If exophthalmos rapidly worsens, despite careful management, there should be no delay in applying such measures as lateral tarsorrhaphy, radiotherapy to the orbits or pituitary gland, and, as a desperate sight-saving measure, orbital decompression (Naffziger's operation). Corticosteroids equivalent to a daily dose of 100 mg. cortisone may assist in reducing the orbital oedema. The eyes should be protected with oily drops and shielded by dark glasses.

Cardiac Complications

The most common cardiac complications of hyperthyroidism are auricular fibrillation or flutter and congestive failure; these are the reactions of an ageing heart to the long-sustained demands of increased cardiac output. Other lesions of the heart may be present coincidentally. Thyrotoxic heart disease steadily increases in incidence from middle age onwards. Recognition of it is a signal for early treatment, for its reversibility depends to some extent on the duration of symptoms.

Until their thyrotoxicosis has been corrected, patients in congestive heart failure should be treated by bed rest and the appropriate cardiac therapy, depending on the severity of the condition. Those with uncomplicated auricular fibrillation will require digitalization only if the heart rate is rapid. If the cardiac rhythm does not revert to normal very shortly after hyperthyroidism has been corrected, the use of quinidine should be considered. Severely toxic patients may respond poorly to digitalization, but overdosage must be avoided.

Muscle Wasting

In the older age-group thyrotoxicosis occasionally presents with severe wasting of muscles, simulating myopathy or myositis. In this event, one of the new anabolic steroids, such as "durabolin" (19-nortestosterone phenyl propionate), 25 mg. once a week by intramuscular injection, may assist return of strength, alongside radical treatment.

Glycosuria

Transient glycosuria is not uncommon in thyrotoxic patients. It may be due to a lag in storage of glucose consequent on rapid absorption from the gut, or to unmasking of a mild latent diabetes by increased metabolism. The condition usually responds to treatment of the underlying disease. If diabetes is severe, or persists after treatment of the thyrotoxicosis, it should be controlled by the usual measures.

Thyroid Crisis

This dreaded and often fatal complication is rarely seen these days. It erupts when the circulating thyroid hormone reaches a critically high level in patients already exhausted from their disease. Most often it is precipitated by surgical manipulation of a toxic goitre inadequately prepared for operation. There is no way, unfortunately, of neutralizing thyroid hormone once it has escaped into the blood-stream, and its degradation is very slow. All that can be done is to prevent further release of the hormone by promptly giving iodide in large doses, and protecting against its effects by digitalization, sedation, and corticosteroid therapy; for there is some evidence that adrenocortical exhaustion may be an important factor in these cases.

ASSESSMENT OF APPLICATIONS FOR REHOUSING ON MEDICAL GROUNDS

BY

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The housing problem in certain areas is still a long way from solution. It has considerable public-health implications, and it places heavy responsibilities on the medical officer of health, who must assess the degree of priority to be awarded to applicants furnishing medical certificates in support of their rehousing claims. The number of these certificates has increased steadily in the London area since the war. Many patients believed that the greater the number of certificates the more priority was obtained and the quicker the rehousing. Though this was not so, it was difficult to explain the real situation to them. The variety of certificates submitted was considerable and their value and accuracy were sometimes obviously doubtful. It was clearly necessary for some regulation to be introduced to produce conformity and a substantial measure of fairness in allocating priority, and also to allow the family doctor a chance to give his objective recommendation confidentially. Argles (1950) drew attention to the increase in the number of rehousing applications; he showed that, whereas in 1938 the number received by the L.C.C. was 1,000, by 1949 (first nine months) it had risen to nearly 23,000. He observed that some applicants used every means in their power to secure accommodation and that the medical certificate was the most favoured method of gaining some preference.

Between 1955 and 1958 the Borough of Camberwell received 3,235 applications for rehousing; during the same period 1,623 housing applicants claimed medical priority. The applications were accompanied by certificates from the family doctor and to a lesser extent from hospital doctors and almoners.

In a review of 1,028 applications for rehousing, supported by medical certificates, submitted to Hampstead Metropolitan Borough, Warren (1954) found that 25% related to respiratory infections, 15% to rheumatic disorders, and 14% to psychological disorders. He stressed the need of the medical officer of health, in awarding "medical points," to have detailed information about the housing and medical conditions before he can allocate points.

After consultations with general practitioners and hospital staffs it was decided to introduce in Camberwell a new system that should prove more equitable. It was agreed that the form of medical certificate for housing should be the same for all cases and that only one certificate should be submitted for each patient unless the medical condition changed.

The Certificate

In 1955 the accompanying housing form was devised and brought into use.

BOROUGH OF CAMBERWELL

CONFIDENTIAL No.

For Official use only	
Recomm.	Date

**APPLICATION FOR PRIORITY
REHOUSING ON MEDICAL GROUNDS**

PART I

Name of applicant

Address

PART II To be completed by MEDICAL PRACTITIONER

Name of patient..... Age.....

This patient suffers from.....

As a result of your visits, what housing features do you consider adversely affect this condition?

.....

.....

Bearing in mind your knowledge and experience of other cases requiring rehousing, into which of the following categories of medical priority should this patient's name be placed

1. Most urgent.....
2. Urgent
3. Soon
4. No priority

Date..... Signed.....

Medical Practitioner

It is regretted that no fee can be paid for this certificate

**PLEASE RETURN FORM IN THE ENCLOSED STAMPED
ADDRESSED ENVELOPE**

PART III To be completed by PUBLIC HEALTH INSPECTOR

(a) Family for whom accommodation is required:

..... adults

..... male children aged.....

..... female children aged.....

(b) Present accommodation:

Room	Living-room	Bedroom	Scullery	W.C.
Number				
Floor				
Whether shared				

Total persons..... Equivalent number.....

Total number of rooms..... Permitted number.....

Statutory overcrowding?.....

(c) Standard of present accommodation:

1. Is separate sleeping room available for patient(s)?
2. Is there serious dampness?
3. Is water supply readily accessible?
4. Any other serious defects?
5. CAN POINTS BE AWARDED FOR BAD CONDITIONS?

(d) REMARKS:

Date..... Signed.....

Public Health Inspector

RECOMMENDATION BY MEDICAL OFFICER OF HEALTH

I recommend that this application should be placed in the following category of medical priority:

1. IMMEDIATE
2. URGENT
3. LESS URGENT
4. NO RECOMMENDATION

Date..... Signed.....

MEDICAL OFFICER OF HEALTH

Part I shows that a responsible person makes the application. Part II is the information given by the family doctor, and the answers show without doubt or possibility of confusion from what the patient is suffering and how this condition was affected by his or her present dwelling. It was expected that the practitioner signing the certificate would have visited and seen these conditions. The practitioner is then invited to assess in which of four grades the amount of priority the patient and the condition warrant, bearing in mind his knowledge of other cases and applications. It was fully realized that most practitioners were not always aware of statutory or accepted standards. Part III is usually completed by the public-health inspector before the certificate reaches the doctor, who is therefore in the happy position of knowing whether there is any statutory overcrowding or structural defect recognized by the borough, and he does not have to rely on the patient's own statements.

Assessment of Certificates

It was felt that a panel should be set up to review the certificates and decide the assessment of priority in one of the four categories. The panel consisted of the medical officer of health, a medical consultant, and a general practitioner. The Table opposite gives an analysis of the results of the 1,623 assessments made.

Discussion

The system described has proved to have many advantages. The special form which gives general

practitioners accurate information on overcrowding and sanitary circumstances was appreciated by them: its introduction was followed by a marked reduction in the number of "medical" applications; indeed, in a number of cases the form was returned with the recommendation "no priority." This was hardly possible previously when the doctor handed his certificate to the patient.

Many "medical reasons" given by patients themselves are groundless. However, we found a fair measure of agreement between the assessment of the family doctor and that of the panel, using this method of arbitration. There was also some progressive diminution in the number of applications in which the panel gave a lower recommendation than the general practitioner.

In addition to the personal medical category, the description of the environmental conditions found by the public-health inspector (see Form, Part III) was of great benefit in arriving at the final priority.

Many remediable housing defects were discovered *pari passu* and appropriate action taken.

Dampness was cited in support of some 159 cases (10%). After public-health inspectors' visits, confirmation was obtained in 137 of these.

Overcrowding.—The family doctor gave evidence of this in 305 cases. Confirmation by public-health inspectors was made in 280 of these and notification of statutory overcrowding was then sent to the housing authorities concerned. However, the limits of statutory overcrowding are by no means liberal and many borderline cases are seriously affected. It is natural that

HOUSING APPLICATIONS FOR MEDICAL PRIORITY JULY, 1955, TO DECEMBER, 1958

Classification by Types of Disease; and Priority Given by Applicant's Own Doctor and by the Panel

Disease	General Practitioner				Panel				Total	% of Total
	1	2	3	4	1	2	3	4		
Tuberculosis	31	49	88	65	35	47	83	68	233	14.4
Functional nervous disorders	54	123	128	18	21	71	118	113	323	19.9
Bronchitis (excluding tuberculosis)	43	104	94	25	16	79	88	83	266	16.4
Cardiovascular	20	52	28	3	13	49	22	19	103	6.3
Diseases of bones and joints	15	35	42	8	6	39	38	17	100	6.2
Organic diseases of the nervous system	16	20	13	—	10	18	14	7	49	3.0
Pregnancy	5	14	6	3	2	14	5	7	28	1.7
Diseases of the digestive system	1	11	11	3	—	10	7	9	26	1.6
Other*	13	44	30	11	7	30	33	28	98	6.0
Unclassified diseases	2	39	44	36	2	34	48	37	121	7.5
Died, gone away, forms not returned; rehoused; no residential qualifications	—	—	—	—	—	—	—	—	276	17.0
Totals	200	491	484	172	112	391	456	388	1,623	100.0
% of total	12.3	30.3	29.8	10.6	6.9	24.0	28.1	24.0		

* Defective sight, blood dyscrasias, senility, neoplasms, skin conditions, poliomyelitis paralyses.

family doctors should believe overcrowding to exist even though by reason of the age of the children the legal limits are not exceeded.

Disabilities

Tuberculosis.—A special points system for tuberculous applicants was devised in 1953, and this, with some modification, has proved successful and has been continued (Chalke, 1953). By this method of assessment, families at the greatest risk by reason of the age and sex of the members, and adverse living conditions, were given the highest priorities. The outmoded and often only criterion of "positive sputum with no separate bedroom" has thus been considerably modified. The special forms were completed at the chest clinic and the number of points calculated at the same time. This simplified the work of the panel, and no instance occurred in which the recommended and the final assessment of priority differed. Fourteen per cent. of all recommendations were in respect of tuberculous disease.

Nervous Disorders.—In 20% of the applications the disability was given as mental illness—chiefly nervous debility or anxiety neurosis. These cases presented the biggest assessment problem, for, while in a number of instances the effects of malhousing were very real, in others there were no grounds for believing that this was so, or indeed that the diagnosis could be accepted as anything but an attempt (for which we had much sympathy) to accelerate rehousing. In these cases the opinion of consultant psychiatrists was invaluable, though unfortunately rehousing could not be assured in all the deserving cases.

Bronchitis.—Bronchitic patients formed the second largest number (16.4%) of applicants. Dampness (though its presence was not always confirmed) was often alleged to be a causative or aggravating factor.

Accidents.—In a previous study (Chalke and Watton, 1959) the value of public-health inspectors' visits in remedying defects was shown. In addition to their routine and statutory visits, these specific housing inspections in respect of medical priorities gave the inspectors opportunities for giving householders much advice.

Friction.—This was an aggravating factor in 75 applications. The problem of young couples sharing houses and flats with "in-laws" or of two women being forced to use a common kitchen occurred frequently.

It became obvious that the "colour bar" problem was increasing in south-east London. Examples quoted included coloured and white tenants in adjacent rooms having to share W.C. accommodation. The purchase of a house by a coloured person caused resentment amongst the white tenants, many of whom had lived there for a number of years; it was often alleged that there was victimization in order to evict them in favour of coloured tenants, the latter often being willing to pay higher rents.

Exchange of Accommodation

Even when no overriding medical factor could give a priority, in 74 cases (5%) simple exchange was recommended. Usually the need is for ground-floor accommodation—for example, old people or persons with locomotor difficulties. In many instances the provision of such exchange would release additional housing units. This aspect of rehousing, though it is administratively complex, merits more attention; its wider application would be advantageous.

Summary

Details are given of 1,623 applications for rehousing priority on medical grounds in a London borough.

A form used for assisting the general practitioner in making a recommendation is described. It is shown that the difficult task of awarding priorities at a time when applications are numerous and available houses limited is best undertaken by a panel, on which the medical officer of health has the assistance of a consultant and a general practitioner.

Doctors are, however, becoming increasingly aware of the difficult housing situation, and of the necessity for taking it into account when giving a medical priority. When they appreciate this to the full, a final assessment by an independent medical panel will cease to be required.

Our thanks are due to Dr. J. M. K. Marsh, consultant in chest medicine, Camberwell Hospitals Group, for his assessment of the tuberculous applicants and for his invaluable help as a member of the panel.

REFERENCES

- Argles, E. B. (1950). *Publ. Hlth (Lond.)*, **63**, 123.
 Chalke, H. D. (1953). *Med. Offr*, **89**, 183.
 — and Watton, R. W. (1959). *Ibid.*, **101**, 225.
 Warren, M. D. (1954). *Brit. med. J.*, **2**, 861.