From the Editor

Clin Med JRCPL 2002;**2**:5–6

Consultant nurses

The role of nurses has evolved dramatically in a single professional lifetime. Florence Nightingale's perception of their role still holds – caring for the hospital sick under strict discipline, while at the same time helping doctors to deliver optimal care – but their tasks have extended beyond recognition. Midwives, health visitors and district nurses were the first 'specialist nurses'; more recently, practice nurses and specialist nurses have introduced entirely new concepts into nursing practice. These are attractive posts in which nurses often gain substantial recognition within their specialties, but at the same time they reduce the numbers of experienced nurses available for general nursing arenas: every doctor has witnessed with dismay the recent decline in standards in hospital wards across the UK.

So perhaps we are all confused with regard to nursing roles. What indeed is a nurse? Some of the first specialist nurses, in diabetes, began work as part of an innovation by Dr Joan Walker in Leicester during the 1950s: she realised that nurses could undertake important tasks which would both improve patient care and allow doctors more time in which to perform their own specific tasks. The introduction of specialist nurses became widespread in the 1980s and now most areas of medicine could not deliver high-quality care without them. Yet specialist nurses are often not practising as nurses, and delivery of many aspects of specialist care could be undertaken by the new grade of health care practitioner proposed by the Royal College of Physicians, enabling nurses to remain nurses[1,2,3]. So there is still some confusion about the identity of some professional roles.

The introduction of consultant nurses, midwives and health visitors[4] now further raises the status of nurses with a welcome emphasis on their clinical expertise, since direct patient care should constitute at least 50% of their time. Yet how will they differ from specialist nurses? Philippa Jones describes this innovation in detail in this issue of *Clinical Medicine*[5]. She writes that they will have higher qualifications, that they will be 'groundbreaking' and, by enlightened thinking, advance 'patient-centred models of care'. They will be expected to develop both practice and service, as well as undertaking research and evaluation. It is proposed that they will have formal university links. But there are still many questions to be answered. Are there sufficient numbers of highly qualified academic nurses to fill posts countrywide and, if not, is there a danger of lowering expectations of the nurse consultant role right from the start? If they are to have different duties from specialist nurses, they must have a reduced clinical workload, but how can this be achieved when there is no additional funding to establish these posts? Is there a sufficient infrastructure to support them in terms of office space and secretaries, when those facilities are already inadequate to support the existing medical staff?

Consultant practitioners will be 'acknowledged experts' in their field[4]. However, there are at present no agreed professional standards denoting the acquisition of 'expert' status. It is good to know that this is being examined by the Expert Practitioner Project at the Royal College of Nursing.

Consultant nurses potentially represent an exciting innovation which should enhance patient care. The development is in line with ideas on skillmix[2,3], and with the philosophy of the NHS Plan[6]. Yet if it remains without central funding, the whole purpose of introducing nurse consultants could fail and the change might scarcely be noticed.

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The views expressed here are those of a physician. In an issue later this year, Dr Beverly Malone, recently appointed general secretary of the Royal College of Nursing, will describe her vision of the future of nursing in Britain.

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