Firstly, our department receives a considerable number of requests for postcoital contraception. Other local departments do not provide this service; provision by family planning clinics and general practitioners is patchy and usually limited to working hours. During January this year 45 women were registered in our department for postcoital contraception. Levonorgestrel-ethinyl-oestradiol was prescribed to 43 of them after evaluation and discussion. The range of ages was 13 to 41 years (mode 16 (n=8), median 19, mean 21 (SD 6.4)). Of the 45, 19 attended on a Saturday, 12 on a Sunday, and five on a Bank Holiday Monday. Thus only nine presented in the working week.

It is of concern that five patients were under 16. None was accompanied by a parent, but all were adjudged sufficiently mature to be treated without parental consent and prescribed levonorgestrel-ethinyl-oestradiol. It is even more worrying to speculate how many of this group fail to attend their general practitioner or a family planning clinic for a follow up pregnancy test, contraceptive advice, and wider counselling. Critics of this approach should ask themselves what alternatives there are: dealing with a situation with a 30% chance of an unplanned teenage pregnancy surely comes into the category of emergency medicine.

Secondly, young adult women not uncommonly present to the accident and emergency department with abdominal pain. Urinary tract infections, pelvic inflammatory disease, normal or ectopic pregnancy, and even labour manifest in this way.

Our point is this: by sitting in their purpose built clinic and waiting for people to come to them are the sexual health specialists in danger of seeing those women most in need pass them by? Providing emergency treatment should be within the remit and capability of any accident and emergency department, and this should apply equally to matters of sexual health. But can the specialists reach out to these women whose attendance is definitely unplanned?

M Q CHOYCE
Senior registrar
A K MAITRA
Consultant in charge

Accident and Emergency department,
Royal Victoria Infirmary,
Newcastle upon Tyne NE1 4LP

1 Stedman Y, Elstein M. Rethinking sexual health clinics. *BMJ* 1995;310:342-3. (11 February.)

Australia and New Zealand have taken the lead

EDITOR,—Yvonne Stedman and Max Elstein's editorial touches on an issue in which Australia and New Zealand have perhaps taken the lead—the development of broad based sexual health services.¹ Indeed, as well as providing services for sexually transmitted diseases and basic family planning under one roof—a common practice for state funded sexually transmitted disease clinics for over 20 years—the clinical staff increasingly receive training in such diverse topics as sexual and relationship counselling, sexual assault, sexual dysfunction, and promotion of sexual health.² As a minimum this promotes the identification of problems and efficient referral. Specialist counsellors on site can manage most of these broader problems, particularly if they give rise to a risk of sexually transmitted diseases or HIV infection. There has been no rivalry with our federally funded (and therefore separately located) family planning services, which have enthusiastically provided many of their clients' needs with regard to sexually transmitted diseases and other sexual health problems for the past decade. Cross referral is confined to problems requiring specialist assessment.

In recent years almost all of Australia's sexually transmitted disease clinics have changed to the title

"sexual health" clinics. This change reflects a population based approach to health. It also gives patients and staff permission to address a wider range of concerns regarding sexual health. A request for "morning after" contraception may be a more reliable indicator of risk of a sexually transmitted disease or HIV infection than a vaginal discharge. Helping a young gay man through the process of "coming out" provides an opportunity to ensure that his sexual career will be safe. Whatever patients' presentation, the prime objective is that they leave the service with the knowledge and means to reduce morbidity from sexually transmitted diseases and HIV infection within their sexual milieu. All patients are screened for bacterial sexually transmitted diseases, hepatitis B status, contraceptive cover, genital neoplasia, drug use, and other personal or cultural risk factors for acquiring sexually transmitted diseases or HIV infection, and most are counselled and tested for antibodies to HIV.² When appropriate the model has included full primary medical care for populations with particular need—for example, gay men, aboriginal people, drug injecting "street kids,"^{3,4} and sex workers.^{2,4,5} General practitioners ensure that they are an essential component of the network by managing most people with symptomatic sexually transmitted diseases or early HIV infection and by addressing the bulk of the population's contraceptive needs.

Australasian sexual health services see their roles as addressing gaps in services; providing specialist support; and functioning as a focus for training, research, and surveillance. Some services also provide clinical services and health promotion on an outreach basis.^{4,5}

The training of Australasian venereologists places less emphasis on training in internal medicine than that of their British counterparts. Australasian venereologists tend to focus on ambulatory care and leave most inpatient care of patients with HIV infection to immunologists and infectious disease physicians when they are available.

Though the model is still evolving, we believe that there is merit in reducing the fragmentation of individual patients' sexual health needs. Discussion has even begun on the notion of partially blending medical training and career structures through an integrated body of sexual health physicians while maintaining subspecialist skill.

BASIL DONOVAN
Director
GRAHAM NEILSEN
Staff specialist
ADRIAN MINDEL
Professor

Sydney Sexual Health Centre and
Academic Unit of Sexual Health Medicine,
Sydney Hospital,
Sydney,
Australia

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Most genitourinary physicians are trained in family planning

EDITOR,—Yvonne Stedman and Max Elstein seem not to appreciate that an integrated model of care for sexual health already exists.¹ One example is our department of sexual health in Bolton, where we have an integrated and comprehensive range

of care. This includes a genitourinary medicine service; family planning; a sexual dysfunction clinic; primary, secondary, and tertiary intervention in screening for cervical cancer; a specialised vulval clinic; and a full range of HIV services. This allows quick cross reference within the department when necessary, and all patients attending have full access to the department's facilities, which avoids duplication of services.

The authors rightly point out that much overlap exists between many medical specialties, including family planning, genitourinary medicine, and gynaecology. Colposcopy services are another area of sexual health that may be included. Many genitourinary physicians have had formal training in family planning, and many are members of the Royal College of Obstetricians and Gynaecologists. In a telephone survey of 60 trainees in genitourinary medicine in Britain 47 had had training in family planning that was recognised by the Faculty of Family Planning. Of the 34 senior registrars and 26 registrars questioned, 30 (88%) and 17 (65%) respectively had had training. This trend is encouraging, with nearly all physicians having had training by the time they became senior registrars.

We agree that the future lies in a more comprehensive sexual health service for patients, and much can be learnt from countries with such a service.² The specialty of genitourinary medicine is ideally placed in terms of flexibility, availability, and trained medical staff to provide this. From our experience, this model of care is highly efficient and comprehensive and provides an excellent service for patients in a seamless way.

DAVID NUNNS
Lecturer

D MANDAL
Consultant in genitourinary medicine

Department of Genitourinary Medicine,
Bolton Hospitals NHS Trust,
Bolton BL4 0JR

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Patients prefer clinics to have non-descriptive titles

EDITOR,—Yvonne Stedman and Max Elstein suggest that genitourinary medicine and family planning services should work closely together in an attempt to provide a comprehensive sexual health service for patients.¹ Many genitourinary medicine clinics have for some time appreciated the need for sexual health care and provide skill in colposcopy, psychosocial medicine, and genital dermatology in addition to prescribing or offering advice on contraception. Although the days of the old style "venereal disease clinic" are gone, the associated stigma remains. The change of name from venereology to genitourinary medicine has helped to emphasise the wider remit of the specialty, which in turn will aid the process of reducing the stigmatisation. The use of the term sexual health clinic might, however, reverse this trend.

To establish which title is preferred by people attending clinics, 150 patients were asked to complete an anonymous questionnaire asking what name they would like to see on signs in the hospital that lead to our clinic. Eight titles were proposed, including our current name (clinic 1A—genito-medical clinic), and more than one title could be chosen. Clinic 1A was chosen by 98 subjects, a "name" (for example, Lydia clinic) by 35, department of GU medicine by 23, department of genitourinary medicine by 20, department of sexual health by 20, GU medicine clinic by 17, sexual health clinic by 17, and genitomedical clinic by 12.

Our patients seem to prefer a non-descriptive

title. Other titles were not well favoured. Omitting the terms "sex" and "genito" may reduce potential embarrassment, and we currently favour the title clinic 1A—department of GU medicine. The next step must be to educate, at a national level, both the lay public and some of our medical colleagues about the nature of genitourinary medicine as a specialty.

C SONNEX
Consultant in genitourinary medicine
C A CARNE
Consultant in genitourinary medicine
SARAH EDWARDS
Senior registrar in genitourinary medicine

Addenbrooke's NHS Trust,
Cambridge CB2 2QQ

1 Stedman Y, Elstein M. Rethinking sexual health clinics. *BMJ* 1995;310:342-3. (11 February.)

Improved communication and referral process may be a better use of resources

EDITOR,—We agree with Yvonne Stedman and Max Elstein that coordination and collaboration between family planning and genitourinary medicine services are urgently needed but believe that this collaboration should be extended further.¹

After identifying that an appreciable number of patients attending our genitourinary medicine unit were at risk of an unwanted pregnancy² we developed on site family planning services provided by medical and nursing staff trained in both disciplines. In addition we provide on site facilities for psychosexual counselling and treatment; psychological support for patients attending with genital herpes simplex infection; therapy aimed at reducing the risk of HIV infection; adolescent services and education; and clinics for specific chronic genital problems, including vulval and penile disease.

Together with others we have shown that genital infection with *Chlamydia trachomatis* is present in 8.0-9.5% of women undergoing a termination of pregnancy,^{3,4} and a collaborative venture with gynaecology colleagues providing coordinated screening for sexually transmitted diseases and contact tracing for women before termination has been highly successful.⁴

More recently we have determined, with a self administered questionnaire, the perceptions and gynaecological needs of women attending mixed sex or women only genitourinary medicine clinics. Of the 186 respondents (110 attending mixed sex clinics, 76 attending women only clinics), 48 reported attending for gynaecological problems, 28 of which concerned menstruation, the remainder appertaining mainly to pelvic pain or issues related to fertility. Discussions about gynaecological issues, regardless of the reason for attendance, would have been welcomed by 50 women. Eighty one women perceived genitourinary medicine doctors as "gynaecologists," with 142 women reporting knowledge of the role of gynaecologists. One hundred and seventy six women thought that there should be open access to gynaecology services, most choosing to access these services within genitourinary medicine clinics, although confidentiality was not cited as a major reason.

We have already extended services widely, and how much further collaboration should extend is debatable—for example, should gynaecology and urology services, well women and well men clinics, breast clinics, and minor surgery also be incorporated into genitourinary medicine clinics? The answer is unclear. It may be that simply improving communication with rapid, easy referral to the relevant clinic, possibly with the institution of walk in assessment units, will be a better use of staff and financial resources. Furthermore, planning of new services needs to equate not only the perceived but also the actual needs of attenders.

Only by doing this can we develop a multi-disciplinary approach capable of providing the optimum environment for improving and maintaining sexual health.

ELIZABETH CARLIN
Senior registrar in genitourinary/HIV medicine
SUE MANN
Senior house officer in genitourinary/HIV medicine
SIMON E BARTON
Consultant in genitourinary/HIV medicine
FIONA C BOAG
Consultant in genitourinary/HIV medicine

St Stephen's Clinic,
Chelsea and Westminster Hospital,
London SW10 9NH

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Hospital banned from doing neonatal heart operations

EDITOR,—In the wake of recent press and television coverage of paediatric cardiac surgery at the Bristol Royal Infirmary and the news report by Owen Dyer,¹ which perpetuates misrepresentations of fact, I wish to clarify the situation.

Concerns were raised in some quarters during 1990-2 about the work of the unit; these concerns related to the results of operations for ventricular septal defect, tetralogy, and atrioventricular septal defects and, more recently, the arterial switch operation for patients with transposition of the great arteries. The switch operation was introduced in 1988 for infants and children with transposition of the great arteries plus ventricular septal defect and related conditions, and the mortality (20% in 1990-4) has been accepted by all members of the unit as being on a par with mortality reported by other units to the United Kingdom cardiac surgical register. For patients presenting as neonates with complete transposition of the great arteries, excellent short term and long term results have been achieved since 1985 with immediate balloon septostomy and a Senning operation at between 6 and 12 months of age.

The group was reluctant, therefore, to introduce neonatal switch operations but started a programme in January 1992, several years after other units. Lack of success with the first few cases prompted a cardiac surgeon and two paediatric cardiac anaesthetists to spend time in another unit to improve their technique. Three of the next four patients survived, but, after a further three deaths, the unit decided in October 1993 to stop doing neonatal switch procedures, after 13 operations. On the recommendation of the paediatric cardiologists and cardiac surgeons the trust's board initiated major developments to the paediatric cardiac service during 1994.

Without the knowledge of the paediatric cardiology team, however, concerns about the results of surgery reached a medical officer in the Department of Health during 1994. In January this year the trust's board sought independent advice from acknowledged experts, who comprehensively investigated the work of the unit in February.

The investigators were critical of the friction that existed between certain members of the team and believed that the tension and lack of confidence and trust militated against success in critically ill neonates. The results of the neonatal switch operation were unacceptable, but the investigators pointed out that five of the patients had had unexpected anomalies, mainly of the coronary arteries, which are known to increase the risks of

surgery. The report, however, highlighted the excellent results of repair of ventricular septal defects (no deaths among 74 patients including 41 infants) and tetralogy (three deaths among 47 patients) between January 1992 and January 1995. Most atrioventricular septal defects were operated on by one surgeon (two deaths among 23 patients, including 18 infants), whose overall results "compare very favourably with the best UK institutions." Results of other operations, including the Fontan procedure and total cavopulmonary connection for complex conditions, are comparable to national figures. The results of closed heart surgery at the Royal Hospital for Sick Children (1990-4) are "excellent" with a mortality of 5.3% among 190 infants and 2.8% among 109 patients aged over 1 year.

The report concluded that the unit should continue to perform all forms of congenital heart surgery, including non-neonatal switch operations; recommended that regular multidisciplinary audit should take place to monitor outcomes and foster teamwork; agreed with the trust's appointment of a paediatric cardiac surgeon; and supported the transfer of children's open heart surgery to the Royal Hospital for Sick Children (a new theatre is presently under construction), after which neonatal switch operations will restart.

The hospital has not been "banned from doing neonatal heart operations"; neither surgeon has been "transferred to another post" or "sent for further training"; results of cardiac surgery have been sent regularly to the United Kingdom cardiac surgical register and the supraregional services committee (until designation of infant cardiac surgery as a supraregional service ended); and other allegations appearing in the press reports about poor results have not been substantiated. The question of "avoidable" or "unnecessary" deaths in small groups of critically ill babies with life threatening conditions remains an issue for debate.

H S JOFFE
Consultant paediatric cardiologist

Royal Hospital for Sick Children,
Bristol BS2 8BJ

1 Dyer O. Hospital banned from doing neonatal heart operations. *BMJ* 1995;310:960. (15 April.)

Why do so few patients appeal against detention under section 2 of the Mental Health Act?

Rate of appeal may be higher elsewhere

EDITOR,—Caroline Bradley and colleagues conclude that if patients were fully informed of their rights they would be more likely to appeal against detention under section 2 of the Mental Health Act 1983: they found that 104 of 384 subjects appealed.¹ We carried out an audit of subjects detained under section 2 at Hollymoor Hospital, Birmingham, between August 1992 and July 1994. The hospital served a population of 350 000. Altogether 255 patients had been detained under section 2, of whom 35 appealed against their section. Our results are significantly different from Bradley and colleagues' ($P < 0.001$, $\chi^2 = 10.589$, 1 df). This could be a type 2 error. The diagnostic groups in the two studies could be different. Our analysis was based on a longer period and a large catchment population. Hence the two samples should not be that different. Bradley and colleagues included all those who had appealed to a tribunal or a hospital manager, or both, and this may account for the difference in the findings.

Our findings raise the question of whether Bradley and colleagues' results are representative of practice throughout the country. In some areas