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

hazard among heavy drinkers. At higher levels of consumption there is a clear and consistent increase in all cause mortality, which is likely to comprise increased risks of liver disease, certain cancers, and some types of cardiovascular disease, such as cardiomyopathy and haemorrhagic stroke.

The balance of risks and benefits seems to shift dramatically at more modest drinking levels such that drinkers of small to moderate amounts of alcohol tend to have lower total mortality than non-drinkers. The J shape may well be the result of the weighted average of cause specific effects. The reduction in mortality among drinkers of small to moderate amounts of alcohol is likely to be due to a fall in deaths from coronary heart disease without substantial increases in other causes of death. The fall in the risk of coronary heart disease seems to be mediated largely by alcohol induced increases in high density lipoprotein cholesterol concentrations,⁵ though other antiatherogenic and antithrombotic mechanisms certainly remain plausible.

Comparisons of types of beverages suggest that alcohol itself is the major factor responsible for the apparent protective effect. While most data are derived from studies of men, the benefits seem to extend to women; the ratio of risk to benefit may, however, be different given, the lower absolute risks of heart disease in women than men and the far higher risks of breast cancer, which alcohol may increase.

While the benefits of small amounts of alcohol on the risk of coronary heart disease and total mortality seem to be real, any individual or public health recommendations must consider the complexity of alcohol's metabolic, physiological, and psychological effects. The differences between daily intakes of small to moderate and larger quantities may be the difference between preventing and causing premature deaths.

The authors of this comprehensive review recommend no change from the prior recommendations of 21 units (168 g of ethanol) a week for men and 14 units (112 g ethanol) a week for women. A recent meta-analysis raises the possibility of an L shaped threshold effect for non-fatal coronary heart disease, with reduced risks beginning at three American drinks (about 5 units) a week and no additional benefit for more than one drink (about 1.5 units) a day.⁶ If maximal benefit with regards to coronary heart disease begins at one drink (about 1.5 units) a day and does not increase substantially with increasing consumption no firm basis exists for increasing the limits of "sensible" drinking.

The recommendations emphasise weekly limits for alcohol consumption because most studies tend to consider only average daily intake and disregard the specifics about how or when the beverage was consumed. Southern Europeans may tend to drink wine with meals while northern Europeans may tend to drink distilled spirits at times other than mealtimes. Furthermore, the risks and benefits of alcohol consumption may be different for someone who consumes seven beers on a weekend night compared with one who consumes a glass of wine with dinner every day—despite an almost identical average weekly alcohol consumption. Setting a weekly limit permits those who binge drink at weekends to regard their drinking habits as "sensible." For this reason, it may be more prudent to emphasise daily limits of 3 units a day for men and 2 units a day for women.

Finally, we also agree that any recommendations should be made individually by the person providing primary health care. A discussion of alcohol intake should be a part of routine preventive counselling. Additional considerations should include coronary risk factors (particularly hypertension, for which alcohol increases risk), liver disease, tendency to excess, family history of alcoholism, and breast cancer. Alcohol consumption can be viewed neither as a target for primary prevention nor necessarily as an unhealthy behaviour. On the basis of the totality of evidence the current recommendations by the royal colleges seem prudent and justified. Increasing these limits would probably have no added net health benefit and might even have an adverse effect.

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New directions in information for patients

More attention should be given to finding out what works

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Providing information for patients is currently a growth industry. Traditionally, health professionals have created their own fact sheets for local use, with consumer organisations, self help groups, and commercial publishers plugging the gaps. But now commercial companies are competing to relieve providers of services of their responsibilities by selling computer disks containing information about hundreds of conditions and procedures. This format allows purchasers to customise this information for their patients.¹

Commercially produced videos on diseases and treatments that permit viewers to experience passively what they may encounter are also becoming available. Interactive video disks take this medium one stage further by inviting patients themselves to exert some control over the flow of information.

Whether patients will be willing to make decisions about treatment on the basis of interaction with a machine rather than a doctor is not yet known. Given the pace of development in information technology, virtual reality systems may become available within the next decade, permitting patients to "experience" aspects of their treatment and potential outcomes in advance.

Patients are placing health professionals under greater pressure to provide information,² and both purchasers and providers of health care could benefit from investing in these new media. These media could be seen as an attractive and cheaper alternative to employing more counsellors. Surgeons and general practitioners may opt to provide such information at the expense of more structured and lengthy consultations.