obstruction due to prostatic disease. A prime consideration in those who are not referred for surgery should be identification of cases at risk by careful abdominal palpation and inquiry about enuresis—and perhaps by more thorough screening of renal function in patients with otherwise minor symptoms.

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What do psychiatric inpatients really want?

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In the age of the consumer the customer's view is all important. Psychiatric patients are perhaps the last people to be consulted about these matters. This is reflected in the dearth of research on the topic in Britain, though it has drawn attention in the United States.[1] Patients' attitudes to specific aspects of their treatment[2,3] have been recorded, as have views on the hospital milieu.[4] The purpose of this study was to obtain the views of current inpatients at an inner London psychiatric teaching hospital on how helpful they found the various components of hospital care.

Patients, methods, and results

All patients from seven wards who had been in hospital for more than one week were approached. From a total sample of 117, seven were too disturbed to be interviewed and 11 refused, leaving 99 patients (54 women, 45 men) who agreed to participate. Twenty eight patients were in a psychiatric hospital for the first time and 24 were being detained compulsorily under the Mental Health Act. Diagnoses according to the International Classification of Diseases (9th revision) were: schizophrenic psychoses 42; mania 13; neurotic depression 18; alcohol or drug dependence, or both, 8; personality disorder 7; organic disorders 8; and three patients with other neurotic disorders. Ninety three patients were receiving drug treatment, 46 taking neuroleptics.

All patients were given a simple structured interview lasting 15 minutes. The interviewer was not introduced with a title—for example, doctor or nurse—thus avoiding biasing the responses. Patients were encouraged to answer freely and in confidence. The interview contained 10 questions requiring a judgment of "helpfulness" on a five point scale (0-4) ranging from "not at all helpful" to "a little," "quite," "very," and "extremely helpful." Items of "helpfulness" were (1) talking to the doctor, (2) talking to the nurse, (3) talking to other patients, (4) ward group (regular meetings composed of patients and staff), (5) occupational therapy, (6) drug treatment, (7) the ward round, (8) just being in hospital, (9) visitors, and (10) free pass (permission to leave the ward). The patients' estimate of the time engaged in these activities was noted. Each subject was rated by his or her ward nurse or doctor on the global assessment scale,[5] a measure of overall psychiatric disturbance scored from 0 (completely disabled) to 100 (normal).

The mean age of the sample was 36·1 (SD 13·7) years. Mean length of stay was 21·0 (SD 31·1) weeks, mode three weeks. Thus the distribution was predictably skewed, most patients staying a brief period in hospital but substantial numbers staying much longer. Average score on the global assessment scale was 59·2 (SD 17·0). The table shows the mean scores for each item of helpfulness and the rank order of items.

Patients' attitudes to hospitalisation and treatment in order of perceived helpfulness (n=99)

Item	Mean score (SD)	No studied
(1) Free pass	2·79 (1·03)	77
(2) Visitors	2·47 (1·13)	88
(3) Talking to doctor	2·34 (1·17)	99
(4) Talking to nurse	2·33 (1·17)	99
(5) Drug treatment	2·19 (1·32)	93
(6) Hospital	2·02 (1·36)	99
(7) Occupational therapy	2·01 (1·31)	85
(8) Ward round	1·91 (1·27)	80
(9) Other patients	1·83 (1·13)	99
(10) Group	1·08 (1·09)	93

When involuntary patients were excluded from the analyses the only substantial change in the judgments about hospitalisation was that visitors assumed less importance. Those who were rated less ill on the global assessment scale found talking to the doctor and going to occupational therapy more helpful (Pearson's correlation: $r=0·24$; $p<0·01$). Increasing age had the same effect. Severity, however, did not influence the perception of the nurses' helpfulness ($r=0·02$; NS) or any other variables. There was a non-significant trend for women to find talking to the nurse more helpful than talking to the doctor (unpaired t test, $p=0·1$). Also women found visitors and a free pass less helpful ($p<0·05$) than did men. Surprisingly, patients admitted for the first time had similar opinions to those who had been admitted before. Similarly, length of stay did not correlate with attitudes to treatment but bore an inverse relation to how helpful other patients were perceived to be ($r=-0·2$; $p=0·02$). Comparing

the ratings of different diagnostic groups yielded no significant differences except that "being in hospital" was more highly regarded by those with alcohol or drug dependence, manic patients rating this as the least helpful (one way analysis of variance; df=6; F=2·224; p<0·05).

Comment

Ironically this study shows that the thing psychiatric inpatients value most about being in hospital is their ability to leave. Of the therapeutic items, simply talking to a care giver, be they doctor or nurse, was widely regarded as the most helpful aspect of care. We emphasise that, unlike some American studies,[1] the sample contained many highly disturbed psychotic patients. Nevertheless, being able to confide in a member of staff was still regarded as rewarding. Contact with other patients, both informally and in ward groups, was not judged favourably. This may be unduly confrontational for some, yet for others may provide a degree of support and exchange of information unavailable elsewhere. Drug treatment was judged on average to be only "quite helpful."

The professionals' opinions were not surveyed, but from the consumer's point of view psychiatric training would be well advised to pay as much attention to "talking therapy" as it does to hospitalisation, treatment with drugs, occupational therapy, and ward rounds. We conclude that just as patients need help to understand the benefits of their drug treatment, so doctors need to be reminded that the time given to talking to the mentally ill in hospital, albeit less than one hour a week according to three quarters of our sample, is time well spent.

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Spacer device with face mask attachment for giving bronchodilators to infants with asthma

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About two fifths of wheezy infants respond to nebulised ipratropium bromide with dramatic improvement in clinical signs and lung function within 15 minutes.[1] Over the past two years we used a disposable coffee cup as a spacer device when administering ipratropium bromide aerosol to young children. Most children aged under 18 months, however, disliked the jet of aerosol hitting their face, and compliance was poor. We adapted a spacer device for a metered dose inhaler (Nebuhaler) by adding a face mask, allowing children of all ages to be given the aerosol.

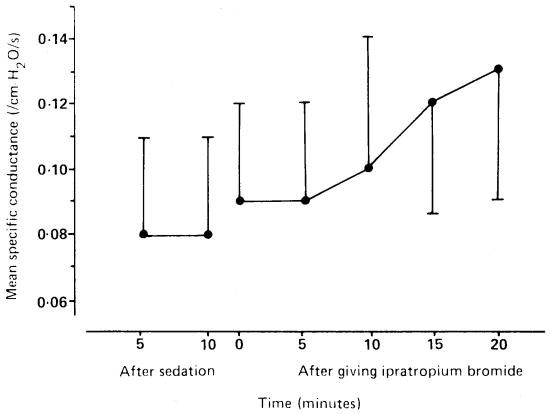
Patients, methods, and results

Eight children admitted to hospital for an exacerbation of wheeze were studied. They were aged 6-13 months (mean 10·5 months), had been admitted with wheezing at least twice previously, and were thought to have benefited from nebulised ipratropium bromide given on admission. Bronchodilator treatment was withheld for at least eight hours before lung function tests were performed.

Infants were sedated with 100-120 mg chloral hydrate/kg. Measurements of airways resistance and thoracic gas volume were made with a modified total body plethysmograph.[2] Specific conductance was calculated and oxygen saturation was monitored. Baseline measurements were made for 15 minutes after sedation.

A soft silicone Laerdal size 2 resuscitation face mask was trimmed to fit over the respiratory port of the spacer device (Nebuhaler). The device was held slightly upright and ipratropium bromide 50 mg was released into the spacer. When placed over the face of an infant it made an airtight seal. The loose valve opening allowed aerosol to be breathed in for about 10 seconds. Five repetitions resulted in a total dose of 200 mg ipratropium bromide. Lung function was measured every five minutes until the child awoke.

Airways resistance and specific conductance improved in seven of the eight patients. Overall, specific conductance at 20 minutes improved significantly compared with baseline values (p<0·01), as did airways resistance at 15 minutes (p<0·002) and at 20 minutes (p<0·001). Oxygen saturation rose from a mean of 89 (SD 6)% to 92 (5)%.



Mean bronchodilatation before and after giving ipratropium bromide to eight children (mean age 10·5 months). Bars indicate 1 SD

Comment

Delivery of ipratropium bromide by a metered dose inhaler with a face mask attachment is a rapid, simple, and cheap alternative to using a nebuliser. Our pilot study showed significant improvement in lung function, a result that correlated well with clinical observation. Most children tolerated the device and its face mask well, and this method was generally preferred to the aerosol with a coffee cup. The face mask seemed to act as a rebreathing chamber: the infants took increasingly large breaths during the 10 second administration, which may have enhanced aerosol deposition in the airways. Paradoxical