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

the percentage of appeals could be much higher than that found in Oxfordshire.

The methodology in Bradley and colleagues' study is well thought through and easy to follow. Interestingly, however, they interviewed their patients on day 13 of the section. If these subjects had been interviewed at an earlier stage of their admission the results might have been different as the subjects' mental state would have been different and would have affected their concentration, initiative, and response rate. Also, the sample was skewed as 40% of the initial sample was excluded.

The authors' conclusions may not be fully justified. This is especially so as only four of the 28 subjects whom they interviewed subsequently appealed against their section. Recently, Blumental and Wesley found that the cost of mental health tribunals had risen considerably; they claimed that about £12m is spent annually in tribunals.[2] Despite these costs it is important to protect the civil liberties of patients. One way forward would be to carry out further audits in other districts and analyse ways of improving the rates of appeal. The Mental Health Commission could take a leading role in coordinating this.

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1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)
2 Blumental S, Wesley S. The cost of mental health tribunals. *Psychiatric Bulletin* 1994;18:274-6.

Managers should review patients who do not appeal

EDITOR,—If authors comment on the law they should cite it correctly. Section 2 (2)(b) of the Mental Health Act 1983 and section 72 (1)(a)(ii), as used by tribunals, both state "health or safety, or . . . etc" and not, as Caroline Bradley and colleagues say,[1] "health and safety, or . . . etc"; this is a considerable difference. The first reason given by the authors for the low rates of appeal against detention is that patients are content to remain in hospital. If that is so, it is said, they should not be detained. Are the authors content to give electroconvulsive therapy to an informal patient in depressive stupor who not unwillingly resides in hospital but who cannot consent? A second explanation given is that patients are deterred from exercising their rights. Could not a third be that the patients are too sick or confused?

No mention is made of patients' responses to explanations given under section 132 (1)(b) of the Mental Health Act 1983, which obliges managers to take such steps as are practicable, soon after detention, to ensure that patients understand their "rights of applying to a mental health review tribunal." These steps "shall include giving the requisite information both orally and in writing." The code of practice advises that a record should be kept of the advice given to each patient; the fact that the information has been properly given; the member of staff designated to monitor the procedures; and, in the case notes, the information given, the patient's reactions, and an assessment of his or her comprehension.

For the patients described, were section 132 procedures not implemented, ineffective, or not recorded? The researchers state, "patients must . . . in the absence of independent help . . . rely on . . . the booklet." Were those who did not appeal given oral explanations under section 132? Did patients who had difficulty in writing an application receive help from members of the multidisciplinary team? It is not uncommon for members of tribunals to see typed or handwritten letters of appeal, or forms, that have only been signed in the patient's own hand.

If more appeals are contemplated do we need the present duality of appeals to tribunals and hospital managers? Patients who appeal to both are often heard twice within days. Was this so for the patients studied, and with what degree of concordance or discordance? Tribunals are costly. Running a parallel system is even more expensive. Should not hospital managers be more concerned about screening those patients who do not appeal to tribunals and refer them on to tribunals if they feel concern? Effectively implementing section 132 should also concern managers.

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1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)
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3 *The code of practice, mental health act 1983.* London: HMSO, 1990.

Intellectually elite are more likely to appeal

EDITOR,—Caroline Bradley and colleagues' conclusions concerning appeals against detention under section 2 of the Mental Health Act are limited since no comment is made about the inclusion of patients with learning disability and mental illness, which could appreciably alter the data.[1] The finding that those educated to A level standard are more likely to appeal is interesting but not surprising and may reflect a bias in favour of the intellectually elite. Patients who do not understand the process of appeal because of mental illness or intellectual handicap, or both, cannot be expected to appeal. We agree with the authors' conclusion that the current procedure does not protect the civil liberties of all patients.

Clearly, the system of appeal against detention needs to be reviewed. The rate of discharge as a result of appeals is low[2]; the current system is expensive to operate; and, as Bradley and colleagues' paper suggests, the process inadvertently discriminates against those it is intended to help. Perhaps a fairer system should be implemented, in which all those detained under the Mental Health Act are automatically reviewed by a local independent body with psychiatric input.

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2 O'Dwyer J, Neville P. Appeals against section 2 of the mental health act 1983. *Psychiatric Bulletin* 1991;15:225-6.

Low appeal rate may reflect trust in doctors' judgment

EDITOR,—Caroline Bradley and colleagues conclude that too few patients appeal against detention under section 2 of the Mental Health Act and that this would be improved if patients were fully informed of their rights.[1] Our experience in Springfield Hospital does not confirm this. An advice and legal representation project has existed at the hospital since 1982.[2] As the table shows, the rate of appeal against detention under section 2 (15%) is lower than that reported in Oxford. Understanding why most patients do not contest their section may require more than attributing it to lack of either knowledge or time.

It is an error to assume that because patients agree that they need to be in hospital then compulsory detention was, or is, a mistake. The relationship between doctors and patients is complex and can simultaneously include a whole range of conflicting and ambivalent attitudes. Patients can disagree with their doctors' decision to detain them yet retain trust in their judgment and often a remarkable willingness to cooperate with both detention and treatment. Most are nursed in open wards. The Royal College of Psychiatrists' unsuccessful proposal for a community supervision order regularly met with a simplistic characterisation of the relationship between psychiatrist and detained patient which acknowledged only the element of compulsion. Viewed thus, the community supervision order was judged unworkable despite the extensive evidence of its clinical workability before 1986 in England and Wales and its continuing use in Scotland.[3]

Bradley and colleagues' figures may reflect the fact that a sizeable majority of patients detained under section 2 (and perhaps many on section 3 (table)) "agree to disagree" with their psychiatrists yet derive a sense of security and containment from being obliged to be in hospital at a time of personal turmoil. This interpretation fits more closely the clinical experience of very little coercion (other than that afforded by the legal sanction of the Mental Health Act) being required for most detained patients.

The Mental Health Act 1983 contains extensive safeguards for patients' civil liberties. Before an increase in the rate of appeals (which inevitably take time and resources from clinical care) is advocated a greater understanding of the reasons for not appealing is required. Bradley and colleagues have made a start on this process.

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1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)
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New Zealand's system has much to offer

EDITOR,—Caroline Bradley and colleagues' audit of section 2 of the Mental Health Act suggests that the current appeals procedure is "not a satisfactory way of protecting the civil liberties of patients."[1] Much more equitable (although more costly) would be a routine appeals procedure, based on a combination of the managers' hearing and the review tribunal. A regular weekly session devoted to reviewing people detained under the Mental Health Act, particularly in the inner London areas where up to 90% of patients are so detained, would

Appeals to mental health review tribunals, Springfield Hospital, 1993

	Patients detained	Consulted law centre	Appealed (%)	Discharged under section 23*	Withdrew	Other
Section 2	188	49	29 (15)	8	2	4
Section 3	224	159	47 (21)	10	1	5

*Consultant discharged patient from section under section 23 of Mental Health Act 1983.