A nurse's place is at the bedside

EDITOR,—I was impressed recently while reading a nursing journal to find an article written by an orthopaedic surgeon, Robert Hay.[1] In keeping with this spirit of interprofessional communication I have chosen to reply to Hay's article in the *BMJ*.

While delighted that Hay chose to communicate directly with the nursing profession, I am dismayed by his comments concerning nursing in general, nursing research in particular, and specifically the role of men in nursing. For the benefit of readers who do not subscribe to *Nursing Standard*, Hay contends that an "increasingly male leadership" is "frogmarching" nursing towards clinical autonomy against the wishes of the "rank and file." He is particularly dismissive of nurses participating in research, apparently because we may not "have got an A-level in maths or science" or be familiar with the term "correlation of bi-variant data." He suggests that nursing sisters should drop the "pseudo-managerial gibberish" of care plans and total quality care and that "only under very special circumstances" should this post be occupied by a man.

I suggest that Hay has not "read and understood all published work in the field" as he exhorts nurses to do. Perhaps he should conduct a further literature search, using such key phrases as "nursing development units" to find examples of nurse led, patient centred clinical innovation and names like Philip Burnard, a male nurse who has had an enormous impact on improving standards of patient care.

I fear that Hay's comments may reflect less the concern that he obviously feels about patient care and more the threat that he perceives to the medical profession's traditional but now outdated ascendency over nursing. Collaboration, rather than confrontation, should be our aim. I see Hay's article as divisive and unhelpful. I hope that in future, when nurses and doctors correspond in each other's professional journals, they do so with more respect for each other's efforts towards the common goal of improved patient care.

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1 Hay R. A nurse's place is at the bedside. *Nursing Standard* 1994;8(27):42-3.

Author's reply

EDITOR,—Nursing is in headlong flight from the role of medicine's handmaiden. Nursing is in headlong flight from the bedside to a promised land of independent practitioner status. This has created a system of nurse education remote from, and dismissive of, traditional nursing. Nurses are no longer taught by practising doctors or nurses but rather by an endless round of marketeers and classroom propagandists, including an increasing number of nurse managers (usually male), whose intention it is to leap directly from the carousel of the classroom to the bandwagon of management.

Some nurse teaching is frankly subversive, and many doctors would be dismayed to learn of the poor press that their profession gets in the nursing classroom. Medical activity is increasingly portrayed as unnecessary or insensitive and something against which the nurse might have to defend her patient. No wonder the two professions have lost eye contact.

Worse still, nurses are now exhorted to "get involved in research," the intention being that nursing will set its feet on to the bedrock of scientific knowledge, from which position it will be able to challenge the (medically determined) dogma. Research is a career in itself, not something into which nurses or most doctors can make fruitful excursions. Driving the newly qualified nurse into the ward with a clipboard and questionnaire will not produce useful information. Research that is embarked on to enhance the status of the individual or in this case the entire profession is doomed to failure.

The most serious concern over reforms of nursing seems, however, to be the erosion of the status of nurses who wish to remain at the bedside. Such nurses are made to feel inadequate unless they play their part in the pseudointellectualisation of the profession. In the 21st century we are going to need proper, practical, and realistic nurses, not pseudopsychologists and marketeers tinkering in research.

The solution to the problem lies in restoring to the centre of the nursing stage the nursing sister who wishes to retain a career at the bedside. Such a sister should be paid on the same scale as a consultant as a proper reflection of her skill. It is she who should plan and deliver a vigorous and relevant programme of nurse education to those who follow her. This would attract and retain women of the highest quality into the areas nurses are needed, for without this return to basics the nursing profession faces chaos and fragmentation.

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Open access echocardiography

General practitioners use echocardiography appropriately

EDITOR,—C M Francis and colleagues report their experience with open access echocardiography in the management of heart failure in Edinburgh.[1] General practitioners were sent a summary of the findings on scanning together with recommendations concerning changes to treatment, although the authors present no information to show that such changes were implemented.

A pilot open access service is available to general practitioners in Darlington, and over 200 patients have been referred. Before the study began each practice was visited so that the service could be explained, and written guidelines were provided later. Unlike in the Edinburgh study, our reports are purely descriptive; no guidance on management is provided.

Of the first 200 patients referred, 141 were taking a loop diuretic, 117 had a history of ischaemic heart disease, and 59 had a history of hypertension. The left ventricular ejection fraction was below 40% in 41, and a haemodynamically important valve lesion was reported in a further 12: mitral regurgitation in five, aortic regurgitation in five, combined mitral and aortic regurgitation in one, and mitral stenosis in one. Appreciable aortic stenosis has not been observed.

Two months after the scanning, general practitioners' notes were reviewed to assess the impact of the findings on management. An angiotensin converting enzyme inhibitor had been started in 38 patients, and a further seven had been referred to start treatment under hospital supervision. Thirty one of the 41 whose ejection fraction was less than 40% eventually started to take an angiotensin converting enzyme inhibitor, and nine of the 12 patients with an important valve lesion had been referred to hospital.

Replies of 18 general practitioners to questionnaire asking their views of open access echocardiography

How easy is it to interpret the results?	
Very easy	4
Easy	11
Difficult	3
Very difficult	0
How helpful to management is echocardiography?	
Very helpful	5
Helpful	13
Unhelpful	0
Useless	0
Should the service continue?	
Yes	18
No	0

The pilot service was offered to 25 general practitioners, and after the first 100 cases a questionnaire was sent to the 20 who had requested echocardiography. Eighteen responded, and the table gives their views.

As in Edinburgh, we have found that general practitioners are keen to use the service and that appropriate patients are being referred. Furthermore, the provision of simple information seems to have resulted in appropriate decisions on management, and consequently the pilot service is being extended to all local general practitioners.

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1 Francis CM, Caruana L, Kearney P, Love M, Sutherland GR, Starkey IR, *et al.* Open access echocardiography in mangement of heart failure in the community. *BMJ* 1995;310:634-6. (11 March.)

General practitioners also use open access computed tomography wisely

EDITOR,—In their editorial J R Hampton and A R Barlow claim, "Few doctors want . . . open access computed tomography for headache."[1] In Bolton direct referral for computed tomography by general practitioners has been available for the past two years; the waiting time for an appointment with a neurologist has recently fallen to 16 weeks. The normal procedure is for the general practitioner to discuss the case with a radiologist on the telephone. Obviously there must be some doubt about the cause of the headache. If the patient has neurological signs associated with the headache then the advice is to refer the patient to a specialist rather than for scanning so that the specialist can investigate as he or she sees fit. If the general practitioner is sufficiently concerned to refer the patient even if the scan shows no appreciable abnormality then the advice is the same.

There is no evidence of abuse. One hundred scans have been requested by general practitioners