

ADVANCED PRACTICE REGISTERED NURSE (APRN) PRESCRIPTIVE AUTHORITY: “TAKING RESPONSIBILITY FOR OUR PRACTICE”

A brief history: Registered nurses (R.N.) and physician’s assistants (P.A.) were granted ‘delegated’ prescriptive authority in 1980 in Opinion No. 5630 issued by Attorney General Frank Kelley. He concludes that *“A physician’s assistant may prescribe drugs as a ‘delegated’ act of a supervising physician...”*. *“Defines... ‘delegation’... as an authorization granted by a licensee to a licensed or unlicensed individual to perform selected acts, tasks, or functions which fall within the scope of practice of the delegator and are not within the scope of practice of the delegatee and which, in the absence of the authorization, would constitute illegal practice of a licensed profession.”* He also states that the same authorization could also be given to an R.N: *“the legislature has permitted a physician to delegate the prescribing of a drug to a licensed professional nurse”*. As the Michigan Public Health Code does not differentiate between R.N.s and APRNs, the opinion then applies to both in spite of differences in levels of education and scope of practice. Today’s APRNs are educated at the graduate and doctorate level and have extensive education in pharmacology. Independent prescriptive authority is recognized on the national level as an essential part of the APRN role.

Arguments to maintain ‘delegated’ prescriptive authority: Organized medicine generally opposes independent prescriptive authority for all APRNs – insisting that they remain under the ‘supervision and delegation’ of medicine. They consistently express concern that APRNs do not receive adequate education and training in pharmacology, when in reality APRN students (building on their BSN) and medical students have similar pharmacology credit hour requirements. Forty years of substantial research finds no evidence that APRNs have more incidences of medication errors or prescribe more controlled substances than do physicians.

Improving patient safety, access, and quality of care: These goals are shared by physicians and APRNs alike. However, safety, access and quality are actually compromised when patients are confused because the name on the prescription bottle does not match the name of their provider; when one assumes that the ‘delegating’ physician has knowledge of the prescription and patient status; or when patients are denied access because the ‘delegating’ physician is no longer available or willing to serve as the physician of record.

Cost and efficiency: Cost of health care is impeded when there is a lack of transparency. Patient pharmaceutical regimens are often delayed, prescriptions sometimes not filled resulting potential negative outcomes due to the complexities of prescriptive authority in Michigan. Further, the status quo has created a system fraught with potential vicarious liability, reimbursement liability issues, and physician time taken away from patients to document oversight of APRNs. Transparency and better cost efficiency could be obtained through full prescriptive authority for APRNs.

Responsibility: One of the hallmarks of a profession is the acceptance of responsibilities and consequences for ALL services provided. Advanced practice registered nurses are accountable to the public, to the patient and to the nursing profession for their scope of practice – including prescriptive authority. It is time the Michigan Public Health Code reflects the changes needed to better meet the health care needs of Michigan’s residents.