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Changes in practice nursing: professionalism, segmentation and sponsorship

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Summary

• In the wake of recent government policies and legislation, practice nursing has undergone major changes. Not least of these has been the rapid growth in the number of practice nurses.

• In addition, their work role has grown greatly over recent years.

• This has given rise to the question of whether their professional development now justifies their status as autonomous nurse practitioners.

• This and related issues are explored in the empirical part of this paper, which focuses on the changes in the work and responsibilities of practice nurses in two industrial towns in the English Midlands.

Keywords: policy, practice nursing, professionalism, roles.

Introduction

Primary care is yet another part of the National Health Service (NHS) that has undergone major restructuring following the NHS & Community Care Act (1990), especially the internal market reforms and the new general practitioners (GPs) contract (April, 1990) (Bryden, 1992; Starkey, 1992) as well as the general shift to health promotion and prevention (*The Health of the Nation*, 1991). These general developments have signalled a radical re-organization of general practice and an expanding role for the practice nurse.

There has been 'at least one general medical practice in England [that] has employed a nurse continually since 1911' (Bowling, 1981). In 1988 there were around 5000 practice nurses employed in England and Wales, which represented a growth rate of 120% over the previous decade (Greenfield, 1992). Five years later the figure had trebled to 15 183 (9500 whole time equivalents) (Atkin *et al.*, 1993, p. 61). This phenomenal growth in one segment of the nursing profession reflects the changing character of primary care within the community. It also raises questions about the division of labour between doctor and nurse and whether the occupational boundaries between the two are being redrawn. In particular, it has raised the issue of whether the practice nurse has the potential to become a nurse practitioner (see, for example, Reedy *et al.*, 1980a,b; Bowles, 1992; Greenfield, 1992). In order to address this and related issues, this paper starts with an examination of the nurse practitioner

model before moving on to an overview of practice nursing within the NHS. We introduce the concept of professional segmentation as a means of differentiating between subgroups within nursing, and then present and discuss two case studies and offer our conclusions. As 98% of practice nurses in England and Wales are women, we shall use the female gender throughout (Atkin *et al.*, 1993).

The nurse practitioner and the practice nurse

The term 'nurse practitioner' originated from the USA in the mid-1960s, when nurses in primary health care began to act as substitutes for medical practitioners in the rural areas (Reedy, 1978; Greenfield, 1992). This extension was, as Reedy (1978) pointed out, not only the result of nurses filling the gap left by the doctors. It also reflected the aspirations of some highly educated and qualified nurses ambitious to work on an 'intellectual parity with the physicians . . . forming a strong base for N[urse]P[ractitioner]s to negotiate or assume co-practitioner status' (Reedy, 1978). Reedy set out the elements of health care on a continuum between two polarities: physicians need help (to carry out their clinical work) and people need care. He related these to different nursing occupational types. Thus, the rationale for the treatment room nurse is that the physician needs help while 'home nurses' and 'assistants and aides' (to use the North American terms) exist because people need care. Neither category offers much opportunity for the emergence of nurse practitioners. There is, however, an intermediate domain of health maintenance and illness prevention, which Reedy identified as presenting the best prospects for the emergence of nurse practitioners.

In the UK 15 years or so later we find that the practice nurse is now a well-established member of the primary health care team, principally employed on health maintenance and illness prevention work. This has not meant, however, that the practice nurse is a nurse practitioner, for the move within nursing to create a sphere of competence and autonomous practice for nurses in primary care is not solely a matter of health maintenance and illness prevention. The practice nurse typically works alone or with one other nurse within a general practice, thus isolating her from her professional colleagues. This has tended to make her particularly vulnerable to direct medical control of her work. Rather than playing a significant role in determining her role, the practice nurse has this largely defined for her by her medical colleagues. This contrasts with the new nursing approach (Salvage, 1992) within which the

> nurse is . . . portrayed as executing a unique function as an independent health care practitioner whose role is complementary to that of the patient rather than subservient to that of the doctor. (Witz, 1994, p. 30)

This role is people centred (rather than task centred), with patients being treated as partners rather than recipients of care (Dickinson, 1982; Salvage, 1992).

Such a sphere of competence for nurses would create the basis for their autonomous practice completely separate from and independent of medicine. The emphasis here is on an *enhanced* nursing role as distinct from an *extended* nursing role, which is the result of doctors delegating additional medically defined tasks. This distinction has been characterized by Pashley and Henry (1990, p. 46) as one between 'handmaidens of cure' vs. 'professionals of care'. All of this raises the question of whether the two approaches are mutually exclusive or whether they coexist within practice nursing in the UK. It is with this question that the rest of this paper is particularly concerned, for, unlike theory, nurses' professional lives are rarely if ever understandable in terms of such neat dichotomies.

The range of work and responsibilities of the practice nurse are very wide and are summarised by one such nurse interviewed in our study in the following terms:

> We start with the babies, we do all the checks for the doctors, all the immunisations . . . and the child screening throughout the years . . . We normally see the young girls, we do the rubella, we give the contraception talk, we do the smears. the well person checks, breast examinations, 'well woman', 'well man' checks, . . . We're responsible for all holiday immunisations and giving 'jabs' . . . We do a lot of the health promotion for the 'banding' . . . getting information and data and then . . . saying this could be improved, that could be improved. We do the chronic disease management with the doctors. We do ECGs, . . . ear syringing, assist in minor ops, [and] we do a lot of obesity management clinics.

Most practice nurses work part-time, on average 23 h a week (Atkin *et al.*, 1993, p. 31), about one-third of practice nurses have had a career break immediately prior to their appointment (p. 22), and their average age is 42 years (p. 17). In many other occupations such a profile would be evidence enough that these women's employment forms part of a secondary labour market (Dex, 1988). However, as trained and qualified members of a profession, the argument is not quite so straightforward. Practice nursing would appear not to have the problems of low wages and insecurity associated with part-time and female employment. Moreover, this nursing occupation would appear to have absorbed the lessons of Davies' (1990) paper for the

English National Board for Nursing, Midwifery and Health Visiting (ENB) on 'The collapse of the conventional career'. Despite being predominantly a part-time career it does include regular access to postregistration education programmes. In terms of employment conditions, responsibilities and qualifications required, practice nursing is not 'second class' work (see Davies, 1990, pp. 10–11). It may, nevertheless, suffer from the patriarchal and demarcationary strategies of the medical profession in order to ensure the practice nurses' inter-occupational control (Witz, 1992). This has had implications for training. Some informed observers have argued that training is not always properly organized and provided within practices. Monica Tettersal, nurse partner and clinical manager, pointed to the dilemma in her 1991 paper when she stated that 'GPs are holding the purse strings to our education, as the system for reimbursement requires them to pay for courses and then claim' (Tettersal, 1991, p. 120). The situation looks even more difficult for practice nurses when one takes into account the attitudes of GPs to practice nurses. In a pilot study (which therefore needs interpreting with caution) on this issue the Georgian Research Society (1991) reported that GPs wanted to retain control of the practice nurse's role and its expansion and would manage their limited training budgets with such a view in mind.

From the evidence so far it is clear that the growth in practice nursing in this country indicates that the emergence of autonomous nurse practitioners largely independent of their medical colleagues can only be on a very limited scale. Moreover, whilst the work of practice nurses has expanded over recent years it would be foolhardy to equate this extension of responsibilities with any enhancement in professional status. Certainly the number and variety of procedures undertaken by practice nurses has grown significantly. For instance,

> [In] . . . a study (Greenfield *et al*, 1987) in the West Midlands . . . [in addition to] traditional nursing tasks . . . 70% carried out cervical smears, almost two thirds were undertaking breast and vaginal examination, and a number of them diagnosed, investigated and treated common ailments. (Greenfield, 1992, p. 75)

The view that the practice nurse is a nurse practitioner, however, must be treated with some scepticism. Practice nurses have been introduced as an important component of the GP-based managerial model of primary care (Williams *et al*., 1993) and as an alternative to the more autonomous community nurse practitioner model advocated by the World Health Organization (Witz, 1994). In the case of the practice nurse, professional autonomy is severely limited by her organizational subordination to the GPs who (as we have already indicated) employ her, identify the range of work she is to undertake and authorize and pay for any training. Moreover, the bulk of work undertaken by practice nurses is in the area of health promotion, which GPs 'found dull and boring' (Williams & Calnan, 1994, p. 387) and consequently have 'sought to delegate much of the . . . work . . . to a relatively new (and low status) member of the primary health care team: namely, the practice nurse'. There is thus seemingly less fertile ground for the enhancement of one's professional role and autonomy than Reedy (1978) and Reedy *et al*. (1980a,b) suggested.

Bowles (1992) has clarified the matter by pointing out particular important differences between nurse practitioner and practice nurse roles. In particular, a nurse practitioner works *with* a GP and not *for* one. Moreover, a nurse practitioner will take a history and make a diagnosis without referring back to the doctor. Bowles' message for her colleagues is 'beware of those who want to make you a nurse practitioner. They may want you to take on part of their job under the guise of "extending your role"', and role extension is a process of work intensification. In addition, the extended nurse project is one instigated by government and implemented by doctors and managers, and not by nurses themselves (Williams *et al*., 1993; Witz, 1994).

Despite this inauspicious background there is some evidence that these nurses are developing their own particular knowledge and educational base. The objective of these nurses is to establish themselves more clearly as a distinctive group within the nursing profession, and is an issue central to our case studies. It is possible, we suggest, that practice nursing is not an homogeneous category, but is segmented into different groups each with their own understanding of their professional role and occupational project. In order to explain thus it will be useful to introduce the concept of 'segmentation'.

Segmentation

The concept of professional segmentation was first introduced by Bucher (Bucher & Stelling, 1961) but, following Melia (1987), it is in Carpenter's work (1977) that we find a particularly useful starting point for our purposes here. Carpenter distinguished three main groups within nursing: 'new managers', 'new professionals' and the 'rank and file'. To these Melia (1987) adds the 'academic professionalisers'. New managers arose as a consequence of the Salmon Report (Ministry of Health and Scottish Home and Health Department, 1966); new professionals emerged in response to the 'new managerialism' and are the clinical nurse specialists broadly modelled on the American notion of the clinical nurse consultant, who had an interest in taking on the more routine work of medicine; the rank and file can be regarded

as mainstream nurses, who carry out doctor-devolved work and enjoy the associated status of working alongside doctors. The academic professionalisers of the nursing colleges sought to achieve autonomy for nursing and their aim was to promote a style of nursing founded on 'nursing theory' rather than medical dominance. These segments still exist, although the relative influence between them has changed, and their parallels can be found within the primary as well as the hospital sector, reflecting similarly differing versions of nursing work and professional aspirations.

Having contrasted the models of enhanced and extended roles in relation to the nurse practitioner and the practice nurse and introduced the concept of segmentation, we can now turn to two case studies to explore these matters further.

The case studies: practice nursing in Weston and Easton

The case studies were part of an exploratory project looking into the changing organization of primary health care in two towns in the Midlands. One we have chosen to call Weston and the other Easton. Both were of more or less similar size and their local economies were based on traditional industries.

RESEARCH METHODS

The study was based on semistructured interviews with 11 practice nurses. These nurses were interviewed at their place of work and using a private and confidential setting, where the interviewee felt comfortable and relaxed. The interview schedule for both areas addressed similar issues. These included the role of the practice nurse, how recent government policies had affected their work, the effect on nurse professionalism, their educational and training needs and the future of practice nursing as they saw it.

In Weston, we studied four general practices and interviewed, in addition to the practice nurse, the other members of the health care team; these included district nurses, health visitors and a community psychiatric nurse, as well as GPs, a number of practice managers and receptionists. Selection was based on attendance at one of the team-building workshops that are taking place nationally (Spratley, 1989; Dent & Burtney, 1995).

At Easton we interviewed seven practice nurses from a possible 12 surgeries. This second group was selected for two reasons: first, to extend our sample, and second, to begin to explore the variations between practices and localities in terms of their organizational practices and cultures. We make no assumption, however, that these two case studies reflect the full complexity of the national picture. Nevertheless, the studies do allow us to explore the practice nurses' own interpretations and experiences of their work and the recent reorganization within general practice.

In Table 1 information as to the size of each practice and the hours and length of service of the practice nurse interviewed is given.

One difference identified is that Easton nurses work more hours compared with Weston nurses (means: Weston, 19 h per week, range 13·5–25; Easton, 27 h per week, range 20–37). We would stress, however, that the samples are too small for any generalizations to be made.

Table 1 Summary of participating practices

	No. of practice nurses	No. of general practitioners	No. of patients	Hours of work	Length of service in nursing
Weston practices					
A	2	3	4000	Part time	2 years
B	1	1	2000	13·5 h	4 years
C	1	4	9500	20 h	over 18 years
D	3	5	9000	22·5 h	5 years
Easton practices					
E	1	1	2200	25 h	5 years
F	2	2	4000	25 h	16 years
G	1	3	6000	32·5 h	6 years
H	2	4 + 2 locums	8300	25 h	2·5 years
I	3	4 full time + 1 part time	8500	20 h	4 years
J	1	4	8000	Full time	5 years
K	2	4·5	10 000	27 h	10 years

NURSING BACKGROUND AND TRAINING

All the nurses we interviewed (i.e. one from each practice) had come into practice nursing via other nursing routes. In Weston one had been a health visitor, another a midwife and only one came from a general nursing background, whereas at Easton virtually all the nurses had come from a hospital background. It was the part-time and/or 'office hours' that attracted them all, for reasons explained by the following nurse:

> I'd done general nursing and it didn't seem to fit in with the family. . . . the [practice nursing] job . . . was fairly local and it was part time hours. So I took that on and it worked very well and it did fit in very well with family life . . . . (Practice D, Weston)

Given the emphasis on health promotion not found in other areas of nursing, however, all practice nurses required some form of training. Most of the training was based on short courses for specific techniques and practices, as the following shows:

> I've done the 'hypertension' courses, the 'asthma' course, I've done a 'diabetes' course, the 'helping people change' course, . . . the 'psychology of change' [and] a 'No Smoking' course. So I've done all the courses run by the FHSA and the hospital . . . They [the courses] vary from one day to . . . . one . . . month. (Practice H, Weston)

Recently an ENB diploma course has been introduced. Three nurses had undertaken this day release course. Two of these, as it happens, came from single-handed practices. One commented favourably on the ENB course:

> [L]ast year I did the practice nurse course. The six months thing at college . . . that was good. (Practice B, Weston)

The other was less impressed:

> If nothing else you met other practice nurses so you could have a good old moan and discuss things that were wrong and how to do things. I don't think I learnt anything. (Practice E, Easton)

More generally, the approach to training was in terms of the 'need to know':

> I didn't get much in the way of training straight off . . . because I was only doing . . . 12 hours then. . . . [I]t was all . . . , more or less, just the chronic diseases that I covered. . . . monitoring hypertension, diabetes and asthma and there wasn't really much . . . in the way of health promotion . . . . And then . . . bit by bit we started thinking about the menopause and then heart disease prevention and [we've] . . . added on quite gently and in the process I've done study days as I went along . . . that were applicable to what we were thinking of setting up. It hasn't been a hard passage really because . . . the jobs built up as I've gone along. (Practice B, Weston)

In practice, the 'study days' played a larger part in the lives of the Easton nurses than their Weston counterparts, although a Weston nurse commented:

> We've got to be aware of PREP [Post Registration Education for Practice] and we've got to be continually updated . . . to . . . give the service to the patients. (Practice A, Weston)

Reference to study days in the interviews occurred far less with the Weston nurses than with the Easton nurses:

> Five days per year of study [is required under PREP] but probably we do more than that because there are quite a lot of courses that come up at the hospital and that's where we tend to go for most of them. Some [however] are in the form of seminars in various other hospitals. (Practice I, Easton)

The study days at Easton provided a focal point (the nursing college) where the nurses could meet, exchange information and experience some collegiality to a degree not found at Weston. We emphasize 'to a degree', for the nurses at Weston also attended courses and seminars, as well as their local practice group (i.e. the Practice Nurse Association):

> I go to regular monthly meetings of the [County] practice group and you hear a lot of things said in chit chat . . . things that are going on and a lot of courses you meet people . . . and you realise that . . . there are some [practice nurses] that get more benefits that we do. (Practice D, Weston)

This last comment neatly brings us to the nature and organization of practice nursing.

WORK SITUATION, MARKET SITUATION AND PROFESSIONAL STATUS

There were two noticeable differences between the two groups of practice nursing. First, the Easton nurses tended to work fewer hours than their Weston counterparts (see Table 1). Second, the Weston practices were also being reorganized as a fundholding consortium. The differences in hours may well be an accident of the practices selected and a larger sample might well have 'ironed out' the difference. The consortium bid, however, was a distinct difference and may have contributed to the nurses being more aware of issues relating to professional status. This would, in part, be because the reorganization would make the nurses more conscious of their role and the threats and opportunities provided by the changes. It also meant that these nurses would become less isolated from their col-

leagues in other practices as they were becoming part of the same consortium. Another and related aspect of this same development was the role some of these nurses were expecting to play in co-ordinating the work of community nurses attached to the practices. We cannot assert definitely that these were the basis of the differences between the two towns, but we would suggest that they are issues that warrant further exploration, as working hours and the size of the work organization relate directly to the evidence elsewhere on labour markets, segmentation and work organizations (see, for example, Amsden, 1980), even among qualified professionals (Crompton & Sanderson, 1990).

The work situation of the two groups of practice nurses varied in more detailed respects too in relation to funding arrangements. The Department of Health has moved away from their original strategy of a payment per person attending health promotion clinics to a system of 'banding', by which the practice is awarded health promotion funding calculated on the basis of the health mix of the local population. This is equivalent to 'health related groups' (HRGs) or case-mix in primary care. This policy shift has had a significant effect on the organization of health promotion and prevention in general practice. Yet some of the Weston practice nurses continued to run specific health promotion/prevention clinics even after the introduction of the new 'banding' arrangements:

> I do asthma, diabetes, hypertension [and] heart disease prevention clinics, menopause, ... (Practice B, Weston)

However, Easton nurses were much more wedded to an 'opportunist' approach, their term for general purpose 'drop in' clinics. In Practice F, for instance, the practice nurse described the arrangements in the following terms:

> I see people opportunistically as they come into the surgery. The doctor wants them to be seen . . . If they haven't been examined for a long time he'll say: 'Could you just check them over and do a well person check on them'. Then we also have them coming in by appointments as well. (Practice F, Easton)

Moreover, whilst the general approach of the practice nurses is to keep the 'well person' healthy – 'to make sure that the patients are in a good state, a healthy state . . . making sure that they're OK' (Practice G, Weston) – this is not their only concern. The same nurse said that the 'doctor [may] need some diagnostic investigation, ECGs and blood tests'. It is also the case that the practice nurse will 'come across acute things such as burns or various accidents'. All these add up to the general aim described by this one nurse as being, 'to take the weight off the doctors, [for] the things that I do the doctors can do as well … I'm just easing their burden'. Not that many nurses would have described their work in those terms. Generally an overt 'anti-handmaiden' stance was adopted. In the words of one nurse:

> well I'm not a doctors' handmaiden. . . I see all my . . . [own] patients. I have my own appointment list anyway. (Practice C, Weston)

This was a fairly 'strong' version. Most described their situation in terms similar to the following nurse:

> I'm left to my own devices unless I say. . . 'what shall I do with this' or 'I'm not sure', in which case he's happy to check or change or whatever, or advise, but on the whole, I'm just left to my own devices… (Practice B, Weston)

However, some, such as the following Easton nurse, would put the emphasis in more assertive terms:

> Over the years the [practice] nurses have taken over a lot of work of the GPs and although it might seem on the sidelines and not . . . the height of medicine, its very much an integral part of the patient's care. (Practice H, Easton)

Here the view was that the practice nurse equated to an 'equal but different' professional status with the doctors:

> I'm not saying that we think of ourselves as mini-doctors, we don't at all. We've got two separate roles. It doesn't mean anyone is superior to the other. We just have to work together.

Or as another Easton nurse argued the same point:

> [I] think now practice nursing has evolved into a profession in it's own . . . and . . . this is why its become a very important part of any practice because its much more an *extended role*. (Practice I, Easton; emphasis added)

The practice nurses at Easton were generally keen to point out their extended role, whereas this was less so within Weston practices. In terms of the segmentation argument, it appears that the Easton nurses are more inclined towards being new professionals whereas the Weston nurses were content with a more rank and file role. The difference, however, is a matter of degree only. As indicated already, the difference may well have related directly to the impending move to fundholding consortium status (coupled with longer working hours), that heightened the nurses' interest in these matters. They then had real consequences for them as it was within this changing environment that they were beginning to be drawn into a managerial role, co-ordinating the nursing work of the attached community nurses (district nurses, community psychiatric nurses, health visitors etc.):

> We're taking on . . . a scheme whereby. . . . [a] nurse team leader [i.e. manager] will liaise with [a Community Trust] for those people in the team that

Table 2 The changing role of practice nursing

1. Pre-health promotion	2. Health promotion	3. 'Banding'	4. Fundholding
(i) Treatment room nurse and chaperone	(ii) Health promotion	(iii) Extended role	(iv) Management function

> are [their] employees. But [they] basically are stepping back and letting us as a practice dictate how we're going to give our care. (Practice I, Easton)

It appeared that the Community Health Trust:

> are very keen on this partnership at the minute . . . the [primary care] consortium will probably take it on board. (Practice J, Easton)
>
> [The nurse manager] will actually manage all the nurses, the nursing budget, will do part management and part clinical . . . and I think be employed by [Community Health] but to manage the surgery. (Practice J, Weston)

But whether the employer was the general practice or Community Health, the two nurses quoted were keen on the development. Rather than greater *professional* autonomy this aspect of an *extended* nursing role reflects more a reconfiguring of patient care coupled with a more direct involvement in the NHS's internal market. This is clearly seen in a quote from one of the Weston GPs:

> [I]f you think about it we're paying them £20,000 a year, our practice nurses, and then the Health Authority is paying superannuation and national insurance on top so the real cost is probably, what, £25,000–£26,000, and then there's the training… £25,000–£30,000 a year you're probably talking about. It's a hell of a lot of money and you can't have somebody who's costing that much just taking blood, you might as well have somebody on £8000 a year with just very basic training. (GP, Practice A, Weston)

What is emerging is a model of the practice nurse currently undergoing a sponsored elevation in her professional status within nursing. The process is unfinished but the indications from this study are that the 'new' nursing professional in general practice will involve closer liaison with the doctors but not as nurse practitioner equals.

Paradoxically, this process has led to a part-time, feminized occupation (practice nursing) emerging out of a secondary labour market niche within nursing. This has led to the position of a practice nurse being 'a much sought after position' (practice nurse, Practice J), mainly by others in the nursing profession. 'Unfortunately', according to several respondents:

> there's still within the hospital world [those who think] practice nursing is a 'jammy' job, its an easy job, . . . 9–5 and all that. But we're trying, now there's a diploma in practice nursing so we're gradually trying to up the educational stakes so that you do become a branch of nursing within your own right. It is recognised as a branch of nursing. (Practice K, Easton)

This alleged 'jammy job' status is the result of the demarcationary strategy of GPs who have sponsored the rise of the practice nurse in order that they might better fulfil government policy.

Discussion: the practice nurse, professional aspirations and segmentation

The periodization of the changing role of the practice nurse referred to in this paper is represented in a simplified form in Table 2. The table crudely but usefully summarises the main steps in the development of the practice nurse's role, whilst the range of possibilities are set out in Fig. 1 as alternative strategies for practice nurses.

Thus, the nurse practitioner shows the most professional development in terms of autonomous practice based on an *enhanced* role. None of the practice nurses included within our study were pursuing such a strategy. This was a consequence, perhaps, of the limited influence of the academic professionalisers (Melia, 1987). On the other hand, there was evidence of the new professional's role; practice nurses

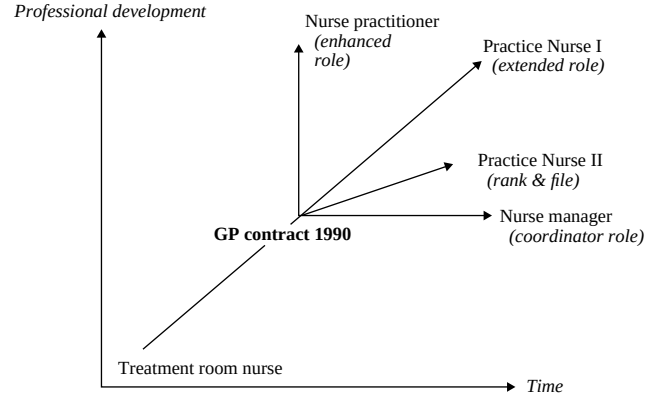

Figure 1 Alternative strategies for practice nurses' development

who were actively interested in *extending* their role by taking on additional responsibilities delegated by GPs. These nurses are represented as 'Practice Nurse I' (see Fig. 1) to distinguish them from the rank and file segment, who passively accept the doctors' definition of their role, and who are labelled 'Practice Nurse II'. The distinction between types I and II, we believe, is an important one, as those seeking professional development in order to *extend* their role are actively engaging in a professional discourse which will include consideration of the *enhanced* role strategy of the practice nurse role, whereas the rank and file segment are not. Finally, we include the emerging co-ordinator role (nurse manager), which is one that would enjoy the role and status of a manager rather than a nurse in the co-ordination of multidisciplinary primary health care teams.

Professional segmentation can help to explain the variation between and within localities and within practice nursing. Thus, in general terms, Weston nurses more easily fit the category of rank and file ('Practice Nurse II') whilst nurses within the Easton practices tended to identify themselves with the role of the new professionals ('Practice Nurse I'). There was also some early indication that the role of new managers appealed to at least two of the nurses. We must stress, however, that these conclusions can only be tentative, based as they are on such a small sample. At the same time they do provide us with an interesting and useful insight into 'grassroots' thinking within the profession. Moreover, the study has allowed us to explore the usefulness of the 'segmentation' schema outside the acute sector. We would suggest that it has useful explanatory potential.

Concluding comments

The comments of the practice nurses we have quoted give some insight into how practice nurses view their role within the changing organization of general practice. They help explain how these nurses perceive their changing role within primary care. The trajectory this has followed has been that one started out as the 'treatment room nurse' and is now beginning to develop into a 'nurse manager' role, at least for some, while the majority are currently having their roles extended in order to help doctors meet their new responsibilities for health prevention and promotion. Opportunities for the emergence of the enhanced role of the nurse practitioner currently appears to be very limited within practice nursing. There is, however, neither a single type of practice nurse nor a simple dichotomy between *enhanced* and *extended* roles. In this article we have identified four alternatives: enhanced, extended, rank and file and co-ordinator roles. Rather than being the result of an initiative from within the profession, however, practice nursing has been largely created by medical sponsorship – in the wake of the new doctors' contract (Bryden, 1992; Starkey, 1992) – redrawing the boundaries between medicine and nursing in order to meet the new demands that health authorities are putting on general practice but not to create an autonomous and independent group of nurse practitioners within primary care.

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