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feels about patient care and more the threat that he perceives to the medical profession's traditional but now outdated ascendancy over nursing.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 management 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

in the period. No one has requested more than nine scans. The waiting time for an appointment for scanning as an outpatient is one week, regardless of the source of the referral.

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1 Hampton JR, Barlow AR. Open access. *BMJ* 1995;310:611-2.
(11 March.)

Service is valuable for evaluating murmurs too

EDITOR,—For the past 10 months we have been offering general practitioners in the Brighton area an open access echocardiography service similar to those in Edinburgh¹ and Nottingham.² Ours differs principally in that we encourage referral for the evaluation of murmurs as well as heart failure.

In total, 106 patients (43 male, 63 female), have been referred: 49 with heart failure with or without murmurs (mean age 72), 46 with murmurs alone (mean age 55), and 11 for other reasons. In those with murmurs alone no abnormality was found in 25 and we were able to reassure the patients and general practitioners and avoid unnecessary referral to a cardiologist. Not surprisingly, given the selection criteria for referral, we found a higher incidence of valve disease than that reported by Francis and colleagues.¹ Overall eight patients had appreciable aortic stenosis (which was severe in two cases, with a gradient >70 mm Hg). Other findings were mitral stenosis (two cases, both mild); aortic (13), mitral (19), and tricuspid regurgitation (five); and mitral prolapse (two). Of the 49 patients with suspected heart failure, only 26 had heart failure confirmed by a low ejection fraction. Five of these were already taking angiotensin converting enzyme inhibitors, which were recommended in the remainder. The general practitioners subsequently reported that all but five were started on these drugs.

Unlike in Edinburgh and Nottingham, which have similar populations, the uptake of our service by general practitioners has not been great, even though we publicised it widely in a newsletter, by direct contact, and at meetings. Nevertheless, in a brief audit questionnaire 92% thought that the examination had been helpful in the management of both heart failure and murmurs, and only nine cases were subsequently referred on for assessment by a cardiologist.

It is difficult to know from this brief experience whether this service is cost effective and identifies patients with important disease who would otherwise slip through the net. Whatever the perceptions of those who work in hospitals, this service seems likely to be continued by fundholding practices.

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

2 Hampton JR, Barlow AR. Open access. *BMJ* 1995;310:811-2.
(11 March.)

Hospital patients need open access echocardiography

EDITOR,—We agree with C M Francis and colleagues that echocardiography is useful in patients with heart failure and that an open access service may be used successfully by general practitioners.¹ Heart failure is also common among patients admitted to hospital,² but we have noted a reluctance to use echocardiography in such patients.

To investigate this further we recently conducted a prospective audit of all patients acutely admitted to our district general hospital with heart failure to assess current strategies in the investigation and management of this condition. Over six months (March to August 1994) we identified 348 patients (178 female and 170 male; mean (SD) age 73.2 (11.2) years) who were admitted with heart failure.

Complete data were available for 260 of these patients (75%). Only 60 patients had echocardiography during the admission, a further 20 had had it within the six months before their admission, and nine were to have it arranged at a future date on an outpatient basis. Thus only 89 patients would have had echocardiography despite their acute admission with heart failure. Echocardiography showed poor left ventricular function (global) in 43 patients, left ventricular hypertrophy in six, mitral valve disease in six, and other disease in eight; no abnormalities were present in three patients, and in 14 cases the echocardiogram was uninformative. These results suggest that treatment would have been influenced in most cases, with, for example, the introduction of angiotensin converting enzyme inhibitors in patients with poor left ventricular function.

We suggest that despite the usefulness of open access echocardiography for general practitioners, many hospital inpatients who are admitted with heart failure should also be considered for echocardiography as useful information would be obtained. The availability of this service to hospital patients should not be neglected while echocardiography services in the community are developed.

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

2 Parameshwar J, Poole-Wilson PA, Sutton GC. Heart failure in a district general hospital. *J R Coll Physicians Lond* 1992;26:139-42.

Open access to specialist opinion is preferable

EDITOR,—C M Francis and colleagues' report on open access echocardiography¹ highlights the fears of many cardiologists about open access services.² The principal aim of the authors' service—the identification of patients with left ventricular dysfunction so that treatment with an angiotensin converting enzyme inhibitor could be started—occurred in only 50 (19%) of 259 patients, while valve disease was identified in 12. In a similar study of an open access exercise electrocardiography service McClements *et al* identified ischaemic heart disease in only 18% of the 192 patients tested.³ It is argued that a negative result of the test is reassuring, but many patients remain symptomatic despite reassurance.⁴ Furthermore, screening a low risk population will result in a much higher proportion of false negative results. It remains to be seen whether open access to investigations represents an effective use of expensive and scarce resources. Hampton and Barlow argue that specialists are most useful in giving an interpretation of the clinical problem with the aid of results of appropriately selected investigations.⁵ Another approach to general practitioners having improved access to cardiology services is to offer rapid open access to specialist clinical assessment and opinion.

We have over 18 months' experience of a same day open access cardiology clinical service for patients with chest pain or palpitation of less than 48 hours' duration. On three afternoons

a week this fast track outpatient service is incorporated into the routine cardiology clinic, and on two afternoons patients are seen by a trainee in cardiology. Patients are assessed clinically by electrocardiography, and further investigations are ordered as indicated. After investigations have been performed the patient is seen at a dedicated follow up clinic by a consultant cardiologist. Activity in the clinic took only four months to reach a steady state, and an average of 51 (range 43-63) patients per month have been referred over the past six months. Initially 97 of the first 100 patients referred had symptoms in the pre-specified categories, and this was the case for 87 of the last 100 patients referred.

Our experience does not suggest that general practitioners are indiscriminate in their referrals or that an unmanageable increase in workload has occurred. When the first 100 patients referred to the fast track service were compared with 100 patients referred to the routine clinic over the same period, a higher proportion of patients with chest pain were diagnosed as having ischaemic heart disease (42% (25/60) *v* 33% (14/43)) and a higher proportion of patients with palpitations were thought to have a clinically important arrhythmia (54% (20/37) *v* 39% (9/23)) in the open access clinic. Overall 78% of the 100 patients referred to the fast track clinic had their drug treatment changed at the first or second clinic visit, compared with 63% (54/86) in the routine clinic. Because the cardiologist acts as gatekeeper to investigations, 55 of 106 echocardiograms obtained in the fast track clinic showed a clinically important abnormality (18 showed appreciable valve disease, 26 left ventricular impairment, and 11 left ventricular hypertrophy); a further 21 showed an echocardiographic abnormality; and only 30 were reported as normal. Similarly, 46% (16/35) of the exercise electrocardiograms obtained in patients seen in the fast track clinic showed an abnormality.

Overall, the service seems to be popular with our local general practitioners. We believe that rapid access to clinical assessment by specialists constitutes a more effective service and overcomes some of the problems associated with direct access to clinical investigations.

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(11 March.)

2 Working Group of British Cardiology Society. Cardiology in the district hospital. *Br Heart J* 1994;72:303-8.

3 McClements BM, Campbell NPS, Cochran D, Stockman S. Direct access exercise electrocardiography: a new service that improves the management of suspected ischaemic heart disease in the community. *Br Heart J* 1994;71:531-5.

4 Channer KS, James MA, Papouchado M, Russell Rees J. Failure of a negative exercise test to reassure patients with chest pain. *Q J Med* 1987;63:315-22.

5 Hampton JR, Barlow AR. Open access. *BMJ* 1995;310:611-2.
(11 March.)

Study's conclusion is misleading and cannot be generalised

EDITOR,—C M Francis and colleagues' conclusion that echocardiography led to advice about a change in management in 70% of patients with established or suspected heart failure as diagnosed by their general practitioners is misleading.¹ Their 70% represented 82 of 119 patients receiving treatment at the time of referral, 53 of whom, they concluded, were taking unnecessary diuretics. But the actual figure should also include those in the group with suspected heart failure for whom the authors advised a change in management (14/99). Therefore