Conclusions

Obviously there is much room for improvement in hospital discharge reports, both in the type and amount of information recorded and in the presentation of this information. The data that family doctors find important is accurate identification of patient and consultant, a diagnostic assessment, information on drug reactions and treatment on discharge, and, possibly most important in the case of seriously ill patients, a note on how far the patient has been informed about his prognosis—should not be lost among narrative but should be immediately identifiable.

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Occasional Survey

Medical care of homeless and rootless young people

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Attention has recently been drawn to the plight of the many homeless young people who drift into our big cities. Though the problem is by no means new^{1 2} it is only within the past 10 years that much public concern has been expressed about them.^{3 4} The problems of homelessness among the young are immense and raise major social issues which are outside the scope of this paper. I would like to focus on some specifically medical aspects of the problem.

Davies drew attention to the inadequacy of medical care for the homeless in her report *The Provision of Medical Care for the Homeless and Rootless*.⁵ Unfortunately most of our social institutions, including the NHS, are geared towards a geographically stable population living in flats or houses. Nomads—be they gypsies, itinerant fairground stall holders, or just drop-outs—are deviant and therefore unpopular both with the general public and the institutions which serve them. The homeless tend to be regarded with suspicion and often disgust and, since they have no homes, they are unable to register with a general practitioner. Although they are frequently seen in hospital casualty departments they are unpopular there also and usually got rid of as soon as possible.

This paper is a short account of my experience as a physician to an experimental scheme providing accommodation for homeless and rootless young people in North London.

The scheme

The scheme was an off-shoot of a detached youth project (the

Soho Project) set up in 1968 to explore the needs of the thousands of young people who, at that time, thronged the Soho discotheques and coffee bars every night. In another paper⁶ I have pointed out that, while a degree of alienation is a common and indeed a necessary feature of adolescence, many of these homeless and rootless youngsters had gone beyond the point of no return and were very much at risk.

In 1970 an attempt was made to provide acceptable accommodation for some of these youngsters, and a house was bought in North London offering accommodation to about a dozen young people of both sexes, either singly or in pairs. The accommodation was in a small terraced Victorian house in a once residential area which had become run-down in the '50s and '60s because of the threat of major road development. Six rooms were let out as bedsitters, either to individuals or to pairs. The residents were expected to pay a small rent (and sometimes did) and they were obliged to do their own catering and cooking in a communal kitchen. No meals were provided. There were also communal washing and toilet facilities.

The staff of three or four worked chiefly in a communal ground-floor office, which was usually full of people (workers, residents, and visitors) and they saw their main job as being "available" to the residents when required in whatever way they felt to be appropriate. The tasks taken on by the staff were largely self-appointed and varied greatly from one worker to another. Like their clients they were usually young and somewhat deviant—constructive rebels who felt alienated from the establishment but nevertheless quite able to cope with society. All were intensely caring people. Some were qualified social workers; others had no formal qualifications, but since the house was new and experimental there could be no clear job specification. A management support group was available and a consultant met with them regularly to help them conceptualise their task. Despite this the staff turnover was high. The frustrations of the work were great and the inevitable pain of watching young people slowly destroy themselves and of being unable to help them became intolerable. Few stayed longer than a year.

The residents varied in age from 17 to 30, and in number from eight to ten. Some stayed only a few weeks, others for months or even years. Nearly all came from deprived backgrounds and most could be described as "damaged," having a very limited capacity for making satisfying personal relationships, working, or indeed getting any pleasure out of life except through drugs. Most were registered nar-

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cotic addicts and many were, in addition, addicted to intravenous barbiturates, with disastrous medical consequences.

Residents' self-assessment

It is not easy to separate the medical from the social aspects of the house and its residents, who felt trapped in a situation from which there was no escape. They knew themselves to be deviant and therefore rejected by most of society. Their self-esteem was negligible and their horizons limited. They felt a deep sense of worthlessness and despair from which the only relief, however temporary, seemed to come from drugs. How to obtain the next "fix" became therefore a major pre-occupation, and any other kind of planning became quite irrelevant. An expertise in psychopharmacology provided some of the residents with a spurious self-esteem. I was frequently questioned about this (and found wanting) and was often subjected to long and unbelievably boring dissertations about the effects of various psychotropic drugs and also how to obtain them illicitly. Considered from a psychiatric standpoint most of the residents were grossly disturbed and some could be regarded as psychotic.

As a result of this preoccupation with drugs most of the residents were malnourished and anaemic. When under the influence of barbiturates they neglected themselves still more, and most, sooner or later, developed severe injection abscesses. Upper respiratory infections were extremely common, and syringe jaundice was always a possibility. Drug overdosage was a constant and potentially lethal hazard, and on several occasions residents set fire to their bedding while smoking under the influence of drugs and sustained severe burns with, in one case, fatal results.

Medical care

All the residents were, in theory, registered with a group practice in the district. Some primary medical care was also provided by one of the drug treatment centres in the area. In spite of this the standard of medical care received by the residents was poor. As a result of their life style and their self-neglect they were not very presentable. They looked dirty and ragged, their arms were covered with needle tracks, and they felt (with some justice) that they would not be very welcome in a doctor's surgery because of these stigmas. Furthermore, they did not find it easy to negotiate doctors' receptionists, waiting rooms, and appointment systems.

The group practice with which they were registered was highly efficient. During the period under consideration it moved into a purpose-built health centre. Individually and collectively the staff were kind, caring, and concerned for their patients' welfare. In practice few of the residents ever went to the health centre nor did they ever request a visit except in acute emergencies. The result was that once a week, on average, a doctor would be called out, usually at night, to deal with a serious crisis, often finding the house in a state bordering on chaos with an unconscious patient and a minimum of information about the nature of his/her illness.

The doctors found it hard to establish good relationships with the residents, who viewed them with some suspicion. They were aware that they were not giving a good medical service to the residents, and this made them feel frustrated and impotent. So the house began to get a bad medical reputation. A further problem was that some of the residents became adept at persuading the doctors to prescribe sedative drugs, especially barbiturates, and this caused tension between the general practitioners and the drug treatment centres. The house staff also felt frustrated and anxious; the residents often turned to them for medical advice which they felt quite unqualified to give.

In 1972 I was approached by the chairman of the management committee with a request that I might act as house doctor to the residents on behalf of the practice. I was at that time working as a full-time consultant psychiatrist but I was known to have a special interest in alienated young people and general practice (to which I later defected). The Tavistock Clinic was willing to spare me for two hours a week and a preliminary meeting was thus arranged with the house staff, who seemed to be guardedly enthusiastic.

Next a meeting was arranged between all those concerned with the medical care of the residents. It emerged that feelings about the house were very strong. The general practitioners regarded it as a symbol of failure and were grateful that someone was prepared to relieve them of the burden. The drug treatment centre staff tended to see the house as a den of iniquity with the staff as diabolical acolytes. They were highly suspicious of the general practitioners, believing

that they gave in far too easily to the greedy demands of the residents. By contrast, the house staff saw themselves mainly in the role of "landladies," offering accommodation without any special control over the activities of the residents. They argued that if they tried to impose a spurious authority the residents would leave and that in any case controls take away the individual's need, right, and opportunity to learn for himself. The ventilation of all these notions seemed to clear the air, and it was agreed that I should start visiting the house each week. It was also agreed that monthly meetings of all concerned should continue, to ensure good communication.

From then on I visited the house weekly, reserving one and a half hours for this purpose. The first impression was very depressing: the paint and plaster were peeling off the walls and several windows were broken, the holes being stuffed with rags or cardboard. Inside was worse: the walls were damp and dirty, the floors littered with rubbish, and the rooms smelly and dimly lit. There was much broken furniture and the banisters were unsafe.

No one consulted me on the first day, but the staff regaled me with horror stories of the residents' destructiveness and violence. It became clear that the depressing appearance of the house was reflected in the low morale of the staff, all of whom expressed a feeling of hopelessness and uncertainty and of imminent destruction.

Practical steps

I could see that there were some obvious public health problems needing urgent attention and being a reasonably competent handyman I offered to carry out a few emergency repairs during my weekly visits. These repairs were not only very necessary but I hoped also that it would provide an opportunity for meeting some of the residents. During the next few weeks I reglazed a number of windows, repaired the banisters, and cleaned out the gutters. In this way I met most of the residents, who came to see what I was doing and usually asked me about my role. I answered as truthfully as possible without emphasising my psychiatric background, since this was not relevant. Gradually the residents began to consult me in my medical capacity. At first these consultations were public and took place in the office with staff and other residents present. Privacy was quite possible but it was some time before the residents could trust me sufficiently to see me alone.

Many of the complaints for which I was consulted were directly or indirectly connected with drug abuse; large abscesses caused by the injection of barbiturate tablets crushed and dissolved in a spoon were common. Other illnesses connected with addiction were infective hepatitis and burns acquired while under the influence of drugs. Resistance to infections was generally low, probably because of poor diet and self-neglect. Otherwise the residents suffered from the same range of minor ailments as the rest of the population, requiring the same mixture of care and medical expertise.

Once I had established a relationship with the house the residents had no difficulty in making appropriate use of me, provided I came to the house at a regular time each week. Except in emergencies, however, they would not submit to hospital investigation or referral unless I insisted and took them there myself. Neither would they attend the hospital for regular dressings, preferring to carry these out themselves in the unsterile conditions of the house.

From the outset I made it clear that I was not going to prescribe narcotics or barbiturates, and that any questions related to their addiction must be referred to the drug treatment centre. My therapeutic repertoire was very limited; the ingredient with which I was most liberal was my time. This was absolutely necessary at first; later I think that the time I spent in the house could have been reduced. It entailed spending much time talking with staff and residents about apparently unrelated matters. At these times it would have been easy to forget that my primary function in the house was to be a doctor and for me to assume the role of a psychiatrist. In fact I never let this happen. I never gave a psychiatric interpretation or a psychotropic drug but I learnt a lot about my patients as people. I cannot claim any significant reduction in the morbidity of the residents. The only certainty is that there was a dramatic fall in the number of emergency visits by the doctors in the group practice. Once I started attending regularly the rate of night calls fell to nil. (There were none during the whole 18 months of my attendance.) Furthermore, I myself was only once called to the house outside my usual visiting hours (for a very good medical reason). Otherwise I was never disturbed, apart from one 'phone call from an over-anxious girl.

Another benefit was the improvement in communication among the staff of the house, the drug treatment centre, and the group practice

as a result of the meetings which took place. Basic differences in the attitude and function of the three groups emerged and were ventilated and though no changes took place a better understanding of their respective roles was reached.

After I gave up my position at the Tavistock Clinic my place at the house was taken by a junior colleague with an interest in the problems of rootless young people. She continued regular weekly visits for a further nine months along the lines that I had established. Ultimately the group practice resumed total responsibility for the house by allocating one of the doctors to visit the house weekly. I understand that these visits are continuing but that they are now considerably shortened. Probably a lengthy visit is no longer necessary.

Discussion

The experience of the residents in the house amply bears out all the points made in Davies's study.⁵ They are, of course, a special and rather atypical group, representing only one section of the many homeless and rootless.⁷ A scheme of the kind outlined in this paper provides no solution for the medical care of those who are sleeping rough, and there is an urgent need for a walk-in centre of the kind outlined in a discussion paper (unpublished) by Co-ordinated Help and Other Services (CHAOS) dated March 1974, which has resulted from Miss Davies's work.

Meanwhile, our experience seems to show that the most important ingredients in the medical care of young homeless people are time and compassion. It is not difficult to meet their

immediate medical needs, provided they are not expected to conform to standards which are really impossible for them to attain, but the provision of such care is likely to be time consuming, especially at first. This is not easy for a busy general practitioner whose time has to be strictly rationed. My therapeutic goals were limited, and for what I attempted no great medical or psychiatric expertise is required (though a knowledge of simple carpentry can be a help.) The fact that I was a consultant psychiatrist is largely irrelevant. An experienced general practitioner would have been much better equipped than I was at that stage.

Any doctor wishing to involve himself in these problems would do well to limit his goals and curb any moralistic fervour he may feel either to "cure" drug addicts or to "change" people of whose way of life he may disapprove.

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Contemporary Themes

Surgical instruments and dressings: an information service

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Summary

A regional information service on surgical equipment, instruments, and dressings is proposed that would be staffed by information scientists. It would appreciably reduce the time spent on administration and make the buying of equipment more efficient. Such a service could be extended to all health service staff.

Introduction

The provision of information for workers in the health services has improved¹⁻³ but there are still many fields in which no

satisfactory information services exist. Even when they do exist they are often inadequate—for example, they may give only references to published articles. Coverage must be extended to include other information, particularly data generated in hospitals and those produced by manufacturers of equipment. Information services can have an important role in hospitals and help to improve the service to patients. But despite major developments, such as in patients' records, biochemical analysis, classification of diseases, and drug information services, doctors and nurses still solve many problems without expert help.⁴⁻⁷ We maintain that information on surgical instruments and dressings merits special and urgent attention on a national or regional scale.

Existing service

Surgical equipment, instruments, and dressings account for 20% of the average general hospital's budget for supplies and services⁸ yet there is no organised information service to help medical and nursing staff to choose items or to keep up to date with new products and materials. In the financial year 1973-4 a teaching hospital group (about 2100 beds) spent £516 000 on surgical instruments, dressings, and sundries.⁹ With inflation we may assume that in two or three years one teaching hospital and its associated hospitals will spend £1m each year on these items, and this without access to any reliably organised information on them. We have been unable to discover any service in the UK that systematically collects and exploits trade and

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