe a range of medications, including anti-infective drugs, hormones and NSAIDs. They also have prescriptive authority during emergency situations such as acute asthma attacks. These nurses are responsible for knowing when a case is beyond their scope; they then consult a physician.

"Nurses don't want to be doctors," says Debbie Phillipchuk, a practice consultant with the Alberta Association of Registered Nurses (AARN). "Nurses want to prescribe within the roles they have." Alberta's extended class of RNs, who work exclusively in Northern and remote settings, prescribe many drugs. Now AARN is trying to give limited prescriptive powers to RN(EC)s in more populous areas, through the province's new Health Professions Act.

The association wants nurses to be able to prescribe certain drugs in certain practice situations. For example, an RN(EC) in a long-term-care setting might adjust palliative care medications or treat urinary tract infections or other common disorders within that population. These nurses would have to advise a physician of their actions. "RNs take very seriously the responsibility of prescribing and they feel there must be real restrictions on when and why," says Phillipchuk.

Alberta recently put another model to the test in Elnora, a town of 250 people 100 km northeast of Calgary, which has no doctor. This past year a nurse practitioner worked independently in the town in an extended role

that included making some diagnoses and writing some prescriptions. She consulted with 2 physicians in neighbouring Trochu. The project was approved by both the Alberta Medical Association (AMA) and the provincial pharmacists' association.

"Sure physicians will feel threatened," says AMA CEO Dr. Bob Burns, "but we aren't going to be paternalistic about this or view it in terms of turf." The AMA wants to ensure that any professional group that has prescribing authority has demonstrated "robust" knowledge, has training standards and is self-regulating. Burns says the AMA's deepest concern surrounds the complexity and interactivity of pharmaceuticals. "The training must be quite extensive," he says.

The CNA concurs. Its brief to Health Canada's Office of Controlled Substances details the knowledge RNs would need to prescribe: training in pharmacology, pharmacotherapeutics, writing prescriptions, teaching and more. The brief also maintains that nurses have adequate systems in place to support expanded prescriptive authority and specifies which controlled drugs RNs should be authorized to prescribe.

The Office of Controlled Substances, which monitors drugs such as narcotics and barbiturates, is preparing regulations for its new Controlled Drugs and Substances Act (formerly the Narcotics Control Act). Currently, the office is looking at which professionals, in addition to physicians, dentists and veterinarians, should be authorized to prescribe these drugs.

But even if the federal government decides to give the nurses the right to prescribe controlled drugs, it's still up to each province and individual nursing regulatory body to decide whether to give the RNs more prescriptive authority.

The CNA brief argues that expanded authority would improve access to primary health care, allow for more flexible service delivery, legitimize current practices and help control spending.

Similar moves are already under way outside Canada. American nurse

practitioners have limited authority to prescribe, and nurses in 11 states can prescribe controlled drugs. They report that their involvement reduces physicians' workload and saves them time. Meanwhile, England is imple-

menting prescribing rights for all district nurses, health visitors and practice nurses by mid-2001. Other countries, including Iceland and New Zealand, are in the process of developing legislation.

"The health care system has to change," says MacDonald-Rencz. "The bottom line is that health care workers must work in a way that is responsive and in the best interest of the public."

— *Barbara Sibbald, CMAJ*

CMA survey shows fee-for-service not dead yet

The declining popularity of fee-for-service (FFS) payments in Canada may have levelled off, the CMA's 2000 Physician Resource Questionnaire (PRQ) indicates. In 2000, 62% of respondents reported receiving 90% or more of their professional earnings from fee-for-service payments, the same level as in 1999. This follows steady declines in the popularity of FFS payments since 1990, when the level stood at 68%.

There has also been a change in terms of *preferred* modes of remuneration. Between 1995 and 1999 there was a large decrease in the proportion of physicians who preferred fee-for-service remuneration (50% compared with 33%), but that proportion increased this year, to 37%. Only 49% of physicians are paid via the method they would prefer. "I would actually prefer salary," one physician noted, "but no plan exists that adequately compensates for the stress and volume that we are expected to cope with."

Almost one-third (32%) of physicians reported a decrease in net income in the 2000 PRQ, while only 18% reported an increase; for 81% of those whose income decreased in the past year, workload stayed about the same or increased.

Thirty-eight percent of surgical specialists reported decreased net income, compared with 27% of medical specialists and 34% of GP/FPs. Urban physicians were more likely to have faced a decrease than their rural counterparts (33% v. 25%).

More than half (55%) of respondents saw their workload increase in the past year. Among those who reported a heavier workload, only 24% saw an accompanying increase in net income, while 31% witnessed a decrease. Overhead expenses increased for 61% of respondents.

The number of hours worked, excluding call, remained virtually unchanged in the last year: 53 hours per week, compared with 54 hours in 1999. Female physicians continue to work fewer hours than males (48 hours per week v. 56 hours). Surgeons work more hours (58) than both medical specialists (54 hours) and GP/FPs (51 hours).

Seventy-six percent of respondents take or share call, with surgeons (88%) most likely to take call, compared with medical specialists (77%) and GP/FPs (71%). Only 12% of doctors who provide on-call services away from the hospital are compensated for being available.

Rural physicians appear to be better off in this regard than their urban colleagues: 37% are paid for carrying a phone or pager, compared with 10% of urban physicians; 60% are paid for being on site, compared with only 31% of urban physicians.

This year, the PRQ queried physicians about factors that impede attempts to provide health promotion counselling. Lack of time was cited as always or often a barrier by 48% of physicians, with 59% of GP/FPs saying that they always or often face time shortages, compared with 32% of medical specialists and 42% of surgical specialists. Thirty-four percent of respondents noted that a lack of services and support in the community is always or often a barrier to counselling; this is always or often a problem for 43% of rural physicians, compared with 33% of urban doctors.

The 2000 PRQ was mailed to a random sample of 8000 Canadian physicians, and the response rate was 36.3%. Results are considered accurate to within $\pm 1.9\%$, 19 times out of 20. More than 20 tables from the 2000 PRQ results are available online at www.cma.ca/cmaj/vol-163/issue-5/prq. — *Shelley Martin, CMA*

"My office has become my prison"

The following random verbatim comments were made by respondents to the 2000 PRQ.

- "I have given up trying to find locums, and I yearn to escape the office that has become my prison."
- "Thank goodness for the feminization of medicine, which is waking up a lot of us old workaholics."
- "After Mar. 17, I will never do call again. I have been on the end of a beeper for a quarter to a third of my life."
- "All physicians should be required to take call. I am appalled that some physicians close at 4 pm and leave a message directing patients to the ER."
- "The demands of providing hospital care to orphaned patients are growing and are going to keep growing as we lose physicians and others give up their hospital privileges."
- "There are no young doctors out there looking to set up shop. Where are they?"