New opportunities in practice nursing

Roles matter more than titles

Important changes in the education of practice nurses are imminent. Hitherto such nurses have come from widely varying backgrounds and have often had little prior training in practice nursing despite undertaking an increasing range of tasks. New courses are about to define areas of professional responsibility and accountability rather than focusing on isolated areas of competence.¹ Nurses will be able to attain a qualification equivalent to a first degree to work as a district nurse, health visitor, or general practice nurse from a common core curriculum. Recognition of advanced practice in nursing will be obtained by showing continuous development in clinical, managerial, or academic skills. This concept of advanced practice will include areas of work currently performed by nurses working as nurse practitioners.^{2,3}

What will this new breed of nurses do? Some of the opportunities can be found in the work of nurse practitioners. Nurse practitioners may be the first contact for patients with acute problems or may provide a substantial part of continuing care in chronic illness. They diagnose new problems and make decisions on management. A recent British study suggested that they are popular with patients and work particularly well with singlehanded practitioners.⁴ They may be particularly effective with populations poorly served by general practitioners—for example, homeless people. Whether they are a cost effective alternative to general practitioners is unknown, partly because they spend more time with patients. Most published evaluations of nurse practitioners have been descriptive, with few accounts of outcome in the patients⁴⁻⁷; the only controlled trials have been carried out in the United States.^{8,9}

Do practice nurses differ from nurse practitioners? A recent British survey found that 84% of practice nurses advised on acute problems, and that a similar proportion participated in clinics for chronic diseases.¹⁰ Most used auri-scopes and peak flow meters, and a few also used stethoscopes and ophthalmoscopes. Many practice nurses are clearly already working as “advanced practitioners,” with or without formal qualifications.

How can we make sense of these new roles? The relationship between nurses and general practitioners is the key to this. General practitioners employ most practice nurses at present. The transfer of purchasing power to general practitioners¹¹ means that they will increasingly exert control over the work of most nurses based in primary care and possibly over their educational requirements as well. Nevertheless, recognition of the key role of practice nurses means that doctors and nurses need to decide together on their mutual roles.

Are nurses merely an alternative to general practitioners—or is there a range of roles for which they are not only better prepared but also cheaper? Nurses are going to be increasingly well qualified, and they will expect to have a substantial voice as practices choose how to develop their services.

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Royal colleges' advice on alcohol consumption

Maintaining existing limits seems justified on current evidence

The complex relation between alcohol consumption and various diseases has been explored for centuries. Britain's Royal Colleges of Physicians, Psychiatrists, and General Practitioners recently reviewed the totality of evidence in order to readdress recommendations for “sensible limits” for the general public.^{1,2}

We concur with the authors that the issue is complicated by several factors. Firstly, except for violent deaths attributable to acute intoxication, the risks and benefits of alcohol consumption are likely to accrue over years or even decades. Secondly, quantitative assessment of drinking is generally based on self reporting, which may lead to some misclassification. Thirdly, changes in drinking habits over time are rarely updated in prospective studies. Fourthly, consumption

of alcoholic beverages tends to be embedded in cultural practices, which are in turn associated with several lifestyle factors. Fifthly, ethanol is a constituent of several different types of beverage, whose other constituents may also affect the risks of disease. Finally, the precise mechanisms by which alcohol affects coronary heart disease are still far from understood.

Despite these inherent methodological difficulties in assessing the risks and benefits of alcohol, epidemiological data on coronary heart disease and even total mortality are remarkably consistent.^{3,4} Both the amount and frequency of alcohol consumption are important factors in the size and direction of the effect. With respect to total mortality there seems to be a J shaped curve, with a significant increased