Mixed sex wards

EDITOR,—Mixed sex wards exist in many hospitals,[1] but there are few studies of their acceptability to patients. We carried out a simple survey to determine patients' opinions before and after relocating the accident and emergency observation ward of this hospital from a ward with single sex six bed bays to a mixed sex Nightingale ward. The ward with single sex bays had separate toilets and washrooms for men and women; the mixed sex ward had shared toilets and washrooms, although the nurses tried to ensure that only men or women used these at any one time. Patients were aged over 13 and required observation or investigation for various acute problems. Most were discharged within 24 hours.

Patients were asked to complete questionnaires anonymously. The important questions concerned the arrangement of sexes in the ward and the toilet and washing facilities. Responses were confined to good, satisfactory, or unsatisfactory. Space was available for comment.

Fifty four questionnaires were completed from the separate sex ward and 194 from the mixed sex ward. In the separate sex ward no patient was dissatisfied with the arrangement of sexes or with the toilet and washing facilities, whereas in the mixed sex ward 60 patients were dissatisfied with the mixing of sexes and 31 with the toilet and washing facilities. Many written comments from patients in the mixed sex ward indicated disapproval: some were shocked to find themselves in such a ward.

We could not find any previous study on this topic in medical journals. We found two recent reports in nursing publications, one generally advocating and one opposing mixed sex wards. In the study advocating such wards patients were given the option of refusing admission; there were no emergency admissions.

Our study was of a short stay observation ward. It has been suggested that having a mixed sex ward for overnight admission is not unreasonable, but nearly one third of our patients disagreed. Perhaps the extreme range of conditions and ages is a factor. Why has this subject not been more fully addressed? In these days of the patient's charter what would patients choose? We believe that concern for personal privacy may be submerged by administrative demands.

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1 Tonks A. Women patients vulnerable in mixed psychiatric wards. *BMJ* 1992;**304**:1331. (23 May.)

London's health care

EDITOR,—The King's Fund's study of health care in London over the next 18 years accurately describes some of the deficiencies of the existing services, but some of the proposed solutions seem unrealistic.[1,2]

The report states that beds in London will fall by a quarter over this period and suggests that hospitals should act as high tech treatment centres from which patients can be quickly shuttled back to convalescent and nursing homes or the care of their general practitioner. To take one quoted example, knee and hip replacement operations would take place in "dedicated day case or short stay treatment centres" and the patients would then be transferred to "hospital hotels" or hospital at home arrangements. How can these patients, nearly all elderly, convalesce and be rehabilitated without 24 hour medical or nursing care?

Dermatology, we are told, would probably cease to exist as a hospital specialty as consultants would hold clinics in local health centres and more consultants would visit and treat patients at home. How, with 30% fewer medical posts, they would continue to see the same number of patients when travelling would triple consultation times is not explained.

Psychiatric patients should also be "almost entirely primary and community based." The report ignores the fact that overenthusiastic closure of psychiatric hospitals has already meant that a high proportion of London's schizophrenic population sleeps rough or is in prison cells.

The report points out that financial constraints have led to general practice in London being below the national standard, with more elderly and singlehanded practitioners working from inadequate premises. Yet it does not propose how to change this. We are simply told that "London's primary health care practitioners would have the main responsibility for health promotion, care and treatment in the capital in the twenty-first century" and that much work currently done in hospital could be transferred to "primary health care premises." For example, in one of the sample cases described the general practitioner supervises chemotherapy for a patient with breast cancer (and also, incidentally, organises travel vouchers to get her to hospital, which suggests that the general practitioner has assumed the role of social worker as well).

How are these health centres to be funded? And how would general practitioners cope with the extra work when they are already overstretched by the demands of the new contract? Obviously, list sizes would have to fall and new general practitioners would have to be attracted to work in London. Yet no mention is made of how this might be done. In general terms the report states that money realised from selling hospitals can be used for new developments. But the closure of Friern Barnet psychiatric hospital in my area has not been encouraging: the slump in the property market has greatly reduced the value of the site and a large proportion of the funds available has been spent on a succession of plans, with little definite so far.

In my part of London the local district general hospital has seen its beds more than halved in the past 10 years with dire effects on waiting lists, and I can find little in the report to convince me that the situation is going to improve in the next 18 years.

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1 Smith J. London's health care again. *BMJ* 1992;**304**:1646-7. (27 June.)
2 Smith J. London's health care in 2010. *BMJ* 1992;**304**:1651. (27 June.)

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.

EDITOR,—The King's Fund has recommended a reduction in the number of acute beds in London, and the arguments in favour of this are presented in detail in appendix 4 of its report.[1,3] Though the case for reducing the number of surgical beds is based on the impact of day care surgery and the effective treatment of patients locally in district general hospitals, the proposed 47% reduction in the number of acute medical beds seems to be based mainly on a planned increase in the availability of community based health care concentrated in health centres.

The report is not explicit about the resources that would be required to achieve these objectives, and the authors have not defined the kinds of clinical problems that the health centres are intended to manage, although sample clinical stories are presented. Undoubtedly, such a course of action would mean a change in the way that many, if not most, general practitioners manage their patients, so that many more patients with acute problems would be cared for at home rather than in hospital.

It would be surprising if there were any large scale models in the United Kingdom on which such radical changes could be based, desirable as they may be; no doubt the authors would have referred to them had such models existed. Would it not be helpful to identify the problems and costs by setting up a community based pattern of care of this nature in one or two districts before decisions are made to withdraw so many acute medical beds from London?

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1 Smith J. London's health care in 2010. *BMJ* 1992;**304**:1651. (27 June.)
2 Smith J. London's health care again. *BMJ* 1992;**304**:1646-7. (27 June.)
3 King's Fund Commission on the Future of London's Acute Health Services. *London health care 2010: changing the future of services in the capital.* London: King's Fund, 1992.

Reporting to NCEPOD

EDITOR,—L Clark and colleagues emphasise the difficulty in ascertaining cases of perioperative death from routine hospital information systems and from a special scheme for coding deaths based on the records of patients who have died in hospital.[1] As the national confidential enquiry into perioperative deaths does not include Scotland we depend on local audits.

In the Glasgow audit of surgical deaths we make telephone inquiries to mortuary attendants in six major hospitals three times a week to identify all deaths. The date of death, date of birth, and ward number are recorded. A list of wards and their specialty is referred to, and a subsequent telephone call to nursing staff, secretaries, or ward clerks in the relevant wards establishes whether there was a surgical intervention in the 30 days before the patient died and the name of the surgical consultant in charge. Because one person in the surgical