should inform clinical judgment; they cannot dictate practice. The individual clinician should be practising in a way which takes into account properly developed guidelines, just as he or she would take into account the opinions of respected colleagues. However, guidelines do not remove the need for judgement.

Guidelines are inevitably abbreviations and abstractions secondarily derived from actual practice: explicit but crude summaries of implicit and subtle skills.[14] Where complex human activities are concerned, explicit is equivalent to incomplete. What is left out is that tacit knowledge which makes a difference to practice, but which cannot be written down or captured in prescriptive form because it is inaccessible to reflection.[15] Tacit knowledge is what makes the difference between inexperience and experience, between learning by apprenticeship and learning from a book.[16] At best guidelines can merely allow space for the exercise of judgement. As James McCormick has said, judgement should be based upon knowledge, tempered by scepticism, and enriched by experience of medicine and familiarity with the patient.[17]

As the costs of health care rise, so will the demand to regulate medical decisions, and a proliferation of guidelines seems inevitable (NHS Management Executive. Improving clinical effectiveness, 1993).[18,19] A battle between clinicians and various non-clinicians (such as public health doctors, managers, health economists, medical sociologists, insurance companies, pressure groups and politicians) for control of clinical guidelines may be anticipated, as each group has rather different objectives. In such circumstances, the limitations of guidelines may be forgotten. Guidelines can be generated and will function, only against a background of internalized (tacit) professional values and standards developed through the wise exercise of clinical autonomy.[20] Good guidelines depend upon pre-existing good practice; guidelines are not the cause of good practice.

BRUCE G CHARLTON

Lecturer, Department of Epidemiology and Public Health, University of Newcastle upon Tyne

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Address for correspondence

Dr B G Charlton, Department of Epidemiology and Public Health, School of Health Care Sciences, University of Newcastle upon Tyne, Newcastle upon Tyne NE2 4HH.

Nurse practitioners in primary care: here to stay?

OVER the past decade there has been a steady expansion in the number of nurses practising as nurse practitioners. Inconsistencies and ambiguities in the literature relating to the nurse practitioner have led to a debate regarding the definition of the term.[1,2] In essence, it is a form of advanced nursing practice legitimized by a specific training programme. This formal training for those who aspire to the nurse practitioner role has been pioneered in the United Kingdom by the Royal College of Nursing (Institute of Advanced Nurse Education). This is a course at diploma (and soon degree) level validated by the English National Board for Nursing, Midwifery and Health Visiting and accredited by the University of Manchester.

The evolution of nursing practice has led to the inclusion of skills not previously encompassed within a nursing role. This role expansion was in the past intended to complement and supplement the physician's care.[3] The nurse practitioner is a provider of health care whose responsibilities cross the traditional boundaries between nursing and medicine.[4]

Nurse practitioners have developed in the UK in two key areas; as members of primary health care teams, and as specialists in the care of specific groups such as homeless people, mentally ill people and children.[1] It is perhaps no coincidence that nurse practitioners have emerged in areas where there has been a paucity of medical services, and in many cases with the cooperation of a member of the medical profession.

The introduction of target payments and performance-related pay into the primary health care arena has led to general practitioners reviewing their methods of working in order to accommodate new clinical sessions as well as their traditional surgery and home visiting commitments. The changes envisaged under both the new contract for general practitioners and the 1990 National Health Service act have necessitated general practitioners delegating a greater proportion of their workload to other workers. The primary health care team, Stott suggests, will of necessity be expanded to cope with these increasing demands.[5] This is one of the main contexts within which the nurse practitioner is likely to come of age. The rise in the number of practice nurses has facilitated this process and indirectly unlocked the potential for an advanced nursing role.

The emergence of the nurse practitioner has not been accom-

panied by a corresponding level of research activity to evaluate this worker, though a number of studies have shown the feasibility of the nurse practitioner role in the UK and its use as an extra resource rather than a cheap substitute for a medical practitioner in primary care.[6-8] The most comprehensive study by far on the nurse practitioner role has been carried out by the United States of America Congress Office of Technology, finding nurse practitioners to be both cost effective and able to provide care equivalent to that of a physician.[9] A recent study of past and present students on the Royal College of Nursing nurse practitioner diploma course found that the introduction of the nurse practitioner role into primary care settings can be strongly facilitated or inhibited by the medical profession. It also stressed the importance of flexibility in training and role development to enable nurse practitioners to respond to local needs and concluded that further progress will be made through experimentation and careful evaluation (Lenehan C J, unpublished study, 1993).

A South East Thames Regional Health Authority project, evaluating the work of 20 nurse practitioners in a variety of settings in the UK including primary health care teams, accident and emergency departments, community pharmacy and family planning, is due to be published in October 1994. The development of this project is a measure of government and regional health authority commitment to the wider use of advanced nursing skills in primary health care, as advocated in previous discussion documents.[10,11] It has been suggested that a main reason for government support was reduced cost to the service since nurse practitioners 'come cheaper than doctors'.[12] Also, in an analysis of medical manpower into the next century, Maynard and Walker[13] have been critical of the recent report by the Medical Manpower Standing Advisory Committee[14] which envisaged a continuing reduction in the general practitioner: population ratio. They argue that it is inappropriate to protect doctors from the effect of NHS reforms, technological change and substitution possibilities.

It is clear that the flexibility inherent in the nurse practitioner role offers new opportunities to meet existing and future needs, especially in primary health care. It is possible, as one nurse leader in the USA has predicted, that the nurse practitioner will come to be seen as 'the deviant of yesterday, the norm of today and the traditional of tomorrow' (Ford L, unpublished paper, 1993).

Thus, an idea which has been germinating over the last decade has emerged at a time when government policy, management objectives, and professional and individual motivation have converged to produce a favourable climate. Only time will tell if nurse practitioners will live up to the expectations of UK health policy planners.

CHRISTINE LENEHAN
Health visitor, London

ANDREW WATTS
General practitioner, London

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Address for correspondence

Ms C Lenehan, Honor Oak Health Centre, 20 Turnham Road, Brockley, London SE4 2LA.