distinctions between professions and trades. The reality, Downie argues, is that we are all in the business of selling services: the recipient must be protected both by legislation and by a society which teaches moral responsibility. Robert Veatch[4] sees no virtue in the language of covenant, indeed suspects that it encourages a paternalistic attitude. Veatch suggests a 'triple contract', in which the obligations of practitioners to patients, to fellow professionals, and to society as a whole will be clearly spelled out. The vulnerable patient is thus to be protected by a kind of medical bill of rights.

The debate continues, but it should be noted that none of the theorists quoted here supposes that making the patient into a 'consumer' will enhance choice and quality of care. The vulnerability of the recipient of health care is surely incontestable, and it is hard to see how competitiveness between providers can do other than increase it. A possible advantage of market forces is that, because the doctor is encouraged to outline and explain possible courses of treatment, the patient is more involved in his or her own care, and less of a passive recipient of what is given. However, this advantage is likely to be taken up only by the more confident and articulate patient, and possibly the patient whose condition is less urgent. Market forces might therefore serve to put the more vulnerable patient at a still further disadvantage. If patients are to be turned into 'consumers' by legislative fiat (and this appears to be the inevitable outcome of the white paper), a central issue is whether there will be the mechanisms — either political or professional — for ensuring equity of provision of what are not, after all, consumer goods, but some of the basic necessities of life.

Another central issue concerns the widespread acceptance of the patient as consumer. This will encourage public understanding of the transaction between doctor and patient as a trading relationship, with all the implications which this entails, leading to an erosion of the trust which must exist between patient and doctor, if the therapeutic relationship is to achieve its full potential. Thus, although it has been constantly asserted that the white paper[2] pays more respect to the individual autonomy of the patient by widening choice, in actuality its philosophy of consumerism will enhance neither the choice nor the quality of medical care. On the contrary, there is a real danger that, by undermining the whole basis of the doctor–patient relationship, it will lead to a reduction in both quality and choice. One cannot trade in trust and commitment: one can only create structures which either enhance or destroy them.

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The future for practice nurses

In *Promoting better health* in 1987, the government stated that the role of the nurse in the community is fast developing, and better use can be made of their skills and experience.[1]

The roles of practice nurses, community nurses and health visitors have fluid boundaries, the differences reflecting the differing views of their employers, as well as personal and professional preferences. General practitioners employ practice nurses for specific tasks which health authority staff may be unable to undertake. In fact, there is evidence that some nurse managers restrict the range of tasks that community nurses may perform.[2] General practitioners often feel nurse managers do not share their aims and direct employment of the practice nurse by the general practitioner provides the mechanism for rapid decisions about patterns of work, so permitting adaptation to the changing needs of the practice without the need to negotiate change with community nursing managers.

No precise figures are available, but in England there are in excess of 4000 practice nurses. This figure has doubled over five years.[3] There continues to be debate about who should employ the practice nurse. The community nursing review recommended that these nurses should be employed by the district health authority,[4] a view supported by the Royal College of Nursing, and one which reflects the difficulties in accepting that one profession can be employed by another,[5] while acknowledging the flexibility and innovation which is possible when nurses are directly employed by a practice.[6]

General practitioners have rejected this recommendation of the community nursing review because of concern about the possible loss of control over the role of practice nurses. This rejection overshadowed another apparently radical recommendation of the review — the introduction of an independent nurse practitioner into primary care. The concept of the nurse practitioner was initially derived from North America, and the separation of the role from that of the practice nurse is now less distinct. Key tasks that have been described for nurse practitioners include: interviewing patients, diagnosing and treating specific conditions to an agreed medical protocol; referring to the general practitioner patients whose medical condition lies outside agreed protocols; conducting screening programmes; and referring patients for further nursing services. Many practice nurses undertake all of these tasks already.

Stilwell[7] found that patients consult a nurse practitioner appropriately, and that the presenting problems are managed without further referral in one third of consultations. She concluded that nurses could have a much larger and more autonomous part to play in patient care. A comparison of the work of a nurse practitioner with that of a general practitioner has shown that nurse practitioners can be a valuable extra resource for the development of new areas of care, rather than a cheaper substitute for a general practitioner.[8] Evidence exists that an organized programme, including a nurse with specific responsibility for adult prevention, is likely to make an important contribution to the recording of risk factors, and to the follow up of patients with known health risks. Better management of chronic disorders in general practice can be achieved with the support and coordination of a nurse.[9] Clear evidence exists for the development of the role of the nurse in primary care, especially in the areas of preventive and anticipatory care.[1,4,10-12]

Aside from the present fragmentary situation for employing nurses in the community, what are the pressures for change in practice nursing?

The imposition of the controversial new contract this month[13] will increase the responsibilities of general practitioners for screening, anticipatory care and health promotion. Much of the new workload generated by these responsibilities is within the capabilities of practice nurses. If general practitioners are to cope with an increased workload, they will have to delegate, and are likely to turn to their practice nurses. The stage is therefore set for an expansion in the numbers of practice nurses, and also an extension of their role. However, there are many factors which may impede these developments. Demographic changes will bring about a shortage of nurses within the NHS, resulting in difficulties for general practitioners in recruiting qualified staff.[14] Cash limits on salary reimbursement in the new contract may stifle innovation and progress. The current arrangements for training practice nurses are inadequate and there is an urgent need for continuing education which is responsive to the evolving needs of general practice. As a result of the omissions in the white paper,[15] rivalry and conflict may occur with health authority staff, as practice nurses extend their role. Agreement on the sharing of services between general practitioners and community nurse managers may prove difficult, when services provided by the health authority produce payment for the general practitioner. For the minority of general practitioners holding a budget, purchase of nursing services will be an option, but the position for the majority not holding a budget is unclear.

The role of the practice nurse therefore looks set to grow in a poorly planned, uncoordinated way. Are general practitioners best suited to be nurse managers? Do they have the knowledge, training and vision to extend the role of the nurse in the community? Are the professional nursing associations ambivalent about practice nurses? Do nurse managers have sufficient experience and understanding of general practice?

The time has come to cut through the organizational structures limiting the rich potential of the nurse in the community. We need a single community nursing team with independent professional standing, sharing aims and objectives with their general practitioner colleagues. These nurses should be employed by the family practitioner committees. Every practice would include a nursing manager heading the nurses caring for its patients.

Our fragmented system will continue until there is a single employing authority for the community. A golden opportunity for change is being squandered.

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Courses and Conferences

QUALITY CARE IN INNER CITY PRACTICES

The subject of care in inner city areas never fails to provoke discussion, and in discussing such an issue it is important that successful initiatives are highlighted. In order to put quality inner city practices on the map, and to focus attention on what has been achieved, the College is holding a one-day conference at the Royal Society of Medicine on Tuesday 24 July, 1990.

For the first time in the College's history, HRH The Prince of Wales will be a guest speaker. There will also be presentations on AIDS, the homeless, ethnic minorities, deprivation, multidisciplinary team work, and the elderly, and also open discussion sessions in which GPs from throughout the UK can share what they have achieved.

The conference is limited to an audience of 180 College members, so early applications are recommended. The fee for the day is £80, and approval in principle under the Postgraduate Education Allowance is being sought. For further details and an application form please contact the Projects Office, RCGP, 14 Princes Gate, Hyde Park, London SW7 1PU. Tel: 01-823 9703 (direct line for courses).