right to fight. Stop your employer getting away with the murder of your career.

Neil O’Cor
Maidstone

Some ENB courses are more equal than others
I feel that I have to reply to views expressed by John Dean (Letters April 7) concerning the ‘irrelevance’ of some ENB courses.

As part of a team which is committed to ensuring that the ENB 998 meets the demands of both students and service colleagues, such sweeping generalisations can only have a detrimental effect on the links between some providers and purchasers of education.

While I am aware that some educational institutions have failed to keep pace with changes in practice, to tar all ENB 998s and institutions with the same brush is grossly unfair, and potentially damaging.

We at Anglia Polytechnic University now provide a successful, practice-focused programme, geared to both practitioners on the programme and our service colleagues.

As for the staff and managers who attended courses and ‘did not know why they were there’, it might be useful for those purchasing such programmes to consider having at least some dialogue with the education institutions with whom they deal. We would be delighted to meet with Mr Dean to discuss our programme with him.

David Fogg
Anglia Polytechnic University

Taking ownership of nutritional standards
I write in response to the item ‘Nutrition should be integral to care’ (News April 21). While I agree a patient’s nutritional status should be screened/assessed once in hospital, I feel that important issues have been overlooked.

Firstly, there is the question of who should be nutritionally assessing patients?

Are professional boundaries being overstepped with the assumption that this is the nurse’s role? Secondly, there is the question of education. Does the current nursing curriculum adequately prepare ward based nurses for this role?

It is apparent from the literature that there is uncertainty about whose role it is, surely a multidisciplinary collaborative approach should suffice for the identification of ‘at risk’ patients, as opposed to the ‘year role’ tactic.

Finally, if it is agreed to be a nurse’s role to routinely nutritionally screen/assess patients, surely nurses can refer for specialist nutritional input, without the signature of a doctor at the bottom of the referral form. I find it an insult in today’s healthcare system that it is necessary to obtain a doctor’s signature, when it wasn’t the doctor who identified the patient as being ‘at risk’ and requiring dietetic input. Surely we possess the professionalism to refer on our own!

Kyle Hastings
Milton Keynes

Don’t compare consultant nurses with doctors
Reading your article on consultant nurses and comparing them to medical consultants (Analysis March 31), I found it difficult to visualise how they would acquire their clinical work – especially when there was talk of their having their own case loads.

Expert practice education and research leadership and management are already within the province of senior nurses. The clinical side I can only see as providing a second opinion for advanced help to nursing colleagues who request this for patients. This is the same service that exists between consultants and GPs or colleagues in another specialty. However, these patients are those of the consultant – referred to him by his colleagues – they are not referred to the nurse consultant by the GP.

Genuine nursing problems from the various residential homes of all kinds – elderly, disabled, mental – could provide a ‘case load’ or ‘own list’, but there would probably not be that many.

The clinical side would appear always to be rather limited – so the job would still be very like that of the present nurse administrators.

I notice in the table you did not put in the fact that consultants have to do several consultant specialist exams at their particular Royal College – though you mention the nurses need to have an MSc, not at all comparable as consultant specialist exams are extremely competitive with a failure rate of about 70 per cent.

I fear with some diagnosis, some prescribing as you put it and fewer referrals for problematic nursing care, this will not warrant the same level of salary as a medical consultant.

Tom Murray
Exeter

Is higher level nursing a ‘far out’ idea?

The confusion surrounding PREP will be as nothing when compared with the chaos which is likely to follow the attempt by the UKCC to define ‘higher level’ practice.

The term ‘higher’ and ‘level’ imply a vertical arrangement with the possibility of ordination, superordination and subordination. However, the UKCC wishes to be politically correct and has stated that the system will be rigorous but not elitist (Analysis April 21). The council appears to be endeavouring to produce a system in which ‘higher’ means different from, but not necessarily superior to.

We are assured that it may be possible for a second level nurse to practise at the higher level. This presumably means that one may have a second level nurse, grade C working at the higher level and a D or E grade first level nurse working at the ordinary level.

When the UKCC uses a word, it means exactly what the council wants it to mean, nothing more and nothing less.

Tom Murray
Exeter