FREQUENT HOSPITAL ATTENDERS
at the Acute Receiving Area
of the Western Infirmary, Glasgow

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I. Preface

In 1975, the medical staff at Glasgow's Western Infirmary expressed concern that a small group of patients were making frequent and inappropriate use of the acute receiving area. This study was set up to see whether such a frequent attender group existed, its size and characteristics, the proportion of visits recorded as inappropriate, the amount of resources consumed by the group, and to see whether there were differences between the frequent and non-frequent attender patients in medical, social, or psychological factors to account for their different hospital attendance rates.

II. Glossary of Glasgow Terms

Barlinnie	Glasgow prison
Barmy cane	mental hospital
Belair	hair laquer
Burroo	unemployment bureau
Carry-oot	alcohol from an off-licence
Clubbed up	beaten up
Decanted	temporarily moved to another house
Eldorado	cheap wine
Gi'en a bung	given a bribe
Polis	police
Room and kitchen	two rooms
Single end	single room
Scherik	scold in public
UCS	Upper Clyde Shipbuilders
Wee double double	a good large measure of whisky
Wee bubble	a good cry

Glasgow Hospitals

Canniesburn	Plastic Surgery Unit
Gartloch	Mental Hospital
Gartnavel Royal	Mental Hospital
Gartnavel General	General Hospital
Leverndale	Mental Hospital
Woodilee	Mental Hospital
Yorkhill	Children's Hospital

III. Acknowledgements

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IV. Summary

In 1975, the medical staff at Glasgow's Western Infirmary suggested a study of patients making frequent and inappropriate use of the hospital's acute receiving area. The staff claimed that these patients seldom had acute medical problems; they wasted the doctors' time; and consumed a substantial amount of hospital resources. The staff wondered what prompted the behaviour of these patients and whether they could be better managed in the future.

In order to identify the frequent and inappropriate users of the acute receiving area, we reviewed the past acute attendances of the 3,284 patients in our patient sample. As we had no objective measures of inappropriate patient behaviour, we used the frequency of presentation as our sole selection criterion, knowing that any frequent and inappropriate users would thereby be included. After sampling the patient records, we defined frequent attendance as six or more acute attendances between 1st January 1970 - 31st July 1975, a 5 year 7 month study period. We found 150 (5%) of the 3,284 patients studied had been frequent attenders.

We looked for ways to identify the frequent attenders at presentation but found no significant difference in age, sex, or presenting complaint between the frequent attenders and the 3,284 patients sampled. We then used these characteristics (age, sex, and presenting complaint) to select matched controls from the patient sample for each of the 120 frequent attenders who proved available for interview.

We found inappropriate use of the acute receiving area mentioned in all but two of the 120 frequent attender records and 68% of the frequent attenders' acute presentations were attributed to inappropriate patient behaviour.

While few (12%) frequent attenders were diagnosed as having greater medical problems than their matched controls, psychological problems were diagnosed in 77% of the frequent attenders in contrast to only 22% of the controls.

The patients' answers at interview showed frequent attendance strongly associated with a number of background variables, with no single variable proving pathognomonic of frequent attenders. We found that, on average, the frequent attenders had greater health, housing, and employment problems, greater difficulties in relating to others, and were more accident-prone than their matched controls.

We found most of the acute receiving area costs to be fixed costs and thought little would have been saved had the frequent attenders not presented. We thought the amount of hospital resources consumed by the frequent attenders was too small to adversely affect other patients.

Our study showed that a small number of frequent and inappropriate users of the acute receiving area indeed existed at the Western Infirmary. However, we thought that little could be done either to alter the social and psychological factors we found associated with frequent attendance or to prevent future acute attendances by these patients. At a hospital level, we thought the costs and risks involved in excluding the frequent attenders were outweighed by the benefits of simply treating these patients. At a community level, we thought that seeing the frequent attenders on demand in the acute receiving area was an efficient and relatively inexpensive way of supporting and maintaining these patients in the community.

V. Introduction

In 1973, we had been asked to run a small-scale study of 'problem patients' in a health centre close to Glasgow. The general practitioners (GPs) in the centre had identified a group of patients who, they said, made frequent but inappropriate use of the health centre services.

The GPs said they were not worried by the frequent visits of patients with chronic disease, and they accepted that there would always be patients who made occasional misuse of medical services. The 'problem patients' were those who persistently presented with unsubstantiated complaints.

Of the patients identified by the GPs, we studied those who had been frequent attenders at the health centre over the preceding year. We defined frequent attendance as 12 or more GP contacts over the year. On examining the records of the 33 patients who proved to have been frequent attenders, we found that the number of GP visits made by these patients could not be explained by their medical problems. Instead, we found unemployment, loneliness, housing problems, alcoholism, and drug dependence had been important factors in the attendance rates of these patients.

Having published the results of this study (McArdle, Alexander, and Boyle, 1974), we presented our findings to the medical staff at Glasgow's Western Infirmary. The medical staff responded by suggesting that we set up a similar study of the Western's 'problem patients', those patients making frequent but inappropriate use of the hospital's emergency facility, the acute receiving area.

The staff claimed that frequent use of the acute receiving area implied inappropriate use. Patients with recurring medical problems were normally referred directly to the specialists concerned; patients with minor injuries were treated in the Casualty department. Thus, patients arriving at the acute receiving area could be expected to present with medical emergencies. When a patient repeatedly presented on an emergency basis, doubts arose as to the authenticity of the complaints.

We found the medical staff each had a tale to tell of a frequent attender patient, of stories used by the patient to gain admission, of time and resources wasted, and of the doctor's discomfort when the patient's complaints proved to be fraudulent. The staff could only cite specific instances; they urged us to mount a detailed study of the problems posed by these frequent and inappropriate users of the acute receiving area.

However, our health centre study had taught us many lessons, one of which was the importance of an objective selection process. Our initial selection of frequent attenders at the health centre had been based on the subjective impressions of the doctors. In mounting a new study we looked for a selection process that would allow all patients in the sample an equal chance of inclusion. We also wanted to use a selection process that could be replicated by other workers in the future.

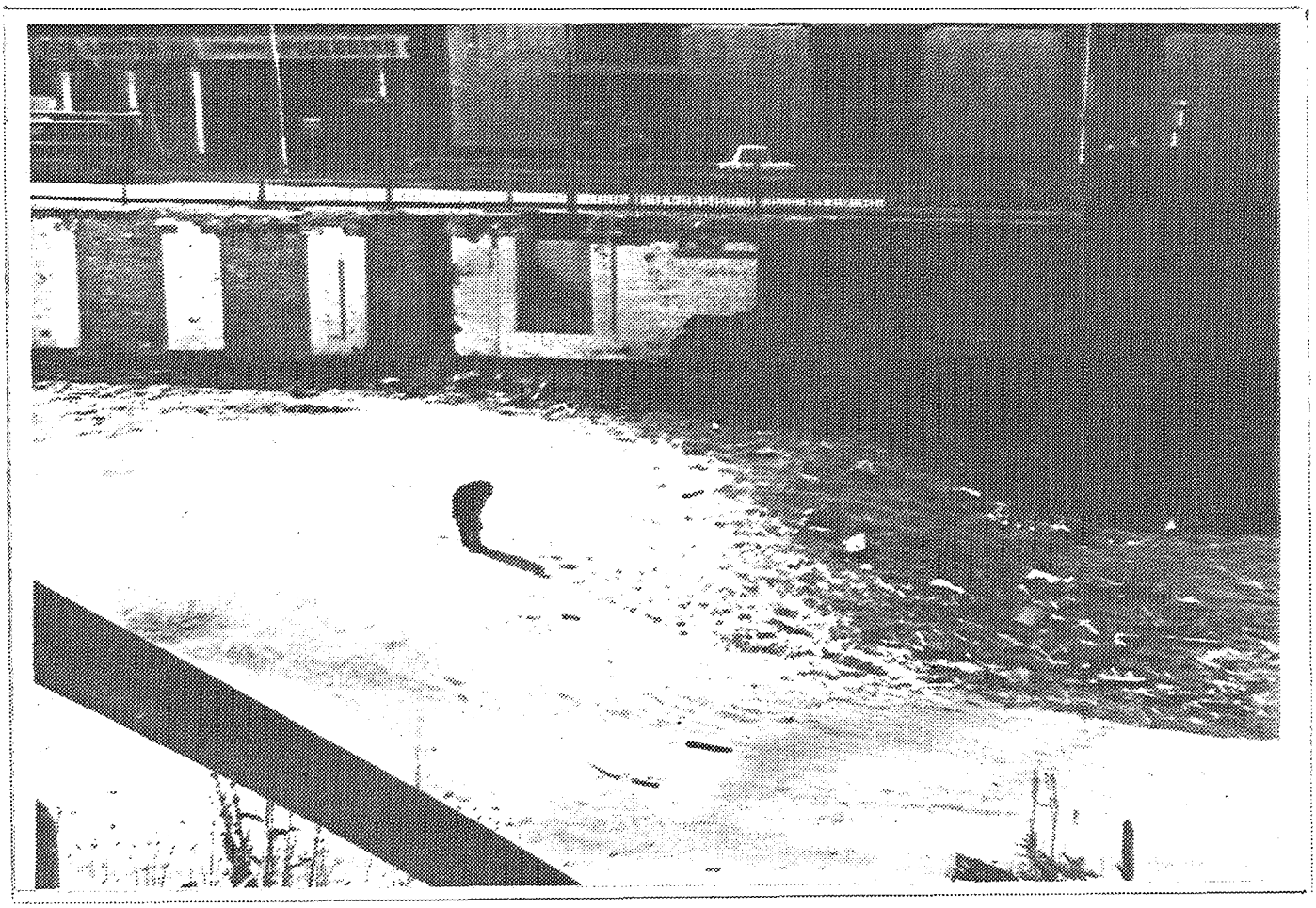
Although we were interested in studying the frequent and inappropriate users of the acute receiving area, we decided that the term 'inappropriate' was in itself too subjective to include in the selection process. We could, on the other hand, be completely objective about the frequency with which a patient presented at the

acute receiving area by referring to the patient records. If the staff were correct in their assumption that frequent attendance implied inappropriate use of the acute receiving area, then by studying the frequent attenders, we would automatically include those making inappropriate use too. Furthermore, we would be able to empirically test the staff's assumption.

It was at this point, in 1975, that we learnt of a study being run by Dr. Arvind Patel in the Western Infirmary. Dr. Patel was collecting information on all patients attending the hospital's acute medical receiving area (AMRA) over a six-month period. This included the number of acute presentations made by each patient, and Dr. Patel generously offered us use of his data in selecting the frequent attenders.

We began our study of frequent hospital attenders wondering who the frequent attenders were, whether they were making inappropriate use of the acute receiving area, what factors prompted their hospital attendance, how much of the hospital's resources they consumed, how they had been managed in the past, and how they could be better managed in the future. However, before embarking on our own study, we turned first to the medical literature to see what research had already been done on frequent attender patients.

VI. Literature Review



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"At the frayed end of ... (the human) spectrum is the fascinating derelict, human flotsam detached from its moorings, the peripatetic medical vagrant, the itinerant fabricator of nearly perfect facsimile of serious illness — the victim of Munchausen Syndrome." Bean (1959)

VI. Literature Review

1. Overview

Our study of the medical literature revealed that 'frequent hospital attenders', patients repeatedly presenting as hospital emergencies, were not a new phenomenon. Although no other writer had used exactly the same term or definition as ours, many writers had described similar patient groups: patients who repeatedly presented themselves for medical treatment at emergency units, out-patient departments, or general practitioners' surgeries; patients who claimed factitious illnesses; hypochondriacal patients; patients who repeatedly inflicted injuries upon themselves; and patients who exhibited other forms of abnormal patient behaviour. In this chapter we refer to all such patients as 'persistent patients'.

Last century, Gavin (1843) warned:-

> "The occurrence of feigned disease among the patients of our hospitals and dispensaries is by no means extremely rare, and our charitable institutions are frequently abused by impostors of this kind."

Earlier this century, Menninger (1938), in his book Man Against Himself, analysed abnormal patient behaviour patterns and included self-mutilation, malingering, polysurgery, and alcohol addiction.

However, it was Asher (1951) who aroused widespread interest in the problem of persistent patients when he described a group of patients as suffering from Munchausen syndrome. Asher named the syndrome after Baron von Munchausen, a German cavalry officer in the eighteenth century, reputed to tell exaggerated tales of his military exploits, and who was the subject of Raspe's (1785) book Singular Travels, Campaigns and Adventures of Baron Munchausen. Asher used

Munchausen's name in describing the syndrome because:-

> "Like the famous Baron von Munchausen, the persons affected have always travelled widely and their stories, like those attributed to him, are both dramatic and untruthful."

Asher's selection criteria for patients with Munchausen syndrome differed slightly from those we used for frequent hospital attenders. Asher selected patients who presented with factitious illnesses and who travelled from hospital to hospital, while we were interested in patients who made repeated visits to the same hospital and we subsequently questioned the validity of their complaints. These differences apart, we thought there would be an interesting overlap between our study patients and those of Asher. His patients, like ours, made frequent visits to hospital, presenting themselves as acutely ill, and we turned with interest to the literature on Munchausen syndrome.

Many papers and letters have been published on Munchausen syndrome since Asher first coined the term in 1951, but these have been largely anecdotal. Most writers have described individual patients and their exploits, warning their fellow doctors to be wary of being duped by these people.

One of the most extensive studies of Munchausen syndrome was that made by Barker (1960) for his doctoral thesis, though even this study consisted of only seven patients. We found Barker's methods questionable, his conclusions more subjective than scientific, and his writing dogmatic. We were, for instance, disappointed in his selection process, which consisted of circularising the larger hospitals asking that any Munchausen syndrome patients be referred to him. He received five replies and, having found two such patients himself, based his study on a sample of seven patients.

We were alarmed by comments in Barker's thesis, such as:-

> "Standard prefrontal leucotomy produced disappointing results in two of these patients."

and the caption under a photograph of a young female patient, lined up naked against a wall, which read:-

> "Note the tense expression on the patient's face."

However, as Barker has been one of the principal writers on the subject of persistent patients over the past two decades, and his views have been accepted and widely quoted by many other authors, our literature review includes several references to his work.

In this chapter, we review the general literature on the subject of persistent patients. References to specific points which we wish to compare to our own findings are noted under the appropriate sections in our Results and Discussion chapters. Throughout this thesis, we repeat the date of publication each time we refer to an author's work, unless the work has already been cited in the same paragraph.

2. Nomenclature

Persistent patients have been given a wide variety of titles over the last thirty years. These are summarised in Table 1 on the following page.

Several authors chose titles indicating travel as the common factor among the persistent patients they studied: Asher (1951) with 'Munchausen syndrome'; Chapman (1957) with 'peregrinating problem patients'; and Clarke and Melnick (1958) with 'hospital hoboes'.

Some writers focused on the fraudulent aspects of the patients' complaints: Sjoberg (1951) referred to his patients as 'hospital frauds'; Hawkings et al. (1956) wrote of 'deliberate disability';

Table 1

Titles given to persistent patients and their behaviour

Year	Author	Title
1951	Asher	Munchausen Syndrome
1951	Sjöberg	Hospital Frauds
1956	Hawkings et al.	Deliberate Disability Patients
1957	Chapman	Peregrinating Problem Patients
1958	Clarke and Melnick	Hospital Hoboes
1962	Barker	Hospital Addiction Syndrome
1963	Kemp	Familiar Faces
1966	Abram	Van Gogh Syndrome
1968	Spiro	Factitious Illness
1968	Lipsitt	Problem Patients
1969	Pilowsky	Abnormal Illness Behaviour
1973	Dudley	Odd Patients
1978	Groves	Hateful Patients
1980	Carney	Artefactual Illness Patients

Spiro (1968) of 'factitious illness'; and Carney (1980) of 'artefactual illness'.

Barker (1962) suggested the term 'hospital addiction' and objected to the title of 'Munchausen syndrome' because:-

> ". . . it suggests a new and sharply delineated clinical entity, whereas these patients share a border territory with other well-known conditions."

Writers differed in their definitions of persistent patients. Lipsitt (1968) defined his 'problem patients' as:-

> ". . . those, whose physicians found them difficult to treat because of an absence of organic findings, as well as complicating psychosocial factors."

and Kemp (1963) had an even simpler definition of his 'familiar faces':-

". . . patients having no disease to explain their complaints."

We thought the most useful definition of persistent patients came from Henderson (1974), who described 'abnormal illness behaviour' as:-

". . . the persistence of an inappropriate mode of perceiving, evaluating and acting in relation to one's health."

3. Socio-demographic characteristics

Ireland, Sapira, and Templeton (1967) reviewed the literature on Munchausen syndrome following Asher's (1951) paper and found 59 patients described with Munchausen syndrome. Reed (1978) reviewed a further 43 patients described in the literature after publication of the review by Ireland et al. These reviews reported the age/sex balance summarised in Table 2. Ireland et al. found that men outnumbered women 3:1, while Reed found the sexes almost evenly balanced.

Table 2

Age/sex distribution of Munchausen patients described in the medical literature (1951-1978)

Author	% Male	Age Range	Mean Age
Ireland et al. (1951-1967)	75%	19-62 years	39 years
Reed (1967-1978)	56%	21-72 years	36 years

However, a predominance of young (15-25 years) women was reported among those persistent patients making self-mutilating attempts: Hawkings et al. (1956); Sneddon and Sneddon (1975); and Simpson (1976). Frequent hospital attendance through clinics was described by Kemp (1963) as "almost exclusively a complaint of middle-aged women" and,

similarly, Lipsitt (1968) found the typical high-user of his clinic was "a married women in her 40's with vague somatic complaints".

Kenyon (1964) found no difference in incidence between the sexes in his study of hypochondriacal patients, and most studies found persistent patients in all age and sex categories.

4. Aetiology and motivation

The literature provided no common motive to explain the behaviour of persistent patients. Asher (1951) suggested possible motives, and these have been repeated in most papers on Munchausen syndrome since then, with Trew and Anderson (1970) listing them as follows:-

> "It is suggested that some are narcotic addicts; that some are trying to escape from the police and impending prosecution; that they are 'free loading' on hospitals, that is to say they enjoy the services and attention of the hospital environment; that they are seeking attention from their families, nurses and doctors; that they obtain gratification by deceiving the medical profession; or that they are working out a grudge against some former attending physician, or more generally, against society as a whole."

However, Cahill and Laubach (1958) thought that Munchausen syndrome patients gained nothing from their hospital presentations, and Ireland et al. (1967) could find "no readily discernible ulterior motive" in any of the Munchausen syndrome studies they reviewed. Martin (1974) cites Freud (1914), who describes hypochondriasis as a result of libido withdrawn from the outer world and concentrated on a particular organ or organs. Carney (1980), while admitting that discussion of the psychogenesis of factitious illness was purely speculative, suggested the primary gain was predominantly sexual. Barker (1962), Ireland et al. (1967), and Blackwell (1968) also mentioned sexual frustration in connection with persistent patients.

Menninger (1938, p. 256) described as motivating factors behind abnormal patient behaviour:-

> ". . . the wish to suffer, the wish to conceal, the wish to injure oneself and, to an even greater extent, the wish to cause other people pain, distress and embarrassment. In other words, here are all the factors one finds in suicide."

Menninger (p. 169) described a type of patient who, in his need for self-punishment, puts himself into the hands of an official agency (such as a hospital) in order to be punished (by undergoing unpleasant investigations and procedures).

Ireland et al. (1967) saw the motivation for frequent hospital admission in more passive terms:-

> "The relinquishing of all personal responsibility doubtless appeals to the homeless, friendless, wandering patient."

Reed (1978) suggested that some patients who were admitted to hospital at a time of social stress then came to rely on the hospital for short-term relief when further stresses arose.

Several authors suggested that fraudulent patients began their deceptions after being hospitalized for a genuine illness: Blackwell (1968); Trew and Anderson (1970); Reed (1978); and Carney (1980).

Writers also remarked on the number of persistent patients who had worked in the allied health fields. Roth (1962) noted that nurses and members of medical families predominated in his supposedly 'ill' patients. Cramer, Gerschberg, and Stern (1971) thought the health workers in their persistent patient group had failed to identify themselves with the care-givers and had, therefore, turned themselves into patients. Carney and Brozowic (1978) noted that nurses were particularly prone to express personal problems by simulating illness.

Kreitman et al. (1965), studying patients with hypochondriacal symptoms, remarked on the number of "conspicuous environmental events

coincident with the onset of illness". Spiro (1968), talking of patients with factitious illnesses, had similar findings:-

> "As with the compulsive wanderer, the impostor, the drug addict and the alcoholic, seemingly wilful acts are determined by unconscious factors and environmental cues to produce a psychiatric illness of profound dimensions."

5. Psychiatric findings

We found much debate on the psychological background of persistent patients. Asher (1951) suggested that Munchausen syndrome resulted from:-

> ". . . some strange twist of personality. Perhaps most cases are hysterics, schizophrenics, masochists or psychopaths of some kind."

Almost thirty years later, Reed (1978) admitted that "the psychopathology remains as obscure as when Asher first described the syndrome". This does not mean that attempts at defining the psychopathology of persistent patient behaviour have not been made; they exist in plenty.

Barker (1960), in customary style, claimed:-

> "It is clearly possible to differentiate those masochistic individuals with a lust for operations from malingerers who simulate illness to excuse them from their responsibilities."

but failed to explain the distinction. Lyell (1972), on the other hand, said:-

> "The convenient pigeon-holes of disease entities are the creation of our collective medical mind, which quite legitimately seeks to produce order out of chaos. But to believe that, for example, 'dermatitis artefacta' . . . is an immutable species always clearly distinguished from, let us say, malingering, . . . is to strain the intellectual device beyond reason."

Most writers mention hysteria or malingering as making some contribution to persistent patient behaviour. Samuel (1977) wrote:-

> "The overlap between organic disease and hysterical illness is great, and malingering may be superimposed on either."

Cramer, Gerschberg, and Stern (1971) said that malingering cannot be easily separated from hysteria, and that "simulation is often mentioned as part of the hysterical picture (as in the trait of multiple hospitalizations)". Carney (1980) made the distinction:-

> "In patients with artefactual illness, there is always evidence of deliberate deception and incomplete awareness of motivation. In conversion hysteria the patient is said to be unaware of both method of production and reason for the symptoms, while in malingering he is obviously aware of both."

There was some debate as to whether hysteria really existed as a diagnostic entity. Slater and Glithero (1965) claimed that hysteria was "a label assigned to a particular relationship between observer and observed", more likely to be given if the case was obscure and the treatment unsuccessful, and even more likely if the patient had a personality disorder. Hawkings et al. (1956) called it "a matter of inference rather than proof whether a patient's suffering is hysterical or simulated".

There was also disagreement in the literature about the meaning of the term 'malingering'. Miller and Cartlidge (1972) used it "for all forms of fraud relating to matters of health" and would, therefore, include all feigning patients. Cahill and Laubach (1958), Spiro (1968), and Reed (1978) thought there was a distinction between malingerers and other fraudulent patients, the former having a clear-cut long-term goal, which the latter did not.

Writers disagreed over whether persistent patients showed psychopathic traits. Hawkings et al. (1956) and Carney and Brozovic (1978) found no evidence of psychopathic behaviour in the deliberate disability patients they studied; Barker (1960), on the other hand, described Munchausen syndrome patients as "severely disturbed psychopaths".

Masochism was another trait discussed. Barker (1960) was surprised at his patients' tolerance of unpleasant investigations and referred to an article by Durkin (1957). Barker pointed out the similarities between his Munchausen patients and Durkin's masochistic subjects: an inability to accept or give love; identifying with the underdog (e.g., the deprived, the crippled); and a tendency to idealize parental substitutes followed by rejection (idealising doctors and then taking their own discharge).

Lipsitt (1968) listed dependency, masochism, low self-esteem, and hostility as the prominent personality variables in his 'problem patients'. Ireland et al. (1967) thought Munchausen patients had failed "to make the transition from a dependent childhood role to one of independence and autonomy".

Culpan and Davies (1960) thought that rather than needing a knowledge of abstruse psychopathology in dealing with persistent patients, one needed an appreciation of every-day human problems. Dudley (1973), writing on 'odd patients', agreed:-

> "The patients show an illness which expresses itself in physical terms, the origins of which are psychosocial with the emphasis on the social, rather than the psychological."

6. Attitudes towards persistent patients

We found the majority of writers expressed anger and outrage upon discovering the patients had no organic disease with which to explain their complaints. As Menninger (1938) wrote forty years ago:-

> "What impresses one most is the apparent irritation, hostility, even righteous indignation of the authors towards the subjects of these investigations."

Barker (1960) said that, after encountering his first Munchausen patient, he found himself humiliated at having been completely taken

in; Vail (1962) said that "even psychiatrists can become anxious and defensively hostile" in dealing with such patients: and Vaisrub (1974) wrote in an editorial:-

> "...the edifice of confidentiality, empathy, sympathy, and common striving for the same goal topples where the foundation proves to be deliberate deceipt. The physician is left with a sense of betrayal."

But the most extreme tirade came from Bean (1959):-

> "At the frayed end of...(the human) spectrum is the fascinating derelict, human flotsam detached from its moorings, the peripatetic medical vagrant, the itinerant fabricator of nearly perfect facsimile of serious illness - the victim of Munchausen Syndrome."

Lipsitt (1968) explained this antipathy on the part of the medical profession, saying that doctors had been taught the importance of cure and the relief of suffering, and that this:-

> "...renders such complex psychological concepts as 'use of illness for secondary gain' or 'the masochist's need to atone for guilt by retaining some degree of symptomatic discomfort' at times incomprehensible and at times morally unacceptable."

Lipsitt pointed out that although doctors agree that anywhere between 25-85% of their practice consists of emotional problems, most doctors prefer to deal with the physical problems and look with disdain on the neurotics of medical practice.

7. Management of persistent patients

Recognising persistent patients as such appeared to be the first problem in managing these patients. Writers wondered how to identify a patient with factitious illness before investing too many resources in investigating their complaints. Some writers suggested that a thick case file should alert the doctor to the possibility of a persistent patient (Kemp, 1963; Lipsitt, 1968). Others suggested that each hospital keep a 'black book' (Blackwell, 1968) or'rogues gallery' (Short, 1955); however, Harold (1951) stated that St. Bartholomew's

had kept a black book since the 1930's, but this had seldom proved effective in identifying persistent patients.

Persistent patients who travel from hospital to hospital are even more difficult to recognise. Birch (1951) suggested giving these patients a diagnosis of Munchausen syndrome and hoping that they would repeat this when presenting themselves at the next hospital; Clarke and Melnick (1958) suspected that these patients had a secret system of intercommunication and that they would soon learn not to use the term.

Stretton (1951) suggested that a central register be kept of Munchausen-type patients, but Blackwell (1968) reported that this was discussed and deemed both impracticable and unethical by the Ministry of Health in 1958. Barker (1960) suggested that the only course was to follow Asher's (1951) example and describe the patients, without giving their names, in the medical journals. This has not always been effective: Barker and Grygier (1957) pointed out that three different authors described the same patient in The Lancet in one year without reference to each other.

Miller and Cartlidge (1972) advised the doctor suspecting a patient of simulation to make a thorough examination and to record all findings with meticulous care, for:-

> "Given a polite hearing, a claimant will often press on until the evidence of faking is inescapable."

Samuel (1977) thought that one should start with the patient's mental rather than physical state when suspecting the validity of a patient's complaints:-

> "The time spent in establishing a sound psychological and psychiatric basis for the symptoms is often much less than in ordering an ever-widening spectrum of diagnostic tests."

and Dudley (1973) complained that the usual course was to exclude organic disease by every possible means before looking for social and psychological causes.

Having identified a patient with factitious illness, we found widely differing views on how the doctor should proceed. Bass and Selson (1957) thought there was no reason to cosset malingerers, and Vail (1962) had a 'shape up or ship out' attitude towards persistent patients. Lyell (1972), on the other hand, thought it best to "indicate indirectly that you know of their activities but sympathize". Ireland et al. (1967) recommended "tolerance and an air of interested concern" on the part of the doctor.

Other authors emphasize the importance of a thorough work-up of the patient. Kemp (1963) felt that as soon as a diagnosis of factitious illness was reached it was worth "spending a great deal of time on this type of patient in an attempt to prevent the chronic waste of energy and happiness that is otherwise inevitable". When the tests proved negative, Kemp suggested that the doctor should come up with a hypothesis as to why the patient had abandoned the normality of health and then point out to the patient the results of the ilness in "herself, her work and her family".

Waggoner (1947), suggesting a management plan for patients with no physical basis for their symptoms, wrote:-

> "I am much impressed with the need for taking a little more time in order to give the patient that extra understanding that may relieve him of his tension and allow him to take his place again in society without the manifestation of these symptoms."

Lipsitt (1968) reported setting up a clinic in an American hospital (Beth Israel Hospital, Boston) specifically to deal with problem patients—patients with no apparent diagnosis, chronic complainers,

and other patients posing management problems. Lipsitt knew from experience that these types of patients tend to be wary of psychiatric help. The clinic, known as the Integration Clinic, was, therefore, set up like any other medical clinic, but was "non-partisan in its attention to the psychic and somatic components of total health". Lipsitt, reporting the results four years after the start of the clinic, found that there was no change in the number of emergency visits made by 74% of the patients and that, while a further 12% of the patients decreased their emergency visits, 14% showed an increase in visits. However, Lipsitt thought that the overall care of these problem patients was better co-ordinated as a result of the clinic and that the various doctors involved were able to manage the patients more effectively. Lipsitt noted that the majority of referrals from the Integration Clinic to the main psychiatry department provided disappointing results, with either the psychiatrists considering the patients unsuitable for treatment or the patients dropping out of therapy. He concluded:-

> "This suggests that, if a patient initially perceives his distress as physical and first presents himself to a medical facility, his suitability for insight-oriented psychotherapy is highly doubtful, even in those cases where there appears to be some capacity for psychological mindedness."

Several authors (Brody, 1959; Barker, 1960; and Ireland et al., 1967) thought that long-term psychotherapy was the most appropriate treatment for their persistent patients. Barker (1960) blithely recommended:-

> "Repeated admissions to general hospitals should be actively discouraged by psychotherapy, aggression diverted into other channels and their anti-social behaviour made unrewarding."

Blackwell (1968) reported a two-year association with a patient who had made repeated hospital presentations and to whom he had offered

"all necessary support and social supervision". Blackwell's failure to modify the patient's behaviour led him to believe that prolonged in-patient treatment was the only way to prevent such patients from destroying themselves.

Chapman (1957) also thought confinement in a mental hospital appropriate:-

> "Such patients have enough social and mental quirks to merit permanent custodial care, otherwise their exploitation of medical facilities will go on indefinitely."

Barker (1964) wrote of an in-patient under his care for several years:-

> "She has gained insight through psychotherapy and has responded to the warmth and security provided by our environment. Her restlessness has been countered by phenothiazines. She may possibly need indefinite mental hospital care, but if so the results will surely justify the costs."

Ireland et al. (1967) appeared to agree with Barker that the only way to stop frequent hospital attenders was to incarcerate them in a mental hospital on a permanent basis. They became almost passionate in their argument:-

> "Even the limited gratifications of institutional life—a home, a constant social environment, an opportunity for useful participation in the hospital community, and the continued understanding, interest and therapeutic efforts of the staff—appear to be a more desirable alternative than a chaotic liberty involving material insecurity, hazardous diagnostic and surgical procedures, repeated castigation by the medical profession, and brushes with the law, with no prospect of resolving the disturbing anxieties and conflicts responsible for such a way of life. The Munchausen patient should come to be regarded legally as a special case, whose best interests are not served either by refusing him commitment on the grounds that he is not insane or releasing him from commitment, supervision or treatment on the basis of a few months or even a few years of good behaviour."

Thus, in order to prevent persistent patients from making frequent short-term visits to hospital, the above writers were willing to make them permanent in-patients. It is interesting to note that Blackwell (1968), in advocating long-term in-patient therapy, contradicted an

earlier letter (1962) in which he said:-

> "The most cogent reason for detaining these patients is that they are a danger to themselves. Yet our patient has survived at least 50 barbiturate overdoses and six laparotomies, and such a record is not unusual (in frequent attender patients). Although they are undeniably masochistic, these patients seem largely indestructible, and their apparent urge to self-destruction is not sufficient reason for indefinite compulsory detention."

Carney (1980), writing of self-inflicted injuries and factitious illnesses, agreed that confinement in a mental hospital was not the answer:-

> "Though the security engendered by a locked ward often produces a pause in the habit, this is invariably temporary."

Dudley (1973) doubted the validity of psychiatric help even on an out-patient basis for persistent patients:-

> "Conventional psychotherapy does not seem called for and is rarely successful because the patient is not basically mentally distressed. They keep reasonably in tune with their environment. They cope with a disturbed or entrapping social situation by producing what might be called compensatory conversion symptoms. The hospital is used as a respectable retreat from insoluble difficulties."

Kemp (1963) said that although he felt the 'familiar face' was a purely psychiatric condition, he did not think that the solution lay in psychiatric treatment:-

> "Psychiatry fails for the same reasons that surgery and medicine fail. With gentle but implacable obstinacy the patient is not mentally ill and the psychiatrist who believes that she is joins the band of doctors who also have failed to improve the case."

Kemp thought that patients should be persuaded that they would be much happier in a symptom-free world and that their demands should be met with obstruction, denial and firmness. He claimed his approach was based on simple common sense rather than professional psychiatry. His views on psychiatric treatment are at the other end of the spectrum from Barker (1962) who recommended "prolonged enforced in-patient treatment" by psychotherapy in a mental hospital.

Various other forms of therapy were suggested. Sneddon and Sneddon (1975) reported encouraging results from relaxing exercises, taught by a clinical psychologist, in their patients with self-inflicted skin lesions. Hawkings et al. (1956) recommended the help of a psychiatric social worker in treating patients with deliberate disabilities and referred to Meduna's (1956) success in using carbon monoxide inhalation therapy to cure somatic symptoms. Barker (1962) reported disappointing results after trying hypnosis, ECT, insulin coma, and leucotomies on hospital addiction patients. None of the above treatment plans were subjected to controlled trials.

Other writers suggested legal recourse against fraudulent patients. The legal correspondent of the British Medical Journal (1958) reported a six-month sentence being given to a patient who pleaded guilty of feigning abdominal pains and receiving £57 worth of food and drugs. In 1976, The Scotsman reported a man fined £20 for defrauding the Perth Royal Infirmary casualty team of 90 minutes' worth of time and services. Shribman (1961) described a patient who had been admitted to more than 300 general hospitals over a five-year period and who was taken to court after stealing a lorry in order to drive himself to a hospital. The patient was convicted of theft (this being far simpler than proving intent to defraud the hospital), and in light of his hospital history was sent to a mental institution for five years. However, after eight months he absconded and was found a week later working as a mortuary attendant in a hospital; five weeks later he again absconded and managed to have himself x-rayed in two different hospitals before being found. Three weeks later he escaped from a closed ward, and Shribman suggested that there would have to be a high wall around the hospital that detained him and that the treatment did not appear effective.

Many writers advised caution in managing persistent patients: some writers warned against providing too much treatment, others warned against too little. Kemp (1963) came in the former category:-

> "Very few of us have the patience to work out, in these long stories, exactly what has been done in the way of treatment. But it is worth doing because it will finally prove to us that any new therapeutic approach is doomed to failure. Unfortunately, nearly all doctors feel themselves possessed of some magic formula. Each failure adds capital to the incurable patient. Ineffective drug dependence is one of the more serious sides of this type of case."

and Dudley (1973) advised the doctor to be careful not to create new symptoms by unnecessary treatment. Vaisrub (1974), an American writer, worried about the legal implications of treating fraudulent patients and the risk of a spouse or family member suing for unnecessary surgery.

Blackwell (1962), on the other hand, reminded the reader that:-

> "...the credulous doctor stands to make less dangerous mistakes than the incredulous, and these patients can offer valuable diagnostic lessons, and may sometimes have a genuine co-existing illness."

and Jensen (1963) gave a cautionary tale of a frequent attender patient dying when further abdominal surgery was refused.

Most authors merely suggested management plans; few reported results. Kemp (1963) gave no figures but said that he thought enough patients responded to his management (thorough investigation followed by a refusal to give unnecessary treatment) to make the time spent worthwhile. However, he noted that not all persistent patients were prepared to be "led like children away from their ill health". Lipsitt (1968) also came up against a hard core of patients "who remain refractory to every treatment attempt" because of basic personality factors. And Sneddon and Sneddon (1975) concluded their discussion on managing persistent patients by saying:-

> "It must be admitted that essentially the patients who have recovered have done so when they have matured or when their life situation has changed and not as a result of medical intervention."

8. Discussion

Our review of the literature showed that although no other writer had used the same definition as ours, a number of studies had been made of frequent hospital attenders.

However, the number of patients included in these studies was small, usually under ten, and often a single case report. We found the selection criteria subjective in the majority of studies, with the writer studying those patients that he or she considered to pose a problem. We found no study in which control methods had been used, and in only a few studies had the results been subjected to statistical analysis.

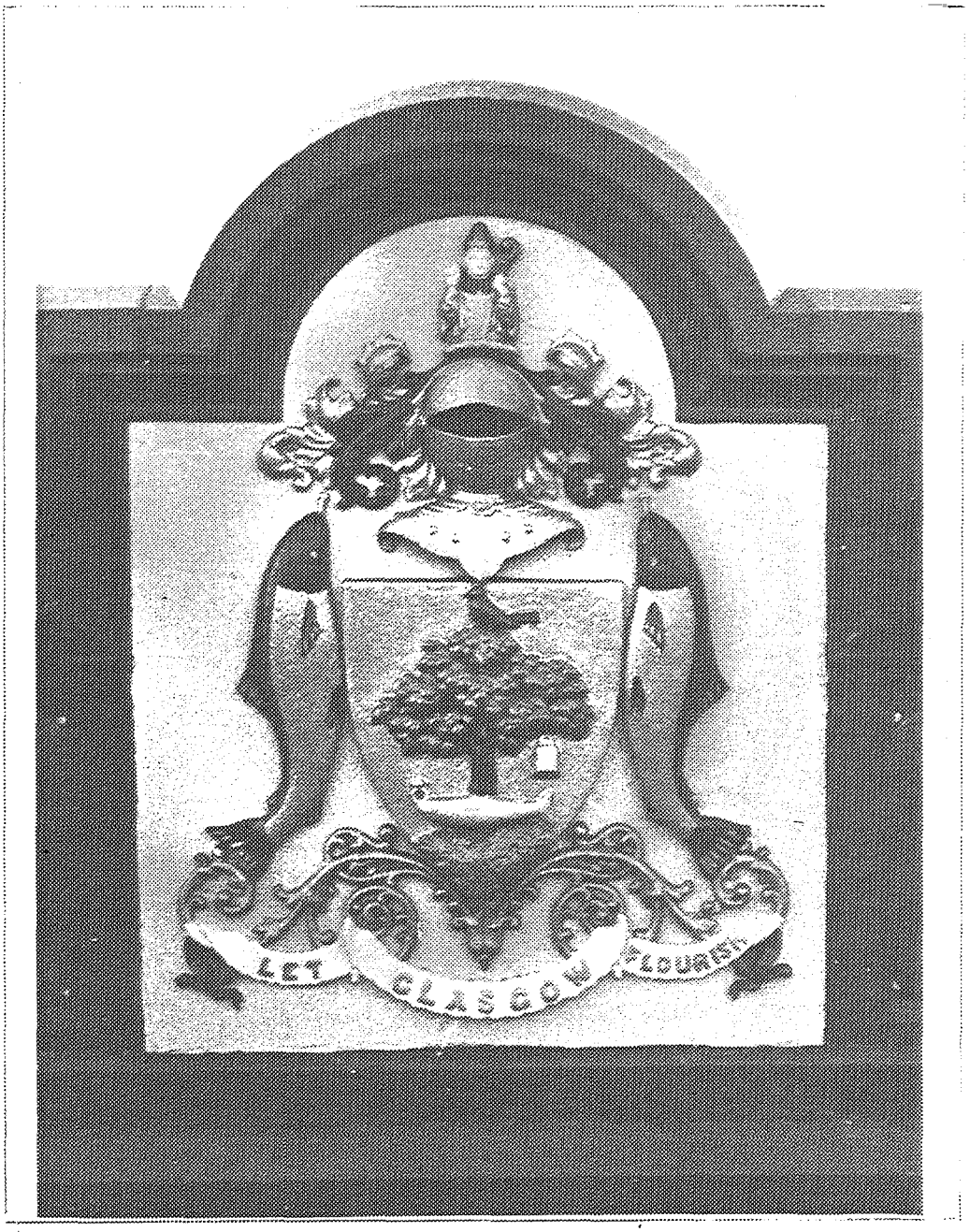
The majority of writers appeared hostile in their attitudes towards the patients studied, and their work was directed at protecting the medical profession from the vagaries of persistent patients. The studies tended to be anecdotal and to dwell on the eccentricities of individual patients rather than considering the wider implications of persistent patient problems. The few exceptions (Menninger, 1938; Kemp, 1963; Lipsitt, 1968; and Dudley, 1973), writers who considered the long-term future of the patients as well as the short-term impact on the medical staff, gave thoughtful commentary but made no attempt at objective study of these patients.

We found widely differing management suggestions, varying from granting persistent patients minimal attention to permanent in-patient care in a mental institution. We found the latter suggestion surprising. The same writers who complained of patients making

frequent but intermittent use of the hospitals and thereby wasting medical time and resources now suggested that these patients become constant consumers of hospital resources on a long-term basis. We concluded that although management of persistent patients had been pondered over for many years and many different treatment plans suggested, no method had proven effective in reducing the hospital attendance of these patients.

We continued our literature search on the subject of persistent patients as we completed our own study. We found no mention of any other case-controlled study of persistent patients; ours would be the first. We would use an objective selection process in choosing our study patients; few other researchers had done so. We would continue our study until we had traced enough patients to provide meaningful results, and we would then subject our findings to statistical analysis. We looked forward to making the first scientific study of persistent patients.

VII. Methods



CM

"The bird that never flew, the tree that never grew,
The bell that never rang, the fish that never swam."

- Anonymous

VII. Methods

A. Background

1. Glasgow

Glasgow is Scotland's largest city. The population was estimated at 1,129,387 as of 30th June, 1974, in Scottish Health Statistics, 1974 (Scottish Health Service, 1976). Glasgow is an industrial city with a predominantly working-class population.

Glasgow flourished at the end of the last century with the production of steel. In 1879, the first steel ship was launched, and a thriving shipbuilding industry grew up along the Clyde, employing as many as 100,000 men at its height. Heavy engineering, textile, and chemical manufacture also provided employment for thousands of workers earlier this century, with companies like Singer in Clydebank employing 20,000 people. However, by the 1970's, these industries had declined, some quite rapidly, in the area. The new industries, light engineering and manufacturing, had mostly been sited on industrial estates and new towns outside Glasgow, attracting the more skilled workers away from the city. Unemployment was, and has been, a major problem for Glasgow over recent years.

Inadequate housing is another continuing problem in the city. Many of the tenements, built in the middle of the last century, are as overcrowded today as they were then. Many still have no bathrooms. Despite various slum clearance schemes, 70,000 of the houses standing in 1975 were considered unfit for habitation (Wright and Worsley, 1975).

Glasgow has the highest incidence of alcoholism of any city in Scotland, as well as the largest number of public houses per capita (Wright and Worsley, 1975). In 1975, the pubs closed at 10 p.m.; the

hours were extended a year later. However, the 'carry-oot' meant that there was no real limit to the time that could be spent drinking.

Despite the economic and social problems that face the people of Glasgow, there is a pride, a warmth, and a sense of humour that marks them as Glaswegian. They can afford the self-parody in this version of the motto to the city crest:

> "The bird that never flew, the tree that never grew,
> The bell that never rang, the fish that never swam."

and a Glasgow toast boasts:

> "Here's tae us, Wha's like us? Gey few, an they're a' deid."

2. Western Infirmary

The Western Infirmary is a long-established teaching hospital of the University of Glasgow. In 1975, the hospital had an approved bed complement of 488 beds, as well as out-patient clinics and emergency services for those living within its catchment area. The catchment area is the western side of the city as outlined by the Western Regional Hospital Board (1975) in Appendix A. The population served by the hospital in 1975 was estimated by the hospital board as approximately 283,000 people.

The Western Infirmary is an acute care hospital. The Western Regional Hospital Board (1975) gave the following definition:

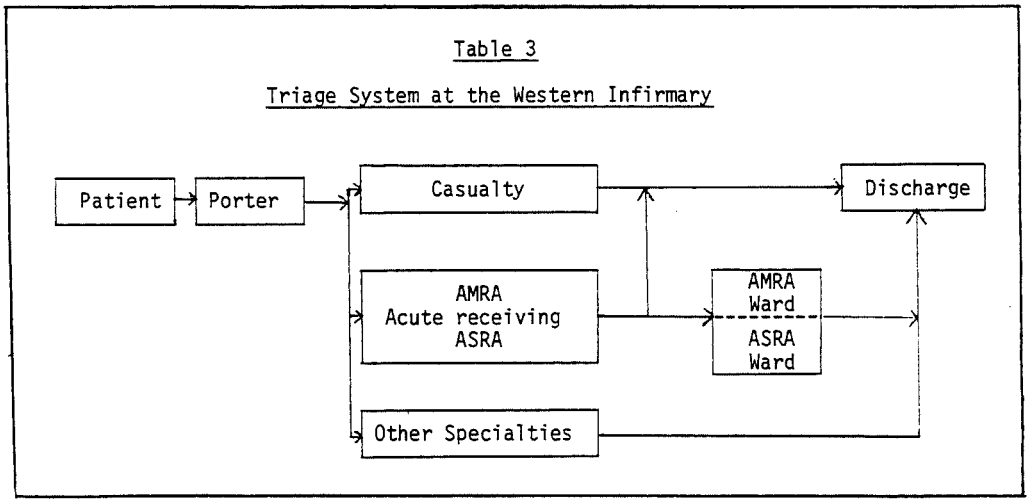
> "An acute case is in direct contrast to the waiting list or arranged admission case and requires admission to the hospital immediately or within the time defined by the general practitioner."

When a patient arrives at the Western Infirmary on an emergency basis, an admission form is filled out by a hospital porter. On this, the porter records the patient's basic information and presenting complaint. He then refers the patient to the appropriate department.

The porters are not medically trained, so rely on experience to triage the patients. A simplification of the referral process would be that patients with life-threatening signs or symptoms are referred to the acute receiving area, while patients with less severe complaints are referred to the casualty department. (Direct referrals are, of course, also made to such specialty departments as orthopaedics and ophthalmology.)

Table 3

Triage System at the Western Infirmary



The acute receiving area is subdivided into the acute medical receiving area (AMRA) and the acute surgical receiving area (ASRA). Patients referred to the acute receiving area are either treated in the receiving hall and then discharged or admitted to the receiving wards.

This study was concerned with frequent attenders to the acute receiving area. Visits to the casualty department were noted but not counted in the number of acute presentations. Similarly, scheduled appointments at out-patient clinics and arranged admissions were noted but not included as acute visits.

VII: B Methodology

CG

"We pursued an energetic follow-up policy in tracing these patients."
Text

VII:B Methodology

1. Preliminary selection

We began by referring to the study mounted in the acute medical receiving area (AMRA) by Dr. Arvind Patel. This study, referred to as the AMRA study, provided us with a record of past hospital attendances for each patient who presented at the acute medical receiving area over the six-month period, February to July, 1975.

Information was provided on a separate index card for each patient in the AMRA study. These cards showed the patient's name, address, sex, date of birth, the date and diagnoses of all previous acute presentations to both the acute medical and acute surgical receiving areas, whether these presentations resulted in admission, and whether the patient died before discharge. The cards were filed alphabetically so that patients who attended the area more than once during the six-month period were still only represented by one card.

By the end of the six-month selection period, the AMRA patient sample consisted of 3,284 patients. We had a record of the past acute attendances of each. Now we had to limit the period over which we were to measure the patients' acute attendance rates; otherwise, the older patients had a greater opportunity of being classified as frequent attenders. Our selection period ended on 31st July, 1975, and we used this date as the end point of our study period. We decided that the beginning of the decade, 1st January, 1970, would make a convenient reference point for the beginning of our study period.

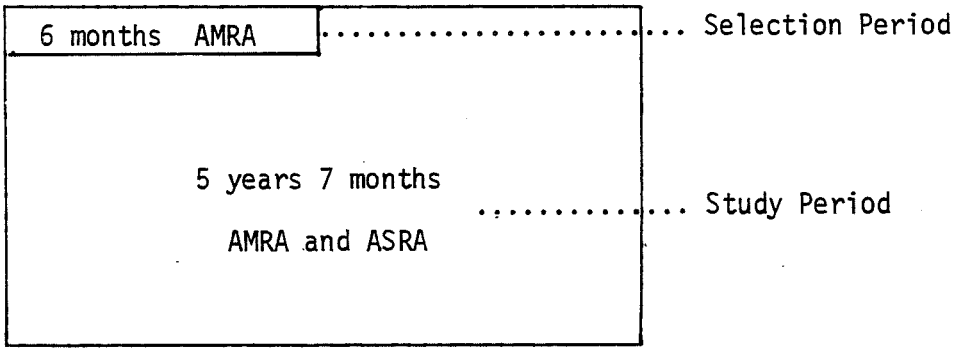
Thus, the selection period ran for six months, February to July, 1975 (inclusive), and our study sample included all patients who attended

the acute medical receiving area (AMRA) during that period.

The study period ran for 5 years 7 months, from the beginning of January 1970 to the end of July 1975 and all acute attendances, whether to the acute medical receiving area (AMRA) or acute surgical receiving area (ASRA), were noted for each patient in the AMRA sample.

Table 4

Selection and study periods



We divided the 3,284 patient index cards first by sex and then by decade of birth (1880's, 1890's, etc.).

2. Selection of frequent attenders

First, we had to decide how many visits to the acute receiving area over the study period constituted frequent attendance. The patients we hoped to study were those who made inappropriate as well as frequent use of the acute receiving area.

We started by sampling the records of those patients who had made four acute visits over the study period, but their records indicated that the majority of these patients had needed emergency medical care at all four visits. Similarly, those who had made five presentations

were noted as having had bona fide medical problems. But the majority of patients who had presented either six or seven times over the study period were noted as making inappropriate use of the acute receiving area on at least one occasion during that time. We therefore decided on six or more presentations over the study period as our definition of frequent attendance, an average of more than one acute presentation a year. So, although six presentations was an arbitrary dividing line between frequent and limited attenders, the number was empirically derived.

We found 150 patients had made six or more acute presentations over the study period and were therefore considered frequent attenders. We removed their index cards from those of the rest of the AMRA sample, the 3,134 patients now termed 'limited attenders'. We then subdivided both sets of cards, frequent and limited attenders, into patients alive at discharge and those who died in hospital. We found 134 frequent attenders and 2,798 limited attenders alive at discharge, as of 31st July, 1975.

3. Selection of Controls.

We wondered how the frequent attenders differed from the limited attenders in terms of medical diagnoses, psychiatric diagnoses, resource consumption, and social background. In order to answer these questions, we selected a control group from the limited attenders in order to compare them to the frequent attenders. To strengthen the power of the comparisons between the two groups, we matched each individual frequent attender with a control patient rather than matching the frequent attenders as a group. We matched the individual patients for sex, decade of birth, and presenting complaint. When a frequent attender had multiple presenting complaints, we chose the

most frequently presented complaint or, if that was unclear, the most severe. We controlled for presenting complaint so that we could compare the attendance behaviour of patients with similar index problems.

Although we matched the controls as closely as possible tothe frequent attenders for age, sex, and presenting complaint, we tried to keep the attendance rates as disparate as possible within the matched pairs. We did not want to use as a control a patient who was just about to manifest as a frequent attender. We excluded patients making three, four, or five acute presentations over the study period from being selected as controls. We looked first for controls who had made only one acute presentation over the study period, but, when we were unable to find a good match for 29 (24% of the final study group) frequent attenders, we turned to those limited attenders who had made two acute presentations, and we selected these controls from them.

We hoped to exclude control patients who had made more than two acute visits to any hospital, not only the Western, during the study period. We first checked the selected controls' Western Infirmary records for mention of acute admissions to other hospitals (almost always included in the medical history) and then asked the patient at interview about previous hospital admissions. After reading the records, we replaced five control patients who had made acute presentations to other hospitals over the study period, but no further controls had to be excluded because of hospital presentations mentioned at interview. Although it was possible that one of the controls was, in fact, a frequent attender at another hospital, we were satisfied that the patient's record and interview provided us with a reliable hospital attendance history.

In selecting controls we also excluded patients with an address outside the Western's catchment area: patients who, during the study period, had been brought to the Western on an emergency basis but who would normally attend another acute care hospital. We excluded those who lived within the Western's catchment area but beyond the Burgh of Clydebank because we thought the distance involved might itself be a deterrent to frequent attendance.

After all these exclusions, we still had more than 2,000 limited attenders from whom to select the 120 matched controls.

4. Record analysis

Having matched the 134 surviving frequent attenders with controls, we reviewed in detail the hospital records for both groups of patients. From the records, we completed a Record Summary Sheet (Appendix B) which listed the following information for each patient:

Patient identification number—we gave each frequent attender a chronological identification number. (We revised these numbers after excluding 30 frequent attenders not available for interview; the revised numbers are used in this text.) We gave each control patient a number 200 digits higher than that of the frequent attender he or she matched. Thus, Frequent Attender 1 was matched by Control 201, Frequent Attender 100 by Control 300. This made it simple to identify matched pairs and to differentiate between frequent attenders and controls, patients 1-120 being frequent attenders and patients 200-320 being controls.

Name—we gave each patient a false name to ensure confidentiality of the patient's identity. We gave patients under 40 both first and last names (e.g., Peggy Thompson, Cyril Wilder); patients over 40 were given surnames only (e.g., Miss Martin, Mrs. Clay); and we added the title

'Senior' to patients over 65 (e.g., Mrs. Cathcart, Snr). We used this format in order to give the reader an immediate indication of the patient's sex and approximate age. We added the patient's precise age, as of 31st December, 1975, in brackets after his name. We indicated control patients by placing the letter 'C' before their age (e.g., Mrs. Curran C[55]).

Age - as of 31st December, 1975.

Date - of each visit to the acute receiving area between 1st January, 1970, and 31st July, 1975.

Time - of each visit.

Type of Referral - whether the patient was referred to the hospital by a general practitioner, self-referred, or brought in by a third party, such as the police, social worker, neighbour, or passer-by. We also noted arranged admissions and Casualty visits, although these were not included in the number of acute attendances made by the patients.

Stay - duration of stay for each visit. This included all days spent in the receiving wards following admission through the acute receiving area.

Complaints and Diagnosis - a summary of the medical findings made at each presentation.

Out-patient Department (OPD) Clinics - the number of visits made to each specialty clinic attended over the study period. We also noted the number of clinic appointments made which the patient did not attend.

General Practitioner (GP) – the name(s) of the patient's general practitioner(s).

Occupation – as well as the patient's own occupation, given to the porter upon arrival at the hospital, we also noted the husband's occupation as recorded for married and widowed women.

Comments – general comments found in the patient's record which reflected the medical staff's view of the patients.

In addition, we also completed an Investigation Sheet (Appendix C) for each patient, noting the type and number of radiological and laboratory investigations performed on the patient over the study period.

5. Tracing the patients

Having abstracted the patients' records, we set out to interview the 134 frequent attenders alive on discharge from the hospital and their matched controls. However, many frequent attenders were not at the address given in their hospital records. We pursued an energetic follow-up policy in tracing the patients. In order to obtain their new addresses, we consulted patients' neighbours, family doctors, the hospital social work department, and, in areas where people had been 'decanted' because of renovations, the Corporation housing department.

We ultimately excluded 14 of the 134 frequent attenders from detailed study, as summarised in Table 5.

Although we found 21 (16%) of the 134 frequent attenders had no fixed abode, we managed to trace twelve of these patients and so only excluded nine of the homeless frequent attenders. We traced the

Table 5

Reason for exclusion of 14 frequent attenders from detailed study

	Number of Patients
Homeless and untraced	9
Died after discharge	4
Senile dementia	1
Total	14

twelve patients interviewed by giving the porters a list of the patients' names and pseudonyms; the porters contacted the author when any of these patients was recognised presenting at the Western. We set up the same system at the Glasgow Royal Infirmary and traced three of the patients there. (Hospitals are good places to find frequent hospital attenders!) Although we preferred to interview patients in their own homes, thinking the patients would be more relaxed and their answers more candid, we decided that interviewing homeless patients in the hospital was preferable to excluding them from the study. We conducted these interviews in the privacy of a side room within the hospital.

In addition to the nine homeless patients, a further five frequent attenders were excluded from the study, four having died after discharge from the hospital and one, suffering from senile dementia, was not coherent enough to be interviewed.

Having excluded 14 of the 134 frequent attenders alive at discharge, there were 120 frequent attenders we wished to interview. None refused

Of the 120 controls initially selected to match these frequent attenders, 21 patients proved unavailable and were therefore excluded.

Table 6

Patients excluded from control group

Reason for exclusion	Number of Patients
Patients not traced	6
Not living in Glasgow area	6
Died after discharge	4
Too ill to be interviewed	2
Refused to be interviewed	2
Frequent attender using pseudonym	1
Total	21

Although we found neighbours and the Corporation housing department helpful in tracing these patients, the controls tended to have less contact than the frequent attenders with their general practitioners, the hospital social work department, and the hospital in general, thereby reducing our sources of information. Of the six patients we were unable to trace, three had left their spouses, who either could not or would not provide forwarding addresses, and the homes of the other three had been demolished.

Six controls were excluded as not being in the Glasgow area: two had not lived in Glasgow for the entire study period (and therefore had not had full opportunity of becoming a frequent attender); two lived more than 30 miles from the Western Infirmary (and were served by other hospitals); and two had since left the Glasgow area.

Of the two control patients who refused to be interviewed: one said she was a private patient and did not want to discuss her visit to the hospital; the other patient refused to open the door.

One patient, selected as a control, proved to be a frequent attender using a pseudonym, who had given a false date of birth and slightly

altered address. Eventually traced by the interviewer, the patient said he had already been interviewed, and we discovered he had been chosen as a control for himself!

We selected another 21 control patients to replace those excluded from the study. Our study finally consisted of 240 patients: 120 frequent attenders and 120 matched controls.

6. Patient interviewing

The author conducted just over half the interviews of both frequent attenders and controls herself; the remaining interviews were divided among the other nine members of the interviewing team.

Each interviewer worked alone, but the team was carefully selected to ensure as much similarity as possible in the interviewing technique of its members. There were many applicants for the interviewer posts. Each applicant was first asked to interview the author, who took on the persona of one of the frequent attenders she had already interviewed, giving the same elaborate responses to the questions asked. The nine applicants accepted as interviewers produced answer sheets very similar to that completed by the author; the applicants noted similar remarks verbatim and gave the patient's answers similar computer codings.

We did not make appointments to interview the patients in advance but consulted each patient's record for indications of the best time to call. We visited housewives, retired or unemployed patients by day and working people in the evening. If patients were out when we visited, we left a letter suggesting another time and a number to call if that was not convenient.

Each interviewer carried an identification card showing that he or she was from the Western Infirmary. We began with the same opening

remarks (Appendix D) and explained that we were carrying out a survey on how patients felt about the Western Infirmary. The vast majority of patients were friendly and eager to help with the study. Privacy was usually provided either by a separate room or by the sound of the television occupying the rest of the family. Offers of tea were accepted if that removed a spouse or other adult from the room. A few interviews were conducted on the doorstep when there was no chance of privacy inside.

We used a structured questionnaire (Appendix E) in interviewing the patients but noted all remarks that seemed relevant to the study, not merely direct answers to the questions. At times, the patients' remarks seemed to contradict their answers to a given question. One frequent attender, for example, replied that she had no worries over health but followed this with the remark "I'm past worrying". Throughout the interview, she had focused on her ill health, so we coded her as 'worried'.

During the interview, we showed the patient an empty pill bottle, with both handwritten instructions and a typed line on the label. We asked patients whether they could make out the handwriting and, if not, whether they could read the typewritten line. The stated purpose was to see whether a recommendation should be made that all labels be typewritten for clarity; the actual purpose was to try to determine whether or not the patient could read.

After asking the final question of the interview, we invited comments from the patient. Directly after the interview, the interviewer reviewed the questionnaire, writing out the patient's comments in full and coding the patient's answers to questions so that they were ready for computer input.

7. Statistical methods

We entered the data collected on each patient into a computer and began by using 'SPSS, Statistical Package for the Social Sciences,' (Nie et al., 1975) to provide frequency distributions. We then used a Massachusetts Institute of Technology (MIT) computer program in order to use more sophisticated statistical techniques.

In examining the individual variables and their association with frequent attendance, we considered the sign test and the t-statistic, but finally chose to use the Wilcoxon rank-sum test. We preferred the Wilcoxon rank-sum test because, unlike the sign test, it takes account of the size of the difference within the matched pairs and because, unlike the t-test, it does not assume a normal (or any other) distribution of scores. Unless otherwise stated, all significance levels given relate to the Wilcoxon rank-sum test.

The null hypothesis of the Wilcoxon rank-sum test is that the study and control group values are drawn from the same distribution. The p value (descriptive level of significance) provided by the test is the probability of a difference as extreme as that observed being made under that null hypothesis.

Using step-wise multiple regression analysis and correlation methods, we then examined and compared the association between the variables and frequent hospital attendance.

In comparing the differences between the two groups, frequent attenders and controls, we made a distinction between the statistical significance of an observation and its clinical importance. Our sample size (120 patients with matched controls) was sufficiently large that even modest clinical associations would be likely to be detected at a conventional level of statistical significance.

As we present the results of our study, we show percentages to one decimal place in the tables and round them to the nearest whole number in the text. The reader will note that the sum of the percentages given in the tables do not necessarily add up to exactly 100%, although this is the figure indicated at the bottom of the column. This discrepancy is due to the figures being shown to one decimal place only; we thought more decimal places would appear cumbersome and such precision was not necessary, considering the nature of our study.

Definitions of the statistical tests used in this study are given by Mosteller and Rourke (1973) and by Crow, Davis, and Maxfield (1960).

8. Methodological caution

In explaining the methods of our study, we should extend the following caution: Although we extracted an epidemiological result, finding 5% of the patients studied were frequent attenders, we should point out that we made our selection on the outcome variable. That is, our sample population consisted of patients known to have made at least one acute presentation and from them we selected the frequent attenders. We did not follow a random sample of the population over a period of time to see how many subsequently became frequent attenders. Our results should, therefore, be examined in the context of patients using a hospital emergency facility, not that of the population as a whole.

9. Stylistic methods

In presenting this study, we used the following conventions:

Having prefaced this study with a 'Glossary of Glasgow terms', we do not explain them again when they occur in the text.

We use the male gender when making non-specific references to frequent attenders in order to avoid such cumbersome terms as 'he or she' or 'his or her'.

We use the term 'groups' to refer to the division between frequent attenders and controls, 'sets' as a collection of variables, and 'categories' as a collection of values.

A discussion follows each set of results, rather than giving a general discussion of all the results at the end of the work, in order to save the reader referring back and forth between different chapters.

10. Information sources

Our primary sources of information were the patients themselves and their Western Infirmary records. However, information was also kindly provided by the Western Regional Hospital Board, Common Services Agency (Scottish Home and Health Board), Glasgow Police Department, Glasgow Corporation Housing Departement, Department of Social Security, Consortium for the Relief of the Adult Single Homeless (CRASH), Scottish Census Office, Manpower Services Commission for Scotland, and the Glasgow Room of the Mitchell Library.

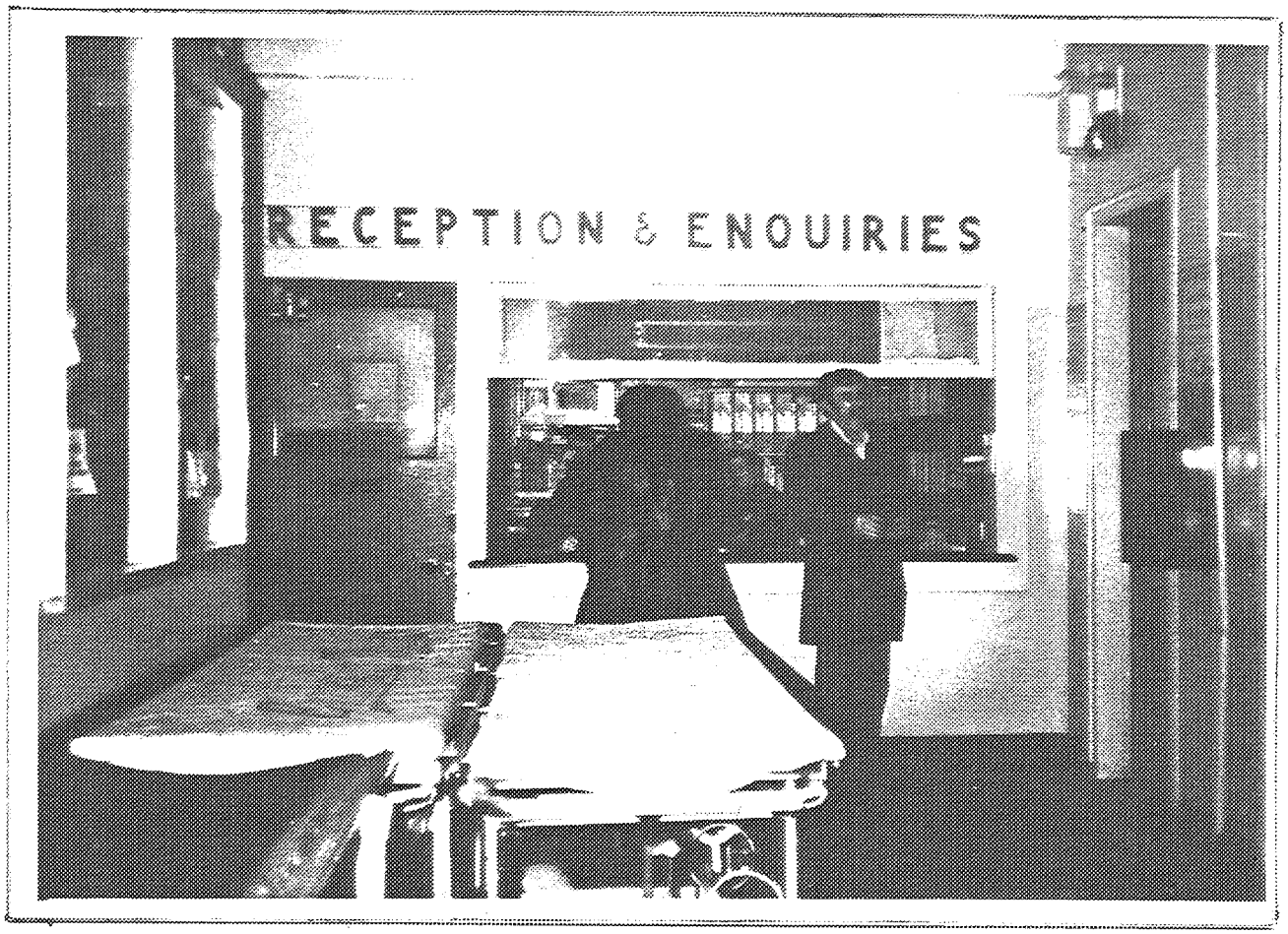
11. Photographic sources

The photographs used to illustrate this text were taken by the author (CM), Neil Rutherford (NR), Colin Guthrie (CG), and by a member of the Western Infirmary's Medical Illustration Department (MI). We are grateful for permission to use these photographs.

The subjects of the photographs are not the patients quoted in the captions beneath the pictures but are instead people in similar

situations. Far from being camera shy, most Glaswegians appeared to enjoy having their photographs taken. The author travelled by scooter, and, from under her helmet and goggles, would hear a cry of "Hey son, take mae photie too!".

VIII. Preliminary Study



CM

"We looked for ways to distinguish the frequent attenders from the rest of the patients as they presented at the acute receiving area, but found no readily discernible differences." Text

VIII. Preliminary Study

1. Introduction

In order to identify the frequent attender patients, we looked at a sample of all patients using the acute receiving area of the Western Infirmary. We used as our sample the 3,284 patients who presented at the acute medical receiving area (AMRA) over a six-month selection period, February to July 1975. We refer to these patients as the AMRA sample.

2. Attendance rates

Over this six-month period, the 3,284 AMRA patients made a total of 3,597 presentations to the acute medical receiving area; 313 of these presentations were repeat visits by patients already in the sample.

We then made a retrospective study of the presentations made by the AMRA patients to both the acute medical and acute surgical receiving areas over a 5 year 7 month study period, January 1970 to July 1975 inclusive.

As detailed in the preceding chapter, we defined frequent attendance as six or more acute presentations over the study period. We found 150 patients (less than 5% of the sample) fell under this definition of frequent attender. We termed the remaining 3,134 patients 'limited attenders'.

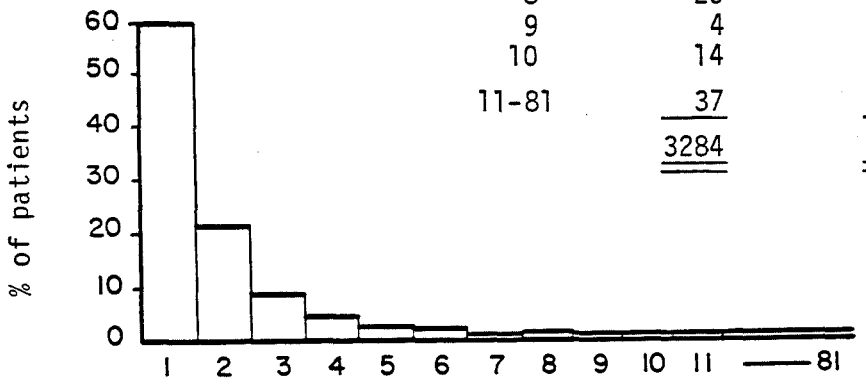
Almost 60% of the AMRA patients had attended only once, and 80% had not attended more than twice over the study period. The number of acute visits made by limited attenders ranged from 1-5 visits over the study period, while the frequent attender visits ranged from 6-81 (Table 7 over). We found that 37 frequent attenders had made more

more than ten acute presentations over the study period, and we refer to them as the most frequent of the frequent attenders.

Table 7

Number of acute visits made by AMRA sample patients over the study period

Visits	Patients	% Patients
1	1952	59.4
2	703	21.4
3	286	8.7
4	144	4.4
5	49	1.5
6	45	1.4
7	30	0.9
8	20	0.6
9	4	0.1
10	14	0.4
11-81	37	1.1
	3284	100.0



We compared the attendance rates of the two groups, the AMRA patients and the frequent attender sub-group, over the study period and found:-

Table 8

Attendance rates of AMRA patients and frequent attenders (Fas)

Acute visits over study period	AMRA Visits	Fas Visits
Mean	2.0	10.2
Median	1.0	7.5
Mode	1.0	6.0

Thus, on average, a frequent attender made five times as many acute presentations over the study period as a typical AMRA patient.

3. Sex

Although there were slightly more men than women in both the AMRA sample and within the frequent attender subgroup, the sex ratios of the two groups were not significantly different:-

Table 9

Sex ratios of AMRA patients and frequent attenders

	AMRA	Fas	AMRA (%)	Fas (%)
Men	1753	83	53.4	55.3
Women	1531	67	46.6	44.7
Total	3284	150	100.0	100.0

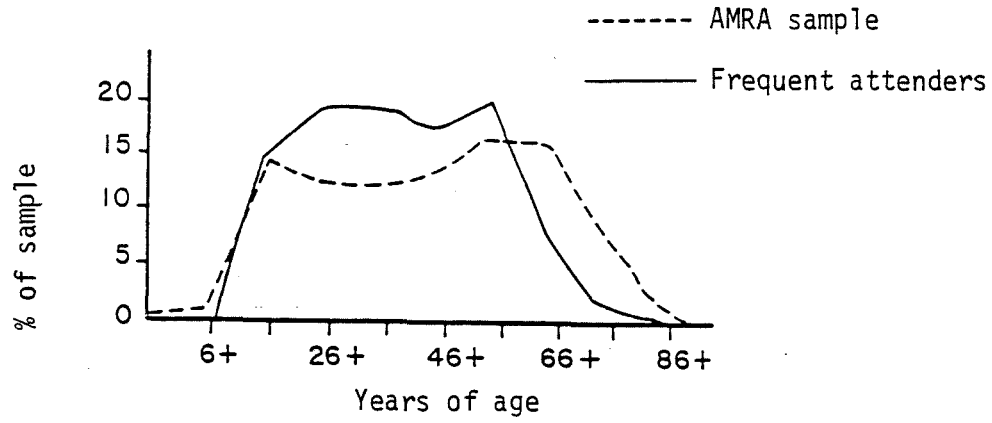
4. Age

We grouped the patients in the AMRA sample according to the decade of birth (1880's, 1890's, etc.), which meant the age categories began at 6 years with increments every 10 years. No patients under the age of 6 and only 44 (1% of the sample) patients under 16 were admitted to the acute medical area during the selection period. Instead, most young patients were referred directly to the Hospital for Sick Children, less than a mile from the Western Infirmary.

The age distribution was fairly similar for the two groups, though we found the median age decade was 46-55 years for the AMRA sample, and a decade younger, 36-45 years, for the frequent attenders. The modal age decade was 56-65 for both groups (Table 10 over).

Table 10

Age distribution of AMRA patients and frequent attenders



Percentage of patients in each age group

Age	6+	16+	26+	36+	46+	56+	66+	76+	86+
AMRA	1.3	14.2	12.3	12.7	14.4	16.8	16.3	9.3	2.3
Fas	-	15.2	19.2	18.9	17.6	19.9	7.6	3.6	-

5. Survival

We found that 352 (11%) of the patients in the AMRA sample died before discharge. This number included 16 of the 150 frequent attenders, and these 16 formed 11% of the frequent attender subgroup. There were no deaths among the most frequent attenders, the 37 patients making more than 10 acute presentations over the study period.

6. Presenting complaint

We compared the presenting complaints of the frequent attenders to those of the 3,284 patients in the AMRA sample over the study period. We used the World Health Organisation's (1967& 1969) 'Manual of the

International Statistical Classification of Diseases, Injuries, and Causes of Death, 8th Revision, 1965' (commonly referred to as the ICD) to categorise the patients' presenting complaints. As many of the ICD categories have long titles, we have abbreviated them in the following table (Table 11). The full titles of the ICD categories are listed in Appendix F.

Table 11

Presenting complaints of AMRA patients and frequent attenders according to WHO International Classification of Disease

	AMRA			Frequent Attenders	
	No.	%		No.	%
1. Heart disease	584	17.8	1. Adverse reaction	39	26.0
2. Adverse reaction	479	14.6	2. Mental disorders	38	25.3
3. Ill-defined	384	11.7	3. Heart disease	22	14.7
4. Mental disorders	368	11.2	4. Ill-defined	17	11.3
5. Digestive	282	8.6	5. Central nervous system	9	6.0
6. Respiratory	280	8.5	6. Respiratory	9	6.0
7. Peripheral circulatory	266	8.1	7. Endocrine	7	4.7
8. Central nervous system	264	8.0	8. Digestive	4	2.7
9. Endocrine	89	2.7	9. Peripheral circulatory	4	2.7
10. Head injuries	88	2.7	10. Malignant	1	0.7
11. Musculoskeletal	69	2.1			
12. Genitourinary	49	1.5			
13. Malignant	33	1.0			
14. Skin	23	0.7			
15. Blood	23	0.7			
16. Infectious	3	0.1			
	3284	100.0		150	100.0

The ICD Classification codes self-poisoning attempts under 'All injuries and adverse reactions (except fractures, dislocations and sprains)'; self-poisoning attempts accounted for all but 13 of the 479

AMRA patients and all 39 of the frequent attender patients in our 'Adverse reaction' category. We included alcohol problems under 'Mental disorders', again following the ICD Classification.

We combined the ICD categories for genital and urinary diseases into one 'Genitourinary' disease category.

We found that a few of the patients presented with a number of complaints, each equally debilitating and, rather than force these complaints under any particular disease category, we included them under the ICD category 'All symptoms and ill-defined conditions', noted as 'Ill-defined' in our classification.

7. Discussion

The preliminary study showed us that the majority of patients using the acute medical receiving area had made no more than two acute visits over the 5 year. 7 month study period. This did not surprise us. Patients with chronic conditions were normally referred directly to the appropriate specialty; patients with minor problems, where repeated incidents could be attributed to bad luck, were generally referred to Casualty. The acute receiving area handled patients with life-threatening emergencies, and it was, therefore, surprising to find any patients making repeated presentations at the receiving hall. However, we found that a small group of patients, less than 5% of the sample, had made more than five acute attendances over the study period. We looked for ways to distinguish frequent attenders from the rest of the patients as they presented at the acute receiving area, but found no readily discernible differences. The two groups were similar in age, sex, and presenting complaints.

We noted that the death rate was no higher among the frequent attenders despite their more frequent calls for emergency treatment. We also noted that there were no deaths among the most frequent of the frequent attenders, patients who had made more than ten acute visits over the study period. We saw this as an early indication that these most frequent of attenders were probably not suffering from life-threatening complaints.

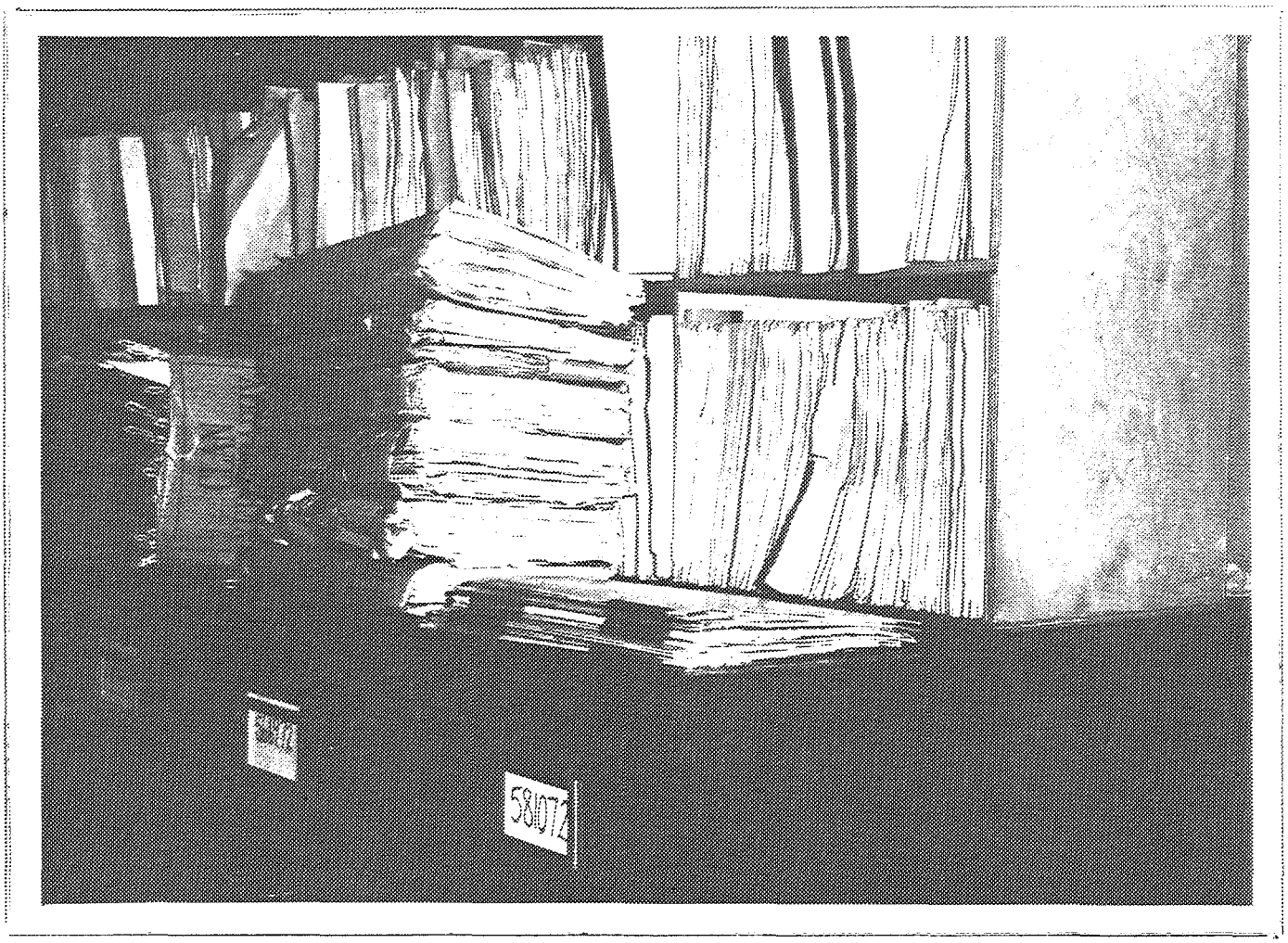
IX. Results and Discussion: Medical History

A. Introduction

Having identified 150 frequent attenders among the 3,284 AMRA patients, we found 120 frequent attenders available for interview. We selected a control patient, matched for age, sex, and presenting complaint, for each of these 120 frequent attenders.

We examined and compared the information contained in the hospital records on the matched pairs.

IX:B Resource Consumption



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Hospital records: six frequent attender records stacked on the left six control records stacked on the right.

IX:B Resource Consumption

1. Resource usage: frequent attenders versus hospital population

In suggesting this study, the medical staff complained that the frequent attenders used a substantial amount of hospital resources. We wondered whether this was so. We began by comparing the resources used by all 150 frequent attenders to the resources consumed by all patients using the Western Infirmary over the study period.

The annual accounts of the Western Regional Hospital Board provided us with the total number of admissions, in-patient days and out-patient visits made to the Western Infirmary over the years ending March 1970 to March 1975. As our study period ran from the beginning of January 1970 to the end of July 1975, we calculated the figures for the first three months of 1970 and the four months April to July 1975 as a proportion of the annual totals.

The 150 frequent attenders had made 854 acute admissions over the study period. When we compared this figure to the total patient admissions at the Western Infirmary over the study period, we found:

$$\frac{\text{Frequent attender acute admissions}}{\text{Total patient admissions}} = \frac{854}{114,161} = 0.8\%$$

The 150 frequent attenders' acute admissions accounted for less than 1% of all admissions made and, on average, only one patient in every 133 admitted was a frequent attender making an acute admission.

We calculated the average length of stay by dividing the number of in-patient days used by thenumber of admissions. We found the average length of stay was 5.7 days for frequent attenders making an acute admission and 7.9 days for the hospital population. Thus, the average

length of stay was two days less for the frequent attenders than for the total patient population.

Of the 1,796 out-patient visits made by the frequent attenders, we found that 1,014 were visits to clinics, 28 were visits to the Casualty department, and 754 were acute care presentations for which the patient was treated in the receiving hall and not admitted to the wards. We compared the total number of out-patient visits made by the frequent attenders to the figures for the Western Infirmary over the study period and found:

$$\frac{\text{Frequent attender out-patient visits}}{\text{Western Infirmary out-patient visits}} = \frac{1,796}{2,203,369} = 0.08\%$$

The frequent attenders had made less than 0.1% of the total out-patient visits. This meant that, on average, less than one in a thousand patients making an out-patient visit was a frequent attender.

We based the hospital costs for the two groups on the figures provided by the Western Regional Hospital Board specifically for the Western Infirmary in their annual accounts. We found that the Western Infirmary's costs had trebled between the years ending March, 1970, and March, 1975: the cost of an in-patient week had risen from £70.58 to £.258.73 and the cost of an out-patient visit had risen from £1.23 to £3.27. We decided that costing hospital use according to the year of the visit would provide a distorted picture, one 1975 in-patient week being equal to three weeks in 1970, and so used 1975 costs for all visits made over the study period.

We costed resources used according to the number of in-patient days and out-patient visits consumed by the two groups. The 1975 cost for an in-patient day was £36.96 and for an out-patient visit was £3.27. These costs were fully inclusive of all x-ray and laboratory tests as

well as the cost of medical staff, hotel facilities, and general hospital overhead.

We calculated the costs (including arranged as well as acute admissions) for the 150 frequent attenders over the study period as:

5,046 bed days at £36.96	£186,500
1,796 out-patient visits at £3.27	5,873
	£192,373

and the total costs for the Western Infirmary over the study period as:

909,188 bed days at £36.96	£33,603,588
1,854,264 out-patient visits at £3.27	6,063,443
	£39,667,031

When we compared the frequent attenders' costs to the total hospital costs over the study period, we found that:-

$$\frac{\text{Frequent attender costs}}{\text{Western Infirmary costs}} = \frac{192,373}{39,667,031} = 0.5\%$$

the frequent attenders had consumed 0.5% of the total hospital expenditure.

In summary, the frequent attenders accounted for 0.8% of all admissions, 0.1% of all out-patient visits, and 0.5% of the hospital costs over the study period.

2. Resource usage: frequent attenders versus AMRA sample patients

The hospital board accounts provided figures for the hospital as a whole rather than itemising these by department. We therefore used the data collected in the preliminary study to see what proportion of visits to the acute medical receiving area were made by the frequent attenders. We found that the 150 frequent attenders (4.6% of the AMRA sample) accounted for 229 (6.4%) of the 3,597 acute medical

presentations made by the AMRA patients over the six-month selection period. Thus, the frequent attenders represented 4.6% of the patients using the acute medical receiving area and made 6.4% of the visits.

We noted that only 53% of the frequent attender presentations resulted in admission while 74% of the other AMRA patients' (the limited attenders) presentations led to admission. We wondered whether this 20% difference in admission rate indicated that the frequent attenders, although presenting more often than the limited attenders, in fact consumed fewer resources per visit. We turned to the controls as being representative of limited attenders in order to compare the per visit costs of the two groups.

3. Resource usage: frequent attenders versus controls

We made a detailed study of the hospital resources used by the 120 frequent attenders who proved available for interview and their matched controls. We again used the 1975 costs given for the Western Infirmary, this time for 120 rather than 150 frequent attenders, and controls.

Table 12

Hospital resources consumed by frequent attenders and controls over study period

	Unit Cost	Number		Total Cost	
		Fas	Ctrls	Fas	Ctrls
				£	£
In-patient days	£36.96	4350	996	160,776	36,812
Out-patient visits	£3.27	1548	338	5,062	1,105
				165,838	37,917

We found that the frequent attenders had used 4.4 times as many in-patient days and 4.6 times as many out-patient visits as the

controls. The frequent attenders' hospital costs proved to be 4.4 times as great as those for the controls:

$$\frac{\text{Frequent attender costs}}{\text{Control costs}} = \frac{£165,838}{£37,917} = 4.4$$

We compared the number of acute presentations made by the two groups over the study period and found:

$$\frac{\text{Frequent attender acute presentations}}{\text{Control acute presentations}} = \frac{1286}{149} = 8.6$$

So, although the frequent attenders had made 8.6 times as many acute presentations as the controls, we found the estimated hospital costs for the frequent attenders to be only 4.4 times that of the controls.

We wondered whether the per diem or per clinic attendance costs were the same for frequent attenders as controls. Perhaps fewer investigations were ordered for patients making repeat presentations. We compared the number of radiological and laboratory investigations for the two groups. First, we compared the radiological investigations. We divided the diagnostic x-ray examinations into the four cost groups used by the British Medical Association in 'Fees for Part-Time Medical Services' (April, 1975), as shown in Appendix G. The cost groups indicated the amount of resources used in the examinations.

Table 13

Number of x-ray investigations on frequent attenders and controls over the study period

Group Number	Unit Cost	Number		Cost	
		Fas	Ctrls	Fas	Ctrls
1	£ 7.69	570	137	£4,383.30	£1,053.53
2	11.37	72	21	818.64	238.77
3	15.09	167	34	2,520.03	513.06
4	22.62	19	6	429.78	135.72
		828	198	£8,151.75	£1,941.08

We compared the costs of the x-rays received by the frequent attenders to those received by the controls:

$$\frac{\text{Cost of frequent attender x-rays}}{\text{Cost of controls x-rays}} = \frac{£8,151.75}{£1,941.08} = 4.2$$

and the number of x-rays received by the two groups:

$$\frac{\text{Number of frequent attender x-rays}}{\text{Number of controls x-rays}} = \frac{828}{198} = 4.2$$

and found that according to both cost and numbers the frequent attenders had received 4.2 times as many diagnostic x-rays.

We compared the number of laboratory investigations performed on the two groups and found that the frequent attenders had had 4.5 times as many test results reported as the controls.

In summary, the frequent attenders used 4.4 times as many in-patient days and made 4.6 times as many out-patient visits as the controls; they received 4.2 times as many diagnostic x-rays and 4.5 times as many laboratory investigations as the controls. This indicated that the ratio of investigations to time spent in the hospital was the same for the frequent attenders as the controls.

4. Discussion

At the outset of our study, the medical staff had suggested that a substantial amount of hospital resources was being wasted on the frequent attenders. However, we found that the frequent attenders represented less than 5% of the patients using the acute medical receiving area over a six-month period and had made only 6% of the emergency medical presentations. We also found that the frequent attenders had consumed only 0.5% of the total hospital costs for the Western Infirmary over the study period. We did

not consider that these figures indicated any significant impact on the resources of either the hospital in general or the acute receiving area in particular.

Nor did we consider resources used by the frequent attenders as 'wasted.' The medical records (see Section IX:C) indicated that almost a third (32%) of the frequent attenders' acute presentations were considered to be an appropriate use of the hospital's emergency facilities. As for the other visits, the presentations considered an inappropriate use of the acute receiving area, we were not sure that there would have been a saving had these frequent attender visits not been made. Most of the costs involved in treating patients in the acute receiving area are fixed costs. Had the frequent attenders not presented and had there been 6.4% fewer patients treated in the acute medical receiving area over the six-month selection period, this would not have altered the number of staff needed in the receiving area, the number of staff needed in ancillary departments, the number of examining rooms, or the number of beds. Very small savings might have been made, for instance, in the materials needed to perform investigations, food served to in-patients, and other minor costs. We concluded that the additional costs of treating the frequent attenders in the acute receiving area were so small that any management plan that involved the hiring of personnel either to identify or to treat the frequent attender patients was likely to cost more than the possible savings.

We wondered about costs other than financial incurred in treating the frequent attenders. We wondered how often the frequent attenders jeopardized other patients' medical care. Were patients genuinely in need of acute care being neglected because the police, ambulance, or hospital services were deflected by frequent attenders? How often

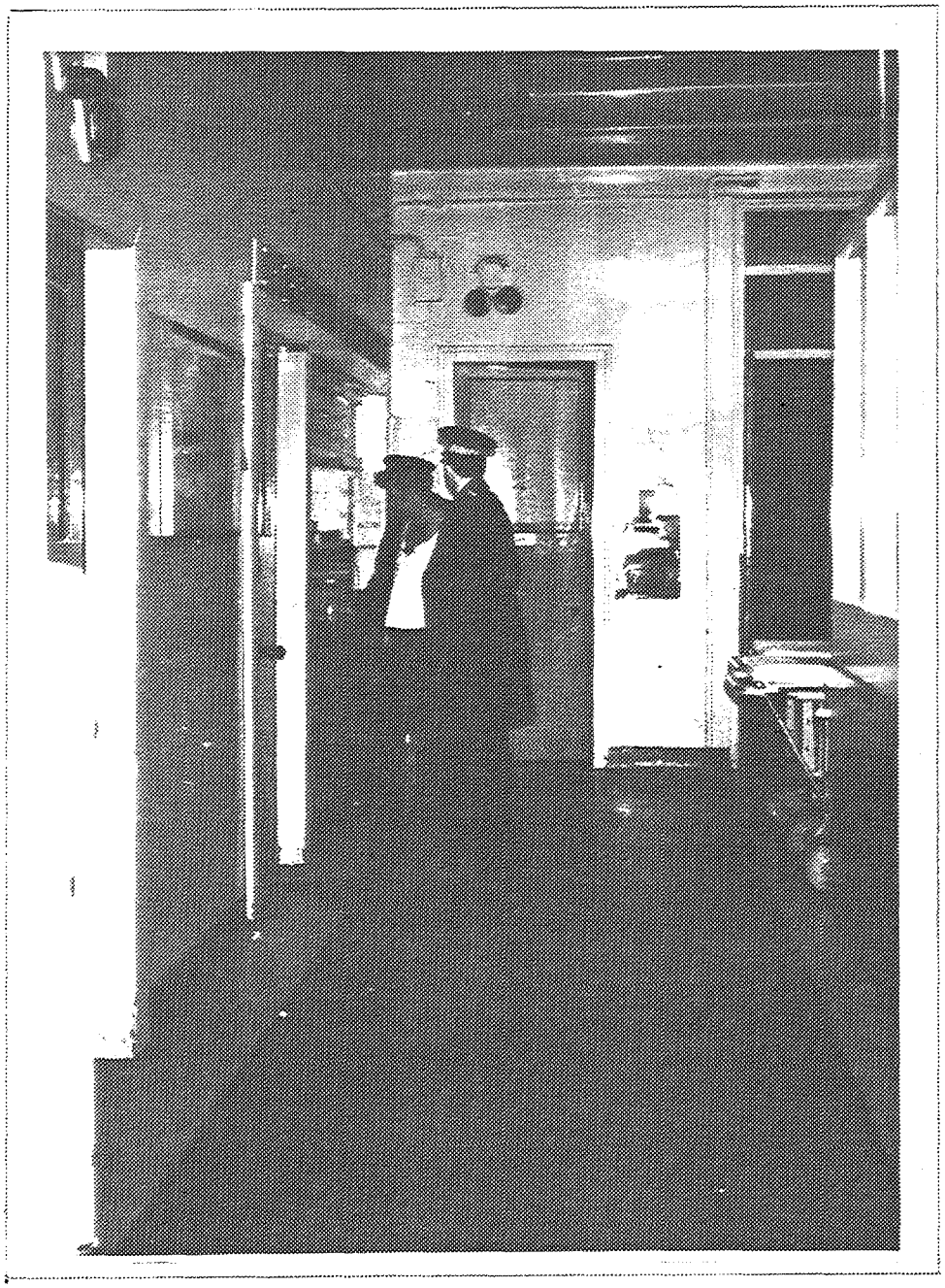
was a sick patient deined a bed occupied by a frequent attender feigning illness? We thought not often for only one in every 133 patients was likely to prove to be a frequent attender and the frequent attenders' length of stay was on average two days shorter than that of other patients.

As well as the risks to other patients, we wondered what risks the frequent attenders posed to the emergency personnel who treated them. Were ambulance and police drivers unnecessarily endangering their own lives when they rushed these patients to hospital with what proved to be factitious illness? Again, we realised that the risks existed but thought the likelihood of this combination of factors - a traffic accident, a frequent attender, a feigned illness - was small.

We wondered about the risks to the frequent attenders themselves: the risks associated with self-destructive gestures, exposure to numerous x-ray examinations, the side effects of unnecessary investigations and surgical procedures. Were the frequent attenders making themselves invalids, believing in their own acting of the 'sick role'?

Quantitative answers to all these questions would involve extensive cost/benefit analysis beyond the scope of this study. Although we believed that the cost of the frequent attenders' acute presentations extended beyond the direct cost of treatment, we did not think that these patients represented any significantly greater hazard to the health and welfare of the community than other member of the population served by the hospital.

IX:C Medical Diagnoses



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Record: "This 44-year-old epileptic and social parasite is well known to the hospital and police as a Saturday night event." Mr. Connelly (44)

IX:C Medical Diagnoses

1. Comparison of medical findings

In looking at the difference between the frequent attenders and matched controls, we turned first to the medical diagnoses. Although the frequent attender and control pairs had been matched for presenting complaint, this did not necessarily mean that the diagnoses were the same. If we found the frequent attenders had greater medical problems than the controls, we would then have an explanation for the difference in the hospital attendance rates of the two groups.

In only 14 (12%) of the 120 matched pairs did we find greater (more severe or more frequent) medical problems diagnosed in the frequent attender than in the matched control patient. Thus, we could not explain the increased hospital attendances of the frequent attender group as being the result of greater medical problems.

We often found a question mark before many of the frequent attender diagnoses, indicating a discrepancy between a frequent attender's presenting complaint and the medical findings. For instance, the staff were uncertain whether one frequent attender actually suffered from renal colic or whether he was a pethidine addict; whether another patient had, in fact, had a haematemesis or was he merely in search of a bed for the night?

'No abnormality detected' was a common diagnosis in the frequent attender records, and this was the only consistent diagnosis in the records of 24 (20%) frequent attenders. These 24 patients had presented with a wide variety of complaints and had been referred to numerous different specialists, but little or no organic disease had ever been found:-

> Record: "I fully echo your sentiments about the problems she has caused for a number of years in so many different departments of the hospital. I have despaired of ever improving her." Mrs. Davidson Snr (76)

> Record: "Complaining of abdominal pain like a knife but seen as an overweight female lying comfortably in bed. We feel very strongly that her symptoms have all got a very definite functional background and there is no organic disease." Mrs. Jessop (57)

The changing nature of the problems described by these patients made diagnosis difficult:-

> Record: "Her previous main complaint of diarrhoea stopped dramatically six months ago and she is, if anything, now constipated. She seems to have transferred her complaints to her muscular skeletal system. I found it quite impossible to assess this lady." Mrs. Davidson Snr (76)

> Record: "The patient is a complete mystery. She came in with abdominal pain but when we opened her up we found complete normality. For at least a fortnight thereafter she showed no improvement and then suddenly, her progress became spectacular and she was discharged in apparently normal health." Mrs. Lacey Snr (67)

2. Inappropriate patient behaviour

Although we found 60 frequent attenders, half of the 120 studied, had been diagnosed at least once over the study period as having a problem in need of immediate medical care, we also found that most frequent attenders had been suspected of misusing the hospital's emergency facility over the same period. We remembered the medical staff's contention that many of the frequent attenders' presenting complaints were fraudulent or their visits an otherwise inappropriate use of the acute receiving area, and so examined the patients' records again. This time we sought to quantify the alleged misuse of the acute receiving area and looked for patient behaviour noted as inappropriate by the examining medical team.

We found complaints in the records of patients discovered fabricating or greatly exaggerating their symptoms; patients who had no apparent

medical problems but who presented as lonely, drunk, or homeless; patients who presented repeatedly with diabetic or epileptic problems, having ignored the prescribed treatment regimen; and patients considered to be merely seeking attention by threatening self-injury. (In regard to the latter, we found the notes generally sympathetic to patients thought to have made genuine suicide attempts, while the staff were antagonised by those patients who made impulsive gestures with no apparent intention of harming themselves.)

We gave patients an inappropriate patient behaviour score according to the comments found in his or her record. A patient with no inappropriate behaviour noted was scored as 0. If a quarter of a patient's acute visits were noted to be due to inappropriate patient behaviour, the patient was scored as 1; if half were noted as inappropriate, the score was 2; if three-quarters, then 3; and if all the visits were noted as inappropriate, the patient was scored as 4. The score reflected the proportion rather than the number of visits thought due to inappropriate patient behaviour.

Table 14

Inappropriate patient behaviour scores

Proportion of visits	Fas	Ctrls	%Fas	%Ctrls
0. No inappropriate behaviour	2	65	1.7	54.2
1. ¼ inappropriate behaviour	33	14	27.5	11.7
2. ½ inappropriate behaviour	33	20	27.5	16.7
3. ¾ inappropriate behaviour	28	11	23.3	9.2
4. All inappropriate behaviour	24	10	20.0	8.3
	120	120	100.0	100.0

We looked at the difference in score between the matched pairs and found that the frequent attenders had a significantly higher proportion ($p < 0.001$) of inappropriate use of the acute receiving area noted in their records. In fact, only two frequent attenders, as opposed to half the controls, had records without any mention of misuse of the hospital's emergency facilities. These two frequent attenders both had severe medical problems. Mr. Hendrik (63) was diagnosed as having atrial fibrillation, ischaemic heart disease, congestive cardiac failure, cerebrovascular disease, and this patient died shortly after interview. Mrs. Maxwell Snr (75) was noted as having asthma, ischaemic heart disease, and congestive cardiac failure. The other 118 frequent attenders were all noted as having made some misuse of the acute receiving area. The medical staff doubted the validity of many of the medical emergencies with which these frequent attenders presented.

Having compared the inappropriate patient behaviour scores within the matched pairs, we then compared the number of inappropriate visits made by the two groups. We found 68% of all frequent attender presentations over the study period were considered an inappropriate use of the acute receiving area, while only 28% of the controls' presentations were noted as inappropriate.

3. Dramatic presentations

In feigning complaints, the frequent attenders tended to be dramatic. Hugh Atwood (33) had twice been rushed to hospital having collapsed, muttering "leaky valves" and "mitral stenosis", though no cardiac problems had been diagnosed according to his record. Mr. Jackson (52) presented with "crushing chest pain" at half of his 16 acute visits over the study period, but, again, no cardiac problems were found. The

notes in his record described him as "a regular customer and well-known chancer", "alcoholic rascal", and "con-man". Another frequent attender was described in a newspaper article as "Back from the dead 10 times!":-

IT CAN HAPPEN TO ME AGAIN, SAYS

DEAD? Husband t ordeal as comes back

AND ALIV!

EXPRESS HEADLINE YESTERDAY ON THE STORY OF ....

Back from the dead 10 times!

T E - HAIRED

red when he up on a cold slab. . . . he took off a round his right

und his clothes— m shoes and jacket neatly beside his bed." And, dressing he hurried home lasgow's Western

nutes later, anxious ed on his door and ife: "We're sorry— nd is dead. But he anished."

STORY: James Kerr
PICTURE: Jack Wallace

found to be still alive this week after being pronounced dead at Glasgow Royal Infirmary.

. . . who suffers from automatism, a rare nervous disorder, goes into a deep coma when he gets over excited. He appears to have died.

He said: "When I was taken to hospital on the two occasions I was certified dead, doctors could find no trace of my pulse or any sign of breathing.

"They stuck pins into my legs and ear lobes without any

much drink or ge just flake out and I am dead.

"It happened f York in 1945. But were not quite actually dead and side room bed.

"The first time I dead was at the W mary in 1956. I ca on a marble slab friend who had com me where I was. H morgue." Then he life!"

No spir

It was a year late came round in mortuary, dressed home.

. . . whose w (38), is expecting h

The newspaper account describes the patient waking to find himself in the mortuary, having been taken for dead for the tenth time; the patient's record noted, less dramatically, that the patient drinks himself into a stupor but could be aroused from apparently deep coma by mention of a "wonder drug which causes excruciating pain".

Mr. Connelly (44), according to his record, was known to dial 999 and report a road accident, and then, when he heard the police and ambulance

arriving, would lie by the side of the road at the reported scene of the accident. He had so misused the emergency services that the notes in his record were often far from complimentary:-

> Record: "This 44-year-old epileptic and social parasite is well known to the hospital and police as a Saturday night event." Mr. Connelly (44)

The frequent attenders often continued their dramatic behaviour once in the acute receiving area:-

> Record: "He intimated his intention to faint, leapt two paces backwards, jumped on the examination couch and then appeared to go into a 'dead faint' but responded to a slap on the face and asked 'Where am I, Doctor?', apologising for having had an attack." Mr. Rafferty (56)
>
> Record: "History of chest pain, a textbook description. Oscar-winning performance of pain, dyspnoea, hand holding, last gasps, followed immediately by request for cup of tea. Drunk." Mr. Youngman (59)

and in the wards:-

> Record: "We were doubtful about her having hypo attacks. In the ward, she was found to have normal or raised blood sugars when she was theoretically hypo." Lydia Borden (19)

4. Motivation for misuse of acute receiving area

We wondered about the frequent attenders' motives in presenting with exaggerated or frankly fraudulent complaints. In some the motivation seemed deliberate, the patients having a definite reason for seeking hospital admission. For instance, some of the homeless patients admitted, at interview, that they looked to the hospital for shelter:-

> "I came out of Barlinnie this morning and tomorrow I get the money. I've got nowhere for tonight. They have a means test at the Great Eastern (hostel), you have to pay before you get in." Keith Steel (35)
>
> "I move around. I'll get money from Social Security tomorrow. I just need a bed for the night." Peter Kelly (37)

Others appeared to use the hospital to escape the police:-

> Record: "Had been drinking and arrested by the police and it was at this stage that he promptly vomited up bright red blood." (Patient known to bite cheek to produce blood.) Christopher Tomlins (39)
>
> Record: "Collapsed in police car on way to prison after failure to pay a small fine." Mr. Larkin (62)

In other frequent attenders, it was less clear to what extent the motivation in making fraudulent claims on the hospital was a conscious one. We found many frequent attenders thought to be exaggerating their complaints out of loneliness:-

> Record: "He was readmitted two days later. I feel this is going to be a continuing problem as Mr. J. very much enjoys being in hospital. He claims not to be well enough to go home and refused to put on his clothes. Nevertheless, he was discharged after a short talk with Sister." Mr. Jamison Snr (73)

or using 'ill health' to manipulate their families. Mrs. Fairbairn (57) for whom no medical problems were detected, was noted commanding her family from the sick bed; Mr. Lawrence (52) said he hoped his hospital admissions would bring his estranged children back to his side; Nell Radnor (16) was thought to feign haematemesis to gain the attention of her busy parents, preoccupied in running a guesthouse.

5. Compliance with treatment

We found six diabetics and eight epileptics among the frequent attenders who were noted as disregarding medical advice:-

> Record: "Resents being on two injections instead of one a day and has in fact only been taking one." Catherine Sills (36)
>
> Record: "She hasn't taken Epanutin as feels they cause loss of libido." Carol London (36)

Treating these patients had proved difficult. The staff were often unsure whether their symptoms were fabricated or real. One frequent

attender given any quantity of drugs took an overdose which meant that controlling her epilepsy through drugs was a difficult task.

6. Staff response to frequent attenders

We found that the frequent attenders, particularly the alcoholic patients, often created a major disturbance on arrival at the hospital:-

> Record: "This patient showed no effect of any sedation and by 5:30 a.m. had every other patient in the ward awake, had assaulted one student nurse, thrown water over another, and had required three people to prevent her from injuring herself and others." Mrs. Hinckley (45)
>
> Record: "Seen after he had assaulted two police constables and several porters in the Receiving Hall." Fred Beacons (37)

The records showed that the medical staff often found the frequent attenders' behaviour intensely annoying, particularly when the doctor had invested both time and energy in investigating a patient's complaints late at night, only to find, when the patient's record arrived, that the patient had made similar presentations before and that the complaints had proved fraudulent. A note in a frequent attender record - "I have been conned by this man" - expressed the sense of outrage and ridicule we found in many of the medical notes on the frequent attenders.

7. Discussion

Although we had found that the frequent attenders were not without acute medical problems, half of the group having been diagnosed in need of immediate medical care at least once over the study period, we could not explain the frequency of their hospital presentations on medical grounds. In fact, we found the medical notes suggested that

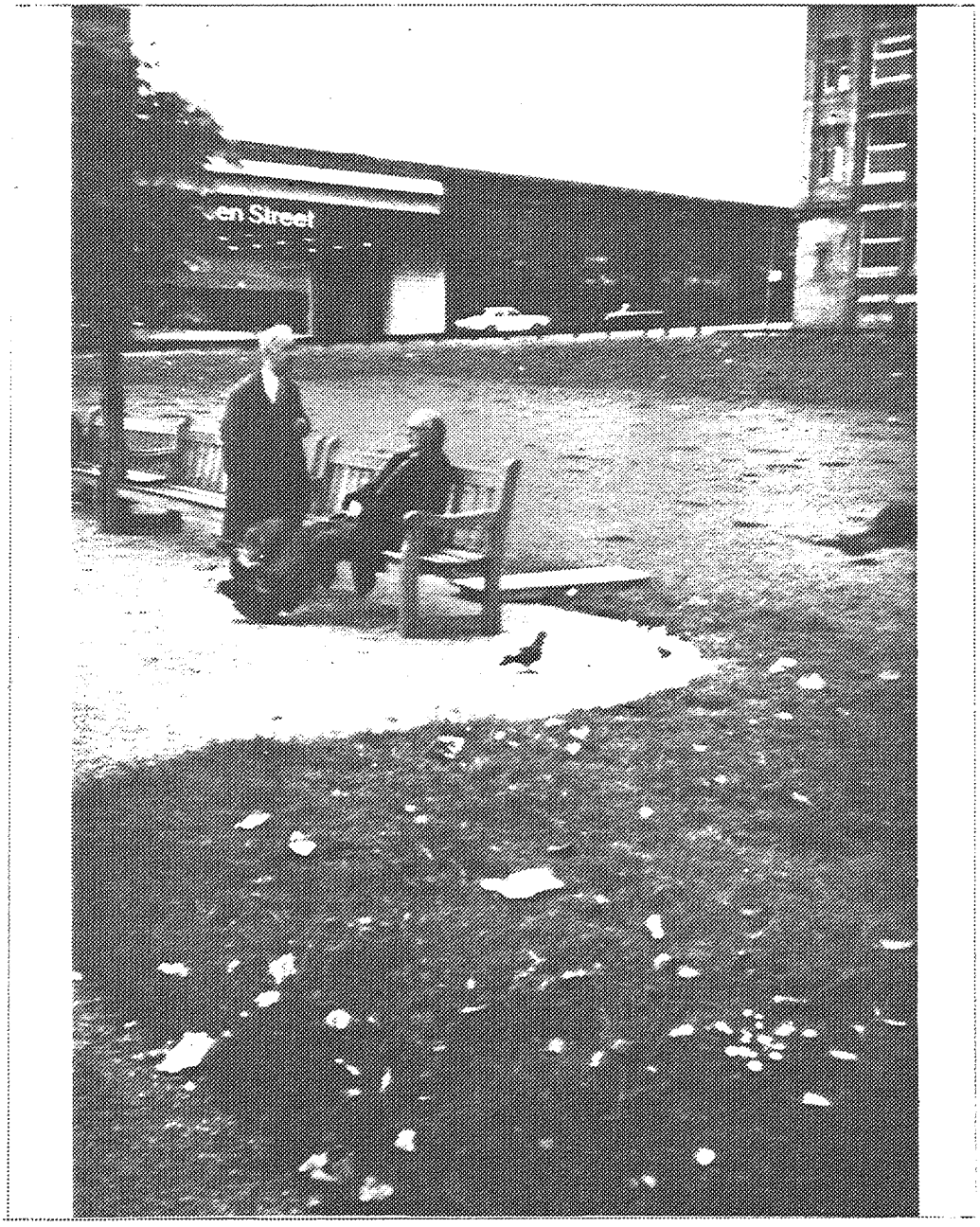
almost 70% of the frequent attenders' acute presentations over the study period were the result of inappropriate patient behaviour.

However, we found that a quarter of the acute presentations made by the control patients were also thought inappropriate, and we realised that, even if we somehow managed to dissuade the frequent attenders from presenting at the acute receiving area, we were still most unlikely to prevent future misuse of the hospital's emergency facilities.

While the frequent attenders presented with complaints that were dramatic and physical, the medical findings tended towards the chronic and the psychological. We will examine the psychological findings in greater detail in the following section. Having found 68% of the frequent attenders' acute presentations attributed to inappropriate patient behaviour, we were left unsure as to how much of this inappropriate behaviour was deliberate and how much unconscious.

Intentional or not, we found the frequent attenders' inappropriate use of the acute receiving area greatly annoyed the medical staff and that the staff remembered time spent on these patients long after the event.

IX:D Psychiatric Diagnoses



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Record: "He says he was talking to a pigeon in the park. He felt that this was the reincarnation of his dead wife. He wished to join her and so took the tablets." Mr. Rafferty (56)

IX:D Psychiatric Diagnoses

1. Comparison of psychiatric findings

We restricted description of the patients' psychological problems to those made by the psychiatric staff in the Western Infirmary records. We found psychological problems diagnosed in 92 (77%) of the frequent attenders and 26 (22%) of the controls. That is, 3.5 times as many frequent attenders as controls had reported psychiatric problems; we found this to be a highly significant difference ($p<0.001$).

Table 15

Psychiatric diagnoses found in patient records

Diagnostic group	Fas	Ctrls	%Fas	%Ctrls
1. No psychiatric problem recorded	28	94	23.3	78.3
2. Affective disorders	17	15	14.2	12.5
3. Alcoholism	18	8	15.0	6.7
4. Personality disorders	57	3	47.5	2.5
	120	120	100.0	100.0

Under affective disorders, we coded patients with problems for which the psychiatrists thought they could offer treatment, such as anxiety and depression.

Under alcoholism, a problem considered difficult to treat, we coded those patients diagnosed as having alcohol problems, and without a diagnosis of personality or affective disorders. (We discuss alcohol use and abuse later in section X:A.)

Under personality disorders, problems considered not amenable to treatment, we coded patients with innate personality problems. Among

the frequent attenders, we found 2 patients considered psychotic, 4 hysterical, 8 psychopathic, 30 patients considered to have inadequate personalities, and 13 patients with a general diagnosis of personality problems. Among the three control patients listed under personality disorders, we found one considered psychotic, one with a hysterical personality, and one an inadequate personality.

We would not have expected to have found psychological problems diagnosed among as many as 22% of the controls had we chosen them at random; only 11% of the AMRA patients fell under the 'All mental disorders' category. We thought the proportion of psychological problems was as high as 22% among the controls because so many of them had been selected on the presenting complaints of self-poisoning attempt, alcohol abuse, or anxiety state, all complaints likely to indicate psychological problems.

2. Psychiatric treatment

Although 92 frequent attenders had been diagnosed as having psychological problems, the psychiatrists noted very few of these patients as likely to respond to psychiatric treatment. Almost half (48%) of the frequent attenders had been diagnosed as having innate personality disorders. As one psychiatrist pointed out in a frequent attender's record, once a patient has been diagnosed as an inadequate psychopath on six separate occasions, it is hard to see the benefit of arranging a series of out-patient appointments. Psychiatric reports on the frequent attenders concluded with such comments as:-

> Record: "I find it difficult to see how psychiatry can help this woman." Gloria Conti (32)

The psychiatrists also expressed frustration in trying to treat those frequent attenders with alcohol problems:-

> Record: "After 22 admissions to Gartnavel Royal, he is now regarded as a hopeless case. The psychiatrist is not interested in Mr. Petrie in 'any way, shape or form.'" George Petrie (38)

Thus, with 48% of the frequent attenders considered to have innate personality disorders not amenable to treatment and a further 15% diagnosed as alcoholics and difficult to treat, we found a total of 63% of the frequent attenders noted to have psychological problems unlikely to respond to treatment. In contrast, we found only 3% of the control patients diagnosed as having personality disorders and only 7% as alcoholics, making a total of only 10% of the controls with psychological problems considered unlikely to respond to treatment.

3. Self-injury attempts

According to the patients' records, 40 (33%) of the frequent attenders and 33 (28%) of the controls had presented claiming an overdose attempt at least once over the study period. Again, we thought the rate among the controls was artificially high because of the number of patients matched for attempted overdose; self-injury attempts (including overdose attempts) only accounted for 14% of presentations in the AMRA sample.

Although the median and mode were two overdose attempts for the 40 frequent attenders, the mean was as high as 4.7 attempts after three frequent attenders were recorded presenting with 13, 17, and 25 supposed overdose attempts respectively. Only one of the 33 control patients presenting with attempted overdose had made more than one attempt over the study period; this patient made two attempts.

In addition to the overdose attempts noted above, 11 frequent attenders, but no controls, had attempted some other form of self-injury. All

but one of these frequent attenders had also taken an overdose, so this one additional patient brought the number of frequent attenders attempting some form of self-injury to 41 patients.

The other forms of self-injury practised by the eleven frequent attenders varied in severity. Six patients had slashed their wrists, but the slashes were not deep enough to be life-threatening; Gail Arthur (28) had swallowed various pieces of china; David Jason (36) was found in a gas-filled room; Peggy Thompson (20) had stabbed herself in the stomach while two months pregnant, as well as having swallowed needles and injected herself with melted Mogadon, using a sewing needle, on another occasion. Two of the more bizarre accounts were those of Mrs. Eustace (44):-

> Record: "She decided to commit suicide by cutting the inside of her vagina with a pair of scissors. Not much bleeding but she says she feels as if she is emptying herself from her head downwards into her vagina." Mrs. Eustace (44)

and of Mrs. Harrington (62), who on different occasions had stabbed herself in the neck with a pair of scissors, penetrating the trachea and presented at the hospital with the scissors still embedded; had made two other throat incisions; and who had drunk both liquid cleaner and turpentine.

The patients' records suggested that most of the patient's self-injury attempts were merely gestures. Among the frequent attenders, only two patients, Mrs. Eustace (44) and Mrs. Harrington (62), mentioned above, were considered to have made serious suicide attempts. Four of the control patients who had taken overdoses were considered suicidal. None of the patients died as a result of their self-poisoning or other self-injury attempts. In fact, notes in the frequent attender records indicated that staff were often uncertain as to whether these patients had actually made a self-poisoning attempt at all or whether

they merely claimed to have done so. All 33 control patients were believed to have taken the overdoses claimed, although most were noted to have made certain of receiving immediate help.

Alcohol consumption was noted as a precipitating factor behind 73% of the frequent attender overdoses and 70% of the control overdoses, the latter likely the result of patients being matched on the joint presenting complaint 'Alcohol and Overdose'.

The majority of controls gave domestic rows as the reason for their self-poisoning attempts, while the frequent attenders' reasons varied greatly:-

> Record: "He says he was talking to a pigeon in the park. He felt that this was the reincarnation of his dead wife. He wished to join her and so took the tablets." Mr. Rafferty (56)

Nell Radnor (16) took an overdose consisting of four Redoxon (Vitamin C) tablets after being called a 'big, fat cow' at school; Hugh Atwood (33) slashed his wrists because he was unhappy that he was a homosexual and that his dog had died.

4. Discussion

We found that at least three-quarters of the frequent attenders had psychological problems formally diagnosed by a psychiatrist. We thought that several more frequent attenders had psychological problems but only noted those recorded by a psychiatrist in the patient's Western Infirmary notes.

We compared the psychiatric findings in our study to those in other studies on persistent patients. Carney (1980) classified his artefactual illness patients as psychopaths if they were "aggressive, violent, abused drugs or alcohol and had court convictions". Had we

used Carney's definition, we would have found a substantially higher number of psychopaths than the eight noted among the frequent attenders, but we had restricted our terms to those used by the psychiatrists in the individual patient records.

A third of the frequent attenders had presented at least once over the study period with a reported overdose. Reporting an overdose is a guarantee of medical attention. We thought this, in part, explained the prevalence of self-poisoning attempts among the frequent attenders' presenting complaints. The taking, or supposed taking, of an overdose is also a simple problem with which to present. A claimed overdose does not necessitate the signs and symptoms required by most other medical emergencies to convince the hospital staff of their validity. The worst that can happen to a patient feigning an overdose is having his stomach pumped out; several frequent attenders were noted discharging themselves at the sight of a nasogastric tube, while others did not appear to object to the procedure.

The percentage of overdoses preceded by alcohol (73%) was even higher in our study than that reported in other studies. Krasner, Moore, and Goldberg (1973) found 50% of self-poisoners in their study had taken alcohol before the attempt, and Patel, Roy, and Wilson (1972) found heavy drinking preceded an overdose in 72% of men but only 40% of women in their study.

Henderson (1974) suggested that parasuicide (attempted suicide) was prevalent among problem patients, for "this is the abnormal behaviour which most closely lends itself to the care-eliciting paradigm". We thought that whether the frequent attenders had taken the overdoses they claimed or not, they were still cries for attention. In fact, although frustrating and an apparent waste of time to the medical staff involved, we thought a feigned overdose preferable to a genuine

and potentially lethal attempt.

The prognosis for psychiatric treatment of the frequent attenders was not good. We found 63% of the frequent attenders considered to have psychological problems unlikely to respond to treatment.

After examining the patient records, we concluded that, although the frequent attenders in our study presented often at the acute care facility of a general hospital, their presentations owed more to their psychological than to their medical problems.

X. Results and Discussion: Background Variables

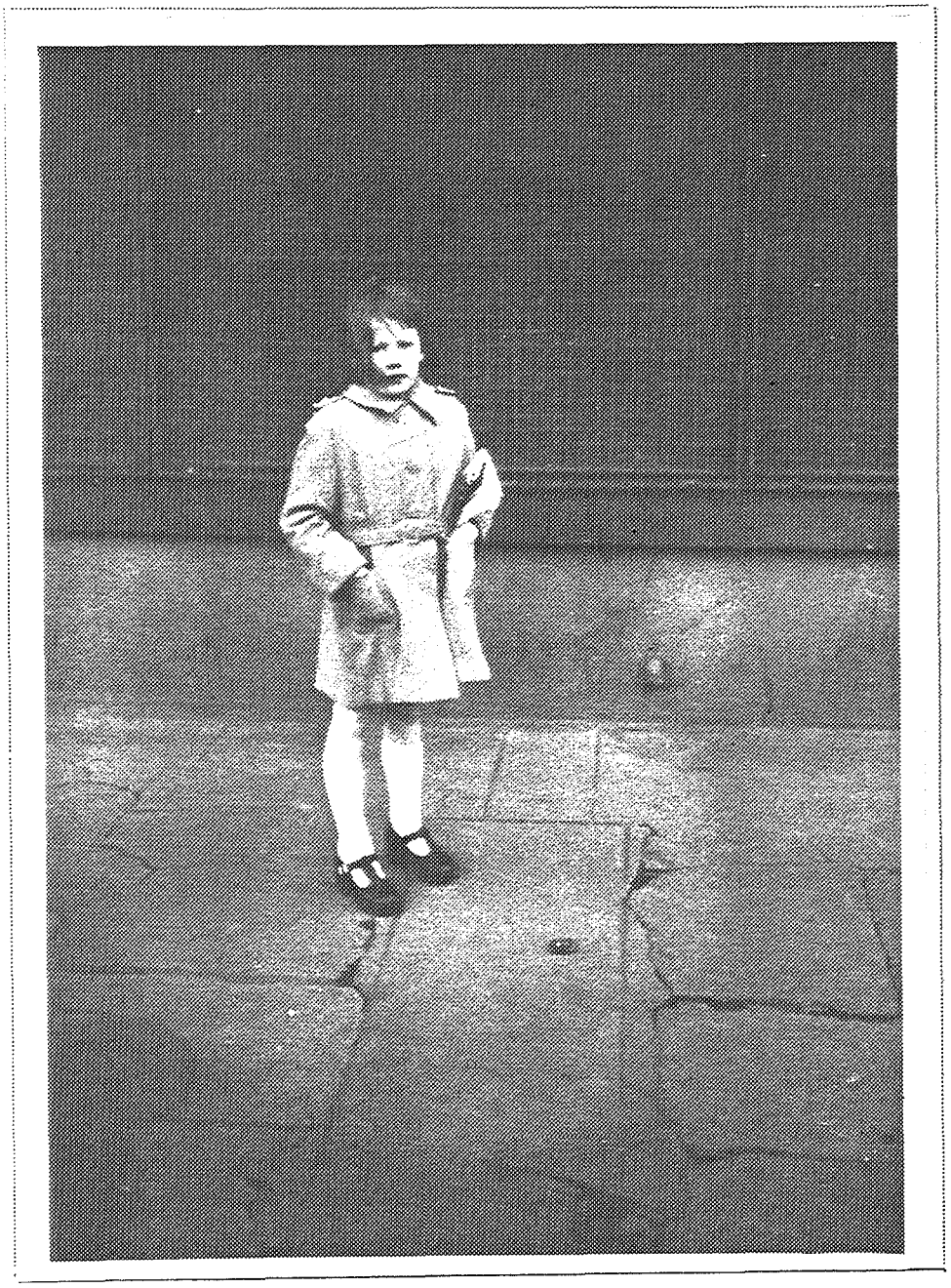
A. Introduction

Up to this point in our study we had used the information supplied in the patients' records; we now set forth to interview the patients in their homes and collect our own data.

The questions we asked the patients covered five main areas, each of which, in turn, form the subject of the following five sections: Health, Employment, Housing, Relationships, and Accidents.

We looked for differences in the answers given to these background questions between the frequent attenders and controls. One of the statistical strengths of our study was the fact that we had a closely matched control for each frequent attender. In order to make maximum use of this strength, we used the Wilcoxon rank-sum test, which compared the differences within the matched pairs rather than simply comparing the differences between the two groups. However, we also ran frequency distributions for the two groups, frequent attenders and controls, in order to indicate the scale upon which the differences were measured in each of the variables. So, as we examine the relationship between hospital attendance and the various background variables in the sections that follow, we give both the statistical significance (according to the Wilcoxon rank-sum test) of the difference between the matched pairs, and the frequency distributions showing the difference between the two groups, frequent attenders and controls.

X:B Health



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"I had fluid in the tummy when I was five and went to Yorkhill. They found it was TB in the bowels and so I went to Mearnskirk for four years." Mary Dean (29)

X:B Health

1. Childhood illness

We began the interviews by asking the patients questions about their health. We asked about childhood illness and scored the patients' answers according to the amount of medical resources each patient had used as a child.

Table 16

Childhood illness score

1 - patients who had seen their GPs for an occasional illness.
2 - patients who had seen their GPs more frequently than above.
3 - patients who had attended a hospital clinic as children.
4 - patients who had been admitted to hospital as children.

Each patient could score a maximum of six points depending on their resource usage. We found that the frequent attenders had used significantly ($p < 0.004$) more medical resources as children than had their matched controls.

Asked if they had seen the doctor often as children, many frequent attenders said they were "never away from him":-

> "I saw the doctor often – for a chill in the kidneys, a leaking valve, my appendix, dislocated shoulders. I kept falling over, I couldn't stay on my feet." Mrs. Hart (49)

> "I wasn't allowed to do sport at school. I was in bed for nine months after rheumatic fever. I had diphtheria at 1, measles at 5, chickenpox at 8, pneumonia at 8½, and rheumatic fever at 9." Mrs. Jessop (57)

Eleven frequent attenders (9%), as opposed to one control, had had tuberculosis as children. These patients had spent long periods in hospital:-

"I had TB from the age of four on and spent most of my time going in and out of hospitals and sanitoriums." Record: "He spent 23 of the first 26 years of his life in hospital with pulmonary TB and TB of the left hip." Hamish Tate (39)

"I had fluid in the tummy when I was five and went to Yorkhill. They found it was TB in the bowels, so I went to Mearnskirk for four years." Mary Dean (29)

Tuberculosis was not the only reason the frequent attenders had been hospitalised as children:-

"I had a bowel obstruction when I was two. When I was 7, someone smashed a bottle in my face and I was in hospital for 11 months. I got burned at 10, and then my foot got badly burned when I was 15. I also had rickets as a child." Mr. Lawrence (52)

"When I was 5, I got dragged by a chip van and was in Canniesburn for a long time." Luke Johnson (23)

Several of the older frequent attenders reminded the interviewer that there was no National Health Service when they were young and their parents had not been able to afford a doctor's services:-

"It was too expensive when I was a boy. It was cheaper to die." Mr. Cheevers (65)

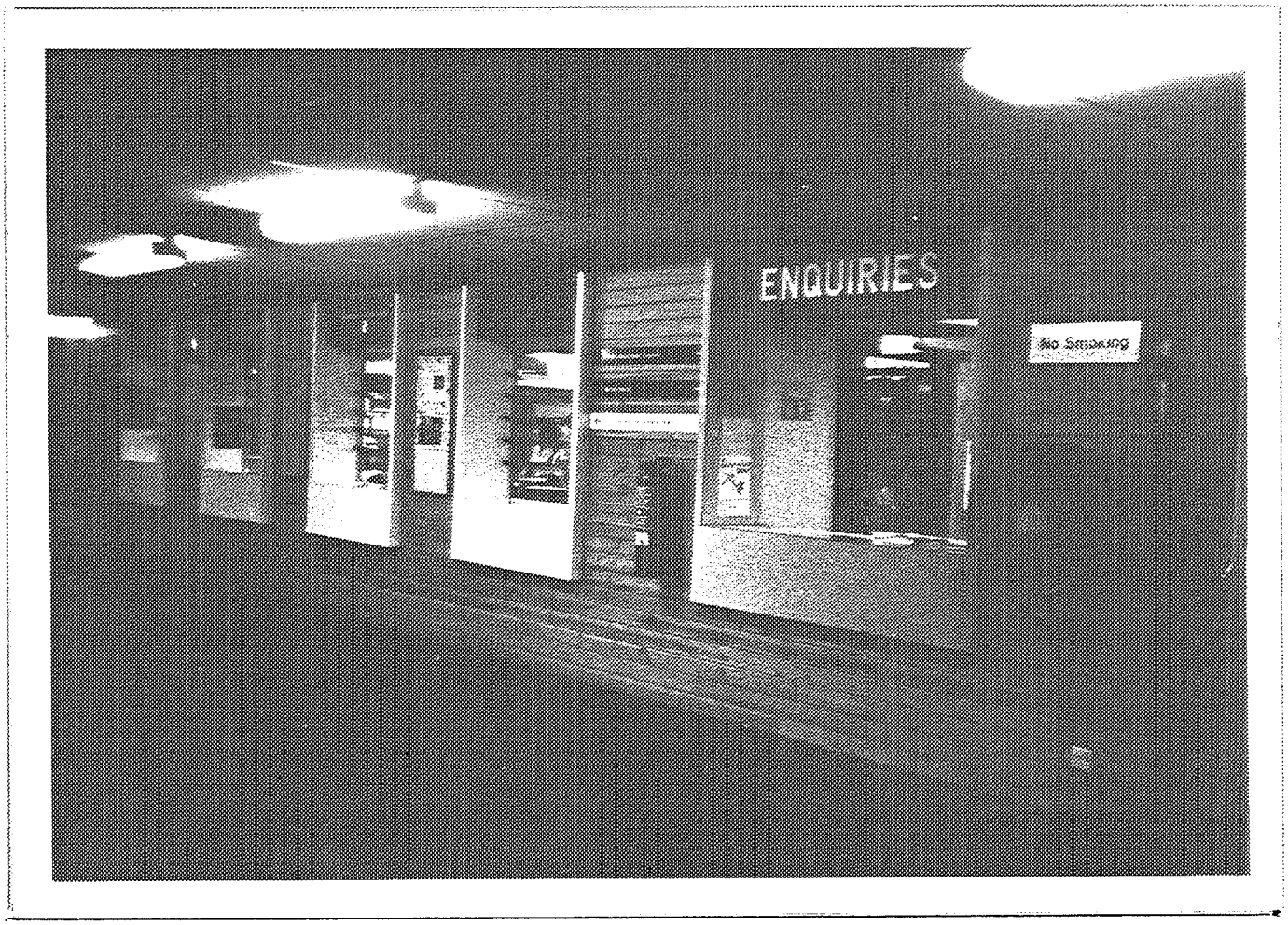
"Then you had to pay half a crown just to bring the doctor out. Mother washed stairs and only got tenpence." Mrs. Lane (65)

The majority of controls said they had simply used medical services for childhood epidemics – mumps, measles, chickenpox – and minor injuries. Some prided themselves on their good health:-

"I was fine then. Nae measles, nothing." Hamish Thorn C(28)

"I was disgustingly healthy as a child." Mrs. Ryman C(55)

2. General practitioner services



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"He used to be all right in his own wee surgery but now he is at the Health Centre you have to make an appointment to see him and he won't come to you." Chloe Herbert (25)

2. General practitioner services

We asked patients how often they had seen their general practitioners (GPs) over the past year. We coded their answers on a seven-point scale from 'Not at all' to 'Once a week,' summarised in the table below:-

Table 17

General practitioner contacts over preceding year

	Fas	Ctrls	%Fas	%Ctrls
0 to every 14 weeks	15	45	12.5	37.5
Every 13 weeks to 3 weeks	74	71	61.7	59.2
Every 2 weeks to weekly	29	4	24.2	3.3
Missing	2	0	1.7	0
	120	120	100.0	100.0

The two frequent attenders coded 'Missing' had spent most of the preceding year in hospital and had, therefore, had little opportunity to visit their GPs.

We computed the difference in score between the pairs and found the frequent attenders had seen their GPs significantly ($p < 0.001$) more often than their matched controls.

Seeing the GP apparently played an important part in the lives of many of the frequent attenders. Their comments focused on the personal relationship between doctor and patient rather than on the medical treatment received. While some frequent attenders spoke fondly of their GPs:-

> "He's the only one I can turn to. I confide in him all the time and tell him all my problems." Mrs. MacCauley (49)

"He's more like a friend. You can trust him and speak to him." Mrs. Jessop (57)

and one patient listed his GP as next of kin on his hospital admission form, other frequent attenders criticised their GPs for not giving them enough time and attention:-

"I can't even talk to him. They don't care, they've hundreds of patients. You're supposed to have one complaint only. If you've got two or three, then they don't listen." Shirley Owen (24)

"He is available for five minutes and takes three to decide how to spell my name, one to write a prescription, one to talk, and in the end I don't say anything." Mrs. Fairbairn (57)

"Doctors for the present day are just like everyone else, they can't get out of the surgery quick enough. You're as well getting a handful of sweets from the sweetie shop as to go for a prescription." Mr. Millman Snr (70)

Some frequent attenders blamed the GPs' move into a Health Centre for what they interpreted as decreased personal interest on the part of the doctors:-

"He used to be all right when he had his own surgery, but now he is at the Health Centre, you have to make an appointment to see him and he won't come to you." Chloe Herbert (25)

"The receptionists at the Health Centre are too nosey for anyone. One wrote out a line herself and just got the doctor to sign it." Frank Rhodes (31)

The majority of controls said they were well satisfied with their GPs. Their criticisms were directed toward the system rather than the individual attention they did or did not receive:-

"It's this appointment lark. You have to wait three days before you can get an appointment." Mrs. Lawson C(59)

We asked patients whether their doctor was available during the night and on weekends. We realised that the patients' answers may not have accurately reflected the availability of the GP. Patients may have thought their GP available when in fact he or she was not available, or

the reverse might have been the case. We did not check these answers with the GPs, for we were interested in the patients' perceptions of GP availability rather than the actual facts, the former being more likely to have influenced whether a patient had contacted the GP out-of-hours or gone straight to the hospital.

Table 18

Perceived GP availability out-of-hours

	Fas	Ctrls	%Fas	%Ctrls
1. GP available	77	85	64.2	70.8
2. Patient does not know	22	32	18.3	26.7
3. GP not available	21	3	17.5	2.5
	120	120	100.0	100.0

The frequent attenders perceived their GPs as less available out of surgery hours than did the controls. Although the difference was just statistically significant ($p = 0.048$ with $z = 1.98$), it was not substantial.

In both groups there were patients who did not know whether their doctor was available; we ranked their answers as a midpoint between those who thought their GP was available and those who thought he was not. Patients may not have known the availability of their GP for a number of reasons: they may have only had to contact their doctor within surgery hours, have been taken directly to the hospital by the police or passer-by, or have never tried contacting their GP before going to hospital.

Of the 21 frequent attenders who said their GP was not available, nine had either been struck off their GPs' list or were not registered with

a particular doctor and so had no GP to call. Another two frequent attenders said their GPs had told them not to call after hours as the GP would have to pay a locum to answer the call.

The GPs' use of a locum service, the 'emergency doctor', was a frequent complaint among the patients who said that a doctor was available out of hours. The frequent attenders in particular expressed dissatisfaction with the service:-

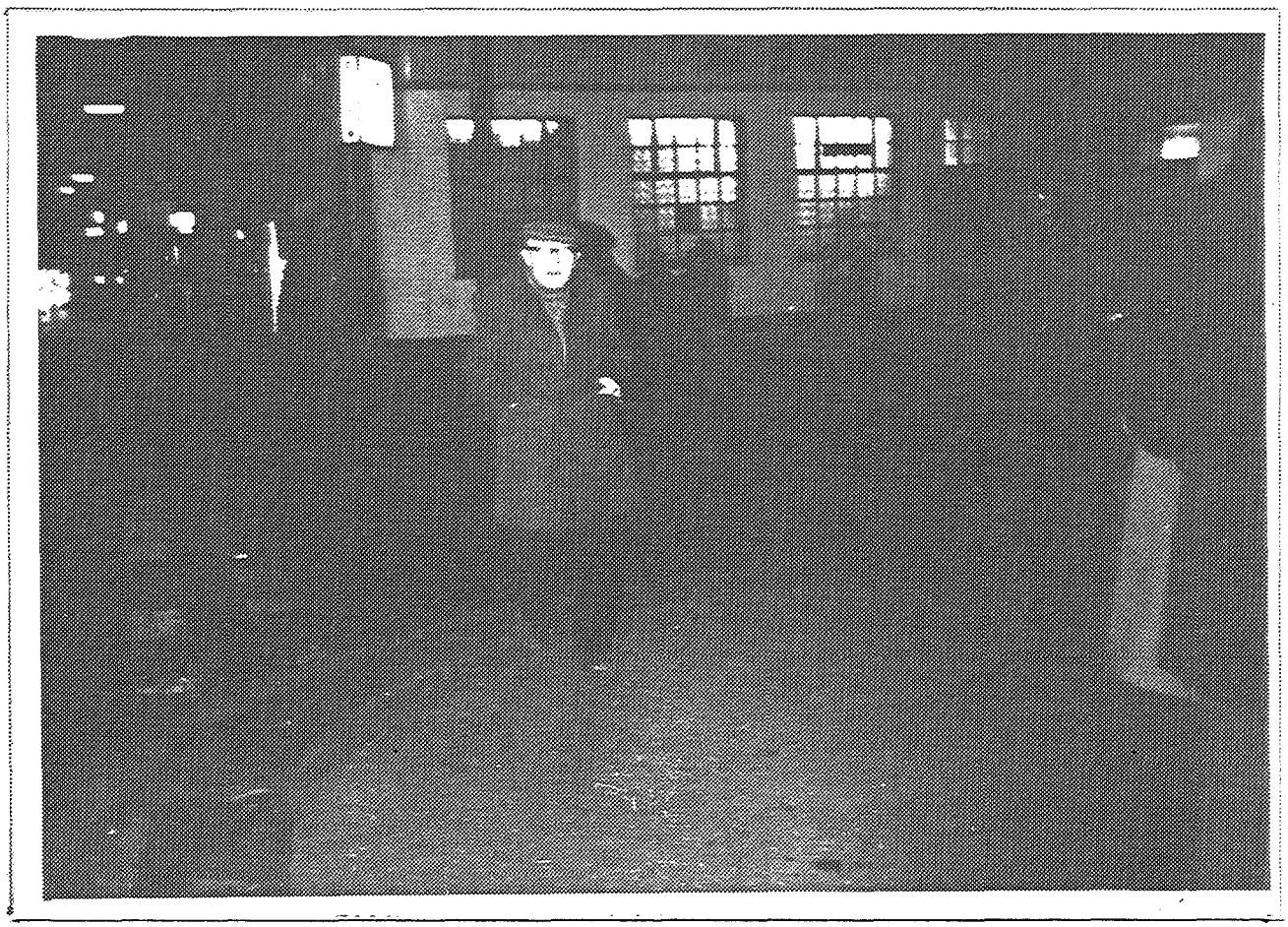
> "Over the weekend you only get the emergency doctor. Sometimes you have to wait two hours." Mrs. Kraft (51)
>
> "Twice I have required an emergency doctor and neither of them knew my medical history." Mr. Cheevers (65)

Many frequent attenders intimated that, whether their GP was available or not, 'serious conditions' were beyond the scope of the general practitioner and should be taken directly to the hospital:-

> "Yes, he's available but I always go straight to the hospital. Always go for the higher people. I learnt that in the British Army." Mr. Bonilawski (52)
>
> "It's better to go to the hospital as the GPs don't have the same facilities." Len Ulrich (28)

Only 20% of the frequent attenders' emergency visits were referred through the GP; a few patients were brought in by the police, social workers, or passers-by, but the majority were self-referred.

3. Alcohol history



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"Being lonely drives me into a pub." Mr. Leonards (64)

3. Alcohol history

We asked patients to estimate their weekly expenditure on alcohol. We then compared this estimate to the alcohol history shown in the patients' records. In most instances, the two sources of information agreed (having both originated from the patient); when they differed, we took the higher amount.

Table 19

Categories of alcohol consumption

	Fas	Ctrl	%Fas	%Ctrls
1. Non-drinker	32	22	26.7	18.3
2. Moderate drinker	17	59	14.2	49.2
3. Heavy drinker	23	31	19.2	25.8
4. Alcoholic	48	8	40.0	6.7
	120	120	100.0	100.0

We found that, on average, the frequent attenders consumed significantly ($p < 0.001$) more alcohol than their matched controls.

Non-drinkers—we were surprised to find more frequent attenders than controls in the abstainer category, patients who said they "never use the stuff".

Moderate drinkers- half the controls fell into this category, but only 14% of the frequent attenders were classified as moderate drinkers. Patients in this category described occasional or social drinking. One control patient described this as "drinking for pleasure".

Heavy drinkers- there were slightly more controls than frequent attenders in this category. These patients were coded as heavy

drinkers rather than alcoholics because they were still able to function in their jobs and daily lives despite a heavy alcohol intake.

Alcoholics—while 48 (40%) frequent attenders were coded as alcoholics, only 8 (7%) of controls fell into this category. These patients all fitted the definition of an alcoholic put forward by the World Health Organisation's Alcoholism Subcommittee (1952):-

> "...those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning...."

We found the alcoholic frequent attenders frank about their drinking habits, but asked how much they spent on drink, few could actually make a sum:-

> "Just about everything. Last month, a friend and I spent £50 in a week between the two of us out of what we got from Social Security. Wine, surgical spirit, refills for hair laquer are what I usually take." George Petrie (38)

> "As much as possible. About ten bottles of whisky and 60 pints of beer a week." Peter Blaney (39)

> "I spend all my money on drink. I have a carry-oot twice a week on Monday and Friday. Eldorado and a wee double-double." Mrs. Clay (58)

Several were noted spending their money on drink rather than food or housing:-

> Record: "She had drawn £10 from Social Security and spent half on whisky and needs the rest for rent so has none for food. She says she has not eaten for two days. She is carrying a bag of coal she stole from a bunker." Miss Fordyce (44)

In addition to drinking cheap wine and beer, three frequent attenders said they drank Belair hair laquer refills. This was one of the

cheapest forms of alcohol, and its sale was not restricted to licensing hours. One, asked how it tasted, replied that he had long since lost his sense of test.

We found 16 alcoholic frequent attenders had used drugs at times to heighten the effect of the alcohol:-

> "I take a tablet at the same time to help. I usually take Librium, Valium, Largactil, or Melleril, or anything else I can get. I gets them off mates if I need them. And some from the family doctor." Bill Monks (38)

A psychiatric report in this patient's record could have applied to most of the drug-taking alcoholic frequent attenders:-

> Record: "This man is in a vicious cycle again of alcohol and drugs, using the one to counteract the withdrawal effects of the other."

Mr. Crockett (61) admitted buying pethidine from a pusher in George Square and coming to the hospital when he ran out; four other frequent attenders were suspected of being pethidine addicts.

Although patients were not directly asked why they had started drinking to excess, the frequent attenders volunteered a number of reasons for their drinking habits. Loneliness was the chief reason given for alcoholism. Some patients said they drank in order to meet people:-

> "Being lonely drives me into a pub." Mr. Leonards (64)
>
> "I started to drink after I left the army. I felt isolated. I started drinking with the wrong crowd." David Jason (36)

Some said they drank for solace because they found themselves alone:-

> "Drink was a friend when I was lonely in Bournemouth." Miss Fordyce (44)
>
> "It was loneliness. The others at work were all married. I was too much on my own so I drank. I started buying Carlsbergs

when I was 21 and waited until my mother had gone out to work in the evenings. I was drinking secretly." Nora Fleming (27)

while others blamed the company they kept:-

"Coal put you on the road to drink - running about with older men." Sam Talbot (34)

"I could cut down if I didn't have contact with heavy drinkers. I would like to live somewhere no alcohol was allowed." Mr. Melrose (54)

"Living in Drumchapel, you can't get away from drinkers. I want to dry out, live with my mother, save up some money and move right away." Sam Talbot (34)

Most frequent attenders said they had started drinking in their teens:-

"I started drinking when I was 16 or 17. My family never stopped me. I started drinking because I was young and insecure. Now I'm a man, I'm still insecure." Peter Kelly (37)

"I was sent to an approved school when I was 12. I started drinking when I came out at 15 with friends I had met in there." George Petrie (38)

We wondered whether there was an association between a patient's drinking habits and that of his or her parents. We found the correlation (0.043) was not significant.

Asked if they had been told to cut down, all the alcoholic patients admitted they had:-

"The hospital doctors said it was okay in moderation. My own doctor said I didn't know anything about moderation and he will cut my throat, if he catches me drinking." Mr. Youngman (59)

Most of the alcoholic frequent attenders said they had tried to give up alcohol but had failed:-

"I did attend AA meetings but my car was taken away for drunken driving and now I can't get to the meetings." (!) Hamish Tate (39)

and another frequent attender explained that he drank when lonely:-

> "I'm alone most of the time. There only is my AA friend - and he's teetotal." George Petrie (38)

Most of the alcoholic frequent attenders had been admitted to psychiatric hospitals in order to 'dry out' but said they had not found the treatment helpful:-

> "I was in Gartnavel. The treatment wasn't any good. The patients were fighting or smuggling in bottles of wine. It's easy, you just go down to the Pond for a bottle and then they all get together and pass it round." Frank Rhodes (31)

> "I don't really feel the psychiatrists can do anything to help. The bed is better used on someone who really needs it. I don't yet want to give up drink. It does give you a lift for a short time. It gives you some confidence." Nora Fleming (27)

Although the frequent attenders had little positive to say about psychiatric treatment, the psychiatrists were even more pessimistic in their comments on these patients:-

> Record: "He professes to be anxious to give up drink. Like most alcoholics, he takes this idea down from his mental mantelpiece every so often to give it a polish, but, other than this, makes no further use of it....He has been seen on innumerable occasions over the last six years, discharging himself after only a few days with monotonous, to say nothing of infuriating, regularity....This man is as fixed in his form as are the planets in their orbits. It is difficult to see what lasting benefit we could afford him." Bill Monks (38)

> Record: "He was his usual intelligent plausible self....He has just spent five months as an in-patient, receiving every possible treatment and being the subject of much discussion among the staff, but finally signed himself out on Tuesday morning last. He began drinking immediately and was inebriated within a few hours, after which he phoned the Council of Alcoholics, who sought his admission to the Western, Royal, and Leverndale. He was discharged from the latter yesterday morning and again began drinking immediately." Charles Jordan (25)

> Record: "He remained dry for six weeks after discharge from Gartloch but then started drinking again. He said that when he was in hospital he felt safe and secure, and, in fact, virtually indicated that he would be quite happy being an in-patient for the rest of his life." Mr. Lewiston (43)

4. Psychiatric history

CG

"If you were an effing psychiatrist, I wouldn't let you in."
Mr. Millman Snr (70)

4. Psychiatric history

We asked patients whether they had ever suffered from a 'bad case of nerves or depression' and whether they had ever seen a psychiatrist. We also consulted the patients' records and coded their answers according to the highest use of mental health reported by either patient or record:-

Table 20

Mental health services used by patients

Service	Fas	Ctrl	%Fas	%Ctrl
1. No mental health services used	15	56	12.5	46.7
2. GP or other than psychiatrist	12	30	10.0	25.0
3. Saw psychiatrist after overdose	26	13	21.7	10.8
4. Out-patient or in-patient 2 days	21	12	17.5	10.0
5. Short stay (9 months or less)	42	9	35.0	7.5
6. Long stay (more than 9 months)	4	0	3.3	-
	120	120	100.0	100.0

When we compared the matched pairs, we found the frequent attenders had obtained significantly more assistance for mental health problems ($p < 0.001$). Nearly three times as many frequent attenders as controls (78% vs. 28%) had been seen by a psychiatrist.

We asked patients about the cause of mental problems and found alcohol (discussed in the preceding section) described as the main cause. Other causes included:-

> "My whole life, no childhood care, I was battered about. My husband used to drink and get into debt. Loneliness and boredom. I've taken several overdoses and I feel like taking another one. I get very depressed and then I don't do any

housework. I bite my husband's head off and batter the wee boy." Shirley Owen (24)

"I had bouts of depression eleven months ago. I used to keep the curtains closed so I couldn't see out and nobody could see in. I think it was them saying I had TB and having to take 900 mg. of tablets every morning. Then it turned out I didn't have it." Mrs. Kraft (51)

Many of the controls dismissed the subject of psychological problems with scorn:-

"No, never. We don't make problems for ourselves." Mrs. DiCarlo (64)

"Not myself. We got called at 5 a.m. last week as my daughter-in-law had a nervous breakdown. I got the impression all she needed was a good kick in the pants." Mrs. Kean (54)

We found the frequent attenders talked more readily than the controls about their overdose attempts. Several frequent attenders admitted that despite a number of attempts they had no intention of killing themselves. Annabel North (18) said she would not in fact kill herself as she was a Catholic; Mrs. Blute (51) was surprised to have been referred to a psychiatrist after "only my first attempt"; and Nora Fleming (27) said:-

"The last time I was in the Western I had slashed my wrists and was picked up by the police. They said I was trying to kill myself but that wasn't it. I was drunk and just did it to attract attention." Nora Fleming (27)

Mrs. Irving (48) had taken two overdoses over the study period, but, now afraid the pain in her hip was "something worse", said she no longer felt like taking overdoses: "Now that I'm scared I'm going to die, I want to live".

Only 8 of the 93 frequent attenders who had received psychiatric help said they had found it helpful. The frequent attenders complained

that, as in-patients, they had not received enough individual attention from the psychiatrists and that out-patient care meant "hanging around waiting in corridors". The scant praise they gave was directed at the "good listener" or the hotel facilities of the mental hospital:-

> "I was in Woodilee. It's a beautiful place and the rest helped." Mr. O'Leary (48)

> "I really enjoyed my first stay in Woodilee. They couldn't do enough for you. I felt great when I came out. I asked to go in again but I got bored the second time. The people were not so nice so I left after two weeks." Mrs. Irving (48)

Most of the frequent attenders had harsh words for the psychiatrists (just as the psychiatrists had for the frequent attenders, as we described in Section IX:B):-

> "If you were an effing psychiatrist, I wouldn't let you in." Mr. Millman Snr (70)

> "I thought he was daft, making me ten times worse. Psychotrists [sic] ask you a lot of daft things like 'What makes the difference between an apple and a pear?'." Annabel North (18)

> "The hospital psychiatrist was no help. They just have a talk with you. They ask you stupid questions such as 'Who is the Prime Minister?'." Mrs. Harrington Snr (62)

> "In the barmy cane? Aye, I've been in there. They don't do anything for you in there. They prefer playing table tennis with each other or sitting smoking or hoping the birds will fancy them." Frank Rhodes (31)

5. Health worries

CG

"Your health gets on top of you. Nothing else can upset you apart from that. Every twinge you wonder: 'Is this it?'." Mr. Roper (58)

5. Health worries

We asked patients whether they worried over their health and found:-

Table 21

Worries over health

	Fas	Ctrls	%Fas	%Ctrls
1. No worries	42	60	35.0	50.0
2. Aware of health	2	9	1.7	7.5
3. Sometimes worries	18	27	15.0	22.5
4. Worries a lot	58	24	48.3	20.0
	120	120	100.0	100.0

The frequent attenders reported significantly more health worries than their matched controls ($p < 0.001$). Few of the frequent attenders' worries about health were specific:-

> "I worry a lot about my health. I've been in hospital so often and seen people die, that it worries me a lot." Peter Blaney (39)

although several patients mentioned fear of cancer:-

> "I eat a lot, yet put on no weight. I suppose it's cancer I'm scared of." Hugh Atwood (33)

> "I worry that I might have cancer. When I was in the x-ray department, they kept shouting 'Cancel', and that really worried me." Mr. Rice (41)

As a generalisation, the frequent attenders approached life waiting for ill health and old age to overtake them. Although none of the four frequent attenders quoted below were more than middle-aged, they said:-

> "Some days I feel 100%. Other days, I feel I've got to rest and I can't do anything. I've got to remember I'm getting old, I'll soon be 50." Mrs. MacCauley (49)

"My health. You don't get any fitter as you get older." Ken Innis (30)

"I'm beginning to realise that the sky's not the limit. I've got to be careful. I've got a bad ticker." Mr. Cheevers (56)

"It sounds selfish but I worry about myself not being well, of taking ill, of dying. I sit at home and worry about my health." Mrs. Irving (48)

The control patients tended to take more active steps to maintain their health:-

"I try my best to keep the weight down and keep myself fit." Mr. Andrews Snr C(68)

and said they spent little time worrying about being ill:-

"I never have time to worry about it. Hard work has trained me, kept me fit." Mr. Dellari C(62)

The alcoholic frequent attenders said they were concerned about the ill effects of drinking on their health:-

"I'd like to stop drinking. I'm going to die soon. That frightens me." Keith Steel (35)

"I'm living in fear, wondering what will happen to me. Just how it's going to end up, with my drinking. I'll never get to Heaven." Nora Fleming (27)

Some frequent attenders said they did not worry about their health but their answers caused us to code them as worried:-

"I know I'm going to my resting place. I'll have no worries then. I don't give a damn now." Mr. Rafferty (56)

"I don't give a damn anymore. I don't look to tomorrow. I can't be bothered. But I'd rather be dead. I've seen many a folk who are happier dead than alive." Mr. Lawrence (52)

6. Discussion

The frequent attenders certainly reported a greater number of dramatic illnesses as children than their matched controls. We saw in these results an early pattern of dependence on doctors and hospitals among the frequent attenders. While the controls tended to have had short-term admissions as children (for tonsillectomies, fractures, etc.), we found that many of the frequent attenders had spent months and even years in various hospitals and sanitoriums. These frequent attenders had become 'institutionalised' at a young age. We thought the routines of hospital life might well be welcomed as familiar by patients feeling lonely, inadequate, or homeless.

We had wondered whether the frequent attenders used the hospital instead of a family doctor; we found that the frequent attenders, in fact, made greater use of both GPs and the hospital when compared to the controls. The frequent attender comments suggested that they looked to their GPs for support and friendship in their daily lives and expected the hospital to provide a dramatic array of emergency services as and when they called for them.

Given the high rate of alcoholism in Glasgow (the highest in Scotland, according to Wright and Worsley, 1975) and the fact that we had selected controls to match those frequent attenders presenting with alcohol-related problems, we were surprised to find six times as many alcoholics among the frequent attenders as among the controls. We wondered why alcoholism was so much more prevalent among the frequent attenders.

Having studied the alcohol history of the patients we agreed with Goldberg et al. (1973):-

> "...The aetiology of alcoholism seems a confusing complex of psychological, social and physiological factors related to the individual and his total environment...."

and with Martin (1973):-

> "...that to search for a single over-riding explanation is to yearn for the unattainable."

We could make no claims for a cause-and-effect relationship between alcoholism and frequent attendance. We did not believe that alcoholism led to frequent attendance, for there were many more alcoholics living in the Western Infimary catchment area than there were frequent attenders. Nor did we think that frequent attendance led to alcoholism, for 40% of the frequent attenders appeared to be no more than moderate drinkers, with more than half abstaining from alcohol altogether.

Although we could make no claim for a causal relationship, we found a highly significant association between frequent attendance and heavy alcohol consumption; an alcoholic patient was significantly more likely to be a frequent attender than a control. We thought this was because frequent attendance and alcoholism shared many of the same characteristics; the same factors that made it more likely that a patient become an alcoholic also made it more likely that a patient become a frequent attender. As we interviewed the frequent attenders, we discovered characteristics often associated with alcoholism: feelings of inadequacy, isolation, and deprivation. Martin (1973) writes of the association between alcohol and homelessness, marital discord, family breakdown, and industrial inefficiency, all factors we found associated with frequent attendance.

Although many of the frequent attenders readily admitted that they had had psychiatric problems, most agreed that they expected or had

received little help from the psychiatrists. This echoed the opinions of the psychiatrists, who indicated that many of the frequent attenders had innate personality problems, not amenable to treatment.

However, the frequent attenders described the problems as lying with the psychiatrists' methods, rather than as a reflection of their mental state. They spoke with scorn of the "blabber blabber", the "usual patter", the "stupid questions", and complained that "all they do is talk to you". The frequent attenders looked for physical treatment; we had heard several GPs criticised with the words "He could examine you a wee bit more". Psychiatric medicine lacks the drama associated with acute medical or surgical treatment: the sense of urgency, the sophisticated machinery, the threat of the surgeon's knife. The frequent attenders found it infuriating to present as an emergency case and then be offered a psychiatric out-patient appointment.

An effective way of gaining physical attention for emotional problems is to present claiming to have taken an overdose. We thought that the frequent attenders were well aware, perhaps unconsciously, of this; we found a third of the frequent attenders had presented with overdose attempts over the study period.

Although the frequent attenders appeared dependent on the hospital and its medical staff, this did not apparently include the psychiatric staff. We found mutual antipathy between the frequent attenders and psychiatrists.

We found a marked difference in attitude to health between the frequent attenders and controls. While we heard control patients talk of ways to maintain good health, the majority of frequent attenders appeared to see themselves as invalids, or potential invalids, to be cared for by others.

Pilowsky (1969) described the 'sick role' as socially acceptable provided that the sick person recognised the state as an undesirable one and was willing to cooperate with others to get well again. This was not the case in the majority of frequent attenders. We thought many of them welcomed, and even devised a sick role for themselves. Many of the frequent attenders appeared lonely and inadequate, and their comments suggested that the only time they received attention from others was when they were ill. In the hospital, these patients could surrender their responsibilities and be assured of receiving not only medical care but also food and warmth and the companionship of other patients. Moreover, we noticed that many of the frequent attenders who spoke of worrying over ill health had adopted habits likely to jeopardise their health, habits such as alcohol abuse, drug abuse, vagrancy, or repeated self-injury attempts.

X:C Employment

CM

"I've been unemployed the last five years. It's a long time, isn't it?" Frank Rhodes (31)

X:C Employment

1. Occupation and social class

We asked patients about their job history and coded them according to their 'best' occupation and social class. We chose 'best' rather than present occupation and social class in order to compare the employment potential of the two groups. We coded both occupation and social class according to the Classification of Occupations 1970 published by the Office of Population Censuses and Surveys (1970).

Table 22

Patients groups according to 'best' occupation

Occupation unit group	Fas	Ctrls	%Fas	%Ctrls
Service, sport and recreation*	28	24	23.3	20.0
Engineering and allied	24	19	20.0	15.8
Labourers not elsewhere classified	10	13	8.3	10.8
Sales workers	10	10	8.3	8.3
Clerical workers	7	11	5.8	9.2
Transport and communication	8	6	6.7	5.0
Professional, technical, artists	8	5	6.7	4.2
Housewife	8	12	6.7	10.0
Other**	17	20	14.2	16.7
	120	120	100.0	100.0

*This group consisted mostly of domestics and catering personnel.
**Other unit groups consisted of no more than three patients per group.

Although we had not matched the controls on either occupation or social class, we were surprised at how similar the composition of the two groups proved to be on these points.

The majority of married women were either housewives or worked only part-time. We coded married women according to their husband's

social class but listed their occupations as their own:-

Table 23

Patients grouped according to 'best' social class

Social Class	Fas	Ctrls	%Fas	%Ctrls
I	1	0	0.8	0.0
II	6	14	5.0	11.7
IIIN	11	21	9.2	17.5
IIIM	44	41	36.7	34.2
IV	34	34	28.3	28.3
V	24	10	19.9	8.3
	120	120	100.0	100.0

Using the social class classification as a numeric scale, we found no significant difference in social class between the matched pairs. We also found no difference between the matched pairs when we asked the patients about their school-leaving age and job training.

Although when we looked at the patients' 'best' occupations we found that the frequent attenders had held jobs of equivalent status in similar fields to the controls, many of the frequent attenders had since fallen down the social scale, as we found when we asked about current employment status.

2. Current employment status

We coded patients' current employment status according to the following criteria:-

Employed - those employed at the time of interview, including housewives with part-time jobs.

Not in the work force – those retired (including those who, although officially retired, held part-time jobs on the side), housewives, students, and the mentally or physically disabled.

Unemployed – those on unemployment or Social Security benefits, including divorced and widowed former housewives.

Table 24

Present Employment Status

	Fas	Ctrls	%Fas	%Ctrls
1. Employed	33	64	27.5	53.3
2. Not in work force	28	36	23.3	30.0
3. Unemployed	59	20	49.2	16.7
	120	120	100.0	100.0

We found the frequent attenders significantly less employed than the controls at the time of interview ($p < 0.001$). The unemployment rate for those patients in the work force was 64% unemployed among the frequent attenders and 24% unemployed among the controls.

3. Unemployment history

We asked those patients who had been in the work force during the study period how much unemployment they had experienced over the preceding five years. We coded their answers according to the number of months a patient received benefits, either in the form of unemployment or Social Security payments. This meant that housewives who were unemployed between part-time jobs and did not receive benefits were not coded as unemployed. The frequent attenders reported significantly more unemployment than their matched controls over the preceding five-year (60-month) period ($p < 0.001$).

Table 25

Number of months unemployed over the preceding five years

	Months		% 60 months	
	Fas	Ctrls	Fas	Ctrls
Mean months unemployed	29	7	48.3	11.7
Median months unemployed	24	0	40.0	0
Modal months unemployed	60	0	100.0	0

We found that the frequent attenders had on average been unemployed almost half of the preceding five years and that the most common amount of unemployment, over that period, was all five years. In contrast, the control patients had on average only been unemployed 7 (12%) of the 60 months, and their most common reply was no unemployment over that period.

We heard several suggestions by frequent attenders that their unemployment was caused by ill health, but most of these suggestions were not substantiated by the hospital records:-

> Record: "Although he declares himself to be sick and unemployable, he none-the-less is driving a taxi in the evening." Roy Howard (33)
>
> Record: "I can see no reason for him to remain unemployed and suggested that he go back to work as soon as possible. He then defaulted from the clinic." Christopher Tomlins (39)

whereas a control patient entry read:-

> Record: "He was told to go home and rest but said he didn't want to do so as he was a crane driver and no one else could do his job." Mr. Webster (59)

Some frequent attenders admitted that, although they pleaded ill health, it was, in fact, lack of desire to work that caused their unemployment:-

> "I'm fit but not fit when it comes to a job." Peter Kelly (39)

and several frequent attenders said they preferred to be unemployed:-

> "I'm worse at work. I can't face people so I start drinking. Money's nae use to me. I can't live without drugs." Mr. Lewiston (43)

> "I've mostly been unfit for work because of alcoholism. I disliked work, caused me a lot of worry. With ten kids, I'm better-off not working." Peter Blaney (39)

The amount of time the controls 'took off' from work was generally on a smaller scale:-

> "Just unemployed between jobs. I like a week or a fortnight off before starting a new job. It's like a holiday." Ann Sergeant C(23)

> "Sometimes I get fed up after a bad day on the buses. Then I go off sick for a day." Mrs. Gardner C(47)

and although several control patients said they would rather not be doing the work that they did, they said that they could not afford the insecurity of being unemployed:-

> "I'm at a dead end. I would like to walk out but at 47 I'm not sure of another job and, anyway, I have too much responsibility to my family." Mr. Groves C(47)

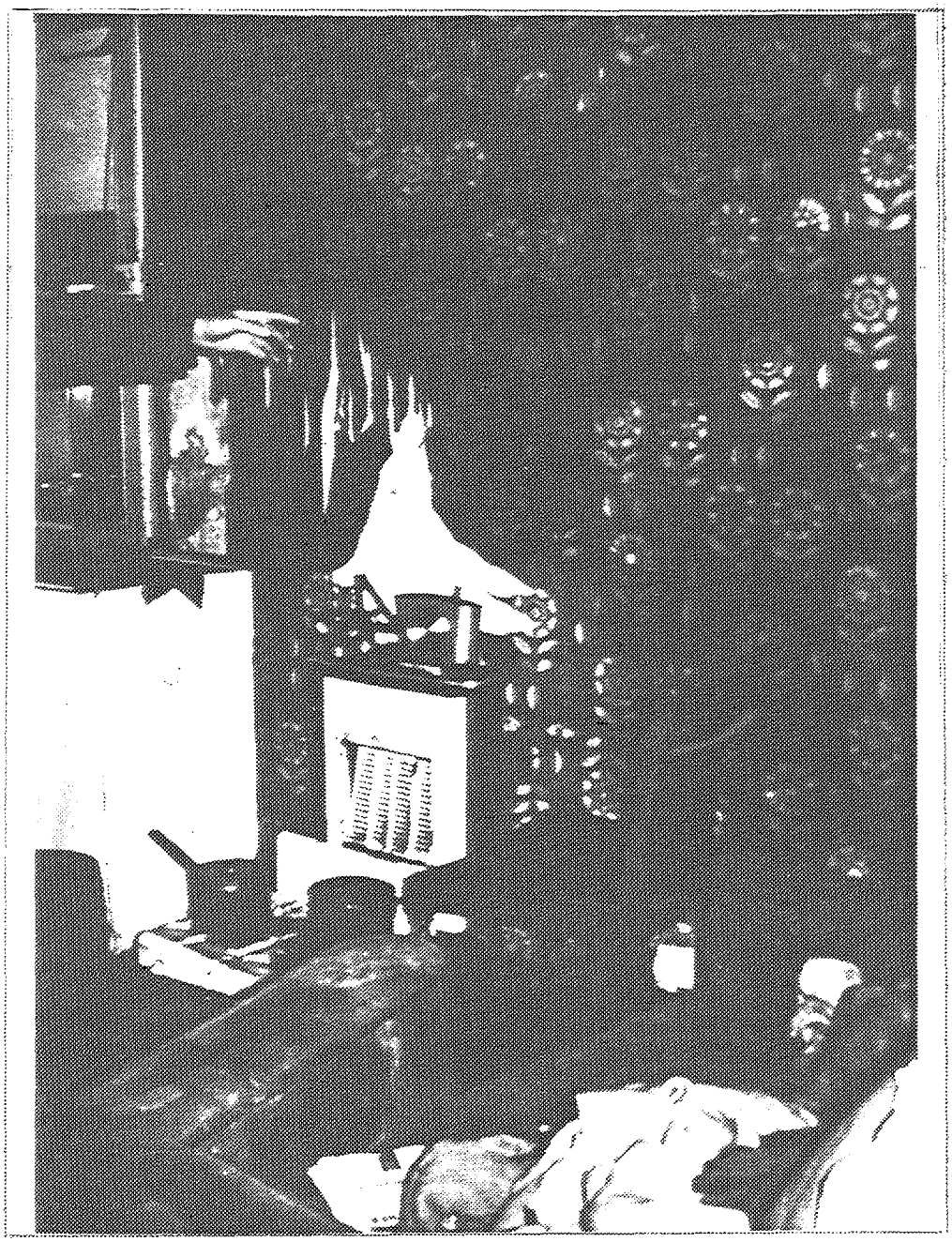
> "I left my job as a plumber in John Brown's shipyard in 1970 when the crisis occurred, when UCS closed down. I left the yards as industry was coming to a dead end and then took up janitorial work as it was a safe, secure job. I seem to be shut in working in the school but I haven't had any unemployment." Mr. Lyman C(45)

4. Discussion

Unemployment was a very real problem in the Glasgow area during the study period (1970-1975). The 1971 Census showed the male unemployment rate in the Exchange Ward of the Central Clydeside conurbation as 27%. And yet we were hesitant to ascribe the frequent attenders' hospital behaviour to the effects of unemployment. The frequent attenders and controls had similar job skills within similar areas of Glasgow in similar fields of work. We might have expected the effect of unemployment to be the same for the two groups. Instead, the frequent attenders had a 64% unemployment rate among those in the work force, while the controls had a 24% unemployment rate.

We could not explain the frequent attenders' higher unemployment rate as being the result of poorer health, for, in most of the matched pairs, we had found no greater morbidity among the frequent attenders than their matched controls. But, we had noted that, whereas many control patients had adapted their job skills in order to minimize their unemployment, the majority of frequent attenders had accepted, and a few apparently welcomed, living on the 'burroo'. The frequent attenders generally displayed less sense of responsibility than the controls in their attitudes to work and appeared willing to be supported by others. We thought this mirrored the attitude of many of the frequent attenders to their health.

X:D Housing



CG

"The factor is crying out for the rent, but he won't do any repairs." Mr. Phillipson (58)

X:D Housing

1. Area

We interviewed all but the homeless patients in their own homes and so were able to make our own observations on the upkeep of the area in which the patients lived. We used the streets off Byres Road, the site of the Western Infirmary, as our reference point for an average neighbourhood. These streets were lined with tenements, all of which appeared occupied, and neither gave evidence of particular pride of ownership nor of vandalism. We coded the homeless frequent attenders as living in run-down areas, which indeed they did. We used a five-point scale, summarised in the table below:-

Table 26

Type of area in which patient lives

	Fas	Ctrls	%Fas	%Ctrls
Well-kept	24	57	20.0	47.5
Average	46	30	38.3	25.0
Run-down	50	33	41.7	27.5
	120	120	100.0	100.0

We found the frequent attenders lived in areas which appeared to be significantly more run-down than the areas in which the controls lived ($p < 0.001$).

We wondered whether, on average, the frequent attenders lived closer to the Western Infirmary than their matched controls and whether this contributed to the frequent attenders' increased attendance, as compared to the controls. We excluded the twelve homeless frequent attenders and their controls and then measured the distance in miles

from each patient's home to the Western Infirmary. We found no significant difference in distance from home to the hospital between the matched pairs.

2. Home ownership

Table 27

Home ownership

	Fas	Ctrls	%Fas	%Ctrls
1. Owner-occupied	14	38	11.7	31.7
2. Rented	94	82	78.3	68.3
3. No fixed abode	12	0	10.0	0
	120	120	100.0	100.0

The frequent attenders reported significantly less home ownership than their matched controls ($p < 0.001$). We found also that they had significantly fewer rooms in their homes ($p < 0.001$). While most of the home owners among the controls had mortgages on houses or flats with several rooms, the home owners among the frequent attenders tended to have bought a room and kitchen in a run-down area:-

> "I bought the place (room and kitchen) on instalments seven years ago. It cost £350. Now I would like a Corporation house but they say we are not overcrowded, the five of us. We don't have a bath and the children don't like washing in the kitchenette because people can see in. We don't have any friends with a bath either; we keep ourselves to ourselves." Carol London (36)

> "We bought this place (room and kitchen), but it's far too small for us, the cat and dog. I like things to be kept nicely, but it's a losing battle. I can't ever catch up. We've partitioned the bedroom to separate the boys and girls. There's no bathroom and no room to put one. The children take themselves down to the public baths once a week." Pam Neville (34)

"I used to move between digs but two years ago I bought a room and kitchen and stayed in the same place. But now I'm being evicted for not paying off the mortgage. The toilet's in the close. It gets cold in the winter." George Petrie (38)

Several frequent attenders moved frequently rather than establishing a permanent home. Some moved between lodgings; some lived in condemned buildings waiting for the demolition teams to arrive before moving; one lived without heat, spending most of the day in bed in order to keep warm. Several had been evicted from Corporation property and so had to turn to private rentals, where low rents generally meant poorer housing conditions than in the public sector:-

"The factor is crying out for the rent but he won't do any repairs. There's a rat hole under the sink." Mr. Phillipson (58)

Two frequent attenders lived in permanent hostels. One lived in an institute for ex-soldiers; the other described his hostel as:-

"It's a church hostel. The men cater for themselves; there's no warden. A woman comes once a week and changes the sheets. We each have an individual room. The other men are friendly but if I died in my sleep, nobody would know for a week." Mr. Jackson (52)

Twelve (10%) of the frequent attenders had no fixed abode . Ten of these homeless patients were men, who either 'slept rough' in parks and derelict buildings or visited a variety of hostels and model lodging houses in Glasgow, such as the Talbot Centre, the Simon Community, the Salvation Army, or the Great Eastern Hotel:-

"The hostels give you a little place to yourself with no windows. It drives you round the bend - you don't know if it's morning or night." Mr. Rafferty (56)

"Mostly I go to the Simon Community but the place closes up at midnight. You have to sleep on a hard bit of wood there and you get kicked up at 8 o'clock." Mr. Eastern (55)

Notes in the records of the two homeless women suggested that both were prostitutes. One, Annabel North (18), was reported frequenting Central Station and was said to be "easily led". Her notes continued:-

> Record: "If she finds herself homeless in the small hours of the morning, she takes a fit in the street and so gets taken to hospital." Annabel North (18)

At the time of our study, there were only two hostels in Glasgow offering accommodation to women, with all but a few of the beds in these occupied by long-term residents (CRASH report, 1976). Little shelter apart from the hospitals was available to homeless women.

Although Annabel North had been diagnosed an epileptic, most of her fits were thought to be feigned in order to gain admission to hospital. The other eleven homeless patients were not considered to be suffering from any organic complaint needing acute medical care. Nevertheless, each of these 12 homeless patients had made an average of 19 acute presentations over the study period. Four of these patients had between them claimed to have taken 54 overdoses over that period, although doubts were expressed as to the authenticity of most of these supposed overdoses.

All the homeless patients, with the exception of Annabel North, were considered to have alcohol problems. Often the small charge made by the hostels for accommodation was beyond their means, the patients having spent all they had on drink, and some hostels refused entry to those who had been drinking.

3. House moves

We compared the number of times the patients within the two groups had moved house, and the results are summarised below:-

Table 28

House moves over the study period

	Fas	Ctrls	%Fas	%Ctrls
No house moves	53	67	44.2	55.8
1 or 2 moves	32	46	26.7	38.3
3 or more moves	35	7	29.2	5.8
	120	120	100.0	100.0

The frequent attenders reported moving house significantly more often over the study period than their matched controls ($p < 0.001$).

4. Bathroom facilities

Table 29

Bathroom facilities in patients' homes

	Fas	Ctrls	%Fas	%Ctrls
1. Bath and W.C.	77	107	64.2	89.2
2. W.C. only	20	12	16.7	10.0
3. Shared W.C.	11	1	9.2	0.8
4. No fixed abode	12	0	10.0	0
	120	120	100.0	100.0

The frequent attenders had significantly fewer bathroom facilities than their matched controls ($p < 0.001$). Contrasting the two groups,

we found 36% of the frequent attenders, as opposed to 10% of the controls, had no bath. While 11 frequent attenders had to share access to a toilet with another household, only one control patient had this inconvenience. Several frequent attenders had outside toilets:-

> "There's no hot water here. The last place was a room and kitchen, three floors up, with an outside toilet." Mrs. Jessop (57)

> "There used to be an outside toilet but they took it all away about four months ago. I use the public lavatory when it's open." Mr. Phillipson (58)

6. Housing problems

We found the frequent attenders dramatic in their descriptions of housing problems. Mr. Wilkie Snr (69) described a house, that he had squatted in, as so infested that the cat had killed "57 rats in 57 days". Mr. Wilkie's record described him as being brought in by the police on one occasion, having been found drunk and disorderly with no address to give. On the way to the police station, Mr. Wilkie complained of an asthmatic attack and so was taken to the Western Infirmary instead. Mr. Wilkie's account of the incident on admission was:-

> "I stopped by the wayside on my way back from a camping holiday...."

Another frequent attender took her housing problems to the press, saying that she needed to live close to the hospital in order to receive weekly treatment. The patient's record showed no abnormalities found, despite numerous investigations and referrals, nor any treatment prescribed. A newspaper account is shown overleaf.

HEARTLESS!

That's The Only Word For The Shameful Way This Elderly Couple Have Been Treated

HOW would you like to be evicted from your own home, have ur furniture stolen, p rough, wrapped in

lasgow

It's
Two

Glas
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tene
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not.
home
grant.
To the
arrived
poration
firming
It bore the stencilled signature of Theodore Crombie, Home Improvement Officer.
In the same post was another letter informing the
their house was condemned!

Please help us," they asked. "You're our last hope . . ." They told the horrifying story of humiliation and despair.
After the demolition order was served, the Master of Works assured everybody they would be rehoused be-

penny compensation or to buy the property under a compulsory purchase order.
ie were told they hadn't lived there long enough.
e were offered a ouse in Drumchapel. It was xtensively vandalised.
is an invalid.
r years ago she fell down airs, fracturing her skull and breaking her back.
Her 18-year-old daughter, helps look after her.
But Mrs has to live close to a hospital and needs treatment every week.
Her doctors agreed Drumchapel was out.
Next thing, the demolition were given two weeks to get out.
The council did offer another house at this stage.
It was undecorated, needed rewired and had no hot water.
The would have had to renovate it themselves.
They'd no money left, so they'd to turn it down.
By now, Mr ' day had become an endless round of pleas and protests.
At night, he worked as a watchman.
The strain became too much.
On medical advice, he was forced into early retirement.

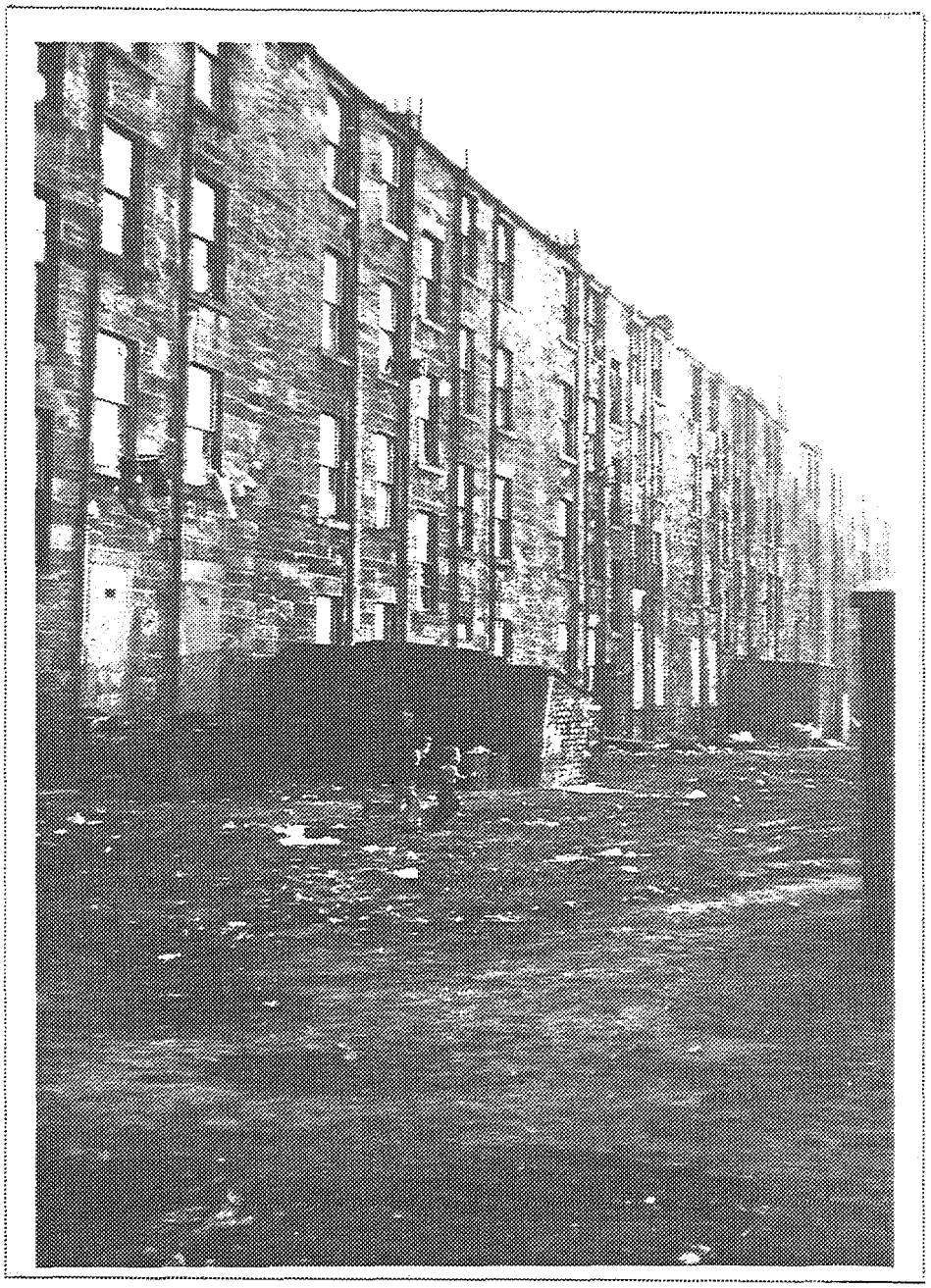
6. Discussion

Despite the dramatic presentation of their housing problems, the general impression we received of the frequent attenders through their housing conditions was that of people unable to cope with maintaining a home. Even those patients who appeared settled in one place showed us into homes that were, on average, far more run-down that those of the controls. We found cold ashes heaped in the grate; a spittoon filled with beer cans, cigarette butts and vomit; greasy chips mashed into the couch (on which the interviewer was offered a seat); and a can opener used as a door latch. Several frequent attenders said they had "given up" trying to keep their homes in order or said they

were so behind with the rent that they were expecting to be evicted soon.

Having seen the housing conditions of the frequent attenders, we were not surprised that many of them sought admission to hospital. The Western Infirmary provided greater material comfort than many of the frequent attenders could find at home. We thought the frequent attenders' housing problems indicative of a general inability to accept responsibility for themselves.

X:E Relationships



CM

"I never had a happy childhood in my life."
Mr. Phillipson (58)

X:E Relationships

1. Childhood

We asked patients whether both their parents were living with them during their childhoods and ranked their answers as below:-

Table 30

Stability of home during childhood

	Fas	Ctrls	%Fas	%Ctrls
1. Both parents at home	70	98	58.3	81.7
2. Father away often	4	2	3.3	1.6
3. No father at home	27	11	22.5	9.2
4. No mother at home	6	6	5.0	5.0
5. Patient not at home	8	1	6.7	0.8
6. Both parents missing	5	2	4.2	1.7
	120	120	100.0	100.0

The patients' accounts of their childhoods revealed that significantly more frequent attenders than controls had come from broken homes, that is, one or both parents were missing or the patient was removed from the home as a child ($p < 0.001$).

Eight frequent attenders had spent major portions of their childhoods in an institution, either because of ill health or because their parents could not cope, or both:-

> Record: "She was sent to the Home because control of her diabetes was so poor at home. Probably these lengthy absences from home gave her the impression that she was being rejected and she has never quite come to terms with this." Lydia Borden (19)

"I never had a happy childhood in my life. Mother took a drink and I was boarded out when I was just a baby. I was a government baby. At 15, I was sent to a Home in Carstairs but I ran away." Mr. Phillipson (58)

As well as the eight frequent attenders living in institutions as children, a further seven spent part of their childhoods living with relatives other than their parents:-

Record: "As a child she was terrified to enter her own home and frequently stayed with aunts." Pam Neville (34)

"When I was eight, I was with my elder sister when she drowned. My father blamed me and I was banned from the house and went to live with my grandmother for four months, then I moved back. I thought I would be happy, as now I was the eldest, but it never worked out that way." Mrs. Wren (40)

We asked patients whether their childhoods had been happy and ranked their answers as follows:-

Table 31

Happiness during childhood

	Fas	Ctrls	%Fas	%Ctrls
1. Happy	66	92	55.0	76.7
2. Fairly happy	26	20	21.7	16.7
3. Fairly unhappy	14	5	11.7	4.2
4. Unhappy	12	3	10.0	2.5
Missing	2	0	1.7	0
	120	120	100.0	100.0

The frequent attenders reported their childhoods as significantly less happy than those reported by the controls ($p < 0.001$). Two frequent attenders gave no reply to this question and so were coded as missing.

Four times as many frequent attenders as controls remembered their childhoods as unhappy and spoke of those days as:-

"Never happy. I couldn't say happy, not laughing or smiling. I ran away because I had to look after the kids. It was 'watch the wains' all the time. I went to a children's home when I was seven." Annabel North (18)

"No troubles except one grave trouble. I tried to throw myself down the stairs when I was eight because of my Daddy. A bad daddy. He did what he oughtn't to have done to me." Mrs. Clay (58)

"Father committed suicide when I was two and my mother remarried when I was three. My stepfather was a drunk and beat me about and was vulgar. He worked in a lamp factory but he didn't really work, he spent all his time getting drunk. Mum never bothered about me much." Pam Neville (34)

Several blamed their unhappiness on their parents' drinking habits:-

"It was very unhappy, ridiculously out of hand. My mother drank, left home, went with other men. She didn't care about me and the house was a mess." Shirley Owen (24)

"My father was a drunken bum. He was a window cleaner and fell off his ladder and died in hospital. My mother brought us up alone." Carol London (36)

Even those frequent attenders, who said that they had had happy childhoods, often added provisos about the times being hard:-

"Happy though not an easy one. As a boy, I used to stand and watch Mother cleaning the close until midnight. She didn't begrudge anybody." Mr. Lawrence (52)

"I was born in Partick in a single end. I was the youngest of three. Eight other families on the same landing shared the toilet." Mrs. MacCauley (49)

We asked patients about the number of siblings in their families and their rank amongst the siblings. There was no significant difference between the frequent attenders and controls in their answers.

2. Marital status

CM

"All my problems were because of his drinking." Mrs. MacCauley (49)

2. Marital status

We ranked patients' marital status as married, single, or apart using the following definitions:-

Married- those who were married or living with a partner of the opposite sex on a permanent basis.

Single- those who had neither married nor lived with a partner of the opposite sex on a permanent basis.

Apart- those who had been married or lived with a partner but were no longer doing so because of death, divorce or separation.

Table 32

Marital status at time of interview

	Fas	Ctrls	%Fas	%Ctrls
1. Married	41	79	34.2	65.8
2. Single	33	26	27.5	21.7
3. Apart	46	15	38.3	12.5
	120	120	100.0	100.0

We found the frequent attenders were significantly less likely than the controls to be married at the time of interview ($p < 0.001$). We subdivided those patients coded as being 'apart' and found:-

Table 33

Patients coded as being 'apart' under marital status

	Fas	Ctrls	%Fas	%Ctrls
Widowed	20	11	16.7	9.2
Divorced or separated	26	4	21.7	3.3
	46	15	38.3	12.5

The divorce or separation rate was six times as high among the frequent attenders as the controls at the time of interview. We also asked patients about any previous marriages and found the frequent attenders had had significantly more broken marriages than the controls ($p < 0.001$). A total of 31% of frequent attenders had, at some point, undergone marital separation while this applied to only 8% of the controls.

Among the frequent attenders who had been separated, alcohol appeared to have been a major cause of friction:-

> "My husband was a commercial traveller. We had a nice new house in Perth. But he became almost an alcoholic. He lost his job and we came back to Glasgow. Then he threatened to kill the children. He rang me up while I was at my mother's and said he was going to gas them. When I got back, he was unconscious and the children were back in bed. I called the doctor. The police took him to jail but said if I stood by him, he could go to Woodilee, which he did. I never saw him again." Mrs. Irving (48)

> "My husband died in August. We were married for 16 years, but separated for the last three, because he was an alcoholic and knocked me about. But when I'm lonely I sit and read his old letters and remember old times." Mrs. Salter (49)

As well as those who left alcoholics, there were several frequent attenders whose drinking habits had caused their respective spouses to leave them:-

> "We seperated because of my drinking. She thought I was having a bad influence on the children. I've been living in a Salvation Army hostel the last four months." Mr. Melrose (54)

But alcohol was not the only cause of marital breakdown:-

> "I separated from my wife, who has since died. She became pregnant and tried to do away with the kiddie by taking pills. And she came out of a convent! I never saw her after that. I don't know whether the kiddie was born or not." Mr. Phillipson (58)

"She took off with her fancy man. I didn't chase after her." Mr. Larkin (62)

One frequent attender said he was separated in 1957 and when asked if he had married again replied with a grin:-

"No, I don't hold with Big Amy!" Mr. Wilkie Snr (69)

(He was not divorced, so a second marriage would be a bigamous one.)

Four recently widowed frequent attenders explained that their marriages had been far from happy:-

"I felt very guilty when he died because I had so often wished him dead. This past year, I have kept seeing him in the chair where he used to sit. All my problems were because of his drinking. He used to work as an ambulance man, but he was caught drunk in uniform. Then he started a scrap car business on his own and did that until he died. Financially, we were more worse off because he only gave me the housekeeping money every now and then instead of regularly. I thought of leaving him a year before he died but I decided against it because of the children." Mrs. MacCauley (49)

Just over a third of the frequent attenders were married at the time of interview, as opposed to two-thirds of the controls. Many of the married frequent attenders described their relationships with their partners as unhappy. Several described themselves as lonely and feeling isolated from their partners. Five frequent attenders mentioned sexual problems. Mrs. Clay (58), the most frequent of all frequent attenders studied, said that her husband refused to share a bed with her and so she had taken to riding the late night buses (perhaps on a route that covered the Western!). The hospital records depicted other frequent attenders experiencing sexual problems:-

Record: "She was sexually molested by an uncle, and also by her stepfather. Her husband then pointed out that she was not a virgin on their first attempt at sexual intercourse and frequently verbally abuses her because of this." Pam Neville (34)

Again we found a dramatic story of a frequent attender in the press. One of the frequent attenders, reported to be working as a prostitute, had been charged with killing the man for whom she had worked. She was cleared of the charge on the grounds of self-defence:-

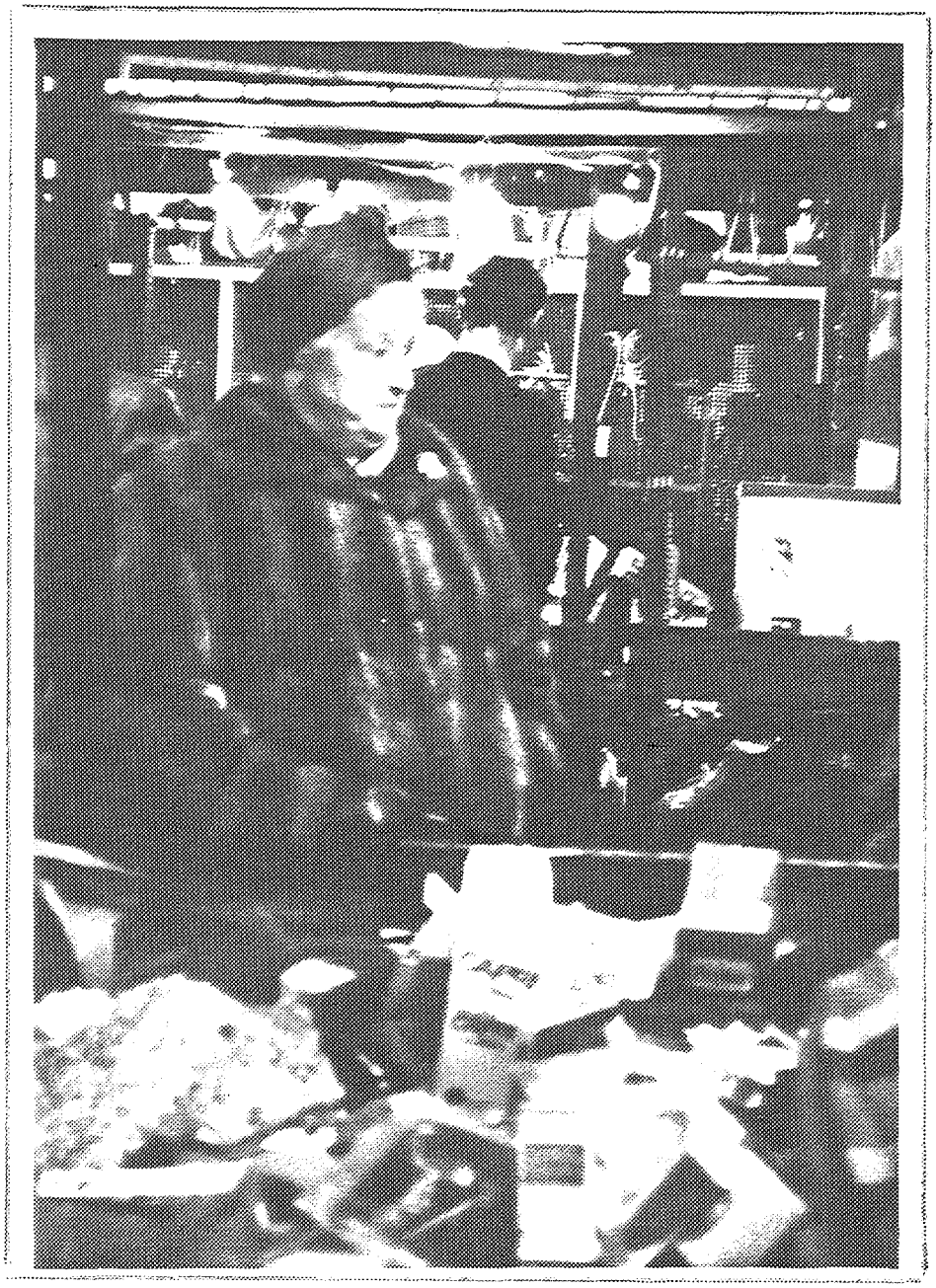
Woman cleared of killing man who tortured her

Mrs surrounded by friends yesterday after being found not guilty of murder at the High Court in Glasgow.

Of the 33 single frequent attenders, four patients had presented at the hospital claiming problems due to homosexuality:-

> Record: "Mild overdose, gross psychosexual problem. Says he is fed up being called a poof and having abuse hurled at him." Cecil Godwin (30)
>
> Record: "He has been drinking very heavily since his boyfriend got married earlier this year." Hugh Atwood (33)

3. Family support



CM

"I don't see them at all. I'm entirely alone, a horrible situation." Mrs. Harrington (62)

3. Family support

We asked patients whether there were any relatives they did not see as often as they would like, either because of distance or because the relatives did not bother to see them.

Table 34

Family support

	Fas	Ctrls	%Fas	%Ctrls
1. No relatives missed	88	106	73.3	88.3
2. Missed because of distance	13	9	10.8	7.6
3. Neglected by relative	19	5	15.8	4.2
	120	120	100.0	100.0

We found significantly more frequent attenders than controls who said they missed their relatives ($p < 0.004$). Several frequent attenders became upset answering this question:-

> "I don't see them at all. I'm entirely alone, a horrible situation." Mrs. Harrington (62)
>
> "You're no use as an OAP." Mr. Jennings Snr (71)
>
> "That's one of your most sensible questions. It's too expensive for the children to visit me." Mr. Millman Snr (70)

One frequent attender said he expected his ill health to summon the attention of his children, but he had been disappointed:-

> "I've fallen out with my son and youngest daughter. My son separated from his first wife and came to stay here. I would have none of it and said: 'You made your bed, lie on it.' I've hardly heard from him since. He knew when I was sick but he never phoned. My daughter left the house to move into her own flat. She knew I was ill and didn't call." Record: "He puts all the onus on his daughter to come back and at the same time gives her conditions which appear to me

> to be punitive. He seems to be desperate for her to return. It is hardly surprising that he continues to have symptoms of anxiety and depression." Mr. Lawrence (52)

Several alcoholic frequent attenders had been cut off by their families:-

> "All they do is sherik. you. They just don't like me." Bill Monks (38)
>
> "They're afraid I might turn up drunk." Mr. Melrose (54)

Patients in both groups had relatives abroad or in England. While the controls looked forward to visiting or being visited by the relatives, the frequent attenders tended to feel abandoned:-

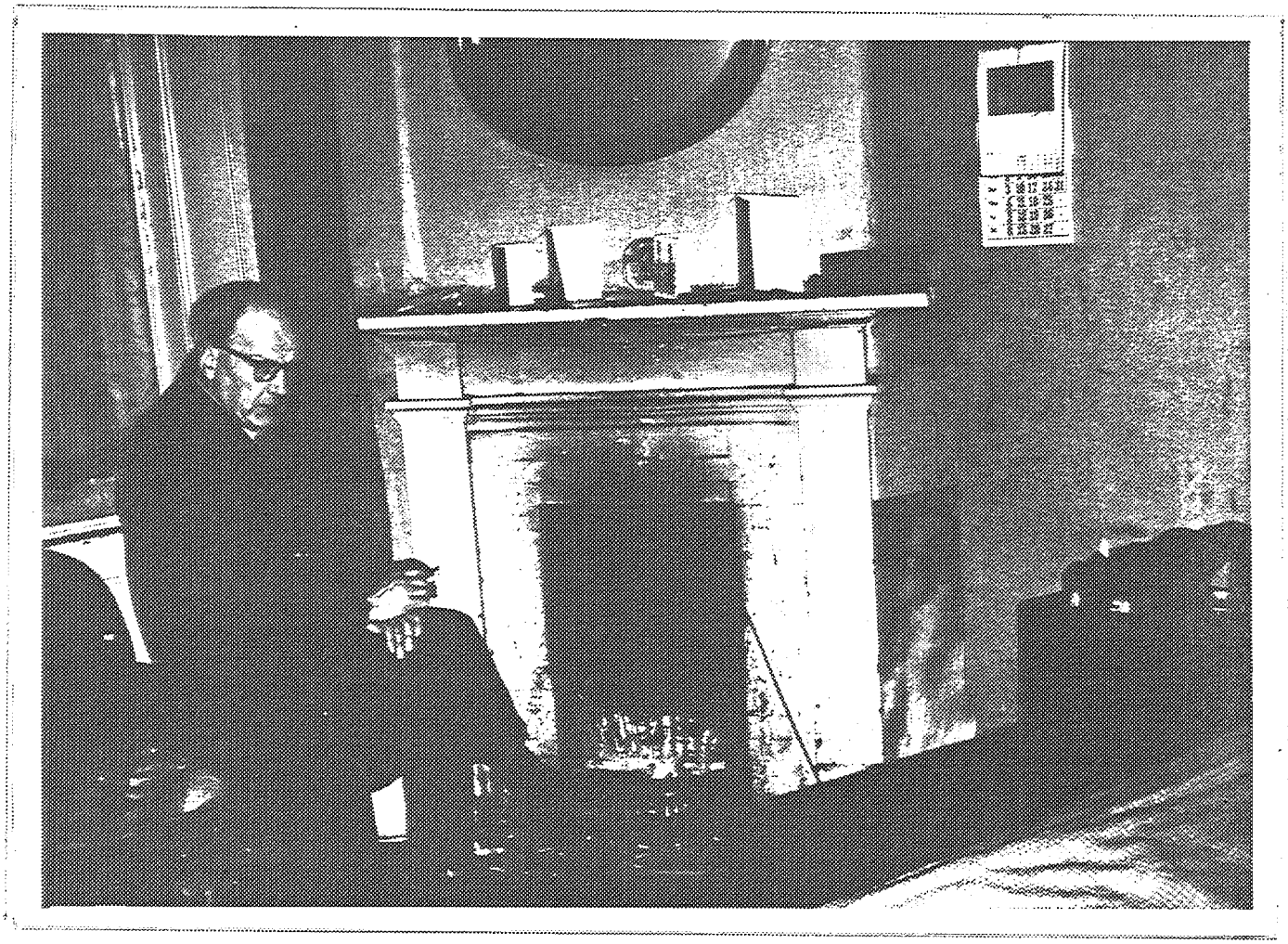
> "She stays in England, my daughter. She doesn't bother about me. I don't want her to bother with me." Mr. Hendrik (63)
>
> Record: "She wept appropriately when talking about her family in Canada." Mrs. Atholl Snr (76)

Thirteen frequent attenders (11% of the group) had young children they rarely saw because of marital separation, alcohol abuse, or both. Two of these frequent attenders were women whose children had been taken into custody.

Ten patients in each group had lost children in infancy, but the frequent attenders tended to dwell on this more than the controls. Mrs. Clay (58) spoke at length:-

> "My first baby was born when I was 19, that was before we were married, he didn't marry me until five-and-a-half months later. The baby died the week we were married. The church lady told me not to cry because she had lost a daughter who was 21 and I wasn't even married. Then the green lady (health visitor) came and said the baby had caught the germ from the church lady's daughter. She had galloping consumption, even though she was the daughter of church people. The baby got TB meningitis."

4. Loneliness



CG

"If you sit in sobriety, you keep thinking and that makes you lonely."
Mr. Millman Snr (70)

4. Loneliness

We asked patients whether they often felt lonely and ranked their answers as below:-

Table 35

Loneliness expressed by patients

	Fas	Ctrls	%Fas	%Ctrls
1. Never lonely	15	58	12.5	48.3
2. Very occasionally lonely	8	21	6.7	17.5
3. Occasionally lonely	51	26	42.5	21.7
4. Often lonely	46	15	38.3	12.5
	120	120	100.0	100.0

The frequent attenders expressed significantly more loneliness than their matched controls ($p < 0.001$). We asked the patients what they did when they felt lonely. We found the frequent attenders more ready to sit and feel sorry for themselves than the controls:-

"I just have a wee bubble." Mr. Glynn (52)

Many frequent attenders said they drank, at home or in the pub, when lonely:-

"To tell the truth, I get drunk. It makes things seem not so bad." Chloe Herbert (25)

"If you sit in sobriety, you keep thinking and that makes you lonely. If you've got the price of a pint, you've company." Mr. Millman Snr (70)

"You never feel lonely in a pub." Mr. Norris (59)

Many frequent attenders said they had few or no friends:-

"I can't seem to get on with people. I don't seem to hit it off." Grace Budge (31)

"Nobody wants to talk to me. I think the whole world is against me." Mr. Rafferty (56)

"I'm never anything else but lonely." Mrs. Harrington (62)

Some proclaimed themselves as 'loners':-

"I have a friend in Glasgow but I'm a loner. You don't get into trouble that way. I drink anywhere. After the pub shuts, I sit in Kelvingrove Park if it's a nice evening." Mr. Rafferty (56)

Several frequent attenders admitted that they looked to the hospital in order to meet people:-

"I never go out except to the hospital. The only people I see are at the hospital." Mrs. Lacey Snr (67)

"I meet people in hospital. I don't like Gartnavel because you don't get as much company." Mr. Findlay (52)

and the frequent attenders' records often mentioned loneliness:-

Record: "He said the real reason for his visit was to see if he could be taken into hospital, that he was lonely living alone and wanted to be kept away from alcohol." Mr. Jennings Snr (71)

Record: "He complains of feeling lonely. He could not hear himself speak this morning and would like in-patient treatment." Peter Kelly (37)

Only 13% of the controls said they were often lonely. Most said they saw family and friends regularly:-

"No, not with six grandchildren. We go over and babymind a lot. It's mainly family and having people in." Mr. Dewar C(65)

5. Discussion

A sense of loneliness permeated the replies made at interview and the hospital records of the majority of frequent attenders. These patients described feeling isolated as children, estranged in their marriages, neglected by their families, and having no friends. High unemployment

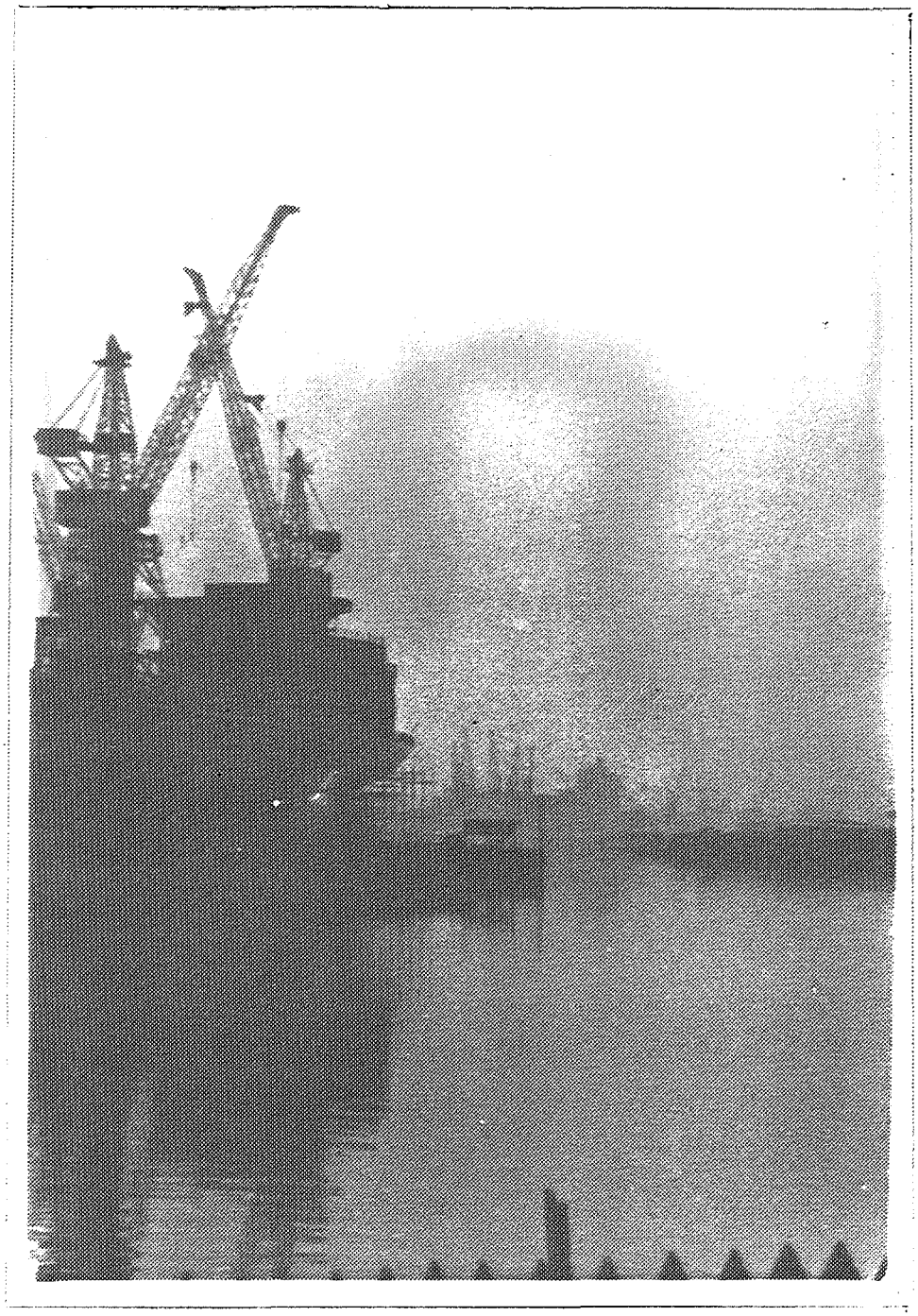
meant lack of work companions, mobility in housing meant lack of neighbours. Many frequent attenders had no one to whom they could turn for either material or moral support, no significant other person in their lives.

We thought these patients made frequent hospital visits, in part, to compensate for this lack of support. Many frequent attenders had spent some period during childhood in hospitals and other institutions and for some, we thought, the institution had become the 'significant other'. These patients now turned to the hospital at times of stress, knowing that provided they presented with appropriate complaints, they would always receive attention.

We also thought several of the frequent attenders used emergency hospital visits and ill health to manipulate their families and that this was likely a continuation of behaviour learned during childhood.

We thought the frequent attenders' difficulty in maintaining relationships indicated that many of them were likely to continue feeling lonely. The frequent attenders appeared to need short, intense periods of care and attention rather than any long-term relationship, and this need was apparently answered by the staff in the acute receiving area rather than any continuing psychiatric support.

X:F Accidents



NR

"Welding is danger no' to hell with the rods burning."
Stewart Nash C (35)

X:F Accidents

1. Injuries

We asked patients whether they had ever been hurt in any accidents and scored their injuries according to the following scale:-

Table 36

Scores for injuries received in accidents

0 - no injuries received as a result of an accident

1 - for each time a patient received minor injuries as a result of an accident (e.g., superficial cuts, sprains)

2 - for each time a patient received moderate injuries as a result of an accident (e.g., simple fractures)

3 - for each time a patient received major injuries as a result of an accident (e.g., internal injuries)

Each patient's accident score represented the sum of injuries received, and we found that the frequent attenders had received significantly more injuries than their matched controls ($p < 0.001$).

Several frequent attenders described traumatic accidents resulting in major injuries when they were young:-

> "When I was five, I was playing round a mobile chip van and the driver told me to clear off because I was being a nuisance. The next thing they knew, I got caught up under the moving van and dragged along. I was in Canniesburn for a long time with burns. They took the nerve out of my leg and put it in my face." Luke Johnson (23)

> "I fell off Jacob's Ladder in Oban when I was 18. It paralysed my legs. I was lucky to get over it." Mrs. Jessop (57)

> "I lost my eye when I was seven years old. A bottle was smashed on my face. I was in hospital for eleven months." Mr. Lawrence (52)

As one control patient pointed out, the shipyards and engineering works which employed a number of patients from both groups, could be

dangerous places to work unless one was careful:-

> "I havna had any accidents but welding is danger no' to hell with the rods burning. You get extra money and a respirator. They say there's nae danger but I don't know if they've been gi'en a bung to keep theyre mouth shut." Stewart Nash C(35)

and several frequent attenders had been injured in the yards:-

> "I was a shot blaster at work blasting rust off the new plates before they go on a ship. A fight broke out and a five-ton plate fell." Mr. Roper (58)

> "I was run into by a fork lift truck at work." Mr. Youngman (59)

Nine frequent attenders gave dramatic accounts of war injuries received:-

> "I was dive-bombed on the ships. We got wounded near the Arctic with a burst of machine gun fire. From '43 to '45 I was in a field hospital in the Adriatic." Mr. Roper (58)

> "I was torpedoed during the war while in the Atlantic. My ankle was injured and frostbitten and needed to be operated on a few years later." Mr. Phillipson (58)

> "I was in the Army and the jeep was blown up by a mine. I was ripped from the stomach to the back." Mr. O'Leary (58)

while the two control patients reporting war injuries gave one-sentence descriptions:-

> "I had war wounds and was in a military hospital." Mr. Yarns C(58)

Several frequent attenders admitted that alcohol had contributed to their accident rate:-

> "I was hit by a car two years ago when I walked behind a bus while drunk. I had just come out of a pub." Mr. O'Leary (58)

> "Coming out of a bar, a stranger knocked me out for no reason." Peter Blaney (39)

"I was sitting in a pub in Byres Road when a stranger came in and started hitting me and some of the others in there with a spanner." Paul Shields (29)

We coded unprovoked attacks by strangers, such as those quoted above, as accidents, but coded attacks following a disagreement, albeit with strangers, as fights.

2. Accident compensation

We asked patients whether they had been granted any compensation or disablement money for injuries. Several patients thought themselves entitled to such money but had not received it.

Table 37

Accident compensation

	Fas	Ctrls	%Fas	%Ctrls
1. No compensation	87	106	72.5	88.3
2. Wanted but not received	7	4	5.8	3.3
3. Received compensation	26	10	21.7	8.3
	120	120	100.0	100.0

We found the frequent attenders had both expected and received significantly ($p < 0.006$) more compensation than their matched controls.

The frequent attenders had long memories for compensation they felt due but had not received:-

"Our ship was torpedoed in the Bay of Biscay in 1943. I hit my head on the engine room skylight while I was making for the lifeboat. I started having epilepsy later and was declared unfit for further duty by the Merchant Navy. I tried for benefit but didn't get any." Mr. Henry Rhind (49)

"After the war, I was discharged as medically unfit. I should have received disablement pension from the navy. I didn't claim as I didn't know about it at the time." Mr. Phillipson (58)

"I've been trying to get a war pension. I broke my ankles during the war and I have to have special boots from Belvidere. The first time was while playing compulsory football. The second was while I was on disembarkation leave. I was drunk and carrying a pack through the station and I cracked the bones again. One of the nurses took me home with her from the hospital." Mr. Leonards (64)

while many of the frequent attenders who had received compensation thought that they should have received more:-

"I was in a bus accident twelve years ago. The bus halted suddenly and I got fractured ribs. I got £75 compensation but I was off work twelve weeks and that wasn't enough." Mrs. Clay (58)

3. Fights

We asked patients whether they had ever been involved in any fights. We coded their answers, making a distinction between fights within the home and those involving outsiders, as follows:-

Table 38

Patient involvement in fights

	Fas	Ctrls	%Fas	%Ctrls
1. No fights	81	107	67.5	89.2
2. Domestic fights	15	3	12.5	2.5
3. Fights with outsiders	24	10	20.0	8.3
	120	120	100.0	100.0

The frequent attenders reported having been involved in significantly more fights than the controls ($p < 0.002$), with a higher proportion involving someone from outside the family circle.

Most of the domestic fights were reported by frequent attender women:-

"He used to fight with me at least once a week, but only when he was drunk. Once he pushed me down the stairs and broke my nose and arm and I was taken into the Western. I told the doctor I

fell. I didn't want my husband to go to jail." Mrs. MacCauley (49)

"I've been battered about plenty. We had to buy a new door after the last fight." Shirley Owen (24)

"I have fights with my wee man and he has pushed my nose in, but then I've hit him too." Mrs. Clay (58)

while the fights outside the family circle were mostly described by men, particularly the alcoholic frequent attenders:-

"I was clubbed up in Clydebank. It caused this scar to my cheek." Bill Monks (38)

4. Discussion

In comparing the accident histories of the two groups we used the patients' accounts of injuries, fights and compensation received. These accounts were not necessarily accurate; the frequent attenders may have exaggerated their reports and the controls have forgotten incidents. However, accurate or not, we found the frequent attenders' reported accident history strongly associated with frequent hospital presentations.

The frequent attenders appeared accident-prone. Several had received much attention as the result of accidents as children, and we thought this perhaps contributed to their accident rate as adults. For the majority of frequent attenders we saw their accident history as a reflection of their general difficulties in coping with life and their involvement in physical fights as a sign of their immaturity.

Miller and Cartlidge (1972), in their study of accident neurosis, reported such neurosis as inversely proportional to the severity of injuries sustained, and the neurosis likely to continue until claims had been settled and compensation made. We thought that almost a quarter of the frequent attenders exhibited some degree of accident

neurosis, remembering unpaid or underpaid compensation which they thought was their due.

X:G Statistical Analysis

Sunday Mail, 1976

"We found employment status to be the best predictor of outcome." Text

X:G Statistical Analysis

1. Overview

Having looked at each of the background variables independently in the preceding sections, we then examined them collectively. We divided the statistical analysis into three parts:-

Univariate comparisons between frequent attenders and controls: We summarised the results of the Wilcoxon rank-sum tests as presented in the preceding five sections. We looked at the strength and direction of association of each background variable with frequent attendance.

Multivariate comparisons between frequent attenders and controls: We used multiple regression analysis and correlation methods to compare the strength of association between each variable and attendance behaviour, to look at the cumulative strength of these variables and to see which carried the most predictive power, as well as the intercorrelations among the variables.

Multivariate comparisons within the frequent attender group: We again used multiple regression analysis, this time to identify any factors associated with the differences found in hospital attendance rates among those in the frequent attender group alone.

2. Univariate comparisons between frequent attenders and controls

In the preceding section, we used the Wilcoxon rank-sum test to analyse the difference in scores between the frequent attender and control pairs. The results of these tests showed us the predictive power of each variable in determining whether, on average, a patient with a given score on that variable was likely to be a frequent a attender or control.

Of the variables tested. 21 had a highly significant association with frequent attendance ($p < 0.01$); 12 were not significantly associated; and one variable (availability of GP) was significantly, but not substantially associated ($p < 0.05$). These results, already presented in the preceding sections, are summarised in Tables 39 and 40. First, the 12 variables found not significantly associated:-

Table 39

Variables without a significant association to frequent hospital attendance

Variable	Direction of association with frequent attendance	p value*
Health		
Family Alcoholism	More alcohol problems in family	0.84
Employment		
Job Changes	Less jobs over study period	0.17
Job Training	Less job training	0.09
Job Responsibility	Less responsibility at work	0.28
Social Class	Lower social class	0.42
Father's Social Class	Lower social class	0.39
Literacy	Less able to read	0.44
Relationships		
Siblings	More siblings	0.59
Rank in Family	Younger in family	0.36
Household Size	Lives with fewer people	0.07
Number of Children	More children	0.14

*p value according to Wilcoxon rank-sum test.

The variables with a significant association to frequent attendance (Table 40) covered five areas, each the subject of a preceding section: health, employment, housing, relationships, and accidents. In summary, the results showed:-

Health- compared to the controls, the frequent attenders reported having consumed more medical resources as children (Childhood Health),

more general practitioner services (GP Contacts), and more psychiatric treatment (Psychiatric Help); they appeared to worry more over their health (Health Worries); and they had greater alcohol problems (Alcohol Problems).

Table 40

Variables with a significant association to frequent hospital attendance

Variable	Direction of association with frequent attendance	p value*
Health		
Childhood Health	More medical treatment as a child	0.004
GP Contacts	More GP contacts over past year	0.001
Alcohol Problems	More alcohol problems	0.001
Psychiatric Help	More psychiatric help received	0.001
Health Worries	More worries over health	0.001
Employment		
Employment Status	More current unemployment	0.001
Unemployment History	More past unemployment	0.001
Housing		
Bathroom Facilities	Less bathroom facilities	0.001
Rooms	Less rooms in house	0.001
Home Ownership	Less home ownership	0.001
House Moves	More house moves	0.001
Neighbourhood	Less well-kept area	0.001
Relationships		
Childhood Happiness	Less happy as a child	0.001
Broken Home	Less stable home	0.001
Marital Status	Less living with marital partner	0.001
Divorces	More broken marriages	0.001
Loneliness	More lonely	0.001
Family Support	Less family support	0.004
Accidents		
Trauma	More injuries received in accidents	0.001
Fights	More fights	0.002
Compensation	More accident compensation claimed	0.006

*p value according to Wilcoxon rank-sum test.

Employment—the only job-related variables which proved significantly associated with frequent attendance were the two which reflected unemployment (Employment Status and Unemployment History).

Housing — the frequent attenders owned significantly less in the way of housing. They had fewer rooms (Rooms), fewer private baths and toilets (Bathroom Facilities), had moved house more often (Moves), lived in a more run-down area (Neighbourhood), and were less likely to own their home (Home Ownership).

Relationships—the frequent attenders reported significantly fewer happy relationships than their matched controls: more frequent attenders had lost one or both parents as children (Broken Home), described their childhoods as unhappy (Childhood Happiness), had undergone marital separation (Divorce), were not currently living with a partner (Marital Status), considered themselves neglected by their families (Family Support), and declared themselves lonely (Loneliness).

Accidents—the frequent attenders reported significantly greater injuries as a result of accidents (Trauma), had been involved in more fights (Fights), and made more claims for accident compensation than their matched controls (Compensation).

3. Multivariate comparisons between frequent attenders and controls

Using step-wise multiple regression analysis, we examined the comparative association between the variables tested and frequent hospital attendance. We found that knowing a patient's history on the following nine variables (Table 41) improved the chance of correctly estimating whether or not the patient was a frequent attender and reduced the variance in outcome by 44% (adjusted R square):-

Table 41

Nine 'best' predictor variables
(frequent attender versus control)

Variable	F-ratio	Significance
Employment Status	13.32	0.001
Psychiatric Help	11.76	0.002
Trauma	10.66	0.002
Loneliness	10.06	0.003
Bathroom Facilities	7.62	0.007
Fights	5.25	0.024
Marital Status	5.16	0.025
Compensation	4.18	0.043
Broken Home	3.55	0.062

Of these nine 'best' predictor variables, we found the top five represented each of the five sets of variables:-

Table 42

Variable sets represented by five 'best' predictor variables
(frequent attenders versus controls)

Variable	Variable Set
Employment Status	Employment
Psychiatric Help	Health
Trauma	Accidents
Loneliness	Relationships
Bathroom Facilities	Housing

Thus, all five sets of variables contributed to the distinction between frequent attender and control.

We computed a matrix of pairwise correlations between the variables in each of the five sets (see Table 43 below). We use an asterisk* to indicate the five best predictor variables, there being one in each set.

Table 43

Correlation matrices of significant variables within each variable set

HEALTH	Psychiatric* Help	GP Contacts	Childhood Health	Alcohol Problems
Psychiatric Help	-			
GP Contacts	0.229	-		
Childhood Health	0.186	0.062	-	
Alcohol Problems	0.243	0.036	0.072	-
Health Worries	0.176	0.207	0.018	0.013

EMPLOYMENT	Employment* Status
Unemployment History	0.476

HOUSING	Bathroom* Facilities	Rooms	Home Ownership	Moves
Rooms	0.738	-		
Home Ownership	0.588	0.512	-	
Moves	0.693	0.605	0.619	-
Neighbourhood	0.487	0.363	0.434	0.376

RELATIONSHIPS	Loneliness*	Childhood Happiness	Broken Home	Marital Status	Divorce
Childhood Happiness	0.210	-			
Broken Home	0.077	0.291	-		
Marital Status	0.317	0.036	0.041	-	
Divorce	0.225	0.076	0.150	0.353	-
Family Support	0.286	0.117	0.055	0.232	0.155

ACCIDENTS	Trauma*	Fights
Fights	0.163	-
Compensation	0.309	0.066

* indicates the five 'best' predictor variables

We noted that these five 'best' predictor variables were also the most highly correlated with the other variables within their set. This was

not coincidental; these variables carried the most predictive power because they were the best representatives of the other variables within that set and vice versa.

The multiple regression analysis and correlation matrices indicated:-

Health - the variable Psychiatric Help proved to be one of the best predictors of frequent attendance and the intercorrelations suggested that those patients who had received psychiatric help were more likely than those who had not received such help to have seen their general practitioner often (GP Contacts), worried over their health (Health Worries), had alcohol problems (Alcohol Problems), and, although a low correlation, have consumed an unusually high amount of medical resources as a child (Childhood Health).

Employment – Employment Status and Unemployment History were, not surprisingly, intercorrelated; both reflected unemployment trends, one present and the other past unemployment. Employment Status, reflecting current unemployment, proved the better predictor of whether a patient was a frequent attender or a control.

Housing – Bathroom Facilities, the variable indicating whether a patient's home contained a private bath and toilet, proved the best predictor among the housing variables and was highly correlated with the number of rooms in a patient's house (Rooms), whether a patient was a home owner, tenant, or homeless (Home Ownership), the upkeep of the neighbourhood (Neighbourhood), and the number of house moves made over the study period (Moves).

Relationships - among this set of variables, Loneliness proved the best predictor variable; the frequent attenders were found to be lonely more often than the controls. Loneliness was correlated with unhappy childhood (Childhood Happiness), living alone (Marital Status), a broken marriage (Divorce), and feeling neglected by one's family (Family Support). We found no significant association between present loneliness and having lost one or both parents as a child (Broken Home).

Accidents - we found Trauma, the sum of injuries reported as received in accidents, was the best predictor among the accident variables and, as we expected, found this correlated with claims for accident compensation (Compensation). We also found a low correlation between Trauma and Fights, that is between injuries from accidents and involvement in fights.

In addition to a correlation matrix within each of the five sets of background variables, we also drew a correlation matrix of the nine best predictor variables:-

Table 44

Correlation matrix of nine 'best' predictor variables (frequent attender versus control)

	Employment Status	Psychiatric Help	Trauma	Loneliness	Bathroom	Fights	Marital Status	Compensation
Psychiatric Help	.202							
Trauma	.075	.140						
Loneliness	.250	.394	.172					
Bathroom	.268	.249	.176	.348				
Fights	.189	.186	.163	.115	.212			
Marital Status	.322	.138	.194	.317	.316	.053		
Compensation	.092	.019	.309	.026	.049	.066	.047	
Broken Home	.099	.029	.038	.077	.107	.128	.041	.050

We found moderate correlations between the nine best predictor variables. Had we found high correlations, this would have signified that the different variables were essentially measuring the same thing. Instead we found substantial independent variability among the background variables, and this explains why the step-wise regression was so successful.

4. Multivariate comparisons within the frequent attender group

Having looked at the variance in hospital attendance behaviour between the frequent attenders and controls, we then examined the variation in attendance among those patients in the frequent attender group alone. This variation was substantial: some patients had presented six times over the study period, while others had made 30, 53 and even 81 acute presentations over the same period.

Using the actual (log transformed) frequency of attendance for each of the frequent attenders as an outcome variable, we again ran a multiple regression analysis on the background variables. This time, we found only two background variables (Bathroom Facilities and Unemployment History) had significant predictive power:-

Table 45

Two 'best' predictor variables
(frequency of frequent attender visits)

Variable	F-ratio	Significance
Bathroom Facilities	8.681	0.004
Unemployment History	4.428	0.037

These two variables accounted for 11% of the variance (adjusted R-square) in the frequent attenders' attendance rate. Thus, we could improve our error performance in estimating how frequently a frequent

attender presented at the acute receiving area if we knew what bathroom facilities the patient had and how long the patient had been unemployed over the preceding five years.

5. Discussion

Statistical analysis showed that our questionnaire had identified a number of variables with a positive association to hospital attendance behaviour. We stress the word 'association', for that was what we were studying, not cause. We make no claim for causal connections between the background variables and hospital attendance. Instead, we looked at a variable's predictive power of the odds that a given patient would prove to be a frequent attender.

Although we made no claim that unemployment caused or was caused by frequent attendance, we were able to claim that an unemployed patient was more likely to be a frequent attender than a control. Further, if we were told that the patient was not only unemployed but had also spent several months in a mental hospital, had incurred major injuries as the result of an accident, had no fixed abode and appeared lonely, we still could not say that the patient was definitely a frequent attender, but we could give even greater odds of this being so.

In predicting attendance, we examined both prior variables and variables reflecting a patient's current state. At times, it was difficult to distinguish between variables which pre-existed before the patient manifested as a frequent attender and those which were inextricably linked with the process of being a frequent attender. However, we thought the inappropriate patient behaviour we found associated with frequent attendance was likely to have developed slowly, without any clearly identifiable starting point.

Although, at first glance, the variables relating to childhood health and happiness appeared to be prior variables, we were not sure that this was, in fact, the case. At the time of interview, the frequent attenders reported that they had had more ill health, fewer parents at home, and had been less happy as children than reported by the controls, but we had no other source for this information. The possibility exists that the frequent attenders did not, in fact, have less healthy, happy childhoods than the controls but now said, and perhaps even believed, that they had, as part of the distorting process or outcome of being a frequent attender. Thus, childhood factors may have been current state rather than prior variables, and a patient's present perception of his childhood a better predictor of hospital attendance patterns than the actual events of youth. However, having raised the possibility of distortion, we should point out that we tended to believe that the frequent attenders' childhoods had, on average, been less happy and less healthy than those of the controls.

The only two variables we could say with certainty were prior variables were Age and Sex, variables identified in the preliminary study. But these variables carried almost no predictive power, for there was no significant difference between frequent and limited attenders on these measures. Thus, all the variables we used to study the phenomenological relationships between the frequent attenders and their present lifestyle may have been current rather than prior variables.

The five variables which proved most helpful in predicting whether a given patient was likely to be a frequent attender or control covered different aspects of the patient's life: employment status, psychiatric history, accident history, personal relationships, and housing facilities. To question each patient presenting at the acute

receiving area on these five topics would be impractical, and we concluded that this would not be an efficient way of identifying the frequent attenders at presentation.

We found different variables proved best at predicting the frequency with which a frequent attender was likely to present at the hospital to those which had proved best at predicting whether a patient was likely to be a frequent attender or a control. Whereas current unemployment (Employment Status) was the best predictor between frequent attenders and controls, past unemployment (Unemployment History) proved a better predictor of frequency of attendance within the frequent attender group. A patient currently unemployed was more likely to be a frequent attender than a control; the more a patient had been unemployed over the preceding five years, the more frequently he might be expected to have visited the acute receiving area. Current unemployment predicted an either/or situation; past unemployment predicted the degree of frequency.

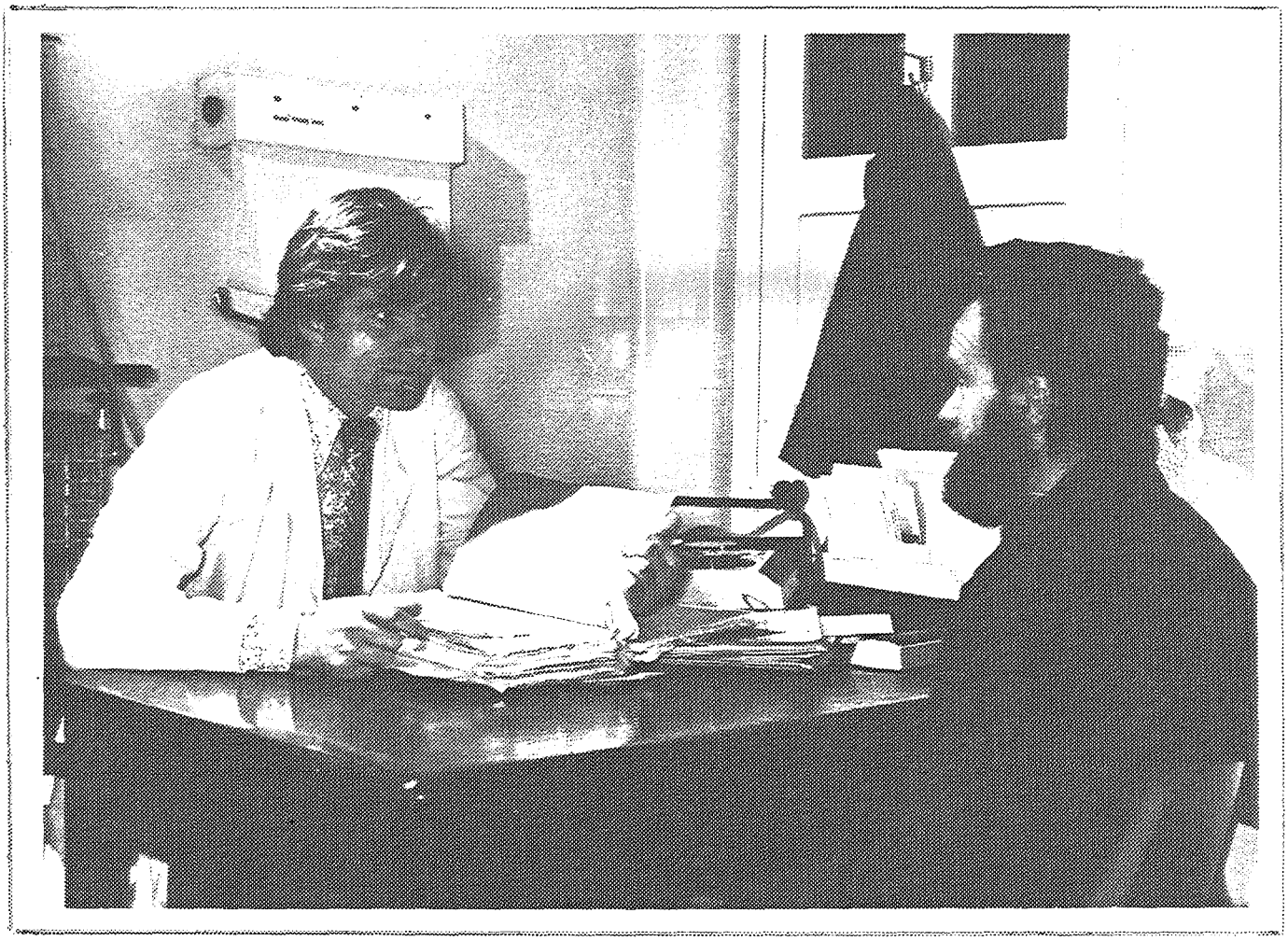
Bathroom Facilities, private use of a bath or toilet, proved to be the best predictor of frequency of attendance among the frequent attender group. (This variable, Bathroom Facilities, had also proved to be the fifth best variable in predicting whether a patient was likely to be a frequent attender or control.) We wondered why this variable should prove to be such an effective predictor. A simplistic view would be that those patients with the poorest housing conditions sought the warmth, cleanliness, and comparative comfort of the hospital, and that this was why those with few or no bathroom facilities frequently attended the hospital.

However, we saw bathroom facilities as reflecting more than just a patient's housing conditions. We saw this variable as an indication

of general living standards. (We are not the first to do so. A substantial part of the assessment for local rates rests on bathroom facilities.) The income of individual patients varied but, living in a welfare state, we thought a certain baseline income available to all those in our study, either through unemployment benefit or Social Security payments. This income could be spent on basics (food, housing, heat, etc.) or on luxuries (alcohol, tobacco, drugs, etc.). However, these luxuries could become as necessary as the basics to a person in an addictive state and so force a patient to lower his living standards to allow for their cost. While two patients might take home equivalent unemployment pay, they might spend it in different ways. We saw the variable Bathroom Facilities as an operational proxy for lifestyle in our study and thought this explained its effectiveness as a predictor of the frequency with which a frequent attender was likely to present at the acute receiving area: the poorer the lifestyle, the more often a frequent attender was likely to present.

Although we found a number of different background variables associated with frequent attendance, they all led us to a similar conclusion: the frequent attenders were inadequate people. Whether we studied their health, mental problems, alcohol use, employment, housing, personal relationships, or accident history, we found them far less able to cope and manage their lives than their matched controls. We thought the frequent attenders' problems a reflection of their inability to cope. Because of this, we thought it most unlikely that the medical staff or anyone else could effect changes in the frequent attenders' lives leading to decreased hospital attendance by these patients.

XI. Management



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"Appointments at the clinics are a waste of time ... you never see the same doctor." Roy Howard (33)

XI. Management of Frequent Attenders

1. Frequent attenders' accounts of past management

Before making suggestions on the future management of frequent attenders, we reviewed the treatment these patients had received in the past. We began by looking at the frequent attenders' comments on the treatment they had received at the Western Infirmary.

The frequent attenders had mixed opinions of the medical staff:-

> "I love the Western. I'd put my chest through a grater for the doctors there." Mrs. Knisley (60)
>
> "I feel that the hospital has lost its personal touch. The nurses are not 'Angels of Mercy' nowadays." Mr. Glynn (52)
>
> "If ever I should go to the Western again, I would prefer it to be to the mortuary. The Western in the past and now are two completely different places. The nurses now are all dancing girls with union cards." Mr. Millman Snr (70)
>
> "The treatment is good, but I don't think they pay enough attention to what is really the matter with you. They cut you off when you're trying to tell them something. The doctors and the nurses are a bit too abrupt. You don't go to be pampered, but a bit of sympathy would have helped me. They were too cheeky, too cutting. As if to say, you're here too often, get out of my road." Shirley Owen (24)

A few frequent attenders admitted that they had not always been ideal patients:-

> "The nurses took a lot of abuse from me while I was doped up. They were very kind to me." Chloe Herbert (25)
>
> "I may have been a nuisance in the past but not now, now it is genuine." Mr. Jackson (52)

while others were vituperative about the treatment they had received:-

> "I'm treated like a dog in hospital because I'm an alcoholic. The doctors and the nurses have always messed me about, shower of bastards. Treated me like a leper because I'm an alcoholic. I hate hospitals because I've spent most of my life in them." Hamish Tate (39)

"After the overdose, I was treated like dirt. They were very rude. I was left to ask for everything so, in the end, I signed myself out." Carol London (36)

The frequent attenders impressed on us how well they knew the Western. Mrs. Hart (49) called it her "second home", Mrs. Lane (65) brought out her collection of "bracelets" (identity tags she had saved from each hospital admission), and Mr. Lawrence (52) claimed to have been in "almost all the wards".

The frequent attenders appeared to enjoy recounting the details of the various investigative procedures and operations which they had undergone and saw these procedures as indicative of the severity of their complaints. They failed to mention that no abnormality was found, as had been recorded in the majority of cases:-

"During my last visit to hospital I had a cardiograph over my arms and legs. They found a beat missing in my back. I had a lumbar puncture at 9 o'clock in the morning and 6 o'clock at night. I had three IVPs one day." Luke Johnson (23)

"I had an investigation at the Radcliffe Infirmary under Pennybaker, a Canadian. He was the head surgeon there, but he'll be retired now. They did the same at Killearn, they put a big needle in the jugular vein. They strapped me down. I've had everything, a lung puncture, a brain scan, a broken neck." Mr. Rafferty (56)

The frequent attenders were less enthusiastic about the minor routine investigations involved in a hospital stay than they were about the major ones:-

"I would rather go to a surgical ward than a medical ward any time. You're allowed to smoke there. You're not getting your bottom rubbed twice a day; they're not taking X-rays; you're not disturbed in surgical." Mr. Millman Snr (70)

"They could have stopped annoying you every ten minutes. It was like Barlinnie." Bill Monks (38)

and several frequent attenders said they had "signed themselves out",

leaving notes like the two below:-

> "Dear Doctor, I do not like the way of your treatment. I have taken all I can stand so I've decided to go home but I pledge you nor no one in the hospital at fault if any thing should happen to me. I am your (Gordon Single)." (59)

> "I am getting so fed up without any clothes for walking around that I can't settle down here but living in hope seems to be getting me down I am afraid Sister that I may do something contrary to the order and discipline of this very fine Hospital so knowing that you are an understanding person I think you will forgive me yours in all humility Mr. (Wilkie)." (69)

The hotel facilities of the Western came in for attack from many of the frequent attenders:-

> "I've no complaints about the medical staff, but the wards are a disgrace, the screens are dirty, the nurses don't like giving bedpans, the food is served badly, and there is no telly. Gartnavel General is different. It's like wan o' they American hospitals." Mrs. Hinckley (45)

> "The Western is just a dump. The food is awful. I was given sausage rolls and spaghetti after a heart operation! Gartnavel is like a hotel compared to the Western." Mrs. Kraft (51)

The frequent attenders said they enjoyed the company of other patients and preferred the open ward arrangement of the old Western hospital building to the small rooms of Gartnavel. However, they were selective in their choice of companions and several frequent attenders complained about the number of geriatric patients in the wards:-

> "It was depressing being caged up with three other (sic) senile old ladies who couldn't hold a conversation." Mrs. Salter (49)

and a couple of frequent attenders, not exactly teetotal themselves, complained of sharing a ward with alcoholics:-

> "The Western is just a butcher's shop. You lie next to drunks and drug addicts. They should be segregated off." Mr. Crocket (61)

The part of the hospital which received the heaviest criticism from the frequent attenders was the out-patient department:-

> "Appointments at the clinics are a waste of time since there is no follow-up, no proper communication or treatment sent to the GP, never the same doctor each time, and so no progression as each doctor must start at the beginning again." Roy Howard (33)

> "I don't like getting a different doctor each time and different lotions which don't work." Mrs. Vine (61)

2. Medical staff's account of past management

Entries in the frequent attender records indicated that in the majority of cases the doctor examining the patient in the receiving hall was unaware of the patient's past hospital attendances. A frequent attender's hospital record was often not immediately available: it might, for example, be awaiting a discharge summary in some other department after the patient's last visit, or could not be found as the patient had used an alias to avoid recognition. We found investigations repeated at successive visits without reference to previous negative results. Admitted to the wards, the frequent attenders often took an irregular discharge, leaving before their records were found or before someone on the morning ward round recognised them. (One night in hospital often appeared sufficient for the frequent attenders.)

Only half the frequent attender presentations resulted in admission. The medical staff often had difficulty persuading the frequent attenders to leave instead of being admitted. Some patients were left alone while the doctor saw to other patients and took their own discharge, the police were asked to remove some, and in a few instances the records noted painful stimuli used to rouse patients feigning unconciousness and to prompt their departure:-

> Record: "Found in a state of supposed unconsciousness. Aroused to the point of getting up, uttering an expletive and dressing himself after having his external genitalia anointed with ether. Left the hospital under his own steam." Mr. Henry Rhind (49)
>
> Record: "He took another of his attacks, feiging unconsciousness. He responds briskly to painful stimuli and made a remarkably speedy recovery." Luke Johnson (23)

We found several instances of patients recognised as frequent attenders being investigated 'once and for all' in order to satisfy the doctor:-

> Record: "Although she has cried 'wolf' in the past, I feel it would be unwise to ignore these symptoms and have arranged a barium swallow and meal." Avis Swain (33)
>
> Record: "One has always to remember that the most hysterical and depressed patient may have organic disease and I just wonder if...." Mrs. Davidson Snr (76)
>
> Record: "While the probability is still strong that this patient is a malingerer, it seems only fair to give him a chance to have any organic cause for his complaints found." Mr. Eastern (55)

or to satisfy the patient:-

> Record: "I was disappointed but not really surprised to hear that Mrs. Davidson has had a relapse of all her symptoms. Perhaps you would like to reassure Mrs. D. that her chest X-ray was normal, though it seems unlikely to bring her much comfort. My impression is that this woman will never be happy and that even if we miraculously cured all her symptoms, she would probably be even more upset than ever." Mrs. Davidson Snr (76)
>
> Record: "Clinically I can find nothing wrong with her, but I will carry out the laparoscopy to settle the matter once and for all, if such indeed is possible with a person of her nature. ...No abnormality was seen, and when I told the patient that I found absolutely nothing wrong with her and that seeing was believing, I am far from sure that she was even pleased." Mrs. Fairbairn (57)

The 'once and for all' approach seldom seemed successful; once one set of symptoms had been dismissed, the frequent attenders presented with another.

The frequent attenders were referred to various parts of the hospital as their symptoms changed, or as particular departments excluded problems that fell within their jurisdiction. Many were referred to the psychiatric and medical social work departments. The frequent attenders appeared adept at using the facilities of the hospital social work department. One frequent attender almost had himself sent to a " convalescence home by the sea" until the request was checked with the referring physician. Another frequent attender, Luke Johnson (23), asked a medical social worker for his bus fare home. When the social worker challenged the amount quoted, the patient admitted he could travel for much less on a Corporation bus but found the airport bus faster and more comfortable!

The records showed differing views on patient follow-up for frequent attenders. Some members of staff thought frequent attenders could be deterred from further emergency presentations by being seen at out-patient clinics at regular intervals. Other doctors thought that all contact with the hospital should be kept to a minimum:-

> Record: "I feel that it is important to keep her away from hospitals as far as possible and I have not given her any further clinic appointments." Mrs. Jessop (57)
>
> Record: "He is an anxious neurotic person, and it was felt that follow-up would probably exacerbate his symptoms." Mr. Scanling (41)

The impression we received after reviewing all the frequent attender records was that, in most instances, the medical staff held little hope of altering the attendance behaviour of the frequent attenders:-

> Record: "It may well be that his life will consist of recurrent self-referrals to different hospitals." Luke Johnson (23)
>
> Record: "I would suspect that the pattern of recurring hospital admissions will continue in the future, and I can see no measure to reverse this trend." Mr. Griffen (46)

Record: "No matter what is done for him, this man will always remain a problem". Mr. Findlay (52)

3. Suggestions for future management

We believe that it may become easier to identify frequent attenders on arrival at the hospital as computers become more widely used. 'Black lists' have proved impractical as the process of checking each patient's name is too unwieldy. We foresee a time when a patient's past admissions and diagnoses are readily available through a computer. In the meantime, we hope the porters will be encouraged to identify the frequent attenders to the duty doctor, as they have done in the past.

Having recognised a frequent attender, we do not think that the medical staff could, or should, refuse treatment. Sometime in their lives, the frequent attenders are likely to have a genuine complaint and the doctor who then refuses treatment will receive little sympathy from his peers or the court.

However, when a patient with a history of negative test results presents and is suspected of fraudulent behaviour, we would then limit investigations to those deemed essential. Esoteric testing on frequent attenders has, in the past, served to frustrate the staff, consume limited resources, unnecessarily expose the patient to any risks involved in the procedure, and give the patient the impression that he might well have serious underlying disease, if only the doctor could find it.

We suggest observing patients suspected of fraudulent complaints in the receiving hall or side room rather than in the wards. We think this preferable both on economic grounds and in order not to

encourage use of the hospital for its hotel facilities.

We are concerned over the occasional use of painful stimuli to prove that a patient is feigning unconciousness. We believe that proof of conciousness can be as effectively achieved through non-painful stimuli, such as smelling salts, and that the infliction of pain is unnecessary.

We think referring frequent attenders for psychiatric treament unlikely to prove helpful. We found the frequent attenders usually presented with dramatic physical problems and regarded psychiatric referral as an insult, as a sign that the doctor did not believe in their complaints. The psychiatrists, on the other hand, believed that the majority of these patients had innate character disorders for which they had little help to offer. We are greatly opposed to the more extreme psychiatric practices suggested in the past: the prefrontal leucotomies used by Barker (1960) and the permanent incarceration in a mental hospital advocated by Chapman (1957), Barker (1964), and Ireland et al. (1967). We consider such measures violate the rights of the patients concerned and are not necessary in protecting society. In addition, Barker (1962) found that the leucotomies failed to deter his patients from making further acute hospital presentations and we see permanent hospitalisation as considerably more costly than the problem it attempts to solve.

We also think referring a frequent attender to a social worker unlikely to help. The frequent attenders tended to regard the social workers as a source of material assistance rather than emotional aid; the social workers indicated that they had little more to offer these patients. Again, the frequent attenders appeared to be seeking immediate medical attention, not long-term support.

The 1976 Consortium for the Relief of the Single Adult Homeless (CRASH) report called for the Glasgow social service agencies to set up more day centres for the homeless and support systems for patients discharged from psychiatric and general hospitals. The CRASH report looked for assistance for institutions such as the Wayside Club, founded in the 1930's to help "the Alcoholic, the Gambler, the ill, the simpleton, the lazy and inadequate, and the drug addict", a description which covers many of the frequent attenders. However, we think this type of support likely to reach only the homeless among the frequent attenders and, while proving helpful to the patients themselves, unlikely to decrease the number of acute hospital presentations made by these patients.

We considered the idea of suggesting a special clinic in the hospital for frequent attender patients. However, such a clinic would have to be staffed 24 hours a day, as the frequent attenders present themselves as in need of immediate attention around the clock. We do not think the number of frequent attenders presenting at the Western large enough to justify the staffing of such a clinic. Nor do we think that being seen in a clinic, seperated from the normal facilities of the acute receiving area, would satisfy the frequent attenders' apparent need for drama.

Out-patient visits by the frequent attenders appeared to extend the amount of hospital resources consumed by these patients without decreasing the number of acute presentations made. (Lipsitt (1968) found his 'problem patients' used his Integration Clinic in addition to, rather than instead of, the hospital emergency room.) We believe out-patient appointments should be scheduled for the frequent attenders when medically necessary and not as a supportive

measure.

Taking legal recourse against the frequent attenders does not appear to be a satisfactory solution. Although we realise that at times it is necessary to physically restrain and remove a violent patient from the hospital, handing over to the police a patient misusing the acute receiving area involves the resources of yet another agency. Taking a frequent attender to court is a time-consuming course of action action and it is hard to prove that a patient has intentionally defrauded the hospital. In addition, we found no evidence to suggest that a court action diminishes future presentations by the patient.

We found much debate in the literature on whether a doctor should confront and denounce a patient misusing a hospital's emergency facility. Our study of the frequent attenders' hospital records showed that such confrontations usually left both doctor and patient feeling hostile and angry. We think it important that the patient be allowed to retain a sense of dignity. We hope that a doctor recognising a frequent and inappropriate hospital attender will listen to the patient's complaints, perform some form of physical examination, however brief, in order to reassure the patient, order only those investigations deemed essential, and then, once the doctor is assured that no urgent medical problem exists, tell the patient that he is all right but he should take things easy for the next couple of hours or some appropriate time span. We think there is a substantial difference in the effect of the two remarks 'There is nothing wrong with you' and 'I think you will be all right' on both doctor and patient. We hoped that this approach, which we call the 'Dixon of Dock Green' approach (after the kindly but authoritarian policeman of the television series), would leave the doctor with a sense of

having given the patient some positive help and leave the patient with the reassurance to return to life outside the hospital.

4. Discussion

It is customary to conclude a study such as this by suggesting a new management plan, a way of preventing the problem studied, or a way of curing it. Previous studies of persistent patients have suggested the intervention of social workers, psychiatrists, special clinics, in-patient treatment, out-patient treatment, new methods of record keeping, placebo therapy, and diagnostic tests to solve the problem posed by these patients. None of these suggestions have proved to be effective, while all have carried associated costs.

For us to propose a plan to rid the hospital of frequent misusers of the acute receiving area would be to disregard the findings of our study. We found frequent attendance associated with a number of disparate background variables and innate character disorders which meant that there was no simple solution to the frequent attender problem. We found that the factors associated with frequent attendance extended far beyond the hospital and that, by the time a patient manifested as a frequent and inappropriate user of the acute receiving area, there was little that could be done to alter the patient's attendance behaviour.

We believe that patients such as those we found in the frequent attender group have a need for drama, a need to be the centre of attention. These patients could be costing the community far more by using more destructive methods of calling attention to themselves and thereby pose greater management problems. The Glasgow prison service is already overextended and the cost of permanent psychiatric care is far higher than that of intermittent care in a general

hospital.

Referring a frequent attender on to another department or agency merely appears to extend the cost of patient care rather than altering the patients' presenting patterns. While individual counsellors, such as family doctors, ministers, and social workers can not be expected to see these patients at any time of the day or night, the acute receiving area is staffed around the clock. We think using the acute receiving area as a support system for the frequent attender patients is one of the most effective and least expensive ways of allowing these patients to function in the community.

We think there will likely always be a small proportion of patients making both frequent and inappropriate use of the hospital's acute receiving area but we believe this a small price for the community to pay to ensure having emergency hospital services readily accessible to all.

XII. Conclusions

Preliminary Study

1. We found that 3,284 patients used the acute medical receiving area (AMRA) of the Glasgow Western Infirmary over a six-month selection period, 1st February - 31st July 1975. We refer to these patients as the AMRA patients.

2. After studying the past presentations made by the 3,284 AMRA patients, we defined frequent attendance at the acute receiving area as more than five acute attendances between 1st January 1970 and 31st July 1975, a 5 year 7 month study period. We found that 150 patients (4.6% of the AMRA patient sample) had been frequent attenders.

3. While the AMRA patients made an average of 2.0 (range 1 - 5) acute presentations during the total study period, the frequent attenders made an average of 10.2 (range 6 - 81) acute presentations.

4. We found little difference in age, sex, or presenting complaints between the AMRA patients and frequent attenders.

5. We found no difference between the AMRA patients and the frequent attenders when we compared the proportion of patients who died in hospital after making an acute presentation over the six-month selection period.

Resource Consumption

6. We found that the 150 frequent attenders (4.6% of the AMRA patient sample) accounted for 6.4% of the presentations to the acute medical receiving area over the six-month selection period.

7. We found that the 150 frequent attenders accounted for 0.8% of all hospital admissions, 0.1% of all out-patient visits, and 0.5% of the total hospital expenditure during the study period.

8. Of the 150 frequent attenders, 120 proved available for interview and in-depth study. We selected a control, matched for age, sex, and presenting complaint, for each of these 120 frequent attenders.

9. We compared the resource consumption of the frequent attenders to that of their matched controls and found that, on average, the frequent attenders had used 4.4 times as many in-patient days, 4.6 times as many out-patient appointments, 4.2 times as many diagnostic x-rays, and 4.5 times as many laboratory tests as the controls.

Medical Diagnoses

10. We compared the severity and number of medical problems diagnosed for the matched pairs. In only 14 (12%) of the pairs did we find greater medical problems diagnosed for the frequent attender. Thus, we could not explain the increased acute presentations made by the frequent attenders as being the result of greater medical problems.

11. In our review of the hospital records, we found that 118 (98%) of the 120 frequent attenders had made at least one inappropriate visit to the acute receiving area during the study period. Of all acute presentations made by the frequent attenders during the study period, 68% were considered to be due to inappropriate patient behaviour.

12. However, we also found inappropriate patient behaviour mentioned in 55 (46%) of the 120 control records and 24% of the controls' acute presentations over the study period were considered to be due to inappropriate patient behaviour.

13. We found a psychiatric problem diagnosed in 92 (77%) of the 120 frequent attender records, The psychiatric reports showed 68% of the frequent attenders considered to have psychological problems unlikely to respond to treatment and almost half (48%) of the frequent attenders diagnosed as having innate personality disorders.

14. The psychiatrists had also noted psychological problems in 26 (22%) of the controls. However, in contrast to the frequent attenders, only three (3%) of the controls were diagnosed as having innate personality disorders and only nine (8%) of the controls were considered to have psychological problems unlikely to respond to treatment.

15. We found 40 (33%) of the frequent attenders claimed to have made one or more self-poisoning attempts during the study period, with a mean of 4.7 attempts. As a result of matching patients on presenting complaint, we also found 33 (28%) of the controls had presented claiming an overdose attempt during the study period but only one of the controls had made a second attempt.

Background Variables

16. We asked patients questions at interview about their health, employment, housing, personal relationships, and accidents. We compared the answers given by the frequent attenders and controls within the matched pairs and found the following variables to be significantly associated with frequent hospital attendance ($p < 0.01$ Wilcoxon rank-sum test for matched pairs):-

17. Health - the frequent attenders had, on average, consulted their general practitioners more often during the preceding year, used more medical resources as children, reported more alcohol problems,

received more psychiatric help, and worried more about their health than their matched controls.

18. Employment - the frequent attenders reported higher past and present unemployment rates than their matched controls, although we found the two groups similarly composed in regards to occupation and social class.

19. Housing - the frequent attenders lived in poorer housing than the controls and had fewer rooms, fewer bathroom facilities, and less home ownership. The frequent attenders had moved house more frequently over the study period than the controls and the frequent attenders currently lived in poorer neighbourhoods.

20. Relationships - in comparison to the controls, more frequent attenders reported having lived apart from one or both parents when young and described their childhood as less happy; fewer frequent attenders were living with a partner of the opposite sex and the frequent attenders had experienced more broken marriages than the controls; more frequent attenders said they felt neglected by their families and that they were lonely.

21. Accidents - the frequent attenders reported more injuries as the result of accidents, a higher involvement in fights, and had expected or received more accident compensation than the controls.

Statistical Analysis

22. We found we could improve our chance of correctly estimating whether a patient was a frequent attender or control by knowing a patient's history in respect to nine variables. Using step-wise multiple regression analysis, we were able to reduce the variance in

outcome by 44% (adjusted R square). These nine variables, in order of predictive power, indicated: the patient's current employment status (Employment Status), the amount of psychiatric help the patient had received (Psychiatric Help), the extent of injuries received in accidents (Trauma), the degree of loneliness expressed by the patient (Loneliness), the availability of a private bath and toilet in the patient's home (Bathroom Facilities), whether the patient had expected or received compensation for injuries received in an accident (Compensation), and whether the patient was separated from one or both parents when young (Broken Home). The first five of these nine best predictor variables represented each of the five sets of background variables studied: health, employment, housing, relationships, and accidents.

23. After running a correlation matrix on the background variables, we found the five variables which proved to be the best predictor variables were also the most highly correlated with the other variables within their set. We only found a moderate degree of intercorrelation among the nine best predictor variables.

24. We then examined the association between the background variables and frequency of attendance in the frequent attender group alone. Using the actual frequency of attendance (log transformed) as an outcome variable, we found only two variables, Bathroom Facilities and Unemployment History, had significant predictive power, these accounting for 11% of the variance (multiple regression analysis). This meant that we could improve our ability to predict how frequently a frequent attender presented at the acute receiving area if we knew what bathroom facilities the patient had and the amount of unemployment experienced over the preceding five years.

Management

25. After reviewing the patients' hospital records, and after an extensive search of the medical literature, we found no evidence of any management plan which had proven effective in preventing misuse of hospital emergency facilities by frequent attender patients. Neither could we suggest any other methods likely to curtail future presentations by frequent and inappropriate attenders.

26. We believed that the amount of hospital resources consumed by the frequent attenders was too small to adversely affect the medical care of other patients. We concluded that the costs and risks involved in excluding frequent attenders from the hospital's acute receiving area were outweighed by the benefits of simply treating these patients.

27. We suggest that treating the frequent attenders on demand at the acute receiving area is, in fact, an efficient and effective way of maintaining and supporting these people in the community.

XIII. Bibliography

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XIV. Appendices

Appendix A

Western Regional Hospital Board (1975) definition of the Western Infirmary's area of responsibility for admission of acute medical and surgical cases

1.

WESTERN REGIONAL HOSPITAL BOARD

Hospital Admission Arrangements

Acute Medical and Surgical Cases

AREA OF RESPONSIBILITY

Western Infirmary

From	To	Remarks
The River Clyde at the new motorway (Formerly Clydeferry St.)	The Boundary of the City of Glasgow at Yoker.	Following the line of the North Bank of the River Clyde.
The Boundary of the City of Glasgow at Yoker.	The Boundary of the City of Glasgow where it meets the River Kelvin in Dawsholm Park.	Following the line of the Boundary of the City of Glasgow.
The Boundary of the City of Glasgow where it meets the junction with the River Kelvin in Dawsholm Park.	Great Western Road at Kelvinbridge.	Following the west Bank of the River Kelvin.
Great Western Road at Kelvinbridge.	St. George's Cross.	Both sides of this part of Great Western Road are included.
St. George's Cross.	Charing Cross.	Both sides of this part of St. George's Road are included.
Charing Cross .	Argyle Street.	Both sides of North Street are included.
Argyle Street.	The River Clyde.	Following the line of the new motorway.

NOTES

The Infirmary's responsibility is:-

Within the Boundary of the City of Glasgow:- The Wards of Partick East, Partick West, Whiteinch, Yoker, Knightswood and Kelvinside, and part of Anderston and Park Wards.

Outwith the Boundary of the City of Glasgow - In Dunbartonshire, the Burghs of Bearsden, Milngavie, Clydebank and part of the Landward District of Old Kilpatrick. In Stirlingshire parts of Landward Districts Western Nos. 1, 2 and 3.

Record Analysis Sheet

Patient number: Name: Age:

Dates	Time	Referral	Stay	Complaint and diagnosis

OPD Clinics

GP:

Occupation:

Husband's occupation:

Comments:

Appendix C

Investigation Sheet

Name:

Number:

Bacteriology	Biochemistry	Haematology	X-rays	Other

Appendix D

Opening remarks used at interview

I am from the Western Infirmary. We are carrying out a survey on how patients feel about the Western. May I come in for a few minutes?

We are interested in how you feel about the Western and what has affected your health in the last few years. If I may I'll ask you some questions first and then add your comments at the end. Everything you say will be completely confidential - your name will never be used.

Appendix E

Questionnaire used at interview

1. How do you feel now compared to when you left the Western? Better, the same or worse? (Note comments made)	Better: Same: Worse:
2. Did you contact your family doctor before you went into hospital last time? (If not why did you not?)	
3. Is your own doctor available during the night/at weekends if needed?	Yes: Or partner: Or emergency doctor: Just emergency doctor: Don't know: No:
4. How often have you seen your doctor the last year? Once a week, once a month?	
5. What have been the main things you have had to go and see him for over the last year or so? (Note if mention lines)	
6. Medicine Do you have to take any tablets or medicine regularly?	Tablets For
7. Are there any other medicines that you find helpful, either from your doctor or the chemist?	Medicine For From
8. As a child What about when you were a child - did you see the doctor often then? (If often, what for?)	Often: Just measles etc. Never:
9. Were you sent to any hospital clinics as a child - before you were 14? (For?)	
10. How old were you the first time you were a bed patient in hospital? (For?)	Age: For: Hosp:
11. Which hospitals have you been to during your life? (For and long ago?)	Hosp. For How long ago

-2-

12. Accidents Have you ever been hurt in any accidents?	Place	Injuries	How long ago
12a. How many accidents in last 5 years?			
13. Have you been assaulted or hurt in any fight? - during the last five years?	Place	Stranger?	How long ago?
14. Have you been granted compensation or disablement money for anything?	From	For	When
15. Employment Have you a job at present? (If not, how long ago left last?) (How many jobs have you had in last five years?) (Why changes?)			
16. Have you ever done any other kind of work?			
17. Clarify main occupation			
18. Did you have to do an apprenticeship or training when you left school?			
19. How old were you when you left school?			
20. Have you ever been self-employed?			
21. Have you ever been responsible for others, e.g. supervisor or shop steward?			
22. Have you ever worked in a hospital? (Type of hospital and what as?)			
23. Have you enjoyed your work, done it because you had to or disliked it?	Enjoyed:	As a job:	Disliked: Depends:
24. Unemployment Have you had any unemployment over the last 5 years? (How many months would it add up to?)			
25. (Were you unemployed because of ill health or was it another reason?)	Ill health:	Other:	
26. Are you much worse off, when you are unemployed, is it the same or are you better off?	Much worse:	Bit worse:	Same: Better:

27. Sickness How many months have you been off sick in the last five years (if worked)?	
28. Strikes Have you been on strike at all during the last five years?	
29. Living with How many people do you live with? Was there someone at home to look after you when you left hospital?	
30. Marriage Are you/have you ever been married?	Single: Marr: Sep: Div: Wid:
31. (Just been married the once?)	
32. (Been/were you married a long time?)	
33. (If sep., divorced, widowed - how long have you been...?) Note cause if offered.	
34. Children How many children have you had altogether? (Note separately those died in infancy)	
35. (What ages are the children?)	
36. (Are any of them still dependent on you?)	
MARRIED MEN ONLY (Or living with 'friend')	
37. Does your wife work? Full or part-time? (What does she do?)	
MARRIED WOMEN ONLY (Or living with 'friend')	
38. What type of work does your husband do? (Again be specific)	
39. Has he a job at present?	
40. Does he ever have to work nights or his job take him away from home?	
41. Has he been unemployed in the last five years? (How many months?)	
42. Has he been off sick in the last five years? (How many months?)	
43. Has he been out on strike in last five years? (How long for?)	
44. Does it worry you when he is off work?	

ALL PATIENTS - Family 45. What about the family you came from? How many brothers and sisters did you have? (Discount those died in infancy)	
46. Were you the eldest or where did you come? (Note sex of older siblings)	
47. Parents Were both your parents at home until you were 15? Neither died or left home? (If so - age of patient when it happened) (Cause of death or departure) 48. Who brought you up?	
49. What kind of work did you father do? (Stepfather if more applicable)	
50. Childhood Would you say you had a happy childhood, a very happy one or not happy? (Expand)	Very happy: Happy: Not happy:
Area lived in 51. Were you born and brought up in this area?	
52. Have you ever lived anywhere else either in Britain or abroad at any time?	
53. You have lived in the Glasgow area for the last five years - that's since 1970?	
54. Housing 54. How many times have you moved house since 1970?	
55. Have you had any housing problems in the last five years?	
56. Is the house Corporation, Scottish Sepcial, rented from a landlord or your own?	Corp: Scottish Spec.: Rented: Owned:
57. How many rooms do you have? (Can you sit in the kitchen or is it a kitchenette?) Include if used as room.	
58. Do you have a bath or just a toilet? (Do you have to share the toilet?)	

59.	Nerves Did you ever take anything for nerves or depression in the last year? (What?) (Do you take them often?)	Often: Occasionally: Very seldom:
60.	Have you ever had a bad case of nerves or depression? (What do you think caused it?) (How long ago was that?) (Did you see a psychiatrist or go to hospital?) (Was the psychiatrist and/or hospital helpful?)	
61.	Has anyone in your family had bad nerves? (Did they see a psychiatrist about it?)	
62.	Has anyone you have lived with had bad nerves? (Did they see a psychiatrist?)	
63.	Sleep problems Do you ever have difficulty getting to sleep?	
64.	Do you find you wake up too early ever? (Note if it is need to urinate that wakes)	
65.	Produce pill bottle - Do you ever find it hard to make out the writing on pill bottles like this one? Can you read that handwriting? We are trying to get them typewritten. If does not read it - do you feel you were taught to read properly when you were at school? (Refer to school leaving if approp.)	
66.	Bereavements Has anyone close to you died in the last five or six years? (Does that still upset you very much, now and then or have you got over it?)	Relation Cause When Very upset: Now & then: Got over:
67.	Relatives Are there any of your relatives you don't see as often as you would like either because of distance or because they don't bother?	
68.	Are there any of your relatives that you see too much or get you down?	
69.	Do you ever have any quarrels or fights at home that upset you?	

70. Work and illness Do you think the work you have done has caused your illness in any way? (How?)	
71. What do you think has been the main cause of your illness?	
72. Do you often feel lonely?	Often: Occasionally: Never:
73. What do you do if you feel lonely? (Get verbatim remark)	
74. Where do you meet your friends?	No friends:
75. Do you go to a club, or have a regular lounge or meet people anywhere else?	Club: Pub:
Drinking 76. What about drinking? Has the doctor ever advised you to cut down drinking? (Is that easy for you?) 77. Roughly how much do you spend on drink in a week? 78. What sort of things do you drink usually?	
79. Family drinking Has anyone close to you had an alcohol problem - your father or anyone? (Did that worry you?)	
80. Do you have any worries that get you down? (Note if mention health here unprompted)	
81. Do you worry about your health? A lot?	A lot: Sometimes: No worries:
82. Do you feel your own family doctor has done everything he could?	
83. How satisfied were you with the Western? Very satisfied, fairly satisfied or not?	Very: Fairly: Not:
(TUCK QUESTIONNAIRE AWAY - but leave room to write)	
84. Was there anything else you feel the hospital could have done for you?	

Appendix F

Full titles of disease categories used in the World Health Organisation 'Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 1965'

Abbreviated title used in Section VIII	Full title used in ICD
Heart disease	All heart diseases (including rheumatic fever and hypertension)
Adverse reaction	All injuries and adverse reactions (except fractures, dislocations, and sprains)
Ill-defined	All systems and ill-defined conditions
Mental	All mental disorders
Digestive	All diseases of digestive system
Respiratory	All diseases of respiratory system
Peripheral circulatory	All diseases of peripheral circulatory system
Central nervous system	All diseases of central nervous system
Endocrine	All endocrine, nutritional, and metabolic diseases
Head injuries	All head injuries
Musculoskeletal	All diseases of connective tissue and musculoskeletal system
Genitourinary	All diseases of urinary system All diseases of male genital organs All diseases of breast and female genital organs
Malignant	All malignant neoplasms
Skin	All diseases of skin and subcutaneous tissue
Blood	All diseases of blood and blood-forming organs
Infectious	All infectious and parasitic diseases

BRITISH MEDICAL ASSOCIATION

FEES FOR PART-TIME MEDICAL SERVICES

(APRIL 1973)

X-RAY EXAMINATIONS

The following scale of fees has been agreed with the Department of Employment and the Department of Health and Social Security for x-ray examinations and reports undertaken for Government Departments where the work is outside the National Health Service.

Group No. 1 .. .. £p 5·30

- Extremities (one area)
- Spine (one area)
- Pelvis
- Mandible
- Teeth (restricted area)
- Salivary glands
- Chest (simple routine)
- Abdomen (plain)
- Gall-bladder (plain)
- Foreign body, demonstration

Group No. 2 .. .. £p 7·85

- Extremities (multiple areas)
- Skull (without special techniques)
- Sinuses
- Facial bones
- Mastoids and petrous bones
- Teeth (whole mouth)
- Chest (with screening or extended techniques)
- Urinary tract (plain)
- Cystography
- Urethrography
- Pregnancy (simple)
- Cephalometry
- Abdomen (with screening or extended techniques)
- Foreign body, location

Group No. 3 .. .. £p 10·40

- Arthrography
- Spine (multiple areas)
- Skull (routine plus special techniques)
- Cholecystography (complete with plain film)
- Pelvimetry (with or without cephalometry)
- Hystero-salpingography
- Barium enema
- Oesophagus, barium swallow
- Barium meal, stomach and duodenum
- Excretion urography (without plain films)
- Retrograde pyelography
- Cholangiography
- Sialography
- Tomography
- Kymography
- Fistula, exploration with contrast medium
- Femoral neck pinning, x-ray control

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- Bronchography
- Angiocardiography
- Excretion urography (complete with plain films)
- Ventriculography
- Encephalography
- Arteriography
- Myelography
- Barium meal, complete tract
- Barium meal, special small gut examination

(Category B) (Last increase April 1972)