going to knock their socks off, let it creep up on them. Modesty and understatement is the best policy. Remember Watson and Crick and the double helix? "It has not escaped our notice that . . ." this is the most mind blowing discovery of the century. Use phrases like "it could bëargued that . . ." and "one possible explanation is . . ." you don't have to shout. The discussion is the most important part of the paper. People skip the methods and most of the results sections. Remember to criticise yourself first before anyone else gets the chance. After all in a couple of decades or centuries you may turn out to have been slightly wrong. Things like "some observer bias cannot be entirely excluded . . ." and "it remains possible that some of the responses occurred by chance . . ." go down well with the sceptics but save yourself for "however" or "nevertheless . . . steps taken in the experiment render this highly unlikely" and "this would not explain the central finding," etc. Generally keep it short and to the point. It is not a novel you are writing. If you get stuck, take a break. Leave the draft by your bedside. Sometimes a phrase just comes to you and its a shame to lose it.

Conclusion

Well, that is all the help you can get, from now on it is up to you. If it doesn't work out try not to get disheartened you will have made a contribution. Those hours or days spent listening to soothing music, daydreaming of Newton, Einstein, Darwin, and Freud have not gone to waste—you will have learnt what it means to write a classic paper.

Letter from. . . Chicago

Symposium

George Dunea

At medical dinners the conversation often drifts to shop talk about patients. Sometimes it becomes a veritable symposium. With a little wine and a long stretch of the imagination it brings to mind Plato's symposium. Missing, however, are the comfortable couches for the guests and the libations offered to Olympian Zeus.

A recent such dinner symposium turned out to be largely about strokes. One of the doctors related how a kindly 84 year old Mexican man had found one morning that he could not move his right arm without picking it up with his left. He also was dragging his right leg. His cranial nerves were normal, sensation and speech too difficult to test in Spanish, and only pyramidal signs were present. Clearly a stroke, so why not treat him at home, especially since his large family would take care of him. But somehow he ended up in the emergency room and then vanished into the immensity of a large teaching hospital for the next month.

You may well muse about cost effectiveness and the good old days when the sick were cared for in their own homes and 84 year old men did not require computed tomography. But when the patient reappeared it turned out that he had had burrholes to drain his clinically undiagnosable chronic subdural haematoma. Unlike the former president, he had not even fallen off his horse. But he remained well and enjoyed life despite calculations that computed tomography is not cost effective in people with strokes. The cost of computed tomography, incidentally, is now far less than that for one extra day spent in hospital waiting for the neurologist's opinion.

The second story was about a neurologist consulting about a woman who had been held up by a street gang. The men had revealed their unfriendly intentions by thrusting a gun in the woman's mouth and pulling the trigger. But as she had averted her head sharply to the left the bullet escaped through the soft tissues, leaving her with no more deficit than a sixth nerve palsy. The neurologist ordered computed tomography, but a utilisation reviewer said that is was not needed and that he would not approve payment. While the two doctors argued the sixth nerve palsy subsided. Nevertheless, the neurologist went ahead and obtained the scan. It showed a large aneurysm of the circle of Willis, presumably chronic, but likely to rupture without surgical intervention. The reason for the (presumably) false localising sign, however, remained unclear in this triumph of serendipity over reason and cost efficiency.

Too much time in hospital

The third case concerned the same neurologist. He had treated a doctor for a severe stroke with aphasia that had resulted in many months of hospital treatment. About a year later the neurologist received a telephone call from a health maintenance organiser reviewer about another patient with a stroke who was deemed to have spent too much time in the hospital an was to be sent home. It seemed to the neurologist that the man at the other end of the line was spending an awful lot of time trying to explain why he had reached this conclusion. He seemed to have difficulty in finding the right words. At last the neurologist realised that the man was dysphasic. Then it dawned on him that this was his old doctor patient with the stroke, who had once spent many months in the hospital, but was now ready to summarily order him to discharge from the hospital another patient suffering from the same illness.

The talk now turned to rationing health care. Someone mentioned hearing a radio programme about a community hospital that had a computed tomographic scanner, a cobalt unit, a lithotripsy machine, and a dialysis unit. A hospital of comparable size in Canada, a country that often warms the heartstrings of American health experts, had no such facilities, its complicated patients having to be transferred to a regional centre. Those familiar with such arrangements commented that this rational system was rationing indeed, remembering how in the bad old days many patients were referred too late or not at all. Cost effective indeed, but not for the old gentleman with the subdural haematoma.

Then talk turned to the young doctor who had chills and fever and was suspected to have malaria, having recently been abroad. When he became dehydrated his wife took him to the hospital where they gave him two litres of saline and then confirmed the diagnosis. There was no chloroquine in the pharmacy but the wife happened to have some in her handbag. The bill for

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Br Med J 1990;300:31-2

two days in hospital was $3500. Not bad, commented someone else, considering that hospitals now charge $5000 for a routine delivery. Moreover, the obstetrician's fee is extra, and quite high indeed, because it has to include a $40 000 a year malpractice premium. It goes to show that the problems are complex and the solutions hard to come by.

So ended this particular symposium. The one described by Plato, however, was not about sickness but about love. Socrates was there, as were Aristophanes and Alcibiades, and they drank well into the night, achieving some degree of "divine madness," for it was before the automobile and the breathalyser.

But later in the night, on the car radio, there was tenor John McCormak singing from the Rubaiyat:

Myself when young did eagerly frequent
Doctor and saint, and heart great argument
About it and about: but evermore
Came out by the same door as in I went.

An appropriate finale for the evening.

Housing and Health

Health and homelessness

Stella Lowry

Homelessness has been the backdrop of English life for many years—with harsh vagrancy laws under the Tudors, the *Hard Times* of the Victorians (Engels found no fewer than 50 000 homeless in London alone[1]), and the cardboard cities outside the National Theatre and other landmarks today. But how big is the contemporary problem?

A recent survey found that 751 people were sleeping rough on the streets in 17 of London's boroughs on one night, and that did not include people sleeping in derelict buildings, parks, or car parks.[2] In 1988 local authorities in England accepted that people in no fewer than 117 550 households were homeless (up nearly 5% on the previous year)—representing, according to the housing charity Shelter, about 337 000 people, though their own estimates are nearer 500 000. Here I discuss the health problems faced by homeless people and explore ways of providing care.

Born homeless

The number of homes available for rent in Britain has decreased by a million in the past 25 years. Legislation giving council tenants the right to buy their homes, often at heavily subsidised prices, has creamed off some of the better public housing to private ownership, and public sector building has not kept pace with the loss. In 1986-7 some 1700 new dwellings were built by the London boroughs, but 13 500 houses were expected to be sold to tenants.

British Medical Journal, London WC1H 9JR
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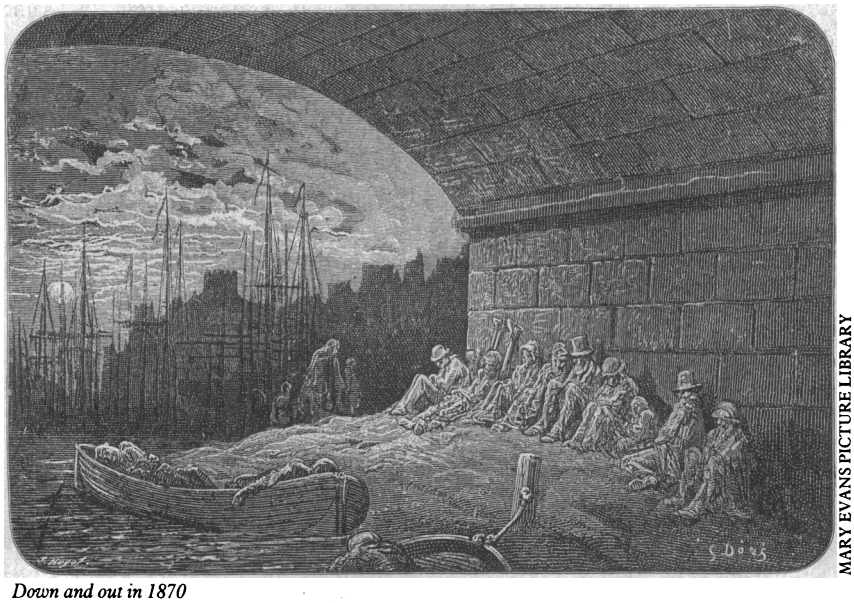
Br Med J 1990;**300**:32-4



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Down and out in 1870

Families with children have a right to housing under part 3 of the 1985 housing act. But because there are so few public sector houses available homeless families are often placed temporarily in bed and breakfast hotels. Not unusually such "temporary" arrangements may last for several years.

Living in a bed and breakfast hotel is not an extended luxury holiday. It means keeping all of your belongings in one room, living out of suitcases, and having no privacy. Children are born and brought up in one room, where they live with the rest of their family. There is no safe place to play. Washing and cooking facilities are shared with other families, and there may be nowhere to store food. If the cooking facilities are several floors away residents have to choose between eating takeaways, having cold meals, or carrying saucepans of hot food up several flights of stairs, often with children in tow.

The adverse effects of these conditions on health have been well documented.[3] Homeless women are twice as likely to have problems and three times as likely to need admission to hospital during pregnancy as other women. A quarter of babies born to mothers living in bed and breakfast accommodation are of low birth weight, compared with a national average of less than 1 in 10. The children are more likely to miss out on their immunisations, while poor sanitation and overcrowding encourage the spread of infections and diarrhoeal illnesses. Good nutrition is almost impossible because of the poor facilities for storing and cooking food. Accidents are common among the children, and their parents often suffer from depression.

Sleeping rough

No one knows how many people sleep on the streets in Britain each night, but it is probably several thousand. Some people choose to live rough, but many drift on to the streets because they cannot cope with personal and financial problems. An increasing number have been discharged from disbanded long stay mental hospitals.[4] High interest rates mean that some people are homeless because they cannot meet their mortgage repayments. In 1987 building societies repossessed 22 930 homes, and by June 1989 over 45 000 buyers were more than six months in arrears.

Once on the streets it is hard to keep healthy. The shelter, warmth, and privacy often taken for granted do not exist; good food may be hard to find or expensive; it is almost impossible to keep clean; "minor" illnesses are hard to cure.

Dr Malcolm Weller, a consultant psychiatrist in London, conducted a survey of the homeless people attending the Crisis at Christmas venue in 1986. About