

Ready or not, here we come: framing nutrition prescribing rights and responsibilities

South Africa is critically short of the necessary health professional workforce needed for comprehensive and quality delivery of services to all citizens. In 2025, the country was modelled to have reached an undersupply of close to 100 000 healthcare personnel in various disciplines, among which number thousands of doctors including intensivists, anaesthetists, and specialist physicians,¹⁻³ who may typically be involved in prescribing parenteral nutrition. This severe skills shortfall is a threat to the achievement of national strategic health goals and outcomes, and impacts negatively on access to timely and appropriate clinical interventions for patients. Given the constrained healthcare environment, the globally supported concept of task-shifting/task-sharing advocated and promoted by the World Health Organization⁴ (WHO) is a valuable tool for enhancing pressurised clinical services. Task-shifting is the rational and strategic redistribution of health intervention tasks among workforce teams and multidisciplinary professional groupings.^{4,5} One application of task-shifting is the authorisation of non-medical prescribing.

Traditionally the authorisation to prescribe scheduled medicines has been the sole domain of the medical doctor. However, professional prescribing rights for scheduled medications have been afforded to various additional categories of healthcare professionals in more than 100 countries, making it a feature of current international healthcare.⁶⁻⁸ Non-medical prescribing expands the legal capabilities of suitably trained non-medical health personnel to prescribe medications within their scope of practice and expertise, while reducing dependence on medical doctors for prescriptions. It is a foresighted reform that introduces many benefits, which include removing administrative obstacles to care, improving patient access and clinical support, reducing treatment delays, improving resource use and efficiency, reducing inappropriate prescribing, improving use of diverse expertise, and enhancing the integrity of the multidisciplinary team.⁶ While this is true, relatively few countries – notably the United Kingdom (UK), New Zealand, and Australia – have certified registered dietitians (RDs) as licenced prescribers of medicines. South Africa is now in the midst of this process.⁹

This issue of SAJCN features a research article¹⁰ that reports on the knowledge, attitudes, and practices of South African RDs regarding prescribing of parenteral nutrition (PN) and intravenous (IV) nutrients. The article by Kroukam et al.¹⁰ is framed around questions of readiness and responsibility in foreshadowing pending prescribing rights for dietitians. Perhaps not surprisingly, the study reports that most of those participating in the survey thought that RDs should have the legal authority to prescribe parenteral nutrition (77%) and intravenous nutrients (66%), and an even higher proportion (> 90%) showed a keen interest in receiving advanced training on these topics. Respondents also indicated that having prescribing rights would bolster and protect their professional profile and scope.

This goes towards answering the question of readiness, because professional readiness incorporates the concepts of cognitive openness to changing work environment dynamics and

demands, expectations to take on new competencies, and readiness for learning and development.¹¹ Non-medical prescribers displaying higher readiness for learning and development show concomitant greater readiness to take on new competencies in prescribing medicines, which is associated with new professional opportunities, innovations, and expectations.¹¹ It is also relevant that the scope of practice of the RD in South Africa was updated in 2024,¹² incorporating greater professional capacitation of dietitians as independent practitioners. These are important considerations in conceptualising readiness of dietitians for prescribing rights in South Africa, as previously published data showed that low job satisfaction was linked to lack of opportunities to develop professional expertise and low professional image¹³ – issues that task-shifting such as non-medical prescribing has also been shown to address successfully.¹⁴

The study by Kroukam's et al.¹⁰ also critically assessed the knowledge of PN and IV nutrients in various proficiency domains and reported it to be generally poor. In their discussion, the authors therefore question prescribing readiness based on competency indicators and suggest that universities should investigate improvements in undergraduate curriculum content, and ensure better training and competency of graduating dietitians. This commentary concerns responsibility, specifically the responsibility of university training institutions to create competent graduate dietitians. Yet, given that the scope of practice of RDs has only recently been upgraded, and the certification process for prescribing dietitians is not yet in place, is it the current responsibility of universities to train entry-level RDs to the level of PN prescriber? This conflates the ideas of foundational workforce-ready competency with professional tuning. The first is the expectation that, upon graduation, basic skills are in place to fulfil general professional tasks in the practice arena. This is the responsibility of training institutions. The second is the progressive evolution of mastery in a particular field of practice that comes with clinical experience, continuous professional development, and growth in expertise. This is the responsibility of the dietitian. Kroukam et al.¹⁰ showed evidence of this phenomenon in their study: dietitians with more than 7 years' experience had better knowledge surrounding scheduled nutrients, had more confidence in multidisciplinary team discussions of PN, expressed their own capabilities with conviction, and recognised that additional responsibilities would be attached to prescribing rights.

This study is also not the first to question South African RD's knowledge or competencies,¹⁵⁻¹⁷ but findings questioning competencies were typically shown for entry-level practitioners or for niche practice areas. Similarly, on more discrete analysis of the data of Kroukam et al.,¹⁰ the knowledge deficiencies were statistically worse among early career RDs or new graduates and those who had received no additional post-basic training. Knowledge test performance was also low in knowledge domains related to pharmaceutical aspects of PN and administration of other IV nutrients. In fact, the elements of pharmacology and technical pharmaceutical aspects are also the areas where nurse prescribers have been perceived to be

inadequately equipped, and where the quality of prescribing education has been doubted.¹⁸ Therefore, this is not novel to dietitians only. It is the responsibility of universities to impart this advanced and enhanced level of knowledge in the form of post-basic training that allows dietitians to practise at the top of the professional licence and scope. Competency can be taught. In this regard the study by Kroukam et al.¹⁰ provides a very useful window onto the gaps that universities would have to fill in postgraduate prescribing rights training programmes and reveals limitations in the knowledge of RDs that would have to be addressed in certifying PN prescribers.

There is certainly evidence that properly trained and authorised dietitian prescribers can prescribe and deprescribe a range of scheduled nutrients and medications (including parenteral nutrition, intravenous fluids and electrolytes, oral rehydration solutions, and micronutrients, as well as codeine phosphate, loperamide, lansoprazole, and vitamins) safely without adverse events.^{19,20} It has also been demonstrated that RD prescribing rights reduced inappropriate PN use and saved costs, while PN prescribing errors were found to be 1.5 times higher in non-dietitian prescribers compared with dietitian prescribers.^{21,22} Therefore, the positive clinical influence of dietitians in such advanced PN practice roles should be embraced and fostered. This could also include areas beyond critical care nutrition practice, for example intra-dialytic PN in maintenance dialysis patients, home parenteral nutrition, and complex refeeding such as in eating disorders.

A balanced consideration of possible reservations around PN prescribing by RDs should not scupper the professional advancement and improved clinical nutrition patient care potential of this practice reform. As evidence of progress in this matter, having authorised supplementary dietitian prescribers to operate in the UK since 2016, the British Dietetic Association is now arguing for full independent prescribing rights for dietitians to empower them to operate to the highest level of sound, evidence-based clinical practice.

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