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.

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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 pregnancy[2] 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 multidisciplinary approach capable of providing the optimum environment for improving and maintaining sexual health.

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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 sepal 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.

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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' ($P < 0{\cdot}001$, $\chi^2 = 10{\cdot}589$, 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