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Mixed gender accommodation in acute care: Time to end another 'unfortunate experiment'

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Summary The introduction of mixed gender wards that have permeated Australian hospitals in recent years may have begun as an ill-conceived experiment, but their continued existence despite expressed patients' wishes is an affront to modern health service provision. While the UK has witnessed an uproar resulting in a ban on mixed gender wards, Australian services have been slow to react to this trend. We examine the literature documenting the introduction of mixed gender wards, focusing especially on their evaluation by staff and patients. There is little if any evidence showing any benefits of mixed gender wards and research suggests that they are antithetical to basic human rights and person-centred care. It appears that the barrier to their eradication is little more than a short-term focus on financial 'feasibility'.

1. Introduction

An in-hospital episode of acute health care follows a clinical decision where the patient requires care or treatment and the hospital accepts responsibility for this care. This experience for the patient is commonly accompanied by feelings of powerlessness, which commences with the allocation of a hospital bed within a system of care the patient has little or no control over. The idea of sharing a hospital room with complete strangers contributes to feelings of powerlessness, embarrassment, awkwardness, and fear associated with hospitalisation. These feelings are magnified when having to share a hospital room and bathroom facilities with complete strangers of the opposite gender. Mixed gender accommodation was initiated by healthcare providers as a way to meet increased hospital bed demand and rising healthcare costs (Rogers, 2006), and is defined as where 'both men and

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women are sharing the same ward, bay, room or bathroom facilities' (Same Gender Accommodation Policy Guideline, South Australia, 2014, p. 16).

Mixed gender accommodation has been loosely defined in the literature, being variously referred to as mixed sex accommodation (Beasley & Flory, 2010), mixed sex wards (Batcup, 1997), mixed-gender wards (Jenkins, 2005; Rogers, 2006) as opposed to single sex bays (Baillie, 2009), single sex acute units (Lees & Buggy, 2011), same gender accommodation (Same Gender Accommodation Policy Guideline, South Australia, 2014, p. 16), single-sex wards (Felton & Abu-Kmeil, 2012), and segregated wards or gender-specific services (Brunt, 2008). To be housed in mixed gender accommodation in the acute care setting when extremely vulnerable and powerless has been described as:

> '. . . a hateful experience for all concerned, as both sexes are forced to cope with individual illness alongside an appalling lack of privacy. Just think about that dreadful, endless bed-ridden business of sluicing, hawking, coughing, impaired bodily functions and those tell-tale male thunderclap night-time noises, plus shoals of vomit, leaky urine bags, catheters, drips, mass incontinence, freight train snores, pyjamas that don't tie up properly in the front and general depression at being ill' (Moir, 2006, para. 5).

In some instances, mixed gender accommodation is accepted where it reflects the patient's personal choice or is in his or her overall best interest (Beasley & Flory, 2010), such as critical care, high dependency, post-operative recovery and emergency departments where intensive monitoring and highly specialised care are required (Rogers, 2006). Mixed gender accommodation that does not follow this guideline is argued to be a violation of human rights that reduces the quality and safety of patient care, and is not consistent with person-centredness, which is:

> 'An approach to practice that is established through the formation and fostering of therapeutic relationships between all care providers, patients, and others significant to them. Person-centred care is underpinned by values of respect for persons, individual right to self-determination, mutual respect, and understanding' (McCormack et al., 2010, p. 13).

This opinion paper highlights the current and ongoing problem of mixed gender accommodation in acute healthcare settings from an Australian perspective. We critique the continuation of this practice which endures despite strong opposition over decades and even sanctions to prevent its existence internationally. Few quality research studies have been conducted on mixed gender accommodation, in particular in Australia and New Zealand (Burrell, 2003). Such a paucity was unexpected as maintaining patient privacy and dignity is a critical aspect of the nurse's role and inextricably linked to quality of care and the care environment. Recommendations to address the ongoing problem of mixed gender accommodation in acute care concludes this paper.

2. Background

Following on from the creation of single sex wards in the 19th century based on moral grounds, mixed gender accommodation was introduced in the 1960s in psychiatric care in the UK and was considered therapeutic, progressive and normal for patients (Batcup, 1997; Brunt, 2008). A decade later, the negative aspects of mixed gender accommodation in psychiatry came to the fore, when single gender units were required to protect women from being abused by male patients (Brunt, 2008). A decade later, mixed gender accommodation had expanded into other settings in the UK including emergency and intensive care departments, as a fiscal decision to make the best use of high technology equipment and staff (Royal College of Nursing, 1994). Since then, mixed gender accommodation has gradually infiltrated other areas, such as medical and surgical wards and commensurately, other developed countries including Australia, Canada and New Zealand. It has been argued that co-habitation of men and women reflects everyday living arrangements which are considered therapeutic (Royal College of Nursing, 1994), at which point a conceptual if not entirely sensible leap was made to: Why cannot male and female patients share sleeping accommodation, toilets, or washing facilities in acute hospital wards?

By the mid-1990s, half of all acute UK hospital wards were mixed gender (Burgess, 1994), where key concerns included patients not being informed about the ward being mixed before admission, a pervasive lack of privacy and disquiet about the proximity of patients of the opposite gender. There has been rising public pressure against the practice of mixed gender accommodation which has been allowed to continue despite patients and their advocacy groups highlighting the inherently upsetting and undignified nature of the practice (Bryant & Adams, 2009). The patient care environment poses one of the greatest challenges to person-centred care when its foundations are based on clinical efficiency or cost-saving imperatives rather than person-centredness (McCormack, Dewing, & McCance, 2011).

In response to public and political pressure, a drive to enforce a previous government policy to eliminate mixed gender accommodation commenced in 2010 in the UK (Beasley & Flory, 2010). Strict guidelines were developed by the Department of Health (England) to identify breaches to this policy which included separate gender sleeping, toileting and washing facilities and patient access to their facilities without having to pass through opposite-sex areas unless in exceptional circumstances (Beasley & Flory, 2010; Bryant & Adams, 2009). Yet multiple breaches have been reported that represent a serious service failure and hospitals are penalised for each breach (Beasley & Flory, 2010; Smith, 2011). However, hospitals entrenched in a medical model that focuses essentially on the patient's reason for admission and goals of clinical efficiency may consider this breach insufficiently important or not feasible to address.

2.1. Advocating for the patient

Patient advocacy and the preservation of patient dignity are core roles of nursing practice. The UK Human Rights