than simple central venous catheterisation.¹⁰ Careful interpretation of haemodynamic information is required as well as clinical experience in the management of severely ill patients.

The cost of bedside haemodynamic monitoring is relatively small considering the overall cost of modern intensive care. At current prices each procedure costs about £100 for disposable items. The initial outlay for a transducer, pressure monitor, and cardiac output computer is about £6000. Fluoroscopic screening is available in most radiology departments, but a portable bedside image intensifier in the cardiac care unit is an added advantage for right heart catheterisation as well as for emergency cardiac pacing.

An invasive and technologically specialised procedure requires careful application in a general hospital. It is becoming apparent that the district general hospital has an increasingly important role in the assessment of cardiological disease.¹¹ Bedside haemodynamic monitoring is now a well established technique which is often invaluable in the management of critically ill patients and can be performed safely and effectively in a general hospital.

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Contemporary Themes

Parental access and family facilities in children's wards in England

ROSEMARY THORNES

The National Association for the Welfare of Children in Hospital works to improve the care of children in hospital. Twenty four years after the publication of the Platt report,¹ which recommended that parents should have unrestricted access to their children and that young children should be admitted with a parent, we still receive several telephone calls and letters each week from parents. Many require support for what they intuitively know is the right thing for them to do—to stay in hospital to help care for their child. A series of regional and national surveys² carried out by the association have shown a gradual relaxation of rules and a greater part being played by parents in the care of their sick children. Progress has been very slow, however; by 1975 only 19% of wards had introduced unrestricted access. In 1979 the Consumers' Association sample survey³ investigated the opinions of staff and parents and found a considerable gap between staff attitudes and parents' expectations. The Platt committee also stated: "We strongly recommend that children should not be nursed in adult wards."¹ The National Association for the Welfare of Children in Hospital celebrated its 21st anniversary in 1982, and this seemed an appropriate year to survey the situation, review the trends, evaluate the association's own work and update thoroughly the index of wards that is kept at its head office.

Methods

The survey covered all acute wards in England that nurse children up to the age of 16, excluding psychiatric units, day wards, and special care baby units. In practice, most children over the age of 12 were excluded as most are nursed in adult wards; such wards were included only if they nursed more than 50 young children a year. Experience has shown that practice on the ward does not always conform to hospital policy; as we were anxious to gather the same information that a parent would be given we approached ward sisters by telephone, and administered a questionnaire consisting largely of structured questions on access, overnight accommodation, and facilities for parents.

Results

A total of 1143 ward sisters were approached; 1063 (93%) questionnaires were completed, of which 887 were considered suitable for analysis. Table I shows the designation of these 887 wards. Despite the recommendation of the Platt report, a total of 250 of the 887 wards in which children were nursed (28%) were adult wards. This shows little improvement since 1978, when 31.7% of all children aged under 16 were still being nursed in adult wards or annexes.⁴

In 1971 the Department of Health issued advice to health authorities to gather children together into comprehensive units.⁵ The largest proportion of wards studied, representing paediatric general and mixed medical and surgical wards, certainly fall into this category, as do many of the children's surgical wards, though some are still located in separate hospitals, isolated from other children's services. Most burns and plastic surgery wards; orthopaedic wards; ophthalmic wards; isolation wards; and ear, nose, and throat wards are not in

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the children's unit. Table II shows the proportion of wards for each specialty in this survey.

A total of 727 wards in England admit children for surgery. Table III shows that just over half are either paediatric general or children's surgical wards.

Of all the specialties, the ear, nose, and throat departments have the greatest number of specialised wards to which they admit children for surgery. Of all wards admitting children for ear, nose, and throat surgery 42% are specialised, 34% are paediatric general, 18% children's surgical, and 6% others.

TABLE I—Designation of 887* wards in which children were nursed

	No	%
Children's	632	72
Adult	59	7
Adult with children's beds	127	14
Adult with annexe	64	7
All adult wards	250	28
Total	882*	100

*Five wards could not be included in any of the categories.

TABLE II—Specialty of 887* wards studied

	No	%
Paediatric general	332	38
Children's surgical	119	13
Ear, nose, and throat	111	13
Isolation	72	8
Ophthalmic	65	7
Orthopaedic	62	7
Burns/plastic surgery	34	4
Other specialties	90	10
	885*	100

*Two wards did not give details.

TABLE III—Details of wards admitting children for surgery

Ward type	No	%
Paediatric general	257	35
Children's surgical	119	16
Ear, nose, and throat	111	15
Ophthalmic	64	9
Orthopaedic	58	8
Burns/plastic surgery	32	4
Other specialties	86	13
Total	727	100

ACCESS

The National Association for the Welfare of Children in Hospital maintains that parents are not visitors and that they should be encouraged to come and go according to their own and their child's needs, in consultation with the ward staff. Four hundred and thirty one of the 887 wards studied (49%) now follow this practice and have abolished visiting hours for parents (table IV). A comparison of the figures for adult wards and children's wards shows two immediately

TABLE IV—Hours of access for parents on wards to which children are admitted. Figures are numbers (%) of wards

	24 hours	24 hours except operating day	10-23 hours	10-23 hours except operating day	9 hours or less
All wards (n = 885)	430 (49)	30 (4)	234 (26)	66 (7)	125 (14)
Children's wards (n = 635)	330 (52)	29 (5)	177 (28)	32 (5)	64 (10)
Adult wards (n = 250)	97 (39)	1 (1)	57 (23)	34 (14)	61 (23)

apparent differences: 52% of children's wards have unrestricted access, compared with 39% of adult wards; and 23% of the adult wards are open to parents for less than nine hours a day as against only 10% of the children's wards. At the lowest end of the scale there are now only 12 wards that allow less than four hours' visiting for parents. Nine of these are adult wards. The figure shows the percentage of wards in each National Health Service region allowing unrestricted access.

Access on operating day—Some children have access to their parents severely limited on the day of their operation. We compared the responses of paediatric general and specialised ear, nose, and throat wards to this question. Table V shows that children who are being nursed in paediatric general wards are far more likely to have their parents present after the operation than those in ear, nose, and throat wards. Thirty six wards had blanket restriction rules on operating day; several banned parents for 36 hours.

Unrestricted access by National Health Service regions. Wards with unrestricted access are shown as percentages of total number of wards surveyed in each regional health authority.

TABLE V—Comparison of parental access in paediatric general and specialised ear, nose, and throat wards on day of operation. Figures are numbers (%) of wards

	Visiting allowed	Visiting restricted	No visiting
Paediatric general (n = 256)	237 (92)	12 (5)	7 (3)
Ear, nose, and throat (n = 111)	64 (58)	20 (18)	27 (24)

OVERNIGHT ACCOMMODATION

In this survey parents' beds were defined very widely to include folding beds and comfortable chairs, and a question was also included on the location of the accommodation. We believe that parents do not mind a little discomfort: the great need is to be within sight and hearing of their children, especially if the child is young or in hospital for only a few days. Accommodation away from the noise of the ward is valuable for parents of older children or when a child is admitted for a longer term.

A total of 790 (89%) of the wards can provide some sort of overnight accommodation for parents. Overall, the ratio of parents' beds to

children's beds is 1 to 3.4, but this figure hides great extremes. For instance, 303 wards say that they have a parent's bed for every child's bed or that they would never turn a parent away, whereas 97 wards, including 27 paediatric general or children's surgical wards, can offer no accommodation whatsoever, on or off the ward, except in a case of emergency.

Hospitals were flexible about the location of the accommodation. A total of 363 (46%) of the 790 wards contrive to have all their parents' beds on the unit, either in parent/baby cubicles or beside the child in the open ward; 126 (16%) can provide accommodation only off the ward; and the remainder manage a mixture of the two.

Discussion

These findings indicate that we have reached a halfway stage in the implementation of the Platt recommendations. Parents are still looked on as visitors in half the wards, which limit their presence by blanket rules. These wards need to think through the implications of this policy; if it is desirable for a parent not to be present at any time or on operating day it should be discussed individually with the particular child's welfare in mind. The analysis of the data for ear, nose, and throat wards confirms the picture we have built—namely, that parents have more problems in these wards than in any other. These wards have, however, improved more rapidly than other wards over the past seven years—for instance, the proportion of wards with unrestricted access has risen from 8% to 32%.

The provision of overnight accommodation for parents is still far from satisfactory. In wards where parents are encouraged to stay and help with the care of their children more

than half choose to do so. Elsewhere, wards provide no accommodation at all or the ward sisters claim that parents' beds lie empty; in these cases, we feel that there may be a negative attitude that discourages parents from asking to stay. The wards that welcome parents display enormous ingenuity in finding and locating beds, even though the ward might be old and crowded.

At least half of the wards that nurse children are not yet part of comprehensive children's units. There has been a welcome trend to admit children to the district general hospital rather than to the small local hospital, especially for surgery. Nevertheless, few specialist surgical wards are being incorporated into the children's unit, even in new hospitals. More disturbing is the problem that arises with the modern trend to open a hospital in parts; in certain cases, the comprehensive unit has been threatened by plans to hive off one part.

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Aviation Medicine

Is the crew fit to fly?

II: Specific medical considerations

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No matter how a pilot reaches the doctor's consulting room there are several well recognised areas to which the examining doctor must pay particular attention.

Cardiovascular disorders

In civil aviation the most common reason for loss of licence is a cardiovascular disorder and this accounts for 60-65% of such losses each year in the United Kingdom.¹ Furthermore, about 75% of these are due to coronary artery disease.² Clearly, if coronary artery disease is overt there is no dilemma for the licensing authority; but considerable difficulty follows the

discovery of asymptomatic electrocardiographic changes on routine examination. Evidence of unequivocal infarction should lead to immediate revocation of the licence but any other changes—for example, ST segment and T wave abnormalities, which are common in normal people—demand referral for further assessment. This will usually require exercise testing with perhaps beta-blockade. These tests will often correct the ST segment and T wave changes if the myocardium is healthy (although beta-blockade has also been shown to improve or even return to normal the electrocardiograms of those with ischaemic heart disease³). Where doubt remains exercise thallium scanning or three dimensional echocardiography or both may be performed, while coronary arteriography may be required in selected cases.⁴ The need for such careful assessment, particularly when a professional career is threatened, was amply illustrated in a study in which all but one of 20 asymptomatic subjects with ischaemic changes on electrocardiograms were shown to have unobstructed coronary arteries.⁵

A pilot who presents only a slightly increased overall risk of sudden incapacitation may be allowed to continue flying with, or

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