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 submerging 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

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.

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.)

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

audit office makes all the telephone calls a good relationship has been built up with the hospital staff, and it seems unlikely that many cases are missed.

On the basis of this telephone information two forms are sent to the consultant surgeon: one is for the surgeon, and his or her secretary passes the other, with the case notes, to the appropriate anaesthetist. In three successive six month periods we acquired similar numbers of deaths in surgical wards (about 600), of which around half occurred perioperatively.

The advantage of this system is that it does not depend on the medical records and that follow up calls to staff are made, and forms reach surgeons, soon after the patient's death, when the case is readily recalled. The medical records, however, are needed subsequently by the surgeon and anaesthetist to complete the forms.

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1 Clark L, Doyle P, Duran E, Kishore P. Effective audit: reporting to the national confidential enquiry into perioperative deaths. *BMJ* 1992;304:1472-4. (6 June.)

EDITOR,—L Clark and colleagues' report on the effectiveness of computer and manual systems for identifying perioperative deaths clearly shows the problems entailed in collecting such data over a long period and highlights potential implications with regard to large scale underreporting.

In line with the request from the National Confidential Enquiry into Perioperative Deaths that all reports for the period 1 April 1991 to 31 March 1992 should be submitted by 30 June we have used the patient administration system for a retrospective analysis of deaths during this period (in addition to using the routine manual system in operation). The hospital information department supplied the data, and a simple computer program was written to eliminate all those cases that did not fit the confidential inquiry's criteria.

The table shows that the patient administration system proved the most effective method of reporting cases, recording a third more deaths than the manual system. Assuming that the computer system and manual system in tandem discover all deaths in hospital, the manual system found 64% of all cases eligible for reporting to the National Confidential Enquiry into Perioperative Deaths whereas the computer system found 86%. The computerised search proved preferable in terms of saving the time of the local reporter and assistants.

Although the computer proved the best system, the 15% of deaths that were missed (compared with the 50% reported by Clark and colleagues) is still rather high, and further attention needs to be given to improving the system by which patients' details are entered into the computer. This is shown by

our analysis of the 28 cases missed. For 13 of the patients picked up by the manual system we could not find any apparent reason for their omission from the patient administration system; eight patients were emergency admissions who died within 24 hours; three patients were operated on outside the district and transferred to Brighton; and four patients were admitted under physicians but passed on to a consultant surgeon for an endoscopic procedure. This last group highlights a problem with using the information kept in the patient administration system because the admitting doctor is the only indicator of the person who performed the procedure, and this potentially can lead to unreliable data for those patients who, for example, have an endoscopic procedure that could be done by a consultant surgeon or physician. Fortunately, our endoscopy unit uses its own clinical information system, which can clarify who performed the procedure.

Experience in Brighton shows that it is not necessarily true that hospital information systems cannot be used to replace a manual system. The main drawback at the moment seems to be not the extent of completeness of the records in the patient administrative system (although there is scope for improvement) but, firstly, the fact that a data item required by the National Confidential Enquiry into Perioperative Deaths—the name of the anaesthetist—is omitted and, secondly, that you have to assume that the operating surgeon was also the named consultant at admission.

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1 Clark L, Doyle P, Duran E, Kishore P. Effective audit: reporting to the national confidential enquiry into perioperative deaths. *BMJ* 1992;304:1472-4. (6 June.)

EDITOR,—We were disappointed to read the paper by L Clark and colleagues because of the false emphasis that its title and some of the discussion give to the National Confidential Enquiry into Perioperative Deaths.¹ The material reported has nothing to do with the inquiry. The paper was shown to us in March 1989, when we were still finalising systems for reporting. The authors were then students in community medicine and were commissioned to investigate various systems of notification of death in hospital that might be useful if Lewisham and North Southwark Health Authority was to participate effectively with us. They studied only the first six weeks of the first year of the national inquiry but now draw invalid conclusions as if the data still apply to the rest of the country.

The authors' hospital reporting system was indeed unsatisfactory, but some of those in the remainder of the country were much superior and have improved further since the inquiry began. Our local reporters work hard in conjunction with

medical records and medical audit staff to achieve this, and the profession should be grateful for their efforts.

Both our reports (1989 and 1990) comment in clear terms about the imperfections of hospital information systems, and this report does not add anything to what is already known except that 21% of dead patients' records were (in 1989) lost in Guy's and Lewisham Hospitals.

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AUTHOR'S REPLY,—I regret that those who have done so much to establish surgical audit were disappointed by our paper. It was because of our belief in the importance of the National Confidential Enquiry into Perioperative Deaths and other emerging audit systems that we submitted the paper for publication even though the fieldwork was two years old. Two points that we made, critical to any audit system, are still relevant and will remain so for the foreseeable future.

Firstly, whatever system is used to ascertain cases for audit needs to be validated and revalidated at intervals or cases will be missed and audit performance will deteriorate. Secondly, when considering installing or improving hospital information systems doctors and managers should ensure that the system is capable of capturing and delivering the clinical information needed for medical audit.

I trust that our paper will remind doctors reporting to the confidential inquiry, or involved in other audit systems, or audit their own performance from time to time to ensure that the high standard set by the inquiry is maintained.

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Misuse of temazepam

EDITOR,—In their letter on intra-arterial injection of temazepam Roy N Scott and colleagues state that the gel used in temazepam capsules is insoluble in water.¹ This is incorrect. All macrogols are highly soluble in water, forming clear solutions. In the anhydrous state the macrogols used in the temazepam gel fill formulation range in appearance from viscous clear liquids through white, soft paraffin-like masses to hard crystalline wax-like substances. When these are blended together a stiff gel is produced. All these ingredients are, however, water soluble, and so is the resultant gel.

In the capsule temazepam is dissolved in this macrogol blend; experimental work has shown, however, that when this formulation is mixed with a small volume of water (as Scott and colleagues describe) the temazepam is precipitated out, being practically insoluble in water (maximum solubility less than 0.01%). Both Scott and colleagues and M Adiseshiah and colleagues refer to suspensions, fine particulate matter, and blockade of vessels by microemboli.^{1,2} It is the temazepam particles rather than the formulation's excipients that are likely to initiate the microemboli. This applies to any solid form of temazepam for oral dosing.

Scott and colleagues refer to the Home Office having requested withdrawal of liquid filled capsules and then suggest that manufacturers responded by substituting the liquid fill capsule by the gel formulation. In fact, before the Home Office's action Farmitalia Carlo Erba and R P Scherer had initiated an extensive reformulation

Performance of manual system and patient administration system in identifying deaths eligible to be notified to National Confidential Enquiry into Perioperative Deaths

Month	Manual system	Patient administration system	Matched cases	Cases eligible for National Confidential Enquiry into Perioperative Deaths
April 1991	13	16	12	17
May	16	15	10	21
June	9	13	7	15
July	8	7	2	13
August	11	16	9	18
September	7	9	5	11
October	10	18	8	20
November	8	13	7	14
December	8	16	8	16
January 1992	10	11	7	14
February	10	16	10	16
March	13	14	10	17
Total	123	164	95	192