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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

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 relationship 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[1] 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.[2] This need was also uncovered in a recent survey of the homeless destitute men at the Camberwell Reception Centre,[3] 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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1 Scott, R., Gaskell, P. G., and Morrell, D. C. *British Medical Journal*, 1966, 2, 1561.
2 Davies, A., *The Provision of Medical Care for the Homeless and Rootless*. London, Campaign for the Homeless and Rootless, 1974.
3 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