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# BRITISH MEDICAL JOURNAL

SATURDAY 17 MAY 1975

## LEADING ARTICLES

<b>When Does Lactose Malabsorption Matter in Adults?</b> page 351	<b>A Criminal Approach to</b>		
<b>Abortion</b> page 352	<b>Salvage in Melanoma</b> page 353	<b>Pancreatic Biopsy</b> page 354	<b>Safer</b>
<b>Cigarettes</b> page 354	<b>Pills Over the Counter</b> page 355	<b>Tiny Target</b> page 356	

## PAPERS AND ORIGINALS

Response of Lymphocyte Guanyl Cyclase to Propranolol, Noradrenaline, Thymoxamine, and Acetylcholine in Extrinsic	
Bronchial Asthma ANN MARIE HADDOCK, K. R. PATEL, W. C. ALSTON, J. W. KERR.....	357
Atropine, Sodium Cromoglycate, and Thymoxamine in PGF <sub>2</sub> $\alpha$ -induced Bronchoconstriction in Extrinsic Asthma	
K. R. PATEL.....	360
Actions of Vitamins D <sub>2</sub> and D <sub>3</sub> and 25-OHD <sub>3</sub> in Anticonvulsant Osteomalacia	
CLAUS CHRISTIANSEN, PAUL RØDBRO, OLE MUNCK, OLE MUNCK.....	363
Disappearing Diabetes M. MCB. PAGE.....	365
Controlled Study of Atenolol in Treatment of Hypertension L. HANSSON, H. ÅBERG, B. E. KARLBERG, A. WESTERLUND.....	367
Psittacosis and Disseminated Intravascular Coagulation D. V. HAMILTON.....	370
Severe Peripheral Neuropathy after Mandrax Overdose K. CONSTANTINIDIS.....	370
Renal Carcinoma in a Cadaver Kidney Graft Donor R. N. BAIRD, H. J. O. WHITE, C. R. TRIBE.....	371
Recurrent Iritis J. O. DOYLE.....	371

## MEDICAL PRACTICE

Psychological Medicine: Management of Depression G. W. ASHCROFT.....	372
Cost-Benefit Analysis of Long-term Haemodialysis for Chronic Renal Failure M. J. BUXTON, R. R. WEST.....	376
Individual Differences in Selecting Patients for Regular Haemodialysis	
T. R. TAYLOR, J. AITCHISON, L. S. PARKER, M. F. MOORE.....	380
Outside Medicine: John Coakley Lettsom C. NEWMAN.....	382
Letter from Chicago: Foreign Visitors GEORGE DUNEA.....	383
Conversations with Consultants: Contrasting Standards in Old and New Hospitals	
FROM A SPECIAL CORRESPONDENT.....	385
Any Questions?.....	387
Personal View A. W. BEATSON.....	388

## PROCUREMENT SECTION

CORRESPONDENCE—List of Contents.....	389
OBITUARY NOTICES.....	396
BOOK REVIEWS.....	398
SUPPLEMENT	
The Week.....	401
Superannuation—Buying Added Years.....	402
Clinical Academic Staff.....	402

## NEWS AND NOTES

Epidemiology—Infections in a Boarding School.....	399
Medical News—Gastrointestinal Services in Hospital.....	399
B.M.A. Notices.....	400

## CORRESPONDENCE

<b>Cost to N.H.S. of Social Outcasts with Organic Disease</b> R. A. S. Keighley, M.B., and others; D. Tidmarsh, M.B. ....	389
<b>SI Units</b> B. H. Hand, F.R.C.S., and others. ....	389
<b>Treatment of Falciparum Malaria</b> L. J. Bruce-Chwatt, F.R.C.P. ....	390
<b>Oral Contraceptives and Myocardial Infarction</b> J. S. Robertson, M.F.C.M.; Mavis W. M. Stratford, M.R.C.S. ....	391
<b>Intracardiac Short Circuit</b> R. Sutton, M.R.C.P., and others. ....	391
<b>Hormone Patterns in Anorexia Nervosa</b> J. M. Tanner, F.R.C.P.; B. Alderman, M.R.C.O.G., and M. Burke. ....	391

<b>Serum <math>\alpha</math>-Fetoprotein in Cystic Fibrosis</b> J. C. Wallwork, PH.D., and others; D. J. H. Brock, PH.D., and others; J. A. Smith, M.D. ....	391
<b>Manipulation in Treatment of Low Back Pain</b> J. H. Ebbetts, M.R.C.S. ....	393
<b>Approved Names</b> J. W. Dundee, F.F.A.R.C.S. ....	393
<b>Tepid Sponging in Pyrexia</b> A. Aynsley-Green, M.R.C.P., and D. Pickering, M.R.C.P. ....	393
<b>Consultant Negotiations</b> M. P. Coplans, F.F.A.R.C.S.; J. F. Rickards, F.F.A.R.C.S. ....	393
<b>Practice Premises</b> A. Elliott, M.R.C.G.P. ....	394

<b>Consultants' Contract Shopping List</b> R. S. Morton, F.R.C.P. ....	394
<b>Health Care Planning Teams</b> C. P. Vellenoweth, A.M.B.I.M., and J. R. Gibson, PH.D., M.F.C.M. ....	394
<b>Consultants' Fees for Dental Anaesthetics</b> R. L. McMillan, F.F.A.R.C.S. ....	395
<b>Fees for Insurance Reports</b> D. Hartley, PH.D. ....	395
<b>Points from Letters Related Ancillary Staff</b> (B. J. Stafford); Age Limit for Seniority Payments (D. M. O'Connor); Manipulation in Treatment of Low Back Pain (R. C. B. Barbor, A. H. G. Murley, R. Burns, A. R. Montgomery) ....	395

*Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are now being received that the omission of some is inevitable. Letters should be signed personally by all their authors.*

#### Cost to N.H.S. of Social Outcasts with Organic Disease

SIR,—Drs. N. J. Cooke and I. W. B. Grant (19 April, p. 132) are probably not to blame for the interest and comment their communication has aroused in the national press. The facts they present highlight a real social and medical problem; the interpretation of the facts is more arguable.

Their single patient spent 554 of his 1000 inpatient days in one hospital and 796 in only two hospitals over seven years. This does not quite fit the picture painted in their introductory paragraph. The figures also suggest that the record system of some at least of the institutions concerned, coupled with awareness of the problem on the part of admitting officers, might have been adequate to prevent admission on occasions when his symptoms could have been managed on an outpatient basis. Their facts are also an indictment of "routine investigations," to which their patient was "inevitably subjected."

However, our main concern is to highlight the fact that this group of homeless men usually have great difficulty in obtaining primary medical care. They rarely register with a general practitioner and usually are not encouraged to do so. The result is no continuity of care, with the consequent attendance at a variety of casualty departments and admission to a variety of hospitals.

There is no easy solution to this formidable problem but at least we need to recognize its presence. In Leeds a group of volunteer doctors run a G.P. service for the homeless men who are cared for by St. George's Crypt. This service, apart from dealing with a great deal of minor suffering—bronchitis, piles, painful feet, etc.—is also able to provide maintenance therapy for epileptics, bronchitics, depressives, etc. and in addition is able to detect at any early stage and refer to appropriate sympathetic consultants previously undiagnosed mental and physical illness, including drink problems. Incidentally we enjoy a good relation-

ship with our local chest physician, with whom we work closely. This voluntary service, by attempting to meet these needs, is able to control to some extent hospital admissions of this type of patient and thereby save the N.H.S. considerable sums of money.

We believe that primary medical care should be supplied in those places where such men congregate—hostels, reception centres, and shelters such as ours—and would plead with local authorities, community physicians, and family practitioner committees to exert themselves to overcome the bureaucracy that usually prevents such a service developing and inhibits the service at its point of application—that is, the doctor-patient encounter.—We are, etc.,

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SIR,—However much one may disagree with the tone of the article by Drs. N. J. Cooke and I. W. B. Grant (19 April, p. 132) there is no doubt that the authors have drawn attention to a significant social and medical problem, though it is one which has been with us for a very long time.

In 1966 a paper from the department of general practice of Edinburgh University<sup>1</sup> drew attention to the very considerable morbidity of common lodging-house users and the high proportion of their consultations which led to referral to hospital. The authors suggested that "some attention might profitably be given to the problems of communication between hospital outpatient departments, as well as between these departments and the general practitioner or voluntary agencies in the community, so as

to minimize unnecessary referral and unnecessary repetition of examinations and tests." It would appear that these suggestions have not borne fruit in Edinburgh.

In London the prototype for a better system has been in existence for 20 years. Many homeless and destitute men with physical illness come to the Camberwell Reception Centre specifically to avail themselves of the services of the visiting medical officers and the sick-bay. X-ray and pathology services are provided by local hospitals and it is probable that the patient described by Drs. Cooke and Grant could have been treated quite adequately in these facilities. Unfortunately these few beds are under pressure, and for the lodging-house population the problem of access to medical care remains, as the voluntary organizations continue to remind us.<sup>2</sup> This need was also uncovered in a recent survey of the homeless destitute men at the Camberwell Reception Centre,<sup>3</sup> the clients of which are drawn largely from common lodging-house users. It was found that the mentally ill and physically handicapped were retained in the centre in most unsuitable surroundings for long periods for want of proper alternative facilities. It was recommended, *inter alia*, that "all common lodging-houses should have a general practitioner service available to all users and large common lodging-houses should have both clinic and sick-bay facilities." Surely this is not an impossible aspiration?—I am, etc.,

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<sup>1</sup> Scott, R., Gaskell, P. G., and Morrell, D. C. *British Medical Journal*, 1966, 2, 1561.

<sup>2</sup> Davies, A., *The Provision of Medical Care for the Homeless and Rootless*. London, Campaign for the Homeless and Rootless, 1974.

<sup>3</sup> Tidmarsh, D., Wood, S., and Wing, J. K., *Report on Research Carried out at Camberwell Reception Centre. Summary of the Research Findings and Recommendations*. London, Department of Health and Social Security, 1972.

#### SI Units

SIR,—The Department of Health and Social Security has now circulated to regional and area health authorities, family practitioner committees, and boards of governors advice