The first attempt at repair should be carried out by a surgeon with the greatest available skill and experience. The likelihood of a recurrence is reduced by recognising that strictures are lined by granulation tissue and that anastomosis must therefore always be from mucosa to mucosa. If symptoms do not recur within two years of initial repair there is a 90% chance that the satisfactory results will be permanent.[13] The results of operative repair have improved over the years, operative mortality being about 13% in the 1950s[3 5] and as low as 2% more recently.[11] In the larger series a good or excellent result has been obtained in about 80% of patients over a minimum of four years.[2 3] When the more difficult hepaticojejunostomy alone is considered, a satisfactory result has been reported in 60% of cases at three years[11]; and this proportion fell to only 53% over 17 years in another series.[5]

1 Warren, K W, and Braasch, J W, *Surgical Clinics of North America*, 1965, **45**, 617.
2 Lindenauer, S M, *Surgery*, 1973, **73**, 875.
3 Warren, K W, Mountain, J C, and Midell, A I, *Surgical Clinics of North America*, 1971, **51**, 711.
4 Maingot, R, *British Journal of Clinical Practice*, 1972, **26**, 53.
5 McAllister, A J, and Hicken, N F, *American Journal of Surgery*, 1976, **132**, 567.
6 Smith, R, *British Journal of Surgery*, 1964, **51**, 183.
7 Smith, R, *British Journal of Surgery*, 1964, **51**, 186.
8 Longmire, W P, and Rougel, D M, *Advances in Surgery*, 1970, **4**, 105.
9 Cattel, R B, and Braasch, J W, *New England Journal of Medicine*, 1959, **261**, 929.
10 Rahim Moosa, A, *et al*, *Surgical Clinics of North America*, 1976, **56**, 73.
11 Smith, R, *Proceedings of the Royal Society of Medicine*, 1969, **62**, 131.
12 Braasch, J W, Warren, K W, and Blevins, P K, *American Journal of Surgery*, 1975, **129**, 34.
13 Way, L, and Dunphy, J E, *American Journal of Surgery*, 1972, **124**, 287.

Making better use of our nurses

In 1971 the schools of medicine and nursing at McMaster University in Canada began an educational programme for nurse practitioners. The results, just published,[1] should provide NHS planners with food for serious thought. The nurses chosen for training were already working in family practices in Ontario. They were mostly in their late 20s or 30s, married, with an average of 7½ years' nursing experience. The course organisers insisted that no nurse applicant would be accepted unless the doctor with whom she would be working agreed to take part in the scheme himself. The McMaster programme was not intended to train nurse assistants: it set out to give nurses the skills and the confidence to make independent clinical decisions and to carry them through. Five years and 99 nurses later, these aims have been fulfilled. The nurses are doing twice as much clinical work as before and only half as much administration. In general they have taken over the management of patients with obesity and established hypertension; they give advice on contraception and marital problems; and they provide antenatal care, school examinations, health checks, and routine surveillance of elderly patients. The doctors find they have more time for patients with complicated problems. This change in working patterns does not seem to have led to clashes of temperament, for over 80% of the nurses are still in the same practices as before.

How applicable are these findings to Britain? While two-thirds of our general practices have one or more nurses attached, the use they make of them is very different.[2] On average, the Canadian nurses work 37 hours a week, with 70% of their time spent on the clinical care of patients. British nurses work only 23 hours a week, and spend only half that time on nursing duties and half as receptionist/administrators—a pattern similar to that of the Canadian nurses' lives before their specialist training.

There is no practical or legal obstacle to nurses taking on more clinical commitments within the NHS. Already some practices here have shown that nurse practitioners are acceptable to patients,[3] and the BMA and the Royal College of Nursing have agreed[4] on guidelines on the range of duties that a nurse can undertake—when properly trained. Part of the impetus for the McMaster programme came[5] from the existence of too many nurses in Ontario; there, as in Britain, nurses who marry and leave their hospital careers have difficulty in finding work that makes full use of their training. Attitudes will have to change, however, if British nurses are to become primary care practitioners on the Canadian pattern: for many doctors (in both countries) still see the practice nurse's role as that of a procedural assistant rather than a decision-maker and her relationship to the doctor as "servant rather than colleague."[2] Yet a new professional group of nurse practitioners could help to maintain the revitalisation of general practice as much as has the new generation of vocationally trained practitioners.

Such a change would be welcome—but it has longer-term implications for our manpower planners. Already there are growing fears that we may be admitting too many students into medicine.[6] If we are to look ahead to a time when general practice has many more nurses and, perhaps, fewer doctors, then we need to start cutting the intake to our medical schools now.

1 Scherer, K, *et al*, *Canadian Medical Association Journal*, 1977, **116**, 856.
2 Reedy, B L C, Philips, P R, and Newell, D J, *British Medical Journal*, 1976, **2**, 1304.
3 Marsh, G N, *British Medical Journal*, 1976, **2**, 626.
4 Royal College of Nursing and National Council of Nurses of the United Kingdom, *The Duties and Position of the Nurse*. London, RCN, 1970.
5 Spitzer, W O, and Kergin, D J, *Canadian Medical Association Journal*, 1973, **108**, 991.
6 *British Medical Journal*, 1977, **1**, 465.