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Doctors and nurses

The popular image of doctors and nurses working harmoniously together is not always matched by reality. Relations between the professions are sometimes uneasy, with nurses resentful[1] at being seen by the public as "doctors' handmaidens." For their part doctors are often ignorant or critical of innovations in nursing methods and most seem unaware of the profound changes now taking place that may lead to a redefinition of the boundary between medicine and nursing.

Traditionally, the nurse's job was to follow plans of management outlined by the medical staff. Though a doctor might ask the ward sister's opinion, he was responsible for assessing the patients' problems and deciding treatment. The sister then allocated tasks to her staff—some nurses to make beds—now often done by housekeeping staff—some to administer drugs, and so on. This system led to frustration among nurses, in part because they had no official voice in decisions made by other professionals such as doctors or social workers, and in part because a job orientated towards specific tasks depersonalises patients.[2] Another factor was the Salmon reorganisation,[3] which replaced senior ward sisters with younger sisters less adept at informally influencing medical decisions and which placed an emphasis on administration at the expense of clinical nursing that even the influential Briggs Report[4] did not wholly reverse.

To remedy some of these problems, increasing numbers of hospitals are introducing the "nursing process."[5] This is a far from self-explanatory name for a method developed in America and consisting of four stages: assessment of the patient's needs, planning of care, nursing itself, and the evaluation of its success. All these stages, including taking a nursing history, are performed by the nurse herself, and nurses are allocated patients rather than tasks.[2] The introduction of the nursing process has not been universally praised by nurses in the wards. It has been criticised for being no more than a new name for something that good nurses already do; for producing extra paperwork; for being useful to students but not to trained staff; and for being difficult to apply with small numbers of nurses of varying experience. Even so, it should increase nurses' job satisfaction.[6-8] Whether patients will like the change is less clear from reports,[9] which tend to be long on jargon and short on data. The nursing process is, however, popular with influential nurses, and the Royal College of Nursing has recently published a booklet, *Towards Standards*,[10] suggesting that the nurses' responsibility should be extended further.

This discussion document is intended to provide a framework for improving nursing standards and developing nurses' accountability. Deliberately broad in scope, and with its ideas packaged in verbal cotton-wool ("Purposeful behaviour includes a specific cycle of nursing behaviour which can be observed to be goal-directed"), the booklet identifies prerequisites for the control of standards by nurses themselves. These requirements include delegating more authority to nurses in the wards, with nurses' accountability being independent of "cover" by medical staff. The document draws attention to the function of the ward sister, implying that her importance should increase and regretting that the Salmon reorganisation, while strengthening nursing management,[11] has had an "unfortunate" effect on nursing practice.

Nurses below the rank of nursing officer may take the Royal College of Nursing's pronouncements with a pinch of salt[12] (and there was only one ward sister on the committee which produced this booklet), but no doubt changes will occur. Recognition of the importance of the ward sister is long overdue.[13-16] The college recommends wider application of the nursing process, but, despite the enthusiasm of converts,[17] it will be more applicable in some specialties than others. What is appropriate in a long-stay geriatric ward may be less appropriate in an operating theatre. As the booklet points out, changes should be slow, since they require discussion and education. Innovations should not be foisted on nurses, who may be exercising sound judgment in being reluctant to accept increased responsibility, particularly as many specialties—for example, mental illness and geriatrics—often have a disturbingly low proportion of trained to untrained staff in the wards. The present system should not be immutable, but it has worked effectively for over a century and is understood by all concerned, including the public.

The patients' interests should be paramount in deciding the boundaries between medicine and nursing. In any debate both doctors and nurses tend to assume too easily that patients' interests coincide with their own. Demarcation disputes between professions will certainly not benefit patients, and if, as the discussion document suggests, doctors' and nurses' "goals for a patient may differ or even conflict," this conflict had better be settled amicably well away from the bedside. Good will and open minds will be needed: few doctors would maintain that a ward sister should be subordinate to a new house officer, but most doctors will be dismayed by the booklet's suggestion that a patient needs a nurse as his advocate against the doctor. In the end, division of responsibility is decided not by committees of managers but personally,

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by the people at the bedside. They are the ones doing the work; they should treat one another with respect, and they deserve to be treated respectfully by professional pressure groups.

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Management of patients with bilateral amputations

Most patients in Britain who have had amputation of both their legs above the knee are over 60 and have peripheral vascular disease. Inevitably such patients have problems in regaining adequate mobility for daily living and their life expectancy is frequently short. Among the many factors contributing to the complex problems of rehabilitation are the physical difficulties—an aging body attempting to use two above-knee prostheses—and the unsuitability of most houses for the disabled. Other difficulties include obtaining a proper assessment of the patient and the accommodation at an early stage of rehabilitation (and passing on the result to all members of the care team) and halting the automatic prescription of a sequence of prostheses that may be inappropriate to a patient's abilities and displeasing to his self-image.

The fundamental problem is that most surgeons are willing to create this abbreviated form of the human body without accepting responsibility for its rehabilitation. Not until they assume this responsibility will they know what double above-knee amputation means in terms of human misery—and only then will they urge the research and activity that could mitigate that distress.

The very fact that artificial legs can be issued to such people tends to mask the severity of the loss of function that bilateral amputation entails. Other patients with comparable handicaps are expected to take to a wheelchair. Those with double amputations above the knee are expected to walk—and are themselves led to expect to walk again in most cases. All too often they are given artificial limbs irrespective of their physical and mental ability to cope with them; their failure to use these limbs is then seen as a defeat and leads to disappointment and depression. Recognition of this failure may be staved off for months or even years of training in walking or limb fitting, with two or three visits each week to a physiotherapy department. There the patients practise walking on a smooth flat surface between parallel bars. Many trips to the local artificial limb and appliance centre are interspersed between these visits, and the patient may be fitted in turn with short rocker pylons, articulated rocker pylons, and definitive limbs, until he and his medical advisers finally concede that neither the training nor the prostheses are at fault but the patient himself, who is not suited to walking with prostheses. For any one patient this adds up to a formidable amount of misspent time in a life span that may be as short as two years, and to an equally formidable waste of money.

For someone with a double above-knee amputation to receive the right treatment and equipment, expert assessment is essential at the various stages of his rehabilitation (see p 707). The object of the initial assessment, which is the responsibility of the hospital team and should be done as soon as post-operative recovery permits, is to decide whether or not the patient is physically and psychologically fit to wear prostheses of any kind. Assessment of mental function looks for confusion, dementia, severe perceptual problems, or loss of memory sufficient to rule out the use of limbs. Assessment of physical function estimates exercise tolerance, the function of the arms, the structure and function of the stumps, and balancing ability.

Such a patient must be able to tolerate weight bearing on his ischial tuberosities, assisted only by whatever relief his upper arms can provide by the use of walking aids, and he must be prepared to accept the discomfort that walking and sitting in two rigid metal sockets frequently produces in the perineum. He must be able to understand and remember how to put his prostheses on and how to take them off again and be physically capable of managing or assisting in both procedures. His exercise tolerance must be sufficient for him to walk at least two lengths of the parallel bars without angina, palpitations, or unacceptable dyspnoea. Mild flexion deformities of the hips can be accommodated, but bilateral flexion deformities greater than 15° cannot; and so he must also be willing and able to do hip extension exercises to discourage the development of hip deformity.

Assessing the patient's home is the prime responsibility of the hospital team, though liaison with their community colleagues is essential. The assessment must take account of the possible need for structural alteration or for rehousing and the supply of equipment, as well as the ability and enthusiasm of the patient's family to have him home again. His own ability to manage a wheelchair or prostheses in the home surroundings is an equally important issue, since a patient who copes moderately well with either in a gymnasium may be virtually immobilised by the presence of thick-pile carpets, steps, and sills in his own home. Prescription of the wheelchair most appropriate for the particular needs of the patient—whether self-propelled, propelled, or powered—soon after operation is as important to overall independence as is the prescription of prostheses.

A patient can now be tested to see whether he is suited to walking with prostheses before being referred to artificial limb and appliance centres by use of a pneumatic pylon—a recently introduced and invaluable aid to rehabilitation. He can be observed in the hospital gymnasium while attempting to walk in a pneumatic pylon paired with the pylon or definitive prosthesis for the original amputation. Such an assessment should show both the care team and the patient whether or not walking with prostheses is a realistic proposition. If it is not

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