



Mixed Gender Wards: What Does the Evidence Indicate?

Abstract:

Currently, hospital rooms on inpatient units at the University Health Network are designated to be either male or female, depending on the gender of the individual in the room. The practice upon admission to the ward has been to place new patients into rooms where the "roommate" is of the same gender. since 2001, performed in such a way.

This practice causes a delay in the admission to the ward and simultaneously results in patients remaining in the emergency department for longer than necessary while a suitably "gendered" room is made available. This results in increased length of stay (LOS) in the ER. Currently, no data are collected organizationally by the admitting departments on the amount of time patients remain in the ER prior to being moved to the unit due to "gender appropriate room placement." The admitting department estimates that the wait can range from one to two hours to as long as 48 hours.¹ This wait translates into patient dissatisfaction, as demonstrated by patient complaints.² Although not documented, anecdotal comments by patients, family and staff members suggest much longer waiting times. Media coverage has created a perception of overcrowded and uncomfortable emergency departments; this perception may in fact be the reality in many emergency departments. More worrisome are the anecdotal comments made by physicians who allege that delayed admission to a ward bed could cause a delay in patients receiving specialized care thereby impacting morbidity and mortality.

The need to place patients in "same gender rooms" causes considerable burden on staff. In a study conducted circa 1997 as part of a resource utilization strategy at the University Health Network, investigators sought to determine the cost of transferring patients from one room to another. At that time, it was determined that the average cost of a patient transfer was approximately \$100 per transfer. This cost was calculated on the understanding that transfers within the unit would likely cost less, while transfers from unit to unit would cost more. The calculation of transfer cost included the cost of moving the patient, the bed and belongings.³

Current Questions

Would adoption of a mixed gender ward policy at the University Health Network accelerate the admission of patients to a ward bed, thereby positively influencing patient care and improving patient satisfaction? Would reducing transfers positively impact staff satisfaction by eliminating an onerous burden? How would patients and staff react to the idea of mixed gender rooms? Would eliminating transfers have a positive financial impact on the organization? At the request of the senior management team, UHN CEO Tom Closson asked for a review.

Literature Search: What Can We Learn from Other Jurisdictions?

It is known that mixed gender rooms are the norm in other health systems. A literature search was conducted to determine whether any pertinent information existed on the matter and whether we could learn from the experiences of other healthcare jurisdictions.

The History

"Mixed sex wards" were first introduced in the sixties and seventies in Great Britain in order to make the best use of high technology equipment, most notably in the ER, haemodialysis and in the ICU environment (*Nursing Standard* 1994). Gradually the practice was applied to medical and surgical wards. It is known that other countries in central Europe follow the same practice. The practice was introduced in Australia in the late seventies. Closer to home, the practice of mixed gender rooms is de rigueur in Quebec and has been for some time.

Findings

A literature search uncovered some interesting information about Great Britain. Little has been written about the central European and Australian experiences. No literature was available about the Quebec experience, but given the proximity of the University Health Network to Quebec and the existence of collegial contacts, telephone interviews were conducted with representatives of Montreal-area hospitals in December 2000.

As mentioned, in Great Britain the driving force behind mixed gender rooms was the notion of utilization and efficiency, particularly of high technology equipment. Proponents of the idea also argued that the rooming of men and women reflected the typical living arrangements of society. Furthermore, proponents argued that there was therapeutic value in "normalizing" the hospital environment by having mixed gender cohabitation. Areas identified as being likely to experience particular benefit were psychiatric wards and elderly care units (*Nursing Standard* 1994). Opponents to the idea of mixed gender wards argued that what might be "normal" in broader society was entirely inappropriate in a therapeutic environment. Furthermore, the idea might be practically impossible, particularly when considering the logistics of converting the available physical space (Nightingale-style wards versus alcoves) into mixed gender rooms/units. Of particular concern were the logistics of washing and toileting. Opponents argued that health authorities had an obligation to ensure that patient dignity, privacy and safety were maintained, particularly for the vulnerable patient (Fraser 1993). A few individuals engaged in the ethical discussion of the morality of "using" one patient to "modify" the behaviour of other patients (Hughes 1992). Some concerns were expressed about the extra burden on staff to ensure that carelessness about nakedness and intimacy did not occur.

In Great Britain, the response from patient advocacy groups was highly critical and vocal. As a result of their advocacy efforts, the Department of Health announced in March 1999 that it pledged to eliminate mixed gender wards in the NHS. The Department of Health stated that "as part of our concern to ensure quality, we will work towards the elimination of mixed-sex wards É a target of 95% of health authorities to achieve this by 2002 has been set" (10 Downing Street Facts 1999). It is interesting to note that some legal experts in Great Britain suggest that the implementation of the Human Rights Act, which became law on October 2, 2000, created a window (between the implementation of this Act and the proposed target date of the Department of Health) that would give patients the opportunity to mount a legal challenge against the Department of Health on the basis of mixed gender rooms being inhuman and degrading treatment (*Nursing Times* 2000).

In Australia, the practice of mixed gender rooms was adopted in the late seventies and appears to be an extension of the practice in Great Britain. The driving force in Australia appears to have been improved bed utilization and reduction in waits in the emergency department. The first documentation on the matter was found in 1998 in response to submissions of concerns raised to the Health Authority review panel. At that time, the Auditor General in Victoria reported that as a result of the practice of mixed gender accommodation, "health care professionals and hospital

management have contributed to a deterioration in the quality of clinical care at their respective hospitals" (Auditor General Report 1998).

Specific concerns raised were:

- "the non-segregation on some occasions of male and female patients, and the old and the young, leads to a loss of dignity and privacy";
- "the placement of surgical patients in obstetric wards increases the risk of patients not receiving the most appropriate care from nurses who have specialized in midwifery" (Auditor General Report 1998).

The review panel chose to study the issue further by ongoing monitoring. The Final Report (Auditor General Report 2000) "recognizes that at times there is no option available in terms of admitting or transferring a patient into a mixed gender ward/unit/room other than retaining the patient inappropriately within the emergency department. The distinction between wards/units/rooms accommodating females or males should not prevent appropriate transfer or admission from occurring." The report goes on to suggest that "appropriate transfer" (i.e. to a room of same gender) should occur as quickly as possible. The review panel suggested that the following policies should be adopted, "should this unavoidable situation arise." These are:

- "the patient or patient's family/representative should be informed of the situation which necessitates accommodation in a mixed gender setting";
- "staff should deal with this issue sensitively, given patients' concerns for safety, privacy, dignity as well as the possibility of cultural sensitivities";
- "consultation with patients should be conducted on an individual basis";
- "patient (or the patient's family/representative) consent should be obtained before the patient is admitted to a mixed gender ward/unit/room";
- "the patient should be transferred to a single gender ward/unit/room as soon as possible, preferably within twenty-four hours" (Auditor General Report 2000).

The report went on to outline a complaint process once a mixed gender room assignment takes place: "Should a patient, during the course of their stay in a mixed gender ward/unit/room feel threatened or concerned in any way, then that patient should be encouraged to raise these concerns with staff without feeling that their care will be compromised. Even with such encouragement, a patient may feel that their concerns are not being addressed by speaking with staff responsible for their care or may feel anxious about raising concerns with staff. In view of this, staff and management must ensure that patients are made aware of Health Services Liaison Officers (sometimes called patient representatives or complaints officers) with whom patients (or their family/representative) can speak and know that appropriate solutions will be implemented to allay their fears or concerns" (Auditor General Report 2000).

In Quebec, the practice of mixed gender room allocation, known in the French as "cohabitation," has been going on for sometime and in fact patient representatives in Montreal-area hospitals and officers of the Association of Hospitals of Quebec were not able to date the onset of this practice. No data are formally kept on complaints received by the

Association, and it is their impression that the public accepts this practice as a necessity with little or no resistance. Representatives from the Bureau de la Commissaire aux Plaintes en Matière de Santé et de Services Sociaux had a similar view in discussion. Discussion with representative of Montreal-area hospitals (St. Mary's, Royal Victoria, Jewish General and Montreal General) who were involved in receiving complaints on a day-to-day basis had a different viewpoint. It was their impression that patients generally accepted this practice because it was "a necessary evil" and the alternative meant longer waits for treatment and longer waits in uncomfortable ER departments. The degree of public resistance has decreased over time, and in the last two years under review (1998 and 1999) each hospital complaints department was receiving a modest number of complaints annually.

Policy has been developed that dictates patients be transferred to a suitably gendered room accommodation within 24 hours of placement. As a group, patient representatives indicated that, in fact, this policy was not enforced, and if patients did not voice a concern they were not moved to a same gender room. By policy, all patients were to be asked beforehand and consent acquired before placement into a mixed gender room, but patient representatives indicated that, again, this policy was not strictly applied and only those patients who were thought "likely to refuse" were asked. Likelihood to refuse was dictated usually by obvious religious or cultural affiliation. Cultural groups that were identified as being most likely to resist the practice were Orthodox Jews and Orthodox Muslims. Specific areas excluded from this practice included a significant portion of the hospital. These were: surgical units, obstetrics, long-term care and psychiatry. Areas where "cohabitation" was practised included: medical short stay, general internal medicine, all holding areas, ICU, CCU and ER. Areas where the practice varied included: urology, plastics, ENT.

By patient profile, the group that is most likely to complain are young women and those of specific religious groups. While one might assume that older patients (with more traditional views of privacy/modesty) might resist the practice, patient representatives in the Montreal area reported few complaints from elderly patients. It was assumed that all patients were provided with a pamphlet about the practice upon entry into the hospital, either through the elective admission process or through the ER department process. Montreal-area patient representatives expressed doubt as to whether this actually occurred.

What Do Nurses Think about Mixed Gender Wards?

Nurses apparently are equally unenthusiastic about the practice of mixed gender rooms. In a study commissioned by *Nursing Times* (1994) in Great Britain, "half the nurses surveyed had received complaints about the mixed sex setting from patients or relatives." The study reveals that many patients were not informed of the arrangement prior to admission and, once situated, were so grateful to have a bed that they often were afraid to voice their concerns and were prepared to endure any circumstances imposed on them. Seeing patients in such vulnerable states appears to be a difficult moral struggle for many nurses. Moreover, nurses reported that their work was made more difficult, particularly in bathing, toileting and giving intimate procedures (enemas, wound dressings) when different gendered patients are separated only by a flimsy curtain. Nurses expressed particular concern on general medicine units where female patients suffering from dementia were frequently known to disrobe and walk about naked. Nurses also felt that they were acting in a manner that was not consistent with their professional practice guidelines by nursing patients in mixed gender wards (Royal College of Nursing 1993).

A second study was conducted by Wharfedale General Hospital in anticipation of the potential development of mixed gender wards. The results were similar to the above study in that subjects were consistent in stating they felt uncomfortable in nursing different gender patients in the same room and worried that it was not possible to maintain privacy (*Nursing Standard* 1995).

How Would Mixed Gender Room Accommodation Impact UHN?

The Financial Impact of Eliminating Same Gender Wards

As a result of the 1997 study on the cost of transfers of patients, one of the compelling factors to the argument of implementing mixed gender wards is the issue of potential savings. As has been mentioned previously, precise data on the extent to which patients are moved due to the need to accommodate gender do not exist in any system at any of the three sites. As a result, existing data on transfers were "guesstimates" by knowledgeable stakeholders .⁴

Toronto General Site

Data for transfers for November 2000 were reviewed. November was chosen since it seemed to represent an average month to all stakeholders and data had been collected and analyzed at all three sites, allowing a comparison.

For November, there were a total of 1,772 transfers at the TG, of which 829 (47%) were from one unit to another while 943 transfers (53%) were within units. The majority of these transfers were for medically justified reasons (60%). Approximately 20% were to accommodate requests for room accommodation. It is estimated that approximately 10% of all transfers were to accommodate gender issues.

On an annualized basis, this would mean recoverable costs associated with staff time, with the calculations as follows:

$$10\% \text{ of } 1,772 = 177 \times 12\text{-month period} = 2,124 \text{ moves per year}$$

$$\text{Annualized potential savings: } 2,124 @ \$100 \text{ per transfer} = \$212,400$$

Toronto Western Site

Again, data for transfers for November 2000 were reviewed. In this month there were a total of 610 transfers, of which 302 (50%) were from one unit to another while 308 transfers (50%) were within units. Again, the majority of these were for medically justified reasons (60%) while 20% were for room accommodation requests. It is estimated that approximately 8% of all transfers were to accommodate gender issues.

On an annualized basis, this would mean recoverable costs associated with staff time, with the calculations as follows:

$$8\% \text{ of } 610 = 49 \times 12\text{-month period} = 588 \text{ moves per year}$$

$$\text{Annualized potential savings: } 588 @ \$100 \text{ per transfer} = \$58,800$$

Princess Margaret Site

Estimates of moves at PMH were broken down by floor, and then an average was calculated as a result of gender issue moves.

Floor	Monthly Average	Annualized
17	approximately 25 moves per month of which 12% were for gender= 2 moves per month	24 moves per year
14B	no moves since all rooms private	
14A	six moves per month of which one might be for gender reasons	12 moves per year
15B	average estimate of one move/month for gender reasons	12 moves per year
14C	closed	
18	short length of stay, lots of movement, no estimate of gender related moves given	
15	seven moves per month, average of 1 move due to gender reasons	12 moves per year
Total PMH moves due to gender		60 moves per year
Annualized potential savings: 60 moves @ \$100 per transfer		\$6,000
Total UHN annualized potential savings: \$6,000 + \$58,800 + \$212,400		= \$277,200

Other Considerations - What Will Patients and Staff Say?

While savings is a consideration to UHN, one must consider the implications of this practice to patients and staff given the novelty of the idea and the potential reaction to issues of privacy and intimacy. To measure the potential response of both of these groups, a simple opinion survey of stakeholders was conducted.

What Do UHN Patients Think about Mixed Gender Wards?

The purpose of this survey was to ascertain patients' inclination to accept the notion of mixed gender rooms. A research assistant was employed to conduct the survey. Methodology included going to busy outpatient clinics at each of the three sites at UHN to seek respondents willing to participate in the survey. The important questions concerned the patients' inclination to accept mixed gender rooms and the extent to which that decision might be influenced by the prospect of shorter waits in the ER department. Responses were confined to yes or no where possible. Space was available for comment. At the Toronto General site, patients in the Peter Munk Cardiac Clinic and the ER department were approached. At the Toronto Western site, patients in the Patient Management Centre, Fracture Clinic and the ER department were approached. At the Princess Margaret site, patients in the ambulatory clinic areas in the second floor were approached. The research assistant was instructed to approach a patient to ask whether he or she would be willing to fill out a survey. Some patients asked to have the research

assistant "do the writing for them." Since the research assistant was conducting this survey in a fairly open manner, other patients in the area overheard the conversations and asked to be interviewed, suggesting a selection bias. The results are given in Table 1. What Do Staff Nurses Think about Mixed Gender Rooms?

As we consider this change in practice, the operating assumption has been that the requirement to move patients to suitable gendered rooms is onerous and wasteful, ultimately resulting in time lost from patient care and staff dissatisfaction. When reviewing the experiences of staff in other jurisdictions that have implemented this change in room accommodation practice, the net result has been a negative response by staff (*Nursing Times* 1994; Royal College of Nursing 1993).

A second survey was drafted to determine what the likely "top of mind" response of front-line nursing staff might be. Logistically the distribution of a staff survey was more difficult, and as a result, a request was made to four units at each site, via their nurse managers, to distribute staff surveys to their nursing staff. The distribution strategy and the self-selection of respondents therefore should be considered to have some selection bias. The results are shown in Table 2.

Table 1 Patient Responses					
	PMH	TG	TW	UHN	% of total
Number of respondents	38	31	47	116	
By Gender					
Female	25	18	24	67	58%
Male	13	13	23	49	42%
By Age range					
Under 20	0	0	1	1	1%
20 - 30	1	5	10	16	14%
31 - 40	7	5	4	16	14%
41 - 50	8	8	8	24	21%
51 - 60	9	4	6	19	16%
61 - 70	9	4	14	27	23%
71 plus	4	5	4	13	11%
Would you accept placement with opposite gender?					
Yes	21	22	32	75	65%
No	17	9	15	41	35%
Would you accept placement with opposite gender if faster admission?					
Yes	25	24	39	88	76%
No	13	7	8	28	24%

Table 1 Patient Responses... continued on next page >>>

Patient Comments:

Toronto Western Site:

- Concerned about safety
- Only if needed
- Health and life are more important than gender issues
- Depends on procedure (2 times)

Princess Margaret Site:

- No ... men complain too much
- People should have a choice
- In general, men's hygiene differs from women's hygiene
- Okay, if a more suitable room can be found soon
- I don't want to be concerned about privacy (2 times)
- It matters if procedure is female oriented ... it doesn't matter if general surgery
- I am concerned about safety ... I am a sound sleeper

Toronto General Site:

- I have privacy issues
- Nothing would convince me
- Maybe in an emergency (2 times)
- Doesn't matter at all
- I don't care (2 times)
- I am uncomfortable using the restrooms (2 times)
- Okay as long as it's a short stay
- I am concerned about possible sexual relations between patients ... I have fear for my safety
- Security is a fear
- Only for non-female illnesses
- Depends on the age of the male patient

What do UHN Nurses Think about Mixed Gender Wards?

Out of interest and to determine whether top-of-mind responses from staff were similar to top-of-mind responses from nurse managers, the survey developed for staff was directed to nurse managers at all three sites. Again, this should be considered a selection bias and does not reflect a very strong response from all managers. Breakdown by site was not conducted. The results are shown in Table 3.

Table 2 Staff Nurse Responses

	PMH	TG	TW	UHN	% of total
Number of respondents	7	13	11	31	
By Gender					
Female	7	12	9	28	90%
Male	0	1	2	3	10%
By Age range					
20 - 30	1	2	0	3	10%
31 - 40	1	2	4	7	23%
41 - 50	2	8	5	15	48%
51 - 60	3	1	2	6	19%
Do you think this is a good idea?					
Yes	0	1	5	6	19%
No	7	12	6	25	81%
Do you think the patient would agree with this type of accommodation?					
Yes	0	1	2	3	10%
No	7	12	9	28	90%

Staff Nurse Comments

Toronto Western Site:

- Patients don't want male nurses, never mind a male roommate
- Only as a temporary measure
- Remember, you are trying to be internationally recognized and to meet your community's needs
- The new patient might agree but the other patient would not ... patient relations would be required
- Good idea ... less moving patients to accommodate admissions
- I think many men or women would not accept situation especially for privacy... this would be a problem for me
- Increased need to pay attention to privacy
- I would need to check patients more often because of safety concerns ... problem for some religious patients
- Embarrassment for patients would mean more complaints from patients and relatives
- This would be easier in terms of locating beds for patients but more difficult due to problems that would arise

Toronto General Site:

- A patient is a patient whether male or female
- This is impossible for all patients (3 times)
- Would you like your parents in this situation?
- Patients often walk around half naked and curtains don't close properly
- How did you come up with this bad idea?
- Who will enforce this - NOT nursing ... perhaps patient relations and admitting
- HORRIBLE idea ... DON'T do this!

Table 3 Nurse Manager Responses (from all three sites)

		% of total
By Gender		
Female	25	92%
Male	2	8%
Do you think this is a good idea?		
Yes	10	37%
No	17	63%
Do you think the patient would agree with this type of accommodation?		
Yes	10	37%
No	17	63%

DISCUSSION

Financial

From a purely mathematical calculation, there is a compelling financial argument to adopt the practice of mixed gender rooms, *provided that patients are not moved again to same gender rooms. Movement would reduce potential savings.*

Patient Responses

In total, 116 patients were surveyed with 38 (33%) from PMH, 31 (27%) from TG and 47 (41%) from TW. This sampling is disproportionate to the actual census of each site to the overall UHN patient population.

In response to the question of whether they would accept placement with patients of the opposite gender, 65% of all respondents indicated that they would. This pattern was evident at all three sites. When asked whether they would accept placement with patients of the opposite gender if this meant a faster admission, 76% of all patients indicated that they would. The same pattern was seen at all three sites. Fifty percent of respondents were 50 years of age or older, suggesting that a substantial proportion of respondents fell into what had been described as "older patients who would not be willing to accept the practice" and yet seemed to indicate a willingness to accept the practice.

Front-line RN Responses

In total, only 31 front-line staff nurses responded to the survey request. Eighty-one percent of nurse respondents were under 50 years of age.

When asked whether mixed gender rooms were a good idea, 81% of staff said "no." When asked whether they thought that patients would agree with the practice of mixed gender rooms, 90% of front-line staff nurses said "no." Staff identified ICU, CCU, NSDU, PACU and step-down units as areas where this practice would be easier to accept. It is not clear whether these areas were identified since they are areas where the practice exists in some way already and therefore are more acceptable locations, or whether it is a sense that patient resistance would be reduced since the patients are unconscious/intermittently lucid. Other areas identified as possible areas for the implementation of this practice were holding rooms, DSU and ER. It is interesting to note that a number of staff felt this practice

would be easier where both patients were married to each other since this situation might not arise often.

When nurses were asked which units or situations might prove to be more difficult in terms of implementation, responses included: alert and oriented patients, elderly or confused patients, young patients, old patients, female patients, religious patients, patients requiring intimate procedures or large abdominal wound care or mobilization.

When asked whether nurses felt that this practice would make their workday easier, the same or harder, 68% indicated that this practice would make their work more difficult.

RN Manager Responses

In total, only 27 nurse managers from all three sites responded to the survey. Of this group, 10 (41%) were age 50 or over. When asked whether they thought that the practice of mixed gender accommodation was a good idea, 63% of nurse managers indicated "no." When asked whether they thought that patients would agree with the practice of mixed gender rooms, 63% of respondents indicated "no." When nurse managers were asked what impact this practice would have on the day-to-day work of front-line staff nurses, 67% indicated that it would make the work harder.

Conclusion

Given the response of this particular sampling of patients, there is an indication that many patients would accept the practice of mixed gender accommodation, particularly if it meant a faster admission. There is a good indication, however, particularly from the anecdotal comments, that for a sizeable portion of the patient population, the sharing of a room with a patient of the opposite gender would be unacceptable. It is likely that those patients would refuse such an accommodation and remain in the ER. For these patients, a longer LOS in the ER would therefore continue to be a problem. It is also likely that a number of patients would initially accept placement in a mixed gender room to gain faster admission but would request transfer to a same gender room within the 24-hour period. Should this latter situation arise, then the burden of moving patients would still be present for nursing staff, and no savings would be realized.

It is likely that some patients will come to accept the practice of mixed gender room accommodation as "the necessary evil" it is perceived to be in Quebec. It is highly probable that the experience of resistance and complaint seen in England and Australia would be evident in the UHN population and there would be considerable anger around this practice. The rise of complaint, anger and conflict would require a corporate response, particularly around issues of policy, complaint process and conflict resolution. It is unclear whether UHN is exposing itself to risk in terms of contravening human rights legislation.

It is likely that staff nurses would not experience satisfaction with the implementation of the practice of mixed gender accommodation. Both front-line staff nurses and nurse managers believe that this practice would make the day-to-day life of the staff nurse more difficult since there would need to be greater attention to issues of privacy and safety. While greater attention to these two issues would be of benefit to the patient, it is not clear that this method is the best way to achieve such sensitivity/attention.

Finally, it is not clear whether this practice would support the organization's stated strategy of increasing patient and staff satisfaction. If the corporation feels that a trial is worth the risk, it is recommended that implementation of this strategy should be considered on a trial basis only, with stringent consideration given when choosing the unit. Furthermore, it is recommended that well-defined processes be established to seek consent from all

patients impacted (in-room and newly admitted to room) *and* staff prior to moving a patient into a mixed gender room. Given that increased complaint is likely, processes and personnel to manage these complaints will be required.

About the Author

Since 1993, **Sharon Rogers** has been the Director of Patient Relations (the Hospital Ombudsman) at the University Health Network and serves the patients and families of the Toronto General Hospital, the Toronto Western Hospital and the Princess Margaret Hospital. She is a 1993 graduate of the University of Toronto, Health Administration program.

Footnotes

¹ Admitting Department, Toronto Western Manager, Catherine Kohm. Estimate provided is presented as being reflective of the Toronto General experience also.

² Patient complaints on the issue of "accessibility/waiting times" as they related to transfer from the ER to a ward room are collected by the Patient Relations Office.

³ Study conducted by Dr. Michael Guerriere, UHN, circa 1997, based on GRASP workload charts. The time taken to move a patient from one room to another ranged between five and 30 minutes, with the average time taken being 20 minutes. This did not include the cleaning of the room and the set-up for the next person. In the absence of corporate archiving of the report, confirmation was attained from UHN Corporate Director of Nursing, Ms. Jane Moser.

References

- Auditor General Report. 1998. Final Report. Victoria, Australia: Department of Human Services. <http://hna.ffh.vic.gov.au/ahs/min/nettin/11.htm>
- Auditor General Report. 2000. Final Report. Victoria, Australia: Department of Human Services. <http://hna.ffh.vic.gov.au/ahs/min/nettin/11.htm>
- Fraser, J. 1993. "Mixed Sex Wards - Not Ideal Care?" *Nursing Times* 89(14).
- Hughes, P. 1992. "Women: Therapeutic for Whom? Vulnerable Women Are Being Abused on Mixed Psychiatric Wards." *The Guardian*, July 2.
- Nursing Standard*. 1994. "Mixed Sex Wards: The Choice of Patients?" Vol. 8, No. 33, May 11.
- Nursing Standard*. 1995. Vol. 9, No. 22, February 22.
- Nursing Times*. 1994. Vol. 90, No. 31, August 3.
- Nursing Times*. 2000. "Health Law." Vol. 96, No. 27, July, pp. 6 - 12.
- Royal College of Nursing. 1993. *Issues in Nursing and Health: Mixed Sex Wards*. London. RCN.