to "publish or perish," regardless of the quality of the research, still has too much truth in it for doctors to try to claim the moral high ground.

We—a doctor-nurse team—share nursing, medical, and teaching postgraduate qualifications. We condemn poor research and undisciplined thinking, wherever it is found.

SALLY KNIGHT
Staff nurse

Accident and Emergency Department,
Watford General Hospital,
Watford WD1 8HB

JONATHAN KNIGHT
General practitioner

Watford WD1 8HW

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Nurses' role is narrowing in Germany

EDITOR,—We were interested to read of the progress that British nurses believe is being achieved in patients' care and research and, in particular, that nurses are keen to undertake new roles previously the job of doctors.¹ In Germany the tendency over the past few years has been the reverse. Whereas a considerable proportion of German nurses, especially in larger hospitals, previously incorporated taking blood, inserting catheters, and giving antibiotics and blood products into their daily duties, they are now unwilling to take on these additional roles. Organising patients' appointments and investigations is not considered to be their responsibility. In addition, nurses are now reluctant to dress wounds and remove stitches, even on surgical wards. These jobs have to be delegated to final year students, who spend their time doing whatever the nurses believe is not their job. In other words, the shrinking duties of nurses mean that the education of our student doctors is suffering.

There is also evidence that continuing education of nurses, even on specialised wards, is gradually diminishing, such that, for example, those on cardiology wards cannot or do not want to interpret electrocardiograms. When information is required by relatives, nurses seem not to feel confident about relaying details about the patient's condition and are therefore unable to reassure those who are anxious about the patient. This is partly because they are increasingly unwilling to accompany doctors on ward rounds and therefore do not receive up to date information.

The developing situation leads us to wonder what the role of nursing has become in Germany. Are nurses now just to give out tablets and make beds, or, as seems already to have occurred in Britain, will there eventually be a move to upgrade their status by some nurses who are motivated and wish to be regarded as professional patient carers?

SIGRID NIKOL
Lecturer in medicine

TANYA Y HUEHNS
Lecturer in medicine

Medical Department 1,
Klinikum Grosshadern,
Ludwig-Maximilians University,
D-81377 Munich,
Germany

- 1 Salvage J. What's happening to nursing? *BMJ* 1995;311:274-5. (29 July.)

Nursing eulogies ignored ethos of control and punishment

EDITOR,—Several recent articles indicate how nurses view themselves.¹⁻³ Discussion with medical colleagues has shown that none of them recognise the nursing described. The articles repeat clichés and myths for which there is no evidence.

Firstly, nurses have never been handmaidens to doctors. Many employees in all walks of life carry out instructions given by other employees. That does not make any of the former handmaidens to the latter.

Secondly, power often does not lie with doctors. Many routines and policies in wards, labour suites, theatres, and clinics are instigated and maintained by nursing staff. Nurses have considerable power, which, unfortunately, many readily use in a negative and unassertive way.⁴ Suggestions about different practices and attitudes are often met with hostility and resistance and sometimes with vindictive behaviour.

Thirdly, doctors are accused of not knowing what nurses do. The converse is more accurate. Many nurses, even experienced ones, do not realise that when they go home the doctors often do not. My efforts to explain to nurses that a doctor's behaviour may be influenced by the fact that he or she works at least twice the hours in a week that they do (as well as carrying considerably more responsibility for more patients in several parts of the hospital) have been met with disbelief, sarcasm, and facetious comments—hardly the quintessence of a caring profession.

My experience of teaching on numerous training courses for nurses and health visitors and from discussions with nursing colleagues is that derogatory and defamatory comments about doctors in general or about specific doctors seem to be part of nursing culture from the earliest days of training. The participation of senior nurse managers in this and their reluctance to challenge it perpetuates this unsafe and unprofessional behaviour.

Nursing does not acknowledge that issues are often not black and white, that there is often not a right or wrong answer, and that making decisions will mean making wrong ones. Rather, there is an ethos of control and punishment, whether of colleagues, other health professionals, or patients whose actions and decisions do not conform to expectations.

Nurses do not have a monopoly on a caring, holistic approach to patients and their families, and most doctors are not oppressive technocrats who see patients only as a collection of symptoms. Many doctors carry a burden of guilt, doubt, and an excessive sense of responsibility,⁵ which is largely unrecognised. Being aware of their failings, doctors allow unfair and ill informed comments on their profession and pomposity by others in the health field to go unchallenged. The articles on nursing, written mostly by nurses, are self eulogising.¹⁻³ Unless doctors start being proactive in promoting what they do and reactive in response to the comments of others, they will have no one to blame but themselves if their standing in the health field falls.

CHARLES ESSEX
Community paediatrician

Birmingham B16 0LR

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Macintosh PC is better than Windows

EDITOR,—To read the articles by Nicholas Lee and Andrew Millman on choosing and installing software,¹ you might think that there is only one type of computer and two types of software. They refer to either DOS or Windows operating systems based on IBM compatible PCs. In doing this they ignore an important area of the market, which is

particularly important for those who are just starting their computing careers.

Macintosh computers that have major advantages over IBM-PC compatible computers have been available for several years. The graphical user interface on the Macintosh was a major advance over the DOS system. This was acknowledged by the development of the Windows software, which uses a graphical user interface but does not perform as well as the latest Macintosh interfaces. Newcomers to the world of computing would be best served by at least being informed of the availability and benefits of using the Macintosh interface. In a comparison of DOS and Windows with the Macintosh the advantages of the Macintosh are

- A more attractive and user friendly graphical user interface than Windows
- A more consistent feel and look to the programs
- As with Windows, a WYSIWYG screen
- Software that has long been able to show colour pictures and colour text or black and white text simultaneously
- Many programs can run simultaneously
- Moving between programs is even easier than with Windows.

Connection to other Macintosh systems, the Internet, and other peripherals is extremely easy and is easier, in my experience, than with Windows. The disadvantage that Lee and Millman relate of Windows being more liable to crash is not a great problem with Macintosh based software. Although no doubt Macintosh software can crash, in my experience using several Macintosh computers and a wide variety of software over the past five years, crashes are extremely rare.

Though Macintosh computers have been more expensive than IBM-PC compatibles, the costs have recently dropped considerably, as have the costs of the associated software. Extensive software is available for Macintoshes, and with the recent licensing of the Macintosh operating system to non-Macintosh manufacturers, hardware costs are likely to fall even more.

Anyone looking into acquiring a new computer system, particularly those who are not already experienced in computer matters, should investigate Macintosh as an alternative to IBM-PC compatible computers.

GEORGE G HARTNELL
Director of cardiovascular
and interventional radiology

Deaconess Hospital,
One Deaconess Road,
Boston, MA 02215,
USA

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Software package makes counting episodes easier

EDITOR,—I agree with the comments made by the Radical Statistics Health Group concerning the lack of data on the number of people treated by the NHS compared with data on the number of finished consultant episodes.¹ I have recently undertaken several studies to try to determine the causes of the increased number of emergency admissions in the NHS. Counting the number of people treated is a prerequisite for this, and the simple trick that I devised to enable this to be done from data on episodes may therefore be of interest to others. In the data on episodes every record contains a date of birth and a unit postcode. The probability of two people having the same date of birth and unit postcode is effectively zero. It is therefore possible to "identify" people by using this trick and to count them and the number of episodes that apply to each of them. Thus a good