KING EDWARD'S HOSPITAL FUND FOR LONDON.

REPORT

OF

THE COMMITTEE

APPOINTED TO INQUIRE INTO

THE SYSTEM PREVAILING IN THE LONDON HOSPITALS

WITH REGARD TO THE

ADMISSION OF OUT-PATIENTS,

WITH

MINUTES OF EVIDENCE AND APPENDICES.

VOL. I: REPORT OF COMMITTEE.

JULY, 1912.

LONDON:
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BY GEO. BARBER, 23, FURNIVAL STREET, HOLBORN, E.C.,
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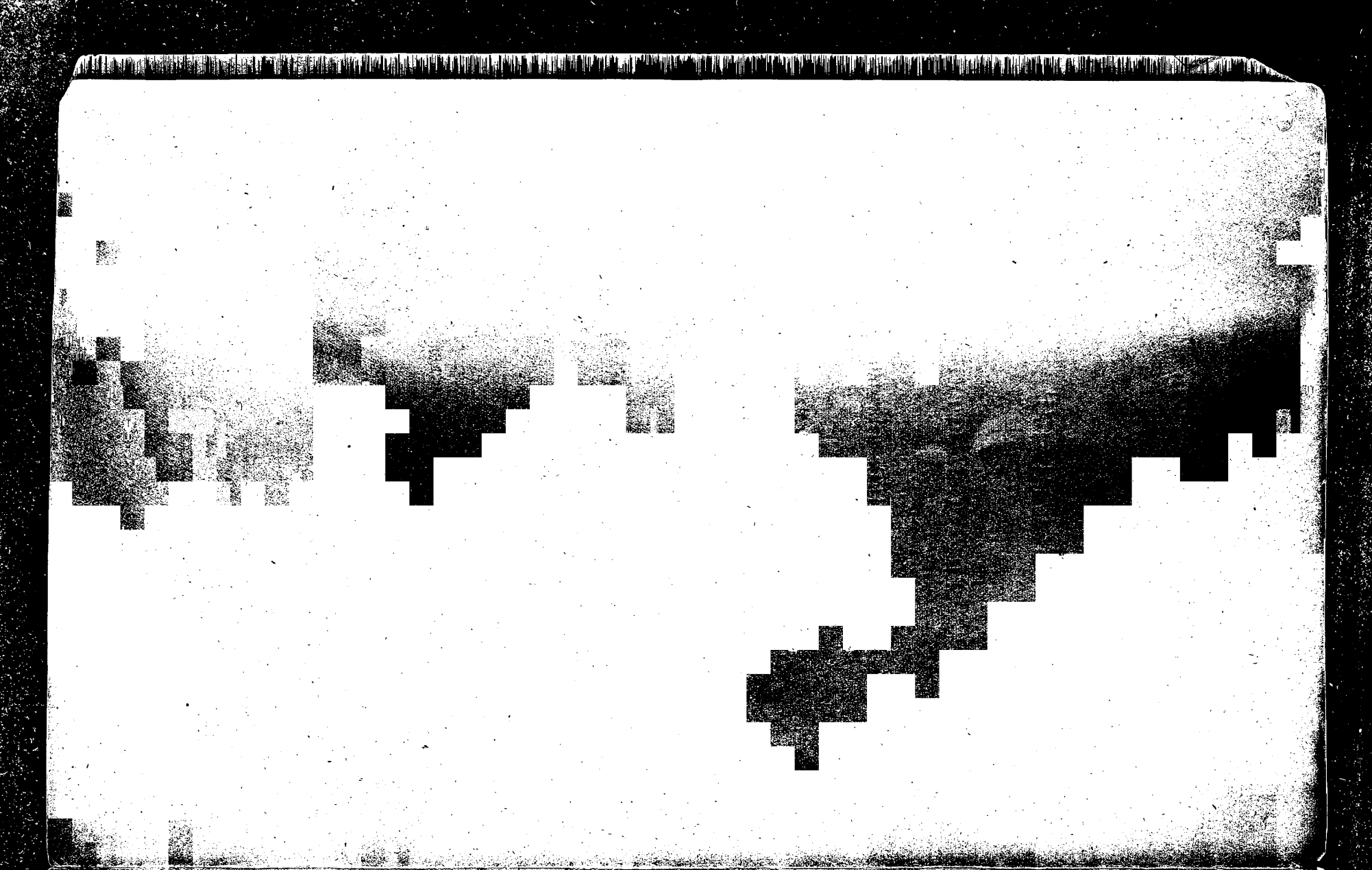

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PART I.

DISCUSSION OF EVIDENCE: WITH RECOMMENDATIONS.

I. INTRODUCTION.

1.—In January, 1911, H.H. the Duke of Teck, Lord Iveagh and the Speaker of the House of Commons, Governors of King Edward's Hospital Fund for London, appointed us, together with the late Lord Northcote, as a Committee to undertake the inquiries indicated in the following terms of Reference :—

> To consider and report generally as to the circumstances and conditions under which patients are admitted to the Casualty and Out-patient Departments of the London Voluntary Hospitals, and especially as to what precautions are taken to prevent the admission of persons who are unsuitable, and as to whether adequate provision is made for the admission of such persons as are suitable; and to make such recommendations as may seem to them desirable.

2.—We have the honour to submit the following Report of our proceedings and of the result of our inquiries under the foregoing Reference.

3.—It is with deep regret that we record the lamented illness and death of our colleague the late Lord Northcote, which deprived us of his most valuable assistance during the receipt of about one-half of the evidence and during the whole of the consideration of our Report.

4.—We have held 27 meetings, and have received oral evidence from 48 witnesses. Of these 27 attended in response to invitations addressed to particular Hospitals, the number of separate Institutions thus represented being 21. Of these Hospital witnesses, six were medical men, and 21 laymen, while of the other witnesses 11 were medical and 10 lay. In addition to the oral evidence we received written statements from 44 other Hospitals as well as from four personal witnesses.

5.—We find that the word "admission" is often used at Hospitals in a technical sense, as meaning admission to the wards for In-patient treatment. In this sense it would mean, when applied to an Out-patient, admission from the Out-patient Department into the wards. In the terms of Reference set out above the word is used in the non-technical sense of admission to the Out-patient or Casualty Departments themselves, and throughout our Report we have followed the same practice.

II. THE OUT-PATIENT SERVICE OF LONDON: ITS NATURE, EXTENT AND DISTRIBUTION.

6.—The following statement will show the nature and extent of the Out-patient service of London within a radius of nine miles from Charing Cross.

A. Hospitals.

7.—The number of Hospitals with Out-patient Departments from which detailed returns have been received amounts to 65, classified as follows[1] :—

[1] Statistical Appendix, Sec. A.

Class.	Number.
General Hospitals with Medical Schools ...	12
General Hospitals without Medical Schools ...	16
Children's Hospitals	7
Hospitals for Special Diseases	30

Besides these there are Out-patient Departments at 28 smaller General Hospitals and Special Hospitals from which no detailed returns have been obtained.[2]

[2] *Ibid*, Sec. D.

8.—These Hospitals are all comprised within the radius of nine miles from Charing Cross, but they are by no means regularly distributed within that area.[3] Of the 12 General Hospitals with Medical Schools no less than nine lie within one and a-half miles of Charing Cross, and of these all but two are north of the river. Taking the 28 General Hospitals together, six lie within the E.C. and W.C. postal districts, 10 more lie round these districts but still within three miles of Charing Cross, making 16 within that radius. Nine more lie between three and six miles distance, while only three (besides 10 Cottage Hospitals taking but few Out-patients) lie beyond the six-mile radius, an area which includes some of the most populous parts of Outer London.[4]

[3] Holland, 69
Davis, 958/7
Sandhurst, 1114
Michelli, 1789/25
Gray, 2842
Johnson, S., 3191/90
Heron, 3380/36
Shaw, H. B., 3717
Statistical Appendix, Sec. D.

[4] Holland, 69

In the case of the Special Hospitals the concentration towards a centre is still more marked. Out of the 37 Children's and Special Hospitals only four lie outside the three-mile radius, and of the 33 which lie within, 21 are situated in the Central and Western postal districts.

9.—This distribution is due to historical causes. It arises partly from the fact that the growth of the outer parts of London is of comparatively recent date, and partly also, particularly in the case of the Special Hospitals, from the same forces which have made the Harley Street area the home of the medical consultant, upon whose services the Hospitals depend. Its effects, so far as the convenience of Out-patients is concerned, are to some extent modified by recent developments of travelling facilities[5]; and the striking lack of Hospital accommodation in South London will be greatly reduced when the removal of King's College Hospital to South London is complete.[6]

[5] Royal Westminster Ophthalmic. App. 56/1 (*d*)
Prior, 2053

[6] Davis, 958/7, but *cf.* Capes, 4084-6

10.—But the disparity between the distribution of population and that of Hospital accommodation remains an important factor, and renders any organisation of Out-patient Departments on a basis of locality extremely difficult.[1]

[1] Buckle, 276
Thies, 432/20
Shaw, H. B., 3773
Nunn, 3855-3867

11.—The numbers of Out-patients, including Casualties, treated at these Hospitals in the year 1910 were as follows[2]:—

[2] Statistical Appendix, Sec. A, col. 2

Class (see paragraph 7).	Number of Hospitals.	Total Out-patients.
General Hospitals with Schools	12 ...	884,634
General Hospitals without Schools	16 ...	355,589
Children's Hospitals	7 ...	156,352
Hospitals for Special Diseases	30 ...	276,916
Other smaller General and Special Hospitals	28 (about)	102,000
	Total ...	1,775,491

12.—No conclusions,[3] however, can be drawn from the total figure, unless the following considerations are taken into account.

[3] *Cf.* Loch, 680-95
Gray, 2928-31
Montefiore, 2474/9

13.—The Out-patients can be divided into various classes, some of which, at all events, would have to be Hospital patients under any system of Out-patient organisation.

14.—One of these various classes is that known as "Casualties."[4] The term has no fixed definition common to all Hospitals, but it usually includes cases which are either too urgent or too trivial to be referred to the Out-patient Department proper at the hours of attendance of the visiting staff, and it thus includes cases as to whose suitability there is least doubt, and cases as to whose suitability there is most doubt. It is said that there is a tendency for the Casualty Department to grow until it becomes a duplicate Out-patient Department, differing from the Out-patient Department proper in being subject to less regulation as regards hours of attendance and inquiry into circumstances.[5] True Casualties, however, if their numbers were recorded, would stand in a class by themselves for the purpose of this inquiry. They comprise injuries by accident and sudden attacks of illness which require immediate attention and treatment.[6]

[4] Statistical Appendix, Sec. A, col. 3

[5] See par. 51

[6] *Cf.* Thies, 450-53

15.—Another class of Out-patients is made up of those who have already been, or who subsequently become, In-patients.[7] The available statistics indicate that in themselves these cases do not form more than about 4 per cent. of the Out-patients. But they illustrate one of the important uses of the Out-patient Department as a channel for the admission of serious cases to the wards.[8]

[7] Statistical Appendix, Sec. A, col. 5

[8] *Cf.* Thies, 539
B.M.A., 1481/26
Butlin, 3505/26, 3673
Tirard, 4330

16.—A third class which stands by itself is that of Out-patients attending special departments.[9] These grow in number with the growth of special treatments.

[9] Statistical Appendix, Sec. A, col. 6

They are represented partly by the patients of Special Hospitals and

partly by the special Out-patients at General Hospitals. These appear to form about 30 per cent. of the whole number.

17.—Yet another class consists of patients who are recommended by medical men.[1] No complete records are available, but at some of the Hospitals they form a not inconsiderable proportion of the whole.

[1] Statistical Appendix, Sec. A, cols. 7 and 8

18.—In estimating the proportion which these various classes taken together bear to the total number of Out-patients, allowance must be made for the fact that some of those recommended by doctors may also be counted among the special cases, or among those who have been or subsequently become In-patients, or sometimes among both classes successively.

19.—Other facts must also be noted before drawing conclusions from the total number of Out-patients, *e.g.*: (i) the fact that many patients attend more than one Hospital for the same ailment[2]; (ii) the fact that the same person attending the same Hospital at different times of the same year for different ailments, or for different attacks of the same ailment, is counted as so many different patients; and (iii) the fact that a large number come from the Home Counties, or even from distant parts of the country.[3]

[2] Thies, 432/20

[3] Thies, 432/20
B.M.A., 1481/55
Johnson, S., 3191/14
Butlin, 3505/24 (c)
Shaw, H. B., 3773

20.—But after making allowance for all these factors, there is no doubt that the total number of Out-patients treated in a year by the Hospitals is very large,[4] and that any system of charitable assistance offering benefits on such a scale requires careful organisation if abuse is to be avoided.

[4] Currie, 889
Gray, 2928-2931
Butlin, 3676

21.—Various methods are in force for the control of the admission of these vast numbers to the Out-patient Departments. (i) Sometimes subscribers' letters have to be produced by patients.[5] (ii) Sometimes payments are taken either of a fixed sum per head, with exemption in case of inability to pay, or on a scale varying with the means of the patient.[6] (iii) At most Hospitals there is some system of inquiry into the suitability of those applying for assistance.[7] The scope and efficiency of the systems vary. In many of the largest and best-managed Hospitals a special class of inquiry officers, called "Almoners" (usually ladies), have been introduced. These Almoners are trained in charitable as distinct from merely detective work, and they aim not only at preventing abuse but at bringing the Hospital into relation with other forms of medical and charitable assistance, wherever this is thought necessary either to render the treatment complete, or to prevent overlapping. At many Hospitals this side of their work is facilitated by the existence of a special fund for the non-medical assistance of patients, known as a Samaritan Fund.[8] (iv) Some Hospitals limit the number of new patients selected in any one day for treatment by the visiting staff in proportion to the number of physicians and surgeons in attendance.[9]

[5] See par. 108

[6] See pars. 55, 110, &c.

[7] See pars. 113, &c.

[8] Loch, 744

[9] See pars. 72, 127

These methods will be more fully discussed in later sections of this Report.

22.—Although the terms of reference appear to limit the inquiry to the circumstances and conditions of admission to the Out-patient Departments and not to extend it to the medical treatment of the patients when once admitted, it is obvious that the inquiry must involve some reference to the staffing and equipment of the Departments themselves. The suitability of a case for admission depends largely on the nature of the ailment; and thus the medical staff has to assist in determining the question of admissibility.

23.—The Out-patient staff usually consists of two grades: (i) the honorary visiting staff, who are physicians and surgeons in consulting practice and of established repute; and (ii) assistants* of various kinds, sometimes paid and sometimes unpaid—resident medical officers, casualty officers, house physicians, and house surgeons—for the most part picked men, but at the same time more or less newly qualified, whose experience has been limited to Hospital practice in the Out-patient Departments and the wards. At some Hospitals, particularly in Special Hospitals or in special departments of General Hospitals, there are also qualified "clinical assistants"—sometimes in general practice—working for the sake of experience.[1] At the Hospitals with Schools the work of examining and treating the patients is combined with that of teaching medical students, and the students assist the doctors in various ways.[2]

[1] Bland, 2237 Jennings, 2613 Betteridge, App. 19

[2] *Cf.* Buckle, 165 B.M.A.(Shaw,L.), 1675 (Macdonald), 1675

24.—There is no question as to the high efficiency of the Hospital staffing and equipment. But witnesses have differed as to the extent to which this efficiency is actually brought to bear upon the large crowds of patients—what proportion are actually seen by the visiting staff, and how far the assistant staff are able, in the circumstances under which the work has to be done, to give sufficient attention to the cases which remain under their care.[3]

[3] See pars. 65, &c.

B. Dispensaries.

25.—In addition to the Out-patient Departments of the Hospitals there are within the nine-mile radius some 52 Provident Dispensaries, about 54 Non-Provident Dispensaries, and 43 Poor Law Dispensaries.[4]

[4] Statistical Appendix, Sec. D

The Provident Dispensaries supply medical treatment for a given period in return for the payment of a fixed sum.[5] The medical staff consists of general practitioners, who are paid. But unless the Dispensary is very large the contributions do not cover the cost, and the charitable element enters in.[6]

[5] *E.g.*, 6d. to 1s. 6d. a month according to the size of family. Warren, 1189/8; or from 1d. a week Buchanan, 1982 Capes, 4134

[6] B.M.A. (Whitaker), 1586-88 Michelli, 1829 Buchanan, 1880-84 Capes, 4088, 4137

26.—The Non-Provident Dispensaries supply treatment either free or for a small payment per attendance. They are charitable institutions differing from Hospitals, so far as Out-patients are concerned, chiefly in the fact that they are usually staffed by general practitioners and equipped only for ordinary treatments.

* The term "assistant" is here used in the ordinary sense. Technically the members of the visiting staff who have charge of Out-patients are often known as "assistant physicians" and "assistant surgeons."

27.—Both the Provident and the Non-Provident Dispensaries differ from the Hospitals in that they have no In-patient provision for serious cases. But, on the other hand, all the Provident Dispensaries and many of the Non-Provident (unlike the Hospitals) supply attendance in patients' own homes where necessary.

28.—The Poor Law Dispensaries also supply medical treatment by general practitioners. But their sphere is at once narrower and wider than that of the other institutions mentioned. Access to them involves application to the relieving officer and contact with the Poor Law machinery, and though it does not bring with it disfranchisement it is said to be often a step towards pauperism.[1] On the other hand, the Poor Law can supply food and other forms of non-medical assistance where these are needed, and can admit to the Infirmary cases requiring indoor treatment.

[1] *Cf.* Report by Miss Roberts: Royal Commission on Poor Laws. Appendix, vol. xxii, par. 45

C. Private Doctors.

29.—Besides the Hospitals and Dispensaries the needs of the poor are supplied by a very large number of private doctors. Many of these have clubs whose members they contract to treat for a fixed payment not unlike that charged by Provident Dispensaries. Some of them are said to charge their private patients quite small fees, 6d. per visit to the surgery, or even 3d. And it is well known that whatever their normal charge may be the medical profession of all grades supplies a very large amount of treatment in many cases without thought of fee or reward, and in many others without reasonable anticipation of receiving payment.

III. CLASSES SUITABLE FOR ADMISSION TO HOSPITAL OUT-PATIENT DEPARTMENTS.

30.—Out-patient Departments may be abused or their work unduly restricted if proper precautions are not taken:

(A) Patients may be admitted who are financially unsuitable for the particular form of charitable assistance offered.

(B) The special resources of the Hospital may be wasted by a confusion of the functions of the Hospital with those of other medical agencies, leading to the admission of patients who are medically unsuitable.

(C) Suitable patients may be unable to gain admission, or may fail on admission to obtain the assistance they need, or may be deterred from applying at all by fear of the inconveniences they may suffer. This may be the direct result of the admission of unsuitable cases.

To form an opinion on these points it is necessary to determine what classes are suitable as Out-patients, and to see what provision is made for their treatment.

Original Objects.

31.—In the charters, trust deeds and Acts of Incorporation creating the Hospitals, their object is usually defined in some such words as these: "to afford medical and surgical relief to sick and necessitous "persons." In some cases the relief must be "gratuitous."[1]

[1] Sandhurst, 1174

32.—The question however arises as to who are the "necessitous." Mr. Sydney Holland's definition is as good as any:—"A legitimate "Hospital patient is a person who is a wage earner who is unable to pay "for that medical or surgical advice which he requires in order to keep "him in health, and of the greatest value to the community."[2]

[2] Holland, 15, quoted by Loch, 697, 794

This definition, however, needs to be extended so as to include pensioners, dependents and other persons who, though not wage earners, are, except for sickness, independent of outside help.

In applying the definition to any particular case, regard must be had to the kind of relief needed, and to the question whether the Hospital is the most suitable agency for supplying it.

Later Widening Tendencies.

33.—The conception of the function of Hospitals has widened in recent years in some directions, while in other ways it has narrowed. Among the widening tendencies are the following:—

(A) The development of costly special treatments and methods of diagnosis. This has raised the whole idea of the standard of medical treatment which a Hospital should afford. It has also raised the financial level below which a patient needing these costly treatments is "necessitous."

(B) The recognition of the fact that medical treatment is often inadequate unless associated with other forms of assistance. This idea has widened the conception of the duty of a Hospital as a charitable institution, especially as the ideals of organised charitable administration tend to grow higher.

(C) Hospitals have become centres of ever more and more elaborate medical education and the advancement of medical science. This side of their work will sometimes require that the rules restricting admission should be relaxed so as to permit patients who may not come within the definition of the necessitous poor to enter, and by their presence enable the Hospitals to fulfil these functions.

Later Narrowing Tendencies.

34.—In other directions, however, the Hospitals, as their work expands, find themselves liable to compete with agencies whose operations tend to narrow Hospital work. Among such agencies are

(A) The Provident organisations, which are designed to enable a whole section of the poorer population to raise themselves above the necessity of applying for charitable assistance, and which find their development hampered by the unlimited offer of free treatment at the Hospitals to those who can afford to make provision for their needs.

(B) The Poor Law medical service, which offers a special means of treatment to those who may be said to come within the pauper class.

(C) Other forms of public medical assistance, such as the Public Health Departments of the municipalities and the medical care of school children by the Education Authorities. And in this connection regard must be had to the possible developments of National Insurance.

(D) The private doctor, whose interests would not be affected by the establishment of a charity to deal with the very poor, but who finds occasion for anxiety when the great Hospital, with its Out-patient Department, attracts, as it does, patients of the class which contributes to his practice.

35.—It becomes more and more necessary, therefore, for the Hospitals to consider what position they should take up with regard to these agencies: whether they should compete with them, or co-operate with them, or attempt to confine their work to spheres not touched by them.

Wage Limits.

36.—When all the factors are taken into consideration it is not surprising that there is a general agreement among witnesses that no very definite line can be drawn between the suitable and the unsuitable, so far as financial circumstances are concerned. Only in a few Hospitals is a wage limit laid down as a test of suitability, and in these only for the purpose of affording a guide to the inquiry officer—all cases above that limit being specially investigated, in order to see whether the number of dependents, the expenses of illness, or other circumstances, justify the admission of the patient. Provided, however, that this is borne in mind, the wage limit may be taken as "crystallising" the definition of financial suitability, and it thus forms a convenient basis for its discussion.

37.—Examples of such wage limits for ordinary ailments are:—

For single men: London Hospital—15s. to 19s. for the labour class, 20s. for a class above[1]; Great Northern Hospital—25s.[2]; Middlesex Hospital—30s.[3]

[1] Holland, 2/8
[2] Glenton-Kerr, 622/6
[3] Thomson & Johnson App. 12/6

For married patients the limit varies with the number of children, beginning either at 25s., 30s. or 35s., and ending usually[1] with 40s.

Special Hospitals naturally tend to have higher limits.[2]

It is interesting to compare these with the wage limits for Provident Dispensaries affiliated to the Metropolitan Provident Medical Association, viz., 30s. for single men, 40s. for married.[3] This comparison shows that the general Hospitals, so far as wage limits are any evidence, recognise in the case of single men that the offer of free assistance should be confined to a class below those for whom the Provident Dispensaries cater. The only exception is the Middlesex Hospital, and there the wage limit of 30s. is admitted by witnesses to be too high.[4] But in the case of married patients it seems that the Hospitals tend to recognise no such distinction, but to adopt as their limit for free medical advice the same figure as the Dispensaries adopt for treatment at Provident rates. It is worth noting that the Secretary of the Hospital Saturday Fund supports the Hospitals in the 40s. limit,[5] while the medical representative of the Charity Organisation Society would put it as low as 30s.[6] The Provident Dispensary attached to the Metropolitan Hospital and the Camberwell Provident Dispensary have 35s. as their limit.[7]

It must be remembered however, that, while the Provident Dispensary wage limit is fixed with reference to earnings during a period of health,[8] certified by a medical examination, the Hospital wage limit has reference to a time of illness, when perhaps the patient's earnings have been diminished and his expenses increased.[9]

Provident Dispensary Class.

38.—In spite of this overlapping in wage limits, it is held by a large number of witnesses, both within the Hospitals and outside them, that those able to make provision for ordinary ailments by means of Provident Dispensaries, clubs and other forms of insurance, are not suitable for admission to Out-patient Departments for such ailments.[10] Some apparently would do no more than urge such patients to make provision,[11] but others go further, and (at all events in some cases) hold that even where it is necessary to treat them when they first present themselves, they should be given to understand that if they apply at some future time for another similar illness they will not be admitted.[12]

Many of the witnesses who accept this view in theory maintain, however, that in the absence of a sufficient supply of Provident Dispensaries it cannot be adopted in practice.[13]

Poor Law Class.

39.—There is also a difference of opinion as to the point at which the lower limit of suitability should be drawn.

On the one hand it is held by a large number of witnesses that the Out-patient Departments should not be opened indiscriminately to all those who are poor, without reference to the question whether they are in receipt of Poor Law Relief, or are in such a state of destitution as to be unable to benefit by the treatment the Hospital can supply.[14] It is contended that to do this is a waste of the special resources of the Hospitals.

[1] London, 35s. for labour class, 40s. class above
Holland, 2/8
G.N.C., 40s.
Glenton-Kerr, 622/6
London Homœopathic 40s. App. 35/6
Prince of Wales' 40s. App. 48/7
Belgrave(Ch.),30s. App. 21/5
New H. for Women, 40s. App. 45/3
Royal Waterloo Wom. and Ch., 35s. App. 55/4
St. Mark's (Rectal), 35s. App. 58/5

[2] London Throat £200 p.a. App. 37/3
National (Paralysed), over 60s. App. 44/3
Samaritan Free (Wom.), 60s. App. 61/3
cf. par. 53

[3] Warren, 1189/7 except for Friendly Societies and Clubs

[4] Thomson, 2671-4 and *cf.* Warren, 1331

[5] Davis, 958/2

[6] Gray, 2946

[7] Buchanan, 1871/7
Capes, 4132

[8] Ryan, 2414
Tirard, 4173/20
There are special rates for persons not in good health.
Warren, 1189/8, 9
Ryan, 2416-7

[9] *Cf.* Holland, 2/9
Davis, 1015

[10] Davis, 976
Kemp. 1348/1 (3)
B.M.A., 1481/17
B.M.A. (Whitaker), 1510

[11] Holland, 2/24
Alvey, 331/11
Glenton-Kerr, 622/6
Michelli, 1789/10

[12] Thies, 549-53
Buchanan,1919-20
Ryan, 2333/8, 2420
West, 3365-72
Tirard, 4173/20
Roberts, 4411/9
cf. B.M.A. (Whitaker), 1689

[13] Currie, 897
Sandhurst, 1108A
Church, 3108
West, 3349/5-9
cf. Warren, 1332
B.M.A., 1481/55

[14] Holland, 9, 15
Alvey (Charing Cross), 331/15
Buchanan, 1931
Ryan (St. Mary's), 2333/12
Montefiore, 2500, 2551
Gray, 2835, 2909, 2944-5
Church, 3119
West (St. George's), 3251/5
Nunn, 3918
Roberts (St. Thomas'), 4411/3, 17
Royal Chest, App. 53/10

On the other hand the practice at some of the large Hospitals indicates that this view is not held by them, and that they do not refuse assistance on this ground.[1]

[1] Glenton-Kerr (Great Northern), 622/11
Thomson (Middlesex), 2702
Shaw, H. B. (Univ. Coll.), 3705
Guy's, App. 28/16
See also Statistical Appendix, Sec. B, col. 13.

Intermediate Class.

40.—But assuming that those able to make provision for themselves should be excluded, as also those too destitute to profit by Hospital treatment, the question remains whether there is not an intermediate class suitable for Out-patient treatment. The view held by the British Medical Association is that there is no such intermediate class,[2] their argument being that all sick people are able to secure the attendance of general practitioners, either privately or through a Provident Dispensary or through the Poor Law, and that the Hospitals should be reserved for cases sent for consultation by such general practitioners. The ordinary subscriber to Hospitals, even where prepared to exclude the Provident Dispensary class, probably takes the other view, and considers that it is for just such an intermediate class that the Hospital exists.[3]

[2] B.M.A. (Whitaker), 1620-1625, 1768
(Shaw, L.), 1768
cf. also Prior, 2188
Montefiore, 2524-6, 2530, 2542-4
Gray, 2817/9*b*, 2909
cf. Ryan, 2430

[3] Church, 3114
cf. Montefiore, 2536, 2544

Some witnesses who admit the existence of this class hold that a patient who is unable to pay the small fees of Provident Dispensaries when in health really needs in sickness the help of general charity rather than mere medical attendance,[4] and it is suggested that the help given might, in suitable cases, include the payment of Provident Dispensary fees.[5] But, bearing in mind two facts: first, that no general organisation of charitable and public assistance yet exists, and, second, that however carefully prospective patients are classified, there will always be many individual cases whose circumstances render classification difficult, we are not prepared to say that the Provident Dispensary class and the Poor Law class cover between them all those who cannot pay a private doctor's ordinary fees. The intermediate class is, however, being continually narrowed by the development of Poor Law medical assistance on the one hand and of charitable and public assistance on the other.[6]

[4] Montefiore, 2546-7
Nunn, 3929-30

[5] Kemp, 1433, 1447
Montefiore, 2474/15, 2528
The British Medical Association apparently admits the possibility of such cases.
B.M.A. (Whitaker), 1588
cf. Roy. Com. on Poor Laws Majority Report (Part V, ch. 3, par. 237/18) in certain cases

[6] *Cf.* Barnett, App. 66/2

IV. EVIDENCE AS TO EXISTENCE OF ABUSE.

41.—All the factors mentioned above affect the question whether the Out-patient Departments are abused or misused.

As Regards those Able to Pay.

42.—The first question is whether patients are treated who can afford to pay private doctors. This charge is frequently brought by general practitioners, although for reasons which can easily be appreciated, there is great reluctance to vouch specific instances.[7] It does not appear that there is any appreciable abuse by really well-to-do people.[8] The scrutiny of officials and doctors, to say nothing of expert inquiry officers, is sufficient to prevent this. But there is probably good ground for the feeling on the part of general practitioners that many patients who could without hardship afford the small charge made by

[7] Heron, 3449
cf. Gray, 2820

[8] Holland, 65
Glenton-Kerr, 622/7
Currie, 890
Sandhurst, 1049-50
Michelli, 1799
Ryan, 2333/4, 2411-3
Montefiore, 2505
Gray, 2873-4,
Church, 3047
but *cf.* B.M.A. (Whitaker), 1509

them for ordinary ailments are treated at the Hospitals.[1] It would often be impossible to detect such cases at sight. They can only be discovered by the investigations of trained inquiry officers. But there are large areas not covered by such investigation. At some Hospitals the inquiry is little more than nominal,[2] and even where it is most thorough it is liable to be evaded by false statements.[3] At most Hospitals the Inquiry Officer or Almoner only investigates a portion of the total numbers of Out-patients,[4] and often the Casualty Department is not touched at all. There is thus ample room for minor abuse of this kind. Very few witnesses have gone so far as to deny its existence altogether.[5] As to its amount, however, the evidence has varied. Some Hospitals deny its importance on the ground that their Inquiry Officers find so few cases[6]; but there would seem to be more reason for confidence in those whose Almoners do detect and exclude a good many.[7] One Hospital admits that though its present inquiry discovers but little abuse, a more efficient system would find a considerable amount.[8] The statistics seem to show that where the inquiry is thorough, a not inconsiderable number of cases are discovered, and probably at least as much escapes detection where the inquiry is not thorough.[9] Doubtless the abuse differs in different neighbourhoods,[10] but even in the poorest districts there are comparatively prosperous streets within reach, and abuse by the inhabitants of such streets, though small in proportion to the number of patients, may constitute a greater hardship to local doctors than an equal amount of abuse elsewhere.

[1] Thies, 432/17, 588
Glenton-Kerr, 641
Loch, 702
Warren, 1189/16
Prior, 2046
Gray, 2875-6

[2] Gray, 2885

[3] B.M.A., 1481/37
Butlin, 3657
Tirard, 4294
Royal Waterloo, App. 55/11

[4] Statistical Appendix, Sec. B, cols. 2 and 9, and *cf.* pars. 115 and 121

[5] But *cf.* Tirard, 4284-94

[6] Sandhurst (St. Bartholomew's) 1062A
Church (do.) 3036
cf. Herringham (do.) quoted by Sandhurst, 1104

[7] Statistical Appendix, Sec. B, col. 10
cf. Butlin (St. Bartholomew's), 3505/34, 3635-9

[8] Betteridge (West London) 4369, 4376-80 (July, 1911)

[9] Statistical Appendix, Sec. B, cols. 10 and 11

[10] Holland, 65
Wilcox, 3132, 3140,
cf. Gray 2877-83

As Regards those Suitable for Provident Dispensaries.

43.—There is much stronger evidence that the Out-patient Departments are used on a large scale by the class of patients able to make provision for ordinary ailments by means of Provident Dispensaries or clubs. In the first place, there is the evidence already quoted from the wage limits,[11] which goes to show that many Hospitals draw the line between patients suitable for free treatment and patients unsuitable at the very point where the Provident Dispensaries draw the line between those suitable for treatment on the provident or contract system and those who should pay ordinary fees according to the number of attendances. In the second place, there is the evidence from the statistics of the Hospitals which endeavour to exclude the Provident Dispensary class, showing that a considerable number are so excluded.[12] There is no reason to believe that a similar percentage of cases would not be excluded from the other Hospitals if the same standard were universally applied. In the third place, a good many witnesses have expressed the opinion that the Hospitals are largely used by those who could have made provision, and that this form of misuse is far more common than abuse in the sense of the treatment of those actually able to pay at the time.[13]

[11] See par. 37

[12] Statistical Appendix, Sec. B, col. 12.

[13] Warren, 1189/16
B.M.A., 1481/7
Ryan, 2333/4, 2413
Montefiore, 2484
Gray, 2873-4
Butlin, 3636-8
Nunn, 3846-8
Capes, 4087
Roberts, 4450
Thomson & Johnson, App. 12/33
but *cf.*
Johnson, S., 3191/28
Tirard, 4296

44.—The argument that the admission of such cases is not an abuse because there are not enough Provident Dispensaries is met by other witnesses with the contention that the absence of Provident Dispensaries

is due to the fact that the Out-patient Departments offer free treatment to cases suitable for a Dispensary.[1]

[1] See pars. 85-6

As Regards Cases Suitable for the Poor Law.

45.—The allegation that the Out-patient Departments are used for ordinary ailments by persons who are either too poor to benefit by them, or who are actually in receipt of poor relief, is supported by evidence of the same general character. Some Hospitals do not consider this to be misuse at all.[2] Others do; and the statistics of their partial inquiries made with a view to excluding this class make it certain that considerable numbers would be found if the inquiries at all Hospitals were complete.[3] There is the direct evidence of witnesses that it would be wise to refer to the Poor Law many cases which are not now referred.[4] And there is also on this point the detailed evidence published by the Poor Law Commission to the effect that 11 per cent. of the Out-patients at certain Hospitals were actually in receipt of Poor Law relief, while 38 per cent. might be described as destitute.[5]

[2] See par. 39.

[3] Statistical Appendix, Sec. B, col. 13

[4] Thies, 432/17
Loch, 702
B.M.A., 1481/7, 16
Montefiore, 2483-4
Church, 3054-7
Thomson & Johnson, App. 12/31

[5] Report by Miss Roberts (Report of Royal Commission, Appendix, Vol. XXII, par. 56)

46.—On the other hand there is much evidence to the effect that even where the desirability of referring such cases to the Poor Law is recognised, a difficulty often arises from the side of the Poor Law. Not only are the conditions attached to medical relief often deterrent,[6] but the Poor Law authorities are said to resist the reference of cases to them by the Hospitals.[7] These difficulties seem to indicate that, in dealing with the destitute and the very poor, the improved organisation of the Out-patient Departments should be met by some change in the character and scope of Poor Law administration, and some co-ordination of Poor Law and charitable agencies.[8]

[6] Holland, 9
Montefiore, 2557
Johnson, S., 3191/44-5
Prince of Wales' Hosp., App. 48/9

[7] Holland, 9
Thies, 585
Glenton-Kerr, 622/20
Loch, 831
Kemp, 1456
Church, 3027/23
West, 3337-41
Roberts, 4411/17
cf. Miss Roberts' Report as above, pars. 49 to 54, for an account of the reasons on both sides

As Regards the Medically Unsuitable—Trivial Cases.

47.—In the case of all these classes we have used the phrase "for ordinary ailments." As already noted, the question of the nature of the ailment bears on the question of suitability, and therefore of abuse or misuse; and this for two reasons. First, the nature of the ailment and of the treatment required affects the question of the ability of the patient to pay for the necessary medical attendance. One ailment differs from another in its effect on the earning capacity of the patient, in the number of attendances which it would entail on the part of a private doctor, or in the necessity for costly drugs or appliances. Secondly, the nature of the ailment affects the question whether the necessary treatment can be supplied by the general practitioner, or whether it requires the special skill or special appliances available at the Hospital. There is, therefore a further question to be taken into account in considering whether the Out-patient Departments are abused or misused—the question of medical suitability.

[8] Buchanan, 1967
Johnson, S., 3191/43
West, 3251/23
cf. Royal Commission on Poor Laws — Majority Report, Part IX. (4), (9), (17), (22), (23); Part V., chap. 3, par. 237

48.—It is generally agreed that the Hospitals are specially adapted by personnel and equipment for the diagnosis and treatment of difficult cases and those needing costly drugs or appliances.[1] [2] It follows, therefore, that the admission of such cases (often, though loosely, called "consultative cases") to the Out-patient Departments should be facilitated wherever the patient cannot obtain the special advice or treatment which he needs, even though he is, privately or through a Provident or Poor Law Dispensary, already able to obtain the services of a general practitioner for ordinary ailments. And many witnesses contend that the work of the Out-patient Department should be confined to such cases,[2] and that patients suffering from ordinary ailments should be either excluded or discouraged from attendance on the ground of medical unsuitability. More especially is this policy advocated in the case of what are termed "trivial" ailments.[3] It is held that the admission of such cases is itself a waste of the elaborate resources of the Hospital, and that it hampers the efficient discharge of the true function of the Hospitals in three ways: First, that the crowd of trivial cases leaves insufficient time for the diagnosis and treatment of the serious cases[4]; second, that many serious cases are deterred from coming to the Hospitals by the fear of crowding, waiting and insufficient attention in the end[5]; third, that proper inquiry into the financial suitability of patients is rendered impossible by the large numbers that present themselves when trivial cases are admitted.[6]

[1] Glenton-Kerr, 622/16
Loch, 781
Kemp, 1348/4
Michelli, 1803-6
Ryan, 2433-5
West, 3328/9

[2] Thies, 432/19, 591
Warren, 1189/22
Kemp, 1432-3
B.M.A., 1481/43
Buchanan, 1871/20, 26
Montefiore, 2474/15
Gray, 2817/7
Butlin, 3556-62
Nunn, 3778/14, 3898
Capes, 4047/5 (2)
Lyster, App. 9/2

[3] Glenton-Kerr, 654
Heron, 3380/11
Butlin, 3505/24*e*
Nunn, 3897
Capes, 4047/2 (12)

[4] Glenton-Kerr (Great Northern Central) 622/24, 60% not seriously ill, hampers the treatment of the other 40%
Loch, 738
Shaw,H.B.,3687-8

[5] B.M.A. (Shaw, L.), 1760

[6] Montefiore, 2534

49.—There seems to be little doubt that a great many of the cases now treated, especially in the Casualty Departments, are trivial and should not be admitted. The difficulty arises when the possibility of an alternative is considered. Some witnesses argue that it is as easy to treat a trivial case as to inquire into its suitability.[7] Others maintain that if the Hospitals were to state publicly that trivial cases would not be treated, such cases would soon cease to present themselves.[8] Others lay stress upon the difficulty of defining a medically trivial case so as to insure that no danger of hidden complications is overlooked,[9] upon the risk of turning away any case untreated,[10] upon the fact that from the patient's point of view minor ailments are often serious,[11] or upon the value of trivial cases for teaching purposes.[12] The degree to which exclusion would be right depends very largely upon the extent to which the alternative of treatment by a general practitioner is practicable, and is thus intimately connected with the question of financial suitability already discussed.

[7] Holland, 120

[8] Gray, 2903
Butlin, 3549; 3586-94

[9] Church, 3052
West, 3330

[10] Holland, 120

[11] Shaw,H.B.,3684-6
Tirard, 4250

[12] Shaw, H. B., 3764
Tirard, 4253

In different Departments.

50.—It is obvious that the line between abuse and non-abuse will be different in Casualty Departments, Out-patient Departments proper and Special Departments respectively.

51.—In the Casualty Departments are treated emergency cases of a serious character, which must be dealt with, once at all events, without

reference to financial suitability, and without the delay involved in transfer to the Out-patient Department proper. But the Casualty Departments are frequently called upon to deal with a large number of trivial cases, which individually require only a very small amount of attention. For these two reasons it is rare for the Casualty Department to be included in the inquiry system, even where an efficient system is in force in the Out-patient Department. If, as is frequently the case, the Casualty Department also deals with Patients who happen to come outside the ordinary Out-patient hours, or with such cases as the Casualty medical officers (many of whom are often newly-qualified men eager for experience) may choose to retain in their own hands,[1] the liability of the Department to abuse is increased. At certain Hospitals the rules are specially designed to prevent this particular danger.[2] Unless, however, great care is exercised, there is a general tendency for the Casualty Department to become a centre of abuse and disorganisation, and the more so when the Out-patient Department proper is well organised and protected by inquiry.[3]

[1] Montefiore, 2487-9
B.M.A.(Shaw,L.), 1644

[2] Thies (Royal Free) 468; App. 3 (A)

[3] Kemp, 1432
B.M.A.(Shaw,L.), 1644
Montefiore, 2492
Gray, 2897

52.—In the Out-patient Department proper there will be found mingled the trivial, the ordinary and the serious, except in Hospitals where this Department is first reached through a receiving room or Casualty Department. In these instances the trivial cases will have been already sifted out. As regards the other two classes, the Inquiry Officer or Almoner has to take into consideration the nature of the ailment and the circumstances of the patient, and as a general rule no case is excluded or referred elsewhere without the concurrence of a medical man.[4]

[4] See par. 120

53.—In the Special Departments there will naturally be a large proportion of cases needing special diagnosis or treatment, and the average financial level below which abuse need not be guarded against is accordingly higher.[5] In these Departments, as with the more serious of the cases in the general Out-patient Department, the question usually is not whether the patient can afford a general practitioner's fee, but whether he can pay a consultant's fee, which is normally £2. 2s. 0d. and, even when reduced to meet inability to pay, rarely falls below £1. 1s. 0d.[6]

[5] Church, 3027/7
West, 3275

[6] Bland, 2234, 2237
Jennings, 2530-1
Johnson, S., 3214

54.—When once, however, the higher level is fixed, it is just as necessary as in ordinary cases to make sure by inquiry that all the patients treated come within the limit. With the majority of cases this will be easy, but in borderline cases it may be specially difficult, while abuse will often involve greater cost to the charity and loss to the medical profession than in the case of ordinary Out-patients.

As affected by Patients' Payments.

55.—At some Hospitals the question of abuse or non-abuse is complicated by the existence of a system of patients' payments.[7] These sometimes take the form of a fixed payment of a few pence to cover the

[7] Statistical Appendix, Sec. B, ccl. 6

cost of drugs and dressings required of all ordinary Out-patients who do not give proof of inability to pay it. Sometimes, at special Hospitals, payment is asked not of any fixed sum but of the amount which the patient is supposed to be able to pay, although he cannot afford a consultant's minimum fee. In either case the system amounts to this, that the offer of assistance is modified to meet variations in the financial circumstances of the patients. The elasticity thus introduced may reduce the risk of abuse from the point of view of cost to the charity, but witnesses have differed as to its effect on the risk of unfair competition with private practitioners.[1]

[1] See pars. 110-12
Roberts, 4411/36

As affected by Medical Education.

56.—Finally, in all discussions as to financial or medical suitability, the question of medical education and the advancement of medical science must be kept in mind, for, within reasonable limits, the medical staff must be entrusted with the power to retain, for these purposes, cases which might otherwise be deemed unsuitable.[2]

[2] Thies, 432/12
Loch, 737-8

This necessity has been used as an argument against any considerable restriction of admission.[3] But, on the other hand, it is by no means clear that unrestricted admission produces the conditions most favourable to medical education, and we have evidence from medical witnesses that a reduction in the number of trivial cases and a proportionate increase in consultative cases would be a gain from this point of view.[4]

[3] *cf.*
Thies, 432/13, 490
B.M.A., 1481/26
Shaw, H. B., 3714-17
Tirard, 4330

[4] B.M.A.—
(Whitaker), 1656
(Ker), 1554, 1670, 1676
(Shaw, L.), 1659, 1675-6
Thomson, 2768-74
Gray, 2817/6*b*
Butlin, 3562
cf. 3670 (*note*)
but *cf.*
Shaw, H. B., 3764-67
Tirard, 4253

V. EVIDENCE AS TO DEFECTS OTHER THAN ABUSE.

57.—Passing from the question of admission of persons who are unsuitable to that of the adequacy of the provision for those who are suitable, we find considerable evidence of defects.

Distance from Homes of Patients.

58.—The first defect is the want of proportion between the distribution of Out-patient accommodation and the distribution of population,[5] and the long distances which have frequently to be travelled by patients.[6] This is not only a physical hardship in cases of serious illnesses but also a source of expense, both in loss of work and in fares, and may go far to reduce the benefit of free treatment. South London is the worst off in this respect, and generally the outlying districts suffer while the centre is over-supplied.[7]

[5] See par. 8

[6] B.M.A., 1481/59*b*
B.M.A.(Shaw,L.), 1787

The development of Suburban Hospitals, often with a staff of West End Consultants, and such transfers as that of King's College Hospital to South London, are doing something to remedy this defect. But the defect is not likely to be completely removed.[8]

[7] Holland, 69
Davis, 958/7
Michelli, 1789/25
Johnson, S., 3191/90
Heron, 3380/36

[8] B.M.A.(Shaw,L.), 1595

Overcrowding.

59.—Next to the question of distance comes that of overcrowding.[1] As a rule this is complained of not so much as an evil in itself as because of the evils which it is said to produce[2]—long hours of waiting, inadequate enquiry, danger of infection, and overwork on the part of the medical staff, resulting in hurried diagnosis and treatment. For except in a few instances[3] the evidence points not to overcrowding in relation to the cubic capacity of the waiting halls, but to overcrowding in relation to the means available for dealing efficiently with the crowd of patients. Since the days of the House of Lords Inquiry in 1890–2 a great many of the waiting halls have been enlarged[4]; and such actual overcrowding as remains is attributed largely to the congregation of persons who, in the opinion of the witnesses, are unsuitable for admission,[5] and even of persons who attend the Out-patient Department mainly as a kind of social meeting place.[6] But generally speaking the question of overcrowding and its prevention is bound up with the questions of hours of waiting and overwork of staff, and is best discussed in connection with them.[7]

[1] Gray, 2923
Capes, 4117

[2] B.M.A.—
(Whitaker), 1757-60
(Macdonald), 1758
(Shaw, L.), 1758, 1760
Gray, 2933

[3] *e.g.*, Thies (Royal Free), 432/10
Johnson, (Middlesex), 2712
Roberts (St. Thomas's), 4411/19 and several suburban and special Hospitals. (For particulars as to individual Hospitals see final paragraphs of statements of evidence)
cf. Davis, 958/7

[4] Montefiore, 2474/9

[5] Johnson, S., 3191/88-9
Heron, 3380/37
James, 4542
Thomson & Johnson, App. 12/33

[6] Buchanan, 1923
Capes, 4063
cf. Barnett, App. 66/5

[7] See pars. 60-63 and 65-73

Waiting.

60.—From the point of view of the patients, the question of long hours of waiting is, perhaps, that which gives rise to most general complaint.[8] That it should do so is not surprising; whether the waiting is avoidable, and is, therefore, a legitimate ground for criticising the management of the Hospitals, is another matter.

[8] Currie, 949
Davis, 958/5A; 1013
James and Gasson, 4482/6 (1)

61.—On the question of the actual hours of waiting, as on the question of abuse, it has proved difficult to get from the complainants detailed evidence which could be verified.[9] From Hospital witnesses we have a few particulars, ranging from an average of two and a-half hours to three and a-half hours and even four or five hours.[10] Other Hospital witnesses (though not without exceptions)[11] admit that waiting occurs as an undesirable result of present methods.[12] It is said to cause the patients much loss of time, thus producing in some cases a loss of earnings, which (like expenditure of time and money on travelling) may often nullify the financial benefit of free treatment; in other cases either loss to employers or neglect of homes, besides, in many instances, considerable suffering and increased risk of infection.[13] It also deters from applying for Hospital treatment those cases whose seriousness renders them physically unfit to endure the long hours.[14]

[9] James, 4617 and 4619-20
Gasson, 4616-4620

[10] Johnson, S., (H. Sick Ch.), 3223
Thies (Royal Free), 463
Glenton-Kerr (Great Northern), 656-9
cf. James and Gasson, 4482/6 (1), James, 4620

[11] *Cf.* Sandhurst (St. Bartholomew's), 1152

[12] Thomson & Johnson, App. 12/31

[13] Davis, 1013
B.M.A., 1481/59*d*
Gray, 2817/4*b*, *c*

[14] B.M.A., 1481/60, B.M.A.—(Whitaker), 1760
(Shaw, L.), 1760

62.—At the same time it seems probable that this waiting cannot be avoided under the present system of Out-patient organisation. It does not appear to be due, as a general rule, to any maladministration in detail. The process through which patients must necessarily pass is inevitably a lengthy one. They must be assembled, registered, sorted and provided with cards before they are ready for the doctors,[15] their prescriptions must be made up after the doctor has seen them,[16] and the inquiries of the

[15] Sandhurst, 1155
Gasson, 4532-34

[16] James and Gasson, 4482/4
Gasson, 4596

Almoner take time. At each of these stages, however, it is possible for unnecessary delay to take place, and undoubtedly it is the duty of the Hospital managers to take all practicable steps to shorten the waits.[1]

[1] Refreshments are generally available Thies, 467

63.—But it seems to be generally admitted that the real cause of the waiting is to be found in the large numbers that attend, and is hardly avoidable under the present system.[2] Any increase in the staff or accommodation designed to deal with the excessive waiting is said to have the effect of attracting still larger numbers.[3] Such improvements may also increase the liability to abuse, for if waiting keeps away cases which are medically suitable it also deters many which are financially unsuitable.[4] If this is so, it can only be remedied by some plan which, while admitting the suitable, will reduce the numbers by excluding the unsuitable.[5]

[2] James & Gasson, 4482/6 Dawson, 4746 Thomson & Johnson, App. 12/31

[3] B.M.A.(Shaw,L.), 1758 Dawson, 4746

[4] Thies, 464 B.M.A.(Shaw,L.), 1758 Gray, 2924, 2935

[5] B.M.A. (Whitaker), 1633 James, 4534, 4595 *cf.* Gray, 2924-7

Danger of Infection.

64.—As an incidental result of the crowds of patients and the hours of waiting, there is said to be a considerable danger of infection,[6] especially in the case of minor and non-notifiable diseases,[7] and sometimes even of scarlet fever or diphtheria.[8] The Central Hospital Council specifically mention danger from chicken pox, mumps, whooping cough and tuberculosis, and suggest that all these should be compulsorily notified.[9] This is evidently a question, first, of the prompt and adequate inspection by doctor or nurse of all patients admitted to the waiting hall, and, second, of sufficient provision for the isolation of suspected cases or their reference to some agency specially designed for the treatment of infectious disease.[10] Thus the danger, so far as it exists, is an additional proof of the importance of the reduction of numbers by the exclusion of unsuitable cases, and of co-ordination between the different agencies for the treatment of disease.

[6] B.M.A., 1481/52, 53, 59*a* Gray, 2817/4 Heron, 3380/25 James & Gasson, 4284/6 Butlin, 3505/24*a* Barnett, App. 66/5

[7] West, 3251/25

[8] Heron, 3403

[9] West, 3349/10

[10] Thies, 585 West, 3251/27

Hurried Diagnosis and Treatment.

65.—It is also alleged that as a result of overcrowding the patients often fail to receive thorough medical examination and treatment.[11] The criticism is usually made in quite general terms, but it may mean (A) that some of the patients who need the special skill of a consultant fail to reach the visiting staff at all by reason of the junior assistants omitting to distinguish them, either from inexperience or from want of time; or (B) that the remaining patients, suffering only from ordinary ailments, fail to receive proper attention because their excessive numbers make it impossible; or (C) that the consultant staff themselves are overworked and cannot give sufficient time even to the serious cases.

[11] Loch, 738-9 B.M.A.,1481/59*a* B.M.A. (Ker), 1577 Buchanan 1871/25 Montefiore, 2509 Johnson, S., 2761 Gray, 2817/4*a*, 2937-41 Heron, 3380/30 Nunn, 3983

66.—It is not possible for the visiting staff to see all the patients attending the Out-patient Department. The patients must be medically sorted by someone, and only those who need the special skill of the

consultant, or whose cases are useful for teaching or research must be reserved for the visiting staff. This duty falls upon the assistant staff.[1]

[1] Alvey, 420 (*note*) Glenton-Kerr, 622/5 B.M.A. (Macdonald), 1675 (Shaw, L.), 1675 West, 3251/3 Heron, 3419 Capes, 4111 Roberts, 4411/2

67.—With the positive qualification of the assistant* medical staff of the Out-patient Departments for this work our inquiry is not directly concerned, but we have no doubt that the Hospitals take every care to confine responsible appointments to the best available men. At the same time, we have evidence that the practice as regards the Casualty Departments differs materially at different Hospitals, the Casualty officers being sometimes newly qualified men working with or under house physicians or house surgeons;[2] sometimes men who are themselves holding these appointments, working under the supervision of members of the visiting staff;[3] and sometimes men who have already held such appointments, and are directly responsible to the Hospital itself.[4]

[2] Butlin, 3505/29-33

[3] Butlin, 3505/14, 8

[4] Butlin, 3505/37 Roberts, 4411/2; 4447 *cf.* Montefiore, 2474/11

68.—The question of the qualification of the Hospital staff for this work as compared with that of the general practitioner, is, however, of importance having regard to the alternative proposal to entrust the sifting of patients to the outside medical man. On this question of comparison witnesses differ.[5] It turns largely upon the value of the experience of the general practitioner on the one hand, and on the other hand upon the advantages and knowledge which the recently qualified members of a medical school derive from their frequent contact with the leaders of the profession, their access to modern or costly appliances, and their acquaintance with the newest methods of examination and treatment.

[5] B.M.A. (Shaw, L.), 1660 (Ker), 1670, 1672 (Macdonald), 1675 Michelli, 1807, 1844, 1861-2 Buchanan, 1952, 2013 Montefiore, 2474/11, 2568 Church, 3059-60 Heron, 3415-29 Butlin, 3505/31 Tirard, 4265 Barnett, App. 66/1 *cf.* par. 135

69.—There is, however, a considerable amount of evidence to the effect that the work of the assistant staff is impaired by the pressure under which it has to be done.[6]

[6] B.M.A. (Macdonald), 1662 (Shaw, L.), 1758

70.—Estimates of the average time given to each case have been furnished by some witnesses. The different estimates include one minute, less than two minutes,[7] and three minutes,[8] while one witness finds as the result of a special calculation that the average for minor cases is two minutes[9]. In the Casualty Department, especially, the complaint is made by both medical and Hospital witnesses of hurried diagnosis,[10] and very serious consequences have been attributed to this cause.[11] But on the other hand, it is claimed that experienced casualty medical officers as a rule possess great skill in rapid diagnosis[12] and make very few mistakes, in spite of the pressure under which they work.[13] So long, therefore, as this pressure remains, it is most important that Casualty Officers should be men with experience, for even where senior men are available for cases of difficulty, time frequently does not permit of consultation with them.[14]

[7] Heron, 3380/30

[8] Gray, 2941

[9] Thies (Royal Free), 609

[10] Butlin, 3505/24 (*f*) Glenton-Kerr, 622/23

[11] Butlin, 3505/24 (*f*) *cf.* B.M.A. (Ker), 1577, 1670

[12] Glenton-Kerr, 622/23

[13] Butlin, 3505/37

[14] Butlin, 3505/33

71.—But the evidence points to the desirability of reducing the pressure if possible by lessening the overcrowding of the departments where patients are sorted, and this can only be done by preventing the attendance of unsuitable cases.[15]

[15] See par. 63

* See note on page 5.

72.—With regard to the work of the visiting physicians and surgeons there is little evidence of hurry in either diagnosis or in treatment. For one thing, the highly skilled consultant staff possess great powers of rapid diagnosis.[1] Again, at the teaching Hospitals, plenty of time is necessarily given, for the sake of the students, to the cases reserved for the visiting staff.[2] In many Hospitals the number of new cases reserved for each physician or surgeon is strictly limited. That such limits have been found necessary is evidence that the staff are otherwise liable to be either hurried or overworked, or obliged to depute the actual treatment of some cases to their assistants.[3] The numbers, however, are not the same at different Hospitals, varying, for example, from 12 medical or 15 surgical at the Royal Free,[4] and 15 at St. George's[5] to 19 (admitted to be a heavy number) at St. Thomas's.[6] At Hospitals without schools there are wider variations, ranging from 10 to 20 and even 25.[7]

Different witnesses have given the maximum number that could be treated by one man, at a teaching Hospital, at 12, 12 to 15, and 20 respectively.[8] At one general Hospital with a post graduate college, on the other hand, the average number per medical officer (including clinical assistants) is said to amount to 30.[9]

[1] Buchanan, 1963
Montefiore, 2568
Butlin, 3574

[2] Butlin, 3574
Capes, 4116

[3] *Cf.* Buckle, 156-166
Alvey, 335 (*note*)

[4] Thies, 432/3

[5] West, 3251/3
but *cf.* 3556

[6] Roberts, 4412, 4419

[7] Michelli (Dreadnought), 1790
Buchanan (Metropolitan), 1962
City (Chest), App. 24/2
Queen's (Ch.), App. 49/4 (*d*)
New Hosp. (Wom.), App. 45/2, 5
Royal Waterloo (Wom. and Ch.), App. 55/3
cf. Tirard, 4223

[8] Capes, 4110
Thies, 469
Tirard, 4237-4240

[9] Betteridge (West London), App. 19

73.—Generally speaking the evidence points to the conclusion that in the case of patients who actually reach the visiting staff the danger is not that of hurried diagnosis or treatment, but that of long hours and over-work for the doctors.[10] This difficulty is a serious obstacle to the development of consultative work in the true sense of the word, for such works involves the labour of reporting to the general practitioner who is in charge of the case and for whose guidance the opinion of the consultant is sought.[11]

[10] Sandhurst, 1158
Johnson, A. E., 2712
Thomson & Johnson, App. 12/31 (*c*)
West End Hosp. (Nervous), App. 63/3

[11] Johnson, S., 3191/26
Still, 3248 (*note*)
Tirard, 4262
Roberts, 4411/26
Dawson, 4770

Detachment from Home Conditions and Past History.

74.—A further alleged defect of the Out-patient system lies in its detachment from the home conditions of the patient and his past history, both of which may affect not only the diagnosis of his disease, but also the method and prospects of cure.[12] This is put forward as a strong argument in favour of the treatment of ordinary ailments, not at the Out-patient Departments, but by the general practitioner acting, privately or through Dispensaries, more or less as a family doctor.[13]

[12] Loch, 738, 741
B.M.A., 1481/23 i 59
Gray, 2817/4 (*a*), 2938
Nunn, 3778/2 (*b*)

[13] B.M.A.(Shaw,L.), 1595
Montefiore, 2497
Nunn, 3778/13

75.—Assuming that the general practitioner can be relied on to give full attention to the home conditions and past history of patients attending at his surgery or at the Dispensary, this argument is a strong one. We have evidence, for instance, of a case of a boy attending two hospitals for bronchitis without it being discovered that his bed at home was beneath a leaking roof.[14] The fact that at some Hospitals an Out-patient is frequently seen by different doctors on successive visits[15] makes the occurrence of such misfortunes not improbable.

[14] Nunn, 3778/2B

[15] Quennell, 2799
Gray, 2817/4 (*a*)
Butlin, 3505/31

76.—The practice of relying on Hospitals rather than on private doctors is also said to lead to a neglect of preventive precautions and early treatment.[16] The dangers arising from this might be lessened if the

[16] B.M.A., 1481/59 (*a*)
Gray, 2817/5 (*c*)

Hospitals were in closer touch with general practitioners and thus able to recommend domiciliary treatment.[1] At the same time it must be recognised that many of the Hospitals themselves, through their Almoners, are endeavouring to secure a means of keeping in touch, at all events in selected cases, with home conditions or with agencies that know the homes.[2] In this connection mention ought to be made of the excellent work begun by the Tuberculosis Dispensaries towards supplementing the Out-patient Departments in the specially important case of pulmonary consumption.[3] It seems highly desirable that the practice of co-operating with such Dispensaries, already adopted by some Hospitals, should be extended as far as practicable in the interests both of the patients and of those who are living within the range of their infection.[4]

[1] B.M.A. (Shaw,L.), 1787

[2] Loch, 741
Kemp, 1387–89
Queen's (Ch.), App. 49/9

[3] Loch, 814, 822
Gray, 2846
McGaw, 2962, &c.
Heron, 3467
Shaw, H. B., 3747
Nunn, 3971
Dawson, 4676, &c.

[4] Ryan (St. Mary's), 2333/11 (1)
McGaw, 2971, 2979-80
Nunn, 3778/12
Dawson, 4694

77.—Another way in which this detachment from home conditions is said to reduce the value of Out-patient treatment lies in the absence of specific advice not only as to ordinary home hygiene or special care in diet or the like, but also as to the method of applying the prescribed remedies between the dates of successive visits to the Hospital.[5] This is attributed to the pressure under which the medical work is carried on. It is due, therefore, partly to overcrowding, and partly to the absence of touch with home conditions. Akin to this is the difficulty of ensuring that the patient carries out at home such instructions as are given him at the Hospital.[6]

[5] James & Gasson, 4482/2
cf. Barnett, App. 66/4

[6] Loch, 738
Kemp, 1391-2

Separation from other Charitable Assistance.

78.—The tendency to treat an application to the Out-patient Department as an isolated incident in the patient's life shows itself also in the separation of medical relief from other forms of charitable or public assistance. This has not always been, and is not always now, recognised as a defect.[7] The first instinct of the charitable man is to treat the immediate symptom of distress, and in the case of Hospital charity, where the immediate symptom is illness, this tendency is strengthened by the view naturally taken by the medical man.[8] But from a wider standpoint, it has been argued that illness is often a symptom of general distress, sometimes involving a whole family, and therefore only curable if the whole problem of the patient's circumstances is attacked.[9] This is akin to the modern view that the Hospital as a curative agency should no longer be looked upon as a separate unit, but as a link in the chain of charitable agencies.[10] The growth of the almoner system shows the extent to which this view is spreading amongst the Hospitals themselves.

[7] Currie, 95-6

[8] Loch, 825

[9] Loch, 738, 824-5

[10] Kemp, quoting Morris, 1348/3

79.—There is plenty of evidence, however, that the co-operation is at present very incomplete, for while many Hospitals make considerable use of a large number of charitable agencies, in addition to their own Samaritan Funds, others make no effort at all in this direction, or certainly no systematic effort.

The question whether such co-operation should be organised by the Hospitals themselves, through Almoners or otherwise, or whether it

should be attained by the establishment of some external organisation, is one which will arise during the discussion of remedies.[1]

[1] See pars. 145 and 156

80.—In this connection the Poor Law may be considered as a special kind of public assistance, co-operation with which involves problems of its own. But the idea of co-ordination between the Poor Law and charitable agencies is gaining ground, and finds its completed expression in the recommendations of the Majority Report of the Poor Law Commission.[2] So far as Hospitals are concerned, however, the fact that the Poor Law has its own medical branch makes it a question of the co-ordination of medical agencies rather than of other forms of assistance, and it will, therefore, be dealt with in the next section.[3]

[2] See par. 142

[3] See par. 87

Separation from other Medical Agencies.

81.—The arguments against the isolation of medical relief from other forms of charitable assistance point also to the desirability of co-ordination between different agencies for the provision of medical assistance itself, the absence of which causes much overlapping, waste and confusion.[4] The principal medical agencies outside the Hospitals are the three kinds of Dispensaries (Provident, Non-Provident, and Poor Law) and the general practitioners. The relations of the Hospitals *inter se* must also be considered.

[4] Thies, 432/22
B.M.A., 1481/16
Montefiore, 2484
Shaw, H. B., 3762

Non-Provident Dispensaries.

82.—With the Non-Provident Dispensaries we do not propose to deal in any detail. So far as their place amongst medical agencies is concerned, they appear to be analogous to the Out-patient Departments,[5] differing only in two ways. On the one hand, they are usually staffed by general practitioners instead of consultants, and their equipment is less elaborate.[6] On the other hand, they sometimes provide domiciliary treatment as well as treatment at the Dispensary.[7] Without a special inquiry we can express no opinion on their merits. We must therefore leave open the question how far they can be used to supplement the work either of the Hospitals or of the private practitioners.[8] At present the relation of the Non-Provident Dispensaries to the Hospitals and to the Provident Dispensaries is said to be one of competition rather than co-operation.[9]

[5] B.M.A., 1481/46

[6] Thies, 536
Currie, 934
Sandhurst, 1128

[7] Alvey, 331/13
Thomson, 2733

[8] *cf.* Alvey, 331/13
Spicer, 2191B/10-11, 2310
Thomson, 2733
James, 4547
Barnett, App. 66/2

[9] Warren, 1299
B.M.A., 1481/55*d*
Roberts, 4411/28

Provident Dispensaries.

83.—With regard to the relations between Provident Dispensaries and Out-patient Departments, the object to be aimed at by co-operation should be, on the one hand, for the Hospital to refer to the Provident Dispensary for future treatment cases of ordinary ailments in which the patient can afford to make provision by periodical payments, and, on the other hand, for the Provident Dispensary to refer to the Hospital cases

requiring special diagnosis, advice or treatment. The extent to which the former method of co-operation is carried out has already been considered.[1] The latter appears to be rare.[2] The desirability of some such system of co-operation was recognised by the Central Hospital Council, which in 1905-6 joined with the Metropolitan Provident Medical Association in drawing up a definite scheme for the purpose.[3] The scheme has, however, not yet been brought into operation. The Hospitals were not unanimous on the subject, some suggesting difficulties in practice; while up to the present time it has proved impossible to prepare a list of a sufficient number of Dispensaries for a general scheme.[4]

[1] See par. 43

[2] Glenton-Kerr, 622/17, 645-6 Michelli, 1818 Buchanan, 1983 Roberts, 4411/13 Guy's, App. 28/12 Statistical Appendix, Sec. A. col. 8

[3] B.M.A.(Shaw,L.), 1611 West, 3349/6

[4] B.M.A.(Shaw,L.), 1612 West, 3349/6, 8, 9

84.—From the side of the Hospitals complaints are sometimes made that the Provident Dispensaries are not really competent to treat their members properly, or to pay enough for efficient medical attendance and drugs.[5] It is said that they consequently send on to the Hospitals cases that seem likely to be troublesome or expensive,[6] while failing to detect those which need specialist advice.[7] It has been argued that for an efficient system of co-operation the Provident Dispensaries should be affiliated to the Hospitals, so as to benefit by close relations with their consultants.[8] Under such a system it is suggested that the students of the Medical Schools might receive part of their training in Provident Dispensaries thus affiliated, and that this would compensate the teaching Hospitals for any loss of opportunities for medical education that might result from the exclusion of trivial cases from the Out-patient Departments.[9]

[5] Holland, 125 Currie, 906-7 Michelli, 1832-38 Buchanan. 1958 Nunn, 3902

[6] Holland, 125, Currie, 907 *cf.* Glenton-Kerr, 622/17 but *cf.* Warren, 1347 B.M.A., 1481/57

[7] Michelli, 1832 Buchanan, 1951

[8] Buchanan, 1951 Church, 3027/9-10

[9] Thies, 432/22 B.M.A., 1481/29, 1663-6 (Whitaker), 1657-9, 1665 (Macdonald) 1665 (Shaw, L.), 1665 Gray, 2959 Church, 3027/11 3079-82, but *cf.* Shaw, H. B., 3770

85.—There is strong evidence that the effect of the competition of the Out-patient Departments with the Provident Dispensaries has been disastrous. The Dispensaries are injured by the offer of free medical treatment for ordinary ailments to the class from which their members come.[10] This is proved by the evidence that they flourish in districts remote from Hospitals but fail in their immediate neighbourhood.[11]

Cases are reported of Provident Dispensaries which have suffered a marked falling off of numbers after the opening of an Out-patient Department in the same district,[12] but have begun to recover when a stricter system of inquiry, by the agency of local medical men, has been introduced by the Hospital.[13]

[10] Montefiore, 2474/8 (3) Capes, 4085

[11] Warren, 1189/17-18, but *cf.* 1301 B.M.A., 1481/55*b* (Ker), 1781 (Whitaker), 1781 (Shaw, L.), 1782-6 Nunn, 3778/4, 3905, 3954-5, 3979

[12] Warren, 1333 Capes, 4047/4 (2)

[13] Capes, 4146-8 *cf.* B.M.A. (Shaw, L.), 1785-6 (Ker), 1786

86.—It is essential to the success of Provident Dispensaries that they should have a large number of members not requiring very prolonged or expensive treatment. They cannot, therefore, prosper so long as the Hospital Out-patient Departments offer free treatment to trivial cases. On the other hand, the Hospitals cannot refuse to treat trivial cases on the ground that they ought to go to Provident Dispensaries, so long as Provident Dispensaries do not exist in the neighbourhood. The British Medical Association lays particular stress on this alleged "vicious circle."[14]

[14] B.M.A., 1481/32

Poor Law Medical Service.

87.—The question of co-operation with the Poor Law medical service depends in like manner on the reference to the Poor Law of cases unsuitable for Hospital treatment, and the reference by the Poor Law authorities to the Hospitals of cases on which a specialist or consultative opinion is needed.[1]

[1] B.M.A., 1481/49

88.—We have already dealt with the question of the unsuitability for Hospital treatment, in respect of ordinary ailments, of those actually in receipt of Poor Law relief and of those too poor to benefit.[2] We have also noted the fact that many of these are actually treated at the Hospitals,[3] because of the inadequacy of the inquiry system at the Hospital, or because of the omission to co-operate with the Poor Law authorities.[4]

[2] See par. 39

[3] See pars. 45-6

[4] B.M.A., 1481/7
Poor Law Commission, Majority Report, Part V, ch. 2, par. 188

89.—At present the friction already alluded to between the Hospitals and the Poor Law appears to hamper the reference to the Hospitals of Poor Law cases needing specialist treatment.[5] A considerable number of such cases are no doubt treated by the Hospitals.[6] But there is no organised system for the reference of such patients to the Hospitals.[7]

[5] Kemp, 1456

[6] *Cf.* Alvey (Charing Cross) 331/15

[7] Loch, 798
Montefiore, 2484

90.—Besides preventing overlapping, co-operation between the Hospital and Poor Law authorities might, according to some witnesses, lead to the opening of the Poor Law infirmaries to the students of the medical schools.[8] This would give opportunities for the study of chronic cases in the infirmaries, to the advantage, it is urged, both of the patients and of the students.[9] It would also improve Out-patient organisation by removing the inducement to keep the Out-patient Department open to destitute cases for the sake of medical education,[10] and it would help to compensate the schools for the loss of teaching material which would result from the exclusion of trivial cases.

[8] Thies, 432/22, 575-78
Michelli, 1789/23, 1849

[9] Michelli, 1858
Ryan, 2444
Gray, 2961
cf. Dawson, 4750-1

[10] Buchanan, 1871/26
Gray, 2959

Other Voluntary Hospitals.

91.—There is also evidence of serious defects arising from the absence of co-operation between one Hospital Out-patient Department and another. Sometimes criticism is directed to the mere fact that patients attend more than one Hospital at the same time, or pass successively from one to another, or prefer a Hospital far from their homes to one near at hand.[11] Some Hospitals endeavour to prevent this by the reference back of cases which either are or have been attending another Hospital.[12] Some Hospitals refer to a nearer Hospital (if efficient) those coming from a distance.[13] Many, however, regard these simple forms of overlapping as no great evil. They are attributed to the desire for a change of doctor, to the attraction of a new building, or to a preference for some feature in the management of a particular Hospital;[14] and strict localisation is held to be very difficult, if not impossible, in London, owing to the unequal

[11] Buckle, 135/13
Thies, 584
Currie, 892, 947
Sandhurst, 1111
Royal Waterloo, App. 55/9

[12] Alvey (Charing Cross), 331/12
Ryan (St. Mary's), 2421
Roberts (St. Thomas'), 4411/14
Statistical Appendix, Sec. B., col. 14

[13] Holland (London), 2/25

[14] Holland, 77
Thies, 432/20
Sandhurst, 1111, 1116
Quennell, 2798-9
Butlin, 3620
Shaw, H.B., 3717
Thomson and Johnson, App. 12/24

distribution of Hospitals in relation to population.[1] But some restriction on this wandering is desirable as an aid to Out-patient organisation.

[1] Buckle, 135/13
Thies, 432/20-1
Sandhurst, 1110
Johnson, S., 3191/36
Shaw, H. B., 3773

92.—Far more serious evils result when migration from one Out-patient Department to another is due to want of uniformity in the rules for admission or in the efficiency of the inquiry systems.[2] If cases refused at one Hospital can readily obtain relief at another, attempts at organisation are largely frustrated. In the first place, the reference of unsuitable patients to a more appropriate agency is less likely to be acted upon; and, in the second place, individual Hospitals are reluctant to adopt stricter rules of admission than are generally in force, lest the consequent reduction of numbers, as compared with other Hospitals, should injuriously affect either their appeal to public sympathy or the interests of their medical schools.[3]

[2] Alvey, 403
Glenton-Kerr, 622/17, 18
B.M.A. (Whitaker), 1602
(Shaw, L.), 1724
Buchanan, 1928
Spicer, 2324-6
Nunn, 3984

[3] B.M.A. (Whitaker), 1606, 1618-9
Tirard, 4337
cf. Glenton-Kerr, 655

93.—As a preventive of either of these forms of migration, the Hospitals have been invited by the Charity Organisation Society to co-operate in the Society's scheme for the mutual registration of cases assisted.[4] This proposal is approved by many witnesses,[5] and it has been adopted in varying degrees by several Hospitals.[6] Most witnesses, however, recognise the difficulties arising from the vast numbers of Out-patients,[7] and some consider these difficulties insuperable.[8] The principle of mutual registration can, however, be applied to a limited extent with comparative ease and yet with considerable advantage. Thus, some Hospitals take part in local systems of registration, such as those in operation in Chelsea, Hampstead and St. Pancras.[9] Others report the cases that receive supplementary assistance through the Almoner or the Samaritan Fund.[10] But a very useful modification, and one which could probably be applied without great difficulty, would be to report to the Registrar cases rejected or referred to other agencies.[11] These are comparatively few in number, and a record of them in a central register would greatly facilitate the adoption of uniform standards of admission. Further extensions of the principle might well be practicable as the numbers of Out-patients became reduced by improved organisation.[12]

[4] Loch, 870
B.M.A. (Whitaker), 1731-34

[5] Thies, 432/15, 582, 598
Glenton-Kerr, 622/18, 647-8
Buchanan, 1975-6
Ryan, 2454-59
Johnson, S., 3191/37, 84
West, 3251/22
Nunn, 3953

[6] Ryan (St. Mary's) 2333/11 (6)
Jennings (Chelsea Hosp. for Women), 2582/9
Tirard (King's College), 4173/26

[7] Thies, 604
Glenton-Kerr, 648
Buchanan, 1975-6
Ryan 2454, 2459
Johnson, S., 3191/84

[8] Holland, 76
Spicer, 2329-32

[9] Jennings (Chelsea H.), 2582/9, 20
Nunn, 3953
cf. Thies, 583-4

[10] Tirard (King's College), 4173/26
Paddington Green (Ch.), App. 46/5

[11] Glenton-Kerr, 622/18, 648

[12] Loch, 870, 873
cf. B.M.A. (Whitaker), 1731-4

General Practitioners.

94.—Great stress has been laid by many witnesses upon defects in the relations between the Out-patient Departments and general practitioners. It is said that at present the Hospitals compete with the private doctor in the treatment of ordinary cases, thus injuring him financially and professionally; whereas under a system of co-operation, the Hospitals might to a greater extent than at present leave ordinary cases to the general practitioner and encourage him to send up to them difficult cases needing specialist advice or treatment. By thus developing the consultative side of their work, it is urged, the Hospitals would raise, instead of lowering, the standard of medical attendance on the poor in their neighbourhood.

95.—The question whether the Out-patient Departments actually compete with the general practitioners is, to a great extent, only another aspect of the question whether they are abused through the admission for ordinary ailments of patients able to pay for their treatment. We have already stated that, in our opinion, competition with respect to well-to-do patients is rare;[1] but that in the case of patients able to pay small fees or to join Provident Dispensaries, the competition is not inconsiderable where no complete system of inquiry exists.[2] It is recognised by the British Medical Association that this is due to the "glamour" of the Hospitals rather than to any spirit of competition in the Hospital itself.[3]

[1] See par. 42

[2] See par. 43
Loch, 727-730
Michelli, 1861
Roberts, 4436

[3] B.M.A. 1481/55 (δ)
(Whitaker), 1749

96.—Very serious results are attributed by witnesses to this competition. In the first place, it is said to compel the private doctor to lower his fees in order to retain patients.[4] Witnesses have spoken of fees being reduced from 2s. 6d. to 1s., to 6d., and even to 3d. a visit.[5] In order to make a living out of such charges the doctor is obliged to see a very large number of patients and can give but little attention to each,[6] quite apart from the question of giving time to study. Under these circumstances his professional status and efficiency degenerate, to the great disadvantage of the poor.[7]

[4] Loch, 760
Gray, 2894
Heron, 3380/27

[5] Montefiore, 2516
Tirard, 4265, 4328
Church, 3027/25;
3062
cf. Buchanan, 2014

[6] Gray, 2947
Tirard, 4265
Dawson, 4740

[7] Montefiore, 2516
Church, 3027/25
Barnett, App. 66/5

97.—Other witnesses, however, deny that under the present inquiry system there is any serious competition between Hospitals and general practitioners.[8] It is maintained that competent doctors find no difficulty in making a reasonable income, even in the neighbourhood of Hospitals;[9] and that where low fees exist they are due to purely economic causes—to competition within the profession, to the demand for a cheap form of doctoring, and to the profits to be made out of it.[10] But it seems impossible to doubt that the competition which we have already found to exist, as the result of the incompleteness of the inquiry systems, must have, to some extent, the effect attributed to it.

[8] Holland, 115-7
Currie, 919, 925
Sandhurst (quoting
Herringham), 1104
Tirard, 4267, 4284
cf. Quennell, 2797

[9] Holland, 117
Currie, 925

[10] Holland, 115
Sandhurst
(quoting
Herringham) 1104
Tirard, 4273, 4280
cf. Gray, 2939
Loch, 758-60

98.—Again, Hospital competition is said to affect injuriously the medical treatment of the poor by general practitioners, in that it makes the latter reluctant to send difficult cases to the Out-patient Departments for a second opinion. They are said to find that the Hospital often retains such cases, so that the private doctor loses not only the individual patient but also the connection of his family and friends.[11] Such reluctance would be largely removed if active co-operation were substituted for competition.[12]

[11] B.M.A., 1481/61
(Shaw, L.), 1744
Montefiore, 2509
Gray, 2952
Butlin, 3606
Tirard, 4173/17

[12] Jennings, 2618
Tirard, 4173/17
Gray, App. 13

99.—As a matter of fact a good deal has been done in recent years to reduce competition and encourage co-operation. This is one of the results of the employment of Hospital Almoners.[13] But, taking the Hospitals as a whole, there is as yet no organised system of co-operation either in regard to the reference to general practitioners of ordinary patients suspected of not being suitable for Hospital treatment, or in regard to the method of dealing with cases coming to the Out-patient Departments with recommendations from medical men.

[13] Kemp, 1348/1 (5)

100.—A good many Hospitals communicate with general practitioners in certain cases either as part of the inquiry into the patient's circumstances or as the result of such inquiry. At some this takes place in the case of all patients who are discovered to have been under the care of a private doctor.[1] Sometimes the patient objects to this, preferring that his own doctor should not know that he has sought a second opinion;[2] but the system is found to have the great advantage of encouraging private doctors to send up difficult cases.[3] It does not appear that where there is reasonable ground for the patient's wish to have a second opinion, the doctor refuses to concur, except from fear of Hospital competition.[4]

101.—At many Hospitals an inquiry of the patient's doctor (if any) is a regular part of the process of investigation into financial circumstances, the patient being referred back to the doctor if ultimately found to be able to pay.[5] Sometimes reference to a private doctor takes the place of inquiry—the rule being that all doubtful cases are told that they can only be treated if they bring a recommendation from some general practitioner.[6]

102.—One Hospital states that of the patients referred to their own doctor for an introduction the majority do not return though an appreciable number do;[7] another finds that more than half return with an introduction from the doctor.[8]

103.—With reference to cases recommended by general practitioners there is no uniformity of procedure. At a good many hospitals such recommendations admit the patient without inquiry. At some they give him preference over other patients. At St. Thomas's, where the recommendations ensure access to the visiting staff, nearly one-fourth of the out-patients proper are sent by private doctors.[9] The numbers thus recommended seem to vary considerably at different Hospitals,[10] this form of co-operation being specially encouraged at Hospitals with almoners;[11] while at teaching hospitals former students often send up interesting or difficult cases.[12] It is probable that the records are not complete, and that, for instance, a good many patients recommended by firms or other subscribers are sent on the advice of a doctor;[13] but after allowing for this it is evident that there is not as much co-operation in this way as there might be. The private doctors' reluctance has already been alluded to. From the Hospital point of view it is doubtful whether a doctor's recommendation should excuse inquiry. It is alleged that general practitioners sometimes send on any case which involves more than the simplest form of treatment;[14] or that, in their desire to oblige private patients, they do not pay sufficient attention to the question whether the patient they recommend can afford the reduced fee of a private consultant.[15] But there is no reason why such cases should not be inquired into.[16]

From the doctor's point of view, the reluctance to co-operate might be expected to diminish with every step towards the prevention of the existing competition.

[1] Alvey (Charing Cross), 331/10
Buchanan (Metropolitan), 1871/12
Ryan (St. Mary's), 2333/7
West (St. George's), 3251/13
Tirard (King's), 4173/17
Roberts (St. Thomas's), 4411/12
Belgrave (Ch.), App. 21/5
West Ham, App. 65/6
Paddington Green, App. 46/3
Central London Throat, App. 23/3
Hospital Epilepsy, App. 31/7

[2] Alvey, 422-3
Jennings, 2604

[3] Jennings, 2618
Tirard (King's College), 4173/17
Central London Throat, App. 23/3, 5

[4] Alvey (Charing Cross), 422
Quennell, 2813
Butlin, 3602, but *cf.* Jennings, 2605

[5] Holland (London), 2/23
Glenton-Kerr (Great Northern), 622/6
Buchanan (Metropolitan), 1871/7
Jennings (Chelsea), 2582/10
Wilcox (East London), 3188
West (St. George's), 3251/9
Thomson & Johnson (Middlesex), App. 12/11
Queen's (Ch.), App. 49/9
Grosvenor (Wom.), App. 27/7

[6] Michelli (Dreadnought) 1789/5 *cf.* Prince of Wales' App. 48/5

[7] Ryan (St. Mary's) 2333/7

[8] West (St. George's), 3291

[9] Roberts, 4411/12, 4452-55

[10] Statistical Appendix, Sec. A, col. 7

[11] Kemp, 1470-1

[12] Church, 3027/8

[13] Buckle, 208

[14] Gray, 2947

[15] Heron, 3380/14
Roberts, 4411/12, 26; 4456

[16] B.M.A., 1481/22 *cf*, Alvey, 425

104.—It has been suggested by medical witnesses that from the point of view of medical education closer co-operation with general practitioners would be an advantage in two ways; first, that it would increase the proportion of interesting cases sent to the Hospitals[1]; and, second, that it would continue the education of the private doctor by keeping him in touch with the Hospital consultant.[2]

[1] B.M.A. (Ker), 1554, 1670 (Whitaker), 1656 (Shaw, L), 1659, 1673-4, 1787 Thomson, 2772 Butlin, 3574 but *cf.* Still, 3248 *(note)*

[2] B.M.A., 1481/23 Nunn, 3988 Barnett, App. 66/2. *cf.* Montefiore, 2509, 2563

VI. GENERAL OBJECTS TO BE AIMED AT IN REFORM.

105.—The foregoing discussion of the various defects of the existing Out-patient system points to the conclusion that any scheme of reform should aim at the following general objects:—

(i) The reduction of numbers, partly by the exclusion of those able to pay for medical treatment or to make provision for it by provident methods, and of those too poor to benefit by it; and partly by the discouragement of the attendance of trivial cases.

(ii) The development of the consultative side of Hospital work, and the encouragement of co-operation with general practitioners and other agencies for medical assistance.

(iii) The co-ordination of Hospital assistance with general charitable work and with the Poor Law and other forms of public assistance.

(iv) The provision of adequate safeguards for the interests of medical education and the development of medical science.

The various remedies suggested by witnesses will be considered in relation to these objects.

VII. EVIDENCE AS TO SUGGESTED REMEDIES.

106.—Safeguards against abuse and remedies for the other defects mentioned may be sought in two directions: first, in the internal organisation of each Hospital; and second, in the external organisation of medical assistance. Under the first class of remedies free access to the Out-patient Departments would be permitted to all patients, the Hospital providing within its own walls, and having under its own control the machinery for sifting the patients, and for co-operating with other agencies. Under the second class the sifting would be done by some external agency, on whose recommendation alone patients would be admitted to the Out-patient Department.

107.—Of the various safeguards and remedies at present in operation in the Out-patient Departments of different Hospitals, the following are the most important:—

(1) Admission by subscribers' letters;
(2) Payment by patients who can afford it;
(3) Inquiry into patients' circumstances;
(4) The limitation of the numbers selected for the visiting staff in any one day; and
(5) Admission only on the recommendation of an outside general practitioner.

Subscribers' Letters.

108.—Subscribers' letters have been abandoned at most of the Out-patient Departments, and where they are retained it is usually on the plea that they are valued by subscribers and so assist in raising funds.[1] Since, however, at some Hospitals they confer privileges, such as exemption from inquiry into patients' circumstances, a remission of patients' payments, or a guarantee of access to the visiting staff,[2] it is evident that they are still used as a test of medical or financial suitability.[3]

109.—But the general opinion is in favour of their abolition.[4] The trouble of obtaining them frequently constitutes a hardship on the patient.[5] They are often given without adequate knowledge of patients' circumstances, and thus lead to the admission of unsuitable cases.[6] We therefore recommend the abolition of the use of such letters.

Patients' Payments.

110.—Patients' payments may be regarded as a precaution against abuse in two ways. In the first place unsuitable persons who might be attracted by an offer of free treatment may not be attracted by any less favourable offer. Against this, however, must be set the risk that unsuitable persons who would not care to accept charity may have less hesitation when they are paying something towards the cost. In the second place, persons unsuitable for free treatment may yet be suitable for treatment at a rate of payment below that charged by private doctors. Theoretically the question may seem merely one of amount. So long as the payment asked at the Hospital does not approach that asked by private doctors, it may lessen the risk of pauperising the patient, and yet not increase the risk of competition with the general practitioner. Thus it is claimed by some witnesses that a payment of 3d. per attendance does not compete with the charges of a private doctor,[7] although others admit that a charge of 6d. in respect of ordinary ailments might do so.[8] The narrowness of the line thus drawn shows how dangerous the principle may be, even when it is fully understood that the payment is only for medicines and dressings,[9] that all other expenses are borne by the Hospital,[10] and that the medical attendance is for the most part honorary. But it is said that there is a tendency amongst patients to believe that the payment covers medical attendance and other expenses as well, and that they are in no sense recipients of charity[11]; and many witnesses hold that in

[1] Currie, 935-940
B.M.A., 1481/38
Collins, 4019
Marshall, 4348
Miller Hosp., App. 40/2
cf. Thies, 505
Johnson, S., 3216
Shaw, H. B., 3737-40
Capes, 4055-6

[2] Statistical Appendix, Sec. B, col. 5.

[3] Buckle (Univ. Coll.), 135/8, 20; 219-221; 263
Marshall and Betteridge (W. Lond.), 4347/3
Leyton Hosp., App. 34/5, 6
but *cf.*
Shaw, H. B. (Univ. Coll.), 3729-35
Betteridge, 4376-8

[4] Holland, 102
Thies, 501
Loch, 707-710
Warren, 1189/22
B.M.A., 1481/38
Church, 3073
Johnson, S., 3218
Butlin, 3621-3
Nunn, 3778/14
Capes, 4047/5 (4)

[5] Holland, 98
Thies, 508
Loch, 709

[6] Holland, 100, 105
Thies, 502-4
Loch, 708, 725
Currie, 935
B.M.A. (Whitaker), 1514-20
Capes, 4053-4
Tirard, 4173/15
Cf. Sandhurst (quoting Herringham), 1104
Roberts, 4411/31

[7] Holland, 113
Dawson, 4735

[8] Buckle, 243-249
but *cf.* Dawson, 4736

[9] Holland, 113, 118
Buckle, 250

[10] Statistical Appendix, Sec. A, cols. 10-11
cf. B.M.A. (Shaw, L.), 1746-8
(Whitaker), 1750

[11] Sandhurst, 1171-6
Church, 3027/24
Roberts, 4411/36
but *cf.* Wilcox, 3186

these circumstances even a 3d. payment competes unfairly with the charges of local doctors,[1] and discourages provident methods.[2] On this subject the members of the Central Hospital Council were equally divided.[3]

[1] Sandhurst, 1171-6 B.M.A., 1481/39 Church, 3062-4 Capes, 4047/2 (3) *cf.* Loch, 833 Quennell, 2776/16

[2] B.M.A., 1481/39

[3] West, 3349/4

111.—At special Hospitals, where the comparison is between the patients' payments and the minimum fee of the specialist, and a higher charge can be made without risk of competition, a system of payment according to the means of the patient is sometimes in force.[4] But the same general arguments for or against patients' payments apply also to these, and the objections on the part of medical witnesses have been equally strong.[5]

[4] Statistical Appendix, Sec. B, col. 6

[5] B.M.A., 1481/39 B.M.A. (Macdonald), 1590 (Whitaker), 1645-6 (Ker), 1646 Heron, 3490-3507 Butlin, 3660-3670 Capes, 4047/2 (3), 4093-97 but *cf.* Loch, 832, 837-840

112.—On the whole, we are of opinion that the system of payments might advantageously be abolished.

Inquiry Officers and Almoners.

113.—Inquiry into patients' circumstances by officers of the Hospital is the principal method at present in force of controlling the admission of patients by means of internal organisation.

114.—There are two principal methods of investigation, one by means of an Inquiry Officer whose energies are directed solely to the prevention of abuse; the other by an Almoner (usually a lady) whose inquiries have the additional object of ascertaining whether supplementary assistance is needed, and of putting the patient in the way of obtaining such assistance.*

115.—Of these two types the Inquiry Officer pure and simple is the earlier, the Almoner representing a later development.[6] Of the 12 general Hospitals with schools, three have Inquiry Officers only (and of these, one leaves the ultimate decision to the secretary), six have Almoners only, another has "Lady Out-patient Visitors," and two have both Almoners and Inquiry Officers. Of the 16 other general Hospitals without schools, four have Almoners, two have Inquiry Officers, four entrust the investigations to their secretaries, one to a resident medical officer, one to a nurse, and one to a registration officer. Three report that they have no inquiry system, but of these one admits Out-patients solely on the recommendation of private doctors.[7]

[6] Currie, 886 Montefiore, 2474/6

[7] Statistical Appendix, Sec. B. col. 7 These particulars relate to the year 1911

116.—In the special Hospitals the inquiry systems are less well developed. Amongst 37 Hospitals only four have Almoners, of whom three are at Children's Hospitals, while no fewer than 21 entrust the decision in doubtful cases to the secretary, with or without the assistance of clerks or Inquiry Officers.[8]

[8] *Ibid.*

* The term "Almoner" does not appear to indicate the nature of the work of the official so named. It suggests rather the distribution of relief than the prevention of abuse or even the promotion of co-operation between charitable agencies. Nevertheless its meaning is well understood by those who use the word.

117.—The extent to which an organised system of inquiry is necessary at any particular Hospital depends on the size of its Out-patient Department. It is undesirable that the duty of deciding as to the suitability of patients, whether for free or for part-pay treatment, should be in the hands of any officer who is concerned with the raising of funds for the Hospital, or whose business it is to consider the effect of Out-patient statistics, or of patients' payments, on the financial prospects of the institution.[1]

[1] Church, 3097 *cf.* B.M.A., 1481/39 West, 3349/2

118.—The qualifications of the "Inquiry Officer" vary at different Hospitals. At some he is little more than a registering clerk,[2] at others he is a skilled investigator, sometimes with the general experience of an ex-police inspector[3]; sometimes with a special knowledge of the immediate neighbourhood of the Hospital, which is of the greatest value.

[2] *Cf.* West, 3286

[3] Bland, 2243

119.—The "Almoner" is usually a lady,[4] trained by the "Hospital "Almoners' Council" upon definite and uniform lines.[5] This Council, like the Almoner system itself, was founded by the Charity Organisation Society,[6] but it has recently been re-organised on a representative basis.[7] The training is partly theoretical, consisting of lectures on sociology, hygiene and physiology; and partly practical, consisting of general charitable work in a district office of the Charity Organisation Society, and of Hospital work in the office of a Hospital Almoner.[8] But when the training is completed, the Almoner becomes responsible solely to the Hospital which employs her.[9]

[4] Buchanan, 1933-40

[5] Kemp, 1348, &c.

[6] Kemp, 1350

[7] Kemp, 1348/9, Appendix 6 B

[8] Kemp, 1348/7

[9] Kemp, 1348/8

120.—The principles upon which Almoners are trained to work include: (1) the prevention of abuse by referring unsuitable cases to an appropriate agency, (2) the supplementing of Hospital treatment by securing the aid of other charities and the co-operation of the patient himself, (3) the encouragement of thrift in the form of provision against future sickness, (4) the development of the consultative side of Hospital work.[10] In all her work the Almoner is expected to act in close touch with the medical staff of the Hospital, no case being refused or referred elsewhere without medical sanction.[11]

[10] Kemp, 1348/1

[11] Kemp, 1348/4 Buchanan, 1921 Montefiore, 2474/14 (*a*) Tirard, 4173/13 Roberts, 4411/11, &c., &c.

121.—With regard to the relative merits of "Inquiry Officers" and "Almoners," it seems to be more and more recognised, so far at least as the larger Hospitals are concerned, that the merely negative investigations of the former are insufficient, and that the positive activities of the latter are necessary.[12] This is admitted even by such witnesses as dislike the methods of the present Almoners.[13]

[12] Loch, 744-5 Kemp, 1382 Montefiore, 2497 *cf.* West, 3278

[13] Shaw, H. B., 3701, 3774 *cf.* Davis, 989-994 James & Gasson, 4482/5

It is evident that the Almoner system is well adapted to the prevention of many of the defects already discussed, bringing, as it does, the Hospital work into touch with home conditions, with the past history of patients, with other charitable and medical agencies, and with general practitioners.[14] Some witnesses, however, have expressed the fear that the side of the Almoner work which deals with the prevention of abuse is

[14] Kemp, 1348/3 Montefiore, 2497

liable to be hampered by the more positive side,[1] and to be less efficiently performed than it would be by ordinary Inquiry Officers. On the other hand, we have instances of an Almoner having discovered abuse which had been passed over by an Inquiry Officer;[2] and we find that amongst the great Hospitals with schools, the numbers of cases excluded are comparatively small at those without Almoners.[3] It should be remembered that the principle of the reference of unsuitable cases to more appropriate agencies, which is the special work of Almoners, prevents abuse by enabling a stricter standard of suitability to be applied without hardship to patients. Again, the exclusion of cases too poor to benefit by Out-patient treatment is better enforced after it has first been ascertained that it is impossible to supplement the Hospital treatment by other appropriate charitable assistance.

In both these directions therefore the twofold function of the Almoner actually assists in the exclusion of the unsuitable.

[1] Ryan, 2451 Capes, 4139 *cf.* West, 3278, but *cf.* Kemp, 1461 B.M.A., 1481/56

[2] Johnson, S., 3199, 3207

[3] Statistical Appendix, Sec. B, cols. 7 & 10

122.—On the whole the evidence seems to prove that the system of inquiry through Almoners (either alone or supplemented by ordinary Inquiry Officers) has been very useful both in preventing the abuse of the Out-patient Departments and in remedying some of their other defects, and the question arises whether all that is necessary is to extend the system till the whole field is covered.

123.—As to the possibility of a sufficient extension of the system, it is evident that a large increase in the number of Almoners would be required, and that the expense would be considerable.

124.—Thus the London Hospital, which has at present five Almoners, besides an Inquiry Officer and an Out-patient Superintendent, estimates that 15 would be necessary, at a total cost of £3,000 a year, and that even then the Casualty Department would be untouched.[4] At St. Thomas's, where the Casualty Department is partly investigated and the number of Out-patients proper is limited, there is a staff of nine, besides voluntary workers.[5] Charing Cross has one, and states that it would require three if the Casualty Department as well as the Out-patient Department was to be covered.[6] The Metropolitan would want four.[7] St. Bartholomew's[8] and the West London[9] find the cost of Almoners the chief obstacle to re-organisation—the salary being usually £100 or £120 rising to £200.[10] St. Mary's, in order to investigate the Casualty Department, feels the need not only of more Almoners, but also of more accommodation,[11] and the latter difficulty occurs at the Royal Free and to some extent at St. Thomas's.[12] Some increase of expenditure would therefore be unavoidable in most cases, but it would appear that the Hospitals with Almoners consider them well worth their cost, partly because of what they save by the prevention of abuse, and partly because of the increased value of Hospital treatment when supplemented by the various other forms of assistance which the trained Almoner knows how to secure.[13]

[4] Holland, 27, 38 *cf.* Currie, 925

[5] Roberts, 4411/5

[6] Alvey, 416

[7] Buchanan, 1940

[8] Sandhurst, 1055

[9] Marshall, 4376

[10] Thies, 485 Kemp, 1396-7

[11] Ryan, 2375-6

[12] Thies, 485 Roberts, 4411/20 *cf.* Tirard (King's Coll.), 4338

[13] Holland, 47-49 Currie, 928-930 Buchanan, 1942 Johnson, S., 3191/65 West, 3277-79

125.—The chief difficulty in establishing a complete inquiry system lies in the large number of patients that present themselves. It is estimated that one Almoner cannot satisfactorily deal with more than about 25 cases a day.[1]

But the mere presence of an Almoner tends to deter unsuitable cases from applying, and so diminishes the work to be done.[2]

126.—The preliminary investigations of an experienced Inquiry Officer would reduce the pressure on the Almoner's Department. Sufficient particulars to justify the exclusion of the more obviously unsuitable cases can often be obtained by an officer moving about amongst the patients in much less time than is required for the private interviews with the Almoner, and there is therefore a good deal to be said for this form of "double sieve."[3]

[1] Tirard, 4173/9
Thies, App. 3, C.

[2] Thies, 488-490
Glenton-Kerr, 622/7
Currie, 930
Kemp, 1428-1431
but *cf.*
Sandhurst, 1055
Thomson and Johnson, App. 12/32

[3] Holland, 89
Johnson, S., 3199-3202, 3207
West, 3285

Limitation of Numbers.

127.—We have already described the system,[4] adopted at several Hospitals, of limiting the numbers of new patients reserved for the visiting physicians and surgeons in attendance, on any one day. The cases selected for these purposes are, of course, the most serious of those presenting themselves. The cases not so selected are, according to their seriousness, either treated by the resident or junior staff, or given a preferential chance of selection for the visiting staff next day.[5]

[4] See par. 72

[5] West (St. George's) 3251/3
Roberts (St. Thomas's) 4414-5
Queen's (Ch.) App. 49/4 (*d*)
Roy. Waterloo Women & Ch.) App. 55/3
cf. Tirard, 4230

128.—The advantage claimed for this system is that it draws a clear distinction between patients that need the consultant and patients that do not. Provided that the selection is in the hands of fully competent medical officers, it ensures that all serious cases come under the direct care of the consultant himself,[6] relieves them of much of the liability to long hours of waiting, and enables the Almoner to give them special attention. As evidence that it does not cause any hardship, we are told that at St. Thomas's the maximum number (19) is seldom reached.[7] But it does not in itself relieve the crowding of the receiving room and the pressure on the staff responsible for selecting the more serious cases and treating the less serious,[8] or facilitate the enquiries of the Almoner into ordinary cases, except in so far as the knowledge that only the more serious cases will be attended to by the consultant may deter the more trivial from applying unnecessarily.[9]

[6] Kemp, 1432
B.M.A., 1481/20
Butlin, 3556
Roberts, 4413

[7] Roberts, 4417

[8] Gray, 2942
West, 3362
but *cf.*
Loch, 870, 873

[9] West, 3355
cf. Capes, 4110

External Sifting by General Practitioners.

129.—There are many witnesses, however, who are doubtful whether the extension of the system of inquiries by "Almoners," accompanied or not accompanied by a limitation of numbers, would be adequate to secure the necessary reforms. The alternative plan is therefore put forward, of entrusting the sifting of patients to some external agency, and thus

limiting the applicants to the Hospitals to those who are *prima facie* suitable either medically or financially or on both grounds.

130.—In support of this policy it is urged that the Almoners alone are not successful in preventing abuse,[1] and that it is extremely difficult to turn away patients when once they have passed the doors of the Hospital.[2] It is also suggested that the Almoner tends to decide too much on financial grounds, and therefore to admit patients who are medically unsuitable, while excluding patients requiring Hospital treatment.[3]

[1] B.M.A. (Whitaker), 1640 (Shaw, L.), 1644 Gray, 2896 Capes, 4139

[2] Warren, 1189/20 Montefiore, 2481 Butlin, 3586 Gray, 4122

[3] Barnett, App. 66/3 *cf.* Michelli, 1801

131.—The proposal usually takes the form that admission to the Out-patient Departments should, except in cases of emergency, be confined to patients recommended by medical practitioners, including private doctors, dispensary doctors, and Poor Law medical officers.[4] Under this system, as put before us by the British Medical Association everyone would have access to a general practitioner, either privately or through a Provident or Poor Law Dispensary, who would treat all ordinary or trivial ailments[5]; while in cases presenting difficulty in diagnosis or requiring special treatment, the general practitioner would send the patient to the Hospital for consultative advice.[6] The Hospital would report on the case to the private doctor, and would not retain it for treatment except where special skill or expensive apparatus was required.[7] In all other cases it would be left to the general practitioner to see to the carrying out of the treatment advised by the Hospital consultant.[8]

[4] Warren, 1189/22 Kemp, 1432-3 B.M.A., 1481/20, 22, &c., &c. Buchanan, 1871/26 Prior, 2024, &c. Montefiore, 2474/15 Gray, 2817/9 (*b*) Butlin, 3556-62 Shaw, B., 3694-5 Nunn, 3778/14 Capes, 4047/2 (6) Lyster, App. 9/2 Barnett, App. 66/2 Poor Law Commission Majority Report, Pt. V, ch. 2, par. 189, quoted by B.M.A., 1481/7

[5] B.M.A., 1481/21 B.M.A. (Whitaker), 1685

[6] B.M.A., 1481/22

[7] B.M.A., 1481/43, 63 (2) Gray, 2919 Butlin, 3557 Capes, 4070

[8] B.M.A., 1481/17, 27, 30

132.—The arguments in favour of the proposal for external sifting by general practitioners may be summed up as follows:—

(1) that abuse would be prevented, because no general practitioner would recommend anyone, at all events in respect of an ordinary ailment, who was able to pay a private doctor or join a Provident Dispensary, or was already provided for by the Poor Law. It is admitted,[9] however, that the Hospital would still have to protect itself by means of Almoners against the recommendation of patients able to pay consultant's fees.

[9] B.M.A., 1481/22 Gray, 2817/9 (*b*) and (*d*) Capes, 4047/2 (14) *cf.* Tirard. 4338 but *cf.* Prior, 2029-31

(2) that overcrowding would be prevented together with the other evils that result from the admission of ordinary or trivial cases.

(3) that the treatment of patients for ordinary ailments would be conducted by doctors familiar with their home conditions and past history, and that in special cases the same doctors would be able to see that the treatment advised by the Hospital was duly carried out.

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(4) that co-operation with general practitioners would take the place of competition, and the reluctance of the private doctors to send difficult cases to the Hospitals would disappear.

(5) that a great step would thus be taken towards the co-ordination of the whole medical service of the poor. The Hospital would fulfil its most valuable function as a consultative centre, to the great benefit of the patients both directly, through the provision of the special advice or treatment they might need, and also indirectly through the increased efficiency of the general practitioners, who would be kept in touch with the leaders of their profession and the most recent advances of science.

133.—It is obvious that the attainment of these ends by this means depends upon the soundness of certain assumptions.

134.—The first assumption is that all patients would be in a position without undue hardship[1] to obtain access to a general practitioner, either privately or through dispensaries, or through the Poor Law.

This assumption involves the existence, as part of the scheme, of a sufficient number of Provident Dispensaries to meet the needs of all who cannot afford ordinary fees.[2] It further pre-supposes either the non-existence of any class intermediate between those able to join Provident Dispensaries and those suitable for the Poor Law,[3] or else the existence of charitable or public agencies by whose assistance the members of that class will be enabled to make provision.[4]

Should there be an absence of sufficient Provident Dispensaries, the advocates of the scheme would meet the difficulty by allowing free access to the Out-patient Departments for a time, though with preference to recommended cases, and subject to strict inquiry by Almoners. This would give time for the Provident Dispensaries to be developed on a scale adequate to their function under the scheme.[5]

135.—The second assumption is that the general practitioner could be relied upon to detect the cases which required a second opinion or special treatment, and send them to the Hospital.[6]

In so far, if at all, as the general practitioners accessible to the poor may be at present less reliable in this respect than the Casualty Officers at the Out-patient Departments,[7] it is argued that their competence would improve under the system.[8] Here again the suggested transitional period might assist in preventing hardship,[9] but some witnesses would provide permanently for a means of appeal from the decision of the private doctor either to the Hospital[10] or to some representative authority representing non-medical interests.[11]

136.—The third assumption is that the general practitioners could be relied on to determine on uniform principles the best means of dealing with patients, whether from the medical, the financial, or the sociological point of view. For it would be to the general practitioners that the control of the future policy would be entrusted, in many of the matters in respect of which reforms are at present urged upon the Hospitals. They would in effect be responsible for determining the kind of cases, medically speaking, which should be admitted to the Out-patient

[1] But *cf.* Alvey, 331/22 Johnson, A. E., 2758 Church, 3108-3114 Tirard, 4336

[2] Kemp, 1444-52 B.M.A. (Macdonald), 1557 (Whitaker), 1685-6 *cf.* Church, 3108

[3] B.M.A. (Whitaker), 1620-2, 1768 (Ker), 1696 Montefiore, 2526 Gray, 2909, 2945 *cf.* Ryan, 2430 Church, 3067-9, 3074, and see par. 40

[4] Kemp, 1432-3, 1447 B.M.A. (Whitaker), 1686 Montefiore, 2550-52 Nunn, 3918-3930 Some witnesses however would deal with such cases at Non-provident Dispensaries. Warren, 1300 James, 4547 Barnett, App. 66/2 *cf.* Alvey, 331/13 Thomson, 2732-3

[5] B.M.A., 1461/33-4, (Macdonald), 1557 (Whitaker), 1685-1693

[6] B.M.A.— (Ker), 1666-73 (Macdonald), 1675 (Shaw, L.), 1675-6 Montefiore, 2568 Gray, 2939 Capes, 4058, 4116 *cf.* Church, 3059-60

[7] Michelli, 1803 Buchanan, 1951 Spicer, 2191 s/4-5 Ryan, 2461 Montefiore, 2509, 2518, 2563, 2572 Jennings, 2607-9 Johnson, A. E., 2759 Tirard, 4265, 4327-8 Dawson, 4739-40 Hosp. Epilepsy, App. 31/9 Barnett, App. 66/1 *cf.* Church, 3027/25

[8] B.M.A., 1461/23 B.M.A. (Shaw, L.), 1673-4 Montefiore, 2509, 2520, 2560 Nunn, 3988 Barnett, App. 66/2

[9] B.M.A., 1461/33 B.M.A. (Whitaker), 1685

[10] B.M.A. (Shaw, L.), 1675 *cf.* Loch, 781

[11] Butlin, 3603-4 Nunn, 3981-88

Departments; the financial level which should distinguish the classes suitable for provident, charitable or Poor Law agencies respectively; and the extent to which the administration of medical assistance should keep in view collateral objects such as the encouragement of thrift, co-ordination with other forms of charitable work, or the interests of medical education and the advancement of medical science.

This statement must, of course, be modified to some extent in the case of those witnesses who would associate with the scheme some representative authority for the co-ordination of medical assistance.[1]

[1] Loch, 794
Kemp, 1432
Butlin, 3604
Nunn, 3984-5
Barnett, App. 66/4
Poor Law Commission Majority Report, Pt. IX. (22), and Pt. V., ch. 3, par. 237

137.—Satisfactory assurances on all these points would seem to be necessary, from the point of view of the Hospitals, of the patients, and of the charitable public, before any proposal could be accepted to transfer from the Hospitals to an outside agency the sifting and selection of patients. We are not satisfied that the case for entrusting the selection to general practitioners has been made out.[2]

[2] *Cf.* Holland, 132-3
Alvey, 331/22
Still, 3248 (*note*)
Tirard, 4344
Roberts, 4411/26
Dawson, 4758-62

138.—Our doubts on these points have not been removed by a study of the evidence as to the Bolingbroke Hospital, which is referred to by advocates of the system as an example of its operation in practice.[3] Here the Out-patient Department is purely consultative; patients are seen only on the recommendation of a medical man, and even then they are not treated at all unless special skill or apparatus is required, but are referred back to the general practitioner with a report from the Hospital doctor.[4] We have evidence that, as far as it goes, this system works well; that it satisfies the local doctors, the subscribers, and the patients who belong to friendly societies and clubs[5]; that the system is favourable to the development of Provident organisations; and generally that this Hospital is free from many of the abuses and other defects to which open Out-patient Departments are liable. But it does not appear that the Bolingbroke system comprises any provision for securing to patients access to other charitable agencies. The attitude of the Hospital itself, so far as this aspect of the question is concerned, is purely passive. It makes no inquiry as to the financial suitability of the patients;[6] the question whether a particular patient should join a Provident Dispensary is looked upon as a personal matter between patients and individual private doctors,[7] who may or may not decide such questions on uniform principles. It is assumed that all patients who are ineligible as having no private or dispensary doctor are proper subjects for the poor law;[8] but it is admitted that they may go to other Hospitals.[9]

[3] B.M.A., 1481/54 (Ker), 1552-71, 1574-5, 1786 (Whitaker), 1571-4 (Shaw, L.), 1575-7 *cf.* Lowrie & Prior, 2022-2190 Lyster, App. 9

[4] Lyster, App. 9/2

[5] B.M.A., 1481/38, 54
Lyster, App. 9/3

[6] Prior, 2029, 2035, 2142

[7] Prior, 2144

[8] Prior, 2110, 2188

[9] Prior, 2113, 2146/7

The Hospital Out-patient Department acts (apart from casualties and operations) merely as a consultant centre for patients who are unable to pay for specialist advice, but are able to secure the services of a general practitioner to carry out that advice. We have no reason to suppose that it does not perform this function usefully and efficiently. But, in the absence of any system of local co-ordination, and of any evidence as to the method by which those who are excluded from the Bolingbroke Out-patient Department obtain their treatment for ordinary ailments, there is nothing to show that it meets the whole of the

legitimate Hospital requirements of all classes in its district, or that the introduction of similar methods into all Hospitals would not leave large classes unprovided for. The fact that St. Thomas's Hospital, with its comparatively well-developed Almoner system, treats as many cases from the Bolingbroke district as does the Bolingbroke itself,[1] is alone sufficient to render this extremely doubtful.

[1] Prior, 2146, but *cf.* 2052-2056 Roberts, 4411/1 (*a*) and (*b*) and Statistical Appendix, Sec. A, col. 2

Co-ordinating Agencies.

139.—Several witnesses have expressed the opinion that for any effective organisation of the Out-patient Departments the establishment of some agency for the co-ordination of medical assistance is required. Such an agency would, it is said, supply a remedy for the want of uniformity now existing between one Hospital and another, for overlapping, and for the isolation of medical agencies from other forms of charitable or public assistance.[2]

[2] Thies, 432/22 Loch, 794 B.M.A. (Whitaker), 1607-9 Montefiore, 2556 Shaw, H. B., 3762 *cf.* Davis, 997

140.—At present no such co-ordinating agency exists. There are, however, various bodies which perform, either directly or incidentally, some of the functions of such an agency.

141.—From time to time there have been conferences between the various Hospitals,[3] and between Hospitals and other bodies such as the British Medical Association,[4] and quite recently a British Hospitals Association has been formed, part of whose function it is to organise conferences on Hospital matters.

In 1892 the formation of a Central Body was recommended by the Select Committee of the House of Lords,[5] and in 1897 a Central Hospital Council was formed representing 18 of the leading Hospitals.[6] This Council has made recommendations on such subjects as the appointment of inquiry officers, and the definition of the term "Casualty patients"; and in conjunction with the Metropolitan Provident Medical Association it drew up in 1905-6 a scheme of co-operation between Hospitals and Provident Dispensaries.[7]

The three Hospital Funds—the King's Fund, the Hospital Sunday Fund, and the Hospital Saturday Fund—have used their influence in the past to secure uniform statistics of Out-patients,[8] and, in the case of the two first mentioned, the appointment of inquiry officers.[9]

[3] *cf.* Davis, 997

[4] B.M.A., 1481/8-9 B.M.A. (Whitaker), 1521-25

[5] Sandhurst, 1109 B.M.A. (Shaw, L.), 1709

[6] West, 3349

[7] B.M.A. (Shaw, L.), 1611 West, 3349/5

[8] Ryan, 2472 *cf.* Thies, 432/21

[9] Church, 3096-9 *cf.* Evelina, App. 25/1*d* Currie, 886 The Hospital Saturday Fund has its own system of inquiry so far as its members are concerned, Davis, 976-989 *cf.* Roberts, 4474

142.—In the sphere of general charity a co-ordinating agency already exists in the Charity Organisation Society,[10] whose services in the initiation of the Almoner system, the training of Almoners, and the organisation of the mutual registration of assistance, have already been referred to. Agencies of a more generally representative character have been established in certain districts of London in the form of Councils of Social Welfare,[11] and there is a Central Association of Councils of Social Welfare for the promotion of this movement.[12] The Majority Report of the Poor Law Commission contemplates the establishment of Central and Local Voluntary Aid Committees[13] to work in co-operation with the

[10] Holland, 57, 131 Kemp, 1403-6 Montefiore, 2532

[11] Holland, 1/27, 29 Jennings, 2627-8 Nunn, 3778/1 (iii)

[12] Holland, 57 *cf.* Nunn, 3951

[13] Poor Law Commission Majority Report, Pt. IX. (23); Pt. V. ch. 3, par. 237 B.M.A. (Whitaker), 1607-9 Buchanan, 1871/26, 1964

Public Assistance Authorities which under their scheme would take the place of the present Poor Law Authorities.[1] In association with these authorities, the scheme also proposes Central and Local Medical Assistance Committees representing Hospitals, Poor Law Infirmaries, Provident Dispensaries, General Practitioners, Public Health Authorities and the Public Assistance Authority.[2] The Majority Report, therefore, contemplates the machinery for a complete co-ordination of medical and charitable assistance.[3]

[1] Majority Report, Pt. IX.(8) to (12)

[2] *Ibid.*, Pt. IX. 22 and Pt. V. Loch, 790

[3] Montefiore, 2474/15, 2552 Nunn, 3778/8, 10, 3907-17

143.—At present, however, the work of co-operation between one Hospital and another, and between Hospitals and other agencies, lies chiefly in the hands of the Almoners, acting in concert with the medical staffs; and the reconstitution of the Hospital Almoners' Council, on a representative basis, is a further step along this line of co-ordination.[4] The Council is to consist of representatives of Hospitals, of the medical staffs of Hospitals, of the Charity Organisation Society, and of the trained Almoners and other persons interested in the work of Hospitals or kindred charities.

[4] Kemp, App. 6 (B)

VIII. CONCLUSIONS AS TO REMEDIES.

Development of Almoner System.

144.—The evidence leads us to the conclusion that the most practicable method of remedying the defects of the Out-patient Departments lies in the development of the Almoner system. This development should have in view three main ends. First, the reference to appropriate agencies, of cases unsuitable for the Out-patient Departments; second, co-ordination with other forms of medical and charitable assistance; third, co-operation with general practitioners so as to encourage the use of the Hospitals for consultative purposes.

145.—A question arises as to whether the Almoners themselves should undertake all this work, or whether they should utilise existing agencies. It seems to us that there might be some danger of the Almoner travelling beyond the province of the Hospital as an institution for medical relief,[5] if he or she did all the work personally. It seems preferable that the Almoner should utilise existing agencies,[6] especially where there is any local machinery of co-ordination in existence.[7] As the co-ordination of charitable or public assistance in any area develops, the Hospitals will thus be ready to take their place in the organisation. The Almoners' aim should be to provide a link between the Hospital and general charity.

[5] Buckle, 283 Glenton-Kerr, 668-9 *cf.* Kemp, 1374

[6] Kemp, 1375, 1383, 1386-92

[7] Holland, 49, 53 Loch, 745

146.—Co-operation between Hospitals and general practitioners, with the consequent encouragement of the use of the Hospital as a consultant centre, can, we believe, be developed to a very considerable extent

through the agency of the Almoners. We have been struck with the way in which the existing Almoner system has been utilised for the purpose at some Hospitals. It is part of the regular practice of the Almoner to communicate with the doctor if the patient has one, and the case is often referred back to him (subject to the consent of the Hospital doctor) if he is in a position to treat the ailment. At King's College Hospital the Almoner keeps a card index of patients recommended by medical men,[1] and no future application from such a patient, or from his family, is knowingly entertained without reference to the medical man. This is stated to have led to an increase in the number of cases sent up by private doctors for special advice or treatment.[2] It seems to us that good results might be expected from an extension of this practice.

[1] Tirard, 4173/11, 12, 14, 17

[2] Tirard, 4173/17

147.—This co-operation should be effected by three methods, which between them would cover all the cases where the general practitioner could have any grievance :—

(i) In the case of a patient who has no doctor :—by referring the patient to a private doctor, Provident Dispensary or Poor Law Dispensary, whenever the financial circumstances, combined with the nature of the ailment, rendered such a course appropriate.

(ii) In the case of a patient who has a doctor, and comes without a recommendation from that doctor :—by communication with the doctor. Such communication would take the form of a reference back to the doctor if the case was one which could be adequately dealt with by him, and a report to the doctor if the case needed special diagnosis, advice, or treatment.

(iii) In the case of a patient who comes with a doctor's recommendation :—by reporting to that doctor on the case ; and keeping a record of the fact that the patient has a doctor, for use in the event of the patient subsequently attending without a recommendation.

The carrying out of these methods would be the work partly of the Almoner and partly of the Hospital doctor or his assistants, but (as at present) no action should be taken by the Almoner without the knowledge and consent of the Hospital doctor.

148.—The interest of the patients would be safeguarded, as well as those of the Hospital and of the general practitioners, if the actual arrangements took the following form :—

(1) In cases where the Hospital doctor advised treatment at the Out-patient Department, the Hospital to inform both the patient and the general practitioner of this fact. The patient then to be at liberty to come again for treatment if he wished to do so,

until such time as he was well enough to be referred back to the general practitioner.

(2) In cases where the Hospital doctor considered that the patient could be adequately treated by the general practitioner, the Hospital also to inform both the patient and the general practitioner of the fact; but the patient would then not be admitted to the Out-patient Department.

149.—The development of the Almoner system, on a scale sufficient for the application of these principles throughout the Hospitals of London, is largely a question of finance. We consider that expenditure in this direction would be so beneficial that it would give the Hospitals an added claim on the charitable public.

150.—The work of the Almoners, however, if it is to be successful, requires to be supplemented by two other reforms—first a reduction of numbers through the exclusion, by the Hospital doctors, of those unsuitable on medical grounds for Hospital treatment; and, second, the provision of sufficient Provident Dispensaries or other means of securing medical attendance for ordinary ailments by provident methods. In addition to these, some further development of general co-ordination between Hospitals and other agencies is desirable; while finally it is essential that the interests of medical education and the advancement of medical science should be safeguarded.

Limitation of Numbers.

151.—The reduction of numbers by the exclusion on medical grounds of cases unsuitable for Hospital treatment would, in our opinion, be both practicable and beneficial. It would require the adoption of a deliberate policy, both in the Out-patient Department proper and in the Casualty Department. In the Out-patient Department proper, we recommend the extension of the practice already described as being in operation at some Hospitals,[1] where fully qualified medical officers select each day a limited number of the more serious cases, in proportion to the number of members of the Visiting Staff in attendance. In selecting such cases regard would naturally be paid to recommendations from general practitioners,[2] which should of course be the subject of inquiry by the Almoner.

[1] See pars. 72 and 127

[2] Kemp, 1468-9 Roberts, 4411/12; 4452-55

152.—The cases not so reserved will naturally be less serious, and therefore more likely to be within the capacity of the ordinary general practitioner. They may have to be treated by the medical officer of the Hospital, but the attitude of both Almoner and medical officer to them should be that unless there is good reason to the contrary they should for continuous treatment be referred to a general practitioner. This, it should be noted, amounts to a reversal of the usual attitude at present, which is to retain them at the Hospital unless there is clear

evidence to the contrary. This change of attitude would itself greatly conduce to good relations with general practitioners.

153.—There will remain the cases which are now usually treated in the Casualty Department, namely, the emergency cases that cannot wait for the visiting staff, and the trivial cases which can be disposed of so quickly that they are, as a rule, neither reserved for the visiting staff nor inquired into by the Almoner. The former must, of course, be treated once at all events. The latter, however, should, in our opinion, be sent away by the Casualty Medical Officer untreated,[1] except where there is any element of urgency or risk, in which case "first aid" must, of course, be given.[2] This class of case, we consider, is unsuitable for Hospital treatment for two reasons: In the first place, the resources of a great Hospital should not be employed upon an utterly trivial ailment when they are already strained to the utmost to cope with more important work.[3] In the second place, such an ailment can be treated by a private doctor at so small a cost that the patient who is unable to meet that cost must be practically destitute, and should be provided for by the Poor Law.[4] The extra work involved in ascertaining whether the patients should be treated or be sent away would soon be saved by the reduction of numbers that would follow when the practice became generally known.[5] Cases where there is any doubt, either as to the triviality of the ailment, or as to the financial position of the patient, should be referred to the Out-patient Department proper, where they would come within the cognisance of the Almoner.

[1] *cf.* Glenton-Kerr, 655
B.M.A., 1481/63(1)
Gray, 2901
Heron, 3432
Butlin, 3553, 3584, 3589, but *cf.* 3541-5, 3586, 3593, and Capes, 4126

[2] Holland, 120
B.M.A. (Whitaker), 1652
Montefiore, 2563
Capes, 4047/2 (12)

[3] Loch, 723-4

[4] Church, 3053-4
Thies, App. 3 (c)
cf. Holland, 120

[5] Gray, 2903
Butlin, 3559, 3588

154.—It will be seen that this suggestion implies a rather more detailed, but, at the same time, a much clearer sub-division of patients, than the present haphazard classification into Casualties and Out-patients proper. Whatever the nomenclature adopted, or whatever the number of separate departments provided for in the Hospital building, four classes of patients should be recognised instead of two:—

(1) The emergency cases, or true casualties.

(2) The trivial cases.

(3) The cases of ordinary ailments, not trivial, but not serious enough for the visiting staff.

(4) The serious or otherwise special cases selected, up to a limited number per day, as needing a consultant's advice or treatment.

The first would be treated once as emergencies, and would subsequently fall into one of the other classes.

The second would, wherever possible, be sent away by the medical officer untreated.

The third would be treated once, if necessary, in the Out-patient Department, but would not be retained unless the Almoner, acting in concert with the medical officer, was convinced that access to a competent private or dispensary doctor was impossible.

The fourth would be reserved for the thorough examination both of the medical staff and of the Almoner.

Development of Provident Agencies.

155.—The provision of adequate Provident Dispensaries is undoubtedly a necessary condition of any effective reform of the Out-patient Departments. But there is little doubt that the comparative scarcity of such provision at present is largely due to the competition of the Out-patient Departments as now organised, and this competition would be greatly reduced if the reforms we have recommended were put into operation. We feel confident that a general recognition of the advantages, both to the patients and to the Hospitals, of a transfer of a great deal of the present out-patient work to provident agencies would lead to the provision of the necessary facilities. Certainly such provision, whether it resulted from professional or charitable effort or from some scheme of National Insurance, would greatly assist in the reform of the Out-patient Departments.

Development of Co-ordination.

156.—For successful out-patient reform there is also required some better general co-ordination than at present exists amongst the Hospitals themselves and between the Hospitals and other agencies of assistance, both medical and non-medical. Co-ordination between Hospitals is required in order to secure uniformity as regards the standard of suitability of patients. It is useless for some Hospitals to adopt a standard for admission which other Hospitals ignore. Co-ordination between Hospitals and other medical agencies is necessary in order that exclusion may not be a mere refusal of assistance, with the risk of injury to the patient, but may take the form of reference to a more appropriate agency; and also to secure that all classes of case are provided for. Finally, co-ordination between Hospitals and other charitable agencies is necessary for the purpose of supplementing the mere medical treatment wherever illness is caused or accompanied by other forms of distress, and in order to ensure that reference to the Poor Law is only resorted to in cases that are beyond the reach of voluntary assistance. We consider, therefore, that Hospitals should co-operate as far as possible with any well-considered movement in the direction of co-ordination either amongst themselves or amongst the agencies for charitable or public assistance generally.

Safeguards for Medical Education.

157.—In any system of out-patient organisation it is essential that the interests of medical education and the advancement of medical science should be safeguarded.

PART II.

GENERAL CONCLUSIONS.

1.—Consideration of the original objects of the Out-patient Departments leads to the following conclusions as to their function, the classes suitable for admission, and their relation to other agencies :—

(A) The Out-patient Department is and has always been intended for the provision of effective medical attendance for persons unable to pay for the particular form of treatment required by the ailment from which they are suffering.

(B) The modern Out-patient Department, while available for patients unable to provide for ordinary ailments, is specially fitted for three functions :—

(i) To provide (in the Casualty Department) immediate treatment for sudden and serious accident or illness.

(ii) To provide (in the Out-patient Department proper) special diagnosis, advice or treatment where these are necessary.

(iii) To assist medical education and the advancement of medical science.

2.—The chief alternative agencies for affording relief of the kind supplied by the Hospitals are the following :—

(i) Private Consultants.

(ii) Private general Practitioners.

(iii) Provident Dispensaries.

(iv) Non-provident Dispensaries.

(v) Poor Law Dispensaries.

The question what classes of persons should be discouraged from attending the Out-patient Department must be considered in relation to these various alternative agencies.

3.—Use of the Out-patient Departments by the well-to-do is not common. When it is attempted, the existence of inquiry officers and the vigilance of the medical staffs prevent it at the majority of the Hospitals.

4.—Use of the Out-patient Departments for ordinary ailments by persons able to pay small fees to doctors is in some degree prevented by the inquiry system, but it probably exists to quite an appreciable extent, owing to the fact that the inquiry systems reach only a small proportion

of the total number of applicants, and that patients excluded from one Hospital on this ground can often obtain admission at another.

5.—The use of the Out-patient Departments for the treatment of ordinary ailments by a class able to make provision for such ailments by joining Provident Dispensaries is common. This is proved by the experience of the Hospitals which try to detect and exclude this class.

6.—The use of the "Casualty" Department by persons not well-to-do but able to pay or make provision for the one or two treatments required, is not uncommon. This is due to several causes :—

(1) Many of the cases are emergencies and must be treated at once, without reference to financial circumstances.

(2) The large numbers make inquiry difficult.

(3) It is often easier to treat cases outright than first to ascertain medically that they are not urgent, and then to ascertain whether they are financially suitable.

(4) There is a tendency to extend the Casualty Departments to cases obviously not emergencies, either by a loose definition of "casualty," or by a desire on the part of junior medical officers to retain cases for practice, or by a desire on the part of patients to avoid the inquiry systems in force in the Out-patient Department proper.

7.—These three forms of misuse—the admission of patients able to pay small fees, the admission of the Provident Dispensary class, and the admission of the pseudo-casualties, may well be in themselves sufficient to account for the various defects which are attributed to the Out-patient system, viz. :—

(A) Unfair competition by the Hospitals with doctors on the one hand, and with Provident Dispensaries on the other—with a consequent deterioration of general practice through loss of patients. This competition has the effect of deterring medical practitioners from using the Hospitals for consultative purposes ; it also discourages thrift, and tends to pauperisation, and it substitutes Out-patient treatment for treatment by the family doctor who is acquainted with the past history and home conditions of the Patient.

(B) The overcrowding of the Casualty and Out-patient Departments with minor cases—with consequent waiting, and in some instances hurried diagnosis, and superficial treatment.

(C) The departure of the Hospitals from their most appropriate

function as specialists and consultative agencies, and the comparative waste of their resources in the way of personnel and appliances.

8.—Assuming that adequate provision, Provident or otherwise, is possible elsewhere for the pseudo-casualties, and for the Provident Dispensary class, the admission of these classes to the Casualty Out-patient Department for the treatment of ordinary ailments is detrimental to the Hospitals, to the general practitioners, and to the patients themselves.

9.—The admission of the class able to pay small doctors' fees could be greatly reduced, if not prevented, if the inquiry system now in force in the most highly organised Out-patient Departments were adopted throughout all Hospitals.

10.—The pseudo-casualty class might be largely excluded if a stricter definition of casualty were universally adopted, and if the medical officers in charge of the Casualty Departments were instructed to carry out a policy of refusing to treat (at all events more than once) cases which are not emergencies. Any additional labour which this might cause at first would be soon compensated for by the reduction of numbers that would result when the practice became generally known amongst the class from which the patients are drawn, and the time and trouble now wasted on trivial cases could be devoted to the more thorough treatment of the suitable.

11.—In cases which are neither urgent nor trivial, the refusal of treatment would not amount to an absolute rejection, but would consist of a reference to the Out-patient Department proper at the usual fixed hours, as is now the practice at Hospitals which use their Casualty Department as a receiving and sorting room for all applicants. The patients so referred would then come within the range of the inquiry system in force in the Out-patient Department proper.

12.—The Provident Dispensary class could presumably be largely excluded if the inquiry systems were developed, and brought up to the level of the best system now in force at some Hospitals. The exclusion of this class from the Out-patient Departments would require as a corollary the development of provident medical organisations outside the Hospitals, but at the same time it would remove the chief obstacle to that development.

13.—The use of the Out-patient Departments for ordinary ailments by a class unsuitable by reason of extreme poverty is also proved by the statistics of the Hospitals which exclude such cases. This class consists of two grades :—

(A) Those actually in receipt of Poor Law relief, estimated in

Miss Roberts' report to the Poor Law Commission at 11 per cent. of all Out-patients.

(B) Those who are beyond the reach of charitable assistance and can only be dealt with effectively by the Poor Law.

There is no reason to suppose that this class would not be found amongst the Out-patients who are not at present subjected to a system of inquiry. The exclusion of the Poor Law class, where it is practised, is not the outcome of any desire to limit the sphere of Hospital usefulness, but of the belief that it is a waste of the resources of a Hospital to provide medical treatment for persons unable to benefit by it for want of the ordinary necessaries of life.

14.—Above the Poor Law class, however, there is a class which, though not destitute, cannot profit by medical treatment unless it is supplemented by other forms of charitable assistance, but can profit when it is so supplemented. In such cases the resources of the Out-patient Department are wasted if the further assistance cannot be secured. To secure this assistance involves some organised co-operation between the Hospital and other charitable agencies.

15.—It is desirable to secure a ready access to the Out-patient Department for patients who are under the charge of other medical agencies for ordinary ailments, but who require the specialist diagnosis, advice, or treatment which can only be obtained by attendance at the Hospital. This can best be effected by means of organised co-operation between the Hospital and other medical agencies.

16.—To organise an Out-patient Department on these lines—distinguishing between the different classes of applicant, and co-operating with other medical and charitable agencies, both in referring patients to them and in accepting patients from them—demands the employment of Inquiry Officers capable of something more than the mere prevention of abuse. Such officers already exist in the Hospital Almoners.

17.—Further, such an organisation of the Out-patient Department falls in with a just conception of the proper sphere of Hospital assistance in relation first to other agencies for medical assistance, and, secondly, to public charitable assistance generally, which is of comparatively recent growth. This conception is itself in fact part of the recent development of ideas on the proper function and methods of charitable and public assistance generally. This development, at first largely the work of the Charity Organisation Society, has recently found more general expression in the formation of Councils of Social Welfare, and in the majority report of the Poor Law Commission. In connection with Hospitals it has taken

shape in the Almoner system, and in the growing support given to that system by Hospital Committees.

18.—The extension of the Almoner system to cover all the Out-patient Departments is the readiest method of improving the means of inquiry, and of securing the co-ordination of Hospital assistance with other forms of medical and charitable assistance. It helps to exclude from the Out-patient Departments the class able to pay for medical attendance, the Provident Dispensary class, and the Poor Law class. It supplements Hospital assistance, where necessary, by the aid of other charitable agencies; and it encourages the reference to the Hospital by other agencies (including private practitioners) of cases needing specialist diagnosis, advice, or treatment.

19.—A large number of witnesses have advocated an alternative plan by which access to the Out-patient Departments should, except in the case of the first attendance of true casualties, be permitted only on the recommendation of some sifting agency external to the Hospital. The agency suggested is usually the general practitioner, either in private practice, or acting as medical officer of a Provident or Poor Law Dispensary; but sometimes some more representative organisation to form part of a general scheme of charitable and public assistance is mentioned. The chief arguments for this outside sifting are, first, the difficulty of turning away patients once allowed to come, and, secondly, the difficulty of inquiry with the large numbers who do come. But whatever may be the theoretical advantages of this alternative it would be preferable, at all events in the first instance, to try the development of the existing methods. For the alternative presents two initial difficulties. It would not be possible to close free access to the Hospitals or to entrust the sifting of patients to any outside agency until (i) some general conception of the functions of the Hospital in relation to other agencies had been sufficiently developed to be acceptable to the Hospital and to the public, (ii) some suitable agency had been devised or developed to which the sifting could be safely entrusted.

20.—None of the agencies mentioned by witnesses, and likely to be available in the near future, provides adequately for all the requirements of such a conception and such a sifting agency. The Almoner system is doubtless itself defective at present in some respects, but it clearly meets in many points the needs of the case.

21.—One of the main objects of Out-patient organisation should be to promote co-operation between the Hospital and general practitioners, so as to encourage the general practitioners to use the Hospitals as consultant centres in difficult cases, and to avail themselves of the educational advantages of contact with the Hospital staffs.

22.—The general adoption through the Almoners of co-operation with general practitioners would go far to remove the grievance which at present so often deters the private doctor from sending cases to Hospitals for a second opinion or for special treatment. It would also be to the advantage of the Hospitals, for they would be enabled to fulfil their proper function of consultative agencies, and it would benefit the poor generally through the improvement of medical practice that would result from the frequent contact of the private doctor with the Hospital consultant.

23.—The removal of the reluctance of the general practitioner to send cases to Hospitals would also very largely remove the injury to medical education that might result from a reduction in the number of Out-patients, especially if arrangements could be made for the admission of Hospital students to the practice of Provident and Poor Law Dispensaries in suitable cases.

24.—If Out-patient practice could be localised, *e.g.*, by the reference of patients to the Hospital nearest to their homes, or by mutual arrangements for the allocation of different districts to different Hospitals, or otherwise, the organisation of the Out-patient Departments on these lines would be greatly assisted. The Hospital doctors would become better acquainted with the local general practitioners, and the Almoners with the local medical and charitable agencies.

25.—It is most important that a general uniformity in the principles and methods of Out-patient administration should be adopted in all the Hospitals of London. Without this there would either be injustice as between one Hospital and another and between one locality and another, or else the whole system would be likely to relapse into the former condition of disorganisation.

26.—It is evident that a thorough system of Out-patient organisation would involve a temporary increase in total expenditure and a permanent increase in the cost per patient—the first due to the cost of the Almoners Department and the cost of reporting to general practitioners, the second to the reduction of numbers and the more specialised character of the cases. But the same arguments which justify expenditure upon improved methods of medical treatment may be used to justify expenditure upon improved methods of charitable administration.

27.—Out-patient organisation on these lines would be greatly facilitated by the reduction of numbers to manageable proportions which might be expected to ensue; especially if the system were put into operation simultaneously with the establishment of fresh provident agencies on a large scale.

28.—In making these recommendations we have not considered the

possible effect of the National Insurance Act on the Out-patient Departments of the London Hospitals. It appeared to us that such an inquiry did not fall within the terms of the reference made to us; and further, that even if it did, an inquiry before the Act had come into operation would be of no real value.

29.—We desire (in conclusion) to place on record our high appreciation of the work done by Mr. H. R. Maynard, who throughout the Inquiry has acted as Secretary. He brought to bear on the subject an extensive and accurate knowledge of Hospitals and their methods. He has been indefatigable in providing and placing at our disposal the statistics required for our work. His suggestions have guided us to much of our most valuable evidence, and helped the course of our investigations. He has rendered invaluable assistance in collecting and shaping the material for our Report. It is hardly necessary to add that all this has been done with a willingness and a courtesy that have greatly facilitated the task entrusted to us.

Our thanks are also due to Mr. F. M. Fry for his constant attendance during the Inquiry, and for his valuable assistance in framing the Report.

MERSEY.

H. L. STEPNEY.

H. R. MAYNARD,
Secretary,
July 5th, 1912.