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ILLNESSES OF LODGING-HOUSE INMATES

A Clinical Study of a Medico-Social Problem

by

P. Gordon Gaskell, M.B., Ch.B.

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"Of course they called on God: but he went his way,
Down among the Lost People like Dante, down
To the stinking fosse where the injured
Lead the ugly life of the rejected."

Auden.

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Introduction

Professor Thomas Ferguson in his classic study The Dawn of Scottish Social Welfare (1) writes "Many of the social problems that have faced administrators through the ages have hinged on the control of infectious disease, the relief of destitution, the improvement of environmental hygiene, and the provision of medical care for the people." Our present-day health, welfare and social services in Great Britain have evolved from measures taken to combat these four problems. Since the beginning of this century rapid development has taken place in the provision of medical services and from 1948, through the National Health Service, medical care has been available free to all sections of the community.

Full provision of services and the removal of any financial barrier have not, however, resolved all problems. The present study arose when it was found impossible, for various reasons, to ensure adequate medical care in ordinary general practice conditions for patients presenting from lodging-houses

Difficulties/

Difficulties both socially and in general practice organisation resulted from mixing patients from lodging-houses with patients coming from family homes. Furthermore, it appeared that the patterns of illness in lodging-house patients were so different from those of the other patients that the normal methods of providing medical care within the framework of ordinary general practice were inappropriate.

This study was pursued, then, to discover the medical and social characteristics of lodging-house patients, the problems which these characteristics created and, as far as possible, to decide how difficulties could be resolved so that this section of our community could have adequate and satisfactory medical care.

Chapter 1

Review of relevent past work.

In most of the larger towns in Britain, three types of cheap accommodation may be found - common lodging-houses, houses let-in-lodgings and working men's hotels. Premises have to be registered with the Local Authority if the charges made for accommodation are low and working men's hotels are usually exempt from registration since their charges are slightly higher.

Common lodging-houses and houses let-in-lodgings are registered in this way and come under certain regulations - in Scotland under the Public Health (Scotland) Act, 1897. The principal difference between these two is that segregation of the sexes is required in common lodging-houses. This is not so in houses let-in-lodgings, so that families may remain together.

Very little work has been published about the medical care of people from lodging-houses and there has been none concerned with clinical care where the problems first present in general practice. The work which is relevent to the present study has all been done in the past fifteen years.

In/

In 1951, Sargaison[2] carried out a medical social worker's survey of elderly men in lodging-houses in Belfast.

In 1952-54, Laidlaw[3] reviewed the Glasgow common lodging-houses and their inmates from the position of a medical officer of health.

In 1953-54, Whiteley[4] examined admissions from lodging-houses to a South London observation ward.

In 1958-59, Turner[5] undertook a medical social worker's study of a large London lodging-house.

In the present decade, the Joint Tuberculosis Council[6] estimated the incidence of tuberculosis in lodging-houses and Edwards[7] investigated the circumstances of some of the patrons of a Stepney soup kitchen.

(a.) Sargaison. Growing Old in Common Lodgings

In the latter part of 1951, Sargaison interviewed 371 men over the age of 60 living in common lodging-houses in Belfast, and discussed the results of the interviews under the headings of

Age distribution
Civil state
Social class
Outlook on life
Physical condition
Hospital admissions
Appearance
Mobility
Employment
Previous living and reasons for entering a lodging-house
Duration of lodging-house life
Hobbies
Habits
Income
Food habits
Future plans

She traced the historical development of the lodging-houses up to 1952 and described the 17 lodging-houses with about 1500 beds which were then in Belfast.

Sargaison made the assumption that living and working conditions in Belfast are comparable with those in any large industrial port in England or Scotland and that the problems of elderly lodging-house men in them would be similar. Her work is important in that, finding that there had been no previous enquiry in the United Kingdom into the social background of elderly men in lodging-houses, she/

she attempted to establish reasons why old men live in lodging-houses, to examine their living conditions and to determine which factors could improve conditions for the elderly and reduce unnecessary illness and admissions to hospital. She concluded that "the survey has brought to light various difficulties experienced by wardens and general practitioners in dealing with elderly lodging-house residents."

"The general practitioner's main difficulty lies in keeping elderly lodgers on their feet or in having to arrange for their admission to hospital when they become ill. Many of those with minor ailments are too frail to stay up all day, but yet do not really require hospital nursing care. Thus the main gap in the Welfare State legislation today is found in the lack of facilities for dealing with illness in elderly lodging-house men."

She considered that "Lodging-houses fulfil an invaluable function in the lives of homeless elderly pensioners who are unable to afford private lodgings and who are unwilling to enter a residential home. Lodging-houses will always be necessary as long as the/

the spirit of independence inspires old men to fend for themselves. Measures to make lodging-houses more comfortable and better suited to the needs of the elderly are needed while still preserving the qualities of freedom and independence."

A similar conclusion was later reached by Laidlaw who was considering both sexes and all ages.

(b.) Laidlaw. Glasgow Common Lodging-Houses and the People Living in Them.

Laidlaw's is the most comprehensive study of lodging-houses and was begun before Sargaison's work was published at a time when little was known about the constitution, health and habits of the inmates of common lodging-houses.

From 1952-54 he built up reports on 800 of the inmates of Glasgow lodging-houses on information obtained by interview, by discussion with lodging-house superintendents, relatives of those interviewed, general practitioners, and by reference to hospital records, Labour Exchange and National Assistance Board. During this period, an average of 3,200 men and 400 women were in residence in 19 male and 4 female lodging-houses.

The results of his investigations are discussed under:

Age/

Age	Present occupation
Sex	Previous other occupation
Birthplace	Number of jobs held in the preceding year.
Upbringing	War service
Civil State	State of health
Whether living relatives	Duration of residence in lodging-house
Whether contact maintained	Reason for living in lodging-house
Personal cleanliness	Meals
State of clothes	Alcohol
Source of income	Prison record
Employment state	Estimate of mental capacity and disposition.
Normal occupation	
Apprenticeship	

Part of Laidlaw's work is a description of the historical development of the Glasgow lodging-houses. From the twelfth century to the eighteenth century relief of the poor became the responsibility successively of the Church, Incorporations and the municipality. In the early nineteenth century, economic changes brought an Irish influx to the Glasgow area and people of little means, but with a flair for financial exploitation, bought property which they then converted to lodging-house use. Following on the financial success of these ventures, houses were built for the purpose - to give a good return on the provision of cheap shelter for the homeless. By 1819, it was estimated that 8,000 out of a total population of 75,169 in Glasgow lived in such lodging-houses.

With/

With each secession from its main body, the Church found increasing difficulty in maintaining its contribution to the relief of the poor and Friendly Societies arose out of public concern for the needs of these people. Social conditions in the lodging-houses came to be regarded as a public disgrace and the Model Lodging House Association was formed in 1847 by a group of philanthropists to remedy the situation. While providing better conditions than any that had existed before, the Association yet managed - by astute business methods - to show a profit and pay interest on investment. Thus the 'model' lodging-house came into being.

Inspection of lodging-houses began in 1870 and the first municipal lodging-house was opened in 1871.

The alternative to lodging-house accommodation for poor people was the city poorhouse, administered under the Poor Law Act of 1845. In this, a harsh discipline, hard work exacted in return for keep, inadequate food and a Spartan emphasis on cleanliness were the rules and many preferred the lodging-houses, the number of whose inmates rose slowly in Glasgow to a peak of almost 14,000 in 1913.

The present century saw the gradual disappearance of small common lodging-houses and their replacement by large/

large ones with modern amenities, better sanitation and the social reform which culminated in the National Assistance Act of 1948.

Laidlaw avoided the artificial distinction - which might be assumed from differences in regulations - between 'model' lodging-houses, common lodging-houses and houses let-in-lodgings, all of which serve the same function at different economic levels. "The common denominator of these premises is that they cater for working men who desire cheap accommodation and the least amount of restriction." He suggested that registration should be required on a basis of function and not, as at present, on the basis of the charge for accommodation.

Laidlaw reviewed the legislation, regulations and bye-laws introduced in the past century and a half which affect Glasgow common lodging-houses. These reflect three stages of public awareness of relationships with the inmates.

(1) Police control

(2) Public health risk

(3) Protection of health of the inmates

During the same period, the quality of buildings used for lodging-houses rose and there was a rising standard/

standard in the accommodation offered. Improvement was required in the services which had to be supplied and added amenities also improved.

Before the mode of transmission was understood, the common lodging-houses had provided the origins of major epidemics - typhus, cholera, smallpox and enteric fever. Although this was no longer so, Laidlaw concluded that "This does not mean that all the inmates of common lodging-houses enjoy good health, but it does mean that under prevailing conditions they are no more likely to spread epidemic disease than other sections of the community. It is possible, however, that the lodging-house still remains an important reservoir in the spread of pulmonary tuberculosis."

He then analysed the morbidity and mortality in Glasgow common lodging-houses and working men's hotels in 1953 on information available from notifications and hospital admissions, acknowledging the limitations imposed by being confined to these sources of information.

Among his conclusions, Laidlaw reiterated the need for lodging-houses. He held "that the lodging-houses supply a definite need in the city. Upgrading of them can only proceed at the rate of reform of the lodgers."

"There/

"There is a very clear differentiation in quality between the clientele of each lodging-house. Some achieve a high standard by refusing accommodation to dirty, drunken and disorderly characters. Others keep their profits up by admitting all. In these, summary justice is administered to those who start fights, and the police are called in to aid the superintendent to keep order. Discipline is maintained in all by the superintendent and his warders, but the standards set vary. In the Salvation Army houses drinking and spitting are rigorously prohibited and a strict set of rules enforced, although this results in the houses not being filled to capacity. Those lodging-houses having low standards fulfil a vital function in providing houses for the misfits of society. Many of the modellers are of such low mental calibre and poor behaviour that they could reside nowhere else. To introduce them as lodgers into the family circle of a tenement house would be to court disaster."

In Laidlaw's view, the advantages of the common lodging-house were cheapness, respect for privacy, liberty, general sanitary supervision and provision of very limited amenity. The principal disadvantages were the gloomy atmosphere and the risk of theft.

He/

He thought that classification of the inmates could be made in a number of ways, the membership of groups changing according to the classification used.

In relation to the present study, both Sargaison and Laidlaw have to be criticised in that they assess the health of the lodging-house inmates on quite inadequate evidence. In Sargaison's series, the elderly are classified as healthy, frail or ill, on the basis of the interviewer's assessment at the single interview. The complaints mentioned at interview are indicated and the elderly are divided by five-year age groups. Laidlaw classifies health as good, fair or bad, on the basis of the disabilities complained of in response to enquiry about the state of health. The disabilities are listed and discussed. Although all ages over 15 are included, there is no breakdown by age.

These are the only non-specialised studies which touch on the health of lodging-house inmates and in neither did the medical complaints originate with the patient and in neither was physical examination undertaken.

(c.) Whiteley. Down and Out in London.

Whiteley reported on 100 out of 130 cases admitted to a South London observation ward during 1953 and 1954 from a London County Council reception centre and two common lodging-houses. A total of 1,536 patients were admitted during the period.

Twenty-eight of the 100 were first admissions and these showed a different pattern according to whether they had been admitted from the reception centre or from the lodging-houses. Twelve (of average age 36.7 years) were admitted from the reception centre and 10 of these were schizophrenic. Sixteen (of average age 42.8 years) were admitted from the lodging-houses and 8 of these suffered from depression.

No such pattern could be shown in the 72 relapsed cases.

Whiteley suggested that the down-and-out population comes from two sources - those with asocial personality, and psychotics who lack social ties when they fall ill. He considered that homelessness derives mainly from personality defect which does not allow a man to form relationships and that alcohol is a further important factor in destroying relationships.

He/

He considered that the therapist might be accepted more easily if counselling groups were held in the reception centre or lodging-house and that, when the inmate falls ill, he should be treated in an institution similar to his normal habitat. In his opinion, group therapy may have a place and, in appropriate cases, committal for a definite period would have advantages.

(d.) Turner - Forgotten Men

The importance of Turner's work lies in the depth of consideration of the individual given in pursuing the aim of the study which was to ascertain the mental and physical need of the residents of a large London lodging-house. His work, carried through in 1958-59, was commissioned by the Gulbenkian Foundation and advised by a committee of the London Council of Social Service.

Turner found himself unable to invoke statistical support in his report. His reasons are referred to in the Discussion section of the present study.

He dealt with the relationship between the staff of the lodging-house and the residents, and discussed the latter in terms of deprivation in earlier life, intelligence and emotional difficulty, the mentally ill, the unskilled, the criminal. There was need, in his opinion, for the employment among the staff of lodging-houses of people who will understand the group needs of the inmates and who can so condition the environment of these inmates that it becomes a beneficial and not

a corruptive influence. He thought that the aim should be gradual integration of the individual with the group and of the group with the community, this to replace the segregation which exists at present.

The physical health of the residents was not assessed.

(e.) Joint Tuberculosis Council. Tuberculosis in Vagrants and Inmates of Common Lodging-Houses

This report quoted an estimate of 90,000 homeless in Britain and gave the results of an X-ray survey conducted in lodging-houses and hostels in twelve towns in England.

New active pulmonary tuberculosis was found in 0.82% of 488 persons X-rayed - an incidence thought to be twenty or more times that of the general population.

The report noted the dearth of reliable information about the homeless and the limitations of the law in the control of tuberculosis.

(f.) Edwards. London's Skid Row

"Skid Row" is a term which has come to be used in the United States of America to cover a mixed population of derelict inebriates.

Edwards, a London psychiatrist, together with three social workers, interviewed 51 regular patrons of a soup kitchen in Stepney in an attempt "to diagnose the nature of the disorder which leads men to the bombed sites and to surgical-spirit drinking, and to see whether the diagnosis can suggest action more rational and more constructive than the present policy of repetitive short-term imprisonment."

No physical examinations were undertaken but full social and medical histories were analysed. Forty-seven were found to be men with drinking problems, 2 were not really heavy drinkers, 1 was a compulsive gambler and 1 a barbiturate addict.

In Edwards' opinion "among the elements of the 'Skid Row' personality were, often restlessness, irritability, and profound difficulty in forming rewarding emotional contact." This disorder not only set a man drifting but invited him to quiet his malaise/

malaise by drinking. The end result was seen as "a way of life which fulfils the needs of a damaged personality" and not simply as the consequence of addictive drinking.

Edwards recommended the provision of lifelong hostel care designed specifically to suit the emotional needs of this group more aptly than 'Skid Row', with skilled staff who could accept and encourage dependency on the hostel. He thought that many would accept and that compulsion, for those who rejected treatment, might be invoked by re-interpretation of the Mantal Health Act.

Edinburgh Lodging-Houses

(a.) Historical development

Lodging-house development in Edinburgh has been along similar lines to that in Glasgow, as described by Laidlaw. In the 1840s, crime and violence in privately-owned lodging-houses threatened public order. An itinerant umbrella-mender, James Wemyss, was sentenced and hanged for the murder of his wife in a Grassmarket lodging-house. He was attended before his execution by the Rev. John Sym whose distress at the circumstances prompted action which led to a public meeting on 8th February, 1841. This meeting formed the Edinburgh Lodging-House Association, the immediate object of which was to provide "a place of resort for respectable labouring classes", and the ultimate object the improvement of the whole class of Lodging Houses. It was intended that charges should correspond to the means of people using the lodging-houses and that they should be self-supporting.

The Edinburgh Night Asylum had existed to provide overnight shelter for the destitute from 1840 but the first of these self-supporting Lodging-House Association houses was opened for seventy/

seventy lodgers in September 1844, at 85 West Port - its kitchen the house in which Burke committed his murders. It is still in existence and in use.

Segregation of the sexes and separate accommodation for the married developed after 1848 when the 3rd report of the Association[8] records "Indeed, it is not desirable that unmarried or single females should resort to them (the lodging-houses), as one of the greatest evils of the ordinary Lodging-Houses arises from the accommodation of both sexes in the same house."

In 1882 the city authorities required that lodging-houses should be registered, only after licence granted by the Chief Constable who had satisfied himself as to the character of the proprietor, and after a certificate from the Medical Officer of Health. Regulations[9] were now laid down governing sex separation, overcrowding of accommodation and cleanliness. Breach of regulations incurred penalties.

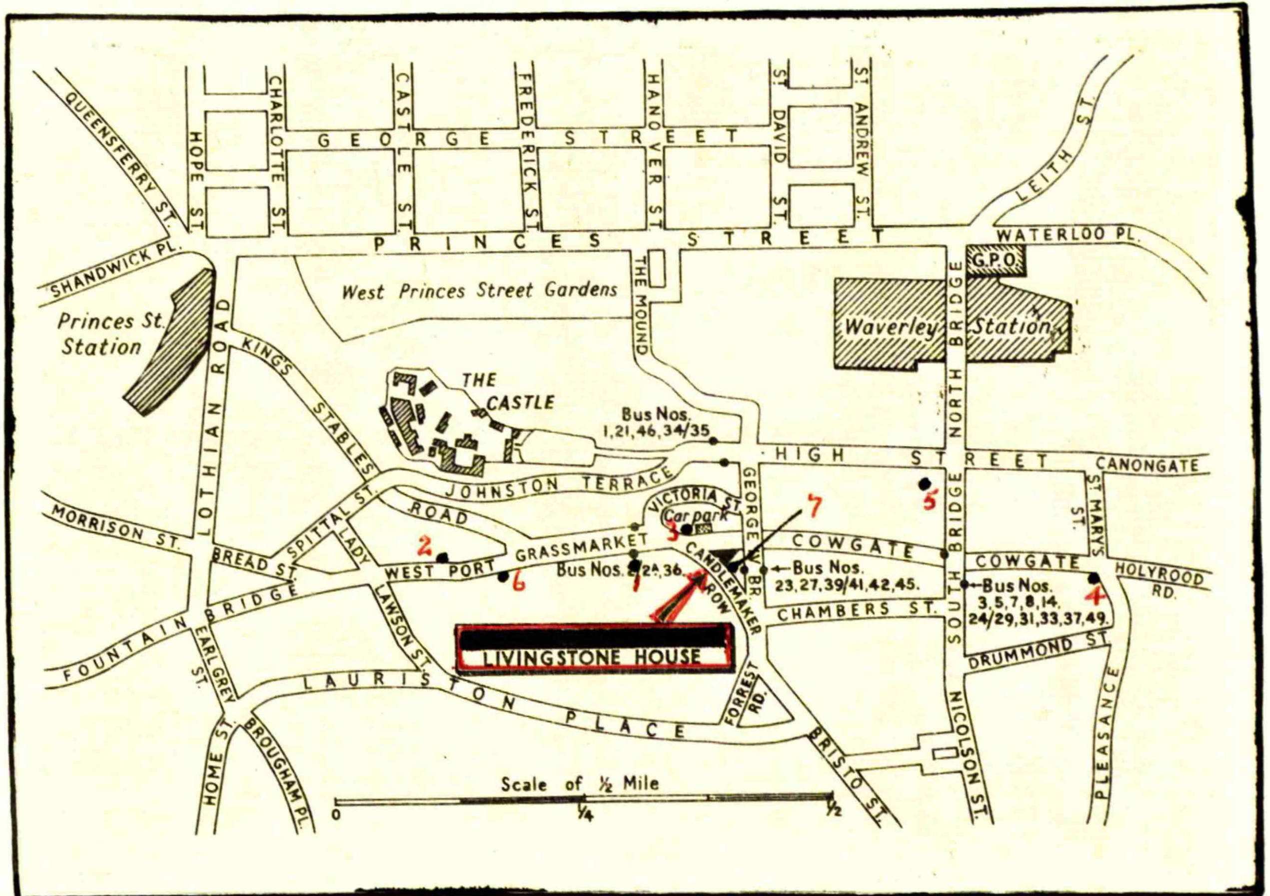
By 1888 the Burgh Engineer declared optimistically in his report[10] "Given suitable and properly adapted premises and a capable and high-toned management and, as far as possible,

a/

a separation of the sexes, and it might reasonably and confidently be expected that physically, morally, and socially this section of our city life would be fairly well provided for." There were then just over 11,000 persons in 62 licensed lodging-houses in the city.

(b.) Present situation

By the time of the present study (1964), accommodation of this nature - licensed common lodging-houses, houses let-in-lodgings and working men's hotels - was little more than a tenth of what it had been in 1888 and was contained in ten sets of premises. Seven lie within a quarter of a mile of the surgery from which this study was carried out. Their location and the number of beds in each is shown overleaf.



<u>**Men**</u>

1.	75 Grassmarket	300 beds
2.	85 West Port	62 "
3.	Greyfriars Hotel	146 "
4.	1 Pleasance	106 "
5.	1 Blair Street	114 "
		728

<u>**Women**</u>

6.	5 Vennel	74 beds
7.	3 Merchant Street	55 "
		129

<u>**Surgery at Livingstone House**</u>

For four weeks in October, 1965, the occupancy rate as estimated by the managers of these premises was 80% of their potential. They thought that four out of five of their lodgers had been resident for more than four weeks and two managers only stated that there were times in the year when people had to be turned away for lack of accommodation. Charges ranged from 3/- for night accommodation in an open dormitory to 7/6 for accommodation in a double cubicle and including breakfast.

(e.) Medical Considerations

Changes in social care have been paralleled by changes in the medical care of the poor. From 1845, under the District and Parish Councils, personal medical care of the poor was organised by the appointment of parish doctors. After applying to the Council and after examination of their financial circumstances, the destitute were referred to these doctors. The same pattern was continued following the Local Government (Scotland) Act, of 1929, the functions of District and Parish Councils having been taken over by the County and Burgh Councils.

As medical services available to the individual were developed, so the role of the general practitioner became defined as the agent through whom these services could be reached. This was foreshadowed in 1920 in the Report of the Consultative Council on Medical and Allied Services (11) - "We regard it as of primary importance that the organisation of the health service of the nation should be based upon the family as the normal unit, and on the family doctor as the normal medical attendant

and/

and guardian. It is not for disease or diseases in the abstract that provision has to be made; but for the persons liable to, or suffering from, disease. The first essential for the proper and efficient treatment of individual persons is therefore, not institutional but personal service, such as can be rendered to the people in their own homes only by a family doctor who has the continuous care of their health; to whom they will naturally turn for advice and help in all matters pertaining thereto; who will afford them such professional services as he can render personally; and who will make it his duty to see that they obtain full advantage of all the further auxiliary services that may otherwise be provided."

The National Health Service (Scotland) Act, 1947, brought about the present system whereby everyone in the population has access free of charge to the services of a personal general practitioner.
A Report of the Sub-committee of the Standing Medical Advisory Committee (1963)[12] notes, "It (the present system) has the advantage of continuity of care, available according to choice and circumstances.
Emphasis/

Emphasis on the patient's background, with the close relationship that the doctor and his supporting staff can develop with individuals and families, can provide stability and adjustability in the practice of medicine in the context of social change and new developments in clinical science."

In this setting of the National Health Service, a practice of some 2,300 patients was built up at Livingstone House as part of the Department of General Practice in the University of Edinburgh Medical School. The clinical staff of the practice consisted of two doctors, a medical social worker and a nurse, and they had the whole-time services of a secretary and receptionist. A detailed description of the functioning of this department has been published.[13]

Chapter 3

Setting of the Study.

(a.) Administrative considerations.

A general practitioner contracts with the Local Executive Council of his area to provide general medical services under the National Health Service Acts. He conducts surgeries at advertised hours when he can be approached by patients on his medical list. Patients who are unable to attend his surgery may request a domiciliary consultation. Consultation records are standardised to a simple pattern and, when a patient changes his doctor, the exchange of records from one doctor to another is effected by the Executive Councils.

In the practice in which this study was conducted, more elaborate records were kept for reasons of student teaching and research as well as patient care. Summaries of medical history were made at the time of a patient's joining and leaving the practice, and at these times additional clerical work was involved. The annual turnover of patients joining and leaving the list was, therefore, of importance in the work of the practice.

Ordinarily/

Ordinarily this turnover represents mainly changes of doctor through shifts of population. When a doctor resigns from the Medical List of an Executive Council, however, the latter - after appointing a successor - writes to his patients intimating the circumstances of the change-over. If letters are returned by the postal authorities, then the incoming doctor is advised that these patients have not been found at the address last known to the Executive Council. If these patients are not traced in the ensuing six months, they are removed from his list.

One of the partners resigned from the practice in the autumn of 1961 and approximately two-thirds of the patients were written to in this way. In 1962 the Executive Council removed 523 patients from the practice list - 23.8% of the average number of patients on the list for that year, as compared with about 10% in recent years for all Edinburgh practices.

Of these 523 patients, 281 had not been found at the end of 6 months' notice after the return of letters addressed to them, and 204 of these 281 had been/

been registered from lodging-house addresses. It seemed likely, therefore, that patients presenting from lodging-house addresses moved frequently and that clinical records maintained on a presumed pattern of permanence of abode were unrealistic.

(b.) Clinical considerations

The administrative difficulties of managing these two population groups – those from private addresses and those from lodging-houses – in identical fashion was accompanied by clinical difficulty.

The practice was at that time run without an appointment system and the waiting-room was sometimes occupied by 20 or 30 people. It became increasingly apparent that the susceptibilities of one group were being offended by the presence of the other. A young mother of good social class with two or three young and impressionable children found difficulty in adjusting to an unkempt and infested epileptic having a fit on the floor at her feet. On the other hand, a depressed and socially isolated man from a lodging-house could be upset by the presence of a woman in advanced pregnancy.

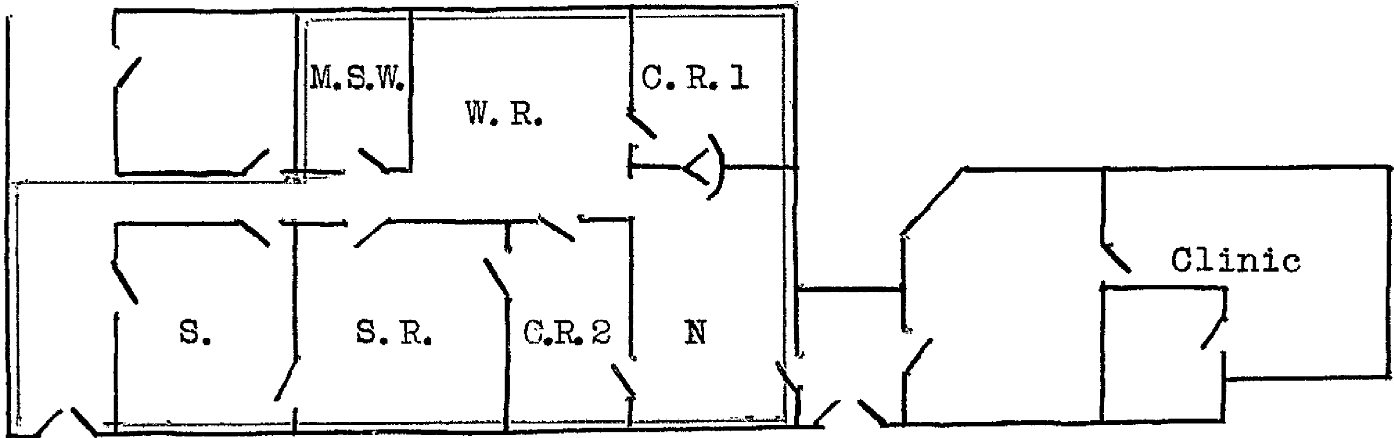
This working atmosphere was felt to be unsatisfactory both to patients from private addresses and to those from lodging-houses, and also unsatisfactory to the clinical and ancillary staff who attempted to cater for their medical needs. To resolve/

resolve these difficulties, a reorganisation of practice routine was undertaken and it was decided to separate the clinical care of lodging-house patients from that of others.

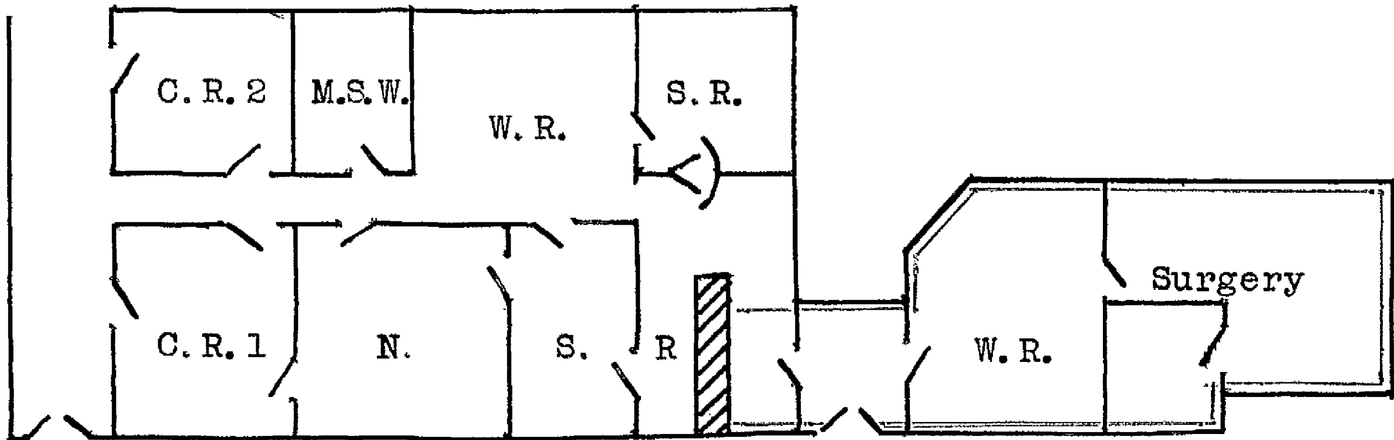
The accompanying diagrams indicate the room arrangements which were used before and after the re-organisation.

Surgery premises

Before - All patients seen in the premises enclosed by the red line.



After re-arrangement - Patients from lodging-houses only seen in premises enclosed by the red line.



N	=	Nurse	S. R.	=	Staff room
S	=	Secretary	W. R.	=	Waiting room
R	=	Receptionist	C. R. 1	=	Consulting room 1
MSW	=	Medical Social Worker	C. R. 2	=	Consulting room 2

Advantage was taken of the regulations under the Health Service whereby persons who did not expect to be at one address for a period greater than three months should register with a doctor on a temporary basis only. It was thought that patients from lodging-houses were so likely to be leading an unstable mode of life that they could be registered in this fashion and a separate and simplified filing system of their records was begun.

A retrospective check on the work load of patients from lodging-houses during 13 weeks of the busiest period of the preceding winter suggested that, if an appropriate scatter could be arranged, then these patients might be seen between 9 and 10 a.m. on week-days, assuming a consultation rate of 8 patients per hour. If necessary, return appointments were given for 9 a.m. on a day of the doctor's choosing. In practice, the lodging-house patients quickly fell into this pattern of attendance and, apart from the arrangements outlined, they were for a year thereafter treated in no way differently from patients who presented from private addresses.

(c.) Retrospective review.

During the year 1st November 1962 to 31st October 1963, 586 patients presented from lodging-houses and recorded 2,426 surgery consultations. 384 (65.5%) of these patients had not been seen previously.

The daily attendance varied from 3 to 18 patients, and the weekly variation was from 20 to 90. The weekly consultation rate was below 50 in the months from April to September and more than 50 from October to March. Seasonal variation also occurred in the pattern of patients presenting for the first time, a higher number presenting consistently from August until February.

Analysis of the age and sex breakdown of consultations in the last four weeks of the year showed a male:female ratio of almost 4:1, both sexes being represented at all age groups from 20 into old age.

The diagnoses at consultations for this last four weeks were classified. Of a total of 208 consultations, 47 were for disease of the musculo-skeletal system and integument,

38 for pulmonary tuberculosis or bronchitis, and 33 for mental illness or alcoholism.

The clinical experience of the year, and the findings which could be made retrospectively, suggested three conclusions:

1. that a majority of patients presenting from lodging-houses suffered from some form of permanent disability.

2. that the patterns of disease exposed were not to be found normally in general practice.

3. that the clinical habits which were being adopted in this separate situation were more effective than those which had been used in the practice. This implied that a conventional general practice approach using the present machinery for medical care was inappropriate when dealing with patients from lodging-houses.

(d.) Plan of study

Certain administrative changes were now made so that continued recording would allow confirmation or refutation of these hypotheses.

As before, patients from lodging-house addresses presented to the receptionist and were shown into a separate waiting-room from which the doctor called them in turn for consultation. They were then directed back to the receptionist to make a return appointment or to be discharged. As far as possible, the services of the nurse and medical social worker were kept to a minimum but, for referral purposes, the doctors used the services of the practice secretary.

A further modification of records was devised. Examples of the records used are shown in Appendix 1.

Two points deserve particular attention:

(1) After 1st February 1964, a specially planned history was taken on the first occasion that each patient presented, and was recorded on the green card shown. Social data were recorded on the facing side and the presence or absence of ten medical conditions on the reverse.

These/

These were conditions thought to be important in this situation and for which the consulting doctors devised the following definitions.

1. <u>Chronic bronchitis</u>

There is a history of cough and spit of at least two years' duration, either continuously or at least through the winter.

2. <u>Pulmonary Tuberculosis</u>

Pulmonary tuberculosis diagnosed at any stage in the patient's life and confirmed radiologically, provided it has progressed beyond the primary complex stage.

3. <u>Mental Defect</u>

Patients who have been found by formal test to have an I.Q. below 70, or who have attended a special school for the mentally handicapped, or been an inmate in an institution for mentally handicapped.

4. <u>Chronic alcoholism</u>

Excessive consumption of alcohol sustained over a period and associated with one or more of the following:

Loss of employment
Breakup of family
Imprisonment
Recurrent ill-health

5/

5. Epilepsy

Patients who have had a diagnosis of Grand Mal made by a doctor and for which treatment has been prescribed. Where this diagnosis is accepted by the authors this constitutes epilepsy.

6. Other Psychiatric disorders

Any person who has been an in-patient in a mental hospital.

Nos. 3, 4, 5 and 6 are to be regarded as mutually exclusive. 'Psychiatric' will therefore be limited to patients who have been in a mental hospital at some time in the past and are not put into one of these other three categories.

7. Cardiac disease

This will be coded only when one or more of the following are present in patients under the age of 65:

(a) congenital heart disease
(b) valvular disease of the heart
(c) angina pectoris
(d) coronary thrombosis
(e) congestive cardiac failure

8. Arthritis

Any form of arthritis in which the diagnosis has been made in hospital and/or has been confirmed by X-ray examination.

9./

9. <u>C.N.S.</u>

Any organic change in the C.N.S. not included in the above.

10. <u>Malignant disease.</u>

Patients in whom malignant disease has, at any time in the past, been diagnosed by a doctor.

(2.) A daily work sheet was planned to record the pattern of each consultation.

Consistency of diagnostic terminology between the two doctors staffing this surgery was achieved during the month of January 1964.

The code designed to chart the pattern of referrals took account of the unusual concentrations of mental illness and chest illness.

Chapter 4

Results of the Study

I. Social and Medical Aspects of the Group

The study was carried out from 1st February, 1964, to 31st January, 1965.

The data offered have been extracted from case records primarily and from the day-sheets and home visits book. The different aspects which have been studied, and for which tables are produced in support of argument, are taken in the following order:

(a) Social Data

(b) Chronic Handicapping Illnesses

(c) Pattern of consultations

(d) Referrals

(e) Domiciliary visits

(f) Deaths

(a) Social Data

The only other non-specialised survey of people in all age-groups from lodging-houses is Laidlaw's and comparison with Laidlaw's figures has been made as far as possible to show certain striking factors which are common to the two studies. Differences also appear and it will be appreciated that the patients in the present survey are selected to the extent that they have all sought medical advice, whereas in Laidlaw's study an attempt was made to survey a lodging-house population in unselected fashion.

Table 1. Age and Sex

Laidlaw

	M.	%	F.	%
-25	21	3.6	13	6.0
-45	118	20.3	49	22.5
-65	220	37.8	93	42.7
65+	223	38.3	63	28.9
Total	582		218	

Gaskell

	M.	%	F.	%
-25	15	4.0	9	11.8
-45	113	30.2	27	35.5
-65	183	48.9	28	36.8
65+	63	16.8	12	15.8
Total	374		76	

As compared with usual experience in general practice, the outstanding difference is in the ratio of male to female patients, men being present almost five times as frequently as women. The other factor which these tables demonstrate and which is of importance/

importance, is the high proportion of patients who fall into the age groups in which physical and social competence is likely to be diminished - 64% of the patients were over 45 years of age.

Table 2. Civil State

Laidlaw

	M.	%	F.	%
Married	18	3.1	27	12.4
Single	377	64.8	71	32.6
Widowed	89	15.3	75	34.4
Divorced	5	0.9	8	3.7
Separated	93	16.0	37	17.0
Total	582		218	

Gaskell

	M.	%	F.	%
Married	20	5.3	10	13.2
Single	223	59.6	26	34.2
Widowed	37	9.9	7	9.2
Divorced	17	4.5	3	3.9
Separated	77	20.6	30	39.5
Total	374		76	

This table indicates how very few have supporting marital relationships.

Table 3. Contact with relatives

Laidlaw

	M.	F.
Frequent	136	69
Occasional	146	41
None	300 (51.5%)	108 (49.5%)
Total	582	218

Gaskell

	M.	F.
Spouse	32	12
Children	23	18
Other relatives	124	17
None	195 (52.1%)	29 (38.2%)
Total	374	76

Different criteria have been used in preparing these tables but it can be clearly seen from both of them that there is a very high percentage without any form of family support. In the present survey, contact with/

with relatives has been recorded in the order shown avoiding multicoding. 51% in Laidlaw's survey and 50% in the present survey had no contact with any relatives.

Table 4. Occupation

Laidlaw

	M.	%	F.	%
Skilled	194	33.3	42	19.3
Semi-skilled	110	18.9	54	24.8
Unskilled	276	47.4	61	28.0
None	2	0.3	61	28.0
Total	582		218	

Gaskell

	M.	%	F.	%
Skilled	52	13.9	8	10.5
Semi-skilled	50	13.4	8	10.5
Unskilled	264	70.6	52	68.4
None	8	2.1	8	10.5
Total	374		76	

Laidlaw's classification was on the basis of the person's normal occupation and the present study on the basis of their most recent occupation. The Registrar-General's classification of 1951 was used in each case.

The very high percentage of unskilled is obvious from these tables.

Table 5. Employment State

Laidlaw

	M.	%	F.	%
Employed	94	16.2	19	8.7
Unemployed	273	46.9	107	49.1
Retired	211	36.3	83	38.1
Other	4	0.7	9	4.1
Total	582		218	

Gaskell

	M.	%	F.	%
Employed	112	29.9	13	17.1
Unemployed	216	57.8	48	63.2
Retired	46	12.3	14	18.4
Other	0	0	1	1.3
Total	374		76	

In the present study more than half of the patients were unemployed. 48% were unemployed in Laidlaw's survey in which a smaller proportion were in employable age-groups.

Table 6. Income Source

Laidlaw

	M.	%	F.	%
Wages	100	17.2	28	12.8
N. A. B.	124	21.3	98	45.0
NAB(suppt.)	316	54.3	81	37.2
Pension	42	7.2	10	4.6
Other	0	0	1	0.5
Total	582		218	

Gaskell

	M.	%	F.	%
Wages	114	30.5	12	15.8
N. A. B.	123	32.9	36	47.4
NAB(suppt.)	30	8.0	6	7.9
M. N. I.	51	13.6	5	6.6
Pension	33	8.8	5	6.6
Other	23	6.1	12	15.8
Total	374		76	

The pattern of statutory social support has altered in the time between the two studies but from both tables it is obvious that a high percentage live at the level of National Assistance support which presumes a state of social need.

In the next three tables there is no recording in Laidlaw's survey which allows reasonable comparison.

Table 7. Length of employment during previous year.

Months worked	M.	%	F.	%
0	160	42.8	45	59.2
1 - 3	37	9.9	10	13.2
4 - 6	32	8.6	7	9.2
7 - 12	145	38.8	14	18.4
Total	374		76	

46% are seen to have done no work in the year previous to their attendance at the surgery and a further 10% to have worked for three months or less.

Table 8. Length of stay in Edinburgh

Duration	M.	%	F.	%
$<$6/12	180	48.1	41	53.9
6/12 - 1 yr.	23	6.1	3	3.9
1 - 5 yrs.	48	12.8	6	7.9
5+ yrs.	123	32.9	26	34.2
Total	374		76	

49% of patients attending had been in Edinburgh for less than 6 months.

Table 9. Length of stay at presenting address

Duration	M.	%	F.	%
1/52	80	21.4	18	23.7
1 - 4/52	70	18.7	19	25.0
1 - 6/12	87	23.3	13	17.1
6/12 - 1 yr.	34	8.1	6	7.9
1 - 5 yrs.	59	15.8	10	13.2
5+ yrs.	44	11.8	10	13.2
Total	374		76	

64% had been less than 6 months at the address from which they first presented.

The foregoing tables allow some observations to be made on this group of people taken together.

A majority are in age groups when social competence is likely to diminish and lack family relationships so that they are without close social support in face of stress.

A majority are unskilled and a majority unemployed. Many live on low incomes in consequence, often with need for financial assistance to maintain themselves.

Although a proportion have been in one town and at one address for many years, it seems likely that a majority move frequently.

These/

These conclusions can be justified from the present study for those who attend a general practitioner. Where Laidlaw's tables duplicate the suggestions, they appear to apply to the larger population of lodging-house inmates.

(b) Chronic Handicapping Illnesses

The definitions which were used for these conditions had been agreed following a year's experience by the two doctors conducting the study and after considerable discussion. At that time, the important factor had seemed to be the functional handicap under which the patient lived and this had to be established during a brief structured history-taking as part of the first consultation. Somewhat crude definitions emerged therefore and, by more usual standards, even higher figures in respect of these illnesses might be obtained. The preliminary experience had also shown that there was likely to be coincidence of more than one of the following conditions in one patient - mental deficiency, alcoholsim, epilepsy and psychiatric illness. It was agreed, therefore, to code these in that order. Thus, if an alcoholic were also epileptic, the latter condition would not be shown. In these four conditions, therefore, the number shown in the table is not necessarily the total suffering from that condition.

Table 10. Chronic handicapping illnesses

	Mental Deficiency	Chronic Alcoholism	Epilepsy	Psychiatric Illness	Chronic Bronchitis	P.T.B.	Cardiac	Arthritis	C.N.S.	Malignancy
Mental Deficiency	6				1	0	0	0	1	0
Chronic alcoholism		40			10	7	1	3	3	0
Epilepsy			18		4	0	0	1	0	0
Psychiatric Illness				58	8	3	2	4	2	0
Chronic Bronchitis	1	10	4	8	78	12	5	6	4	4
P.T.B.	0	7	0	3	12	38	2	4	4	2
Cardiac	0	1	0	2	5	2	20	1	2	1
Arthritis	0	3	1	4	6	4	1	33	5	1
C.N.S.	1	3	0	2	4	4	2	5	24	1
Malignancy	0	0	0	0	4	2	1	1	1	15

(1) In this study the first four diagnoses were grouped and regarded as being mutually exclusive, so that the number in each category within that group is the number exclusive of persons in any of the categories higher in the table.

(2) The abscissa, read against the ordinate, gives the number of any two conditions which co-existed, with the above provision.

Table 10a. Chronic handicapping illnesses by age, sex and employment state.

	Employment State	Men (374) Age 15-	25-	45-	65-	Total	%	Women (76) Age 15-	25-	45-	65-	Total	%	Both sexes Total	%
al	E	-	-	-	-			-	-	-	-				
iciency	U	-	1	3	-	4	1.1	-	2	-	-	2	2.6	6	1.3
	R	-	-	-	-			-	-	-	-				
nic	E	-	2	4	-			-	-	-	-				
holism	U	-	8	17	1	34	9.1	-	1	5	-	6	7.9	40	8.9
	R	-	-	-	2			-	-	-	-				
	E	1	1	-	-			-	-	-	-				
lepsy	U	-	5	11	1	17	4.5	-	-	1	-	1	1.3	18	4.0
	R	-	-	-	-			-	-	-	-				
chiatric	E	-	2	6	-			-	2	-	-				
ness	U	3	17	17	-	47	12.6	-	6	3	-	11	14.5	58	1[illegible].9
	R	-	-	-	2			-	-	-	-				
onic	E	1	1	9	1			-	2	1	-				
nchitis	U	-	9	28	7	66	17.6	-	2	6	-	12	15.8	78	17.3
	R	-	-	-	10			-	-	-	1				
	E	-	1	5	-			-	1	-	-				
.B.	U	-	4	16	2	35	9.4	1	-	1	-	3	3.9	38	8.4
	R	-	-	-	7			-	-	-	-				
	E	-	1	3	-			-	-	-	-				
diac	U	-	2	6	1	16	4.3	-	1	1	-	4	5.3	20	4.4
	R	-	-	-	3			-	-	-	2				
	E	-	2	3	1			-	-	1	-				
hritis	U	-	3	7	1	26	7.0	-	2	2	-	7	9.2	33	7.3
	R	-	-	-	4			-	-	-	2				
	E	-	-	2	-			-	-	-	-				
.S.	U	-	3	12	1	21	5.6	1	-	1	-	3	3.9	24	5.3
	R	-	-	-	3			-	-	1	-				
	E	-	-	-	1			-	-	-	-				
ignancy	U	-	1	10	-	13	3.5	-	-	-	-	2	2.6	15	3.3
	R	-	-	-	1			-	-	-	2				

E = Employed U = Unemployed R = Retired

Considering those below retirement age, only among the men suffering from arthritis is the number of unemployed equalled by the number in employment. In the other groups, the ratio of unemployed to employed is nowhere less than 2 to 1.

Of the 450 patients in the study, 249 (55.3%) were found to suffer from one or other of these ten serious and handicapping illnesses. Mental illness and respiratory disease occurred with greatest frequency. These illnesses tend to chronicity and exacerbation, or recrudescence.

(c) Pattern of consultations

Comparison of one pattern of consultations with another is always open to the criticism that different observers will record using different criteria. Reference has been made to the consistency which was established by the two doctors conducting this study and the best outside study for comparison (which offers least risk of upsetting observer bias because of its scale) is the G.R.O. Study No. 9 [14]. Table 4 of this study analysed 128,527 consecutive consultations occurring in one year in nine practices selected from different parts of England and from urban and rural areas.

The tables presented have been constructed from Table 4 of the G.R.O. study and from the day-sheets used in the present study.

Table 11/

Table 11. Comparative frequency of chronic handicapping disease in consultations.

	Rate per 1000 consultations	
	G. R. O.	Gaskell
Mental deficiency	0.5	9.6
Alcoholism	0.2	35.4
Epilepsy	5.0	45.7
Psychoses	1.3	74.7
P. T. B.	7.2	50.0
Angina pectoris	1.9	6.1
Coronary artery thrombosis	5.0	3.6
Rheumatoid arthritis	5.3	21.8
Osteo-arthritis	7.5	12.5
Carcinoma of lung	3.1	22.5
Fractures	6.7	45.0
Varicose veins	9.8	1.8
Pernicious anaemia	2.9	2.9
Anaemia, other	7.1	8.2

2798 consultations

Note.

In the present study the principal diagnosis only was recorded.

In the G. R. O. study, where more than one disease was diagnosed at a consultation(multiple-diagnosis consultations) each has been fractionally weighted according to the number of different diseases diagnosed. The resulting "weighted" consultations in this table therefore correct the overstatement caused by counting each disease separately.

This shows the disproportionate frequency of consultation in the present study of most of the handicapping illnesses already considered. The number of times by which consultation frequency was increased was:

Mental deficiency	19	Angina	3
Alcoholism	177	Rheumatoid arthritis	4
Epilepsy	9	Osteo-arthritis	2
Psychoses	57	Carcinoma of lung	7
P.T.B.	7		

Fractures were almost seven times as frequent. consultation frequency was less for coronary artery thrombosis and five times less for varicose veins. Frequency was the same for pernicious anaemia, and almost the same for other anaemias.

Table 12. Patterns of diagnoses at consultations

	Diagnostic group	%
Respiratory disease	547	19.5
Mental disease	537	19.2
Musculo-skeletal disorder	511	18.3
Skin disease	214	7.6
Alimentary disease	196	7.0
Cardiac	124	4.4
Arthritis	96	3.4
Neoplasm	80	2.9
Neurological	56	2.0
Vascular	54	1.9
Ophthalmic	48	1.7
Urinary	35	1.3
Anaemia	31	1.1
Obstetric	26	0.9
Ears	17	0.6
Endocrine	14	0.5
Gynaecological	11	0.4
Symptoms	201	7.2
	2798 consultations	99.9

The consultation patterns again show the great frequency of the first three groups of illnesses - illnesses requiring intensive medical support and, by virtue of their concentration, beyond the resource of ordinary general practice. Respiratory disease, mental disease and musculo-skeletal disorder together accounted for 57% of consultations.

The consistency with which consultation diagnoses were made may be judged from the proportion carried through by the two doctors primarily concerned with this work. During holidays, 423 consultations were conducted by two other doctors who were familiar with the study and the pattern of recording.

P.G.G.	1289
D.C.M.	1086
Others	423
	2798

The

The figures shown below indicate the monthly variation which is affected by at least two factors - seasonal variation in illnesses such as chronic bronchitis for which a large number of consultations is sought, and seasonal mobility of a proportion of the population who find farm or construction work in the summer or who go "on the road".

	Surgery Consultations
January	221
February	240
March	268
April	260
May	265
June	218
July	207
August	204
September	233
October	238
November	222
December	222

(d) Referrals

The medical referrals to hospital outpatient departments have been shown in the same form as in "The Edinburgh Hospitals"(15) so that the two studies can be directly compared. "The Edinburgh Hospitals" analysed the hospital referrals of 30 general practitioners in 10 practices for a period of eight weeks in May/June, 1962.

Table 13. Referral to Hospital Out-patient Departments

	"The Edinburgh Hospitals"		Gaskell	
	No.	%	No.	%
General surgery	3475	22.6	28	17.3
E.N.T.	1953	12.7	3	1.9
Dermatology	1512	9.8	10	6.2
General Medicine	1423	9.3	20	12.3
Ophthalmology	1256	8.2	5	3.1
Orthopaedics	1210	7.9	20	12.3
Gynaecology	935	6.1	1	0.6
Paediatrics	794	5.2	0	0
Urology	417	2.7	2	1.2
Chest	302	2.0	28	17.3
Dietetic and Diabetic	289	1.9	1	0.6
Psychiatric	273	1.8	32	19.8
Other	1518	9.9	12	7.4
	15,357	100.1	162	100.0

The difference in referral patterns is apparent and is seen to have justified the separate coding for mental hospital and chest clinic referrals which were eleven/

eleven and nine times as frequent as in "The Edinburgh Hospitals". It should be noted that this enquiry was carried out in two summer months.

In the present study the rate of referral to hospital outpatient departments as a percentage of consultations was 5.8, as compared with 3.1% in the G.R.O. study and 3.1% also in a study conducted by Scott[(16)] in the same practice but at an earlier point in time.

Nine direct admissions were arranged from the 2,798 consultations, representing 0.32%. The G.R.O. study gave 0.5% (range 0.3% to 0.8%) and Scott's study 0.7%.

Mass miniature radiography

60 referrals were made and no record is available for 13. (From experience it seems likely that the patients did not attend.) Of 47 which are documented, 35 were negative and the remaining 12 were as follows:

4 referred to chest clinic for further investigation
3 healed tubercle
1 old pleural thickening
2 inflammatory, of which one later resolved and one did not return
1 hypertension and chronic bronchitis
1 old shrapnel wound

Other/

Other open access X-ray referrals were made on 6 occasions. All of these were for barium meals and two were for the same patient at the beginning and the end of the year. In these two, and in two other referrals, active duodenal ulcers were shown, on one occasion there was deformity of the duodenum and in the last examination findings were normal.

12 other miscellaneous medical referrals were made:

5 Ophthalmic Services Certificate 1
4 Foot Clinic
1 Davidson Clinic (Psychotherapy)
1 Hearing Aid Clinic
1 Letter to new doctor

Referrals to statutory social services were as follows:

National Assistance Board	20 male and 6 female
Ministry of Labour	7 male and 1 female
M.P.N.I.	2 male and 0 female
Regional Medical Officer	18 male and 0 female
City Social Services	11 male and 3 female

Referrals to local authority services were chiefly for disinfestation. There were 13, including one female. There was one male referral for Part III accommodation.

Of referrals to voluntary social services/

Of referrals to voluntary social services, 4 males and 1 female were to the W.V.S. for clothing. There were 5 other female referrals - 4 to lodging-house managers and 1 to an employer.

Table 13 shows the relative frequency in referrals of conditions which require long-term hospital support. There were relatively few referrals to statutory social services and, with the exception of the W.V.S. clothing referrals, the absence of referral to voluntary social services is equally apparent.

(e) Domiciliary visits

During the year of the study, 96 domiciliary visits were made in consequence of requests made at the surgery. Records are inadequate in 12 of these visits, but 84 are fully documented and can fairly be compared with the next visit after each requested in the practice from the same surgery premises.

Table 14. Comparison of Domiciliary Visits

		Lodging-house	Practice
Sex	Male	59	32
	Female	25	52
Age group	0-	0	35
	15-	0	18
	25-	11	17
	45-	30	7
	65-	43	7
Disposal	Admit	29	5
	Refer	8	5
	Revisit	3	21
	Attend surgery	16	17
	"Off"	28	36
Doctor attending	P.G.G.	33	37
	D.C.M.	35	32
	Trainee	5	4
	Other partner	11	11
	TOTAL VISITS	84	84

The/

The table compares the patterns in respect of age, sex and disposal. There are striking differences in all of these.

The sex ratios and the gradients of age groups are reversed while the hospital admission rate is almost six times higher in the lodging-house patients. That this difference is not a consequence of different medical attitudes in the doctors attending is obvious from the figures which show that almost the same number of visits was made by each doctor in each of the groups.

29 Lodging-House Admissions

That hospital admission was not a function of the doctor attending is seen from the pattern of admissions as compared with total attended.

	P.G.G.	D.C.M.	Trainee	Other Partner	
Hospital Admissions	12	15	1	1	Total2
Domiciliary Visits	33	35	5	11	Total8

The/

The hospitals which were used for the 29 admissions were as follows:

Royal Infirmary	9
City Hospital	7
Eastern General Hospital	3
East Fortune	3
Longmore Hospital	2
Chalmers Hospital	1
Northern General Hospital	1
Edenhall Hospital	1
West House Mental Hospital	1
Not known	1
	29

This spread of admissions indicates that the high admission rate does not stem from local facilities specialising in illness from lodging-houses.

The diagnoses, when grouped, show the following pattern:

Respiratory disease	12
Psychiatric illness	5
Trauma	4
Malignancy	3
Congestive heart failure	2
Perforation	2
Anaemia	1
	29

Examination/

Examination of the referral letters shows that the written down indications for admission could be classified under the following headings:

Medical	11
Social	3
Medical and social	7
Emergency order	1
No copy of letter available	7
	29

22 of the patients admitted were men and 7 women. 14 of the men and 6 of the women had no contact with any relatives.

This study of domiciliary visits again shows the exceptional concentration of serious illness occurring in this population, the lack of domiciliary resource to deal with it, and the absence of family support when illness supervenes.

(f) Deaths

Within two years from the start of the study, eighteen deaths among the patients have come to attention. Other deaths may have occurred among people who have moved away from the area and no comparison is possible.

Table 14 A. Causes of death (grouped)

Malignancy	7
Respiratory infection	4
Heart disease	3
Sudden death - police notification	2
Pulmonary embolism	1
Monocytic leukaemia	1
	18

Table 14B. Deaths by age and contact with relatives

	Age group				Contact			
	15-	25-	45-	65-	Spouse	Children	Other Relatives	None
Male	-	-	12	4	0	1	5	10
Female	-	-	0	2	0	1	0	1

Table 14B shows strikingly, however, the absence of contact with near relatives among sixteen of the eighteen known to have died.

II. Personal Aspects

The foregoing section deals with aspects of the study which can be quantified and compared. Other aspects of the work cannot be dealt with in this way but may be no less useful.

Four aspects have been considered:

(a) Reasons for being in a lodging-house

(b) The patient's view of his medical handicaps

(c) Clinical Problems

(d) Geographical distribution of the birth-places of patients

(a) Reasons given by patients for their being in lodging-houses

Turner, who points out the difficulty in arranging controlled observation and the advantages to the observer of being a participant in this social situation, contends that deprivation, aggravated by poor hereditary and environmental conditions, leads to maladjustments, and that it is not possible to assess the part that intellectual handicap or emotional difficulty have played in shaping personality. The mentally ill, and particularly the alcoholics, are not specifically lodging-house problems and their presence in lodging-houses is a reflection on the local authority and the Regional Hospital Board. The limited skill possessed by many lodging-house inmates is a major problem and into the general pattern of immaturity is woven a thread of delinquency. Turner considers that there is immaturity in three-quarters of the criminal population in this country and homelessness in one-third of people who have been more than once in prison. Many of these people need the reassurance of a supportive discipline.

In/

In the present study, with the observer similarly participating in the social situation, questions were asked of 99 people to elicit their reasons for being without homes and in lodging-houses. There was no attempt at controlled selection - indeed questioning on this subject proves to be such an intimate matter that truthfulness of response cannot be relied upon. Trust in the questioner becomes a major factor in obtaining accurate information. Random selection cannot take account of trust built on previous acquaintance and seems unlikely to give a more reliable result.

The reasons offered for the patient's being in a lodging-house could be grouped fairly simply as under:

Relationships
Health aspects
Homelessness
Financial considerations
Work considerations
Personal preference

Breakdown of these groups showed the following conditions:

Relationships:

Marriage break-up	20
Death of parents or grandparents	7
Death of wife	4
Family conflict	5
Loneliness/Companionship	2

Health aspects:/

Health aspects:		
	Drink	9
	Hospitalisation	4
	Mental illness	1
	Low intelligence	5
	Parental illness	1
	Illegitimacy	2
Homelessness:		
	Unable to get rooms	6
	Pressure on family accommodation	5
	House sold/demolished	2
Financial:		
	Poverty	10
	Convenience for N.A.B.	1
	Saving for marriage	1
Work:		
	Leaving employment	2
	Convenient for work	6
Personal convenience:		6

Although these were the primary reasons given by the patients for their being in lodging-houses and although these were supported by what was known of their life and medical history, subsidiary reasons often contributed and rationalisations were sometimes added to give socially acceptable justificatior for the situation. Often, also, where more than one reason was given, there was difficulty in deciding which was the primary cause. Thus, where marriage break-up was the cause, the patient might be alcoholic and the alcoholism the reason for the marriage break-up. Lodging-house life would be undertaken, however, only/

only when social separation occurred. Psychopathy was sometimes present also and, in relation to marriage break-up, was usually of aggressive type. Where the death of parent or grandparent was given as reason, inadequate psychopathy was sometimes an underlying factor. The death of a wife was seldom in itself immediate reason for a man going into a lodging-house, but the social deterioration which ensued after his wife's death sometimes led eventually to this. In situations of family conflict, drink or mental illness (usually instability of personality) became an intolerable burden for a sister or a niece who could not maintain social decencies while trying to keep house for a deteriorating relative.

Two of the men who offered relationship reasons provided examples of how attitudes affect adaptation to circumstances. One man of 70, separated from his wife for 8 years and living alone in a pensioner's flat, gave this up to escape the loneliness of his existence and returned to Scotland in the hope of finding companionship. His primary motive, therefore, was to escape from loneliness and he was unhappy in his lodging-house surroundings./

surroundings. He suffered from chronic bronchitis. The other patient was a man of 51 who had no contact with his relatives, who had a past history of T.B. and of mental illness and who also suffered from chronic bronchitis. He gave as reason for moving into a lodging-house the positive one of desire for companionship and, although he lived in social circumstances which were inferior to those of the first man, he appeared to be happy in his surroundings.

"Health aspects" usually implied alcoholism or some form of mental illness. An alcoholic was often someone who had taken to drink in his late teens or early twenties and was then, as a rule, a single man. Sometimes, however, an older man took to drink, perhaps following on the death of his wife, and became alcoholic in a short space of time and reached the lodging-house by this path. When hospitalisation was offered as reason, it appeared that a landlady would take the opportunity of reletting accommodation while an unwelcome lodger was in hospital and on his discharge he had little alternative but to move into a lodging-house as his first pied-à-terre. Moving back into/

into private accommodation was then beyond the resources of somebody who was in mental ill-health. Low intelligence was not, of course, given as reason and patients have been put into this group where they were of low intelligence and did not know why they lived in lodging-houses.

Parental illness and neglect was advanced probably correctly by one man whose father appeared to have been an inadequate psychopath and whose mother, after her husband's death, became an alcoholic prostitute. This patient had low intelligence and suffered from epilepsy and chronic bronchitis but had remarkable insight into his own way of living.

Where homelessness was given as reason, the problem might have arisen from illness in the patient or from lack of resource in a family. Where a man was unable to get rooms, then drink or mental instability was frequently the underlying cause and the reason offered was simply projection. On the other hand, pressure on family accommodation could mean that an elderly man had to find accommodation in a lodging-house because a niece was having a baby and required the total of her domestic accommodation.

Where/

Where poverty was his reason, the patient was usually unskilled and without the initiative to find 'digs', the cost of which would be borne by the Assistance Board in the event of his being unable to find work which would pay for the accommodation. One man, however, cheerfully offered the reason that it was easier to get money from the National Assistance Board if you came from a lodging-house address, and another young man gave the somewhat unusual reason that he was saving to get married. This man had been brought up in a home and had seen no reason previously to save money. He had decided on marriage and was trying to find a way of life which would allow him to save as much money as possible in a short space of time.

In respect of work, two men had moved into lodging-houses on leaving work which they found uncongenial - one in a circus and the other on trawlers. Six others, however, were moving around the country in casual work and used lodging-houses in consequence as a matter of convenience.

Another six patients offered reasons of personal convenience according to the pattern of their separate lives. One unskilled Irishman stated that "they/

"they was good" by contrast with some private accommodation of which he had experience and another footloose man, after separation from his wife, spent his life in work camps or in lodging-houses when he could not find someone with whom to cohabit.

These reasons broadly confirm Turner's observations and it would seem that disturbed relationships, often a consequence of mental illness or alcoholism, and immaturity of personality, usually implying an absence of personal skills, are so frequently to be found in patients from lodging-houses and so often relate to the reasons which they advance for their being in this situation, that they cannot be overlooked when considering causes. It is, however, almost impossible in any one case to be certain in retrospect that any one factor has been critical.

(b) The patient's view of his medical handicap

These patients were also questioned to establish what, in their view, constituted their principal medical handicap.

The answers were quite unpredictable. Occasionally a man stated that he was fit and had no medical handicap. A straight-forward skeletal limitation would often be clearly described - as by a man who fractured his thumb in a fall. Sometimes light was thrown on a handicap not previously recognised - the handicap "my back" in a young man led to radiological report of spina bifida occulta and spondylolisthesia, and to subsequent Disabled Persons registration. Less articulately "when I was hurted" meant an injury involving fracture of the left parietal bone and evacuation of subdural and left frontal intra-cerebral haematomata.

"My chest" typified chronic bronchitis and "breathless on walking" a man with congestive heart failure. A man might parade his symptoms, however, as one who complained of angina pectoris and/

and who had a letter from hospital in his file which read: "It is difficult to come to any conclusion because of his obvious tendency of falsifying his medical history."

Of alimentary complaints, a man with a colostomy to correct a defective sphincter admitted this furtively, while another, an elderly and anxious psycho-neurotic, blamed "the wind" for his disability.

Psychoneurosis was uncommon, while other mental illnesses were common. One mental defective defined her handicap as "having babies . . . measles."

An epileptic usually gave "epilepsy" or "black-outs" and the alcoholic would give "drink" or "the bottle". One alcoholic extended the handicap to its social implications "no many friends from drink" and another gave the "booze" as his main handicap. He had a long medical history and this was the first time that the problem of alcoholism had been raised with a doctor.

One paranoid man lacking insight offered "my nerves" but a man suffering from chronic bronchitis and paranoia replied "my chest . . .

and/

and a sense of persecution." One depressed man simply touched his head in meaningful despair and comments from others include: "I keep getting they depressions . . . and I can't stick in a job", "Periodically brooding", "What do you do when you can't even speak". The full value of the last observation was not appreciated until months had passed, the patient had been admitted to hospital and psychiatric investigations completed to confirm depression.

The importance to be attached to these answers depends on the relationship between patient and doctor. Patients from lodging-houses place no value on the truth until the bona fides of the doctor has been established to their satisfaction. Complaints of all kinds are likely to be misrepresented in an attempt to manipulate since this is second nature to the patient. Only when the doctor has shown himself to be a non-judgemental physician not open to manipulation will he be given a reliable history and detail furnished in proportion to the extent of his interest/

interest. Since the doctor's interest is related to his ability to help in any situation, the resources which a general practitioner can command in this setting become of paramount importance.

(c) Clinical problems

The retrospective section of this study suggested that a conventional general practice approach using the present machinery for medical care is inappropriate when dealing with patients from lodging-houses. This can be seen from the case records, selecting those conditions which are permanently handicapping and which are present in concentration unusual for general practice.

Problems arose occasionally in diagnosis but much more frequently in management. In the latter, the problem might be inherent in the nature of the illness or in the organisation of medical care. Most striking problems were seen, however, when studying the relationship of the patient with his environment. Of particular importance were the personal resource of the patient, his relationship with his doctor, and the support, conflict or confusion in his environment.

The number of variables in the situation makes further classification impossible.

In the following 44 pages, cases are reported which illustrate this as well as highlighting the points made above.

Illustrative clinical problems

i Diagnosis - difficulty in defining pathological process
(Cases 1, 2 and 3)

ii Management - nature of the illness
(Cases 4,5,6 and 7)

- organisation of medical care
(Cases 8,9,10 and 11)

iii Relationship of patient and environment

- personal resource of patient
(Cases 12,13,14,15 and 16)

- patient/doctor relationship
(Case 17)

- environment, support
(Cases 18 and 19)

conflict
(Cases 20, 21,22 and 23)

confusion
(Case 24)

1 Diagnosis.

Multiple pathology is common and the following cases illustrate difficulties in diagnosing the nature of the illness or the relative importance to be given to different illnesses known to co-exist.
(Cases 1, 2 and 3)

Case No 1 (R.B.)

Male, single, 40 years, Roman Catholic, kitchen porter.

This man was in touch with his siblings. He had not worked in the previous year and was supported by the National Assistance Board.

He had previously been diagnosed, after a spell of imprisonment, as suffering from psychopathy and depression.

When he attended on this occasion, he was referred for day care to a mental hospital, which his brother was then attending, but the clinician in charge felt unable to accept him. The subsequent downhill progress of his illness required later admission and investigation. He responded well to treatment with E.C.T.

The development of depression in a psychopath seems to be not uncommon in this group and presents peculiar difficulty in this setting since communication is never easy and the stages of withdrawal of depression are not readily assessed.

Case No 2 (G.W.)

Male, single, 42 years, Protestant, labourer

This man had no contact with relatives. He had lived for many years in Edinburgh in a number of the lodging-houses. He had not worked for several years and was supported by the National Assistance Board although he made a little extra money on occasions as a bookmaker's runner before the passing of legislation rendered this an unnecessary occupation.

This patient suffered from severe epilepsy and his case illustrates the difficulty of discriminating in the diagnosis of the four conditions which have been grouped - mental deficiency, chronic alcoholism, epilepsy and other psychiatric illness. An extract from a hospital discharge letter after attempted suicide reads: "The original diagnosis of psychopathic personality has been extended to include epilepsy and alcoholism."

This man was subsequently killed in an affray in one of the lodging-houses

Case No. 3 (W.L.)

Male, single, 58 years, Protestant, no regular occupation.

This man had no contact with relatives and no source of income. He had had no regular occupation since discharge from the Army in 1945 and had been "on the road" for about four months before coming into Edinburgh.

He was dirty, malnourished, suffering from skin sores and suggesting mental deficiency in his slurred and inarticulate manner of speech. The letter of medical referral which was later arranged is reproduced in full:

18 February 1965

Medical Outpatient Department
The Royal Infirmary
Edinburgh

Dear Doctor,

W.L. (21.12.07), 1 Pleasance

This is a single man who hails from Kirkwall. He has no contact with any relatives and came into Edinburgh in November of last year to live at the Salvation Army Hostel. He was in a debilitated state at that time and suffering from ulcers of his legs, together with a degree of malnutrition and neglect/

neglect which seemed to require fairly urgent treatment. This has now been dealt with and further appreciation can be given to the remainder of the medical notes.

He has had no occupation since leaving the army in 1945 and until coming here apparently had no regular income. He has been given certificates and support by the National Insurance since last November. He claims to have had no significant past medical history.

When first seen his blood pressure was 170/100 and it has been found to be raised on several occasions subsequently. Once when seen by the Regional Medical Officer, the level was 270/150 and more recently it was recorded at 180/130. I think the initial reading may have been depressed by his debilitated state. Physical examination gives nothing further untoward apart from the appearance of the fundi which is consistent with early hypertension. Further investigational findings are as follows:

S.F.R. - negative

X-ray - A.P. Chest - Cardiac enlargement with left ventricular prominence. Unfolding of the aorta. There is central vascular congestion.

E.C.G./

E.C.G. Sinus rhythm. Rate 72/min. Axis approx. -20°. PR interval 0.17 sec. There is flattening of the T waves with slight inversion in leads 1, aVL, V5 and V6. These changes are non-specific but compatible with ischaemia or left ventricular strain.

B.U. 47mg%

L.F.T. Alk. Phos. 12 units. SGPT <20 units/ml.
T.T. 2 units Billiburin 0.8 mg%

Weight: 10 st. 10 lb. Pulse 88.

B.P. 180/128 Hb. 105% PCV 45% Wbc. 9.200/cu.m

E.S.R. 3mm/1 hr.

Urine - Albumen -ve
Sugar -ve
Urobilinogen -ve
Nitrite test -ve

I feel that in a man of this age more consideratio should be given to this condition and I should be glad to have your opinion.

Yours sincerely,

This man has been treated for hypertension since and has made remarkable improvement. He is now clean and well cared for. His blood pressure is/

is maintained at the upper limit of normal on treatment with methyldopa and his speech is showing much improvement.

It is impossible to judge how many elementary medical problems are overlooked in patients who present in such deteriorated fashion that intimate examination looking for pathology other than gross handicapping illness is not undertaken.

ii Management - nature of the illness

Problems in management may arise because of the nature of the illness - its chronicity and liability to exacerbation, the likelihood that physical distress will provoke overt evidence of latent hysteria, that the disease of hysterical personality itself resists cure, or that disease is so far advanced that the patient can see nothing to live for.

(Cases 4, 5, 6 and 7)

Case No. 4 (L.C.)

Male, widower, 59, Protestant, hawker.

This man had lived alone in a flat near his sister but had moved into the lodging-houses about three years before the study began when the property in which he lived was being demolished. He had done no work in the previous year and lived on a National Assistance allowance.

He suffered from chronic bronchitis and had been in hospital for exacerbations in 1955, 1957, 1958, 1959, 1960 and twice in 1963. He had an exacerbation of chronic bronchitis at the end of December 1963, but was given accommodation by a male friend living in a one-room ground floor house. The accommodation consisted simply of a mattress on the floor but the room was dry, clean and well fired and treatment was started in this setting. He found himself on the street, however, on New Year's Eve when his host had more congenial company available with whom to bring in the New Year and the patient had to make way for his own niece. He had to be admitted to hospital again in these circumstances with broncho-pneumonia.

He/

He had four other admissions to acute medical beds during 1964 and died in hospital at the end of August.

This case illustrates the liability of the chronic bronchitic to repeated exacerbations requiring urgent hospital admission and the difficulty of treating any exacerbation outwith hospital because of the doubtfulness of adequate social support from relatives or friends.

Case No. 5 (M.M.)

Female, single, 29, Protestant, domestic

This woman hailed from Stirling and moved between there, the west of Scotland and Edinburgh. She maintained contact with an aunt by whom she had been brought up. She had done no work in the previous year and lived on a National Assistance allowance.

She suffered from rheumatoid arthritis and inadequate psychopathy. In one year she consulted her doctor on no fewer than 60 occasions - hysterically attempting manipulation to make good lack of personal resource.

Psychometric assessment was arranged and the following report obtained:

"Miss M's scores on the W.A.I.S. and on the Porteous Maze Test place her in the category of high-grade or borderline mental defective. Her Rorshach protocol reveals an immature personality whose mental life is unsophisticated in the extreme. In the Vineland Social Maturity Scale, designed to measure social competence, Miss M. obtained a social age of 11.3 and a social quotient of 45, which suggests that she can only function adequately in a sheltered environment."

She/

She was subsequently placed in a convent as a living-in maid, but refused to stay and reverted to her previous pattern of life.

Case No. 6 (J.J.)

Male, single, 47 years, Protestant, kitchen porter.

This man was in touch with relatives but derived no support from them. He had done no work in the previous year and was maintained by the National Assistance Board.

He was classed by psychiatrists as being "probably a border-line mental defective" and "emotionally unstable". He spent most of his time alternating between a mental hospital and his general practitioner's surgery. His drug treatment had been managed by giving him his bed-time sedative on a daily basis from the surgery since one hospital letter read: "I think it would be a dis-service to him to prescribe any drugs outside hospital setting, but of course he is liable to obtain supplies of barbiturates from his own nefarious channels."

His attention-seeking gestures included lying down in front of cars, chewing barbiturates in the public gallery of a court-room from a bag which he carried like sweets, and waving a razor blade near his throat at the gate of a mental hospital. On the last occasion the psychiatrist, discharging the/

the man after an overnight stay, wrote: "Unfortunately it is always difficult to know exactly what to do with persons such as this inadequate psychopath who is of rather borderline intelligence, when they present themselves at the hospital late at night in this fashion."

It is difficult to know what to do with them in any circumstances.

Case No. 7. (J.McK)

Male, single, 53 years, miner.

This man had no contact with relatives. He was unemployed and supported by the National Assistance Board.

He had been in a mental hospital for many years and, after progressive deterioration from alcohol and barbiturate addiction, leucotomy was carried out in desperation. He stayed out of hospital for 28 days in 1963 and was automatically discharged.

He had come directly into Edinburgh from the Larbert area and presented at the surgery in depression, seeking a purpose in living. The problems of maintaining a patient in the community when his personal resource is so far reduced are self-evident.

ii. Management - organisation of medical care.

The most obvious and frequent problems related to organisation of medical care arise where more than one agency is involved in the treatment of the patient and where communications may become complicated. Sometimes combining agencies are frustrated in that treatment is indicated but is unacceptable to the patient and impossible to enforce in the present state of the law.

(Cases 8, 9, 10 and 11)

Case No. 8 (J. McPh.)

Male, single, 61 years, Roman Catholic, farm labourer.

This man had no contact with relatives when he first attended. He had been unemployed in the previous year and was supported by the National Assistance Board.

He suffered from chronic bronchitis and a year before attending the surgery had been diagnosed in Dundee as suffering from pulmonary tuberculosis.

His anti-tuberculous treatment was continued and the patient was given such support as seemed possible to rehabilitate him. This was made more difficult by the appearance on the scene of his son, whose antipathy to his father led to theft of any valuables or clothing which the patient was able to acquire. The patient was reviewed frequently at the Chest Clinic and admitted for further hospital treatment twice during the year. In August 1964, however, he was found to have an anaplastic carcinoma of bronchus which was removed by upper lobectomy. He was discharged from hospital following this operation, but re-admitted at the end of September and died during December.

This/

This case illustrates admirably the dual care which is the feature of many of the illnesses occurring in lodging-house patients. His anti-tuberculous treatment required daily attendance at the surgery for Streptomycin injections by the surgery nurse. He had frequent reviews at the Chest Outpatient Clinic and he was in hospital 5 times in all during 1964.

Case No. 9 (A. McL)

Female, single, 30 years, Roman Catholic, mill-worker.

This woman had come from the Outer Isles to Edinburgh where a brother had been able to obtain lodgings for her in a home for women in depressed social circumstances. She was unemployed and supported by the National Assistance Board.

From age 18, she had been for ten years in a mental hospital in the north of Scotland where she had been thought to have a low I. Q. and to be suffering from chronic schizophrenia and depression.

She stayed on in Edinburgh, with constant help from the manageress of the hostel in which she lived, the Mental Health Officer of the Public Health Department, the staff of the outpatient department of the mental hospital and her general practitioner.

The question of dual control is discussed by Cammock and Lee[17] and this case illustrates quadruple control. It will be seen that control by more than one agency is a feature common to many of the patients in the survey.

Case No. 10 (J.B.)

Male, single, 58 years, Roman Catholic, watchman.

This man had no contact with relatives. He had been in the same lodging-house for more than five years and was in regular work.

He offered no past history of any of the chronic handicapping illnesses although notes later available showed that he had attended the Chest Clinic in 1956 for treatment of pulmonary tuberculosis.

X-ray of chest on this occasion showed soft shadows at the right apex and right mid zone and he had an E.S.R. of 55mm in 1 hour. Arrangements were made to have him admitted to hospital but he declined to attend and, the question of compulsion having been discussed with the Medical Officer of Health and the Regional Medical Officer, there appeared to be nothing under the present state of the law which would require this man to have treatment.

Case No 11 (H.W.)

Female, socially separated, 33 years, Protestant, waitress.

This woman maintained contact with her family home near Edinburgh. She had worked for 2 months only in the previous 12 and received a National Assistance allowance.

She suffered from alcoholism and the pattern following the year of the survey illustrates the difficulties in helping a deteriorated patient in this category.

March 65. Found to be pregnant. (This woman did not maintain herself by prostitution but would occasionally cohabit, usually as a means of obtaining drink.) Admitted to emergency observation ward for treatment of quinine overdosage, self-administered, in an attempt to procure abortion. She was referred to the alcoholism unit and continued to attend as an Outpatient.

May 65. Hospital booking for confinement. Again admitted to emergency observation ward with over-dosage of Methyl-pentinol.

July/

July 65. Further admission to emergency observation ward, this time with Tuinal overdosage, the drug having been bought from friends. This appeared to be a determined attempt at suicide rather than a gesture. Transferred to mental hospital. Transferred back to maternity hospital for abdominal hysterotomy and sterilisation and returned to mental hospital care.

September 65. Contact with alcoholism unit rearranged - this contact having been broken in spite of the patient's being in mental hospital in the same area.

October 65. Patient referred to another mental hospital, the arrangements having been made by a mental health officer (this was a consequence of manipulation by the patient). Emergency observation ward admission - Seconal overdosage and certification leading to sheriff's order and detention in mental hospital. The patient left against medical advice shortly after the expiry of the four weeks' compulsory detention.

December/

December 65. Extract from psychiatric referral letter: "This matter of drug treatment is something of a problem as she ordinarily seems to derive considerable support from moderate use of sedatives which are abused only when matters get beyond her and some form of suicidal gesture becomes necessary to her".

February 66. Seventh emergency observation ward admission. Overdosage from unidentified tablets. Cross referral to mental outpatient department.

March 66. Eighth emergency observation ward admission - Mandrax overdosage. Admitted to mental hospital again under certificate.

April 66. Discharged from mental hospital having absented herself for 28 days.

The problem of enforcing treatment in the patient's interest is apparent.

iii Relationship of patient to environment - personal resource of patient.

Some of the cases already reported show the importance of the relationship between the patient and his regular environment. In this relationship, the personal resource of the patient in terms of insight or self-control may be important in maintaining function in spite of handicap.

(Cases 12, 13, 14 15 and 16)

Case No 12 (W.Y.)

Male, divorced, 44 years, driver.

This man was in contact with relatives. He had worked for two months only in the previous year and was living on a National Assistance allowance.

He had been brought up by an aunt since his mother was alcoholic and his father had been killed in the First World War. He himself had been wounded and captured in France. He had escaped on three occasions and suffered considerable hardship as a prisoner-of-war. He was discharged with 20% disability pension. He married in 1945 but found himself unable to settle down and rejoined the army in 1948, resigning claim to his pension in doing so. He was divorced in 1955.

This patient suffered from recurrent depression but had considerable insight. One psychiatric assessment read "Depressive illness superimposed on personality aberration." Even when depressed, this man's degree of self-control and insight were such that the aberrant pattern of his social performance would seem in retrospect possibly to have been due to undiagnosed depressive episodes.

Case No 13 (H. McG.)

Male, sihgle, 55 years, night watchman.

This man was in contact with relatives. He was in regular employment and had been in the same lodging-house for more than 5 years.

He suffered from osteo-arthritis and had an osteotomy of his left hip performed in 1962.

He hailed from Co. Antrim and was going home to spend the New Year when he died suddenly on the train to Glasgow. The police found him to have £500 in his possession. This case is a reminder that this is not a homogeneous population group. In spite of handicap this man lived a self-sufficient existence, and was proceeding to his family home with a considerable sum of money legitimately come by in consequence of his own industry.

Case No.. 14 (G.B.)

Male, single 45 years, Protestant, brewery labourer

This man had been brought up in Edinburgh and lived in contact with his siblings. He had lived in the same lodging-house for more than 5 years but had not worked for several years and was supported by the National Assistance Board.

He suffered from post-encephalitic Parkinsonism and had been educated in a special school.

As he grew up he became increasingly self-conscious of his handicap and moved into a lodging-house so as not to be a social encumbrance on his family. He maintained contact but lived an independent life.

Case No. 15 (D.M.)

Male, socially separated, 64 years, Protestant, kitchen porter.

This man was in touch with relatives and had worked for six months in the previous year.

He suffered from chronic bronchitis, ischaemic heart disease, and carcinoma of the upper lobe of the right lung which had been treated by radiotherapy in September, 1963.

Arrangements were made for convalescent holidays in a Marie Curie Home in autumn 1964 and autumn 1965 and May 1966. He continued to attend the surgery and required symptomatic treatment only.

Case No. 16 (R.C.)

Male, socially separated, 58 years, Protestant, jute mill worker.

This man was in contact with relatives. He had done no work in the previous year and was supported by a National Assistance allowance.

When he first attended, an X-ray of chest was reported as within normal limits but medical notes received subsequently showed that a poorly differentiated squamous carcinoma of bronchus had been diagnosed three months earlier after radiological and bronchoscopic investigation. He had declined operation and left hospital against medical advice.

He ultimately agreed to operation and, after right pneumonectomy and convalescence, returned to the lodging-house. He was on the waiting-list for the same Marie Curie Home as the previous case but presents a striking contrast in that he is almost incapable of co-operating in his own treatment.

iii Relationship of patient to environment - patient/doctor relationship

Lodging-house patients show extraordinary suspiciaon of a doctor and do not automatically extend trust to him.

(Case 17)

Case No. 17 (J.L.)

Male, single, 59 years, Protestant, labourer.

This man had no contact with relatives. He was unemployed and supported by the National Assistance Board.

He suffered from chronic bronchitis and paraphrenia, a hospital letter from the previous year reading: "Persecution through wireless and television . . . . he remains fairly well preserved in his actions but is frightened and solitary."

He was admitted to a mental hospital two weeks after his first attendance, but discharged himself against advice after a short stay, maintaining that he could have the same treatment outside. This man had considerable insight into his condition and, when asked what he thought was his medical handicap, he replied in straightforward fashion, "My chest and a sense of persecution."

This degree of insight is unusual in this type of case but, when it exists, trust in the therapist on the part of the patient can be important in management.

iii. Relationship of patient to environment - environment, support.

The social support of relatives which lodging-house patients can enlist may be an important factor in management of their problems. Many have no contact with relatives, however, and contact with relatives is no guarantee of support. Case No. 4 has already illustrated this point.

(Cases 18 and 19)

Case No. 18 (J.H.)

Female, single, 18 years, Protestant, waitress.

This girl was in contact with an aunt. She had come to Edinburgh two weeks before her first attendance and was supported by the National Assistance Board, having worked for only four months in the previous year.

She had a paralysis of her right arm and paresis of her right leg, following tuberculous meningitis at age 7½.

She became pregnant while in Edinburgh and was delivered of twin baby girls in October 1964, both babies being placed for adoption.

It seems likely that this girl will always live in a state of emotional dependency.

Case No. 19 (W. McK.)

Male, divorced, 44 years, Protestant, labourer

This man had lived for many years in Edinburgh and kept in close touch with his brother who lived much of the time in the same lodging-house. He was unemployed and supported by the National Assistance Board.

He had a past history of pulmonary tuberculosis and suffered from chronic bronchitis, chronic alcoholism and Friedrich's ataxia.

This patient was a frequent attender at the surgery and at the local chest clinic. He had to be admitted to a mental hospital during the year of the study and in the following year had separate admissions for Sonne dysentry, alcoholic deterioration and bronchopneumonia.

He was dependent on his brother for much social support and relapses requiring hospital admission were twice at least coincidental with his brother's absence in prison.

iii. Relationship of patient to environment - environment, conflict.

Relationship with the environment is frequently one of conflict for the lodging-house patient. Afflicted by physical handicap the patient may take refuge in hysteria (as in case no. 5) to escape reality or may use this mechanism to achieve his ends. Mental illness may provoke conflict or may expose the patient to exploitation.

(Cases 20, 21, 22 and 23)

Case No. 20 (E.M.)

Male, widower, 56 years, Roman Catholic, baker.

This man hailed from Edinburgh, was in contact with children and had been less than five years in a lodging-house. He appeared able to obtain employment whenever he was fit for work.

He suffered from angina of effort and hemiplegia, however, and the referral letter to hospital on one occasion is reproduced in full as it illustrates the need for hysteria in those patients who suffer from serious handicapping illness intermittently beyond the limits of their tolerance.

23.9.64

M.O.P.D.
Royal Infirmary
Edinburgh

Dear Doctor,

E.M. (5.12.07), 75 Grassmarket

This man is a baker to trade, widowed since 1956 and living in recent years in a lodging-house although he has seven grown children in Edinburgh

He/

He had a partial gastrectomy in 1958, vagotomy in 1959, coronary thrombosis in 1960 and a further coronary and left hemiplegia in Glasgow Royal in 1961. He has chronic glaucoma and, perhaps not surprisingly, is on the D.P. register.

He was in Ward 22 in March, Ward 29 in April and Victoria Hospital, Kirkcaldy in June of this year. He has usually presented with some implied emergency which could scarcely be ignored in the light of his awesome past history. After appropriate attention and exclusion of progressive pathology, he has gallantly insisted on attempting to return to work and received further approval for this. He is occasionally drunk but seldom incapable.

In September, 1963, arrangements were made for supply of a caliper from O.O.P.D., but I do not think he attended to obtain this and he had sufficient control of his left arm and leg to enable him to look after himself and to work between hospital visits.

He presented last night with complaint that, coming off night work and having had his sleep, he awoke to find his balance impaired and his power/

power and control of his left leg and arm diminished. Examination confirms these findings, and suggests an extension of his cerebral vascular lesion.

If this is so, he merits all rehabilitation care in his evident attempt to maintain his independence. His recent pattern, however, savours strongly of chronic hysteria imposed on serious physical handicap.

I should be grateful for your help in clarifying this interesting problem and for your further help in treatment.

Yours sincerely,

Case No. 21 (T.W.)

Male, married, 54 years, Roman Catholic, no occupation.

This man and his wife both lived in lodging-houses. They were supported by the National Assistance Board and spent their days wandering about in the town.

He was of low intelligence and was epileptic.

He caused increasing social disturbance by hysterical mimicry of his epilepsy and was ultimately admitted to an epileptic colony at Bridge of Weir.

His case illustrates the problems of management in the community when close support and benign authoritative handling are required.

Case No. 22. (E.J.)

Female, single, 54 years, Protestant, no regular occupation.

This woman maintained contact with her relatives. Her family home had been sold during one period of mental hospital admission a few years earlier and she had moved into an Edinburgh lodging-house.

She suffered from paranoia, the course of which fluctuated and was quite unpredictable.

When she had been treated for seven years, the Regional Medical Officer considered her still incapable of work and the comment "woman seems to be a very obstinate case" was thought to be apposite.

In consequence of her illness, this woman made herself socially inacceptable in most communities and arranging support outwith hospital was a constant problem.

Case No. 23. (J.McC.)

Female, single, 27 years, Roman Catholic, factory worker (unskilled).

This woman was the fifth child of eight. She visited her parents occasionally but was uneasy in doing so as she felt embarrassed at having herself had four children and one miscarriage without being married. Three of the children were boarded out and one was being brought up by her grandmother. She had not worked in the previous year and was supported by the National Assistance Board.

She was mentally deficient and was to have been admitted to a mental institution at an earlier stage in her life but no vacancy had ever been found for her.

Her four children had all been by different fathers and she attended frequently with abdominal complaint and the suggestion that she might again be pregnant - a situation which she seemed to desire although pretending to deplore. Arrangements were made for consultation with a psychiatrist and a gynaecologist with a view to sterilisation but she moved out of the area before this could be explored further.

Her/

Her case illustrates another problem of management of a patient in her own interest and the liability of a mentally deficient woman to be taken advantage of sexually.

iii. Relationship of patient to environment - environment, confusion.

Lodging-house patients may use different names in different circumstances. This creates difficulties in obtaining medical records from another area or from a hospital at which the patient used a different name. There is a tendency to use common names in this way so that it is not unusual to find more than one patient with the same name.

This is not in itself, perhaps, an exceptional situation but the reason for it - to achieve anonymity - is unusual, and can lead to confusion. (Case 24)

Case No. 24. (W.S.).

Male, widower, 69 years, Protestant, retired.

This man was in touch with relatives. He lived on pension alone.

He suffered from chronic bronchitis and mental illness.

He became incapable of living independently and arrangements were ultimately made for him to be admitted to local authority Part III accommodation.

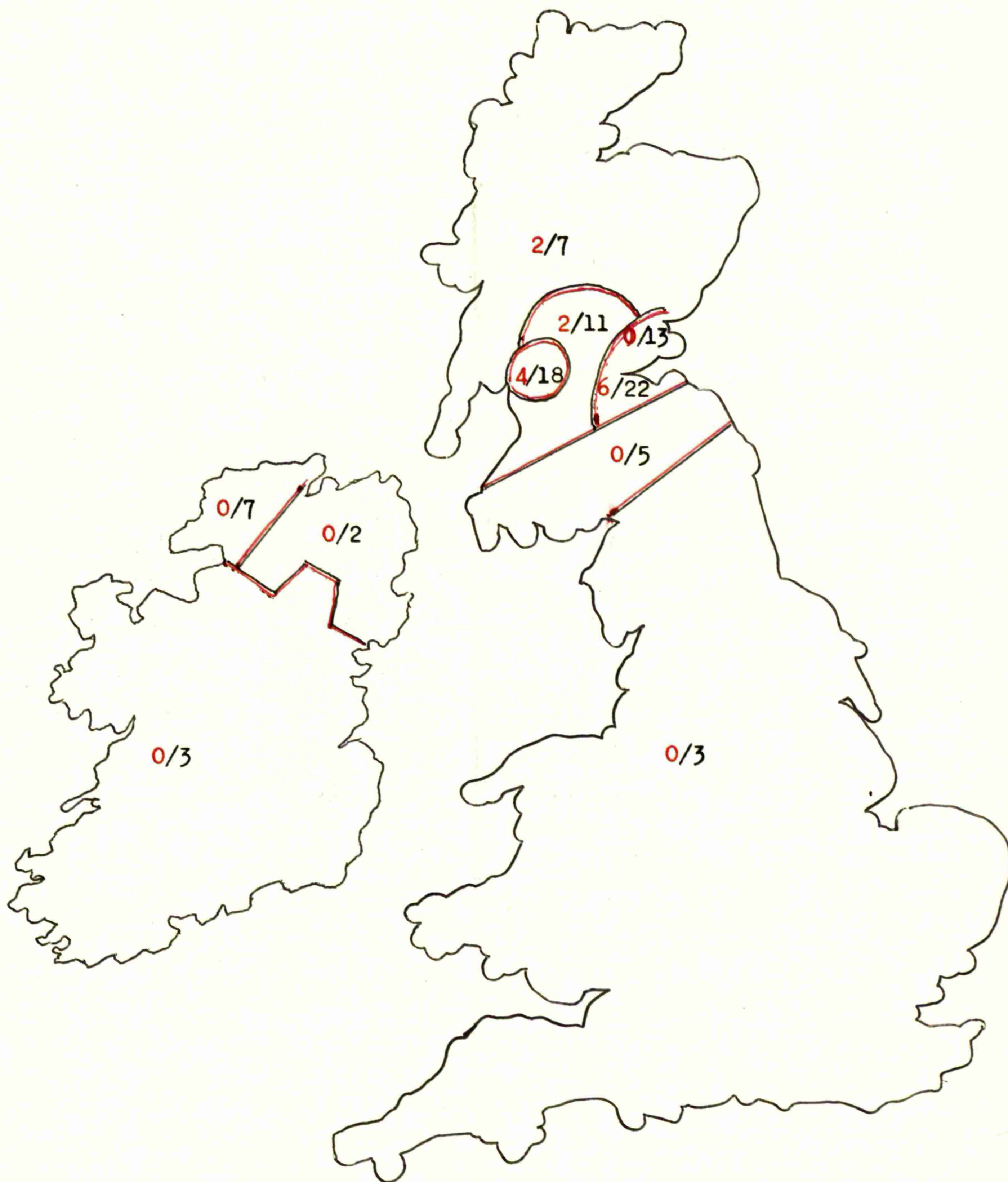
A man giving the same name and living in the same lodging-house was at this time attending a hospital out-patient department. The confusion which resulted when the correspondence became mixed emphasised the need for reliable identification, as by date of birth, of lodging-house patients.

(d). Geographical distribution of the birthplaces of patients.

The patients' birthplace was noted at a number of interviews.

The results are mapped on the following page and suggest that the Edinburgh lodging-house population comes mainly from the industrial waist of Scotland with a contribution, among the men, from Ireland.

Geographical distribution of birthplaces of 105 patients.



Chapter 5

Discussion and Conclusions

(a) Problems of definition

The Research Committee of the Council of the College of General Practitioners[18] considered that to a greater extent than with specialist medical practice, general practice research is the more difficult because "it is carried on in an environment which is constantly varying". Creating definitions which take account of this constantly varying environment is in consequence perhaps the commonest problem of research in general practice. There is, however, an added problem in this study. The population considered consists of people from lodging-houses in Edinburgh or of no fixed abode who attended one general practice during the period 1st February, 1964, to 31st January, 1965. Ashby (writing a foreword to Sargaison's book) observes "To most readers of this book, life in a common lodging-house is as unfamiliar as life in a West African village." In the light of this unfamiliarity, the definition of both population and environment requires some further description.

The/

The Research Committee notes also the desirability of objective tests that are valid, simple, reproducible, and discriminating. This further description, therefore, has to be exhaustive and exclusive so that a basis exists for valid comparison with future studies in this field.

At the present time, however, since no single work has been done which can be compared with all parts of this study, it has been necessary to define each part separately so that agreement of the separate propositions is first demonstrated. "It is a fundamental axiom of all science, as well as of practical reasoning, that there should be no contradictions between true descriptions of real events" (Andreski)[19].

Thus, in considering sociological factors, there is agreement with some of Laidlaw's observations while with other factors - length of employment during previous year, length of stay in Edinburgh and at the present address - a first-hand description of the situation alone is possible. Similarly in considering chronic and handicapping disease, no agreement with any other study is possible/

possible while, in considering consultations, the sequential consultations in the G.R.O. study allow valid comparison to be made between the two groups. The total referrals to hospital outpatient departments in the present study can be compared with the representative sample of referrals from the surrounding population in "The Edinburgh Hospitals." Domiciliary visits to lodging-house patients can be compared with a similar number of visits, matched in terms of the time of placing the call, in the practice conducted from the same premises.

"The strength of the exact sciences is in the fact that over enormous areas there are relationships of mutual implication between propositions, which are supported by independent observational evidence" (Andreski). In this study, then, if descriptions are fairly matched so that no contradictions exist, conclusions can be drawn according to the extent of mutual implications revealed.

The remarks serve to explain a problem which arises frequently in general practice research and the need for comparisons of varying degrees of observational exactness in the present study.

(b)/

(b) Role of the research worker

On first exposure to this situation, the most arresting feature was the difference in this experience from any previous general practice experience. Experience had been obtained in most branches of hospital medicine and in rural and urban general practice. Undergraduate teaching andthis post-graduate experience had not prepared one for this type of medical practice. It seemed likely, therefore, that this problem was in some respects unusual and deserving of study. There was self-selection of patients and a shifting population so that there could be no simple comparison with previous research in general practice so much of which depends on the conception of a circumscribed "population at risk". The weaknesses inherent in the use of this conception have been described fully by Lees and Cooper.[20] In the setting of the present study, these weaknesses are accentuated so that the concept is valueless for purposes of comparison.

It was necessary, therefore, to describe the state of affairs, exhaustively and exclusively, so/

so as to establish areas of agreement with other studies. This initial description implied a method of study more commonly found in sociology than in medicine. Professor K.J. Little (21) had suggested that the appropriate approach would be to place a participant-observer in the scene and this role was accepted by the doctor conducting the study.

Turner discussed this problem in the introduction to his report:

"The role of the research worker could not be clearly anticipated. There was a suggestion that he should become the agent of the health department of the local authority. It was thought that would give him status, as well as benefit of office facilities and other assistance such as the department was in a position to confer. It was suggested alternatively that he should operate as the appointed welfare officer of the lodging-house, identified, therefore, with the staff, and the authority that controlled the lodging-house.

"Neither suggestion was acceptable, for in either case the research worker was identifying himself/

himself with authority which the residents of the lodging-house rejected. The only position he could adopt, therefore, was one of implied identification with the men. He had his reasons for drifting round the lodging-house, as the men had. He wanted to know more about it, to see in what ways it might be improved. When he was able to help a man with his problems he did so, as any man helps his neighbours, rather than as a social worker who was doing his usual job of work. But though his status in the community was higher than that of the residents of the lodging-house - and there was nothing to be gained by attempting to conceal it - his official connection with authority was no greater and no less than that of the residents."

In the present study, the doctor was in the privileged position of a general practitioner - participating as the personal and confidential physician in the lives of his patients and observing in his role as trained medical scientist.

The non-statistical section of the study is an extension of the description of these observations. Andreski/

Andreski states "Reality is inexhaustible and nothing can be described completely - not even the end of one's nose. With descriptions which have a practical aim in view, the criteria of adequacy are fairly evident. With purely cognitive description the matter is more elusive". This section extends description in fields which may have future medical importance and in which no exact comparisons are thus far possible. By giving background to the situation, it may also serve to render more familiar other factors which have been quantified so that a refutable hypothesis becomes acceptable where comparisons have been attempted. "The criterion of the scientific status of a theory is its refutability" (Popper)[22].

Chapter 6

Illnesses of Lodging-House Inmates

(a) Extent and Nature of the Problem

The present study has been concerned with the problem of illnesses in people from lodging-houses or of no fixed abode who attended one general practice in Edinburgh. Although this practice undoubtedly deals with most of the illness from lodging-houses in the town, the exact proportion is uncertain and the extent of the problem, both locally and nationally, is unknown.

Under Section 17 of the National Assistance Act, 1948, the National Assistance Board was given responsibility for trying to stabilise a shifting population. The activities of the Board led to more becoming known about "persons without a settled way of living" and the results of the policy were reviewed in the Report for the year ended 31st December, 1964.[23] The Report notes "It became clear that, although developments in other services, e.g. those providing/

providing hostels for discharged psychiatric patients and for the needs of discharged prisoners, could be expected increasingly to provide accommodation and specialized resettlement facilities for some of the persons now found in reception centres, the Board would still have to go on, for some time, providing temporary board and lodging and resettlement for much the same clientele as at present. Indeed there were indications, particularly from studies made of persons dealt with at the Board's local office in London which specializes in meeting the needs of persons living in common lodging-houses (whose clientele partly overlaps with reception centre users), that even though the number of wanderers, in the literal sense, was falling, the number of unsettled people was increasing. It also seemed clear that such people tended to be found in large urban areas or to congregate there."

A report (24) by Christian Action and the Simon Community Trust to the Prime Minister in 1964 suggested that 90,000 people were homeless in Britain at that time and that the Welfare State had totally failed to help.

More/

More recently, between October, 1965 and March, 1966 a Survey (25) was carried out at the request of the Minister responsible for coordinating the social services. Information was obtained about 567 lodging-houses and hostels, providing among them a total of 34,596 beds for single persons, 92 per cent of which were for men. At the end of October 1965, about 86 per cent of male beds and about 74 per cent of female beds were occupied. Between November and February, 340 of these establishments were full at times and had to turn people away. The occupancy rates of lodging-house beds varies seasonally, but it was estimated that about 13,500 people were sleeping rough at one time or another. 965 people were found sleeping rough in a search of nearly 3,000 sites on one night in December, 1965.

Shifting in this population occurs both geographically and socially and a proportion of the people are at times in lodging-houses, hostels and reception centres and at other times in cheap rented accommodation. The foregoing figures - and particularly the number of beds in lodging-houses and/

hostels - give some guide to the numbers of persons likely to be involved.

As more has become known socially about these people, it has been too readily presumed that their problems would be solved by extension, more intensive use, or better coordination of social services. This presumption is in spite of the fact that comprehensive statutory national, local and voluntary services are available to lodging-house inmates as to others. Most solutions proposed would bring greater regulation to the lodging-houses but tend to ignore factors discussed in this study in Chapter 4, part II.Personal Aspects. The main factors are:

1. the lodging-house inmates' need for maximum personal liberty.

2. the fact that the lodging-house pattern of life is for many the satisfactory adaptation to environment of a damaged personality. Edwards drew this conclusion in relation to spirit-drinkers and it applies equally to other 'injured' patients.

There has continued to be an ignorance of the state/

state of personal health of lodging-house patients which, taken together with their social background, is the true nature of the problem.

Backett[(26)] indicated how the main features in the disease patterns in Western societies are changing and considered the vulnerable age-groups, the sex ratios, the type of disease and the duration of illness. These considerations have particular significance in this study.

Of 450 patients, 83% of whom were male, 49% had lived in Edinburgh for less than six months.

43% lived with National Assistance support, 70% were unskilled, 59% unemployed and a further 13% retired.

64% were over forty-five and 5% only below twenty-five years. 50% had no contact with relatives and 7% only were married.

Point 1. These patients, therefore, are largely without social resourves in terms of skills, money and supporting relationships.

Of/

Of the 450 patients, 85% suffered from one or more of ten chronic handicapping diseases. Consultation frequency for most of these conditions was much higher than is normal in general practice. Mental and chest illness referrals to hospital as a percentage of referrals were more than eight times as high as in the surrounding population.

Point 2. The pattern of illness and care among these patients is thus strikingly different from that in normal general practice.

Chapter 4 describes and illustrates the quite unusual concentration and combination of social want and illness to be found in this population and indicates the consequent difficulties in providing medical care.

Point 3. Because of the type of person, there is very great difficulty in organising adequate medical care for these patients.

<u>(b) Solution of the Problem</u>

It has been previously shown in the study that the <u>medical</u> service available to lodging-house patients is clearly inadequate and that there are medical, social and organisational reasons for this. Adequate medical care and support could not be given because

(1) a majority of these patients suffer from some form of chronic handicapping illness and the patterns of illness found demand more medical time than those normally encountered in general practice.

(2) these patients could not command normal family support when ill.

(3) the type of person who attended from lodging-houses did not mix with patients from private homes and distress was felt on both sides when they were required to share a waiting-room.

(4) difficulties of practice organisation arose from the constant shifting of the population.

Neglect follows inevitably from this inadequacy at the patient's first port of call - the general practitioner's surgery - and this neglect has to be remedied before a satisfactory diagnosis/

diagnosis can be made. The diagnosis made in this setting is essential to the provision of the appropriate curative or supportive services in each case and the general practitioner is responsible for engaging and coordinating these services on his patient's behalf.

<u>Administrative remedy</u>

The study has shown that the efficient working of a practice is impaired by the introduction of lodging-house patients and that these patients add disproportionately to the clinical load without any compensation. These factors act as a positive discouragement to any general practitioner who tries to meet the needs of this highly vulnerable population group.

Following the Seventh Report of the Review Body on Doctors' and Dentists' Remuneration,(27) the principle of increased payment because of the greater work-load represented by a discrete population group has been extended for the first time in the National Health Service. Payment of fees for maternity services has existed from the/

the beginning and to this has now been added the higher capitation payment for patients over 65 years of age.

Similar recognition of the greater work-load involved in treating the illnesses of lodging-house patients and similarly increased disbursement on behalf of this group would remove the main barrier and allow remedy of the present neglect. This increased disbursement cannot simply take the form of a higher capitation fee because the shift in the population prevents calculation of the number of patients "at risk".

<u>Special appointments</u>

Special general practitioner appointments should be created.

1. They should be financed by inducement payment. The Secretary of State for Scotland and the Minister of Health in England can at present obtain funds from the Exchequer for inducement payment and can award this after consultation with the General Medical Services Committee.

2. Surgery premises and ancillary staff should/

should be provided for the general practitioner holding the appointment by the local authority of the area.

3. The appointment should be made by the Local Executive Council which is responsible for the general medical service in the area.

4. These appointments should be full- or part-time according to the work involved and should be in towns having more than 250 lodging-house or reception-centre beds. At the end of 1965 there were 19 reception centres administered by the National Assistance Board and the report "Homeless Single Persons" (25) provides a national survey of lodging-houses and hostels. Under the Ministry of Social Security Act, 1966 (28) the Supplementary Benefits Commission has taken over the work of the National Assistance Board in this field and can identify the towns which fall into this category.

Other lessons which have been learned in the course of this study should be applied.

1. The doctor appointed should have wide general practice experience which is needed to deal/

deal with clinical aspects of the work - multiple pathology, particularly in mental illness, chest illness and musculo-skeletal disorder, will be found frequently; understanding of a patient/doctor relationship and its use is required to add depth to diagnosis of the individual problem; mobilisation and integration of hospital and community services is necessary for the patient whose condition is beyond the personal resource of the practitioner.

2. Adequate supporting ancillary staff should be provided. Hysterical patients are common in this population and a capable receptionist is needed who will ensure ready access to the doctor but prevent the manipulation which is the characteristic of hysteria. The unusual proportion of correspondence and the supervision of record-keeping designed for further research in this setting calls for secretarial help.

Adequate nursing help will relieve the doctor of the disproportionate number of dressings and injections required and the help of a medical social worker will relieve him of the requirement of /

of making social assessments and arranging referrals to agencies.

3. This study has shown that certain illnesses are found commonly in this population and these should be sought fur, using <u>screening techniques in history-taking and physical examination</u>. A history of mental illness should, for instance, always be sought in history-taking and mass miniature radiography service should be available as part of physical examination.

4. <u>Reliable and direct communication</u> should be arranged with the hospital and local authority personnel commonly involved - consultant psychiatrist, chest physician, casualty and orthopaedic surgeon, and the various officers of the local health and welfare department.

5. <u>Further clinical research</u> should be planned. The lessons learnt from this study should be applied on a national basis and the medical care and research coordinated so that successive lessons learnt allow the problem of illnesses of lodging-house patients to be dealt with ultimately at preventive level. Consideration of the/

the three common disease groups, for example, suggests that special provision or extension of medical facilities may be required -

i Mental illness - by the provision of hostels for alcoholics, epileptics and the mentally ill, and the cultivation of their activities by mental health workers.

ii Chronic respiratory disease - by extra hospital beds in winter or special winter hostel shelter.

iii Musculo-skeletal disorder - by additional physiotherapy and rehabilitation services, easily reached from the lodging-houses.

The measures advocated in this chapter are the necessary first moves in solution of the problem of illnesses of lodging-house inmates. Their adoption would go some way towards cleansing "the stinking fosse, where the injured lead the ugly life of the rejected."

Summary

This study describes the medical and social characteristics of 450 patients from lodging-houses who attended one of the practices of the Department of General Practice of the Faculty of Medicine in the University of Edinburgh between 1st February, 1964 and 31st January, 1965.

These patients, largely without skills, financial resources and supporting relationships were found to have patterns of illness different from those of normal general practice. 55% suffered from some form of chronic handicapping disease, of which mental illness and chronic bronchitis were most common.

A comparison with normal general practice patients revealed differences in the patterns of surgery consultations, domiciliary visits and hospital referrals, particularly concerning mental illness, chronic respiratory disease and musculo-skeletal disorder.

The nature of their illnesses and the patterns/

patterns shown are principal reasons for the inadequacy of medical care in this vulnerable population when it is undertaken in normal general practice conditions. Proposals are made for the establishment of special general practitioner appointments to ameliorate the present neglect, and the administrative and clinical factors which would require attention are considered.

The role of the research worker and the difficulty of research caused by the constantly changing environment in general practice are discussed and the limitations and opportunities indicated.

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Dr. D.C. Morrell and Dr. C.A. Gibbs shared in the clinical work. I should like to record my gratitude to them and to the ancillary staff of the Livingstone House practice.

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Finally, my thanks are due to Miss A.D. Johnston who undertook all of the typing.

References

(1) The Dawn of Scottish Social Welfare.

Thomas Ferguson. Nelson, 1948.

(2) Growing Old in Common Lodgings.

E.M. Sargaison, Senior Almoner, Belfast City Hospital.

The Nuffield Provincial Hospitals Trust, 1954

(3) Glasgow Common Lodging-Houses and the People Living in Them.

S.I.A. Laidlaw, Medical Officer of Health, City of Glasgow.

The Health and Welfare Committee of the Corporation of Glasgow, 1955.

(4) "Down and Out in London".

J.S.Whiteley. Lancet, 1955, Vol. 2, p. 608.

(5) Forgotten Men

M. Turner. The National Council of Social Service, London. (no date)

(6) "Tuberculosis in Vagrants and Inmates of Lodging Houses".

A Report by the Joint Tuberculosis Council.

The Medical Officer, 1965, No. 8, p. 103.

(7) "London's Skid Row".
G. Edwards, A. Hawker, V. Williamson and
C. Hinsman. Lancet, 1966, Vol. 1, p. 249

(8) Third Report by the Committee of the Edinburgh
Lodging House Association, 1848.

(9) Rules and Regulations for Common Lodging-
Houses in Edinburgh, under the provision
of "The Public Health (Scotland) Act, 1867"
made by the Magistrates and Council of the
City of Edinburgh, duly convened and held
in the Council Chambers in Edinburgh on the
Twenty-fourth of January, 1882.

(10) Report by the Burgh Engineer of Edinburgh,
31/3/88.

(11) Interim Report of the Consultative Council
on Medical and Allied Services.
H.M.S.O., 1920.

(12) The Field of Work of the Family Doctor.
Report of the Subcommittee of the Standing
Medical Advisory Committee. H.M.S.O., 1963.

(13)/

(13) "Edinburgh University General Practice Teaching Unit".
R. Scott. American Journal of Medical Education, September 1956, Vol. 31, No. 9, p. 621.

(14) Studies on Medical and Population Subjects, No. 9. General Register Office, H.M.S.O., 1956.

(15) "The Edinburgh Hospitals".
R. Scott and M. Gilmore. Problems and Progress in Medical Care, Vol. 2. The Nuffield Provincial Hospitals Trust, 1966.

(16) "Just What the Doctor Ordered".
R. Scott, J.A.D. Anderson, and A. Cartwright. B.M.J., 1960, Vol. 2, p. 293.

(17) "Dual Care".
D.W. Cammock and F.H. Lee. Lancet, 1966, Vol. 1, p. 482.

(18) "A Guide to Research in General Practice".
The Research Committee of the Council of the College of General Practitioners.
Supplement to the Journal of the College of General Practitioners. London, November 1962.

(19)/

(19) Elements of Comparative Sociology

S. Andreski, Professor of Sociology, University of Reading. Wiedenfeld and Nicolson, London, 1964.

(20) "The Work of the General Practitioner".

D.S. Lees and M.H. Cooper. The Journal of the College of General Practitioners, 1963, Vol. 6, No. 40, p. 408.

(21) Personal communication.

K.I. Little, Professor of Social Anthropology, University of Edinburgh.

(22) Conjectures and Refutations.

K.R. Popper. Routledge and Kegan Paul Ltd., London, 1963.

(23) Report of the National Assistance Board for the Year ended 31st December, 1964.

H.M.S.O., 1965.

(24) Non-Citizens of 1964.

Christian Action and the Simon Community Trust, 1964.

(25)/

(25) Homeless Single Persons.
Report on a Survey carried out by the National Assistance Board, with the cooperation of other Government Departments and voluntary bodies between October, 1965 and March, 1966.
H.M.S.O., 1966.

(26) "Future Role of the Family Doctor".
E.M. Backett. Lancet, 1960, Vol. 2., p. 1075.

(27) Review Body on Doctors' and Dentists' Remuneration - Seventh Report.
H.M.S.O., 1966.

(28) Ministry of Social Security Bill, 1966.
Explanatory Memorandum by the Minister of Pensions and National Insurance.
H.M.S.O., 1966.

Appendix I.

List of documents used in surgery record-keeping.

1. Form E.C. 19 (Scotland) (Rev. 3)
2. Form E.C. 7 (Scotland)
3. Form E.C. 8 (Scotland)
4. Social and medical history record card
5. Daily Sheet

(Copies of these are to be found in the pocket on the inside of the back cover)

6. Code for Daily Sheet Referrals (see overleaf)

6. Code for Daily Sheet Referrals

I. Medical

1. Mental Out-patient
2. Chest Clinic
3. Other hospital Out-patient
4. Direct admission
5. Mass miniature radiography
6. Open access X-ray
7. Other - specify

II. Social Services (Statutory)

1. National Assistance Board
2. Ministry of Labour
3. Ministry of Pensions and National Insurance
4. Regional Medical Officer
5. City Social Services
6. Other - specify

III. Social Services (Voluntary)

1. Salvation Army
2. Women's Voluntary Services
3. Epileptics Association
4. Other - specify

Appendix II

Legislation relating to health in Lodging Houses in Scotland

1845 Poor Law (Amendment) Act

1857 Report of Royal Commission on Lunacy

1867 Public Health (Scotland) Act

1890 Housing of the Working Classes Act

1897 Public Health (Scotland) Act

1905 Unemployed Workmen Act

1908 Old Age Pensions Act

1909 Housing and Town Planning Act

1911 National Insurance Act

1929 Local Government (Scotland) Act

1936 Public Health Act

1947 National Health Service (Scotland) Act

1948 National Assistance Act

1966 Ministry of Social Security Act

Appendix III

Bye-laws for Common Lodging Houses in Edinburgh

and

Form of Application

BYE-LAWS

for

COMMON LODGING-HOUSES IN EDINBURGH

Under the Provisions of the Public Health (Scotland) Act 1897

N.B. - In Edinburgh, the expression "lodging-house" means a house or part thereof in which any person is lodged by the night at a rate not exceeding one shilling per night for each person, whether the same be payable nightly or weekly, or at any period not longer than a fortnight, and includes any place where emigrants are lodged, and all boarding-houses for seamen, irrespective of the rate charged for lodgings or boarding; the expression "lodging-house keeper" means the occupier of such lodging-house who lodges such person; and the word "lodger" means any person so lodged.

1. No house shall be used as a Common Lodging-house unless such house shall have been duly inspected and registered and approved by

the Local Authority; and every keeper of a Common Lodging-house shall have painted over the principal entrance to such Lodging-house, in distinct Roman letters, at least one inch and a half in length, his Christian Name and Surname and the words "Registered Lodging-House."

2. Each application to have a house registered as a Common Lodging-house shall be in writing in the form annexed hereto, and lodged with the officer appointed by the Local Authority to receive the same, at or previous to the 15th day of May in every year. It shall be truly set forth the name and residence of the applicant, the situation of the house, the number of lodgers proposed to be accommodated, and the number of the applicant's family, and shall be accompanied by a certificate of character, in the form annexed hereto.

3. If the Local Authority are satisfied with the character of the applicant, and with the fitness of the premises, they may register accordingly, and shall furnish him as Keeper with a Register Ticket for each room of such Common

Lodging-House, setting forth the number of lodgers to be accommodated in such room, and every keeper of a Common Lodging-house shall place, affix, keep, and continue in such part of each room as the Local Authority shall direct, a copy of these Bye-laws and the Ticket above referred to, and shall not remove or deface the same, or allow the same to be defaced or removed.

4. The keeper of a Common Lodging-house shall not at any time receive, or cause or suffer to be received, into such house, or into any room therein, a greater number of Lodgers than shall be fixed by the Local Authority as the maximum number of lodgers authorised to be received into such house or into such room, which shall be in the proportion of not more than one person of the age of eight years and upwards for every 400 cubic feet of space contained therein (exclusive of lobbies, closets and presses, and of recesses not exceeding four feet in depth, and not having a separate windown therein, and not perfectly clear from floor to ceiling, and from wall to wall, and exclusive also of

recesses in which there is any fixture whatever).

5. No keeper of any Common Lodging-house shall allow any room in the basement or any room having the floor below the level of the ground, nor any room used as a Kitchen or Scullery to be used as a Sleeping Room.

6. Every keeper of a Common Lodging-house shall reduce the number of lodgers in such house or in any room thereof upon receiving notice in writing to that effect from the Local Authority, such notice stating the special cause of the same being given, and the period, not exceeding one month, during which it is to continue in force.

7. No keeper of a Common Lodging-house shall allow persons of different sexes to occupy the same sleeping apartment except married couples, or parents with children under ten years of age.

8. No keeper of a Common Lodging-house shall allow more than one married couple to occupy the same sleeping apartment, unless the beds are separated by a partition to secure the privacy of each married couple.

9. Every keeper of a Common Lodging-house shall cause the windows and doors of every sleeping apartment, and of such rooms, lobbies, passages and stairs as the Local Authority may direct in such Lodging-houses to be kept open to full thereof from above and below from ten to twelve o'clock forenoon and from two to four o'clock in the afternoon of every day, unless prevented by bad weather, or by the illness of any inmate in such room, and at such times during which the windows are opened as aforesaid, he shall cause the bed-clothes of every bed in such room to be kept turned down and exposed to the air. In those rooms occupied by persons who are at work during the night and sleep in the day, he shall cause the windows to be kept open from two to four o'clock in the afternoon, unless prevented by bad weather or the illness of the inmate.

10. Every keeper of a Common Lodging-house shall cause every room occupied as a sleeping apartment to be furnished with bedsteads, bedding, bed-clothing, furniture and utensils for the number of lodgers to be received in such room, and shall

cause to be provided basins, or other receptacles for water of adequate capacity and suitably placed, and a supply of pure and wholesome water, and a supply of towels for use in connection with such basins or receptacles; he shall also provide accommodation for cooking and washing for every lodger received into such house, all as directed by the Local Authority.

11. Every keeper of a Common Lodging-house shall cause the beds, bedcovers, blankets, rugs, sheets, pillows, bolster slips, and all the bed-clothing to be kept thoroughly clean and free from filth or vermin, to the satisfaction of the Local Authority, and he shall cause all basins or receptacles for water to be kept clean and in good order, and the supply of towels to be renewed from time to time, as often as may be required.

12. Every keeper of a Common Lodging-house shall provide a water-closet or privy for every such Lodging-house having a yard or other facilities for the erection thereof; and where such facilities do not exist, or where the closet or privy is used in common by the lodgers of two or more houses, he must provide the privy or

closet in some place conveniently contiguous, to the satisfaction of the Local Authority, and for every twenty lodgers to be accommodated, he must provide a separate closet, or privy. He must cause such water-closet seat, floor and walls to be kept free from filth, and clean in all other respects, and he must maintain, at all times, in good order every part of the apparatus of such water-closet, and every drain connected therewith, or with any privy connected with such Lodging-house.

13. Every keeper of a Common Lodging-house shall cause the floors of all the rooms, passages, and stairs of such house, and of the common stairs and lobbies by which access is obtained thereto, to be kept at all times clean, and to be swept at least once in each day before ten o'clock in the forenoon, and to be thoroughly washed on Wednesday and on Saturday in each week before the hour of six o'clock afternoon, and at such other times as the Local Authority may require. He shall cause every window, every fixture or fitting of wood, stone or metal, and every painted surface in such house

to be kept thoroughly clean and in good order, to the satisfaction of the Local Authority and every fixture or fitting of wood to be painted every three years; he shall also cause the walls and ceilings of every apartment, and of the staircases, passages, closets, and presses within such house to be thoroughly cleaned and lime-washed twice at least in every year - viz: in April and October, and at such other times as the Local Authority may by special order appoint or direct.

14. No keeper of any Common Lodging-house shall permit any ropes or strings whereon clothes may be suspended for the purpose of drying or otherwise, to be suspended in or stretched across any sleeping apartment, nor shall he allow any wet or damp clothing to be suspended, by nails or otherwise, in any sleeping apartment, but clothing when wet, if dried within the house, shall be dried in the kitchen or other separate apartment where there is a fire provided.

15. Every keeper of a Common Lodging-house shall cause all solid or liquid filth, and all slops

and offensive matter or refuse to be removed once at least in every day, before ten o'clock forenoon, from every room in such house, and shall, once at least in every day, before ten o'clock forenoon, cause every vessel, utensil, or other receptacle for such filth or refuse, to be thoroughly cleansed. All dust, ashes, and night soil shall be removed daily from every Common Lodging-house. No keeper of a Common Lodging-house shall allow any dangerous or offensive animal, or any poultry to be kept or fed therein.

16. If any person or persons in a Common Lodging-house shall become ill, the keeper of such house shall at once ascertain, from a properly qualified Medical Practitioner, whether the said person or persons be affected with fever or other contagious disease, and if so, such keeper shall give immediate notice thereof to the Medical Officer of Health, and shall act in accordance with any instructions given by him.

17. Every keeper of a Common Lodging-house shall, when a person is ill of any infectious disease, forthwith cause all other lodgers to be removed from the room in which any person is

ill of such disease, and if the Medical Officer so directs, he shall not use the house as a Common Lodging-house, except such part thereof as may be certified by the Medical Officer of Health to be free from infection.

18. Every keeper of a Common Lodging-house shall cause the blankets, rugs, bed-clothes, bedding, and other articles used by any person affected by such infectious disease, to be thoroughly cleansed, and disinfected, and shall not allow the room occupied by such person to be used or occupied by such person until properly fumigated and disinfected to the satisfaction of the Medical Officer of Health; and shall cause any clothes and bedding used by such person to be burned or otherwise destroyed, when required by the Medical Officer to do so.

19. The Chief Constable, the Medical Officer of Health, the Chief Sanitary Inspector, and such others as they may authorise, shall have, at all times, access to every Common Lodging-house, and to every part thereof.

20. Every keeper of a Common Lodging-house shall maintain and see to the enforcement of good order and decorum within the Lodging house occupied by him, and shall prevent persons occupying or resorting to such house for immoral purposes.

PENALTIES

21. Any person offending against any of these Bye-laws shall be liable in a penalty not exceeding the sum of Five Pounds for each offence, and, in case of a continuing offence, in a further penalty not exceeding the sum of Forty Shillings for each day after written notice of the offence from the Local Authority.

"MITCHELL THOMSON", Lord Provost.
"JAMES POLLARD", Magistrate.
"THOMAS HUNTER", W.S., Town Clerk.
Clerk to the Local Authority.

FORM OF APPLICATION

EDINBURGH, ... 19

I hereby make application to have the undermentioned premises at .... registered as a Common Lodging-house, in terms of the Public Health (Scotland) Act 1897.

Name of applicant . . . (here sign Christian name and Surname)

Residence . . . .

Situation of house intended to be used as a Common Lodging-house . . . .

No. of rooms	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
No. of lodgers																					

No. of Kitchens	No. of Sitting Rooms	No of Sleeping Rooms (private)						No. of w.c.'s
		1	2	3	4	5	6	

Number of Family . . . .

To The Local Authority
of the Royal Burgh of Edinburgh.

FORM of CERTIFICATE of CHARACTER

Edinburgh 19

WE CERTIFY that the applicant's character and qualifications are such that, in our opinion, he is qualified to be the keeper of a Common Lodging-house.

....

....

....

....

....

....

(to be signed by two respectable Householders, residing or having their places of business in the Ward in which the Common Lodging-house is situated, paying each not less than £20 of rent. Each will add his Designation and Residence.)

Confirmed by the Local Government Board for Scotland.

EDINBURGH, 26th July 1898.

"G. FALCONAR STEWART"
Secretary.