year, also varies.[2] It would be appropriate therefore for these groups to be separated if the prognostic value of exercise testing after infarction is to be assessed satisfactorily.

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[2] Hutter AM, De Sanctis RW, Flynn T, Yeatman LA. Non-transmural myocardial infarction; a comparison of hospital and late clinical course of patients with that of matched patients with transmural anterior and transmural inferior myocardial infarction. *Am J Cardiol* 1981;48:595-602.

The nursing process

SIR,—I suspect that few hospital doctors have seen the nursing assessment sheets to which Professor Mitchell refers. For those who have not, may I list just some of the headings in the Southampton version?

Colour of eyes
Hair colour and length
Deformities
Pain/discomfort
Measures giving relief
Physical appearance
Physical description
Build
Visible distinguishing marks
Hygiene
Teeth
Skin
Stoma
Social activities/hobbies/play
Religious activities/cultural needs
Any language barrier/speech defect
Financial support
Patient's perception of health problem
Living accommodation
Community services
Mental state
Long standing health problems
Sleep pattern
Menstruation
Sight
Hearing

The relevance of most of these to a patient admitted for avulsion of a toenail may be somewhat obscure, and one might question the presumption of the nurse in assuming the role of doctor, priest, social worker, and passport official, while neglecting that of a proper nurse. The medical profession should act to stop this nonsense, because (*a*) the shortage of nursing staff and the workload on the average hospital ward does not allow the waste of the 30 minutes required for the completion of each of these forms, and patient care will suffer; (*b*) the patient should not be submitted to such an interrogation by nursing staff, when much of the information (if important or relevant) is already contained in the houseman's notes; (*c*) the generation of more unnecessary and useless documents is wasteful and space occupying. Traditionally and properly, the medical staff diagnose and treat patients, and it is their instructions that the nursing staff carry out. I would suggest that clinicians make clear that they do not wish this absurd rigmarole to be included in the management of the patients under their care.

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SIR,—I would like to ask medical staff who oppose the use of the "nursing process" (21 January, p 216) to note the findings of a study that evaluated the effects of nursing care on outcome for patients.

Five matched pairs of geriatric wards were studied and comparisons made between wards using the nursing process and those using "task allocation" nursing (table). Although there was no difference in the levels of dependency in patients admitted to the 10 wards, patients who had been in wards with task allocation nursing for more than a month were significantly more dependent than similar patients in wards using the nursing process. Significant decreases in dependency were also recorded over two years, when one of the wards changed from task allocation to nursing process organisation.

Studies have shown that increased dependency is associated with higher mortality.[2 3] It is likely that the increased mortality in task allocation wards is related to the nursing care given. Nearly four times as many patients were nursed in bed, nearly twice as many patients had open pressure sores, and nearly four times as many patients had an indwelling catheter. All of these practices carry a risk of complications and associated mortality.

If duration of stay in hospital and survival rate can be used as indicators of performance then task allocation nursing is less efficient than the nursing process. In addition, long stay patients in wards using the nursing process were appreciably happier than similar patients in traditional wards.

The findings of this study suggest that the use of the nursing process is associated with increased efficiency and improved quality of life. Although it is not possible to extrapolate these findings to other areas such as medicine or surgery, they do provide some indication that task allocation nursing can be positively detrimental to some patients and that the nursing process tends to minimise some of the "social iatrogenesis" associated with hospital treatment.

Comparison of outcome for patients between "nursing process" and "task allocation" wards. Figures are numbers (%) of patients

	"Nursing process" wards	"Task allocation" wards	p Value
Total No of patients	137	138	
Faecal incontinence	36 (26)	82 (59)	0·000
Urinary incontinence	78 (57)	91 (66)	0·02
Indwelling catheters	7 (5)	25 (18)	0·01
Incidence of pressure sores	18 (13)	32 (23)	0·02
Sometimes or always nursed in bed	19 (14)	67 (48)	0·000
Spoon fed	5 (4)	17 (12)	0·01
Mean dependency scores (CAPE scales)[1]	14·67	16·21	0·01
*Comparative data in three hospitals for 12 months preceding study**			
No of beds	84	84	
Deaths and discharges per available bed	2·58	2·09	
Overall stay (days)	141·2	174·2	
No of patients discharged	131	89	
No who died	86	87	0·06

*Source: SH3.

The study was undertaken during 1980 and 1981 and was funded by the Nurses' Commonwealth War Memorial Fellowship and the Department of Health and Social Security.

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[3] Donaldson LJ, Jagger C. Survival and functional capacity: three year follow up of an elderly population in hospitals and homes. *J Epidemiol Community Health* 1983;37:176-9.

SIR,—Like any writer, I aim primarily to generate discussion, and I think my recent article on the nursing process (21 January, p 219) has achieved this objective.

I have read the correspondence (11 February, p 483) with great interest, and I have also received many letters from medical colleagues throughout Britain. Space does not allow me to respond to individual letters, but I think that it is fair to say that I would accept some of the criticism of my article.

The need for nursing and medicine to maintain and develop an active dialogue is clearly recognised by many correspondents and becomes ever more essential in a health service that is beset by underfunding and constantly changing management structures. Unfortunately, many people would be only too happy to see the relationships between our professions weakened, and if the patient is to get adequate care we must, whenever possible, be in accord.

With this in mind, I wonder whether the time has come for the Royal College of Nursing and the British Medical Association to organise a joint forum. In my view all committees should be as small as possible, but a joint forum could have representatives from all branches of both professions, with a majority input from clinical nursing staff. Such a group could consider a wide range of issues that affect nurses and doctors and could perhaps go a long way in helping to avoid misunderstandings and to ensure that the best traditions of British health care are maintained in a positive and dynamic way. This group could also make some far reaching proposals for the development of joint training.

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***This correspondence is now closed.—ED, *BMJ*.

Do beta adrenoceptor blocking drugs cause retroperitoneal fibrosis?

SIR,—Mr John P Pryor and others (3 September, p 639) argue from a study of 100 subjects with retroperitoneal fibrosis and other published data that beta blockers do not cause retroperitoneal fibrosis. Several of their arguments and their overall conclusion require comment.