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Practicalities of Nursing

The critical letters on the Salmon report¹ that have appeared these last few weeks in the *B.M.J.* reflect a widely felt disquiet about its effects on nursing in hospitals. Not all the troubles complained of can fairly be laid at the report's door, but the effects of putting its recommendations into practice are already seen to be so questionable that a halt should be called.

The report is in some ways its own worst enemy. The mincing jargon it uses on so many pages has often raised a smile and can only detract from its message. We read, for instance, with the report's own characteristic italics, that the ward sister "is under the *control* of the Matron (structural authority) but, in matters of medical treatment, acts in accordance with the *directions* of the medical staff (sapiential authority)." The message that sound administration is as essential to nursing as to any other service does need getting across. Florence Nightingale herself warmly championed the cause all her life, and her comments on some of the local arrangements that have grown up in a somewhat haphazard way would have been brisk. But the report runs into much more serious criticism than may reasonably be directed at its jargon for its exaggerated devotion to the administrative side of nursing services in contrast to the practicalities of nursing. Perhaps this is epitomized most directly in the following two sentences from it:

"On the whole Ward Sisters seem to find their job satisfying. This we attribute largely to the fact that each exercises decentralized control and substantial delegated authority."

It is not unfair to say that this ludicrous idea of why ward sisters find a legitimate satisfaction in their work underlies the whole report. And it may be contrasted with another passage in which some kind of illicit satisfaction is hinted at:

"Senior nurses tend to interfere in ward matters more than they ought to, and, however laudable it may seem to the administrative nurse to 'roll up her sleeves' in the wards, it is often really a satisfying of her own needs and not a service to patients or Ward Sisters."

The committee that produced this report was appointed by the Minister of Health of the day in 1963 in response to several needs of very different kinds in the nursing service of the hospitals. One of these was the need to cope with a clinical practice that had rapidly become much more

complicated than it was a decade earlier. Technical procedures in diagnosis and treatment were being brought into use that required the presence of highly trained and experienced nurses in large numbers as well as technicians and medical staff. At the same time many of the traditional domestic chores that nurses used to undertake were rightly being delegated to a separate staff employed to do them. The idea that at least some nurses should have a university education to fit them for senior posts in due course was generally if somewhat uncritically accepted. Yet despite what seemed to be the undoubted attractions of nursing as a career too few girls came forward to enter it, and of those who did too many fell out during their training. For some years now matrons have been undertaking recruiting trips by jet aircraft to encourage girls to enter the profession, and without the many who have come from Ireland, the West Indies, and many other countries the service would long since have broken down. For nursing has failed to appeal to British girls as a career to the extent that it used to do. Here surely is where the attack should be made. Nursing itself must offer an attractive career, and the terms of service must compete successfully with those of other occupations.

Through the employment of many girls from overseas, whose work deserves to be gratefully acknowledged as well as properly remunerated, the hospital nursing service has, perhaps surprisingly, continued to expand. The Department of Health² has recently reported, for instance, that the total of nursing staff at 30 September 1970 was the highest ever recorded in terms of both numbers and whole-time equivalents. Whole-time staff increased by 0.7% over the previous year and part-time staff by 11%. But the numbers in training were not so satisfactory, there being a slight fall.

No doubt a multitude of motives attract girls (and some men) in the first place to nursing, but undoubtedly one of the rarest of them would be the ambition to become an administrator. Yet the Salmon report in effect opens the way to the top through administration rather than clinical nursing—and to many doctors the epithet "clinical" would seem redundant there. It is as though doctors in the hospital service were to progress through registrar to consultant appointments and then be promoted from there to a succession of administrative posts on their way to becoming manager-in-chief of the health service in their hospital or region. This misconception of the nature of professional

work and skill, of professional responsibilities, ethics, and independent judgement, is as baneful as it is fashionable. In another form it pervades the Consultative Document issued in May by the Health Department, again with its emphasis on managers, though in that case external.³ But if nursing is to offer an attractive career in its later stages to married women as well as single, to part-time as well as whole-time, it must allow them to nurse patients without suffering the jibe that they are "interfering" as the Salmon report puts it. The proper care of patients depends on nursing, not on administration. Likewise, the attractions of nursing as a career depend on the opportunities it offers to care effectively for the sick. This is chiefly a personal matter into which good administration—entirely laudable though it is—enters only to a small extent. If patients are to continue receiving the skilled attention they have hitherto enjoyed, advancement in the career of nursing must largely remain, as it does in medicine, in clinical practice.

¹ *Report of the Committee on Senior Nursing Staff Structure* (Chairman, B. Salmon), Ministry of Health and Scottish Home and Health Department. London, H.M.S.O., 1966.

² Department of Health and Social Security, *Annual Report, 1970*. London, H.M.S.O., 1971.

³ *British Medical Journal*, 1971, 2, 481.

Urinary Tract Infection Presenting as Jaundice

Several reports of an association in young infants between urinary infection and jaundice have appeared over the last decade, but have failed to excite much attention on this side of the Atlantic. In Britain a paper¹ in the *B.M.J.* in 1967 re-emphasized the importance of jaundice as a presenting sign of urinary tract infection in infancy and childhood which had remained forgotten since the description of three cases by E. Gorter and G. O. E. Lignac² as far back as 1928.

The usual clinical picture is of a young infant who is failing to thrive, losing weight, lethargic or irritable, and suffering from fever, jaundice, and moderate hepatomegaly. This year S. H. Ng and J. R. Rawstron³ described six cases all arising in early infancy. These were confined to male babies, four of whom had positive blood cultures but normal intravenous pyelograms, which have been features of American cases.⁴ The majority of cases have been recorded among young infants, but the condition should not be overlooked in childhood. A. B. Arthur and B. D. R. Wilson¹ described an illness superficially resembling infectious hepatitis in a 12-year-old girl, whose condition remitted after treatment of her urinary infection, but who became jaundiced once again when this relapsed, finally recovering after a further course of treatment with another antibiotic.

Hepatocellular impairment is considered the main factor in the production of the jaundice. G. Neale and colleagues⁶ had access to clinical data, biochemical tests of liver function, and biopsy material. They described pathological changes in adult patients who presented with pyrexia of unknown origin and were later found to be suffering from extrahepatic bacterial infections. Though none of their patients was jaundiced, there were profound disturbances of liver function, which might have been erroneously interpreted as having their origin in the liver or biliary tract.

Liver biopsy showed a nonspecific reactive hepatitis with an increase in concentration of Kupffer cells and some infiltration of the portal tracts with inflammatory cells. Portions of the liver sent for culture were sterile, though blood cultures were positive in some at the time of biopsy. Had antibiotics not been given it is reasonable to suppose that more severe histological changes and jaundice would have supervened, as in patients dying of bacterial infection in the pre-antibiotic era.

J. Bernstein and A. K. Brown,⁷ recording cases in infants of jaundice with sepsis which included pyelitis, found similar histological changes of variable degree in specimens of liver taken from post-mortem material. Since the impairment of liver function has no relationship to specific organisms it would not, in the case of urinary tract infections, be necessary to implicate "hepatotoxins" formed by Gram-negative bacilli. Fever, either artificially induced as hyperthermia or in heat stroke, may of itself damage the liver and produce jaundice,⁸ but, though they were febrile, hyperpyrexia was not a feature of those infants in whom the urinary tract was involved.

Haemolysis plays a part in the production of the jaundice, even necessitating blood transfusion at times.⁵ Ng and Rawstron describe a peripheral blood picture of polychromasia, spherocytosis, burr cells, and nucleated red cells reminiscent of the haemolytic uraemic syndrome. In the older textbooks a fatal infection associated with haemolysis, severe icterus, and haemoglobinuria was sufficiently well recognized to merit the name of Winkel's disease.¹⁰ The presence of bilirubin in the urine indicates that the jaundice is not entirely due to haemolysis. Cholestasis as such is probably not an important factor, but in association with dehydration, haemolysis, and liver impairment it plays a part in the overall syndrome. Poor elementary hygiene may be a predisposing factor as in the cases of Ng and Rawstron, whose patients were babies of immigrant parents in social grade V. Most of the other series appear to be of similar socio-economic background.

R. A. Seeler and K. Hahn,⁵ citing eight reported series totalling 88 cases, found a male predominance of 3 to 1 in contrast to the usual pattern of female preponderance found in older children with demonstrable anomalies of their urinary tracts. Speculation on the source of infection has been unrewarding. A. Y. Sweet and E. Wolinsky¹¹ and J. F. Kenny and colleagues⁴ referred to their series as "outbreaks," but no similar numbers have been reported in this country. Specific strains of escherichia were isolated in two Baltimore hospitals,⁴ and the possibility of a pyelopathogenic strain was considered, but on the evidence that hypothesis must be discarded. Though they are frequently associated with positive blood cultures, large numbers of pus cells in the urine denote a pyelonephritis rather than a bacteriuria, which may accompany septicaemia. The primary site and mode of entry have also defied elucidation. Umbilical sepsis, which may ascend the umbilical veins to the liver or descend via umbilical arteries to infect the urine, would offer a neat explanation, but is without any supporting evidence.

The diagnostic importance of associating jaundice with urinary tract infection is obvious. Several deaths were reported in earlier series,⁴ ⁷ ⁹ and others may have occurred when the true nature of the disease was overlooked. Ng and Rawstron rightly stress the early recognition of urinary-tract infection with renal impairment, for the jaundice may divert investigations into other channels, resulting in a fatal delay in beginning treatment. These reports have a simple