PAY BEDS COMMITTEE.

REPORT

OF A

SPECIAL COMMITTEE

OF

KING EDWARD'S HOSPITAL FUND FOR LONDON.

Part II. MINUTES OF EVIDENCE.

JULY, 1928.

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LIST OF WITNESSES.

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

WEDNESDAY, 22nd JUNE, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
PROFESSOR WINIFRED CULLIS.

LORD SOMERLEYTON, MR. LEONARD L. COHEN and MAJOR WERNHER (*Honorary Secretaries*), and MR. H. R. MAYNARD (*Secretary*), being also present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.*2.).

FIRST DAY.

Mr. G. Q. Roberts, Sir Cuthbert Wallace, and Dr. W. W. McLean.

SIR CUTHBERT WALLACE, K.C.M.G., C.B., F.R.C.S. Member of the Honorary Surgical Staff, St. Thomas's Hospital, MR. G. Q. ROBERTS, Secretary, and DR. WILLIAM WALTER McLEAN, M.R.C.S., L.R.C.P. Resident Medical Officer of St. Thomas's Home, called and examined.

1. The CHAIRMAN: We are very much indebted to you, Mr. Roberts, for the very full answers you have given to the questionnaire which was sent out. I do not know whether you will think it convenient that some of the questions put should be answered by either one of you, or whether one of you would answer them ?—(*Mr. Roberts*): When I received this I sent it to the Medical and Surgical Officers, and Sir Cuthbert Wallace can speak from the Surgeon's point of view, and Dr. McLean can speak from the Resident Medical Officer's point of view; he would be able to answer very fully any points in regard to questions in relation to the General Practitioners outside.

2. I would like to ask, on the method of admission, whether you find that these requests for admission come after patients have consulted one of the honorary staff of the Hospital, or whether they come from outside sources altogether ?—Perhaps Dr. McLean had better answer that, because he deals with every one of them directly. (*Dr. McLean*): The majority come direct through our Surgeons.

3. So that most of the patients in the Home are in fact under your own honorary staff ?—Yes.

Mr. LOW: I do not know whether Dr. McLean quite understands you. A good many other cases may possibly arise.

4. The CHAIRMAN: Yes, I understand that. —But the majority; I should say about 65 per cent.

5. You say, in answer to Question 6 on the point of the financial position, that the cases are primarily those who cannot afford the usual Nursing Home fees as well as consulting fees. Do you adopt any scale in coming to a conclusion as to whether a patient fulfils those conditions ?—(*Mr. Roberts*): No, we do not inquire as to any definite scale; it is merely a question of the circumstances which are inquired into, and the recommendation of the Surgeon who has been called in, or of a Physician. That is quite a sufficient recommendation that it is not a case which would be recommended by him to go to one of the Homes in the West End.

6. Do you adopt that principle because you want to keep these beds free for that type of case or because you do not want to compete with what you might call the West End Nursing Home ?—

I think it began years ago principally on that second point, that they did not want to cut out the Nursing Homes. You see, when it first started it was definitely for the purpose of admitting cases into what was one of the general wards with the beds only separated by curtains, and the charge was three guineas a week originally. Then it went up to four guineas to meet the costs, and then about 1907 the present new Home was built, and then the beds were separated by permanent partitions. The cost became higher, and actually it has gone up to four guineas, then to five guineas and now it is six guineas. Six guineas just meets the cost, as you see by the figure there. The average cost per occupied bed for the week is £6 5s. 7d.

7. Does that qualification as applied to patients apply also to those who occupy the rooms at nine guineas ?—Yes, I think so, but they differ a little in their circumstances.

8. I understand that the accommodation is a boarded partition ?—A brick partition: a complete partition in every way. It is an absolutely complete and separate room except for the fact that it has not got a door. It is about 7 feet high and has an iron rail on which are hung heavy curtains, and those curtains have rings and the rings are made silent by whipcord which is wrapped round them, and therefore you can slide them backwards and forwards without any noise. In the case either of a patient being dressed or receiving visitors, it is completely shut up and nobody ever interferes with it.

9. In your answer to Question 10 you say: "The patient has to pay in addition consultants' "fees, Assistant's fees, and for any special X-ray, "Electric Massage and so forth." There again have you any scale, or do you simply ask the patient to pay according to his or her means ?—I think that is principally settled by the Medical Officer who is in charge of the case, and if he finds it is a case which can pay a fee for X-ray, then the patient would be expected to pay it, but in the event of their not being able to pay it, the Surgeon, supposing they could not pay, would send it down and it would be done as an ordinary Hospital case.

10. I was going to ask in any case whether you would give a patient of that class this kind of treatment absolutely free ?—(*Dr. McLean*): It is very rare; they pay 5s. or 12s. 6d.

11. In every case you would deal with it on its merits ?—Yes.

12. You have already said that the majority of the patients are treated by members of the staff. I suppose you have no knowledge of what the proportion is of how many come in from outside practitioners ?—I should say it is not more than 15 per cent or 20 per cent. (*Mr. Roberts*): I can give you that exact figure but I am sorry I have not got it; I will let you have it. It is about 20 per cent. I should say.*

13. I was going to ask another question which do not answer if you feel disinclined to. There have been arrangements made in some cases for members of Hospital Staffs to adopt a certain scale of fee. I think one did appear some years ago in "The Lancet," but I understand it is not done at St. Thomas's ?—(*Sir Cuthbert Wallace*): I do not think there is any rule at all; it is a mere matter between a Surgeon and his patient.

14. But there is no agreement between the members of the Staff ?—No. (*Mr. Roberts*): I should like to say that I know it very frequently happens that members of the Senior Staff who are interested in cases take the cases into the Home; they pay the usual Home fees, they pay the Assistants' and the Anæsthetist's fees, and the Surgeon makes no charge at all. That very frequently happens.

15. The average number of occupied beds is of course considerably smaller than the total number of beds available, and probably the reasons you give for the difference are common to most Institutions of the kind ?—(*Sir Cuthbert Wallace*): I do not know how that comes about, but from personal experience I know that it is extremely hard to get a case into the Home.

16. You say that the Hospital has every reason to believe that there is a much greater demand for beds of that kind than can be met. I was going to ask what proof the Hospital has for making that statement ?—I can give you proof of one yesterday. I asked if I could have a bed and I was told "in a month." (*Mr. Roberts*): You see, of course, the great difficulty arises from the fact that you have got to book dates ahead, and a case may be a day or two sooner than you anticipated, or a case may be delayed in coming in for a day, and those delays are the means of wasting a bed for 24 hours or 48 hours.

17. The real proof is not so much the full number of beds that are occupied ?—But the number of applications that there are.

18. In fact you very very seldom have a bed not engaged ?—Backing up what Sir Cuthbert said, I can very very seldom get a case in under a week. Unless I get an absolutely urgent case I cannot get it in. The only way in which we get it in is that I go along and see the Sister and perhaps go out to the man, and then the Sister gets a telegram which says: "Sorry; cannot "come for two days," and that bed is used for that emergency. You see, of course, in working out an average number you have also got to realise that there is a certain time when patients do not come in, like holiday times, and Surgeons are away, and so on.

19. Then in answer to Question 14, you give there the receipts and expenditure and you include in the expenditure the item of rent. How much do you charge for rent ?—£600 is the charge.

20. That is about 4 per cent. on the original cost ?—On the estimated original capital cost, but of course it would be very much higher now, the capital cost of a building of that nature.

21. Does the building cost include everything including the kitchen ?—That was a general estimate. Actually at the time it was built I think the whole thing cost £60,000, and it is about a fourth.

22. Do you know whether it included accommodation for Nurses ?—No, it does not include any accommodation for Nurses; they live in the Gassiot house above. For some considerable time we did not charge any rent against that.

23. Have you any estimate, or has anyone in connection with the Hospital made any estimate of the probable cost of building per bed if the Home were much extended ?—There will be no possibility of extending our Home in its present position, nor would it be advisable to do so, but

* Operations in St. Thomas's Home.

Year.	Surgeons attached to St. Thomas's Hospital.		Surgeons attached to other Hospitals.		Total.
1924	633	87·6%	90	12·4%	723
1925	612	93·5%	43	6·5%	655
1926	625	91·6%	57	8·4%	682

we have a site which was bought during the time of the War—I think it was in 1919 that we bought it—where we have a dream rather than a scheme ready for development as a place where we could put an out-patients' department on the ground floor with a Home above it, and should we ever acquire the money which is necessary for building that, then that would provide at least 100 beds with residence above for the Nursing Staff that would be engaged in it.

24. But you have not formed any opinion as to what the Home itself would cost, nor what the charges for interest would have to be if it was necessary to make any ?—Not exactly an estimate, because you could not give an estimate until you get your drawings out and get some working idea of it, but the general feeling is that such a building as that would have cost anything up to £250,000 for the part which was devoted to the residential Home and the Nursing side of it.

25. £2,500 a bed ?—£2,500 a bed. That was the idea, but it is only just a general idea.

26. That would mean at least doubling your present charges ?—Yes, but then you see there would be a certain number who would pay up to 15 or 20 guineas and that would not have to be restricted to patients of lower means, but people who would pay a full fee. That would give you an opportunity of having a certain number of cases, say, from five guineas upwards, but I think that five guineas is the absolutely lowest sum for which we could run a Home of any kind at all.

27. So you drop the idea of a patient of moderate means exclusively ?—Yes, you would have to drop that entirely if you built such a home.

28. In answer to Question 19 you say: "The "highest patients' payments normally paid by "ordinary in-patients": "Two guineas per week." I suppose a few may pay a little more, but not very many ?—Well, you see, they do not pay anything as an actual scale of payment, but they make a donation, except perhaps in the smaller cases where they are spoken to and they say: "I can pay 5s. or 6s. a week," but nobody talks of paying six guineas a week or two guineas a week even, but they make a donation, say, for three or four weeks' stay of from 6 to 10 guineas, something of that sort.

29. Do you find as a matter of practice that some patients who would be in the ordinary ward if the pay beds were not in existence, find their way to the pay beds ?—No, I am not quite following you that way. They would find their way into the Hospital if they got half a chance when they ought normally to go into the Home. I will put it the reverse way to yours.

30. Do not you find it possible sometimes to push that class of patient into the Home ?—Oh, most certainly, it is done quite a good deal by our Lady Almoner. When cases are applying for the Hospital they are referred to the Home because they are of a class who can just pay for the Home.

31. That is to say the Home does have the effect to that extent of relieving the general wards of the Hospital ?—Most certainly, yes.

32. I notice under No. 20 you are definitely of opinion that the Home is a general advantage to the Hospital in securing friends ?—Yes, most certainly. Only this morning I have had three letters, one from the South of France, somebody sending 15s. and saying: "I like to "send this each year because I am so grateful for "the operation which was successfully performed "on me in St. Thomas's Home ten years ago."

33. So that in a general way it is good propaganda ?—Very good propaganda.

34. Sir JOHN ROSE BRADFORD: There is one point I am not quite clear about with reference to the question the Chairman asked as regards admission into the Home. Am I right in supposing, I think Mr. Roberts answered it, that the patient is practically admitted on the recommendation of a Physician or Surgeon rather than by deciding as to whether their financial position is such as to justify their admission into the Home ?—Not entirely, but most frequently cases do apply direct either to the Secretary or to the Steward for admission, and then it is referred to the Medical Officer, who generally communicates with the General Practitioner in charge of the case, and he very frequently recommends that the case should come in without specifying a certain definite Physician or Surgeon.

35. I am not concerned with the medical or the surgical aspect of the case; I was dealing rather with the financial aspect of the case. Do I understand that the Physician or Surgeon or Medical Officer in charge or the General Practitioner is the gentleman who decides as to the financial suitability of the case for admission ?—Yes.

36. There is no inquiry by what I may call a lay authority ?—No.

37. I wanted to be clear on that point. Except in so far as the Almoners sometimes refer cases that would come in to the Hospital to the Home ?—Yes, certainly.

38. Then with reference to an answer that was given by the Medical Officer, I think he said that some 10 per cent. or so—I am not concerned with the exact percentage—about 20 per cent. or so were recommended from what we call outside sources, not members of the Staff of St. Thomas's Hospital. Does that mean that 20 per cent. are treated by outside Practitioners, or does it mean subsequent to their admission they are treated by the Staff of St. Thomas's ?—I should think about 15 per cent. out of the 20 per cent. are treated by Surgeons out of other Hospitals and 5 per cent. come up from General Practitioners and asked to be taken in, and then I put them on to the Surgeon on our own Staff.*

39. So that roughly speaking 80 per cent. to 90 per cent. of the patients are under the care of a member of the Staff of St. Thomas's Hospital ?—About that.

40. Mr. LOW: Might I ask about your answer, 12 (A): "Any patient can be attended by any "Consulting Physician or Surgeon." Might I ask how you would define a Consulting Physician or Surgeon ?—Our general acceptance of the definition there is a member of the Staff of one of the Hospitals in London.

41. Do you restrict it to the teaching Hospitals of London, or do you go further than that, because there are numbers of Hospitals ?—I should say that they are practically all teaching Hospitals.

42. That is about 12 Hospitals ?—Yes, but we do get them occasionally. Men who are on the Great Northern or the West London Hospital have cases in there occasionally, but not many, very few.

43. I can realise that you might sometimes have difficulty; I do not know whether you do ?—We never have any difficulty arising. (*Dr. McLean*): Really our outside visitors are old friends, they have been coming there for a long time; we get the same people from outside and they have been there a number of years.

* See note on page 2.

45. The other question I want to ask is this: the Medical Practitioner is not allowed to treat a case in the Home, is he ?—No.

46. He communicates with you, and you communicate with him ?—Yes.

47. Do you ever have any difficulty about that ?—No, none at all. Sometimes of course they would come up and see their patients and I might see them then.

48. I only want to ask this question to get it on the records, and that is you anticipate it would be impossible to work a Home of this sort if the General Medical Practitioners were allowed to come and treat the cases in your Home. Is that your opinion ?—No.

49. Do you mean to say it would not work or it would ?—I do not think so. (*Sir Cuthbert Wallace*): I wish you would repeat that question to me.

50. Certainly I will ?—I did not quite catch the drift of it.

51. My question is this: I only want the answer on the records; I am not asking in any spirit of cavilling. You do not allow the General Practitioner in charge of a case to look after the case in the Home ?—No, I think it would lead to an awful lot of trouble.

52. You think it would be unworkable ?—Yes, I think it would; I think that is our experience; it would lead to all sorts of difficulties. (*Mr. Roberts*): I could personally say from the administrative point of view it is quite impossible to let a variety of practitioners come in and treat cases.

53. The CHAIRMAN: They would want to come in at all sorts of odd times ?—Yes, all sorts of odd times, and want all sorts of requirements from the Nursing Staff which we could not afford them.

54. Mr. LOW: I understand that from the £15,000 which your Hospital expended on this they get £600 a year ?—Yes.

55. The £600 a year represents the interest on the £15,000 which the Hospital expended, the capital expenditure on the Home ?—Yes.

56. Professor WINIFRED CULLIS: If you have cases coming in from outside, do you take the recommendation of that outside Surgeon without any further inquiries into the patient's financial position, as you would if it was one of your own Staff ?—Oh yes, certainly. You see it is rather more inconvenient for a Surgeon to go all the way down there than to go to a Nursing Home in the immediate neighbourhood of his own residence. That is the extra duty which he undertakes, and he almost invariably—I could almost say invariably—takes a reduced fee or something below his ordinary fee.

57. Then there is another small point; you spoke of the donations from patients in ordinary wards. Are those given when the patient goes out of the Hospital, or are they collected weekly ?—They are generally given when they go out of the Hospital, but in many cases they do give them weekly. The relative comes in and sees the Lady Almoner, and as a matter of fact most of them show an anxiety to pay; they like to show their independence. They feel they are receiving maintenance, and they like to pay for it, and they go on paying as they receive it.

58. The Nursing Home fees, are they collected weekly ?—Yes, collected weekly.

59. This is a point about which I have often been spoken to by patients; do you have any kind of common room that your patients can use during convalescence ?—We have one, but we do not encourage the use of it. Also I do not think it is a good thing to get patients to go in and talk over their diseases together in a common room. The men's common room is used a good deal as a smoking room. We have at the Home a good open garden where most of our patients spend their time when they are semi-convalescent. They are wheeled out there and they smoke out there, the men and the ladies.

60. I have heard some of the patients saying that it is a most dreary time since they could not get out ?—That is so. Of course they do feel it if they cannot smoke. We do not have smoking at the present time, but a recommendation has been put up that it should be allowed at certain times. Of course it is not particularly good for the bed clothes, and there are several other objections to it.

61. But you have a room where they can go outside their own cubicle ?—Yes, it would hold about four or five beds and two or three chairs in addition. There is a very good sitting room for the ladies upstairs. (*Sir Cuthbert Wallace*): They do get outside in the quadrangle. I should like to say from a professional point of view I believe the common room is a thoroughly bad thing; they are always talking about one another's complaints, and people come in and they are frightened. They are always talking about their operations and one thing and another. I would not have one.

62. The CHAIRMAN: Have you ever heard it said that the patients are rather dull, that they are boxed up in their cubicle ?—Never. I do not think they are, and I think that is one of the great advantages of having these open beds. We have always got some young fellows in there and they keep the whole place lively. They go about in their wheeled chairs and so on, and they visit one another quite a good deal in their cubicles.

63. What I rather meant was do you ever hear suggestions that it would be more cheerful if there was not a solid partition between the beds ? (*Mr. Roberts*): I am very very strongly in favour of keeping each patient quite separate unless they particularly want to go to their neighbours I think that a two or three-bed ward is a bad thing, because I have heard exactly the same thing as Sir Cuthbert has called attention to; they do discuss anything, including the skill of the Surgeon who has operated on them, or the opposite. (*Sir Cuthbert Wallace*): There is one thing about the cubicle system. People come to me and they say: "We cannot afford a fee; what about your "Home?" and you say: "Yes." They say: "What sort of place is it?" and you say: "Cubicles," and when they hear that phrase they have a sort of idea that they are not private. If you can persuade them to get into a place like that after that, they rather appreciate the fact that they are not cooped up, and I believe as a matter of fact if you did not have solid walls in between you would find a great many of the patients would draw their curtains. I do not think it is a good thing, but they would do it. They like company in that way. (*Mr. Roberts*): I had to deal with quite a good number of complaints when there were curtains between the beds, and that is why I was very very struck with having a solid partition. They used to put it that so and so, the patient next door, "keeps on "drawing the curtains and wanting to talk to me "when I want to be quiet and go to sleep."

64. At the same time I have looked into a Ward of that type and been very astonished to see how very few of the curtains were drawn ?—I think if you have curtains you are better off if they are drawn, if they are not used I mean. I had a case quite recently in the Hospital which was really very interesting as giving one an insight into the psychology of the patient. He is a well-known man from Lambeth, he is not at all well off, but Sir Cuthbert had him in for an operation and he put him into our small Ward which is attached to our big Ward, and a little later the Ward was wanted for another special patient and he was moved into the General Ward. I apologised to him for putting him in there, and then after he had been in the General Ward for about ten days the Special Ward was free again, and I said to the Sister "You had better put this man back again "into the small Ward," and I was sent for by him and when I went back to him he addressed me in rather magnificent language: "Might I ask "your Excellency why it is that I am being "punished by solitary confinement in this way ?" They do prefer the General Ward, but not curtained cubicles.

65. Mr. COHEN: I see according to the figures there are 34 beds at 6 guineas and 6 at 9 guineas; if there were more accommodation available at the higher scale do you think there would be a demand for it ?—I do not know; I really could not answer that, because we very frequently do use those 9-guinea rooms at 6 guineas because they are not occupied.

66. Perhaps I might supplement that question by another. Do you think if superior accommodation were given, even better than that given for 9 guineas, there would be a large demand for it ?—If it were accepted that it was a Home at higher fees, most certainly there would be, but you see it is rather looked upon as a Home where people go who cannot afford to pay the full cost of the General Nursing Homes. You see General Nursing Homes may charge 10 guineas, but then they charge extra for nearly everything, until a patient really does not know whether he is going to pay 20 guineas or not. Our figure absolutely covers everything that a patient really needs. (*Sir Cuthbert Wallace*): Well, if I might add something: of course, first of all, personally I look forward to the time when Hospitals will all have these homes and cater for every status of society. I think it is by far the best thing; it is the best thing for the people and I do not see how any Nursing Home is to afford the facilities that a Hospital can afford and make it pay, and I think it is better for the patients; it is better for the poor people and it is better for the rich, and the rich help the poor in that particular way, and I have always advocated and I certainly look forward to the time when we shall kill the Nursing Homes in the West End as much as possible.

67. Mr. LOW: I want to ask Sir Cuthbert what he means, to make it clear. You mean by having these Nursing Homes attached to Hospitals they would get all the advantages of pathological investigation and so on, which they are unable to get in the Nursing Home ?—Yes.

68. And there are facilities there which they would never be able to get in any sort of Nursing Home you can imagine in London ?—Yes, under the same main roof.

69. Major WERNHER: It has been said that 10 per cent. of the cases are cases of Surgeons who are not St. Thomas's men; is that so ?—(*Mr. Roberts*): Yes.

70. Are there any difficulties in that connection; is there any friction ?—There are one or two men who have made themselves objectionable in the past, and, of course, if they call up and want a bed we suggest their going to another Nursing Home.

71. They take your Nurses, and that is all ?—They must accept our Nurses.

72. They do not want their special Nurses or anything of that kind ?—No, they could not do that at all. We unfortunately have to engage extra Nurses from outside very frequently to run our Home, because we have not got enough. I mean fully qualified Nurses, good Nurses in the Home. You see we do not train any Nurses in our St. Thomas's Home at all.

73. The CHAIRMAN: Do you give an extra Nurse, if she is required, without payment ?—(*Dr. McLean*): From a medical point of view, yes, but they quite often ask for a special Nurse just for one night after an operation. (*Mr. Roberts*): And then they pay for that.

74. A specially bad case ?—We might put it, if it is a luxury they pay for it, if it is a necessity we provide it. (*Sir Cuthbert Wallace*): I would like to add something about what Major Wernher said, about the foreigners, so to speak. I think we have always got on extremely well with the people who come up to us from other Hospitals and I have often talked to people who come there, and I think they are always very well satisfied with us. Of course you quite see that 10 per cent. or 20 per cent. is a very small amount considering the attachment of the Hospital and the nearness of the staff. I do not think it is considered much to be wondered at, and we are the only Hospital in London which has admitted foreigners at all.

75. Major WERNHER: My point was, if you have a 100-bed Hospital you would have to rely on nearly 50 per cent. of cases from outside Surgeons ?—(*Mr. Roberts*): Yes, very probably, but we would not raise any objection.

76. You have tried it out ?—We have tried it out very fully. There is not a great deal of change from what it was when we originally started. When the Home was in its very early days there was the Resident Medical Officer there, and he frequently did the operations, and when I was at the London I used to hear a good deal of abuse of St. Thomas's Home, on the ground that the Surgeons did lose their cases if they went to St. Thomas's Home, and it took quite a long time to live down, but now it is lived down and there is no such feeling at all. (*Sir Cuthbert Wallace*): I do not believe there was any justification for it. I think we had got the greater vilification for being a public office.

77. The CHAIRMAN: Is there anything you want to add ?—(*Mr. Roberts*): I do not think so, thank you very much. I think we have answered as fully as we could.

The CHAIRMAN: We are very much obliged to you for your help, thank you very much for coming to-day.

(The Witnesses withdraw.)

MR. HERBERT LIGHTFOOT EASON, C.B., C.M.G., M.D., M.S., Superintendent, Guy's Hospital, called and examined.

78. The CHAIRMAN: We are very grateful to you for your Return which you sent us in in answer to the Questionnaire. There are one or

Mr. H. L. Eason.

two points which you might raise in connection with it. You say that the method of admission is through the Medical Staff or through the Superintendent ?—Yes.

79. If it comes to you through the Superintendent that would be an application from somebody who is not one of the staff of the Hospital ?—Yes, the great majority of patients come through the Medical Staff. Of course there are a certain number of patients who write to the Hospital and ask if there is any provision for private patients, and then one sends the information about the Ward. Then they ask "What are the arrange-"ments about professional attendance," and I call their attention to the fact that ordinarily patients are attended by the Medical Staff of the Hospital, but they can be attended by Consultants from outside with my approval, and I usually suggest to them that they should invite their ordinary Medical Practitioner to choose for them the name of a member of the staff whom he may think suitable. If they have not got a Medical Practitioner, then we suggest the name of one.

80. When applications are made to you, do you in fact make any inquiries as to their financial position ?—None whatever.

81. In fact you do find that the majority of patients are those who cannot afford ordinary nursing fees, or Nursing Home fees ?—Nursing Home fees.

82. The outside Nurse ?—Yes.

83. I see in your case that you use Probationers in this Ward as in the ordinary Ward ?—Yes, it is one of the ordinary Wards of the Hospital for the purpose of the training of Probationers.

84. And do you not find any difficulty arising in practice ?—No, none.

85. These additional fees that you mention under Answer 10 are constant; that is to say, they do not vary as they do in some cases in the case of some Hospitals according to the means of the patient ?—No, we merely collect them for the particular member of the laboratory staff who does the investigation and it is handed over to them.

86. It matters not what the means of the patient are ?—No.

87. And the same thing applies to the answer to No. 11 ?—Yes.

88. The payment of these fees goes to the member of the staff concerned ?—We merely collect it, put it on the bill, as everything else, and then that is remitted, without deduction, to the member of the staff who makes the investigation.

89. Under No. 12 you say at the end of paragraph (*a*): "Or he may be attended by any "other Consultant, subject to the approval of the "Superintendent." Are there many applications ?—No; there are a certain number, because the question may arise sometimes that the patient may be under the care of two persons at the same time. He may be under the care of a doctor of the Guy's staff, and he may be under the care of a Consultant of some other Hospital for some other disease. If one limits the treatment of a patient to the staff of the Hospital only, one may on occasion cut a patient off from his own Consultant for another disease. I may take an example: Supposing he were being treated by me for some ophthalmic condition and by a Physician or Surgeon for another disease, and the attendance on that patient were limited to the members of our staff, his own Surgeon or Physician could not visit him and treat him in the Ward. That is one reason why it is put in. The number of outside Consultants ordinarily who do use the Ward is very small.

90. In fact over 90 per cent. are attended by the staff of Guy's ?—Are attended by the staff at our own Hospital.

91. Then as to fees. I take it, from what you have already said, that on the average the fees paid would be lower than those paid by a patient in a Nursing Home ?—That is so; and if it came to my notice that anybody were paying a high fee for an operation in the Ward, I think I should probably privately represent to the member of the staff that this is not quite the specific purpose for which the Ward was originally intended.

92. Then we come to this, that although there is no limit to income, the Hospital authorities in fact do look upon it as a place where people of moderate means ought to go ?—And not those who can afford first-class accommodation outside; but there is no regulation as to that.

93. But it is so worked that, in fact, people of moderate means get there ?—Of course I should not ordinarily, as Superintendent, know what fee does pass between the patient and the Surgeon; but if it had come to my knowledge, either from representation by a patient or in any other way, that this was an excessive fee, I should probably have a talk with the Surgeon.

94. I might go further than that; I might ask a question which you cannot answer, or, if you do not want to, do not answer. It is stated here that there is no scale or maximum prescribed by the Hospital ?—No.

95. Do you know, or can you say, whether amongst the staff of the Hospital they have agreed upon any scale ?—I cannot answer that in fact, but I should say, as far as my knowledge goes, and I have no hesitation in answering the question, that there is no agreement whatever.

96. Do you think any individuals work to a scale; they just have a scale in their own mind ?—I do not know that they have.

97. By scale, I mean the sort of thing which appeared in the "Lancet" some years ago, which takes into consideration not only the man's income, but also his liabilities ?—No, I do not think they have. I think it is, as it is in private cases, a matter of discussion between the private Practitioner and the Consultant. For example, that is the way I always arrive at the fee a patient is going to pay. When he goes to a Ward he makes an arrangement for the fee as a rule with the General Practitioner.

98. Would it be too much to ask you whether you have any scale in your mind when you arrange such a matter ?—No, but I should think I seldom get as much as half my ordinary fee.

99. I did not mean the actual amount. Shall I put a concrete case. Let us say that a man has £500 a year and he is married and has one child. Roughly, have you any scale as to how you would treat a man of that income ?—No, I do not think that I have. As I say, I should be guided almost entirely by the suggestion from the General Practitioner; he usually settles the fee.

100. He usually knows the man's position ?—He is the patient's own Practitioner, and he is the person who advises me as to what shall be the fee. May I just amplify that; I do not know whether it is the case with every Consultant in the profession, but as a general rule one does not bargain about fees with the patient himself. If the patient requires a reduction from his fee, that reduction must be asked for by his General Practitioner; he is the person who is cognisant of

the patient's circumstances, or is supposed to be, both financial and domestic, and he suggests to us the fee, and we usually accept it.

101. Mr. LOW: That is the usual practice?—Yes, I have no scale; the scale is what the ordinary Medical Practitioner asks me to do it for, if I think I can do it for that amount.

102. Sir BERNARD MALLET: Do you think the general Medical Practitioner has a scale?—No, I do not.

103. The CHAIRMAN: Do the applications which come to you as Superintendent from independent patients come as a rule direct from the patient or from a General Practitioner?—Generally from the patient.

104. In those cases which might not have a General Practitioner?—I refer them to a General Practitioner.

105. They usually find one?—They usually have got one.

106. Now Finance, No. 14. I notice that you make no charges against the Ward for administration or rent?—They never have been. Of course, it is rather difficult to assess rent.

107. On what the capital cost was in the first instance?—The building was built as long ago as 1865 and I do not know, and it would take a great deal of research to find what the cost was. To get at what one might call the real proper cost of each patient, I suppose one ought to assess them all with a percentage of the general Hospital administration. Administration probably costs 5 per cent. of the total administration. Of course, rent would have to be assessed on cubic capacity, possibly in relation to the whole building, and that is a difficult thing to assess on any integral portion of the building.

108. Especially where the whole Hospital does not pay any rent?—The whole Hospital does not pay any rent.

109. You say, in No. 17: "The experience of "the Hospital for many years past has been that "a much larger accommodation for all classes of "patients could be occupied." Of course, one notices that the beds that you have are not always occupied. The average number occupied is 23·9, and there are reasons known to all of us for that, but at any rate it is not an argument in favour of the suggestion that you know that more beds are desired?—Yes, I think it is impossible to occupy any set of beds very closely, as I dare say you know. Many people may be waiting, and often you telegraph for a person, and he cannot come that day, or can come only 48 hours later. In private cases you have more delay than in Hospital cases. The domestic and other ties of people who use the private Ward are probably greater, and you cannot keep your Ward full right up to what you might consider is the average of 90 per cent. I do not think any Institution keeps its beds much fuller than 90 per cent. Possibly my waiting list figures might help you in that argument.

110. I think the engagement of beds is an important point?—The names are put down, of course, directly they apply. As a rule, the demand for the beds is so great that we can seldom admit anybody within three weeks. That means to say you have always got a three weeks' waiting list. I have at the present time for 31 beds, 45 people waiting, that is to say, more than a patient a bed. I should think probably, excluding special departments like Throats and Ears, there is a longer waiting list in proportion than the general list, and as nobody can come in for about three weeks, you practically can never admit an acute case, so that you cut off practically all acute surgery from the Ward because you cannot take them in. We have to turn away every year large numbers of acute cases. The Surgeons know they cannot take an acute case, so the cases admitted must be those which can afford to wait three weeks. Further, not only surgical cases, but cancer cases and others that cannot wait have to be taken somewhere else. I have not the slightest doubt I could fill three times as many beds easily.

111. Have you formed any opinion as to the cost of building a Nursing Home attached to a Hospital?—I have not, I have never gone into the actual figures; I have never gone as far as that.

112. Do you think with your experience that it need necessarily cost a great deal more than the ordinary General Hospital beds?—I do not think it would; I do not see why it should cost any more, because it is rather in the planning than in the actual construction.

113. If you were building a new pay-beds department would you provide for the class who can pay the highest fees as well as those who can only pay the lower ones?—I think it would depend almost entirely on the size of the Home one was going to build.

114. I am assuming about 100 beds for a Hospital of the size of Guy's. You cannot well there build a Home of unlimited size, because if you expect most of the work to be done by an Honorary Staff you cannot have it too big?—I see no reason, if one were embarking on a Nursing Home of 100 beds, that you could not. If you are building what is obviously a private Nursing Home I do not see why, if you have the funds available for that purpose, you should not. If it is to be assisted or built out of Hospital funds, that is a different thing. I think if it were built or assisted out of Hospital funds in any way, one really ought to put some sort of income limit, though, of course, putting an income limit is an extremely difficult thing.

115. Yes, but on the other hand, if it became necessary to raise the capital by debentures, or anything of that sort, it would be almost essential, would not it, to charge a high fee for a good many of the beds?—I think you would have to make as much money as you could.

116. So that you could provide a percentage of the beds at any rate at a low figure?—Yes.

117. Because you would admit, I am sure, that the need for beds at a comparatively low figure is great?—My personal feeling is that if the provision of private Homes in connection with Hospitals is developed to any great extent it must of necessity develop on the American system, where they take all classes of patient without limit, because then out of your wealthier patients you are able to make better provision for the less wealthy.

118. Do you think that the staff would find it difficult in years to come to deal with a considerable number of their private patients at a much greater distance from their homes than they do now as a rule in the West End Nursing Homes?—I think you save an enormous lot of time if you have not to go to a Nursing Home. I do not know what a Surgeon would think about that.

119. I only thought—now, of course, there are a good many Surgeons who can do an operation within a very few minutes of their home and run in when they want to have a look at the patient—it might be a little more difficult if the patient

were at a distance ?—It might under certain circumstances.

120. On the other hand, you might, I suppose, employ in a Hospital Nursing Home or a Hospital private Ward, rather more experienced medical men than an ordinary R.M.O. ?—Yes, of course the fundamental difference is, I think, that the ordinary Nursing Home has not got a Resident Medical Officer, whereas a paying Ward has, which makes a great deal of difference to the responsibility and the anxiety of the Surgeon. In any case, if there is a Resident Medical Officer, I think that the Surgeon has less anxiety and has to pay fewer visits, because he can always be telephoned to if the occasion arises.

121. You do not give, I think, any figure for the highest patient's payment normally paid. There are a certain number of patients in the General Wards who are able and were prepared to make quite considerable donations towards the cost of their maintenance, but who fall considerably below the scale of the paying Ward. For instance, I think it is found in some Hospitals that there are a certain proportion of patients who can give 2 guineas a week, or a donation which amounts to 2 guineas a week; is that your experience ?—Some of them; but the average contribution of patients, which is quite voluntary, works out at £1 per head. That is the patient's own contribution, not the Hospital Saving Association—£1 a head, not £1 a week.

124. That would only be about 7s. a week ?—It would be about 7s. or 7s. 6d. or 8s. a week; that is the average. Of course it depends to a great extent on the district of the Hospital; ours is a very poor district round the Hospital, with many unemployed who have no money whatever.

125. Do you find that the pay beds do to a certain extent relieve General Ward beds ?—No; the number is so small that they do not. As I say, the waiting list is longer in proportion for the paying Ward than for the ordinary Wards.

126. Do you find that there are a certain number of people who come to the out-patient department, and who, after inquiry, are found to be capable of paying enough to go into the pay Ward ?—I do not think so. I do not think that ever occurs, because they would not be allowed to stay long enough in the out-patient department to find out. They would be turned out straight away unless they came recommended by a General Practitioner, when, of course, it is difficult to turn them away; that is another problem.

127. I will ask the question because I have experienced it: Do you find that any patients are sent to an out-patient department by a General Practitioner who can perfectly afford a paying bed ?—I should say a great number of patients who come to an out-patient department and would ordinarily be considered ineligible are sent by Doctors.

128. Do you find that the paying Ward on the whole makes friends for the Hospital ?—Very much; once patients have been in the paying Ward they never want to go anywhere else again, and you also get donations to the Hospital from old patients of the Ward.

129 Sir JOHN ROSE BRADFORD: Mr. Eason, would you mind looking at Question 10 in the Questionnaire ? I understood from your answer to the Chairman that the fees under 10 are paid to the member of the staff who carries out the work ?—Yes.

130. Would you mind telling me about 11; is any charge made for material there ?—The payments under 11 do not go to the member of the staff.

131. No, of course not. Who pays for all the other material ?—The Hospital.

132. Not the patient ?—Not the patient; the patient pays this fee that is specified here; for example, for an X-ray plate he is charged 2 guineas.

133. Who pays for the actual cost of the X-ray plate ?—The Hospital.

134. Not the gentleman who receives the fee ?—Similarly in No. 11, the gentleman does not receive the fee here.

135. But who receives it ?—He receives it under 10.

136. Exactly?—But 11 practically never arises. I put it in here "Not provided unless specifically "recommended by their medical attendant as "unable to pay for any particular method of "investigation or treatment in private."

137. I am afraid my question was not put very clearly. What I mean is this: supposing a patient has an X-ray examination while in the Ward, involving, say, the production of a plate, the X-ray Officer gets 2 guineas?—The Hospital provides the plate.

138. And the Hospital is put to the expense of defraying the cost of this examination ?—The 2 guineas is really the professional man's fee. He uses the material just in the same way as a Surgeon uses the instruments of the Ward.

139. As regards the question of what I may call outside Consultants, would it be, I will not say possible, but would it be at all usual for a patient to be in the Ward at Guy's and to be under the care, we will say, of a Physician attached to another Hospital ?—It might occur.

140. It would not be usual ?—It would not be usual.

141. My question was a different one from that, you understand. Supposing a patient with any given disease was admitted into a Ward at Guy's, would it be possible for the patient to be practically entirely under the care of a Consultant of another Hospital ?—Certainly, a Surgeon from any Hospital can take a patient into Guy's in that Ward and have him entirely under his care, do the operation and be solely responsible. There are not many, but outside Surgeons do from time to time bring cases in.

142. Mr. LOW: May I pursue that question of Consultants. You say that you would allow a Consultant. As a matter of fact it is not very common knowledge that any Consultant could go to Guy's ?—Yes.

143. To what would you limit the use of the word "Consultant?" What do you mean by "Consultant" ?—What I should mean by a Consultant would be a member of the Hospital Staff of any recognised Hospital.

144. What do you mean by a recognised Hospital ?—I should assume any large General Hospital, I think, more particularly I should assume the staffs of teaching Hospitals.

145. Would you limit it to the teaching Hospitals ?—Not entirely, because you know there are distinguished members of the Profession who are Consultants but are not on teaching Hospitals.

146. If one were starting a Nursing Home of this sort and wanted to find the class of gentlemen who might come in and look after the patients there, one would have to have something in one's mind as to how far you can go into the matter of Hospitals. There are a number of small Hospitals

with gentlemen attached to them who would be regarded by themselves as Consultants and not possibly by you ?—It is not only Consultants, but it is qualified by "subject to my approval," and the Governors leave it to me as a medical man and Consultant myself, to decide in these cases as to whether he may properly be called a Consultant or not. I do not think you can put down any regulation in exact words which will avoid difficulties. I think it has got to be left in the different cases to some person's personal decision.

147. I suppose your answer to such a gentleman as that who did not come with your approval would be "No beds" ?—I think I should frankly say: "Well, I am afraid I cannot let you operate "here."

148. Would you go so far as to tell him why ?—Yes, I should say those were my instructions, and I was not quite sure that I could consider him as a Consultant. I think I should have to, but the case has never arisen in my time.

149. Very few outside applications are made ?—Not many, and of course they are usually very well known people whom one knows by repute, and there are no difficulties.

150. If this became much more general, that would be a question that might arise ?—It might.

151. There are only a very few Hospitals that have these beds, and, if it became general, that would be one of the questions that would have to be laid down ?—Yes, possibly it would arise more often than it does now.

152. A Consultant approved by the Governing Body of the Hospital would meet the case, would not it ?—Yes, I think so.

153. You do not make any inquiries as to the financial position ?—No.

154. At the present moment you do not think it matters; you think that anybody might come there really ?—I think so.

155. Would you exclude anybody whom you knew to be very well off ?—I do not think that I should exclude them. At the present time, not making any inquiries beforehand, it is difficult for me to find out beforehand what is the financial position of a patient. I do not, as a matter of fact, in many cases know who is coming into the Ward and who is not, but if, to take an extreme example, I heard that Mr. J. D. Rockefeller was coming into that Ward, I think I should probably privately ask the member of the staff if he thought it was really a proper place to take him. There might be reasons why he wanted to. I think I should raise it purely personally.

156. I expect you would welcome him. A very important fact you said is that you are unable to have any emergencies there, and I suppose you would agree that the class of case for which these sort of beds are mostly required are emergencies ?—Certainly.

157. Those are the most difficult cases to deal with ?—They are the most difficult to provide for.

158. And those people cannot provide money in a hurry ?—No.

159. Is it a fact that some of those emergencies find their way into Guy's who might otherwise go to a pay Ward ?—I think very seldom, and only in exceptional cases where it is found that the patient cannot afford the fee of a Nursing Home.

160. They cannot afford both the Nursing Home and the Surgeon's fee, and yet they are fairly well to do ?—They do not come into the Hospital. Of course there are in every Hospital a certain number of such cases.

161. I am thinking ot some of the professional people like Clergymen ?—Yes, some of them would, but a small proportion only I should think of the people refused the paying Wards get into the General Wards.

162. They know it is no good attempting to get them into a pay Ward, and therefore they go straight to the Hospital Ward ?—They may go straight to the Hospital Ward or they may go straight to a Nursing Home elsewhere.

163. You think that it would be a great advantage to the medical practice if we adopted something like the American system, namely, had our private patients more or less under the same control as Hospital patients ?—From the financial point of view.

164. Do not you think there would be many advantages from the point of view of the various investigations that have to be undertaken nowadays, because it is always expensive and they are always under the same roof ?—Undoubtedly, from the patient's point of view it is better to get a complete investigation in a private Ward attached to a Hospital than in the Nursing Home. You have got everything under the same roof.

165. There are very few Nursing Homes in London where there would be an X-ray plant ?—I say there is no comparison between the advantages of the two.

166. It was pointed out that a patient in a Hospital is better off in the matter of emergencies that may arise during his illness than even a wealthy patient in a first-class Nursing Home where there is no Medical Officer kept ?—That is so.

167. Professor WINIFRED CULLIS: Do you ever take those emergency cases into the ordinary Ward and then transfer them ?—Rarely. Sometimes a patient may, you mean, be taken into the General Ward and transferred if there happens to be a sudden vacancy. Of course, usually the emergency is over by the time the vacancy occurs, but those cases do occur.

168. I wondered if you would allow that if it could be done ?—Yes.

169. You have just the one Ward ?—Yes.

170. How many beds would you ordinarily get in that sized Ward ?—I have a plan here. We get in a paying Ward half as many beds as we get into the General Ward, because you put the beds only on one side of the paying Ward, and have armchairs and tables. A private Ward of 24 beds would accommodate 48 general patients.

171. Does the extra Nursing staff required involve much additional expense ?—Merely the extra expense of the Nurses' salaries.

172. About how many extra in proportion to the beds ?—The average number of Nurses to the beds throughout the Hospital is one Nurse to two beds. There are, in the private Ward, 20 Nurses altogether to the 31 beds.

173. That is a great deal higher ?—It is a higher proportion.

174. Mr. COHEN: There is only one point: have you any machinery in connection with your pay Ward by which you can discriminate between a person who is able to pay 15 guineas a week, and those entered as a patient paying five guineas a week ?—No, there is no machinery at present. They come into our private Ward as they go to a Nursing Home; that is the charge for the Ward

and they pay it. Whether they could pay more or not we do not inquire. We never assess people as to their income before they go into the Ward.

177. Major WERNHER: I do not know if this is a very reasonable question, it is rather far in advance, but have you ever thought out whether there is an economical unit. Supposing you had the money you could afford anything you liked, 100 beds or 500 beds?—I do not think economy really matters very much. I think you could easily run a paying department of anything like 100 to 200 beds. It would depend, of course, on the position of the Hospital. I mean a Hospital in the West End may probably keep full a larger number of paying beds than a Hospital in a poorer district. For example, however good the accommodation might be, it might be more difficult to fill a paying Ward, say, in Whitechapel or in Bermondsey than it would at Hyde Park Corner, because of people's natural inclination not to want to go to a district like Whitechapel, however good the accommodation; but I think 100 to 200 beds would be quite economical, and unless you have a paying Ward of that size it will not bring in any appreciable income.

178. You must have 100?—I think you must to bring any appreciable income to the Hospital.

179. Sir BERNARD MALLET: With regard to the flat rate of five guineas, have you ever thought of different rates?—We have never thought of that, because the accommodation is identical, and there is no possibility in this Ward of making varying accommodation. These people are all in cubicles. In our paying Ward we have one private small room for which we charge an extra guinea a week, but you could not make any variation in the charges for maintenance to separate patients in identical cubicles. Even if you did you could not charge one cubicle higher than another. To charge varying fees you have got to have varying types of luxury. As ours are uniform you cannot vary the amount.

180. Do you find a rich man who gets treated in this way gives a donation?—Very often, but I wish to say, as a matter of experience, we very seldom get a rich man, though from time to time one does get handsome donations from patients who have been in the Hospital.

181. The CHAIRMAN: Do you find that the class of patients you get now object to the semi-publicity of a Ward of that kind?—No, on the whole, I think they rather like it. I think many patients are much happier in a Ward where they can see and talk to other people rather than shut up in a private Ward all day.

182. Do you think that would apply to a patient who could pay a much higher fee?—No, I think if a patient had a private suite of his own that is a different thing, but I myself see no alternative, no half-way house between a private room or a private suite and a Ward with cubicles in. I do not think there is any advantage in a two or three-bedded Ward. I have seen those in foreign Hospitals where the patients get all the publicity of a General Ward, and I think two or three patients in a Ward would be a much greater nuisance to each other than 12. It is either a private room or a Ward.

183. Of course, the difficulties of nursing in a two or three or four-bedded Ward are the same as the larger?—Quite; I see no advantage in it.

184. Are you acquainted with the present construction of St. Thomas's Hospital?—I have been in it.

185. I understand in that case the rooms have walls which go up to the ceiling with a curtain in front?—Yes.

186. Do you have much advantage in that over the ordinary cubicle?—I do not think you do.

187. And it is much more expensive?—It is much more expensive. My own feeling would be if I were in a room like that, that it is very much like a prison cell with the door off; it feels like that somehow. I think it is rather nicer not to have the walls going up to the top; you get much better ventilation and it is much freer.

188. It boils itself down to this, it is a semi-Ward or private room in your opinion?—Yes, I do not think the half-way house is any good.

189. Sir JOHN ROSE BRADFORD: If I put rather a hypothetical question, supposing what we have called shortly the American system were developed here, having a large paying home attached to a Hospital served by the staff of the Hospital, do you think that that would lead to profound alterations in the relations which exist at present from all points of view in the staff in the Hospital part of the building. You see what I mean?—I think it would. I am not quite sure that the complete American system would ever be suitable for England. I mean—it is rather beside the point—but I do not think that the rich man of England will ever be agreeable to being taxed to the same extent for his operation as is the millionaire in the States.

190. I did not mean that?—But that is really a part of it.

191. I did not mean the financial side of it?—You mean that there might be a tendency that the general Hospital work was neglected to some extent?

192. No, I do not mean that. Putting the thing quite plainly and bluntly, do you think it would inevitably lead to the payment of the Hospital staff for what is now supplied to general Hospitals without payment?—I do not think in the free Wards. No, I do not think it would.

193. You do not think that if a Hospital staff were doing two kinds of duties, in a paying Home and in what we call the free ward, and they were receiving fees from their patients in the private paying Hospitals, that that would afford a very powerful argument for their being paid for their other services?—I do not think so. I was asking that question when I was in France quite recently, where Hospitals are State Hospitals, where you might expect the Medical and Surgical staff to ask for a living wage. It is considered such a distinction to be on the public Hospital staff, in fact, what might be called a laurel wreath in the Profession, that they do this work for practically a nominal salary.

194. Mr. LOW: You do not allow General Practitioners to look after the patients in the Ward?—No.

195. And you do not think it workable?—Well, this is a question of such far-reaching medical importance from a professional point of view, that I do not think I should like to embark at any great length on it. There are difficulties as I say, in the way of admitting any General Practitioner to look after any case in a Ward like that, particularly from the Surgical side, because, as I say, the question of competence and the responsibility of the Hospital arises.

Mr. H. L. Eason.

196. I realise all that, and those are reasons, I take it, why you do not admit them at Guy's ?—I imagine they are; I mean I inherited a tradition, and as far as I know that was the reason which, when the Ward was started, decided the arrangements as to the staff.

197. Then you are not prepared to say if you are starting a fresh thing you would exclude a General Practitioner looking after patients in the Ward ?—I do not think one could definitely express an opinion on that at the present time.

The CHAIRMAN: Thank you, Dr. Eason, we are very much obliged to you for coming here.

(The Witness withdraws.)

(Adjourned.)

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

WEDNESDAY, 6th JULY, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
PROFESSOR WINIFRED CULLIS.

LORD SOMERLEYTON, MR. LEONARD L. COHEN and MAJOR WERNHER (*Honorary Secretaries*), and MR. H. R. MAYNARD (*Secretary*) being also present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.2.*)

SECOND DAY.

MR. G. B. MOWER WHITE, F.R.C.S. Emeritus Surgeon and Member of the Board of Management, Royal Northern Hospital, and MR. GILBERT PANTER, Secretary, called and examined.

198. The CHAIRMAN: We are obliged to you for the answers to the Questions which you have been good enough to send in. You represent the Royal Northern Hospital. There are one or two points that we might refer to perhaps: You have 38 beds in all, I understand?—(*Mr. Panter*): That is so.

198A. Of which 20 are in a cubicled Ward, and 18 in private rooms?—Yes.

199. And you make a charge for the cubicled Ward of 4½ guineas, and for the separate rooms 5 or 6 gufneas a week. Do you consider that both these charges, namely, the 4½ guineas and the 5 or 6 guineas. pay the Hospital?—Yes, they are sufficient to cover the cost, in fact slightly more than the cost; last year there was a small balance left.

200. Do you charge for rent?—Yes, we do.

201. But I think you say you have no account of the capital cost?—No, we have no account of what was in the original bill.

Mr. G. B. Mower White and Mr. G. Panter.

202. Therefore rent is really an arbitrary figure?—Yes.

203. Do you find that the class of patient who goes into the separate room at 5 or 6 guineas is different from the individual who goes into the cubicled Ward?—It is slightly different. We have in the cubicled Ward a class of patient that less often perhaps pays medical fees, and in fact in any case they would be smaller medical fees than in the separate rooms. I think Mr. White could tell you about that. (*Mr. White*): Chiefly that the position of the patient seems to indicate the difference between the patients in the cubicled Wards and those in the private Wards.

204. Now as to the method of admission. It is either through the Medical Staff or the Consultants attached to a recognised London Hospital. Does a Consultant not attached to the Royal Northern send in the application to the Hospital or does the patient?—The patient.

205. And who then is to judge as to whether the patient is a fit applicant for the bed?—The Senior Resident Medical Officer at the Hospital.

206. On medical grounds?—Yes.

207. Or financial grounds?—With regard to financial grounds, it is certified by the patient's

own medical attendants. On the form of application the medical attendant says that he considers the patient to be suitable both from a medical point of view and from a financial standpoint.

208. Is that checked by anybody ?—No, unless any doubt arises.

209. You have, I think, heard of some Medical Practitioners who have a very queer idea of the suitability of patients, even for Out-Patient Departments ?—Yes, we have found that occasionally, but in the case of the private Wards we have not found that so much, because if there is a possibility of a patient paying full medical fees, and Nursing Home fees, generally speaking the local Doctor, the patient's own Doctor, will take steps to get them into a Nursing Home, or somewhere where he can have charge of them.

210. That is to say, as a general rule you do not get, at any rate from outside Practitioners, patients who can pay Nursing Home fees ?—No, we do not.

211. Would you refuse them if they came ?—Well, we should.

212. Let us take the two classes, the Ward and the room ?—Yes, if we found a case that really was of the Ward class, and was not provided for, we should refuse it.

213. That is to say, the Governing Body of the Hospital consider that both the beds in the rooms and in the Wards are provided for people who cannot afford ordinary Nursing Home fees ?—Yes, when I say Nursing Home, that is qualified to some extent ; I mean there are some Nursing Homes where the proper services are not available and patients can be admitted so much more cheaply, but we regard the Nursing Home as a place where full services are available.

214. I may take it, may I, that you have no fixed standard as to the suitability of patients for admission ?—No, there is no fixed standard.

215. You take each case individually ?—Yes.

216. And if there is a doubt, I suppose you, in the last resort, act in the capacity of an enquiry officer ?—Yes.

217. What do you mean by full services in a Nursing Home ; do you refer to the auxiliary services that a Hospital gives in the way of laboratories and X-ray apparatus ?—No, not quite that, because there are so few of them that have them, but there are some Nursing Homes that are in extraordinary poor houses and generally badly equipped. We have a few in the locality served by the Royal Northern where the services are bad.

218. That is to say the nursing would be indifferent ?—Yes, not fully qualified nurses in some instances.

219. You say here that you have in your case a larger proportion of certificated nurses looking after these patients. Do you mean that there would be a certain number of probationers ?—Yes.

220. But you do not use them in a private Ward quite in the same way as you would in an ordinary Ward ?—No.

221. I notice the extra charges which you give in your answer to No. 10, and it is possible, of course, that these might mount up to a considerable sum. Can you tell us at all what the average of a patient is for his 17 or 18 days that he is in the Hospital, excluding, of course, any fees for operation or anything of that sort ?—Yes, the average would work out at about 15 guineas for maintenance, and taking the average I should think not more than about 3 guineas for extras ; possibly 2 guineas for extras, taking the average.

222. That would be putting extras at about 10 per cent. of the cost ?—Yes.

223. Patients, I understand, make their own arrangements, independently of the Hospital, with the Physician or Surgeon for the payment of fees ?—Yes, more often it is done through the Doctor, through the General Practitioner.

224. And never through the Secretary of the Hospital ?—No.

225. So that the fees charged would not come within the knowledge of the Governing Board of the Hospital at all ?—No, not officially.

226. In the case of any of the patients ?—No.

227. This is a question which I was going to ask you, which you may prefer not to answer, or say No to : Can you say whether amongst the members of the staff of the Hospital there is any general scale of fees for patients ; what I mean is this : Do you, in assessing your fees, take into consideration the income of the patient, whether he is a married man and has a family, and so on ?—I do not know of any scale, but the circumstances of the patient are certainly taken into consideration, and mostly, again, that is done through the General Practitioner.

228. Then there is no agreement amongst yourselves ?—No.

229. It is said that the patient's General Practitioner may share in the treatment of the case ; does that mean that he can come in and give directions over the head of the Resident Medical Officer ?—Yes. The Resident Medical Officer is in charge of the cases which are under the care of a Physician or Surgeon not attached to the staff of the Royal Northern. You see, 25 per cent. of the beds are available for Physicians and Surgeons attached to other Hospitals, and of those cases the Resident Medical Officer is in charge.

230. Then what happens in the case of the patients in charge of members of the staff ?—In the case of patients in charge of Physicians or Surgeons in the Royal Northern Hospital, the House Physician or the House Surgeon is in charge.

231. There are two ; the Resident Medical Officer who looks after the cases sent in by Consultants, other than members of the Staff of the Royal Northern ?—Yes.

232. And there is the House Surgeon who looks after, in the ordinary way, cases of his own chief ?—Yes, the Resident Medical Officer would assist at the operation in other cases. As a matter of fact we have made an addition to his salary to cover that, so there is no extra charge on the patients.

233. And the Resident Medical Officer in the case of the Royal Northern would be a man a good deal senior to the House Surgeon ?—Yes, a Fellow of the College of Surgeons, quite a senior man.

234. And what happens in the case of the General Practitioner ?—He very seldom appears.

235. In those cases where patients have been introduced by members of the staff of the Hospital, the General Practitioner very seldom appears ?—Yes, very seldom comes.

236. Anyhow you find no difficulty about that ?—No.

237. Mr. Panter, can you give us in one figure the cost per week of these beds ; I have not worked it out ?—(*Mr. Panter*) : I think I did reckon it out, £4 12s. 10d.

238. That is for maintenance ?—Yes.

239. But 4½ guineas does not cover it?—Well, what is lost on those cheaper ones is made up by those who pay 5 and 6 guineas.

240. That is why I put the question in the beginning. As a matter of fact the 4½ guineas does not quite cover the expenses, but the 5 and 6 guinea ones make up the difference?—Yes.

241. You say that you hope to add to the present number of these beds?—Yes, we do hope to.

242. Have you made any plan as to what form the building is to take; are you going to build another Ward or are you going to have private rooms or what?—It is a little indefinite at the moment; the Committee are just beginning to consider this question, and if it materialises the idea would be to have a number of separate rooms; a building with a number of separate rooms, practically all separate rooms; the large demand on these beds is for separate rooms; people do not even like having two beds in a room.

243. If you had a building with separate rooms you would have to charge more than 4½ guineas a bed per week?—Yes, we should have to charge them a minimum of 5 guineas.

244. You think you could do it for that?—Yes, I think so, a minimum of 5 guineas, perhaps going up to 7, instead of 6.

245. You have not made any calculation as to what a building of that sort is likely to cost per bed?—No, not yet.

246. Are those charges suggested on the assumption that you would not have to pay anything for rent or interest on capital?—Oh, no, on the assumption that we should have to pay interest on capital. If we had a larger number of beds available in the one building, the cost would cheapen.

247. But is it not a fact, if you have a large number of single beds in separate rooms, that the maintenance is going to be a bit increased, nursing for instance?—Not above our present cost. You see, practically half of our beds at the present moment are in separate rooms.

248. In any case, if you build this new building, it would not be the desire of your Governing Body to change the class of patient who could go there; you do not suggest having a more well-to-do class of patients to occupy the rooms?—Not at the present moment, I think; whether public opinion later might influence them, of course, it is difficult to say.

249. What I should gather now, from what you have said, is that the class of patient who goes into your 4½ guinea bed is the class which is possessed of just over the income limit for the other beds?—Yes.

250. So that they can pay for maintenance, but they cannot always pay for fees?—Quite, that is so. (*Mr. White*): Yes, I think that is so.

251. That is a fair description of the class of patient who goes into your beds now?—(*Mr. Panter*): Yes.

252. But the class who go into your rooms are rather different; they can always afford to pay, at any rate the reduced fee for an operation?—(*Mr. White*): Not always. There are some few of those who pay no medical fees.

253. Do you find at all the existence of these beds relieves the ordinary Ward; that is to say, that some people who, if those beds were not in existence, would go into an ordinary Ward, now find their way into the pay beds?—A small proportion, but not a large proportion.

254. From the point of view of the support of your Hospital, you say they are popular?—Yes, I do.

255. When you say that, does that go beyond the immediate occupants of the beds? It may be supposed that they would be ready to support the Hospital and take an interest if they have been satisfied with their treatment, and so on, but does it extend to the class from which they come?—Yes, I think it widens the scope of the Hospitals' activities altogether, and many more people take an interest in them.

256. Sir JOHN ROSE BRADFORD: There is one question I would like to ask you on Question 6, about admission: Can you tell us whether any appreciable number of persons are refused on financial grounds?—No, very few.

257. That their income is thought to be too high to justify admission?—I only know of one instance over the course of a number of years, where we found, after admission, that the patient could have afforded Nursing Home Fees.

258. I am not quite clear about this question. You answered Lord Hambleden about the Resident Medical Officer; I understand that those cases that are not under the care of a member of the staff are under the care of the Resident Medical Officer?—Yes.

259. But under whose care are they in addition?—The Consultant, of course, visits, he pays his visits, but the Resident Medical Officer is in charge of the case.

260. What we may call the outside Consultant?—Yes, what we may call the outside Consultant.

261. What I want to get at is this: Are there any patients who are under the care of the General Practitioner alone; I mean in addition to the Resident Medical Officer, of course?—No, I do not think so at all; no, that would not be according to regulations.

262. I wanted to clear that point up. So that they are either under the care of a member of the staff and the House Surgeon or House Physician, or they are under the care of what is called a Consultant and the Resident Medical Officer?—Yes.

263. What is the definition of a Consultant?—He must be attached to a General Hospital practically in London; he must be a member of the staff of a General Hospital.

264. What is understood by the term "General Hospital"?—That is difficult, not one of the Cottage Hospitals; presumably any Hospital with over 100 beds.

265. I wanted to know if there was a limit?—No, no definite limit is laid down.

266. There is no list of Hospitals?—No.

267. Whose discretion is it to decide whether Mr. X. is or is not a Consultant?—I do not know; I suppose the only man who could have any say in the matter would be the Resident Medical Officer. I have never known the question arise in which it was brought up. Any question on this point would be referred to the Committee.

268. May I ask whether, in the case of patients in separate rooms, are there any instances in which such patients pay what may be called full medical fees?—I would not say that there are no instances, but there must be very few, I think. (*Mr. Panter*): May I say one thing in connection with having outside Consultants as well as the staff of the Hospital in. The Committee decided to open those beds to outside Consultants as well as to the staff of the Hospital, because they came to the conclusion that if patients were to pay fees, they

must have free choice of their own Physician or Surgeon.

269. Mr. LOW: I understand all those beds are limited to 25 per cent. ?—(*Mr. White*): Yes, that is the regulation.

270. 75 per cent. of the beds go to the members of the staff of the Royal Northern ?—Yes.

271. You used to have a more complicated method of admission through the Committee, did not you ?—Yes, in the days when they were not used so much as the private Wards. (*Mr. Panter*): No fees were payable then. (*Mr. White*): No medical fees.

272. Then you started this method of admission, but you increased the fees and allowed the attendant Doctor to take fees ?—Yes.

273. You are quite satisfied with your relationship with the General Practitioners; there is no feeling ?—Apparently it is perfectly amicable.

274. There is no feeling that when a case goes in there they lose control of it ?—No.

275. I suppose if you were to increase your beds and were to take a class of patient at a rather higher income, there might be a possibility of some friction of that sort ?—I think they would come.

276. At the present moment the only reason why they do not come is that they are content to leave it in the hands of the Resident Medical Officer or the House Surgeon, as the case may be ?—Yes, apparently so; I think some hesitate to come because they feel they are charging a patient an unnecessary fee and running up an unnecessary account.

277. But you think they would come. You have just told Sir John Rose Bradford that in no circumstances would a General Practitioner be allowed to look after a patient alone ?—No.

278. It is assumed that these cases are always surgical cases, but they might be medical cases ?—A good many are medical cases, quite a number.

279. In those cases a General Practitioner might be quite capable of looking after them ?—But there would be a Consultant always.

280. There must be a Consultant ?—Yes, certainly there would be.

281. That is to say the patient who, under ordinary circumstances at home would be looked after by a General Practitioner without the assistance of any Consultant, here would have to have a Consultant if he wanted to get the advantage of those beds ?—Yes, he would work under the instructions of the Consultant.

282. And of course with the Consultant ?—Yes, and then there is this other point, that we do not consider a case suitable unless active treatment is necessary.

283. What do you mean by active treatment ?—Either surgical or medical.

284. Which you think would not be done by the General Practitioner ?—Yes, which requires some fuller investigation than can conveniently be carried out at home.

285. Sir JOHN ROSE BRADFORD: We want to be quite clear on that. It is quite clear, is it not, that a patient would not be treated by a General Practitioner and the Resident Medical Officer ?—Yes.

286. Mr. LOW: You think it would not be advisable to do that; you do not think it would be convenient, or would not you like to say ?—No, I think if that suggestion were followed we should think it quite necessary for one of our staff to be indicated to look after the case.

287. If this became very general, for instance, and a number of pay beds were opened, do you think in your opinion it would militate against it; would it not rouse a certain amount of prejudice in the case of the General Practitioner if they were not allowed to look after a case if it went into such Wards; I am talking now of the larger number ?—I think they do appreciate the fact that they are allowed to come in.

288. They have very little control; they only come in as the fifth wheel on the coach ?—Well, they might, they do take up the position, that is that they could visit daily and the member of the staff would only visit, say, twice a week; they could look after the patient and not the House Surgeon if they wished to. But I think there is another point, they hesitate to come into the Hospital organisation, I think they feel they are not exactly *au fait* with the methods employed possibly, and there is diffidence on that account.

289. I am glad to hear there is some diffidence sometimes ?—I think that is so from what was said to me.

290. Professor WINIFRED CULLIS: In connection with that I should like to ask: Would you admit people for whom the real need was adequate nursing rather than the skilled Consultant's advice ?—Well, I can imagine we should admit them, if we were asked to do so, if the evidence was sufficiently good that they were likely to benefit, but I imagine, if an investigation showed that was all they required, we should not keep them very long.

291. Mr. Panter said that the single-bed Wards were generally more sought after. If you cannot give them a single bed Ward would they rather go into a cubicled Ward than into a two-bedded room ?—(*Mr. Panter*): There is not much choice between them; they would come into either if they could not get into the single room, but there is a very distinct desire to be in a separate room.

292. If there is one other person, then they might prefer a Ward ?—Yes.

293. And they would not be willing to pay so much more for the two-bedded room than they would for a single ?—No.

294. In the proposed block that you were speaking of, would you be planning for a separate Operating Theatre ?—Yes.

295. And kitchens and everything of that kind ?—Yes.

296. And you still think you could make it pay at the rate of £5 5s. up to £7 7s. ?—I think it would cover the cost.

297. Sir BERNARD MALLET: I see in No. 19A you say that ordinary patients pay up to £4 4s. a week occasionally ?—Yes.

298. But in other Hospitals they pay £3 3s. to £4 4s. per week. What class of people are those ?—Usually they are accident cases that are admitted, taken in as emergencies. Sometimes that particular class of patient if they came on the waiting list in the ordinary way and were offered a cubicled Ward they would pay an extra 10s. 6d. to be in there.

Sir BERNARD MALLET: I was wondering whether they were the class who would take pay beds if they were available.

299. Lord SOMERLEYTON: I do not think a Hospital would find separate rooms of much use if you desired at any time to revert to ordinary Hospital purposes; so that the patients not satisfied with cubicles ought to be prepared to pay rather higher for separate rooms, because these separate rooms would not be suitable for ordinary

purposes; is not that so?—We have separate rooms in other sections and they are found very useful.

300. But you would not provide separate rooms in constructing an ordinary Hospital?—No.

301. It is rather a handicap to have part of your building given up to the separate rooms in case you ever want to make a change in the Wards?—Yes.

302. It would be rather a handicap in your building really, would not it?—Well, on the other hand we have had these rooms on a smaller scale for the past 30 years, and we have found them always most useful, and there is always a class of contributory patient who would just pay enough to get into a single room.

303. Mr. COHEN: I wonder whether you would be good enough to put in a copy of the form of application and of agreement which these patients have to sign; I think it would be useful to the Committee?—Yes.

304. Major WERNHER: Are the cubicles curtains or partitions?—Curtains.

305. Screens?—No, just curtains on rods.

306. Just a converted ordinary Hospital Ward really?—Yes.

307. The CHAIRMAN: Is there anything else you would like to say? (*Mr. White*): I do not think so.

The CHAIRMAN: We are very much obliged to you for coming here and giving us your assistance.

(The Witnesses withdraw.)

MR. E. ROCK CARLING, F.R.C.S., Surgeon, Westminster Hospital, and MR. CHARLES M. POWER, Secretary, called and examined.

308. The CHAIRMAN: You represent the Westminster Hospital, I understand?—(*Mr. Power*): Yes.

309. The beds for private patients there are of recent date, I understand. You have four-bedded Wards?—Yes, two.

310. Two four-bedded Wards?—Yes, at 6 guineas a week.

311. And 10 guineas per week for a separate room, of which there are six?—Six.

312. Do you consider that both the 6 guineas per week and the 10 guineas per week pay the Hospital for the services rendered?—The cost as far as we have ascertained is approximately 6 guineas per week; that is an outside figure.

313. So that the 6 guineas per week only just meets the cost?—Just pays.

314. And you make your profit out of the 10 guineas?—Yes.

315. Do you find that the separate rooms at 10 guineas are eagerly sought after?—Yes, they are; both types of beds are eagerly sought after.

316. That charge approximates to a Nursing Home charge?—Except that there are no heavy extra charges such as you have in the Nursing Home.

317. There are some which you detail, but a patient knows before he goes in exactly what he has to pay in that way?—Yes, and they are only for special and expensive forms of treatment.

318. Can you tell us at all the average cost to a patient in the Hospital, putting aside altogether fees for operations and so forth?—The cost of maintaining a patient in a private Ward?

319. To the patient. What is the charge to the patient roughly?—(*Mr. Carling*): The average for 21 days is 6 guineas a week, that is 18 guineas plus 2 guineas; 20 guineas.

320. Then he does pay 2 guineas more?—(*Mr. Power*): Yes, he pays 2 guineas as an operating theatre fee.

321. You have got the figures, perhaps you would be able to provide us with them possibly; I think it would be interesting to know about what the average cost to a patient is?—Yes, I have that.

322. Putting aside the Consultant's fees. If you cannot answer it now you might let us have it. Then as to method of admission?—Do you want those figures, because I think I can give them to you; it is approximately £21 for an ordinary surgical case. It would be approximately 18 guineas for a medical case, that is, if the accommodation is in any one of the four-bedded Wards. Three weeks is the average stay in these Wards.

323. Then it would be proportionally increased if they had a separate room?—Yes.

324. The method of admission is generally through the medical staff of the Hospital, and not as I understand through any Practitioner unconnected with the Hospital?—The method of admission is by reference to a member of our staff. The Practitioner gets into touch with a member of the medical staff, and the member of the staff arranges the admission with the Secretary of the Hospital. (*Mr. Carling*): That is not what we consider an ideal arrangement; that is only necessitated by the small number of these beds and the accommodation in the Theatres and that sort of thing.

325. When you say it is not ideal would you tell us in what respect it might be altered?—We do not think that in beds provided for this class of patient it should be restricted to the staff of one particular Hospital necessarily; that if a Practitioner wants to send his patient in he should also be at liberty to call in a Physician or Surgeon. It is not practicable with very small numbers run in connection with such a Hospital as ours at present. We think that if this idea could be extended, as we think it should be, and run on a big scale, then the conditions would more nearly approximate to those of a Nursing Home.

326. Under those circumstances would you suggest that both the outside Consultant and the outside General Practitioner should be allowed to come in?—Yes. The outside General Practitioner, of course, comes in with his case now.

327. He comes in with the consent of the Consultant?—Yes.

328. But he does not give directions?—No, only through the Consultant. We do not think that an ideal arrangement either. We think the outside Consultant should be in a position to treat his patients, but it is not practicable with so few beds as we have. With regard to the arrangements with the Dispensing Staff and the Nursing Staff and so on you are obliged to keep control.

329. That is to say if there was a largish Nursing Home in connection with the Hospital it ought really to be run on the same principles as an ordinary Nursing Home?—I think it is a bigger question than that really; that is to say, the cases do not all fall into one category. If we are going to run a big Institution providing for every class of the community there would be more than one form of provision; there would be a form of provision which corresponds exactly to the present day Nursing Home with improvements which we can easily go into. There should be the provision of Wards such as we have here for patients who only pay their cost and who pay much reduced medical fees, and there should be also provision for

patients, on very similar lines to those that obtain in a Hospital to-day, where they would have an inclusive charge for maintenance and for medical fees. In the last category it would not be possible to have that open to all and sundry Consultants; they would have to be as the Wards are at present, under the charge of an individual.

330. But there are many difficulties which you have mentioned or touched upon for the staff, Nursing, Dispensing and so on, which must arise if anybody is allowed to come in and give orders?—Yes.

331. At the present moment only certain people in the Hospital are entitled to give orders and directions?—Quite.

332. If you had got 50 people coming in and giving orders to the Nurses and so forth, it would be very difficult?—It is not workable at present, but of course we think that all these difficulties can be got over; they are by no means insuperable, and we feel that the demand for such services by the community is so great that they will be got over in any case.

333. You do not look upon the limiting of beds to the honorary staff as being a principle that ought to be maintained?—No, except in certain categories.

334. Only in the poorer category of patients who probably would be in Wards?—Yes.

335. I understand, to put it shortly, that there really is no standard of means which is adopted by the Hospital for the admission of those patients?—(*Mr. Power*): No fixed standard. (*Mr. Carling*): I think perhaps I ought to say that those views to which I have given expression are in a sense personal.

336. And not the views of the medical staff?—They are the views which the medical staff would like to persuade their Managing Board to adopt.

337. That is why we have asked you here?—We are not committing our lay Committee.

338. That is why we have asked you to come here; we understand that is the view of the professional side of the Hospital?—Yes.

339. You have, at the Westminster, no experience of Wards with cubicles. Do you think that people do very much appreciate a single room, or do they like being put in with somebody else?—(*Mr. Power*): It is very difficult to say; it varies with the patient. In these four-bedded Wards we do provide screens so that the patient can be screened off if he so desires, but we find that the patients do not wish to have those screens round the beds unless possibly they have a visitor they want to talk to quietly; most patients prefer the open Ward; they would rather have two or three others with them in a Ward. Others will not go into the four-bedded Ward; they insist on a separate room. It depends upon the nature of the case very much.

340. You provide a scale of charges which are applicable to such patients if they receive out-patient treatment. Am I to assume that that scale also applies to in-patients of this class?—No, in the case of in-patients no charge is made for routine X-ray examination or treatment, electrical treatment or the use of the pathological and bacteriological laboratory. If they have prolonged electrical treatment in the Hospital then they have to pay a fee on those lines, but that only applies of course to the 6 guinea Ward patients?—(*Mr. Carling*): Of course it only applies to those who have already been in the Ward. Supposing a man is giving a course of X-ray treatment to a patient in a 6 guinea Ward, he is not prevented from giving that for a week because the patient has gone out.

341. Then is there a portion of the payment made to the officer concerned?—(*Mr. Power*): Yes.

342. And a portion to meet the cost of material?—Yes. The portion which goes to the Hospital does in fact cover the cost of the upkeep, the overhead charges.

343. Of the X-ray films and so forth?—Yes.

344. I see you give a rather remarkable figure of the average number of beds occupied, 14 out of 14. How do you manage that?—Well, it is nearer 14 than 13; I should put 13·7.

345. If you calculated strictly upon the principle applied to the occupation of the ordinary beds, it would be something over 13?—It would be approximately 13·7. (*Mr. Carling*): The demand is increasing week by week.

346. I was going to ask about that. You have got a waiting list?—(*Mr. Power*): Yes.

347. I suppose you keep a waiting list, do you?—Yes. (*Mr. Carling*): It amounts to more than that, because the waiting list is so great, that emergencies cannot be taken in; that is what it comes to.

348. You say the demand is very great. That means, I take it, that the staff of the Hospital, in their consultant practice, come across so many people who require treatment, who ought not to go into the General Ward, but who yet cannot afford to go into a Nursing Home. Is that a correct description?—Not entirely, because in our 10 guinea Wards, we take in people who might go into a corresponding Nursing Home.

349. And who pay full fees?—Yes. We do not get the wealthy in there, but the same class of patient who would pay 10 guineas in a Nursing Home; and the reason why there is the demand for our beds is this, that every one of us can do much better by our patient in the private Wards of the Hospital than we can in any private Nursing Home; there is no comparison. No member of our own families would dream of going to any Nursing Home that exists in London that I know of, if they could get into a private Ward of a Hospital.

350. You do not think anybody would go into a Nursing Home if they had been in a private Ward of a Hospital?—No.

351. You charge nothing for rent?—(*Mr. Power*): No. (*Mr. Carling*): That is where the justification I think comes in for the 10 guinea Wards; the profit that is made out of them is an offset to rent.

352. It goes to the benefit of the Hospital?—Yes.

353. I take it if you could you would like to increase the number of those beds?—(*Mr. Power*): Yes, we certainly should.

354. Do you find that the ordinary patients occasionally pay 3 guineas a week. Do you ever get patients who come to the Out-Patients Department, and who are found, after inquiry, to be capable of paying the higher charges in the private Wards?—Just occasionally, not very often.

355. Casualties, you mean?—Casualties, yes.

356. Do you move casualties from the General Ward?—We have done so, from the General Ward to the private Ward. It is not possible always, and it brings up a point; we find that many of the patients who now occupy those 6 guinea beds had, before the private beds were provided, to be treated in the General Wards of the Hospital.

357. That is interesting. Of course that is really what I meant by asking that question. You do find that the existence of those beds does in fact go to relieve the beds in the ordinary Ward ?—It does.

358. Sir JOHN ROSE BRADFORD: Mr. Power, with reference to Question 6 in the Questionnaire, is there any appreciable number of patients declined on the ground of their income being too high to justify admission ?—No, the Hospital takes no cognisance of that.

359. Then, Mr. Carling, if I might revert to the General Practitioner question, does he take at the present time any active part in the treatment of any case ?—(*Mr. Carling*): So far as we possibly can we encourage them to come exactly as they do to Nursing Homes. They assist at operations, for example, or are present. Sometimes they prefer not to come, but sometimes they do. They are encouraged to come and see their patients just as they would in a Nursing Home. I think you may take it that all those Practitioners who come, do come in exactly the same way as they would to a Nursing Home.

360. Do they issue orders ?—Well, strictly speaking they do not. What of course happens is this: one's House Surgeon goes with them and they say: "Well, I think so and so," and of course the House Surgeon does it and then tells us. There is no difficulty.

361. What I wanted to get at was whether they visited a patient and gave orders independently of the House Surgeon ?—No. We have made it plain to them that for administrative reasons that cannot be done, and we have not had the slightest difficulty with any single Practitioner; they have always understood perfectly.

362. I understood from one of your answers to Lord Hambleden that you advocate the existence of a Nursing Home which would be unrestricted as regards the coming and going of Medical Practitioners; that the patients should be under the care of any Medical Practitioner; is that so ?—Yes, but at the same time I think that is perhaps a concession to our traditions. I do not know that it really is essential or will be essential in the future, but I think it is a necessity here in London, in England, now; and yet there is a class for whom we ought to be able to make provision under the circumstances in which that would not be possible.

363. My point is this: you advocate the institution of a Nursing Home in connection with a Hospital where patients could be admitted for treatment by any Medical Practitioner selected by the patient; I mean quite regardless of his professional position ?—Yes, in association with the Consultant concerned.

364. That is your position ?—Yes.

365. You realise the difficulties as regards that, of course, from the point of view of the responsibility of a Governing Body; is that a view that is at all generally held amongst your Medical colleagues ?—It is a very difficult question to answer. I do not think it would be right to say yes to that, and at the same time our lay Governors have, in the past at any rate, taken very strongly the view that where a large number of beds is provided for that class of patients they ought to be open to all Practitioners, to all standard General Practitioners and Consultants. Personally I think with most classes of the community that would prove to be impossible.

366. I do not want to argue the point, I only want to define it ?—I thoroughly appreciate the difficulty.

367. I only wanted to define it. At the present time there is some criterion of what is termed a Consultant; there may be a difficulty in defining what is meant, but there is some criterion. The point that I want to make quite clear is that you advocate a state of affairs in which that should disappear and that the patient should simply select a Medical Practitioner ?—I beg your pardon, I had not got that in mind; I am sorry I did not appreciate that.

368. That is what I understood ?—No, I did not appreciate that. You mean that the whole class of Consultants as such should disappear ?

369. Yes. It might be even more than that; it would be rather difficult to define what a Medical Practitioner is; he may be a Homeopath or an Osteopath; we do not know what he may be. I understood your point to be that the patient should be under the care of any person selected by him ?—No.

The CHAIRMAN: I am bound to say I did not take that view of the answer. What I did understand was that any Consultant should be allowed to introduce a patient into a Hospital, and that following that introduction the General Practitioner should be allowed to visit the patient and give orders. That is what I understood.

Sir JOHN ROSE BRADFORD: I understood the Witness to say that the patient was at liberty to be put under the care of any Practitioner that he liked to select. That is what I understood.

370. Mr. LOW: I thought you said that too ?—I am afraid I was dealing with what was asked by Lord Hambleden; did we at present restrict the treatment of patients to the Members of the Staff of the Hospital and so on, and I said we did for reasons which I gave, that the number of beds was small and I thought that that should not be in other circumstances.

371. Sir JOHN ROSE BRADFORD: I will sum up the whole thing; I want to know whether you advocate that the whole selection should rest with the patient or whether the Governing Body of the Institution should exercise some control on the class of person ?—Oh yes, without question; there is not the slightest doubt about that.

372. Mr. LOW: I think Sir John Rose Bradford has asked most of the questions I wanted to ask. There is a little difference between the £6 6s. patients and the £10 10s. patients. It is not only £6 6s. a week, but there is also a slight advantage in favour of the £6 6s. patients for those extra charges that are made ?—(*Mr. Power*): Yes.

373. You say there is no limit; you do not have any limit with regard to their income, but do you differentiate between a £6 6s. patient and a £10 10s. patient ?—Yes, we do, in the accommodation and in the extra charges.

374. Do you differentiate in the conditions of the £10 10s. patient and those which are offered to the £6 6s. patient ?—We do not know at all what their incomes are, but if they choose a £10 10s. Ward they pay slightly higher for extra services such as electrical treatment, etc.

375. I am talking of a patient who should have gone into a £10 10s. Ward and goes into the £6 6s. Ward, who gets the advantage for the conditions of a £6 6s. Ward ?—That has been possible.

376. Have you any means of checking that ?—No.

377. You do not mind if he does do it ?—(*Mr. Carling*): Oh yes, we mind very much indeed, but you know perfectly well that you

may be mistaken under those circumstances and may lose part or the whole of your fees, but you keep alive to that possibility. I do not suppose that a patient very often succeeds in deceiving you, nor do they succeed in deceiving us, and the patient who goes into a £6 6s. Ward because it is cheaper, is charged a much reduced fee by the Staff, who look out, naturally, not to let such patients into this Ward—you were referring to Hospital charges ?

378. Yes, but what I am trying to put is this ; is it left then to a member of the staff to decide whether the patient is a patient who is qualified for the £6 6s. Ward ?—Yes.

379. And that is the only check you have. If a member of the staff decides, then the patient gets the advantage of it ?—(*Mr. Power*) : That is so. (*Mr. Carling*) : And if we found out, I think we should be able to make it very uncomfortable.

380. Professor WINIFRED CULLIS : Is there any teaching done in connection with patients in a private Ward ?—(*Mr. Power*) : Not in the £10 10s. Ward, and very rarely in the £6 6s. Ward. (*Mr. Carling*) : Not without permission.

381. Are students present at an operation in surgical cases ?—They may be, but not necessarily.

382. There would be no objection to that ?—They would not come into the Theatre when an operation was being done on a private case without permission, but of course we find continually the patients do not mind in the least, if you tell them. We hold consultations with the whole staff every week, and it is quite open to a member of the staff to make arrangements with his private patient to attend such a consultation, and some patients do that, but of course it would not be done without permission.

383. I think you said that emergencies could not be taken in. Are emergencies ever taken into the General Ward and then transferred ?—Casualties, yes. If they were taken in as absolute necessities, then the members of the staff get no fees if they are afterwards transferred to the private Ward. It is an absolute rule that no fees under any circumstances whatever are accepted for anything done in the public Ward, no matter that the patient afterwards goes into the private Ward. We do not allow any fees.

384. But in the General Ward I suppose you could alter the fees paid to the Hospital even if the staff do not get any. The Hospital might take in as an emergency into the General Ward of a Hospital the class of patient who could afford to pay larger fees ?—(*Mr. Power*) : If that happens we transfer them as quickly as possible to the private Ward and then charge them the private Ward fee. While they are in the General Ward they contribute what they choose to do ; there is no charge made in the General Ward for maintenance or for treatment.

385. Then you say that the accommodation is a separate floor at the top of the Hospital building. Would that normally have been a Ward ?—No, it was erected for this purpose 3½ years ago.

386. Sir BERNARD MALLET : Have you no general idea of the sort of class of income of the people who use these £6 6s. Wards ?—Yes, I have.

387. One wants to get at the class of people to be provided for ?—The people who principally use the Wards are clergy, retired officers of the Services and professional men, I should think, with incomes of from £400 to £1,000 a year. I think that is principally the type.

388. And they would be mostly people with salaries, earned incomes ?—Yes.

389. People who would perhaps be able to pay because their pay was continuing during their illness ?—Yes.

390. People insured ?—No, not very many are. By insured do you mean the National Health ?

391. Yes.—Oh no, you see the limit of income for the National Health Insurance is £250 a year. In some cases the fees are paid by agencies and in some cases by the Services (Army, Navy, etc.).

392. Then you say clergy, retired officers and professional men ?—Yes, with incomes of from approximately £400 to £1,000 a year, and small tradesmen. (*Mr. Carling*) : The medical members of the staff find that as a matter of fact the class of patient who goes into that £6 6s. Ward, includes, at present, a proportion who do not pay any medical fees at all ; it is a nice refuge for those classes of the community who avoid paying. Some cannot pay the fees and some avoid paying them.

393. Lord SOMERLEYTON : In answer to Question No. 6 you say : " The medical staff " understand that the beds are not intended for " wealthy people." Do you think that any patients who are admitted could pay more than they do ?—Well, it is left entirely to the Surgeons and Physicians. I believe it is a fact that the Surgeons and Physicians do not charge their normal full fees for any of the patients, or very few of the patients admitted to those Wards, and I think if the medical staff understood that they could pay the full fees they would not admit them to the Private Wards of the Hospital.

394. Mr. Carling, I understand you to say that an emergency cannot be taken in under certain conditions ?—Only for the reason that the beds are always full.

395. You mean to say that a case of emergency is often brought to the Hospital and not taken in ?—Oh dear no.

Professor WINIFRED CULLIS : I believe Mr. Carling was referring only to these Private Wards.

396. Mr. COHEN : In answer to Question No. 17 you say : " The demand for this form of Hospital " service is so great and constant that the Committee " would consider the erection of further similar " accommodation if space were available. The " demand is a general one, for all forms of treat- " ment, and from all classes of the community." In the answer which you have just given to Sir Bernard Mallet you said that the income of the patients who are admitted ranges from £400 to £1,000 a year ; therefore you get a large number of applications from wealthier people who cannot be admitted ?—Yes, that is so.

397. In answer to Question No. 18 you say : " There is no definite scheme yet, but there is a " Special Committee now sitting and considering " proposals." Is it premature to ask you whether those proposals embrace the provision for accommodation for patients enjoying a larger income than £1,000 a year, and therefore presumably if the building materialises would have to pay a higher rate than 10 guineas a week ?—(*Mr. Power*) : Yes, the Committee are considering the necessity for providing beds for all classes according to the demand which we get. It is too early to say whether they would fix an income limit, but they are considering the provision of accommodation for all classes.

398. The CHAIRMAN : Do you want to say anything more before you go ?—(*Mr. Carling*) : I was wondering whether we ought perhaps to say in explanation of the answer to the last question that when Mr. Power said that the

Committee are considering the provision of beds for wealthy members of the community, that though it might sound rather curious for the lay Board of a Hospital treating the sick poor, yet they are led to it in this way: they have got demands for greater space for treating the poor and they have got to look round for a possibility of providing it, and one method of providing it which their medical Staff is putting before them, is this provision to meet other demands from the community. We think it would conceivably be possible to extend the opportunity for treating the sick poor, especially emergencies, by making some money in this way. It is a means of treating the sick poor.

The CHAIRMAN: Thank you very much; we are very much obliged to you.

(The Witnesses withdraw.)

DR. H. PRITCHARD, Senior Physician, West London Hospital, and MR. H. A. MADGE, Secretary, called and examined.

399. The CHAIRMAN: Dr. Pritchard and Mr. Madge, you represent the West London Hospital. I must thank you for the answers to the Questionnaire which you have sent in. Taking your answers to the Questionnaire I notice that the charges per week for single rooms are 5 guineas and for two-bedded rooms 4 guineas per week. Do you consider that those charges pay the Hospital?—(*Mr. Madge*): We know they do.

400. The 4 guineas as well as the 5 guineas?—Yes.

401. Can you give the average cost of these beds?—Well, after the Wing had been running six months we took out a very careful estimate of the cost, which was afterwards checked by the costing department of a very large firm, and we found it was just 4 guineas per week per patient.

402. That means that the 4 guineas just meets the cost and the 5 guineas gives you a little balance?—Yes.

403. That is charging something for rent?—Yes, we included everything that we could legitimately include.

404. Is the rent calculated on an economic basis, a percentage on the cost of the building?—Well, we had a difficulty in that, because the actual cost of the building was not a separate thing. We built it with other Wards at the same time and the cost was largely contributed by one friend of the Hospital. We did not have the contract at all; we had more or less to assume what the cost would be.

405. The reason I asked the question was that the 5 guineas a week for a room seems a small charge if you take into consideration the payment of rent; it might meet the ordinary maintenance and administrative cost, but it would hardly cover interest or rent?—Well, I can only tell you that at the time we did put in everything that we thought we could charge towards it and it was with the idea naturally to see that we were not losing money that we did that.

406. I understand that admission can only be obtained through members of the medical and surgical staff, or, in certain cases, through the Secretary?—Yes.

407. The method of admission, or rather the qualification for candidates for admission, is looked into by a Committee?—Yes, a Special Committee, every week. These application forms come before the Committee and they decide what fee ought to be paid; that is unless the fee has been agreed with the member ot the staff outside.

408. Does this Committee adopt any fixed standard when choosing candidates for admission?—When assessing fees, do you mean?

409. No, when deciding whether any one person can properly occupy a bed of this kind?—Well, the Committee looks at it in this way: Supposing you have an application from a man who has only got perhaps £150 a year, put on the form, and he has three children; the Committee then, it is very likely, would take the view that this is not a case for the paying Wing at all, and should be in the General Ward, and we should write to the person accordingly.

410. Is there any limit, any upward limit, for applicants?—Yes, in this way, that when a man's income gets up to £800 or £900 a year, the Committee then begin to look askance at that application.

411. That is to say, their view is that these beds ought to be kept for these persons of moderate means?—Of moderate means.

412. Who cannot afford either high Nursing Home fees or high Consultants' fees?—Exactly, yes. (*Dr. Pritchard*): We then take into account the charges on a man's income also. One man with £1,000 a year, might be eligible and another one with £1,000 might not be eligible.

413. I quite understand, with his liabilities?—Yes.

414. But there is no definite standard of scale?—No, each case is judged individually.

415. Then, as I understand it, the Committee fixes the fee paid to the Consultant?—(*Mr. Madge*): Unless the fee has been agreed outside, between the patient's own Doctor and the member of our staff. If that is so, that fee has to be reported to the Special Committee and approved by the Committee.

416. And no outside Consultant can get a patient in?—No, not under his own care.

417. He is not allowed to come into the Hospital?—No.

418. Is that a rule which the Committee has made, or is it a rule which has been, I will not say forced upon the Committee, but advised by the medical staff of the Hospital?—When the rules and regulations of this Wing were being drafted, the medical staff were naturally consulted, and that is one of the views that the medical staff took, and the Committee agreed to it.

419. I should rather like to ask the representative of the medical staff whether that view was taken because of the type of patient and the type of accommodation which that patient was getting, or as a matter of principle?—(*Dr. Pritchard*): I think mainly, as a matter of principle. The rule is more or less elastic, I think what we really had in our minds was this, that every patient must be under the charge of a member of the visiting staff, but if he likes to come to some arrangement with the patient's own Practitioner, the patient's own Practitioner is allowed to come in and help in the treatment, but then the member of the staff must be responsible to the Hospital for that patient. It is quite obvious some Practitioners would be quite equal to running beds in a Hospital, and others would not. It might raise difficulties with the administrative staff.

420. I understand that these beds are run quite separately from the rest of the Hospital, except so far as cooking is concerned; they are on a separate floor?—Yes.

421. And they are not mixed up with the other Wards ?—No, quite separate, a separate Wing.

422. A floor or a separate Wing ?—(*Mr. Madge*) : It is a floor in a separate Wing.

423. In your view, it is not possible to allow a number of outside Practitioners to come in and give orders to the staff of the Hospital ?—(*Dr. Pritchard*) : No, I think it would create difficulties.

424. And you think that would obtain if the class of patients and the class of accommodation was really altered, if the class of patient was more able to pay high fees and all the accommodation was in single rooms ?—Well, there are the difficulties with regard to the Nursing staff and the difficulties with regard to the house officers. It would be very hard to get the house officers to take orders from anyone except their own chief.

425. Of course there would be the Resident Medical Officer for that branch of the Hospital. I rather gather that your staff think that to run a Nursing Home on those lines in a Hospital would not be advisable, and probably not possible ? —That is the conclusion we came to after very hard thinking ; we had many committees on it.

426. Then, as regards services for which extra is charged, do I understand that all the payments mentioned in your answer to Question No. 10 go to the officer concerned or whether part of the payment is used for material and overhead expenses ?—(*Mr. Madge*) : The 5 guineas a week covers all the Hospital charges. The agreed medical or surgical fee, or the fee that has been assessed, covers the fee to the member of the staff and covers services such as radiologists, anæsthetists and pathologists and all except massage, and for massage we charge 2s. 6d. a visit.

427. These payments are for officers and not for material ?—Yes.

428. Does the Resident Medical Officer in fact receive anything ?—Not from the receipts of this particular Wing ; he is paid out of the ordinary Hospital funds.

429. He does not share in any of the Consultants' fees ?—No.

430. The average proportion of beds occupied I see is very high ; that means, I suppose, there is a waiting list ?—Yes, we frequently have a waiting list ; in fact there is one to-day.

431. Do you think there is a further demand for this class of beds not met ?—Undoubtedly. (*Dr. Pritchard*) : I think so.

432. And that is your own experience and the experience of the staff, there are more applications than you can deal with ?—(*Mr. Madge*) : Yes. (*Dr. Pritchard*) : One seldom gets a patient now who has not been waiting some time.

433. Which is the class of patient that you say generally wants this type of accommodation ?—Of course, people who cannot afford West-End Nursing Home fees.

434. Do you find, too, that the provision of this accommodation is popular in the neighbourhood ; I mean rather apart from the people who come into the beds. Does the fact that you provide this sort of what you might call moderate class accommodation make the Hospital more popular in the neighbourhood ?—(*Mr. Madge*) : I should say yes. (*Dr. Pritchard*) : Patients coming in are not confined, of course, to the neighbourhood.

435. Quite, but I suppose a good proportion of them come from the neighbourhood ?—Yes.

436. Does the General Practitioner in the neighbourhood very often come to the Consultant of the Hospital and ask him to take a patient ?—Yes, as a friendly act.

437. It is just that the General Practitioner is friendly ?—Yes, they were antagonistic at first, but I never hear anything of it now.

438. Sir JOHN ROSE BRADFORD : Are we to understand that every patient applying for admission has to make a statement as to his income ?—Yes.

439. Might I assume that there is any appreciable number of patients declined on the score of their income being higher than you think would justify admission ?—(*Mr. Madge*) : No, we have had very few cases that have had to be turned down on account of their financial circumstances, but some have been, not many.

440. I wanted to form an idea as to the demand from the more well-to-do members of the community, whether you think there is likely to be any great demand ?—You see most of the applicants come in from members of the staff, and the members of the staff would not recommend a patient to apply for admission to the private Wing if he was not in a suitable financial position ; if his income was too much, of course, he would not.

441. What is your opinion ; do you think there is likely to be any large demand for these beds from the class that is relatively well-to-do ?—You mean in preference to going into a Nursing Home ? Yes.

442. Yes ?—Well, my personal opinion would be yes. I should think if such accommodation could be provided they would probably prefer to be in a private Wing attached to a Hospital than in a Nursing Home.

443. Then, Dr. Pritchard, I understand the General Practitioners are encouraged to visit, to see their patients, but they do not really take any direct part in the treatment ?—(*Dr. Pritchard*) : Yes.

444. And they certainly do not give orders ?—No, unless that is agreed with the particular member of the staff.

445. But I mean the General Practitioner would not come in and tell the House Surgeon or Physician to do so and so ?—No, we would not have any of that. In actual practice, speaking personally, I always do my best to get the Practitioner to come into the Hospital and take an interest in the case, and once a patient is in I find they do not do it ; they get busy outside. That is in practice what happens.

446. What I wanted to get at was whether the General Practitioner visited and gave orders independently of the presence of a member of the staff ?—No, never.

447. Mr. LOW : This is exclusively for members of the staff of the West London ?—Yes.

448. Even if you were to extend the beds you would not consider the question of allowing other people of the same class to look after patients ? —Well, we have not considered it at present. The thing is comparatively new and we do revise it all from time to time ; it is quite possible one might revise it in that respect.

449. And you have not, as far as you know, heard any objection to it ?—No.

450. Professor WINIFRED CULLIS : Will you tell us the composition of the standing committee that considers these matters ; is it of the medical staff ?—It consists of the Chairman of the House Committee, the senior Physician and senior Surgeon, and I think there are two other members. (*Mr. Madge*) : The composition of the committee really is the House Committee with the two representatives of the medical staff sitting thereon together with the senior Physician and the senior Surgeon.

451. And the House Committee contains also lay people ?—Yes, there are five lay members and two representatives from the medical staff.

452. And then in addition to that you have these two others, the senior Physician and the senior Surgeon ?—As a matter of fact the senior Physician, Dr. Pritchard, is one of the medical representatives sitting on the House Committee at the moment. The senior Surgeon attends when the Committee is sitting, and the Dean of the Hospital is also one of the members of the Committee. (*Dr. Pritchard*): Actually the House Committee meets on Thursday afternoon, concludes its business on ordinary business and at once resolves itself into this Committee.

453. Then I think you said you would consider income, that there was a definite limit to the amount of income. Supposing a patient had a fairly good income and was giving an expensive education to his family, sending his sons and so on to Public Schools, would that bar him. I mean his liabilities might be very great in that way, and as a result his net income might be comparatively small ?—Well, we have not so far dealt with the class who send their sons to Public Schools; they are mostly people from the shop people class. I do not think it would bar him if he showed his liabilities were such that he could not afford a Nursing Home. I think our Committee would accept him.

454. Sir BERNARD MALLET: Is there a distinct difference between the financial position of your patients; do some of them prefer single rooms ?—No, generally on the ground of finance.

455. We heard in the case of other Hospitals that the classes were professional classes, clergy and retired officers; do you get those classes in your Hospital ?—We do occasionally, yes.

456. But mostly they are shopkeepers ?—Mostly shopkeepers.

457. What sort of income limit would you think is the limit generally; would you consider a man with £800 or £900 a year the upper limit you might put, perhaps between £800 and £1,000 ?—Yes, about that. I think most of the incomes which are returned range about £500 a year, £400 and £500.

458. And you begin with £400; that would be the lower limit ?—Very often a patient returns an income of £150, but they add a note to say that some relation is helping them to pay. That part of it is very difficult to get at.

459. Would you say £500 is rather more normally the range of income ?—Yes.

460. Would they be shopkeepers or officials, salaried people most likely ?—Yes.

461. Lord SOMERLEYTON: With regard to Question 2, weekly charges, 5 guineas a week for a single room and 4 guineas a week for a bed in a two-bedded room, do you think that the 5 guineas is enough for the single room in proportion to 4 guineas for the two-bedded room. I mean that the trouble of looking after a single room is very much greater than a double room, both nursing and service ?—I suppose it is really; it is very hard to estimate; the extra trouble is mostly nursing. (*Mr. Madge*): I should say that the charge is a fair one for the extra service.

462. The CHAIRMAN: Is there anything else you would like to say ?—No, thank you. (*Dr. Pritchard*): One thing I would like to say is, I feel myself that assessing the income part of it is the Committee's greatest difficulty, and I feel (I say it with all charity to the individuals concerned) that as a rule the thing is under-stated rather than over-stated.

463. The income ?—Yes, and I feel we have to watch very carefully the patient from doing that.

The CHAIRMAN: We are very much obliged to you.

(The Witnesses withdraw.)

MR. ST. JOHN D. BUXTON, F.R.C.S., Orthopædic and General Surgeon, King's College Hospital, and MR. C. E. A. BEDWELL, House Governor, called and examined.

464. The CHAIRMAN: Mr. Buxton and Mr. Bedwell, you represent King's College Hospital. There are one or two questions which I think I will put to Mr. Buxton first on the more professional side: Patients to the paying beds of King's College Hospital are admitted largely through the members of the honorary staff; that is to say, they come across them, as I understand, in the course of their practice, Mr. Buxton ?—(*Mr. Buxton*): Yes.

465. Either the patients come direct to them or they are sent to them by a General Practitioner, and then when the member of the staff finds that they are not very well off they recommend them to a bed in the Hospital, because in their case they cannot afford to pay ordinary Nursing Home fees, and probably not the full operation fees. Am I putting the case rightly ?—Exactly, yes.

466. In some cases, as I understand, the members of the staff do refer such cases to the House Governor, and in those cases the House Governor really acts as an enquiry officer ?—Yes.

467. Would it be true to say that in those cases the House Governor settles the fee, or only in consultation with a member of the staff ?—I should think in the majority of cases when it is referred to the House Governor, the member of the staff wishes the House Governor to arrange the fee, and in a lot of those cases, particularly of the patients who are fitted for private Wards, but too well off to go into the General Wards, it is very useful to us if a patient will say "I can "afford so much," and then the Hospital expenses are taken out of that, and if anything is left over, well, then, that is for the member of the staff.

468. That is to say, if you tell me that I must undergo a certain operation, or certain treatment, and I can afford to pay £50, or whatever it is, the Hospital deducts the cost of maintenance and any extra charges which may be charged, and the rest goes to the member of the medical staff ?—That is right.

Sir JOHN ROSE BRADFORD: That is the invariable system ?

469. The CHAIRMAN: No, that is the case of what I might call the poor patient, the poor patient who is too well off to go into the General Ward, but not well enough off to meet the Nursing Home costs ?—Yes.

470. Do you get at King's College Hospital many quite well-to-do people in the single rooms, the £8 8s. beds ?—Do you mean me personally ?

471. No, generally speaking ?—In the £8 8s. rooms I do not quite know.

472. You have not personally had many patients in the £8 8s. rooms ?—No.

473. On that I would like to ask the House Governor whether the kind of individual who goes into the £8 8s. rooms does differ much in means from the individual who goes into the £6 6s. bed or the £5 5s. bed ?—(*Mr. Bedwell*): Yes, as a general rule I should think there is a distinct difference.

474. The sort of patient who might go into a Nursing Home and pay full fees ?—Very likely, but on the other hand there is a section of the community between the private Ward patient and those who would be in a Nursing Home.

475. I should like to know, Mr. Buxton, whether in your practice, or whether you have heard from other members of the staff, that you are able to put into the paying Ward a certain number of people who, if that Ward did not exist, you would think it reasonable to put into the General Ward ?—(*Mr. Buxton*) : Most certainly, yes.

476. Border line cases ?—If they did not exist those patients would go into the general Ward, yes.

477. Without of course having a good deal of conversation about the principle of excluding all other medical men, whether they are Consultants or General Practitioners, from the treatment of the patients; the view that I understand was held strongly by the staff of King's College Hospital was that it was not advisable to admit other Practitioners, either Consultants or General Practitioners. Is that view still held, do you understand, by the staff ?—Yes ; I do not know that it is held rigidly about other Consultants, but it is about General Practitioners.

478. But I understand that the General Practitioners are allowed to visit their patients ?—That is right.

479. And I suppose they consult in the ordinary way with the Consultant in charge ?—Yes.

480. But the General Practitioner would come as an outsider, but would not be allowed to give orders ?—Yes, that is right entirely ; not allowed to give orders at all.

481. But on the other hand if he visited a patient and from his own personal knowledge, which might have extended over a long period or years, he saw something which he thought he would like to report to the Consultant, the Consultant would not be annoyed or upset because he had done so, provided, of course, that he had said nothing to the patient at the Hospital ?—No, I do not suppose so.

482. I just wanted to know what was the probable view the Consultant would have under those circumstances ?—Certainly he would take more notice of it if the patient was in a Nursing Home than if he were in Hospital, because the Consultant looks upon his House Surgeon or Physician as the General Practitioner in charge of the case during the time he is in the Hospital.

483. Do you think that the demand for these beds is increasing ?—Yes, I do.

484. You think that, although in your case you are not completely full, if there were more you would not have a greater proportion of vacant beds than you do now ?—I do not think so.

485. Do you get at King's College Hospital many cases recommended in the first instance by General Practitioners in the neighbourhood ?—Oh yes, a lot.

486. That is to say the General Practitioners in the neighbourhood have fallen in with the scheme and it is not unpopular ?—I am sure that they fall in with it much more now than they used to, but I do not know why that is. Practitioners that I know very often ring one up on the telephone and say, " Will you take this case into a private " Ward ? " without any further concern at all. They want us to deal with it and they do not want to look after it while it is in our care.

487. And you do not find, as a matter of fact, that Practitioners worry about their cases after they get into Hospital ?—No.

Sir JOHN ROSE BRADFORD: I do not think I want to ask any questions.

488. Mr. LOW : You have no upper limitations as to financial position, I understand ?—No, I do not think there is.

489. So that if this scheme were extended—I see the Hospitals do propose or suggest extending it—you might be able to take the number of patients who are really well-to-do in ?—I see no reason why we should not if we wish to.

490. In such a case as that, would the staff consider it right to limit the gentlemen who look after those patients to the members of King's College staff, or would they extend it to members of the staffs of other Hospitals ?—No, I am sure they would not extend it to members of staffs of other Hospitals. If a patient wished for further consultation, I think there is no reason why a member of the staff of King's would object to that, if he asked for a further consultation with a member of some other staff.

491. The CHAIRMAN : May I put a concrete case we had the other day. We were given, as a matter of fact, the other day, a case of a patient who came into King's College Hospital for an operation, but was under the care of a Consultant of another Hospital for another part of his body, but during the time that he was in King's College he had to be transferred to the special Surgeon for that part of his body, leaving the other out of the question. Would there be any difficulty, in that sort of case, for the two Consultants to come together ?—I think that the Surgeon of King's would look on the other man as his assistant, apart from consultation.

492. But this was a case of nose, and the other was a case of eye, and he came in for a particular operation ?—I think we feel rather strongly that this charge should be under a member of the staff of King's. We feel there is no objection to a consultation from outside, but the charge, no. The care of the patient should be under one of the staff of King's.

493. Mr. LOW : If this scheme were on a larger scale, do you think there would be no objection on the part of the General Practitioners from being excluded from looking after their patients. At the present moment there are not an enormous number of those beds and the General Practitioners do not feel it. If it was on a larger scale, the General Practitioners might begin to feel it ?—I do not think it is feasible for the General Practitioners to look after beds as we are arranged at present at King's.

494. Either with or without the Consultant in charge ?—No.

495 Professor WINIFRED CULLIS : The only point I wanted to raise was this : there seems to be rather a small number of beds occupied, 51 out of 63. You were saying, I think, you only allow treatment by the King's staff ?—Yes.

496. I see that at King's out of a total of 350 beds, you have 63 private ; in St. Thomas's they have 574 and 40 private, and they allow other Consultants to come in and treat the patients and so on. You do not think that the difference in occupation of private beds is due to the fact that you have a smaller number of ordinary beds and still limit treatment to the King's staff ?—I cannot tell you about the figures because it has nothing to do with me, but I can quote two instances in the last six weeks where, at 8 o'clock at night, I have wanted a private bed for a woman in King's and there has not been one available and I have had to put her in a Nursing Home, and I am only

one Surgeon. I merely give these as examples, sometimes one's patients have had to wait for admission.

497. There seems to be rather a high proportion of vacancies ?—I do not know what it works out at for the year.

498. If you had more you think you could still fill up the beds adequately without allowing other Surgeons and Physicians to have beds ?—My impression is, in South London we could do so.

Mr. COHEN : I see in reply to Question 14 (*b*) and (*c*), the total receipts are given as £14,727 now.

The CHAIRMAN : Yes.

499. Major WERNHER : The average stay is 17·39 ; that is considerably less than others we have been dealing with to-day. Is there any method of accounting for that ?—I should think quite a number of patients come in for examination, that is to say they come in perhaps under a Surgeon or Physician for an X-ray and various other ancillary examinations, because they would perhaps pay 15 guineas at a place like a Clinic, whereas, if they were done at the house of a Pathologist and X-ray man, it would amount to a great deal more than the patient could afford, and it is an extremely useful method of looking after these patients for those examinations.

500. They probably only stay a day ?—They probably stay five or six days, I should think. That would make a difference, and also in the throat and nose cases a large number are done in private Wards. They may be in only two or three nights, and that would bring down the average.

501. Then the other question I wanted to ask follows on what Professor Cullis was saying ; you have got three types of patient, 5, 6 and 8 guineas. Is there any one class of bed which is less occupied than the other. Do you find you cannot fill up the 8 guinea beds ?—I could not tell you that ; Mr. Bedwell will tell you that.

The CHAIRMAN : We are very much obliged to you, Mr. Buxton.

(Mr. Buxton withdraws.)

502. The CHAIRMAN : There are one or two other points I think we may ask the House Governor. (*To Mr. Bedwell*) : Perhaps you may deal with that matter of the average number occupied first of all ; the total number 63 available, and occupied 51. I suppose it is not often that there are many of those beds which are not reserved ?—No, that is so.

503. But there may be periods in the course of a year, partly owing to the fact that the patient can only be treated by a member of the staff, when there would be a few which are not reserved because of a member of the staff going on holiday ?—No, I think the main point that arises is the curious fluctuation between the sexes. For example, at the present moment it is quite easy to admit a man, and has been for the last fortnight, but there has been a great difficulty in admitting a woman.

504. Will that swing back to the men ?—Yes, it averages pretty evenly.

505. So you may have several vacant beds on the men's side and none on the women's ?—Yes. In Mr. Buxton's two cases it was impossible to get those two in, but if they had been men they could have come in straight away.

506. Of course, that would show itself in the average number of beds occupied, the larger the number of beds there are ?—Yes.

507. The heavier swing of the pendulum probably ?—Yes. Then, of course, another point is it is impossible to work private beds so hard as general beds, because one of the attractions to the private patient is he can make his arrangements beforehand, and then there must be a margin in private bed accommodation available in order that he may be able to have that bed for the time booked.

508. That is to say, you cannot take in a patient if there are three days to spare ?—Quite. At the present time we can see that the women's beds are going to be heavily occupied to the end of this month, and directly the holidays come we know that we are going to have more still coming. There is not the usual demand for men, but early this month we shall probably get those booked so that directly August comes in the male beds will be occupied as well.

509. Can you tell us off-hand what the average cost to a patient is in each of these categories of beds, without including operation fees of any kind and without including any Consultant's fees ?—The figure can be got out.* The difficulty there is from the Committee's point of view that our patients are not quite evenly distributed. It happens that the private patients' Wards are very largely used by the nose and throat and ear Surgeons as compared with other members of the staff, with the result that the expenditure per patient would probably be a larger average than, for example, in St. Thomas's Home, because of the higher proportion of tonsil operations.

510. As to the cost of these beds, is it your opinion that all these various charges pay separately, that is to say, does the 5 guinea charge pay for the 5 guinea bed, and the 6 guinea charge pay for the 6 guinea bed, and the 8 guinea charge pay for the 8 guinea bed ?—Yes. The principle always has been that the bed in the Ward shall pay the full cost with sufficient margin, so that there is quite distinctly no call upon the charitable funds of the Hospital, and that 5 guineas does do so. As regards the 6 guineas, the additional cost of the 6 guinea bed over the 5 guinea bed is not appreciable, so that there is in that case what may be fairly called a profit. In the case of a private Ward the calculation is based so as to avoid, if possible, anything that might be called a profit, the principle being that it shall only clear expenses with an ample margin. That ample margin might be called a profit, but it is not strictly profit.

511. In fact what the private patients get in a Ward is only quite a slight advantage, food and some extra Ward furniture ; is that so ?—Yes, that is so.

512. And curtains round their beds ?—Yes. The great thing they appreciate which does not cost anything is that they have their visitors every afternoon.

513. Is it ever found that a patient, having been brought into one of the 5 guinea beds, finds it difficult to stand the publicity and the certain amount of noise attached to a Ward, and prays to be put into a single-bedded room ?—Yes, that does occur sometimes, and also the converse occurs, that a patient, having been in a single room, asks that he may be transferred to a Ward, not merely on financial grounds, but on the ground

* Beds in Private Ward at 5 guineas each, £12 15s. 6d. per patient.

Do.	6	do.	16	4s. 2d.	do.
Do.	8	do.	26	16s. 0d.	do.

that it is rather dull for himself; he prefers the company he gets in the Ward, particularly in the case of men, who for some reason or other have been admitted into a Ward instead of a room. Then when the room became available they were transferred into it and they found they did not like it, as compared with the Ward, and were re-transferred back to the Ward.

514. Is it found, too, that there are a certain number of cases of people who come to the out-patients' department and who are found to be unsuitable cases for the general Ward and suitable for the pay Ward?—Who come for admission as ordinary patients and are found, upon their coming into the Hospital, that they are unsuitable, or in some cases have not any idea that there is a private Ward and are perfectly ready and willing to be admitted to a private Ward.

515. That is generally discovered after they have come to the Hospital?—After they come in, but not after they get into bed. Under the old arrangement, it used to be after they had actually been put into a Ward; now it can all be done actually before the patient gets into a bed at all.

516. What sort of type are they; are they the shopkeeper type or the comparatively small salaried middle class type?—Both.

517. Are the Wards as a rule occupied by people like clergy, retired officers or their dependents or retired civil servants?—There are distinct groups; there are people who have fixed incomes who are what are commonly known as the new poor; there are the small shopkeepers, and I should imagine probably the largest number are bank clerks and that type.

518. Smaller salaried?—Yes.

519. That would be the 5 guinea beds?—Yes.

520. You say, in answer to Question 14 (*c*): "Separate accounts cannot be kept of the expendi-"ture on these beds." As a matter of fact these beds are taken in with all the beds in the Hospital?—That is so.

521. And the average cost of those beds is the average cost of the beds spread over the whole Hospital?—That is so.

522. So that if it were possible to get an approximate figure, you have got to add the cost of a little more food and the maintenance of some additional Ward furniture?—Yes.

523. Are there any more Nurses?—No more Nurses, but there is in the case of one Ward an additional maid to assist the Nurses.

524. So that the extra cost is very small?—Very small.

525. If there were more single rooms, I take it that the extra cost would be considerable in proportion to the whole, if there were more single rooms in proportion to the whole the extra cost would be considerable?—Yes, on the assumption that the single rooms would require more nursing staff.

526. Well, there would be doors presumably, and they would not be so easily commanded and get-at-able as a Ward?—Yes.

527. I notice in Question 18, where it is asked whether there is any scheme for adding to the present number, the answer is "Yes"; how many; and the answer is "80." Well, in fact, that is hardly aptly put in that way. What is really intended is that there should be a separate block constructed for the beds of this nature, and that the beds now used for this purpose should revert to their ordinary and proper use, as it is for poor people?—That is so, yes.

528. So that really it only means an actual addition of about 20 beds?—Yes.

529. And the existing pay beds are used for their present purpose because the hospital authorities find it impossible to use them for any other purpose?—Yes, that is so.

530. Is it, in your opinion, a popular feature of the Hospital in the neighbourhood?—Yes, quite distinctly; I have no doubt about that.

531. That it is good for the Hospital?—Oh, distinctly.

532. Amongst the surrounding population?—It is a very popular thing; there is no doubt about that.

533. Sir JOHN ROSE BRADFORD: As regards No. 6, admission, I understand no inquiry as to the financial position of a patient is made?—No.

534. Have you any reason to think that any appreciable number are well-to-do?—No, there was a rough sort of understanding with the Medical Board that the figure should not exceed £1,500 a year, but it has never been laid down.

535. £1,500 a year?—Yes.

536. As high as that?—But I should imagine the number who have that income is very small indeed.

537. From your experience, do you think that, if the supply of those beds was increased, it would command the admission of the wealthy, the relatively wealthy?—The difficulty of that is that the relatively wealthy do not very much exist in the neighbourhood of the Hospital.

538. But these persons do not come in from the neighbourhood of the Hospital, do they?—Quite a good deal.

539. I thought they came from the practice of the members of the staff?

540. The CHAIRMAN: I thought Mr. Buxton said a good many came by recommendation from the General Practitioners in the neighbourhood?—I looked to the development to be rather from the neighbourhood of the Hospital. I should doubt whether there would be a great deal of development from the point of view of additional patients being brought by members of the staff.

541. Mr. LOW: We heard from Mr. Buxton just now that he had two emergencies refused lately. Do you think with 60 beds if you have got an emergency coming in you are in a position to take it?—Very nearly always; we do try to have a margin for that.

542. In some Hospitals it is difficult to get emergencies into pay beds?—If they are in a position to pay, we rather take the line that they should not be admitted into the ordinary Wards.

543. The difficulty usually is women; the beds are occupied and you cannot get a bed for a woman?—We do try to avoid that if we can.

544. Then I see that you think that your scheme would cost £60,000, that is about £750 a bed, 80 beds. Are they single-bedded rooms or so many beds in a room?—That plan is upon the basis of Wards similar to the present condition, but it does include a very substantial sum for a foundation which would not be occupied by beds; there would be a basement which would not be a Ward but a basement, and the £80,000 includes that, so that the actual bed accommodation would only cost about £65,000.

545. It works out at about £750 a bed. Is that single beds?—No, Wards with rooms attached to them as at present.

546. So there would not be very many single beds for that £60,000?—No.

547. They would be chiefly Wards?—Yes.

548. Professor WINIFRED CULLIS: Could you tell me what are the numbers in the single Ward as compared with Wards of the same floor

Mr. C. E. A. Bedwell.

space. If you had the same floor space could you get in many more beds in your Ward than you would in the single rooms ?—If the patient in a single room had the same floor space ?

549. No. Supposing you had a given space, could you get in many more than you do if the space were used in making one large Ward, rather than dividing it into single rooms ?—As a matter of fact I think by actual measurement that a patient who is in one of the double-bedded rooms has actually less floor space than a patient who is in the Wards.

550. That is what I thought very likely, so you really would not cut down the number that you would take by making single rooms ?—No, by dividing your Ward.

551. Would they use up in the single rooms considerably more space than if they were in a Ward ?—No, because there is so much space in the centre of the Ward, so that the patient there has really more space than a patient in a single room.

552. The cost of building would not be much greater if they were single rooms, because you would have your foundations and so on ?—It depends on what you use for dividing.

553. It is only the cost of the partitions really, which is a very small matter ?—Yes.

554. One feature struck me as rather uncommon with your private beds ; is not it rather an unusual proportion to have the same number of male and female beds ?—We have no choice, we have got to give up a Ward ; we are using Wards which were intended for the general patients and there are 24 beds in them and we took one Ward. We have taken two Wards for the present, and there it is, there is nothing else to be done.

555. It struck me that very likely this was the reason for the number of unoccupied beds since you will find there are more women than men in most Hospitals ?—I am afraid I have no very definite statistics, but one does get impressed by the fact that the fluctuations are pretty even in men and women, and we do go so far as to bank on it. But there is a cycle. The fact is that we have got women at present, but the probability is that at the end of August or the beginning of September we shall have more men.

556. During the greater part of the year most Hospitals find there are more women than men ?—Do they ? I thought on the other side of the Thames that the Florence Nightingale Hospital relieved the situation.

557. In one Hospital they have 21 beds for women and 15 for men out of private beds. If you had single rooms you would not be limited in the same way, you could take your patients as you wanted ?—We can only do that in the case of one or two because we reckon only to have women attached to a women's Ward and men attached to a male Ward. There are two Wards where there are men and women so that we can interchange them.

558. If you had a nursing block yon would not have that limitation ?—No, quite.

559. Sir BERNARD MALLET : Would you be satisfied with the present scale of charges. Supposing you go as high as an income of £1,400 you might charge more than eight guineas a week and make more profit ?—The difficulty would be that you would have to provide a good deal more nursing staff.

560. It would pay probably ?—It might pay to do it, yes.

561. But five guineas is the lowest you can go ?—One would like to get it down lower.

562. You told us what the class of men mostly were ?—Yes.

563. I suppose you get quite well-to-do people take a single room at eight guineas ?—Yes.

564. Mr. COHEN : In regard to Question 14 (*a*), the answer is that the charges are calculated on the basis so that the receipts cover the expenditure with a margin for administration and interest on capital. In 14 (*c*) you say that separate accounts cannot be kept of the expenditure on these beds. Therefore I think in your answer to Lord Hambleden you said you took the average for the whole of the Hospital as applicable to the patients in the pay department ?—That is so.

565. Do you think that is quite a reasonable or accurate way of doing it, having regard to what is said in answer to Question 9, where private patients have an additional evening meal and various other articles of Ward equipment are slightly different, presumably that includes china. We have had given to us by other Hospitals the actual expenditure. I do not know what the difficulty is that you experience ?—The whole of the plan has been to use Wards which normally would be occupied by general patients and they are included as part of the whole Hospital, and these items that are referred to in No. 9 are so small that it would not really be worth while to set up a system of accounting merely because of those.

566. I do not want to argue the point, but there are eleven patients in separate rooms and they are more expensive than when you have two or three patients in a Ward or in a room ?—It is very difficult to distinguish and show in which way they are more expensive.

567. The CHAIRMAN : Is there anything you want to say ?—There are two points in Mr. Buxton's remarks. I think, perhaps, the Committee may have been a little misled about the statement about inclusive sums ; those are only exceptional cases. As a general rule the patient arranges to pay the Hospital charge and arranges a fixed fee. Mr. Buxton really for the convenience of his patients is good enough to make an arrangement and say : "This is 50 guineas, "and I will pay the Hospital and take what is "left," but it is only an exceptional arrangement. Then the other thing was the reference to that very exceptional case in which the Surgeon of another Hospital was concerned. It was entirely abnormal altogether, the real difference being that the patient was a patient of an Ophthalmic Surgeon attached to the staff of another Hospital, and in the ordinary way he would naturally have referred it to his colleagues when there was an ear difficulty, he being in charge of the eye, but it happened that his aural colleague was away, and for some reason or other the Aural Surgeon attached to King's was consulted. It raised an entirely exceptional set of circumstances which were dealt with entirely out of the ordinary rules in every way.

The CHAIRMAN : We are very much obliged to you for coming here today.

(The Witness withdraws.)

(Adjourned.)

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

FRIDAY, 15th JULY, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
PROFESSOR WINIFRED CULLIS,
MR. LEONARD L. COHEN and MAJOR WERNHER (*Honorary Secretaries*), and
MR. H. R. MAYNARD (*Secretary*), being also present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.2.*)

THIRD DAY.

Dr. E. Climson Greenwood and Mr. F. Dudley Hobbs.

DR. E. CLIMSON GREENWOOD, Medical Superintendent, Hospital of St. John and St. Elizabeth, and MR. F. DUDLEY HOBBS, Secretary, called and examined.

568. The CHAIRMAN: Dr. Greenwood and Mr. Hobbs, you represent the Hospital of St. John and St. Elizabeth. We are grateful to you for the answers you sent in to the Questionnaire. What is the total number of beds in your Hospital?—(*Mr. Hobbs*): 134.

569. Of which 18 are private, or beds for paying patients?—Yes.

570. Of that 18, two are private rooms which are specially endowed?—Yes.

571. For which a patient, if selected by the special committee, pays not more than £2 10s. a week?—That is so.

572. In that £2 10s. per week all the extra charges are included?—Yes; they pay nothing more—nothing more for theatre fee or anything in the way of drugs or anything else. It is absolutely inclusive of their board, lodging and everything.

573. Does the type of patient admitted to those rooms differ from the type which comes into the ordinary beds?—I daresay, inasmuch as they are not so well off.

574. I mean, not the paying beds, but the other beds?—Yes.

575. They do differ?—Yes. (*Dr. Greenwood*): Socially they differ, of course. The object of this endowment was for ladies; if one may use the term, gentlewomen chiefly. We do not exclude men, but we do not encourage them.

576. You say that the normal charge is 8 guineas per week for the rooms?—(*Mr. Hobbs*): Yes.

577. But you sometimes receive 10 guineas, or even 15 guineas?—Yes.

578. Are these rooms intended for anybody, or are they intended for such persons as cannot usually afford the fees of a Nursing Home?—(*Dr. Greenwood*): Everybody. It is the ordinary Nursing Home fee. Eight guineas to 15 guineas would be the ordinary nursing private home fee.

579. And you would take and expect to receive the kind of patient who goes into a West End Nursing Home?—Any medical man can send his patient if we have a vacancy.

580. You have no limitations as regards income at all?—No.

581. And you would expect that the patients

who come into these rooms would pay the full Consultants' fees ?—Yes. (*Mr. Hobbs*): The Hospital, as such, has no knowledge of what the patients pay their Surgeons and Physicians.

582. That is an arrangement entirely between a member either of the staff or the outside Consultant or Practitioner who comes ?—Yes, the Hospital, as such, does not interfere at all in that.

583. To put it shortly, there is no financial qualification whatever as regards a patient ?—No, not upwards, downwards only.

584. As regards the accommodation, are these rooms all together in one block ?—No, they are not, they are scattered about in the Hospital.

585. Would it be necessary to provide special nursing for each room, or is that done in connection with the adjacent Ward ?—No; special nurses for the private rooms.

586. I see there are certain extras which private patients have to pay. I do not know whether it is possible for you to tell us the average cost per week to the patient of a stay in the Hospital ?—The average throughout the year ?

587. Yes, if you like. What one wants to do is really to compare it, if one can, with the average cost at a Nursing Home, excluding, of course, any fees to medical men ?—I have not got that with me now, but when I get back to the Hospital I can tell you exactly what we have got.

588. I think that would be interesting, as comparing it with the cost at a Nursing Home ?—Yes, private rooms.

589. This I understand is run really upon Nursing Home lines ?—That is right; it is under the sanction of the Charity Commissioners.

590. The choice of medical attendant is free, I understand ?—(*Dr. Greenwood*): Yes. In the Tetley rooms they cannot, but in the rest of the private rooms they can choose their own medical men. (*Mr. Hobbs*): Provided we know that they are properly qualified and registered.

591. Who is responsible for seeing that that particular regulation is carried out ?—The Medical Superintendent. As a matter of fact, we generally know the people of our own clientèle among the Surgeons and Physicians.

592. There is, in fact, some check upon the Medical Practitioner who comes to the Hospital ?—Yes, in fact, a little while ago a certain gentleman was told that he either had to change his medical man or he would not be able to stop in the Hospital. There was some question as to his being attended by a man who was not properly qualified in England.

593. You have a Resident Medical Officer, but he is not responsible in any way for private patients ?—Yes, we have two resident medical men.

594. Who might be called upon in cases of emergency ?—Yes.

595. But he has no general responsibility at all ?—None whatever; neither of them is allowed to see private patients, except it might be merely pending the arrival of the Surgeon or Physician in charge of the case; only in real emergency.

596. So there again the practice would be exactly upon Nursing Home lines ?—Yes.

597. I see you keep no separate accounts of the cost of those rooms ?—No.

598. But you do give us some idea as to the weekly cost in answer to 14 (c), as I understand it ?—Yes, that was a special investigation which was made, but we do not do it as a matter of routine. Owing to the fact that they are not in a separate block it is very difficult to keep them separate.

599. That was in 1923 ?—Yes.

600. It is not likely that they are more costly now, but less costly ?—I should think about the same.

601. And you think that £4 19s. 6d. per week, including administration and rates and taxes, but not rent or interest on capital, is a fair figure ?—Yes, I should think so. It must be rather problematical, because it is a little difficult to allocate things like heating and electric light and so on; you have got to guess to a certain extent when they are not in a separate block.

602. The overhead charges are rather heavier probably ?—Yes.

603. Then you look upon the beds as bringing in very considerable profit ?—Yes.

604. Can you tell us too what the average income per bed is in the course of the year ?—Yes, I could let you know that as soon as I get back to the Hospital.

605. I suppose as the rooms are scattered all over the building it would be really quite impossible to give any suggestion as to the capital cost; not even the architect could do that ?—No, I should doubt it; it would be very difficult. Some of it is a very old building and some is in the new part of the Hospital.

606. As to the demand for private rooms, you say that there is a considerable demand for private rooms for patients who can afford 4 guineas a week, but who cannot afford more. Does that mean that there is a greater demand for that class of patient than for the class that can afford anything they are asked to pay; I mean the poorer class ? Is there a greater demand for that class than for the 10-guinea class ?—I think there is a greater demand than for the 10-guinea patient. (*Dr. Greenwood*): The point is, one frequently has to take into the Ward cases who can well afford to pay 4 guineas a week with a specially modified Surgeon's fee, but could not afford to pay the 8 guineas and the ordinary surgical fee. There are a number of tradespeople. An incident occurred the other day where a patient said: "I am quite "willing to pay up to 10 guineas, but I cannot "afford to pay 8 guineas a week for a child with "adenoids and 15 or 12 guineas for the Surgeon." Supposing I am able to say: "I can put you into "a 4-guinea room and the Surgeon will do the "operation for 7 or 8 guineas," then he probably would have said, "Well, then, all right, do it." There is no doubt there is a large number of people who are able to pay about, well, half what the ordinary private Nursing Home charges, and about a quarter of what the Surgeons charge. You see the Surgeons' fees are so very very big when it comes to the question of the fees plus private rooms and nursing.

607. You could not provide, could you, separate rooms at 4 guineas and make it pay ?—(*Mr. Hobbs*): Oh, no.

608. Is it necessary for that class, that type, of case to have separate rooms ?—(*Dr. Greenwood*): No, you could have a room divided into cubicles the same as they have at other Hospitals.

609. You think that would be sufficient ?—At Guy's there is a cubicled Ward, and at the Nightingale Home they have cubicles.

610. I should like to ask you whether you think that the more expensive class of room is not so much, or an extension of them is not so much, required ?—I would not say that, because we have always got our rooms full. I may virtually say if one had more rooms to-day they would probably be full. I know two or three cases that we have

had to refuse in the last day or two. Our private rooms are virtually always in demand.

611. If you made a sufficient profit on your private beds, you could make a Nursing Home of cheap beds pay by getting the balance of the loss on the cheap beds made up from the profits on the more highly charged bed ?—(*Mr. Hobbs*): Yes, that is how it is we are able to a large extent to run free beds in the Hospital, partly on the profits which we make from the private rooms. That is why we are allowed to have them by the Charity Commissioners.

612. I gather that if you had more of the Tetley beds you would be able to pass into those beds a good many patients who come into your general beds ?—Certainly.

613. Sir JOHN ROSE BRADFORD: Can you give the Committee any rough estimate as to the number of patients who come into the Hospital from General Practitioners and others who come in from Consultants on the recommendation of Consultants ?—(*Dr. Greenwood*): Do you mean private rooms ?

614. Yes, I am only concerned with private rooms ?—Well, I should think 50/50.

615. Half and half ?—I should think so. There are certain Consulting Surgeons who always send their cases if they can.

616. But you have a large number sent by a general practitioner ?—(*Mr. Hobbs*): Local general practitioners.

617. What I want to get at, is whether the number sent by general practitioners is considerable or trivial ?—(*Dr. Greenwood*): I should think it is equal.

618. Would you tell us in what way does the general practitioner keep in touch with his patient ?—He is responsible for them.

619. When in the Hospital ?—In the Hospital in a private room. As a general practitioner, if I sent a patient into Hospital to have her or him operated upon by a Surgeon, I am responsible for that patient after the operation is performed. I should consider myself so; it is nothing to do with the Hospital.

620. No, but where does the general practitioner come in ?—It is his case still, unless he is foolish enough to pass it on to the Consultant, which he should not do. The Consultants, of course, are getting fewer and fewer, in the sense of those who only act in consultation; they are dying out, I am afraid.

621. What I want to get at is this: A general practitioner sends in a patient, and that patient is operated on, not by the general practitioner, but by somebody else. Now, what does the general practitioner do whilst the patient is in the Hospital?—Visits him daily and dresses. Unless he makes other arrangements, he is responsible for the patient.

622. He carries out the dressing ?—He carries out the whole treatment. As a rule the Surgeon operates and then hands his case over, and if he is asked to see him again he goes up and sees him again.

623. And then the general practitioner is empowered to give orders to nurses and so on ?—Oh, yes, certainly, just the same as an ordinary private Nursing Home.

624. There is no one corresponding to the position of the House Surgeon or the Resident Medical Officer in an ordinary Hospital ?—No, the only benefit here is, on emergency you have a Surgeon and Physician who can be called in at a moment's notice.

625. You are the Medical Superintendent ?—Yes.

626. What are your duties as regards pay beds ?—Oh, nothing; I have no duties as regards the pay beds, except the Tetley rooms; I am responsible for those.

627. The CHAIRMAN: Can you pounce upon an unregistered practitioner ?—Yes, that is so, but I have no authority over the private rooms. I never go near them except to make inquiries if things are all right, and if the nurses have anything to report in regard to anything irregular.

628. Sir JOHN ROSE BRADFORD: And so the patient in private rooms is entirely under the professional care of a Consultant and a general practitioner ?

(*Mr. Hobbs*): There might not be a Consultant.

Sir JOHN ROSE BRADFORD: Quite so.

629. Mr. LOW: I only want to supplement Sir John's question and you almost answered it. It is quite conceivable there may be no Consultant at all ?—Yes.

630. And the general practitioner would look after the patient entirely ?—Yes.

631. You find there is no objection to that at all, to a general practitioner looking after patients in the Hospital ?—(*Dr. Greenwood*): In private rooms ?

632. Yes, no objection at all ?—No.

633. There are Hospitals where they insist upon the patient who goes into a pay Ward, or pay bed, being looked after by somebody who is on the staff of another Hospital, and it has been urged that it is not convenient to have general practitioners; you see no objection to it ?—No.

634. And you have suffered no trouble at all in your Hospital ?—No.

635. Professor WINIFRED CULLIS: When the rooms were provided, were they converted from the use of ordinary patients, or were they specially provided ?—Some of them were the result of the building of a new theatre, which gave us three extra private rooms, because the old theatre was held in a private room, and the other rooms were all built purposely for private rooms when the Hospital was being built.

(*Mr. Hobbs*): Except those at the top of the old portion of the Hospital, which were bedrooms of the private house originally.

636. Have you any knowledge of the proportion of men and women patients in those private Wards ?—(*Dr. Greenwood*): No, I should say the large majority are women—75 per cent. at least, if not more.

637. Major WERNHER: In Question 16, the cost of this Hospital, of course the pay beds are part of the old building, and so forth, but supposing you had to supply more, would you feel justified or able to use the ordinary funds of the Hospital for providing the pay beds, or do you think you would have to get a special appeal? You are in touch with the Charity Commissioners so much, that is why I asked the question ?—(*Mr. Hobbs*): I do not know what the legal position with regard to that would be, but I should think we could use our general funds for putting up beds of such a kind; I think so. I mean other Hospitals have erected paying patients' blocks.

638. I wondered whether it was done out of the funds of the Hospital or out of a special appeal for the purpose ?—I could not say. (*Dr. Greenwood*): I should think a special appeal. There is very little chance of us doing anything without a special appeal.

639. I suppose you have not got any separate funds ?—No.

640. The CHAIRMAN: We are very much obliged to you for coming?—(*Mr. Hobbs*): I would like to say, before we go, I am not at all satisfied that the question of cost is sufficiently accurate to satisfy an Accountant, unless actual details are got from day to day. Any conclusion must be in the nature of a guess, I should think.

641. Yes, it is rather like allocating a portion of expense to out-patients?—Yes.

642. It strikes me as being rather low?—That is what I mean.

643. There is one question I should like to ask you, perhaps. Do you make any allowance for cost of extra nursing?—Oh, yes, it was taken into consideration. There again it is a little difficult with our Hospital, because sometimes we employ Nuns in the private rooms and sometimes Nurses; that also complicates the matter.

644. Are Nuns generally employed in the Hospital itself?—Yes, I should say generally, but then we have a certain number of training Sisters of other Orders who come to the Hospital as probationers.

645. And that would make the cost of nursing low?—Yes, but then sometimes we have more Sisters at the private rooms, but sometimes more paid nurses, because the number of training Sisters fluctuates very much.

(The Witnesses withdraw.)

DR. F. DEAS, Senior Member of the Honorary Staff, Nelson Hospital, and MISS E. M. PORTER, Secretary, called and examined.

646. The CHAIRMAN: Dr. Deas and Miss Porter, you represent the Nelson Hospital for Wimbledon, Merton and District. We are much obliged to you for the answers to the Questionnaire which you have sent in. The Hospital has between 50 and 60 beds, I understand?—(*Dr. Deas*): 56.

647. And in addition there are 14 beds for which payment is made?—Yes.

648. And the scale varies from 3 guineas to 5 guineas per week for those beds?—Yes.

649. Are all the beds in separate rooms?—Yes.

650. What constitutes the difference between the beds?—The size of the room.

651. And are the beds occupied principally by people who come from the neighbourhood?—Yes, ninety-nine times out of a hundred.

652. And I suppose generally recommended by local practitioners?—Always.

653. Are they occupied by people of that class who would not as a rule be able to afford the Nursing Home fees?—I think in the majority of cases they are. I daresay you sometimes get patients who could afford the Nursing Home fees, but they recognise the advantages of going into a Hospital.

654. You do not refuse patients of considerable means necessarily because they have got the means?—No.

655. I see you state that the method of admission is on the recommendation of the patient's medical attendant; but is any inquiry made by any authority in the Hospital as to the financial position?—(*Miss Porter*): No, that comes, as I say, on the recommendation of the medical attendant.

656. And you think that is sufficient?—We take that as sufficient.

657. Then do you take the opinion of the medical attendant as sufficient as to whether the patient can pay 3, 4 or 5 guineas?—Yes, he consults with the patient before booking the Ward.

658. There is in fact no Hospital inquiry; it is left entirely to the local practitioner?—Yes.

659. There are certain extra charges, I see, which are made to patients?—Yes, for X-ray, electrical and massage treatment and sunlight treatment.

660. Have you any figures which would enable you to give us the total average weekly cost to a patient?—Private patients alone?

661. Yes?—No, we keep no Hospital record for the expenditure on private patients.

662. What I meant was, not the cost of the beds to you, but the cost of the accommodation to the patient. Assuming that the patient pays 5 guineas for a bed per week, you have got in addition to that probably certain extra charges?—Yes.

663. Could you give us any figures which would show what the average weekly cost to a patient was, or the average total?—The average cost to the whole patients combined is £3 2s. 3d. That is the general Ward and private Ward combined. (*Dr. Deas*): No, I think what the Committee wants are these figures you told me just now—how much 76 patients produce.

Sir JOHN ROSE BRADFORD: What Lord Hambleden wants is what the patient has to pay.

664. The CHAIRMAN: What is the patient's bill? We can get at it from that.—(*Miss Porter*): For the six months ending the 30th June the receipts from the private patients amounted to £763 13s.; that is, taking six patients remaining on the 31st December and 70 admitted during those months, so those 76 patients have produced £763 13s.

665. About £10 a patient? You see one of the things we want to find out is, at what cost these beds can be run, in the first instance, and how much you have got to charge a patient in order to make them pay, and how that charge compares with the sort of payment which they would have to make in a Nursing Home, and, therefore, any figures of the kind I have asked for would be useful?—They are the figures; I have just brought you the receipts.

667. You do not keep your accounts separate, and you cannot say offhand whether the beds pay?—We keep what the private patients pay apart from what the general patients pay, but as regards expenditure, we do not keep separate accounts.

668. What extra do you give to private patients which would make the cost heavier?—Extra in the way of diet.

669. Any extra nursing?—(*Dr. Deas*): No, nothing extra in nursing; they get rather a superior tea set and that sort of thing.

670. More maids in proportion?—(*Miss Porter*): No, the Ward maid attends to the private Wards as well.

671. Are these rooms in one block together or are they at the ends of the Ward?—(*Dr. Deas*): All in one block. The general Ward continues on from the private Wards. (*Miss Porter*): We have a children's Ward, a men's Ward and a women's Ward, and down the corridors leading to each of these general Wards are the private Wards.

672. Do the private patients have an extra meal—dinner in the evening and that kind of thing?—Yes, they have what we call a three-course supper, which the general patients do not have; and they have a far greater variety in their diet.

673. And is their food cooked in the general

kitchen ?—All cooked in the main kitchen, but in separate utensils, and separate cooking for the private patients, but all in the main kitchen.

674. Separately cooked in the same place ?—Yes.

675. I understand that so far as the medical attendant's fee is concerned, the Hospital takes no responsibility at all ?—No, that is quite between the patient and the doctor.

676. So that really the only responsibility that the Hospital takes is in respect of nursing attendance and food. Treatment is left entirely to the outside practitioner ?—Yes.

677. Does the Resident Medical Officer act as deputy for the practitioner who is looking after the case ?—(*Dr. Deas*) *:* If he is asked to, yes, and, of course, at times of emergency.

678. The number of beds occupied seems to be rather small in comparison with those available ; is that so ? The average number occupied is 6·44 daily, and there are 14 available ; not quite half ? —Our idea was, when we built the Hospital originally, we knew from time to time extensions would come, and we hope to practically double the size of the general Ward in the next few years, but there will be no more private Wards added, and we always try to keep one on each side vacant for very bad cases, or cases that might be noisy or delirious, so that we can take them out of the general Ward and put them into a private one ; and also to keep one, the same one, in cases of any infectious disease.

679. You do use them in connection with the general Ward of the Hospital ?—Yes, and unfortunately for the last 12 months we have been very much pushed for room for the men, and we are now about to build a temporary enlargement to put in six more beds, but on many occasions this last year we have had as many as 18 general Ward male patients and only 12 beds to put them in, and they have occupied all the private Wards.

680. They would be reckoned as occupied by those patients ; you do not consider them unoccupied when they are not occupied by paying patients ?—No, those figures mean the average number of private patients that were occupying them.

681. Then if they are occupied by ordinary patients you have not counted them as occupied ? —No, we have counted those not occupied by the ordinary patients.

682. So that these beds might have been occupied by ordinary patients ?—Yes, very often they are.

683. So that the 6·44 only refers to private patients ?—That is all.

684. And private patients might have been kept waiting owing to the fact that they were occupied by ordinary patients ?—That has occurred more than once.

685. I asked that question because you say later on there seems to be a demand for further beds, and it did not seem to follow if in fact more than half of them are empty ?—No, I think that accounts for the fact that patients that we should very often take in have to go to one of the more reasonable Nursing Homes, and we make it a rule never to refuse an ordinary patient. We let them who can afford to go somewhere else, go. The ordinary patients take precedence over the private ones.

686. Do you think that the existence of these beds is a good thing for the Hospital as a whole ; does it make the Hospital popular ?—I think it does.

687. They like it ?—I have not the least doubt about that.

688. And have you found that the existence of the beds does relieve the general Wards to a certain extent ?—Yes.

689. That is to say, you get a certain number of patients who might have been taken into the general Ward who were found to be capable of paying enough to go into the private beds ?—Yes, that frequently happens.

690. Does that class of patient as a rule pay anything for Consultant's fees or outside practitioner's fees ?—If a Consultant comes down to see them very often in the Hospital they pay the ordinary fee, 5 or 6 guineas, to come down to Wimbledon.

691. And go to one of the pay beds ?—Yes.

692. But some, I suppose, would find it impossible to pay as much as that even ?—Yes.

693. Some of the ones in the 3-guinea beds, some of those patients ?—Well, one is generally able through personal friendship to get a Consultant to see them for a very modified fee.

The CHAIRMAN : Quite so ; I am not suggesting that a Consultant would not come.

694. Sir JOHN ROSE BRADFORD : As regards Question 12, I understand from the answers given that patients are usually attended in the Hospital by their own medical adviser ?— I do not know that that is quite correct ; they may be attended, but our great difficulty down there is non-recognition by the General Nursing Council because we cannot set aside one-third of our beds for purely medical work; it is only about one-seventh of them, so that six-sevenths of the work is surgical work, and what usually happens with private patients is that they are sent in under the care of one of the Honorary Medical Staff.

695. That is what I was coming to, and the second question I was going to ask: what proportion of these paying patients were treated by the honorary staff and what proportion of them were treated by outside medical officers ?— I should not think 10 per cent. of them.

696. By outside ?—No.

697. The bulk of the operative work is done by the honorary staff ?—Yes.

698. I only wanted to be clear on that point ; but it would be possible for somebody who was not on the staff to operate in the Hospital ?—Oh, yes ; I think this year we have had about half a dozen operative surgeons from London come down to operate.

699. But I did not mean that ; I meant practitioners in the neighbourhood ?—Yes.

700. They might operate ?—They might if they liked, yes.

701. Mr. LOW : I only want to amplify what Sir John has just been asking. These patients are sent in on the recommendation of the patient's medical attendant, but would you say that in the majority of instances that is a member of the staff ?—No.

702. When a patient comes into the Hospital he comes under a member of the staff ?—Yes. What happens is either one of the Honorary Medical Staff is called in, perhaps outside the Hospital, who sees the patient and says, " Well, this patient had " better come in."

703. And he then goes under the member of the staff and not under the original doctor ?—No, then the outside doctor says: "All right, you take the " patient in and do what is necessary."

704. And that patient is an ordinary pay patient under a member of the staff ?—Yes.

705. So that the member of the staff takes the

place of the original doctor who sent him in ?—Yes.

Sir JOHN ROSE BRADFORD : In some cases.

706. Mr. LOW : I understood in the majority of cases. It is only occasionally that one will see a doctor in Wimbledon looking after a patient in the Hospital himself who is not a member of the staff ?—I do not think I recollect a single one, except where they call in an outside Consultant —a Consultant from town. Then the local practitioner will come in and do the necessary dressings and that sort of thing.

707. So it is only in the case of a Consultant from London who has done an operation that the outside doctor, we will say of Wimbledon, looks after the case in the Hospital ?—Yes.

708. Otherwise it is looked after by a member of the staff in the Hospital ?—Looked after by a member of the staff, who does the necessary operation.

709. And the other doctor disappears ?—Yes, but it is purely a matter of courtesy and good feeling. Every man is at perfect liberty to come and do it if he likes, but they never do.

710. Really what they want to do is to get rid of the patient and put the responsibility on to somebody else ?—But they habitually visit them in a friendly visit for which there is no fee, and they remain in touch with them.

711. This all works easily; it works amicably ? —Perfectly.

712. Professor WINIFRED CULLIS : You say that patients of considerable means go into the Hospital ; would they pay the full medical fees to the Surgeons or Consultants ?—Yes.

713. You have no knowledge of what fees they pay ?—Not a bit.

714. But they would expect to pay the full fees ?—Yes.

715. Sir BERNARD MALLET : I see the limit is 5 guineas, and you said you did not refuse people because they have means. Have you ever thought of having a higher charge than that, from which you could make a profit ? Why was it fixed so low ? We often have cases where people pay 8 or 10 guineas ?—I think one reason was, we did not want to interfere with Nursing Homes in the place unduly. I think the only people who come into the Hospital, who can afford really big fees, are cases that are likely to want frequent attention in emergencies ; and they come in simply because there is a Resident Medical Officer, who, of course, does not exist in a private Nursing Home, and those sort of persons usually are a decent sort of people and they give a donation or something in addition.

716. Mr. COHEN : I have only one question bearing upon the scale of fees. Were the fees fixed with the idea that they would cover the expenses, or that the Hospital would make a profit out of the fees paid by the private patients ?—The main idea was that we should not lose over it.

717. But having regard to the scale of fees it may be that they did not pay the Hospital, and, therefore, private patients might come on the general funds of the Hospital ; you see the point ? —I am afraid I do not.

718. Professor WINIFRED CULLIS : May I just ask one question : You did say what the average to the patient was ?—(*Miss Porter*) : The average cost of patients was £3 2s. 3d., and our lowest private patient's fee is 3 guineas, and it is looked upon as though they had fully paid for their cost.

Professor WINIFRED CULLIS : The average receipts from a private patient that was worked out from the given figures was £3 17s. 9d.

Mr. COHEN : It well might be possible, in order to make up that average, the contributing patient in the Hospital might pay more than his share and the paying patient less than his share.

719. The CHAIRMAN : Is there anything you would like to add to what you have said ?—(*Dr. Deas*) : I do not think so.

720. You cannot tell the cost of providing the rooms, the actual cost ?—They are all part and parcel of the original building.

721. Have you any opinion as to the popularity of rooms versus wards for this kind of patient ?—Yes, I think the rooms are very popular with them; one reason, of course, being they can see their friends twice a day, whereas in the general Wards it is twice a week ; and there is also the privacy.

722. What I meant was, do you think that people like to go into a pay bed in a single room better than a pay bed in a Ward where they, so far as seeing their friends, and so forth, would be under the same conditions, but would be in an open Ward, except perhaps that they would have a curtained cubicle ?—I think they prefer the absolutely separate rooms ; I am quite sure they do while they are really ill. When they are convalescent, I think probably they would prefer a little company, but I think on the whole they prefer the absolutely private room.

723. If you were providing more accommodation you would make them single rooms ?—Yes, although we are contemplating a maternity home, and that is designed for, I think, two single rooms and one or two double-bedded rooms and four beds.

724. Have you any experience of pay beds in open Wards ? When I say pay beds, I mean Wards with open curtains ?—No. I think if you had beds in ordinary Wards just curtained off, it would probably create dissatisfaction amongst the other patients ; they would expect the same privileges, although perhaps they did not pay as much.

The CHAIRMAN : Thank you very much ; we are much obliged to you for coming.

(The Witnesses withdraw.)

THE RIGHT REV. MGR. CANON CARTON DE WIART, Administrator, St. Andrew's Hospital, Dollis Hill, called and examined.

725. The CHAIRMAN : You represent St. Andrew's Hospital at Dollis Hill ?—Yes.

726. We understand that the Hospital is designed chiefly for paying patients ?—Yes, for persons of the professional and middle classes, paying if they can, otherwise we do not mind ; we do not insist on payment.

727. But in fact the large majority of your patients do pay ?—Three-quarters pay something.

728. Patients are admitted upon the recommendation of their own doctor, but is any inquiry made into their means ? — Yes, inquiry is made. We have no Almoner, but the Matron or the Secretary inquires what the position is from the patient's medical attendant. There is a question in the form of admission which covers it, and really the only person to judge is their own medical attendant. He does not always answer the question, which makes it difficult for us, especially in the case of emergency, when, of

course, we have to take a patient very often without any inquiry at all, if the patient is really in need.

729. And you do in fact get the type of patient who can afford to pay something, but cannot afford the full fee of the Nursing Home ?—Yes.

730. And that would apply both to your patients who come into the Wards and those who go into private rooms ?—No, not those who are admitted as private room patients. We insist upon full payment from them, unless we ourselves choose, for some special reason, to put them in a private Ward, even if they pay nothing at all. We have power to do that. If a patient, for instance, is in a dying condition, or may be troublesome to patients in the Ward, or may be in a social position which requires differential treatment, we are absolutely free to put in a private room somebody even who does not pay a single penny, and we constantly do it. Also, at times, if the Hospital is overcrowded we very often put Ward patients in private rooms for the sake of the patients.

731. Do patients who pay 6 to 8 guineas a week for private rooms usually pay full fees for their Consultant ?—They must make their own arrangements ; the Hospital has nothing to do with that.

732. You do not make any inquiries ?—No ; they are supposed to be able to pay their Physician or Surgeon, and they must make their own arrangements with them independently of the Hospital.

733. I see that the beds in the Wards are open beds ?—Yes.

734. Are they divided by curtains ?—No. In the ladies' Ward we divided as an experiment two beds with curtains, a partition with curtains in front, and, as a matter of fact, we find that it is not always a success. We find that patients who ask for a cubicle, in course of time do not prefer to have a cubicle, they much prefer an open Ward. It is more convenient to them ; if there is any pleasure, or a visitor coming in, they cannot see anything. That happens very often, and with very few exceptions they insist upon a cubicle, and very often when they have a cubicle some prefer being in the open Ward.

735. Do you find that is so in bad stages of their illness ?—Almost always I should say, and very often the Physician prefers to have a patient in the open Ward for their whole treatment, for their own advantage.

736. But you have the advantage of being able, if a patient is very ill indeed, to remove that patient to a single room ?—Quite, and we constantly do it.

737. Are the patients largely surgical ? — Chiefly, yes.

738. Many of them become rapidly convalescent ?—Yes.

739. At any rate sufficiently convalescent to talk ?—Yes.

740. There are some extra services which are charged for, I see, in addition to the cost of the bed ?—In the private rooms, not in the Wards.

742. Do you know about what the cost to an 8-guinea room patient is for a week—the average cost including extras ; what would be the bill that is sent to the patient ?—It would depend on the case. Supposing the patient may want X-ray or special medicine, you may have special injections which may come to 15s. a week, or something of that sort, so you cannot tell. You may want some special surgical appliances and so on, so it is very difficult to say exactly, but we make it as little as we can, and we charge nothing for fires and things of that sort, which every Nursing Home does charge for.

743. In an ordinary case you would say they would not amount to anything like the cost of a 10-guinea bed in a Nursing Home ?—Oh, no.

744. I see that in the Wards only members of the Staff are allowed to attend patients, but in the private rooms they can choose who they wish ? —No, they must be on the Staff of a recognised London Hospital. We want to safeguard ourselves ; we do not want to allow everybody to operate.

745. Who checks that ; who checks the people who come in ?—Who come in ?

746. I mean you have a private patient in a private room and he says : I want to have So-and-so to attend upon me ?—Well, he does that on his form of admission, on his form of application, and when it is somebody we do not know we communicate with our Medical Staff at once.

747. Does the Resident Medical Officer have anything to do with the patients in the private rooms ?—If desired.

748. If desired by the Consultant ?—By the Consultant, yes ; then a guinea a week is charged on the room for his services, but he is not allowed to receive any fees personally from private patients ; he can only receive from the Consultant.

749. Are you finding that the demand for these beds is greater than the supply ?—Oh, yes. If you will allow me to just mention these figures. We are supposed to have 52 beds. In 1926 our average number of patients per day throughout the year was 53. In 1927 it was 57·138 ; in June, 1926, it was 52·167 ; in June, 1927, it was 62·3—which means that constantly we have to put up emergency beds. The Hospital is absolutely too small.

750. The emergency beds, of course, apply to the Wards ?—Yes.

751. Do you find that the demand for the rooms is also greater than you can meet ?—Yes ; at the present moment we have got several applications for rooms, and we cannot give them, although in some of the rooms we have actually Ward patients.

752. You are quite clear that if you had the rooms they would be occupied ?—Oh, decidedly.

753. I gather from you that about 25 per cent. of your patients come in free ?—Practically.

754. Mr. LOW : The only point I want to ask a question on is, you say the outside Physicians and Surgeons who send cases in are practically judged by the Staff ?—Yes.

755. Their fitness to look after the patients ?—Yes.

756. And you find that works perfectly well ; there is no trouble ?—A number of Physicians or Surgeons come regularly ; it is very seldom we are doubtful about any case.

759. As regards the general practitioner, the general practitioner does not look after the patient at all ?—Not professionally, but of course he may come and visit them, and he is always informed of the day of operation and asked to assist if he wishes.

760. But he would not be able to order any treatment for the patient ?—No.

761. That must be done either by the Consultant in charge or by the Resident Medical Officer for the Hospital ?—Yes, and the Consultant.

762. Professor WINIFRED CULLIS : I do not know whether you would like to answer this question, but supposing your Medical Staff does not think the person suggested for his treatment to be a suitable person, do you tell the patient the reason for refusing him ?—No, we do not tell the patient except in very special cases.

763. Sir BERNARD MALLET : Would you refuse anybody who you thought was rich enough

to go into a Nursing Home ?—In the private rooms, no.

764. There is no limit to income to those ?—No, not in the private rooms ; there is in the Wards, of course. We frequently take them in ; I should not say frequently, but sometimes.

765. And you only have 8 people who pay 6 or 8 guineas, so that does not make much of a contribution to the Hospital ?—No.

766. If you have these new extra rooms will you charge them more ?—No, we probably would charge less. In extra rooms we would probably charge the cost of their maintenance to the Hospital, but it is not settled yet. Probably some sort of scheme by which the medical staff would receive a fee ; it is a very difficult problem.

767. The average cost is about 4 guineas ?—About £3 15s.

768. Mr. COHEN : The answer to Question 12(c) is not quite clear : " Resident Medical Officer " available without further charge ? Yes. With " further charge ?—Yes. At 1 guinea per week." What is the distinction ? — The Wards and the private rooms. In the Wards nothing is charged for the Resident Medical Officer, who naturally does his duty, but it is charged in the private rooms

770. In connection with the general cost, do you pay your nurses, or are they Sisters ?—We have some Sisters who are not paid, and some nurses who are paid.

771. I was thinking that would reduce the actual cost to the Hospital ?—It does to some extent, yes. The Matron is not paid, and some nurses and some of the domestic staff. Nuns who are on the domestic staff are not paid.

772. Major WERNHER : Dealing with that question, it may be of interest—we have just compared the figures—that actually the nursing in this Hospital costs about a half of the nursing at a similar Hospital which does not have Sisters or Nuns ?—The employment of the Nuns means a considerable saving to the Hospital.

773. In other words, the £4 a week is a low figure when one is looking at the other Hospitals ? —Yes.

Major WERNHER : We made it about £600 a year in comparison with other Hospitals of similar size.

774. The CHAIRMAN : There was something you said just now which aroused my curiosity. You said that some of the patients got in either for nothing or at a low figure, who ought to be paying more ?—Quite frequently.

775. And you have no Almoner to make inquiries ?—No, the Matron and the Secretary do that.

776. It sometimes come off ?—To give you an instance, the other day a patient was being admitted, a lady was being admitted who pleaded poverty and who drove a motor car ; in the lane in front of the Hospital was her husband in a beautiful car waiting for her.

777. You had her, I suppose ?—You see, surely they could afford something.

778. Did she want to come into an open Ward ? —Yes.

779. That rather invites another question : Do you as a rule get members of what I call the middle classes, shopkeepers and so forth, as occupiers of these Wards ?—Oh, constantly.

780. In general they are that type ?—Yes, we have got what we call the new poor.

781. Whose incomes have shrunk ?—Yes, people who had a certain income before the war, and that income is still the same, but worth half as much ; they are the people who come to us.

782. Do you consider that the accommodation and the general service in your Wards of pay beds, as they are, is better than that of an ordinary Hospital ?—Yes, well, because they are a little more refined.

783. Rather better food ?—I think I may so say. I mean that is what our doctors think too. For instance, in some of the hospitals you get a mug and a plate ; we give every one of our patients a covered tray, which makes all the difference to a certain class of people.

784. You have a covered tray for each patient ? —Yes, and a little bed table.

785. Is the food sent up separately from the kitchen for each patient ?—No, it is sent to the Ward kitchen, where it is dealt out to every patient; there is a gas stove there.

786. Sir BERNARD MALLET : Is it entirely confined to the professional and middle classes ? —Not absolutely.

787. But that is the object of the Hospital ?— It was chiefly the object.

788. So that the expense of the whole cost of the Hospital would be an answer to Questions 13 and 14. You say, not dissected ; you might take the whole expenditure of the Hospital ?—Well, of course you must reckon, for instance, with accidents, which we are not supposed to take, but do take. We are not supposed to take them because we have only got one Resident Medical Officer, and we cannot pledge ourselves with only one Resident Medical Officer to take accidents, but we do take them. Of course we have never refused an accident so far.

789. It is mainly for this particular class ?— Yes, it is meant for them.

790. The CHAIRMAN : And over £8,000 out of your income of £10,300 is received on account of services rendered to either public authorities or patients ?—Yes.

793. Is there anything else you would like to say to us ?—Well, except that, of course with regard to No. 20, as to our extension scheme, we have got a regular scheme of extension which all deals with a new Nurses' Home. At the present moment the Hospital, the general building, takes in not merely patients but also the nurses and the maids, and the moment we can turn out the nurses and the maids we can at once open at least 14 or 15 rooms for patients. We can give accommodation for an extra Resident Medical Officer, which is most desirable, because we are always sure to have an Anæsthetist on the spot, and also we can open a Children's Ward, which is a very great necessity with us at the present moment.

794. Is there any intention on the part of your Committee to extend the Hospital for the purposes of ordinary patients, non-paying patients ?—Well, at the present moment we have not considered it, although, as a matter of fact, most of the Hospitals now take paying patients.

795. At a very much lower scale than this ?— Yes, but there are very few free patients.

796. There are very few free patients, but they average under 15s. a week anyway ?—Yes.

797. The CHAIRMAN : Thank you ; we are very much obliged to you for coming ?—I hope if some of you wish to see the Hospital, and your Lordship specially, you will come and see us.

The CHAIRMAN : Thank you.

(The Witness withdraws.)

(Adjourned.)

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

WEDNESDAY, 20th JULY, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
PROFESSOR WINIFRED CULLIS.

MR. LEONARD L. COHEN and MAJOR WERNHER (*Honorary Secretaries*), and MR. H. R. MAYNARD (*Secretary*), also being present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.*2.)

FOURTH DAY.

Dr. J. W. McNee.

DR. J. W. McNEE, D.S.O., M.D., D.Sc., F.R.C.P. (Associate Physician, University College Hospital; Physician, Royal Northern Hospital; late Consulting Physician Lewisham Hospital), called and examined.

798. The CHAIRMAN: Dr. McNee, you are an Associate Physician of the University College Hospital?—Yes.

799. You have kindly sent us in a précis of evidence describing your experience in the United States of America and Canada. You have considerable experience of American Hospital management?—Yes, I have; I was interested in the subject and saw a great deal of the paying Wings in American Hospitals. (*See* page 43.)

800. Were you yourself actually attached to a paying wing?—No, I was in charge of a "Public Service" at Johns Hopkins Hospital and was not attached to the paying Wards. I saw, however, a great deal of the work in the paying wing and knew its working arrangements extremely well.

801. You say from your own knowledge that the proportion of private or paying beds in American Hospitals is much larger than in English Hospitals?—Much larger; I am quite sure of that.

802. Is it the habit for the patient in the ordinary Ward to pay anything?—Yes, they pay, but the rate varies a great deal. I think the lowest paid—I am speaking entirely from recollection—at Johns Hopkins Hospital was 14 dollars a week.

803. Nearly £3 a week?—Yes, and even some of the negro patients paid. Everyone, however, was admitted even although they were penniless.

804. As regards the accommodation for paying beds, were they all in separate rooms?—In Johns Hopkins Hospital all were. This, of course, refers to the paying wing, and not to those in the public Wards.

805. I assume that the people who paid £2 10s. or £3 a week were giving something towards their maintenance and nothing towards their treatment?—That is so.

806. But all the people who occupied rooms would be expected to pay for their treatment?—Yes, they paid all Doctors, Nursing and Laboratory fees.

807. I do not know whether you know or whether you can tell us how those fees were graduated?—No, I really cannot. There are many rumours as to the way in which fees in America are graduated, but I have no accurate information. It is said that in the Mayo Clinic the fee is 10 per cent. of the patient's annual income, but while there I obtained no confirmation of this. It is certain, however, that the fees may be very large.

Dr. J. W. McNee.

808. It would be true to say that they would be paying as high fees as they would in a Nursing Home ?—Yes (an example was quoted in detail).

809. That was for opinion and attendance ?—Yes, for his whole treatment. This was the Physician's fee, and did not include Nursing or Laboratory charges.

810. But you do not know at all what these people pay for a room ?—No, I cannot say.

811. And you do not know whether that part of it would be graduated in accordance with their means or not ?—I think it is.

812. Then the inquiry into the financial status of these individuals was made by a person outside the Medical Staff ?—Yes, by the Social Service Staff in association with the Hospital Office Staff. There is nothing in this country exactly equivalent to the Social Service System, our nearest approach being the Lady Almoner. At Johns Hopkins this Service numbered 21 paid officials, and there were also a number of young ladies of the city who gave their services voluntary for a year or more. This service dealt, of course, chiefly with the poorer patients.

813. The poorer patients ?—Yes, but work was also done for the wealthier patients as well, especially for those travelling from long distances —hotel arrangements and so on.

814. And so the member of the staff of the Hospital had nothing to do at all, except—— ?—To treat his patient.

815. It was all done for him ?—He only had to treat his patient.

816. And he received what had been settled beforehand ?—Dependent no doubt on the length of stay of the patient, which could not be determined. He had no worry about it.

817. And the staff were quite content ?—I believe they were, but I can only speak for Johns Hopkins Hospital, which I knew intimately. With regard to financial arrangements in others, I obviously had no opportunity of becoming so familiar with them.

818. But did you hear of the same kind of system existing in other Hospitals ?—Yes, it does.

819. And you did not hear, in the course of your travels, that there was much complaint ?—No, they all seemed content, so far as I heard.

820. Does this system obtain all over the States, or was it only in the Eastern States ?—It extends all over the United States.

821. Has it driven out Nursing Homes, or did they never exist ?—I do not think they ever existed at all in the sense that we know them here. Everything only dates from the fifties and sixties of last century. I discovered only last night from Professor Meakins, of Montreal, that the first paying wing in North America was at the Royal Victoria Hospital, Montreal. Boston and Johns Hopkins followed some time later. I have no doubt that Sir William Osler, when he left Canada for the United States, influenced this development.

822. The Nursing Homes that you speak of in the Mayo Clinic, they are really Hospitals and not Nursing Homes ?—Yes, the nearest approach to a Nursing Home as I know them in England was that belonging to Dr. Barker in Baltimore. This Nursing Home, however, differs from those in England, since Dr. Barker himself employed a salaried staff of medical assistants. This brings out what I regard as one of the main advantages of the American system as compared to our Nursing Homes (*i.e.*, Doctor available at all hours, day and night).

823. In all these cases, of course, you have got a Resident Medical Officer ?—Yes.

824. Only one other question I want to ask you : Were these beds limited to those who would accept treatment by Doctors on the staff of the Hospital ?—Yes, there were, for example, at Baltimore, certain members of the staff, "full Physicians," as you might call them, who had the privilege of admitting patients to the paying wing. One or two Specialists, who were not complete members of the staff, also had similar privileges. Apart from this, nobody could admit patients to the Johns Hopkins paying wing.

825. I do not know whether there is a General Practitioner in America ?—Yes.

826. There would be no difficulty with him ?—Johns Hopkins is not the only paying Hospital in Baltimore. There is at least one other, having at least 300, and possibly 400, beds, and used entirely as a paying Hospital. There are also two Medical Schools in Baltimore, one the famous Johns Hopkins, the other and smaller one being the University of Maryland.

827. Sir JOHN ROSE BRADFORD : I understand you were in charge of what was called the Public Service ?—Yes.

827A. With regard to the patients in that Service, did the bulk of them pay—I do not mean pay you ?—Yes, the bulk of them.

828. From your knowledge of American Hospitals, are there any Hospitals there that are at all comparable to ours from the point of view of voluntary support ?—No, none. Most of the American Hospitals, such as Johns Hopkins, have very large endowments—I fancy bigger than anything we have got. In others there must be voluntary support, but the rest of the income would come from patients.

829. That is the point I want to get evidence about. The rest of the maintenance which was not derived from endowments came from the patients ?—Yes.

830. Have you any idea what sort of proportion of the patients in the Public Services paid nothing at all ; I only want to know quite roughly ?—I could not really give you any idea.

831. Do you think there were any ?—Oh, yes, there were certainly some.

832. Is it a very small number ?—I should say, if I guessed, under 20 per cent., 10 or 15 per cent.

833. As much as that ?—Yes, I should not think more.

834. It is not an exceptional thing ?—No. Around Baltimore, for example, there were certain very poor areas inhabited by white unskilled labourers, who were really, for America, very poorly paid. I do not think they could have paid anything.

835. When you went there you took somebody else's place, did you not ?—Yes.

836. I do not know who it was, and I do not want to know, but I want to ask this question : Supposing there was somebody in your position there who was not a full member of the staff—you were a full member of the staff, were you not ?—I was.

837. But you had not access to these paying Wards ?—No, I had not.

838. Supposing there was somebody in an analogous position to yours, but had not access to the paying Wards, and supposing he was in private practice, what did he do with his patients ?—Sent them to one of these other paying Hospitals, of which ample were available.

839. He then presumably would be a member

of the staff of one of those Hospitals ?—No ; those other large paying Hospitals had, so to speak, no staff except the resident staff.

840. It was rather like a Nursing Home ?—It was like a gigantic Nursing Home with its own laboratories and its own staff.

841. At Johns Hopkins there would be a certain number of the general staff who are in practice and who have not got the facilities of the Hospital for the admission of their private patients ?—That is quite true.

842. And they send their private patients to one of those other Hospitals ?—Yes.

843. You mentioned a fee of 1,000 dollars ; can you give us any sort of idea as to who fixes that fee ?—Yes, the Social Service officials, aided, I believe, by the Hospital Superintendent and his Office.

844. Do you mean to say that the Physician or Surgeon has no say in the matter at all ?—That is my belief at Johns Hopkins.

845. Is it entirely decided by laymen ?—Yes.

846. You are sure of that, are you ?—Yes, there it was ; I made inquiries about that, and I understood that that was the case.

847. Major WERNHER : Is not the Superintendent always a Doctor in America ?—Yes.

848. Sir JOHN ROSE BRADFORD : Well, it is not always laymen then ?—No, in that respect it is not ; I am glad of that correction. The Superintendent and his assistant are generally Doctors.

849. Is it a condition of appointment to the staff of Johns Hopkins that the Physician and Surgeon should agree to this arrangement ?—That I do not know.

850. Mr. LOW : I only want to ask this question : You talked about this paying Hospital at Baltimore which had nothing whatever to do with Johns Hopkins. Have you any idea where the capital came from and how it was started ; who was responsible for its finance ; was it a Company or what ?—I know very well that one Surgeon had had a great deal to do with it, but how it was started and how it was financed I have no idea.

851. It was a purely business concern ?—I believe it was a purely business concern.

852. Then, of course, leaving Johns Hopkins out for a moment, did you, while you were in America, discover—I suppose there is such a person as a General Practitioner in America ?—Oh, yes, I knew some of them.

853. Does he lose touch with his patients altogether when they get into this place ?—You must put it in this way : a General Practitioner may be in Texas or Arizona, anything up to 2,000 miles away, and he sends a patient to Johns Hopkins ; or a patient demands to go, and the doctor sends notes with the patient. He loses touch with him while he is in Hospital, but hears about him when he leaves.

854. There is not that close relationship perhaps in America between the General Practitioner and the patient that obtains here ?—No, not quite the same.

855. If I may ask your personal view, do you think it is a good or bad thing for the General Practitioner to lose all touch with the patient over these intervals when he disappears to a neighbouring State ?—It is obviously bad, but unavoidable, because of the distances there. It might be three days' travel from where the patient comes.

856. Supposing a patient happened to live in Baltimore, he would have to forgo the advantages of Johns Hopkins unless he gave up his Practitioner? —The Practitioner would be in constant touch with the physician in charge of his patient. The local General Practitioners came to Johns Hopkins a great deal, but of course, they had nothing to do with the treatment there.

857. No official control ?—No.

858. They only come in a friendly way, in an interested way ?—Yes, it was open to them, and if they liked they could come.

859. Professor WINIFRED CULLIS : Are the staff paid any fixed amount, or only in proportion to the services they have given to those paying patients ?—I could not really be sure.

860. I wondered whether there was a sort of retaining fee ?—No, I think it was done by a sort of sliding scale.

861. That it would depend on the number of beds which were in charge of a Physician ?—It depended very largely, I suppose, on the patient he had to deal with.

862. Do you know if there is any system by which they could be sure of a fairly regular income ?—That I cannot say.

863. They were doing outside work as well ?—Yes, they all had " Offices," as consulting rooms are called in America, and did outside consulting work.

864. Does the Social Service scheme you spoke of work for Johns Hopkins only, or all the Hospitals ?—No, only Johns Hopkins.

865. Sir BERNARD MALLET : Did I understand you to say American Hospitals are mostly supported by this paying system ?—Again, I would not like to say, but I fancy most of them are very heavily endowed.

866. And buildings have been given very often ? —Yes ; for example at Johns Hopkins there was the Brady Clinic for genito-urinary diseases, the gift of John Brady.

867. There is nothing comparable with our Poor Law Infirmaries ?—Yes, there is a State Hospital. I knew of one of 2,000 beds. These correspond more to our Poor Law Hospitals, and old people who cannot work and require attention may go there, as well as the sick.

868. Are they supported by the State ?—Yes, I believe so.

869. The CHAIRMAN : It might be worth noticing that according to the Report of the United Hospital Fund of New York, for the year 1922, which covers 66 Hospitals, 67 per cent. of the total income of the Hospitals was derived from payments by patients and from the City for care and treatment of public charges. That latter payment, I suppose, is made for certain patients for whom the City pays ?—Yes.

870. And that was, of course, a municipal payment ?—Yes.

871. A very large proportion of the income is for services rendered ?—Yes.

872. Mr. COHEN : You say in your evidence that the patients have to remain a long time in Hospital for convalescence, which you regard as a defect in this system, and you attribute it to the fact that they live such long distances away and there is no Convalescent Home. Are there no Convalescent Homes to which the paying patients from Johns Hopkins can be sent ?—No, a number of them used to go to Atlantic City, a famous seaside resort not far away.

873. Neither for the General Wards nor the paying patients ?—I knew of none. Obviously, anybody who had to travel back to Texas or

Arizona had to be well enough to travel three days before they could leave.

874. The CHAIRMAN: Were they kept in Hospital rather longer because of that?—They realised that it was a defect. They were saving beds by their "Out-Patient System" for well-to-do patients, as I explained in my *précis* (*q.v.*), but they were losing by having to keep people in Hospital until they could reasonably be moved.

875. Did the poorer patients come from a long distance too, very often?—No, the poorer patients on the whole, came from Maryland. I knew, however, of instances in which poor people at a long distance would spend their last pennies to reach Baltimore, and would come into the hands of the Social Service officials almost destitute.

876. Mr. COHEN: There is no kind of Convalescent Home for poor patients in connection with the Hospital?—I know of none.

877. Major WERNHER: With regard to these paying Wards at Johns Hopkins, were they all specially built as paying Wards or were they adapted?—No, this wing was built.

878. Was that given by somebody?—The "Marburg" Paying Wing was heavily endowed.

879. They paid for the building and endowed it up to a point?—I do not know how it was endowed, but I believe the whole building was paid for.

880. I suppose it is really a separate unit with separate kitchens, etc.?—Actually, it was only partly separate as regards kitchens, but that was because the main kitchen happened to be near it.

881. The CHAIRMAN: You were a patient yourself?—Yes.

882. Is there anything you would like to add to what you have said?—No, unless you wish to ask me anything concerning the type of patient, which I understand you are especially interested in, and which I refer to in my *précis* (*i.e.*, above the ordinary Hospital class, and below the Nursing Home class financially.)

884. You mean the border-line cases?—Yes, if they could not pay much they did not pay much; it all evened out.

885. Sir JOHN ROSE BRADFORD: They went into the General Ward?—They either went into the General Wards or went into the paying Wards at low rates.

886. The CHAIRMAN: But they did go into the paying Ward at quite low rates?—They could come into the Paying Wards at quite low rates. Perhaps I did not make the position clear enough. The rooms varied: there were many cubicles, and bigger rooms, and even expensive suites.

887. As far as you know, these cases which were taken into the smaller rooms and paid a small fee for maintenance would also be charged a special fee for medical treatment?—Yes, I think that was understood. I paid for being admitted there, and I chose a small room because I knew it was a small operation, but I paid for my maintenance, but I cannot remember at the moment how much it was. I tried to look up the bill, but I have not obtained it. I gave nothing for the medical treatment, but I paid for my maintenance.

888. Sir BERNARD MALLET: Had you the choice as to whether you would like an expensive room or a small one?—Yes, I chose a small one because I knew I should only be there a short time.

889. The CHAIRMAN: Of course the American has got accustomed, both patient, Physician and Surgeon, to this habit of going into Hospital?—Yes, it has grown in the last 30 years.

890. And it would be a very great change of custom if in this country Hospitals were to start paying wings for the more wealthy class of patient?—It would be quite a new scheme that people would require to be educated into.

891. I think at the same time you say in your *précis* that, in your experience, people are beginning now to realise the advantage of being in a Hospital?—Very definitely so, I believe, because they see that it is the best way for a case to be investigated and diagnosed. It really is a great risk to have a patient in a Nursing Home who requires X-ray treatment, and who may be quite ill, brought out of a very warm room and down to a motor-car and taken somewhere else.

892. Sir BERNARD MALLET: There is quite a large and growing class who like them?—Yes, there are people now who realise that a mere opinion may be of no use, and that investigations may have to be made before a proper diagnosis is arrived at.

893. The CHAIRMAN: It depends a great deal upon the advice which is given to such patients by their Consultant?—I should say to quite a large degree.

894. So that any speculation which was made in this direction by a voluntary Hospital would need support by the Consultant body?—I am quite sure it would.

895. Mr. LOW: I suppose it is only fair to say that America has never known anything else? They never had the Nursing Home system?—I think that is quite true, because it is only in the late '80s that the great American Hospitals were beginning to develop. There is, of course, a magnificent Hospital in Philadelphia nearly 200 years old, but what happened in the earlier times, I do not know.

Mr. LOW: I do not think they ever had a system of Nursing Homes or Consultants in Nursing Homes as they have here.

The CHAIRMAN: Thank you very much, we are very much obliged to you for the time you have given us.

(The Witness withdraws.)

SIR ALAN ANDERSON, K.B.E., and MR. T. DENMAN, British Provident Association, called and examined.

896. The CHAIRMAN: We are much obliged to you, Sir Alan, for your précis of evidence, and also for giving us the time. You have been connected, I think since its inception, with the British Provident Association?—(*Sir Alan Anderson*): Yes. Mr. Denman is here, who works the British Provident Association.

897. If you would like to make a general statement in addition, we should be pleased to have it.—I really have not got anything to tell you which can fairly be described as evidence; but I believe that pay beds are needed and that they can be financed. We have a certain amount of evidence which can be given to you by Mr. Denman; as our Association has been trying the business out on a "Laboratory" scale. As far as we have gone, results have conformed to the estimates on which the Association was started, but I do not myself feel that one can base anything very certain on a small scale experiment. The experience of the people running the British Provident Association (Mr. McAdam Eccles, who, since Dr. Dill died, has been the active head)

certainly shows that there is a great demand. It is perhaps worth noticing that members of the British Provident Association have very few dependants, because our members are very largely single women. My mind works in this way, that we all here think that it is better to provide Hospital facilities for the community by private enterprise than publicly, or charged on the public purse, and the complement to that idea is that we must meet our market, we must cover the trade and provide the facilities that are needed. Comparing Society with what it was a generation ago, a larger fraction of the community nowadays cannot properly be described as very poor and needing charity, or properly described as rich enough to pay for Nursing Homes and provide for serious illness without taking thought beforehand and saving money. Since the Combined Appeal, we have, through the Hospital Saving Association, taken about one-tenth of the whole population of London off the charity queue. That is something, but we have not touched this great wedge of Society immediately above the Hospital income limits, the small clerks and small shopkeepers, and all those people who need organisation and machinery to enable them to make provision. They need also to have medical services organised so that it is easy for them to get the Specialists and up-to-date examination that the very rich or the very poor can get, and that they cannot get without going round to half a dozen places; I do not myself need any specific evidence to make me think that something is needed, and that it can be done really with less difficulty than what we have already done, which is the H.S.A.

One of the great difficulties in the H.S.A. obviously was the income limit of members. We had to be very careful, and we have to be very careful that we do not admit members who ought to pay their Medical man for his work, but in this proposed scheme, members will have to pay their Medical men. That seems to me to make this scheme easier to arrange than the H.S.A., and the danger that made some of us hesitate about supporting the H.S.A. is absent from this proposal.

I think the real snag is that someone has to start a regular insurance business which will undertake to give members, when they come for benefit, a certain sum of money with which to pay for their Hospital or Nursing Home, and to do that a substantial guarantee fund or capital is needed; so when Mr. McAdam Eccles and Mr. Denman have been anxious to enlarge the B.P.A., I have always said to them: "Before you enlarge you "must make yourselves financially secure with a "working board and sufficient capital or guarantee "fund. Once the B.P.A. is put on a proper "financial basis as an insurance company, I believe "the road will be clear and it will find a large "public anxious to join."

898. You would agree, I suppose, that there are different financial classes amongst the population that you do want to serve?—Yes, but what I had in mind was that we should provide first for those immediately above the Hospital income limits, and work up the scale of incomes by degrees. The first thing to do is to get a few people to undertake the work. The King's Fund could launch the scheme better than anyone else; then the board of the new B.P.A. would look into the details and consider how many beds are wanted to start with. They could, I expect, add pay beds here and there throughout London for a long time before they got too many.

It was in my mind that contributors to this scheme might be asked to put up a certain sum of capital, say each contributor put up £10 and bought a share in the company. He would be told that on his death he could sell his share and get his £10 back, and then every year he would, of course, pay his premium. The premium to the B.P.A. is £1, and if the member wants further benefits, he pays more, and then he has to make his own bargain with his Medical man.

899. That is the point I was going to ask; what does the pound give him; what privileges does the pound give him, or benefits?—(*Mr. Denman*): That man has £4 a week for three weeks towards any Nursing or Hospital fees. (*Sir Alan Anderson*): It really gives a sum of money.

900. It does not provide anything for the payment of medical treatment?—(*Mr. Denman*): It provides three weeks in Hospital at £4 a week; for a consultation fee in the patient's own home; in addition it provides the money for a consultation in the Consultant's consulting room. It also provides for radium treatment under certain conditions, and also grants for convalescent treatment.

901. It does not pretend to provide the whole cost?—No, not the whole cost. In the case of surgical operations a subscriber who chooses may, by the payment of an additional annual subscription, cover himself, according to the tables which are set out in the Prospectus, for the Operating Surgeon's fee.

902. Is there any scale intended or agreed as to those fees?—Yes. (*Sir Alan Anderson*): As regards the number of members there is; I will hand in this paper which shows you that the number of subscribers last year was 2,411; income £2,860; costs of benefits and 10 per cent. administration, £2,668; so there was a surplus of £192. We also provide for a 10 per cent. premium to pay for insuring the extra risk, just because we have not a guarantee fund.

903. Do you find that your contributors think that what they get is sufficient when they are sick; does it certainly cover their liabilities?—(*Mr. Denman*): I have experienced this. They are rather disappointed at the meagreness of the benefits that are covered. They would like to pay a little bit more for a little bit more. The real trouble with the majority of our subscribers is this, that when they are sick they find themselves compelled to spend more money than they can afford in the Nursing Homes which are now available. They cannot get into a Hospital. Our contribution of £4 a week, which in total is only £12, does not really attract them, for the reason that, under existing conditions, it is really not sufficient. The average standard of income amongst the 2,000 people that we have got is probably very low. We have got some of substantial means but who have not enough for the purpose of covering the Operating Surgeon's fee; they just pay the subscription to the B.P.A. and the additional subscription which we ask for in order that they may cover a £100 Operating Surgeon's fee should it arise.

904. But there are a considerable number of beds already in existence although not paying beds?—Yes, and we do get a considerable number of people who use the Hospitals.

905. Do you ever get any who go into the ordinary Wards?—Oh yes, several.

906. In their case is the refund limited?—The refund is limited to £12.

907. The refund is limited to £15 total ?—(*Sir Alan Anderson*): My suggestion is that the subscriber should put up a lump sum when he comes in, to help in the capital provision of the beds, what we thought was about £10, and then he should pay his annual premium and that he should have the first call on those beds. Operating on a large scale of membership these existing premia would cover about £5 a week for three weeks.

908. That would be for maintenance exclusive of treatment ?—Yes, and what we thought was on the wholesale line these beds could be run at £5 a week for three weeks; that amount could be covered with this premium.

909. Sir JOHN ROSE BRADFORD: Did you mean £5 a week for three weeks including the medical treatment ?—No, I am leaving that outside altogether.

910. The CHAIRMAN: We find it difficult to get information about the cost of providing these beds, and we have not got any definite information yet, but I think it is rather doubtful, if anything is to be charged for rent, whether £5 would be a possible figure ?—Possibly it would not, but we thought that £5 could probably be squeezed out of this premium.

If I might go to another point, what was in my mind about launching this scheme, if you got to that point, was that we might try to repeat the method which succeeded in launching the H.S.A. You may remember that five contributors to the Combined Appeal said they would like to earmark their contributions, which amounted to £25,000, to propaganda for the purpose of starting a contributory scheme. By the use of this money the H.S.A. has been started, and now enables over 600,000 people in London to pay their way in Hospital. I hope and believe that this success would show these five benefactors what a good use we make of their money and would perhaps encourage them or someone else to help us again in the same way to organise the B.P.A., and to extend higher up in Society the good work they enabled us to start. If we can get the money for propaganda I believe the rest would follow pretty easily.

911. Sir JOHN ROSE BRADFORD: As regards the premia paid, do the bulk of your subscribers simply pay the one guinea or do they pay a further sum for additional benefits ?—I have not got the exact figures. (*Mr. Denman*): We have at present 317 who pay additional subscriptions for their Operating Surgeon's fees, out of our total numbers.

912. You have got a scheme in which you have an additional premium for increased benefits ?—Well, I have that in contemplation if this goes through.

913. I did not know whether you have a sliding scale ?—No, it is merely simple arithmetic to get that arranged.

914 The CHAIRMAN: I rather gathered that in all your proposals you do it on a purely insurance basis, and you do not bring in the payment of fees to the Consultant or Surgeon as part of the scheme. That is to say, you tell the individual that for so much premium we will give you so much cash, and you must make all the arrangements yourself ?—Yes, we do not pay the Consultant direct in any case, that is a matter between the patient and the Consultant or through the General Practitioner, and we require a General Practitioner's certificate before we pay even a Consultant's fee.

915. So that the poorer patient, as he does now, will have to make his own arrangements as to what fees he is to pay to the Surgeon or whatever it may be ?—Yes. (*Sir Alan Anderson*): The Consultant's fee is covered in the premium, but the Surgeon's is not.

916. I was speaking of the subsequent Hospital treatment. For that he will only get at any rate a sum down which may or may not cover his maintenance for three weeks. Beyond that, for any treatment that he receives he would have to make his own arrangements as he does now with the Hospital authorities, or with the Consultant concerned ?—Yes.

917. You have also a proposal for an additional premium to cover the Surgeon's fee ?—(*Mr. Denman*): That is actually in operation. The prospectus which you have in front of you provides that the Operating Surgeon's fee may be insured in accordance with the table you have there, and we limit the contributions according to the severity of the operation, and that is paid for by an additional subscription. That has been working for 18 months and there is no valid reason why that particular principle should not be carried on still further.

918. And how, in that case, is the Surgeon's fee settled ?—The General Practitioner and the patient, as now, arrange with the Consultant what fee should be paid, and then the patient himself pays and we refund.

919. According to what you say in your memorandum, 1,000 beds will serve about 15,000 patients, that is about 15 patients per bed per year ?—Yes, that is assuming between three and four weeks' stay.

920. And the incidence of illness is about 30 per 1,000 ?—I should say so, yes, as requiring Institutional treatment.

921. So that by simple arithmetic you want two beds per 1,000 to serve the subscribers ?—Yes.

922. If, as you suggest, there are 2,500,000 middle class, the middle class will require about 5,000 beds ?—Yes, I believe so.

923. Assuming you try to meet the whole demand and there are now 1,200 beds——

924. Mr. MAYNARD: Round about 1,000; the 1,200 include nearly 200 in the London Fever Hospital, which is a special class.—Of those 1,000, are not the payments in some cases equivalent to what are now received in many of the ordinary beds ?

925. The CHAIRMAN: No, very few, they are almost all a long way above the average.—But in certain cases the Hospitals get as much from ordinary patients. I dare say in some instances they get as much.

The CHAIRMAN: Very few, I should say.

Mr. MAYNARD: Especially where there are private Wards.

926. The CHAIRMAN: But there are quite a large number of 8-guinea, 6-guinea, 5-guinea and 4-guinea beds, quite a number. You do not, as I understand it, attempt to deal or think it necessary to deal with the people who are well-to-do, who can afford now to come into an ordinary Nursing Home ?—No, except in so far as they will already swell the funds available for the poorer subscribers. We, of course, welcome them as subscribers, even though they do not intend to benefit, and we have got a few like that.

927. Of course there remains the difficulty of the capital cost, and your idea is, I understand, that everybody who joins this Association should pay a sum down ?—(*Sir Alan Anderson*): Yes. But the whole scheme must of course be worked out

carefully by the men who are going to run it. I do not myself think there would be any insuperable difficulty if you have got the right people in charge.

928. Mr. LOW: Do I understand your relationship to the scheme for providing paying beds in London Hospitals, which is what this Committee is inquiring into, to be this: if those beds were provided you would be able to provide the money for a certain number of people to go into them at 5 guineas a week, but you would not have anything to do with the capital expenditure on those beds?—I do not think even that quite correctly represents it. This B.P.A., the British Provident Association, is almost a child of the King's Fund, not quite but pretty nearly, and has conducted a laboratory experiment. The people who are running it think they have proved the job can be done. I submit to you that pay beds are needed, and that they can be financed in some such way as by B.P.A. Mr. Denman, who is running the B.P.A., submits the figures of the B.P.A. to show to you what has been done on the small scale, but I think undoubtedly that if this work is to be done on a large scale the King's Fund should design and befriend and help to launch the new organisation. The King's Fund might think the B.P.A. was the right foundation to build on or might decide to start afresh. We submit what we have done so far in the hope that our experience may be of use.

929. Professor WINIFRED CULLIS: Would your scheme contemplate the provision of separate Hospitals supposing you could not get your 5,000 beds in the existing Hospitals?—We have not talked about that, but I think we would all think it very much more easy to have them joined up to the Hospitals.

930. I was wondering whether it would be possible in the present Hospitals to increase the accommodation like that, or whether you would contemplate building special Hospitals?—No, we have not talked about it.

931. Sir BERNARD MALLET: Can you tell me at all how you arrive at your figure of $2\frac{1}{2}$ millions; is it from the income tax figures, or how do you get it?—(*Mr. Denman*): No, I took it in this way; we estimated that $5\frac{3}{4}$ millions represents the present Hospital classes, and that 250,000 are well above the needs of anything we can do.

932. That is a particular case. Do you get that from super-tax figures?—No, it is almost impossible to do so.

933. Of course, the income tax figures cover the whole country?—Yes, that is the real trouble.

934. I was making a few calculations, and I wondered whether they could be checked?—If they can be checked I should be very grateful.

935. So that this result is more or less a guess?—Well, it is in one way, but on the other hand, the eight millions is not a guess. You can add also another half a million of people outside the "11 or 15 miles radius" who use the London Hospitals habitually.

936. That is outside Greater London?—Yes. That works out at 8,500,000, and that is how I arrive at my $2\frac{1}{2}$ millions, and if they were checked I should be very grateful.

(Sir Alan Anderson withdraws.)

937. I understood Sir Alan said there were no dependants at all?—The British Provident Association at the present moment makes it greatest appeal to single ladies. Immediately you bring in the whole bulk then you have got to take in families and everybody else, and there are 600,000 families approximately.

938. Professor WINIFRED CULLIS: Would the guinea include a family or is it one guinea a person?—No, the guinea is for a single person, a guinea and a half is for a married couple without children, and two guineas is for the whole family. In exactly the same way there is a reduction on quantity in the case of the additional benefit.

939. Mr. COHEN: I gathered from Sir Alan that the B.P.A. has not worked out any scheme to provide for the capital expenditure involved in increasing the accommodation for paying patients, beyond the £10 which it is suggested that each contributor should take as a capital share; is that so?—I cannot answer for Sir Alan, but my own view about it is this, that any person, irrespective of whether or not he was a member of the B.P.A., should be permitted and enabled to provide or make an offer of £10, or a multiple of £10, towards the provision of the beds, and the B.P.A. should come in to help a member to pay for a bed should he occupy one.

940. Major WERNHER: With regard to the 2,500,000, do not you think it would be a much more difficult thing to canvass these than it was with the H.S.A., because the H.S.A. might go, for example, to the Metropolitan Gas Works and get thousands of members at once, whereas it needs pretty well a house-to-house canvass to get to these people. Sir Alan suggested that once it is known, people will come to the Association and ask to be admitted, that they will more or less come to you instead of your going to them; but is that so?—I agree with Sir Alan. If the beds were provided and available, and if those beds, through joining the B.P.A., should be free for all practical purposes, the attraction would be as great as in the case of the H.S.A.

941. The trouble is they can only be provided after you have got the funds?—I do not think we ought to limit the invitation to subscribe £10 to the contributors to the B.P.A.; it should be a broadcast appeal, and the B.P.A. steps in alongside and offers its members the facilities for paying for the use of the beds which are provided.

942. Mr. LOW: Do you have any criterion of health with the people joining?—A declaration that they are, at the date of joining, in good health, and, in the case of surgical operations, we may require a medical certificate.

943. For instance, they are not likely to require an operation for the next six months?—There must be only the normal risk of surgical operations.

944. A patient might join who has got a rupture which he wants operating on?—In such a case we exclude all operations for hernia.

945. The CHAIRMAN: Is there anything further which you would like to say to us?—No thank you.

(The Witness withdraws.)

Miss M. M. CHADBURN, M.D., B.S., Senior Surgeon and Member of Board of Management, South London Hospital for Women, and Miss M. E. RIDLER, Secretary, called and examined.

946. The CHAIRMAN: Miss Chadburn and Miss Ridler, Senior Surgeon and Secretary of the South London Hospital for Women; we are grateful for your answers to the Questionnaire which you have sent in. I notice that the scale of

charges is 4 guineas, 5 guineas and 6 guineas; 4 guineas for the two-bedded Wards. Apparently the two-bedded Wards are less popular or less sought after than the cubicled Wards ?—(*Miss Ridler*): No, I should not say that at all; I should say they were probably about equal in popularity. (*Miss Chadburn*): I think the price is more popular, and the two-bedded Ward itself is less popular.

947. It is interesting to see in your answer to Question 6 that the question as to financial suitability is decided, in one case at any rate, by the Committees of four Associations supporting beds in private Wards for the use of their members, all attached to the teaching profession. Would you tell us what these Associations are ?—(*Miss Ridler*): One is known as the Teachers' League, which embraces teachers of all classes and grades; the second is the University Women Teachers' Association, which has a Hospital branch; the third is the National Union of Women Teachers Mutual Aid Fund, which supports a bed; and the fourth is the Private Schools' Association Women's Hospital Union.

948. How many beds has each Association ?—One each; a bed in a cubicled Ward is the one they are permitted to have, but any of the members who can afford an extra guinea are allowed to use a single room on payment to the Hospital of the extra guinea.

949. Have you any knowledge of the subscription which the members of the Association Pay ?—I have not any official knowledge; I think it varies in different Societies.

950. Perhaps you can tell us whether the contribution which is made covers the cost of maintenance only, or also the cost of medical treatment ?—It covers the cost of maintenance only.

951. And in each case arrangements are made with regard to the payment for medical treatment ?—Of that again I have no official knowledge; that is an arrangement made with the Medical staff direct.

952. As an officer of the Hospital you do not know what is done ?—I have no knowledge.

953. I see that in some cases in regard to other patients it is the duty of the Secretary to obtain details as to the financial status from the patient or responsible relative ?—Yes.

954. In that case do you arrange in the first place the fee which is paid to the Hospital for maintenance ?—Yes.

955. Then do you also have anything to do with the arrangement of the fee which is paid to the Consultant or the Surgeon ?—No, I do not, I simply supply the inquirer with a list of the Medical staff and leave it to the patient to make her own arrangement.

956. So in neither case does the Hospital make any arrangements with the patient for treatment ?—No.

957. I understand that so far as accommodation is concerned it is always in the shape of rooms or cubicles, with the exception of the four beds in these two-bedded Wards which can be screened off by movable screens ?—Yes.

958. Have the cubicles doors or curtains ?—Curtains.

959. Does the partition go up to the ceiling ?—No.

960. Only part of the way ?—Only part of the way.

961. Is it a wooden partition ?—Not wooden, no, it is the usual partition slab with teak mouldings.

962. So that sound is not shut off from one cubicle to the other ?—No.

963. Do you find that the patients like the cubicles ?—They are very popular, yes, they prefer them. They get the privacy of the single room without the feeling of being entirely shut away.

964. They do not feel lonely when they are becoming convalescent ?—No, they prefer the semi-privacy of a cubicle.

965. They are all women ?—Yes. They can have the curtains drawn entirely back or part way back, and keep in touch with the Nurses, or they can be entirely screened off.

966. Is there any day room where anyone can go when convalescing ?—No, there is a lounge at the end of the cubicles which is formed by having the upper cubicles placed in a lengthwise direction, so as to form a square lounge round a fireplace.

967. There are, I see, some extra charges for such things as Theatre fee and X-ray, diagnosis, and so on. Can you give us any idea what the average cost to a patient is ?—The total cost for maintenance ?

968. For maintenance and the extra fees. You might get it from the bill that you send to the patient ?—I have not quite got your question. Is it the actual cost to the Hospital of a patient ?

969. No; the average cost of the Hospital to a patient ?—That rather depends on the treatment ordered. In every operation case, there would be the Theatre fee to add, and the actual period of residence varies so very much.

970. The reason I ask is, with any extension of this system one wants, if one can, to try and get at some idea of the kind of premium which the individual will have to pay in order to insure himself against payment to be made for maintenance to a Hospital when he goes in, and it helps us if we can get any kind of average figure ?—The average payment received weekly is £4 9s. 6d. That is maintenance only; it does not include the extra fees paid. I can give you the total receipts for 1926: for X-ray £39 13s. 6d., Theatre fees, £157 10s., Massage £62 6s.

Sir JOHN ROSE BRADFORD: What we want to know is about the amount the average patient pays ?—Almost exactly £12 it averages out at for each patient.

971. The CHAIRMAN: Do you send them in accounts ?—Yes, we do, weekly accounts.

972. And they stay in about three weeks ?—Twenty days is the average stay.

973. I take it that patients, all of them, pay a reduced fee to the Physician or Surgeon ?—(*Miss Chadburn*): Those able to afford it pay a reduced fee.

974. Upon occasions the 4-guinea patients pay nothing at all ?—They may pay a consultation fee before they come in, but nothing after they have gone in.

975. Not even the extra fee for the Theatre ?—For the Theatre they do. (*Miss Ridler*): Yes. The teachers who fill the beds, very considerably, I think I am right in saying, pay no fee to the Medical staff.

976. The average number occupied, I think, is 16, which might appear rather low, as in other cases it appears that the beds are occasionally used for urgent cases from the General Ward ?—I think that was particularly the case in 1926. An unusual number of cases were transferred from the General Wards, as it was considered desirable to do so, also we had many emergencies, and we occasionally had to send a patient out quickly from a private Ward in order to take in an emergency when we had no empty bed elsewhere.

977. And when they are used in that way they are not counted as being used ?—They are not counted as being used as private Wards. They have not, for the purpose of this return, been included.

978. You reckon that your expenditure exceeds your receipts, I notice ?—Yes.

979. That may be partly the reason, the fact that the beds are sometimes used by non-paying patients ?—And partly because I think we have been sometimes compassionate and reduced the fee. We have now in the eight cubicles two patients who are not paying five guineas a week, simply because their means do not admit a payment of that figure.

980. You say that the additional or private Wards form part of a scheme of extension which has been submitted to King Edward's Hospital Fund ?—Yes.

981. But you cannot tell us what the capital cost is likely to be; you have no estimate at all as to the capital cost ?—We have not; quantities are being taken out, but tenders are not invited yet; it is impossible to give any information as to what the cost would be.

982. Are the plans in such a shape it would be possible to separate the cost of the private Wards from any other building which may be undertaken at the same time ?—No. The private Wards are really part of a scheme of extension which may not take place for another eight years or so. The idea is to provide a private Ward Unit by taking part of the present residential quarters, and combining them with the floor above the out-patients' department, which is the first portion of the scheme to be undertaken; this will admit of the present private Wards being converted into General Wards.

983. That would really point to the possibility of your being able to provide, say, before very long, figures which would show the cost of the private beds ?—No. It is intended immediately to use the Wards which eventually will be private Wards, for Nursing staff accommodation.

984. But I understand you are proposing to put up a definite block which is to be used for private beds and private beds only ?—Not a separate block. The out-patients' department is being built, and above that there are to be floors for residential quarters, and in the eventual scheme one of those floors will be included in the private Ward unit.

985. Do you find that the provision of these beds by the Hospital makes them popular in the neighbourhood; people like them ?—(*Miss Chadburn*): The private Wards are very popular.

986. Does the existence of the private Wards gain the Hospital friends or the reverse ?—Gains them, I think. (*Miss Ridler*): We have certain subscriptions which are given particularly for that special branch of the Hospital work in order that we may afford to women of limited means, wives of professional men and others, private Ward accommodation.

987. Sir JOHN ROSE BRADFORD: What is the total number of your beds ?—113.

988. General Practitioners, I take it, have no control over the treatment of the cases once they are admitted ?—No.

989. Professor WINIFRED CULLIS: How much endowment do the teachers provide to reserve those beds ?—They pay an initial sum at the beginning of each year of £50, which admits approximately of 10 weeks' treatment without any further reference to the Society. As soon as this amount is exhausted, we communicate accordingly, and receive payment *pro rata* thenceforward.

990. Have you no individual contribution ?—None at all, no.

991. Are the rates to the Hospital included in the ordinary subscription to the Association, or do the people who come in have to pay an extra subscription ?—I have no official knowledge of the arrangements made by the Associations with their members.

992. I wondered whether it was part of their ordinary subscription rates or whether they had to pay something extra ?—Not so far as the Hospital is concerned.

993. I have just had a niece who has been a resident at the South London, and I understand your private beds are practically never empty ?—(*Miss Chadburn*): Private patients' Wards are rarely empty. There is a waiting list, and those who cannot wait have sometimes to be sent elsewhere.

994. The CHAIRMAN: Is there anything which you would like to add to what you have said or to the answers you have given to the Questionnaire ?—(*Miss Ridler*): No. The Questionnaire is very comprehensive.

The CHAIRMAN: And very completely answered. Thank you very much. We are very much obliged to you.

(The Witnesses withdraw.)

(Adjourned.)

Note to Questions 799 *and* 874. *The following Memorandum was handed in by* DR. MCNEE.

1. Experience in United States of America and Canada on which my evidence is based.
   (*a*) Invited as an Exchange Associate Professor of Medicine to Johns Hopkins Hospital, Baltimore, and spent eight months there during the winter and spring of 1924-25.
   (*b*) Subsequently visited for shorter periods in 1925 many of the larger Hospitals in Eastern United States:—New York (Presbyterian, Mount Sinai, Rockefeller), Boston (Peter Bent Brigham, Massachusetts General, and Boston City), Philadelphia (Jefferson and City), Rochester N.Y. (New Eastman University), Detroit (Ford Hospital), Richmond, Va., and Rochester, Minn. (the Mayo Clinic); also Montreal (Royal Victoria and General), and Toronto, in Canada.
   (*c*) Was particularly interested in the question of Paying Wards, because of my dissatisfaction with "Nursing Homes" conditions in London. For this reason, visited every "Paying Wing" possible in America.
   (*d*) While in Baltimore had charge of a Service in the "Public Wards" only, but was very frequently in the "Paying Wing," seeing patients in consultation with other members of the staff, and knew its working intimately. I was also a patient myself in the "Paying Wing" for a fortnight, during a short illness (tonsillitis and tonsillectomy).

2. Neither the Paying Wing at John Hopkins Hospital nor at other Hospitals in America have been developed to cope with patients of strictly moderate means—i.e., patients in Britain between the ordinary Hospital class and the Nursing Home class. It is well known that all classes enter Hospital in America, and small Nursing Homes are rarer than here.

(I was only familiar in America with one Private Nursing Home, run in Baltimore by Dr. Llewellys F. Barker, for his own patients. Dr. Barker has one of the largest medical practices in America, and besides having patients in the Paying Wing of Johns Hopkins Hospital, was also able to fill a Private Nursing Home of about 60 beds. This Private Home does not, however, compare with Nursing Homes in England, since Dr. Barker had provided for himself a complete salaried medical staff of junior Physicians doing both clinical and laboratory work.)

3. There is an important point of difference between patients coming into either the General or Paying Wards of a large American Hospital such as Johns Hopkins and patients in Britain.

In America the patient often comes long distances (some came to Baltimore from as far as Texas), and they often came more attracted by the fame of the Hospital than of any individual member of the staff. Thus many patients, not specially referred to any particular member of the staff, came into the Paying Wards as " House Cases " and were distributed among the Medical or Surgical Staff apparently roughly by numbers, but also to some extent according to the known speciality or interest of the various Physicians or Surgeons.

4. The whole question of fees in the Paying Wing, for nursing, board, and for members of the staff, was entirely out of the hands of the Medical Staff, and was dealt with by the Hospital and its Social Service officers. The conditions to be met were here again quite different from those in England. Patients from long distances, either wealthy or poor, had to be met and arrangements made for their housing, etc., outside, until they could be examined and dealt with as out-patients or admitted to the Public or Paying Wards.

5. In the Paying Wing, the Physician or Surgeon never knew, unless the patient had been specially sent to him or had a well-known name, whether the patient was relatively poor or exceedingly rich. The fees to be paid were all arranged without his knowledge and came to him from the Hospital Office by (I believe) a monthly cheque. (I was a temporary salaried teacher, and the fees from my patients went to the Department of Medicine.)

Some of the above points show how inapplicable the American conditions are to those in Britain.

6. The greatest advantages of the American system of Paying Wards, as I saw them, were as follows :—

(*a*) A Resident Medical Staff was attached to the Paying Wing at Johns Hopkins (same elsewhere). This consisted of one Doctor of at least several years' experience (i.e., about the grade of a Resident Medical Officer in England) and two more-recently qualified men. One or other of these was available at any time, day or night, and all made late evening rounds.

(*b*) The patients had all the advantages of the laboratory and X-ray facilities of the Hospital, at fees on a sliding scale.

(*c*) The nursing system in the Paying Wards was the same as in the Public Wards, and staff nurses and probationers were changed about from Public to Paying Wards just as part of their training.

The only difference in nursing was that in the Paying Wards many " Special " nurses were available, to be attached to individual patients during the acute stage of illness or after operation.

(I had no special nurse while I was a patient, but I would have been better off with one. Hospital nursing in England is far better than in America.)

A few additional people were also attached to the Paying Wing only—for massage, remedial exercises, and one to look after recreations for convalescent patients—books, work, etc.

(*d*) The Doctors had no worry about obtaining or fixing the amount of fees. This avoids a constant source of worry in Britain.

(*e*) Occasionally some wealthy patients suffering from unusual or particularly interesting conditions, not commonly seen in the Public Wards, were quite willing to be shown either to the Class or to a few Senior Students (i.e., conditions like angina pectoris). This was very much appreciated.

(*f*) It was recognised that to be a House Physician or House Surgeon in the Paying Wing was an ideal preparation for the subsequent conduct of a good Medical or Surgical practice, the intellectual relationship between doctor and patient being obviously very different in the Public and Paying Wards.

7. In America very much more is done, in cases which may later have to be admitted to Public or Paying Wards for operation or treatment, before the patient enters Hospital at all—i.e., they are first treated as out-patients. Well-to-do and paying Hospital out-patients, living in hotels if they come from a distance, is of course a condition scarcely known in Britain.

This circumstance entailed at Johns Hopkins Hospital and elsewhere a far larger out-patient staff and a much better equipped out-patient department than is customary in Britain, to deal with this new class of out-patient. It saved *beds*, however, to a very great degree.

(Example. I complained once to the out-patient Physician at Johns Hopkins who was in charge of gastric and intestinal diseases that I saw too few of his patients—poor and wealthy—in the medical beds (public and private) of the Hospital. He explained, and showed to me, how all these patients were fully investigated as out-patients, and if the diagnosis involved Surgical treatment they were admitted direct to Surgical Wards for operation next day without passing through the medical side as in-patients at all.)

A defect of the system, as I saw it in America, was the long time patients often had to remain in Hospitals for convalescence. This was because they often lived so far away (several days' travel), and no convalescent Hospitals were available for their transfer.

8. I am of opinion that Paying Wards of American Hospitals are so successful because they admit wealthy patients as well as those " above the Hospital and below the Nursing Home class."

It makes the Paying Wards large, economically possible, and seemed very satisfactory to Hospital authorities, patients, and staff alike. Incidentally it gave many wealthy people a great individual interest in a Hospital rather than in some obscure Nursing Home, and brought many large subscriptions and subsequent legacies.

The attitude of mind of the American towards his illness and Hospital treatment is of course very different from what obtains in Britain. But I notice in my private practice a change of opinion, and many well-to-do patients frankly state they would far rather go into a Hospital for investigation and treatment than into a Nursing Home, which they dread, and there their treatment is often less satisfactory both to them and their Doctor than in the Public Wards of a Hospital.

I am of opinion that while there is an obvious immediate need of beds for patients in the stratum just above the so-called Hospital class in Britain, it would be far sounder on all grounds—economic and other—to try to plan our course in future for Paying Wings of Hospitals for all classes of patients, from the relatively poor to the very wealthy.

It has been pointed out to me that many of the London Hospitals are in poor and unattractive parts of the city, and that paying patients might dislike being there in consequence. It is evident that a new attitude of mind might have to be gradually created. Johns Hopkins Hospital, although its site is on the whole attractive, is in a poor part of the City and close to a negro quarter. The same holds for other Hospitals in America with flourishing Paying Wards.

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

WEDNESDAY, 27th JULY, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
MAJOR WERNHER (*Honorary Secretary*), and MR. H. R. MAYNARD (*Secretary*), also being present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.*2.)

FIFTH DAY.

MR. C. H. THORPE, Joint Honorary Secretary, Freemasons Hospital and Nursing Home, called and examined.

995. The CHAIRMAN: You represent the Freemasons Hospital and Nursing Home?—Yes.

996. We are obliged to you for the letter which you have sent in—I am sorry that I have no Medical representative here, but I was not able to arrange it. Sir D'Arcy Power, who is the Chairman of our Medical Committee, has been abroad and only got back on Monday night, and I have not been able to see him, but I shall see him this afternoon. I think it is quite likely that, if you wish to see a member of our Medical staff it could be very easily arranged.

997. I gather that the beds are intended for people of quite moderate means?—Yes, quite; as a rule our patients are General Hospital patients if they do not come to us. We have watched them very closely over the years we have been open, and when we receive applications and they fail to get into our Hospital owing to it being full, they practically, in 9 cases out of 10, go to a General Hospital, and they are the very class of patient, I suppose, you are enquiring about, the people who are wanting to pay their way according to their means, and do not want to take absolute charity at the public Hospitals, if they can help it.

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998. Do they as a rule pay something for fees?—To the Surgeon?

999. As well as for maintenance?—Oh, yes, and they do that on a scale. I have given you an article which appeared in the "Lancet" on July 17th, 1920. Just about that time—I do not want you, if you do not mind, to take this as absolutely correct from me—there was a scheme mooted for starting an Institution somewhere in the West End of London for paying beds and nothing else. It was rather on a large scale, and there were several very prominent business men connected with it, and I think Mr. de la Rue was one of them, but I am not quite sure about that. The negotiations went on for some time, and I fancy that that is the Institution which is referred to in this article; there they speak somewhere of business people having carefully gone into this question with the Medical world.

1000. Sir BERNARD MALLET: It was not actually started?—No, it fell through.

1001. The CHAIRMAN: Is not it the fact that it was worked out in connection with Mr. de la Rue's own business?—I do not know that; there might have been some suggestion of that sort at the start. There is a reference there which possibly might have some bearing upon it; there is a reference referring to business firms and the needs of their people.

1002. So far as the Hospital is concerned, how

do you arrange with the various Consultants and the patients in the Hospital to agree on this scheme ?—Well, first of all the members of our staff had this before them and it was considered by our Medical Advisory Committee long ago. First of all there was a general idea of working on some such lines as these, but at the time this article appeared they had copies of it before them and the Medical Advisory Committee considered it, and the staff thought it was a fair arrangement, and then it was left to us as regards the practical working. That is so far as concerned our own staff, but in our Institution we also take in any case under another Surgeon. Every patient can have his own Surgeon or his own Physician, provided he is in consulting practice, and in such cases we do not interfere with the fees at all; we leave them to arrange it, and that brings in again just the practical difficulty that I think you would find the Medical world feel in this matter, and that is that there is a minimum below which even if a local Doctor asks a Surgeon to reduce his fees he cannot do so, not directly with the patient.

1003. That is to say, that amount or nothing ?—That amount or nothing, and this scale helps to fill the gap. The Surgeon is unable to go below these fees, but I think that they do recognise that the need for this class of accommodation exists below that level, and, provided that they have not the actual financial negotiations and they can leave it to somebody to do for them, they are quite willing to recognise the need for filling up the rest of the gap. When I say we leave a patient to make an arrangement with his own Surgeon, that is not working on these general lines, because in such cases we do not know what the line is. But we have latterly offered to deal with a patient for any Surgeon who wants to send in a case, not merely one of our own staff; there is a certain proportion of operations done by Surgeons who are not on our staff, and now we are willing to arrange the fees, but in that case we should draw the Surgeon's attention to this article, and we should ask him if he agreed with it, and say that if he would leave it to us we would arrange on some such basis as that. He has nothing to do then with the financial transactions; we render a quarterly account to our Surgeons or Physicians, and it is done in that way.

1004. Have you anything in the nature of an Almoner ?—No, with us an Almoner might be a little difficult. Being a Masonic Institution, there being a little, call it a kind of Masonic feeling if you will, they probably would not like the idea of a lady asking these questions, and that is done in our secretarial department by our Secretary. In the ordinary Hospital the secretarial department or the Lady Almoner would be the person to do it.

1005. I understand that you consider that all the staff are really bound by the scale which is set forth in this paper ?—Yes.

1006. Do they agree to the scale set forth in this paper ?—Yes, that is so.

1007. And that in some cases outside Surgeons or Physicians do come to your Committee and ask you to have their fees settled ?—Yes, that is so.

1008. In that case they are shown this scale ?—Yes, they would be shown this scale.

1009. And, as a rule, they are prepared to adopt it ?—Yes, I do not know that we have ever had a refusal where we have been asked to arrange fees because a Surgeon found a little difficulty himself. Perhaps the patient wants to come into the Institution on these lines, and the Surgeon has then asked us to deal with it, and we have then shown him this and he has said "Yes, that "is all right," and left it at that.

1010. Do you know what proportion of patients come in under your staff and what under outside Consultants ?—I should say probably about one-third of our operations. In our little Hospital we had just under 600 patients in last year and about 540 operations possibly, and about one-third of those would be done by Surgeons not on our own staff. We have had a very large number of Surgeons who are not on our own staff, at one time or another.

1011. The charge that you make to patients is 3 guineas a week ?—The normal charge is 3 guineas.

1012. Do you ever make a higher charge ?—Yes. If you look at the circular under the head "Charges to Patients," that will give you the whole of the information about the Wards; it is intended for patients to see. The last part of (1) will require modification, as that is an old circular now, and when it is re-printed we shall have to word it somewhat differently. It reads: "But in such cases he will make his own arrange-"ments with the Surgeon and Anæsthetist in "regard to fees for operations, etc., direct." That is no longer absolutely necessary. We are prepared to do it ourselves, so that wants some slight modification.

1013. That is in the case of people who pay more than 3 guineas ?—No, that is in the case of an ordinary patient. Class I is the class for which our Institution is provided. Perhaps if a patient is not able to afford to pay 3 guineas a week and perhaps 10 guineas fee to the Surgeon, but finds he can pay the bulk of it, or two-thirds of it, then on this second paragraph we assist him from a fund which we call our Samaritan Fund. In paragraph 3 there, we are dealing with the rather, shall we say, superior classes financially; that is those who do not come strictly within the General Hospital provision, and then we take them, provided there is accommodation. We stand very strictly by that. We should not admit anybody under this third paragraph if there is a rush for our beds, and if there are people wanting to come in under the first or second paragraph; but where it is possible to take them in we do. We may do more in this way in the future. There we are dealing with people who perhaps would not have to go into a General Hospital if they did not come to us, but who find probably very considerable difficulties as regards their financial position; they are getting near the kind of case which goes to St. Thomas's or Guy's, and there you see we ask them to pay a charge which is commensurate with cost, and they must entirely make their own provision for the Surgeon's fee. In this way, we deal with applications from people, probably, who can pay perhaps £30 or £40, and it is quite likely that that can be arranged by the local Doctor when he writes to the Surgeon and says: "This is a patient who cannot afford to pay your "ordinary fees; will you do it for so and so."

1014. You have an idea that that class of accommodation for that class of patient can be extended ?—I think most undoubtedly, when we expand our own Hospital, and there is a very considerable field there, just as there is under that first clause, a large field.

1015. What do you charge them a week ?—We may charge them 5 or 6 guineas a week when we take them; they are very few as far as

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we are concerned. If we were willing to do so we could have a large number, but we have very very few as far as our ordinary transactions are concerned.

1016. Then you are quite clear in your own experience that there is a demand, an increasing demand, for this class of bed ?—Most undoubtedly. If I might be allowed to speak generally, and not so much with regard to our own Institution, we feel that there is a very large demand. I should not like to speak so confidently about the big General Hospitals in London, though no doubt there are plenty of people who can speak for them, especially the Surgeons. This I can say, I am quite sure that round about the fringe of London, and any big centre, there is a very big demand. I will give a particular instance, if I may; that is the King Edward Memorial Hospital at Ealing, which has a few beds working on these lower lines, where they are limiting their patients to about £500 a year income, and I suppose the charges by their Surgeons would be somewhere about 20 or 25 guineas. I am only talking of what I have heard, of course. There is undoubtedly a considerable demand for that kind of accommodation, and especially where the local Doctor can look after his case. Now there, there would be no difficulty, but I do not know how that same arrangement would work in a big General Hospital where you have got a large number of House Surgeons on the staff, whether it would be possible for a local Doctor; perhaps he might not be able to do it, even if he were in the neighbourhood. We do not very often come up against that problem because we draw our patients from a very large area, and it is very rarely we are concerned with a local Doctor. We should allow him to come in, and in the few cases where we have been asked to do so, he has come in and looked after his case, but in that case there is no divided authority; he takes charge of his case and our own Resident Doctor has nothing whatever to do with it.

1017. Except in cases of emergency ?—Oh, in cases of big emergencies, certainly, anything of that sort, and so it would be with some of these Hospitals such as I am speaking about round the fringe of London, and I believe it would apply in many large towns as well. I know at Ealing the local Doctor is allowed to go in and look after his cases, and the House Surgeon has, normally speaking, nothing to do with it. That is rather an interesting feature in the field of demand which exists.

1018. One, I think, which would probably be found in many of the Cottage Hospitals ?—Yes, I am sure it would.

1019. As regards cost, I do not know whether you can help us a little; I am not sure whether in this letter you suggest what it is ?—Well, I did not, but I said we would very gladly give you any information you wanted. I did not give that because it would not have helped you very much for what you are asking about, which I take it is the ordinary Hospital; you see, we run our Hospital on different lines altogether. First of all, we have nobody there who is not a fully trained Nurse, and they have got to be paid accordingly; we pay our Nurses £70 upwards, with about £20 or £25 for allowances of various kinds, and so, of course, the Nursing cost is very much above what it would be if we were able to train our own Nurses, because they have necessarily got to do what they describe as Probationers' work. Again, all through our Hospital we have the system of curtained cubicles, and the general system of living and the way in which the food is served—I am not saying, of course, anything against the General Hospital in any way—but we do it all on more of a Nursing Home scale, and the consequence is that our costs increase very considerably, and with a little Hospital of 46 beds it is an expensive Institution to run. We shall get those working costs very much lower, but at the present moment it is just what Sir Arthur Stanley said it would cost, that is about £6 a week.

1020. Is that charging anything for interest on capital ?—That is not charging anything for interest on capital; that is the normal cost of running a bed in our Hospital, and we think that when we have got our Hospital established and when we have got a new Hospital, when we are in conjunction with other Institutions and perhaps training our own Nurses, and we are able to work on a larger scale, the kitchen staff, for instance, will not be proportionately so expensive, and so with the administrative staff and the general clerical staff, and we think we shall get the cost down substantially. Sir Arthur Stanley at the time that we were starting this place, before we opened, said that we should find, from his experience and from the information that he had been able to gather, it would cost us about £6 a week, and he was quite right; that is just about what it does cost. We have looked carefully into the matter of keeping the cost down as if we had been an ordinary Hospital; we keep our accounts for private use on the King Edward's Fund lines, and if you would like any information in detail on those lines, we are quite in a position to give it to you, although we do not put our accounts in that form.

1021. Do you find that the cubicle system is popular, the curtained cubicle ?—Yes, I think so, and I think you will find, if you ask our Surgeons on that matter, that you will get some rather interesting information there. Our original idea, when we were first talking about this scheme in 1912, was to have small Wards of one bed or else to have the place divided up into cubicles more on the lines of St. Thomas's Home, with side walls and curtains along the end. That we should probably have done had we built a place at that time, but we took over at the beginning of the War the old building of the Chelsea Hospital for Women, which is the one we have got now, and consequently after the War, when building costs were very high, we thought we had better stop there and prove ourselves there, and so we were driven to the cubicle system. Now the Surgeons, I think, like it, and they like it for this reason—they would like more single-bedded Ward accommodation than we have got, to put a patient in just after an operation, and to put a patient in, of course, if he is dying or if he is very very ill. But I think in experience the Surgeons would tell you that they have found our cubicle system most helpful in the way that the more convalescent patient unconsciously encourages the patient who is not so well. If we were able to put them into a small single-bed Ward in the first instance and then move them out after a few days into the cubicle system, that would be practically ideal. As far as the patients with us are concerned, we find that most helpful, because naturally there is a little link between the patients in the Hospital and they rather like the system.

1022. I understand they are practically all members of the Masonic craft ?—Yes, they are, or their wives and children.

1023. Mr. LOW: You do not make any appeal to a public fund at all ?—No.

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1024. It is done entirely by Masonic grants ?—Yes, entirely.

1025. I suppose a number of patients ask to come into the Hospital direct to the Hospital itself and not through any members of the Staff; they simply wish to come to the Hospital ?—But, of course, they come through their Doctors.

1026. Through an outside Doctor ?—Yes.

1027. Then you apportion them to a member of the staff ?—If it is one of the cases where the Doctor is leaving it to us to do, in practice the Doctor would ask for a list of the staff. He would receive our little booklet with the list of the staff, and he would say if he wishes to come under any particular Surgeon. If he has no preference it would be allotted on the rota. For instance, we have three General Surgeons; Mr. Arthur Evans, Mr. Tyrrell Grey and Mr. Duncan Fitzwilliams, and cases would go to them on the rota in turn.

1028. As regards the wealthier people that you referred to, the people mentioned under paragraph 3, you propose to extend that class if you can, I understand ?—Yes, to some extent.

1029. You say at present that you have no difficulty with the General Practitioners; the General Practitioners do not mind losing sight of their patients ?—No, because, you see, they come from a big area. For instance, yesterday I was talking to a patient who came from the far side of Pembrokeshire and another one from Milford Haven, and there the General Practitioner has parted with his case. That was why I was mentioning the Ealing Hospital. I would not like to say a difficulty will not arise, and I think that is one of the chief practical difficulties when you are dealing with the London area. A local Hospital, such as the Ealing Hospital, has met the difficulty by letting the local Practitioners come in and look after his case. As to how it would be worked with one of the bigger General Hospitals I should not like to express an opinion.

1030. I think somewhere here you say that these patients would be looked after by their Doctor so long as he is in Consulting Practice ?—No, that is not in the prospectus. We say: "The "regular Medical attendant of a patient may follow "the case during treatment in the Hospital;" that is the ordinary Doctor. In paragraph 10 we say: "A patient may arrange to be attended by "any Surgeon, being an F.R.C.S. in purely "surgical practice, or Physician in consultative "practice, although not on the Hospital visiting "list, but in these cases he must make his own "arrangements as regards the payment of fees. "A trifling charge is made for the use of the "Theatre, if required, and for attendance."

1031. Then you define what a Consultant is ?—Paragraph 10 is when you are dealing with a Surgeon or Physician: "A patient may arrange "to be attended by any Surgeon, being an F.R.C.S. "in purely surgical practice, or Physician in con-"sultative practice."

1032. That is your definition "Being a Fellow of "the Royal College of Surgeons in purely surgical "practice or Physician in consultative practice" ?—Yes, that is the definition which was come to after a very lengthy consideration by our Medical Advisory Committee before we started.

1033. "Or Physician in consultative practice;" that is not so clearly defined, is it ?—Well, broadly speaking, if I may use a colloquial phrase, it means Harley Street. If you get a Physician in consultative practice, anyone you like to mention, they can bring him in.

1034. Of course, it is really rather a loose term ?—A little loose probably, yes.

1035. I suppose that while there are such small numbers in question it really does not matter, but one can see that when the numbers get bigger these difficulties might arise ?—I do not think we have had any difficulty. We have now had some 3,000 to 4,000 patients through the Hospital in the course of seven years, and I do not know of any difficulty that has arisen.

1036. I am thinking of this question: that somebody who thought he was in consultative practice, or suggested he was, might claim to look after a patient in your Hospital and your officer might not consider he was; that is where the difficulty might arise ?—Yes, I suppose it might, but it has not done. I only remember one case, and it is such a long time ago, I have forgotten the details, but I think, right at the beginning, there was a Doctor somewhere on the outskirts of London, who was a Fellow of the College of Surgeons and who was not on the staff of any Hospital, and I think he said, being a Fellow of the College of Surgeons, he thought he was entitled to come and operate in our Hospital. There was some talk about that, and I rather think he did not come. That was probably the class of case you were thinking about. That is the only case I remember, the only case that ever arose. Had he been on the staff of a recognised operating Hospital of course he would have come as a matter of course.

1037. Sir BERNARD MALLET: Under paragraph 3, "Charges to patients"; do you get in a considerable number of people who pay more than three guineas a week ?—No, not at present, because those words at the beginning, "Provided that there is accommodation," cover it. Our accommodation is so small that that really does not arise.

1038. You have not got any of the practically wealthy people ?—We may know, and must know, some who are considerably better off than others, but we have given instructions and our assistant Secretary carefully watches to find out where the patient goes to if we cannot take him, and we nearly always find that he goes to the Wards of a General Hospital.

1039. I suppose they are what you call the small middle class people, clerks and professional people ?—Yes, and people such as travellers, small shop people and so on.

1040. Major WERNHER: Do you happen to know whether as a rule the Surgeons have an all-in charge, including the Anæsthetist, or whether the Anæsthetist charges separately ?—We show them separately as far as our own figures are concerned, but of course if a Surgeon is coming in from outside, he makes just what arrangements he likes. He may charge the patient and we should not enquire, but he may, in those circumstances, make it an inclusive charge to his patient, or he may leave the patient to pay the Anæsthetist on what he is going to charge. No point arises on that in our case, because our minimum scale would be 10 guineas for the Surgeon and 2 guineas for the Anæsthetist, and we should collect that ourselves from the patient, and in due course a list would be sent to the Surgeon and the Anæsthetist, as the case may be, showing the dates of the operation, the name of the patient and the amount of money which we have collected under that "Lancet" scale.

1041. The CHAIRMAN: You have not, I suppose, formed any opinion as to the probable

cost of building to prepare more beds for the rather more expensive type of patient ?—No, it is a very difficult question and we have not gone into it.

1042. You have no estimate ?—No, we have discussed the matter with different people at different times, but I have no estimate. We have not the land yet, and so the practical question has not arisen. We are in the rather fortunate position that we had this building, and perhaps we have not gone into this quite as closely and carefully as we should do if we had got to raise the money on a public appeal. We have got money in hand to some extent, and I have no doubt we could raise the rest.

1043. Do you actually own your own freehold ?—Yes, the freehold was sold to us by the Chelsea Hospital for Women, when they moved. We took it on a three years' agreement, first of all, with an option to purchase, and during the War we bought it, and so we have remained there. That Hospital cost to build, roughly speaking, about £22,000 or £23,000. That was in the early seventies, but to-day it would cost a very great deal more.

1044. We can get the cost of Hospitals before the War, but there are very few instances of this class of building ?—I do not know whether the Editor of the "Lancet" could throw any light upon it.

1045. Thank you very much; we are obliged to you for coming. Is there anything more you wish to say ?—No, there is no more I wish to say. If there is anything you want to know, say about the relative cost, our books are kept privately for use on King Edward's Fund lines, and you can have any information of that kind. If the Committee wants to know anything we will tell them.

The CHAIRMAN: Thank you very much.

(The Witness withdraws.)

MRS. F. G. BURROUGHES, Chairman, and DR. HILDA JOHNSON, Visiting Medical Officer, Florence Nightingale Hospital for Gentlewomen, called and examined.

1046. The CHAIRMAN: Mrs. Burroughes and Dr. Johnson, you represent the Florence Nightingale Hospital for Gentlewomen ?—(*Mrs. Burroughes*): Yes.

1047. We are obliged for the answers you have sent in. I see the private rooms cost 4 guineas per week ?—Yes.

1048. And there are 18 of them ?—Yes.

1049. And the cubicles 2 guineas ?—Two guineas.

1050. And there are 20 of them ?—That is so.

1051. Do the applications for admission come mostly through a General Practitioner ?—I think the bulk we find come from friends of former patients. (*Dr. Johnson*): We get a good many through the General Practitioners and a good many through the Surgeons.

1052. You have a regular Honorary Staff ?—They send us some patients, but we get patients from other Surgeons as well.

1053. Do you find that your own Honorary Staff send the majority of your patients ?—No, I cannot say that.

1054. So that you have quite a large number of Surgeons outside your own staff who operate in the Hospital ?—Yes. (*Mrs. Burroughes*): There are at least 70 yearly.

1055. They look after their own cases ?—(*Dr. Johnson*): They look after the patients they send; they come and see them if they like. If they do not come I look after them, they mostly leave them to me, as a matter of fact, unless anything goes wrong, and then I tell them.

1056. Have you any scale of income in dealing with classes of admission to adhere to ?—(*Mrs. Burroughes*): We say that they should be under £400 a year in income, but that is very difficult to adhere always; a single woman or a woman without any children with £400 a year would be a great deal better off, and would not benefit by the Hospital like somebody who had got a great many children and was applying for a child. But we rely chiefly upon the recommender, who has to fill up a form to say the patient is totally unable to pay the expenses of a Nursing Home. We do go into circumstances as much as we can in every way, and if one of our Surgeons or Doctors thinks that the applicant is too wealthy for us they say so.

1057. Do not you have a system of inquiry at the Hospital itself ?—They have to write their application, and if we do not think it falls within the scope of our application we make further enquiries. If both their Medical Practitioner and their recommender seem to have fulfilled the conditions, we take them; if there is any doubt we put them back for further inquiries and try to find out something more about their finances.

1058. As regards the fees to Medical attendants or operating Surgeons, does the patient make arrangements herself ?—They do not pay any fee to the Surgeon who attends them in the Hospital. In fact the Surgeons cannot attend the patients in our Hospital unless they attend them free. Of course, they generally see them first outside, and they may pay a consulting fee before they come in, but Surgeons who operate with us are not allowed to take a fee from a patient.

1059. Then there are no fees paid to either Physicians or Surgeons after a patient gets into Hospital ?—After coming into Hospital, no. We have thought it may be possible and even probable in the future to adopt some scale of reduced fees, because we find the Surgeons do not send us as many patients as they might, because they can get fees in other Hospitals. Almost every Hospital now which has paying beds has reduced fees for their Surgeons, and we do not know whether we shall be able to carry on in the way we are doing now.

1060. May I ask, has the question been raised ?—The question has been raised twice in the last six years, and on both occasions it was referred to our Medical Advisory Council, and on both occasions they turned it down. Now it is coming up again in October, and it is very probable that we shall fall into line with the practice of other Hospitals and allow the Surgeons to take fees from patients, though only in the private rooms.

1061. The patient who pays 4 guineas ?—The objection up to now has been very marked on the part of the Committee, who say that the Hospital was founded particularly to save patients' fees. But we think that there is a certain proportion of patients, even in our 4-guinea rooms, who would like to pay a fee and quite able to pay a reduced fee, and we think that the scope of the Hospital, the purpose of the Hospital, would still be maintained if we kept the 2-guinea cubicle rooms for the patients who could afford no fee to a Surgeon.

1062. Do you think the patients who go into

the 4-guinea Wards think they are receiving charity?—(*Dr. Johnson*): They do understand that.

1063. They understand that they are receiving charity?—Well, yes, of course they obviously are, are they not, and they do understand that.

1064. I see that you put your cost at £4 15s. 8d. per week, so that they are not quite paying for that?—No.

1065. And they are paying nothing for treatment?—(*Mrs. Burroughes*): No, nothing, they are not even paying for their food, so that they are receiving a certain amount of charity. Of course the patients in the 2-guinea rooms are receiving a great deal more, but there have been a great many of the Committee who have thought, and still think, and the Trustees of the Hospital still think, that the purpose and scope of the Hospital would be altered by allowing fees to the Doctors.

1066. I see from page 2 that free treatment is even extended to patients who come in under the care of their own Consultants?—No Doctor or Surgeon can attend a patient in our Hospital unless they attend them free. That is laid down in the rule of the Hospital, in Rule 1, of our Report. Shall I read it?

1067. No, I think it is quite clear, but I was not quite clear about it before you came to give evidence?—Some years ago, when this Hospital was first opened, it was the only Hospital for this class of patient; and now this class of patient, has a choice of several Hospitals all over London and the Surgeons and Doctors there very naturally do recommend their patients to places where they can get a small fee, and we find that they do not always send them to us.

1068. You think that may be partly accountable for the rather small average number of beds occupied?—We have gone very carefully into the causes, and opinion has been divided on the Committee on the subject, but we all think that that is the reason why we do not get so many, because nothing can be more laudatory than the letters we get from patients. We have over and over again the same patients coming back to us, and their relations, but we do not find so much the proportion of the patients comes from the Doctors as they used to.

1069. You do not allow General Practitioners to come into the Hospital at all?—(*Dr. Johnson*): They visit the patients as much as they like.

1070. But as visitors?—As visitors. They always consult me if they want anything special.

1071. But they are not allowed to give orders?—Well, they do not; you see it would be impossible; they are mostly surgical cases.

1072. I would like to go back for one moment to the average number of beds occupied. Does the difficulty in finding occupants for beds apply both to your 4-guinea beds and to your 2-guinea beds?—(*Mrs. Burroughes*): We do not find very much difference between them; we do not find the extra cost keeps them away a bit.

1073. You would not expect that as far as the 2-guinea beds are concerned the staff would expect any fees?—No, I do not think they would.

1074. That possible cause would not apply in the case of the 2-guinea beds?—No.

1075. You state the cost of building, on page 4 of the Questionnaire, at £764 per bed, and the present building was erected in 1910. It was erected for its present purpose, I suppose?—Yes, entirely. The original Hospital was founded by Florence Nightingale in Harley Street, and it outgrew its scope there, but the present Hospital was built and designed entirely for its present purpose by Mr. Ferrier, the architect. The land was bought before I was Chairman, when Dame Caroline Bridgeman was Chairman of the Hospital. It was built in 1910, and an extra wing added, I think, three years later, but it was built entirely for its present purposes.

1076. Can you give us any opinion as to whether women as a rule dislike a cubicled Ward, curtained?—(*Dr. Johnson*): They vary. It entirely depends on the patient. Some prefer being by themselves and some prefer a Ward.

1077. I was wondering whether women prefer to be alone more than men?—I should say on the whole that they do. I know that very often the extra cost of the private room is paid by some friends of the private patients in order that they should be in there.

1078. They can talk to each other more easily in the Ward?—I should say on the whole that most of them would prefer a room.

1079. Has it ever been suggested to you that they might prefer a room or that it would be better that they should have a room for the first few days when they are seriously ill, and when they become convalescent they could go into a Ward? (*Mrs. Burroughes*): Very often in the case of a 2-guinea patient, if the nature of her case does not admit of her being nursed in the Ward, we put her into a private room without any extra charge. For the extra cost of a private room, and also extra charges like massage and things of that sort, we have got a little private fund which helps in that way, but we constantly put a 2-guinea patient into a 4-guinea room without extra charge if there is one available.

1080. Mr. LOW: I suppose one effect of your not allowing any Doctor on the staff to charge fees for the 4-guinea patient is that, if a Surgeon is wishful and willing to operate on a patient of that particular class, he would probably take her into his own General Hospital?—(*Dr. Johnson*): Yes, that would be so.

1081. If he is wishful to operate. Your Hospital is chiefly intended for governesses?—All classes. (*Mrs. Burroughes*): Originally there were more governesses because there were more poor ladies in that class. Now we cover every class.

1082. For a surgeon who wished to operate on such a lady as that, it would be quicker and easier to take her into his own Hospital?—(*Dr. Johnson*): Yes, it would be more convenient to him if he had her in his Hospital. (*Mrs. Burroughes*): It would not be any cheaper for her because she would have to pay something in every General Hospital.

Mr. LOW: It would be more convenient to him?

1083. The CHAIRMAN: Is there anything you would like to add?—(*Mrs. Burroughes*): The only remark I should like to make is with regard to the comparative cost as compared with other Hospitals. Of course, all the costs except Surgery and Dispensing are higher with us than with ordinary Hospitals; I do not know why that particular one is not, I think that is Dr. Johnson's own personal economy. (*Dr. Johnson*): All our costs in surgery vary, not so much in dispensary as ordinary medical fees. (*Mrs. Burroughes*): I think it is quite understandable why we have always been very high in costs. One reason is we have a very small Hospital and we cannot run things economically; we cannot buy in bulk or store in bulk. We have to have more general staff and more Nurses, and we give patients a better dietary than they get in a Nursing Home. No patient need buy any single thing; they are

given fruit and chicken if ordered. Of course we are always glad when patients' friends do bring something in, but otherwise everything is provided for them. They have a meat breakfast, and they have a full dinner, and they have tea, and a meat supper. We think the class of patient we have ought to have the sort of diet that they are accustomed to in their own homes, and we give it to them, and they have not to buy or bring in a single thing for themselves.

1084. They are largely surgical cases, I suppose ?—Yes, but even if it is a medical case it is just the same, in gastric cases.

1085. They do not eat so much as a rule ?—No, but still they have special diet. That, I think, explains the high cost of the Hospital, because we give them this very liberal diet, and we do not expect them to bring anything in. With regard to the class of patient we can take in, I am not sure that we shall not in the future have to drop the word gentlewomen from our title. That is a great difficulty. In fact we were thinking of asking the advice of King Edward's Hospital Fund on that point.

The CHAIRMAN: I understand that is a difficulty with you.

1086. Mr. LOW: How do you manage at present; who guarantees that ?—On the application form to us the guarantor has to say that the applicant is a gentlewoman. Of course they are not always so by any means. We mostly go by their fathers and husbands. It is almost impossible to define or to keep within limits.

The CHAIRMAN: Thank you very much; we are very much obliged to you.

(The Witnesses withdraw.)

MR. W. McADAM ECCLES, F.R.C.S., Royal College of Surgeons, called and examined.

1087. The CHAIRMAN: Are we to understand that you come here as representing the Royal College of Surgeons ?—I was appointed by the Council at the last meeting to represent the Royal College of Surgeons of England. Unfortunately, I have had to be in Edinburgh ever since, and the consequence is I have not had any consultation with the President over the question of evidence, but I think I might say that the Council of the Royal College of Surgeons of England, its Fellows and Members, are most desirous that persons of the medical classes should have good accommodation for operative surgery to be performed, and I think that is really the position which I take to-day.

1088. I see you divide the classes up into two, those who are well to do and those who are of moderate means ?—So far as the question of paying beds is concerned.

1089. Of course I understand you can only express your own opinion, believing that opinion to be shared by your colleagues ?—Yes.

1090. Do you think that the establishment in voluntary Hospitals of accommodation for the well-to-do, equal to the best to be found in Nursing Homes, would be opposed by the Profession ?—No, it is rather the other way, that if there were beds attached to voluntary Hospitals, but probably in separate blocks under the control of the Hospital authorities, the bulk of the Profession, particularly on the Surgical side, would welcome it.

1091. You would agree, I take it, from what you have said, that a voluntary Hospital, or any Hospital, can provide facilities which it is impossible for a Nursing Home to provide in the way of treatment and examination, X-rays, pathological and so forth ?—Naturally, but on the other hand there are two questions; one is as to whether certain Nursing Homes or, shall we call them, Private Hospitals, might not come into existence with the same facilities as there are at the voluntary Hospitals in the way of special investigation and special treatment. The other point which I have noted a little further down in my précis is whether the voluntary Hospitals—I am thinking of London and in particular of voluntary Hospitals with Medical Schools attached—have at the present time facilities for such extra work in their special investigation departments, for example, as would be required by the establishment say, of a block of 50 to 100 beds for paying patients; whether they have the facilities to undertake that increased work. As you well know, most of our special departments for investigation, X-ray, Clinical, Pathological and Electrical, are pretty well loaded with work at the present time, and to add fresh beds, whether for ordinary or for paying patients, must necessarily throw considerable extra work upon those departments. That is, I think, one of our great difficulties. If I may put a personal point, at St. Bartholomew's we have under consideration now, with the reconstruction of the Hospital, a block of 75 to 100 beds for paying patients, the work for which would be done in our special investigation departments, and how the work is to be done is not settled, and it is a very important matter.

1092. That is to say it is a question of space in the department ?—Space and men and means.

1093. Men you can always get, cannot you ?—Yes, after training.

1094. But if you cannot get the space, of course you are in a difficult position ?—True.

1095. Of course, as Mr. Low suggests to me, if you had the same facilities in Private Hospitals you would have, at any rate, to find the man in those cases also ?—Yes. I have ventured, under heading (1), just to put down notes to indicate the various points we think we should go through.

1096. There is one point under 1 (*c*): I see you mention a Municipal Hospital. We have heard that some Municipal Hospitals do now provide accommodation for private patients or paying patients. Have you any personal knowledge of any ?—Yes. Under Municipal Hospitals I might put two classes; those Hospitals which are or have been up to the present called Poor Law Hospitals, and those Hospitals which have been started in Municipal areas like Willesden, in which they have been catering for this particular class of person. They are at the present time having patients from their own areas; Camberwell, I am thinking of St. Giles', where they take patients under the Guardians for a certain price, and at Camberwell they are very well staffed from the medical and surgical point of view, and I think the patients do exceedingly well.

1097. You know that of your own knowledge ?—Certainly.

1098. Camberwell is, I understand, a regular Poor Law Infirmary ?—It is one of the Poor Law Infirmaries. They have dropped the word "Infirmary," and call them Hospitals; St. Giles' Hospital.

1099. Do you know of any other Infirmary than Camberwell where they make a practice of taking private patients ?—Yes, I believe at Marylebone it is done at their Infirmary; I am not acquainted with the others.

Mr. W. McAdam Eccles.

1100. There is one thing I should like to ask you about, that very vexed question of the part which the Consultant, not a member of the honorary staff of the Hospital, might wish to take in dealing with his own patients, and secondly the part which the general Practitioner might wish to take ?—In treating patients in paying beds attached to voluntary Hospitals ?

1101. Yes ?—Well, first of all I think I may say, and I think I may say it from the point of view of the College of Surgeons, that no staff, no Consultant staff, Visiting staff, of a voluntary Hospital could entertain the treatment of patients by others than the actual appointed staff of that Hospital, and I do not think the Governors of the Hospital either would approve of that.

1102. Not even if they limited the outside staff to those patients who were in single rooms ?—Yes, I see your point. That is to say, supposing you have single room patients, why cannot they be treated by their private Practitioner irrespective of the staff of the Hospital ?

1103. Yes ?—I do not think that that would do in the large Hospitals, certainly not the Hospitals with Medical Schools, but it might do in such Hospitals for instance as the West London, where I believe that is being done at the present time, but I am not quite sure.

1104. I am assuming, of course, that the accommodation for private patients would be separated, at any rate in a separate block, such as we have heard about in other Hospitals ?—I think the difficulty you suggest is this; who is really responsible to the officials, to the authorities of the Hospital, for such treatment ? I am not in any way belittling the treatment by the private Practitioners, but when it comes to surgery I think that there would be a certain amount of diffidence in allowing patients, who after all are patients of the Hospital, to be in the hands of those who would not have been officially appointed to do the surgical work of the Hospital.

1105. Would you say then that the Hospitals have to take the responsibility for treatment ?—I think so. Finally the lay authorities of the Hospitals are responsible.

1106. What I mean is this. Let me put a concrete case; supposing a patient is brought into one of those paying beds on the recommendation of an honorary member of the staff. That patient is operated upon and let us say dies within a few hours of the operation. Questions arise as to whether the operation ought to have taken place at all. Do you think the responsibility could be brought home to the management of the Hospital for employing that member of the staff ?—Well, I have known this to happen, not quite so extreme as yours; where a patient on the operation table was allowed to have his arm over the table, and that patient got paralysis, and he sued the Hospital, not the member of the staff.

1107. He was not a paying patient ?—No.

1108. Does it not make a difference when the only liability which the patient accepts to the Hospital is the payment for maintenance; can the Hospital then accept any liability for treatment ?—I am afraid you are taking me out of my depth there.

1109. Except so far as nursing is concerned. If it could be definitely proved that a Nurse had been careless, there might be a case ?—True, but I take it that the paying block would finally be under the control and direction of the lay authorities of the Hospital in precisely the same manner as the rest of the Clinical side of the Hospital.

1110. I should say not quite; I should have thought not quite, so far as the staff were concerned, the honorary staff ?—No, well of course there are different ways of dealing with that particular class of patient in a Hospital. I have not had experience of it, you see, because we have no paying beds as they have at St. Thomas's or Guy's.

1111. At St. Thomas's they have something like 20 per cent. I think they said, of their cases attended by outside Consultants ?—Oh, yes.

1112. And Guy's have a very few ?—I have operated in St. Thomas's Home and I was partly responsible, but the Resident Medical Officer, who is a servant of the Hospital, was also responsible, and in the intervening time between my visits, that patient was under his charge and care.

1113. In other words the Resident Medical Officer is one of the advantages that the Hospital has ?—Of course.

1114. Mr. LOW: You talk about private Hospitals. Do you know any private Hospital in London, where they do provide what we might call the ancillary services ?—Not actually in the Hospital itself, but by arrangement with certain officers outside. I am thinking for instance of the Florence Nightingale, which is half way between what we might call a really private Hospital and a voluntary Hospital. There, for instance, any pathology that is required is done at the expense of the Hospital by an outside Pathologist.

1115. But there is a great advantage in having what is called Clinical Pathology and Radiology done on the spot ?—It ought to be done.

1116. There is no such thing in London as a private Hospital where they have a special staff of Pathologists and Radiologists on the staff of the Hospital ?—No, the nearest approach to that is the new Nursing Home that has been built at the corner of Devonshire Street and Beaumont Street. There there are, on the spot, two Radiologists privately practising in the building, and therefore, the patients need not be moved from the building to a Radiologist.

1117. Of course it is an enormous advantage to have command of a good Pathological staff and a good Radiological staff ?—It is more than an advantage, to my mind, it is essential.

1118. So that if you were starting a new era, so to speak, it would be cheaper to do it, more advantageous and more easy to do it, in connection with the voluntary Hospitals that already possess these staffs than to set up new services ?—Certainly.

1119. Even though your staff of the Hospital is a little over-loaded at present, it should be encouraged ?—Yes, provided there was room for them to work in.

1120. It would be easier to add to any already established staff than it would be to start an altogether new service ?—Yes, at the present time, but in the future it may be the other way.

1121. The other point is this: Supposing such a scheme as this was suggested, namely, having pay beds in connection with the voluntary Hospitals, you would confine the care of those patients to the staff of the Hospital ?—Yes, the actual treatment, but I would not exclude the private Practitioner of the patient coming in for consultative work with the member of the staff; in other words, I think that the private Practitioner —supposing it is a surgical case and requires an operation—should be present at the operation.

Mr. W. McAdam Eccles.

I think it will be exceedingly desirable that the private Practitioner should see the case several times afterwards with the member of the staff concerned; I think that is most valuable, but I do not think that the private Practitioner should be responsible for the treatment, otherwise you have got two Practitioners treating the same patient.

1122. Do not you think that if you did that the ultimate result would be that the general Practitioner would be squeezed out, the patient would object to pay fees to a person who had no responsibility and would only come in as a sort of adviser. "No," he would say, "I am under "the care of a member of the staff and I do not "want to see this Doctor"?—My experience of the general Practitioner in connection with Hospital cases of patients of the class that I have put down here, who are going into the voluntary Hospitals, and who might be going into these paying beds in the future, is this; first of all that the general Practitioner asks a certain member of the staff to see the patient frequently in private consultation; then the patient is admitted to the Hospital, generally into one of the ordinary Wards, and if an operation is necessary I personally always ask the general Practitioner to come as a visitor to the Operation Theatre to see the operation and take part, as it were, in the treatment in that way, and then I never have any objection whatever to his coming again, at the times when I am there, to see his patient; but frankly I think not more than 5 per cent. of the general Practitioners who, through me, have those opportunities, ever take the advantage of them, and the reason, they say, is that they have not the time.

1123. They only come when a case is somewhat interesting?—Yes. I do not want to squeeze out the general Practitioner, do not think I am doing that at all; I think that the co-ordination and work of the general Practitioner and Consultant ought to be fostered in every way possible.

1124. I was not quite talking of the class of patient you are talking about. I am assuming that in these paying beds there might be quite well-to-do patients who in some Hospitals, as far as I can ascertain, are looked after by their general Practitioner in connection with a member of the staff?—True, just in the same way——

1125. In the Great Northern they are allowed to?—Yes, or in the same way if one goes down and does an operation in a Nursing Home, or beds attached to a Nursing Home some little distance out of town, we go down and do the operation, and the whole of the rest of the treatment is carried out by the general Practitioner as a rule.

1126. You see no objection to that?—I see no objection to that at all, only I did not know that these beds attached to the voluntary Hospitals were really going to cater for the patients of higher income limits, shall we say, than £750?

1127. I have not suggested anything of that sort; I am only just imagining things; I am not prejudging the case. Then the other question would arise in some of these Hospitals, for instance such as St. Thomas's Home and in Guy's, where people of consulting rank can come and either operate or look after the patient?—Yes.

1128. If this movement became very general some question would some day arise as to how to define that?—I am speaking only for myself here, and personally I think that when a block containing beds for paying patients is attached to a voluntary Hospital, it ought to be entirely for those patients who are consigned to the members of the staff of that Hospital. That is my personal opinion. I think to introduce outside members of other staffs, and so on, is not a thing that could be done in a paying block, and each Hospital, having this accommodation, should employ their own staff. That is only a personal expression of opinion.

1129. Sir BERNARD MALLET: Have you any idea of the class of people having this sort of income that you want to provide for? You state here "Beds for patients of moderate means, "especially clerks, male and female, small shop-"keepers, artisans earning more than £5 a week." I suppose that would mean anybody who had over £250 a year or £300 a year?—Yes, between £250, and, shall we say, £800 or £900 a year. That is the class included, and that is the class at the present time that is really suffering.

1130. And you feel strongly that some provision ought to be made?—I am sure of it.

1131. Have you any kind of estimate of the number of beds that would be required?—Yes, there are two ways of getting at that. First of all trying to determine from, shall we say, income tax returns as to the number; and the other is by taking groups of persons of that class who are insured in one way or another. May I just give you one or two figures which I have looked up in connection with this matter so as to be able to put them before you. Here is a class—a male staff of 3,851 persons.

1132. Staff of what?—Well, the staff of a large commercial concern. Wives, 2,267; children, that is dependants, 1,770. A small group, but you see it is a group of more or less healthy lives. Now the sickness, the incidence of illness, requiring in-patient treatment, that is to say, treatment in bed either in a Nursing Home or a Hospital, illness like pneumonia for instance, was 26 last year out of that 3,851, or ·67 per cent.

1133. That is for the males?—That is for the males. The operations were 44, for which the insurance had to pay.

1134. The CHAIRMAN: The 44 are 44 actual cases?—Yes, 1·14 per cent. Wives, 28 cases of illness, which means 1·23 per cent.; and operations 40, which means 1·76 per cent.; children 19, which is 1·07 per cent.; and operations, which I think will probably astonish you, 65, which is 3·67 per cent., but that, of course, included tonsils and adenoids. You had evidence the other day from Sir Alan Anderson, and the figures of the British Provident Association are practically the same. These are figures upon which I think we can work pretty accurately, and you will notice that if you take them all together it is just about 2 per cent.

1135. Sir BERNARD MALLET: Two per cent. of a certain number; the difficulty is to get the number?—Well, I do not know, I think it is about two and a half millions. May I make just a remark or two with regard to the last page, this question which I put down there, No. 3 on page 3: "Can the voluntary Hospital under-"take the extra work"; well, my answer to that at the present time is No, because there are two points. First of all they would have to have capital in order to provide the extra beds; and, secondly, I am not quite sure, when further looking into the question of cost, whether they are going to be able to maintain those solely out of the sums paid by the patients. That is just a question that comes in No. 4.

1136. The CHAIRMAN: We do not, of course,

yet know what the actual cost is going to be; that is one of the difficulties ?—Then, under No. 4, as regards the question of provision for payment, I am whole-heartedly of opinion that it should be through some voluntary and general insurance like the British Provident Association, which is only in its embryo form, but if it was put on a really broad basis, I believe it would go well. Then the number of such beds required must be worked out, as you say, by population and by incidence of sickness. On the question which Hospitals should have these beds attached to them, I do not know whether you have discussed that at all, but my feeling, and I think I should carry all my colleagues on the Council of the College of Surgeons, both London and provincial, with me, is that they should not be attached, if they are going to be done thoroughly, except to those Hospitals which have, as Mr. Low was saying, means for special investigation, otherwise it is really a waste of money.

1137. Those Hospitals would really include all those which come under the category of General Hospitals under the King's Fund ?—No, there are Cottage Hospitals in certain places.

1138. The CHAIRMAN: They would not be called General Hospitals. Your limitation would include practically all General Hospitals under the category of the King's Fund ?—Yes, practically all.

1139. Is there anything else you would like to say ?—I do not think so.

The CHAIRMAN: We are very greatly obliged to you.

(The Witness withdraws.)

(Adjourned.)

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

WEDNESDAY, 5th OCTOBER, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
PROFESSOR WINIFRED CULLIS.

MR. LEONARD L. COHEN and MAJOR WERNHER (*Honorary Secretaries*), and MR. H. R. MAYNARD (*Secretary*), also being present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.2.*)

SIXTH DAY.

Mr. H. S. Souttar, Mr. W. McAdam Eccles, Dr. G. C. Anderson and Mr. N. Bishop Harman.

MR. H. S. SOUTTAR, F.R.C.S. (Chairman of Hospitals Committee), MR. W. McADAM ECCLES, F.R.C.S. (Deputy-Chairman of Hospitals Committee), DR. G. C. ANDERSON, M.D. (Deputy Medical Secretary), and MR. N. BISHOP HARMAN, F.R.C.S., (Treasurer) British Medical Association, called and examined.

1140. The CHAIRMAN: Mr. Souttar, you are the Chairman of the Hospitals Committee of the British Medical Association?—(*Mr. Souttar*): Yes.

1141. Mr. McAdam Eccles, you are Deputy-Chairman?—(*Mr. Eccles*): Yes.

1142. I understand Dr. Anderson is Deputy Medical Secretary?—(*Dr. Anderson*): Yes.

1143. Mr. Bishop Harman, you are Treasurer?—(*Mr. Bishop Harman*): Yes.

1144. The British Medical Association has a membership of 33,000 and includes representatives of every form of medical practice?—(*Mr. Souttar*): Yes.

1145. And you have local machinery which enables you to collect the opinions of the main body of your members?—Yes, that is so.

1146. During the past few years you have been considering problems which affect Hospital policy?—Yes.

1147. And I understand, with that object, you have had special conferences with the medical staffs of Voluntary Hospitals both in London and in other parts of the country?—Yes, we have had many conferences.

1148. And a part of the inquiries which you have been carrying out has been directed to the consideration of accommodation for those who are able to pay for their maintenance in Hospitals?—Yes, I think we have considered the whole range of the people who come to be admitted to a Hospital. We have divided them up, as you see, into various classes: the free patients who are treated entirely free; the tariff patients who pay some portion or the whole of the cost to the Hospital; and, finally, the private patients who come in a different category. Those practically cover all the possible admissions to a Hospital. We have envisaged the possibility that all sick people would ultimately be admitted to the Hospital. It was because we foresaw the possibility of that, that the Association has given a great deal of time during the last four years to that particular problem. We have not limited ourselves to any one class of patient at all.

1149. You say a little bit later on: "The ques-
" tion of the provision of Hospital accommodation
" in London, for persons prepared to pay more than
" ordinary Hospital patients, should be con-

"sidered in relation to the existing Hospital "accommodation, whether in Voluntary Hospitals, "Municipal Hospitals or Poor Law Infirmaries." Do you mean there the existing Hospital accommodation at present provided for paying patients, or for all patients ?—For all patients, because we feel that the whole situation is entirely fluid. It is very difficult to draw a distinction at the present moment between the patient who is paying something in the Hospital and the patient who is paying the full charges ; it is very difficult indeed to know where to draw the line, and, therefore, if you are considering the question of paying beds, you must consider the provision already made in the Hospitals for those who are actually paying, though the beds in which they are placed are not termed paying beds.

1150. Is it your opinion, or have you ascertained from your inquiries, that there are many patients in what may be called the ordinary Wards who do pay full charges ?—There are a considerable number of patients in the ordinary Wards of some of the Hospitals that do pay full charges, but not many.

1151. We have inquired about that, and it has appeared that very few Hospitals had patients who paid the full charges ?—(*Mr. McAdam Eccles*) : Did you ask the question as to whether there were patients there who might be able to do so, and who did not ?

1152. Putting it in another way, you might have found out from your inquiries that where a Hospital has paying beds it has been found possible, not infrequently, to transfer patients from the ordinary Ward to the paying beds. Where there are no paying beds it is no doubt a fact that a certain number of border line cases are taken in, and are taken in probably on the basis of not more than two guineas a week. That is our information, but such cases would, in the case of a Hospital having paying beds, probably be placed in paying beds ?—I am sorry if I am interrupting you, but are they not taken in very often because they are going to be in a general Ward because there are no paying beds in the Hospital, or attached to the Hospital, and by going into the general Ward they are not to be treated free, but are really paying their full maintenance fee because they are not paying medical fees ; that is a very important point.

1153. I think—I may be corrected by the members of the Committee—that in fact they do not often pay full cost, but that there are such cases ?—I have three in my Ward at the present time, so it certainly does happen.

1154. Oh, it happens, I agree, but it is rare ?—(*Mr. Souttar*) : We have no ulterior motive in this suggestion ; it is merely that we desire that, if paying beds are provided, care should be exercised to see that the whole system is co-ordinated. I know it is your desire, but there is nothing behind this at all, that is simply our desire.

1155. I do not suggest that there is ; all that I want to know is whether that word "accommodation" referred to the whole of the accommodation or to paying beds ?—No, it refers certainly to the whole accommodation, because, as I say, we feel that the whole thing is in a state of flux, and it is quite possible that in a short time—for instance, at the London Hospital, a large proportion of beds may be regarded as paying beds ; at the present time a large proportion of the patients pay and some of them pay very considerable sums.

1156. But we may assume, for the purposes of this Inquiry, that a paying patient—or call him a private patient, if you like—is one who pays the total cost of his maintenance or something over ?—Certainly, yes. (*Dr. Anderson*) : Or who could do so.

The CHAIRMAN : No, I should say who pays ; you cannot always find out who can pay.

1157. Mr. LOW : He is a mistake ; he ought not to be there ?—But there are numerous instances of that. (*Mr. Souttar*) : It is extraordinarily difficult to find out. I have had patients under my own charge at the London Hospital who to my knowledge were paying full charges, and with my entire approval, because I considered they were cases of a nature that could only be treated in a Hospital ; and that is a hardship to the medical profession, of course.

1158. The CHAIRMAN : Then you say : "Regard should also be had to the private "Nursing Homes or private Hospitals in the area "concerned." Does that mean that in your opinion the provision of beds by Voluntary Hospitals should not be allowed to compete with outside organisations ?—Yes, I think that is certainly so.

1159. You would not, of course, put all private Nursing Homes on the same level ?—Oh, no, certainly not.

1160. So that in considering the accommodation provided in Nursing Homes you would also have to consider the nature of the accommodation provided ?—Yes, but it is going to be a very great hardship if a Hospital uses its resources to destroy the Nursing Homes. That is another thing that has to be considered.

1161. Of course, here we are only concerned with London, and I understand that, so far as London is concerned, the Association is satisfied that the King's Fund does really supply the place of a Voluntary Hospital Committee ?—Absolutely, Sir, absolutely.

1162. Then you detail certain provisions that you think are necessary in connection with the reception of private patients in the Voluntary Hospitals. That is No. 8 (*a*) ?—Yes. May I just put briefly three considerations that I think the Association has laid great stress on. In the first place, there should be complete financial independence of charitable funds ; the paying patient should pay his way in the Hospital. In the second place, that contact should be maintained with his Private Practitioner ; and, in the third place, that as far as is practicable he should have free choice of Consultant. We do not dogmatise absolutely on any of those points, but those are three points that the Association regards as of very great importance. It is obviously rather unfair, for instance, to admit a patient to a paying bed—call him a paying patient, he pays perhaps three guineas a week and he is only able to get that accommodation because of the charitable funds of the Hospital, which he is essentially using. We do not think that is quite fair. In the second place, it is very undesirable that a patient should be able to walk into a Hospital quite independently of his General Practitioner. We regard continuity of treatment as of very great importance, and in some way we think that the General Practitioner ought to be kept in contact with his patient ; and in the third place the Association feels that it is undesirable that one special group of Consultants should have the monopoly of the treatment of these patients. (*Dr. Anderson*) : Wherever possible we are anxious that the Private Practitioner should be able, if possible, to follow his own patient and to treat him in the institution. Speaking

generally, that is the principle which we have in mind.

1163. Yes, but you would not say that, assuming a patient goes to a Consultant and that Consultant recommends him to go into a private bed in the Hospital, of which he happens to be one of the Honorary Staff, that he should not be allowed to go without the Private Practitioner's, or the General Practitioner's, sanction?—(*Mr. Souttar*): No, we merely stress the point that it is desirable that the sanction of the General Practitioner should be obtained, and in the situation you are envisaging there is no question at all that the General Practitioner would be communicated with by the Consultant.

1164. He might be, but of course patients have a way of flitting about from one Doctor to another sometimes?—Yes. I think the point we want to oppose is a patient simply walking into a Hospital and saying "I have got hernia and "I want it operated on." I imagine that is the situation that you do not desire either.

1165. Oh, no—But we wish to protect, as far as possible, the interests of the General Practitioner and of the Consultant, of the whole body of Consultants, that is to say.

1166. As a general rule it would mean both the sanction of the General Practitioner and of a member of the Honorary Staff in all probability, assuming that the treatment in the Hospital is limited to the members of the Honorary Staff. Upon the question of treatment of a patient by members of the Honorary Staff of the Hospital, there I think you consider that the patient should have freedom of choice of Consultant as far as possible, and that the General Practitioner should be allowed to come into the Hospital to treat him also. I am not quite clear about that?—Well, it depends, you see, on the class of accommodation provided by the Hospital. There are three ways at least in which that accommodation could be provided. The Hospital may erect a Nursing Home under its ægis but external to the Hospital; they may provide special Wards in the Hospital, or they may have paying beds in the General Wards. Now in the last two cases I do not quite see how anyone but the Consulting Staff of the Hospital, that is to say, the staff of the Hospital, can deal with the patient. In the first case it has been found practical, as you know, for instance, at St. Thomas's, to admit other Practitioners, and we think that the greatest possible freedom is desirable. I think that is our position.

1167. I understand that where private beds do really form part of the Hospital, your opinion is that the Visiting Staff of the Hospital should have control?—Within reasonable limits.

1168. But the General Practitioner, as far as possible, should keep in touch with his patients?—That is exactly our position, yes.

1169. If Hospitals did provide a Nursing Home in an entirely different block, with separate administration, the Hospital Committee would still remain responsible, of course, for the administration of that block?—Certainly.

1170. What is your opinion about their responsibility as to the treatment of patients?—It it not quite the same as the responsibility for patients in the Hospital. I think that the view of the Association is that the patient should in that event be able to choose his own Consultant. It is perfectly true that the Hospital Committee cannot escape a responsibility for seeing that things are, so to speak, done decently and in order.

1171. Of course they must not poison a patient or kill him by bad nursing?—No, but they should not allow the admission of a man who had been struck off the Medical Register to perform an operation. They would probably limit in some way the Consultants whom they would admit; they must have a veto, of course, but we think it is undesirable—I will put it the other way—we think it is desirable that if possible they should allow other Consultants than those on the staff of the Hospital to operate in such a Nursing Home as you have mentioned. Dr. Anderson points out to me that I perhaps created an erroneous impression in using the word Consultant; I should have used the word Private Practitioner. (*Mr. McAdam Eccles*): To include Consultant. (*Dr. Anderson*): For instance, there may be a Private Practitioner who is perfectly capable of doing the particular type of work required and he may not be styled in the ordinary course of events a Consultant.

1172. No, but you would not think it unreasonable that even as regards the Nursing Home the Committee of the Hospital, as being responsible, should lay down certain rules or limitations as to the Medical Practitioners who were allowed to come into the Hospital?—(*Mr. Souttar*): No. May I give you an instance that was at any rate somewhat surprising to me of the way in which restriction to the staff of a Hospital may work in a somewhat opposite way to what we usually imagine, if you will forgive a personal reference. A few weeks ago, very late at night, I was called down to a Hospital in a suburb of London to see a very bad motor smash, I was asked to see a man who had been thrown off a motor bicycle, and he had a depressed fracture of the left frontal region. When I reached the Hospital, about 11 o'clock at night, I was informed that nobody but the staff of that Hospital were allowed to operate in it; it was a small suburb. I said, "Well, I happen to know several members of the "staff; is there any of you who has any special "knowledge of cranial surgery." They said, "Oh, no, we do most of the work," but they said "We want you to come into the Theatre and "explain to us what I do." I said, "I am very "sorry, but that is exactly what I cannot do," I said "I am perfectly prepared to operate, but "I cannot stand in the Theatre and tell another "man what to do"; it was an impossible position. I said "I will see the patient and advise you as "to what must be done; but I must then go away "if I do not operate." So I did so; I saw the patient and it was a very bad crash, a piece of bone about 2 inches in diameter was driven completely into the left frontal. I advised them what to do and I came away. Now I just mention that as showing the effect of restricting the work in a Hospital to the Hospital staff. One is a little too apt to envisage it as a restriction in a big teaching Hospital to the Hospital staff, but we, as an Association, have to consider all classes of Hospitals existing in London.

1173. Then you suggest certain scales as to the question of certain charges, which I do not think I need go into now. Generally speaking you think that the arrangements, so far as fees are concerned, should be made between the patient and his General Practitioner and the Consultant?—That is our view, yes. You will see in our consideration of the question of tariff patients we have considered and approved of the idea that a patient should, under certain conditions, pay an inclusive charge, for instance in regard to Municipal Hospitals in paragraph 12.

1174. But are there any Municipal Hospitals in London?—(*Mr. McAdam Eccles*): Oh, yes, there are; Willesden has a very important one.

1175. Yes, that is in the King's Fund district?—(*Mr. Souttar*): And there will, quite shortly, be quite a number of Municipal Hospitals. (*Mr. McAdam Eccles*): And Woolwich, too I think.

1176. Has Woolwich a Municipal Hospital?—(*Mr. Souttar*): Well, semi-municipal.

1177. Then you also refer to Infirmaries. Well, we had a return from Infirmaries as to what beds they provided in London, and it is not very great, but there are a few?—They provide paying beds, and, so far as I can see, upon the lines which you suggest.

1178. Except that I do not know that we asked whether the patients are allowed to have their Private Practitioner or not; I think not?—(*Mr. McAdam Eccles*): No, nowhere are they allowed; they are entirely under the Medical Superintendent. (*Mr. Souttar*): We have discussed that with Medical Superintendents at one or two of the Infirmaries and they did not think there was anything impracticable in our suggestion.

1179. Then we come to a very interesting subject "Contributory schemes for private paying "patients," and I notice that you say in the first paragraph that there should be an income limit scale, and I should like you, if you would not mind, to explain why you think it advisable that there should be an income limit scale as regards this class of patient?—Because in general those patients will be treated at lower rates than are customary. I think in the Terms of your Reference you speak of patients who pay more than ordinary Hospital rates. Presumably you mean patients who are a little above the Hospital class and want to pay their way?

1180. Yes—But these are not patients who will be prepared to pay large fees, and we think it would be absolutely unfair that a man should be able to join a contributory scheme essentially arranged for such a class of patient and then get treatment on that scale, when he is perfectly able to pay the regular Nursing Home and Consultant's fees.

1181. Yes, but let us take, for instance, a large business that perhaps employs a staff of several thousands, whose salaries might vary from a couple of hundred to a couple of thousand. Would it be impossible in such a case as that to graduate the payments which a man would have to make, if he or his dependants went into Hospital in accordance with his salary and his family liabilities?—There would be no such impossibility, that would be essentially an income limit, certainly.

1182. It would be an income limit, certainly, in a sense, but it would go to a very high limit?—But there is nothing in our policy to prevent that. You see we have specially said that it is such as is approved by the majority of the medical profession, resident and practising, within the area of the scheme, because we realise that there would be enormous variations in the income limit, which are desirable.

1183. Of course, you might not be able to limit the scheme to a district, might you?—No.

1184. You might possibly have a scheme which covers certainly an area as big as the Civil Service covers?—Yes, but it is obvious that it is unfair to allow a man with an income say of £2,000 a year to utilise Hospital accommodation and medical service on the same terms as a man whose income is £300 a year.

1185. Agreed, but any scheme of that sort ought to include a scale, and would you object to a scheme which does include a scale of that nature, so that it would not be left to the private individual, when he goes into Hospital, to make his own arrangements with either the Consultant or the General Practitioner, but a payment would be made to the Hospital on a scale?—(*Mr. McAdam Eccles*): According to income?

1186. Yes, and family liabilities; and the payment would be divided, also according to scale, between the medical attendants, the Hospital being paid in every case, a charge which might be fixed between limits say 5 to 8 guineas or 10 guineas?—(*Mr. Souttar*): I do not think that would contravene our policy in any essential particular, but it would depend, of course, on the scale of payments.

1187. That is a matter of agreement, but I meant as a principle would your Association object to a scheme of that kind?—Not at all.

1188. Do not you think it probable, if there is ever any widely distributed scheme of contribution for paying patients, that it is likely to be much more easily worked if it could be arranged upon that basis?—When you come to patients who are able to pay considerable sums.

1189. I am talking now really of professional people, not the people who might be prepared to go into Hospital and pay 10 guineas a week and full fees, as they would in a Nursing Home; I do not mean those; I am talking about professional people?—I think the Association would strongly favour that plan; in fact I am sure they would, but it would be essential that the freedom of choice of Private Practitioner should be safeguarded. (*Dr. Anderson*): If you were to have a big contributory scheme with people of income extending up to £2,000 a year, and you took those into a Hospital under a scheme of that kind and limited the choice of Practitioner, then you would have opposition.

1190. Might not it work out this way: Supposing it was a big scheme, the Hospitals with pay beds would be approached by the managers of the scheme and asked if they would reserve so many beds for use of the members of the scheme, so many beds of different categories, so many beds in a Ward of 5 guineas and beds in rooms at 8 guineas, or 10 guineas as the case may be; if patients were sent to that particular Hospital, and it was a teaching Hospital, then you would hardly abrogate the ordinary rules of the Hospital as regards the treatment of paying patients; that is to say in most cases probably if they went into the beds forming part of the Hospital they would be asked to accept the services of one of the inside members of the staff, but at the same time if he came from London, or any district near by, the General Practitioner would probably be permitted to come and see the patient if he liked, although he would not be able to definitely enter into the treatment. How would that difficulty be got over?—I think it would be quite capable of arrangement; presumably the patient would be given an opportunity of choosing where he would go, and that would mean in actual fact that he chose his own Consultant.

1191. I do not think there would be any difficulty in practice probably, but when you are drafting a scheme of this sort, in theory there might be, and that is really why I asked the question. Probably as each case arose the difficulty would not arise. I think it is true to say that in a great many cases when a

patient goes into a Hospital the General Practitioner really does not take very much interest until the patient comes out again ?—(*Dr. Anderson*): But you do not want to penalise the man who does take an interest. (*Mr. Souttar*): We are trying in Hospitals to encourage that interest in the Practitioners. We find that our members are very keen on being allowed to take an interest. Only yesterday at the London Hospital I was at a consultation between the House Governor and two Practitioners who were urging upon him the importance of seeing that the letters they sent up to the Hospital were answered by members of the staff. These two had thought it worth while, representing a considerable body, to come up to the Hospital to try and arrange with Mr. Morris that definite replies should always be sent to their letters by members of the staff.

1192. From different patients ?—Yes. (*Mr. McAdam Eccles*): Yes, and not only that, but there are quite a number of Practitioners now, of the younger men, who are very keen on seeing the operations performed upon their patients, and I make an invariable rule that General Practitioners should be informed, as near as possible, of the time when the operation is to be done; yesterday, for instance, I had three General Practitioners in the Operating Theatre, one of whom had only received a wire that morning to say what time the operation was. It was a very interesting case and he was there. The difficulty they have always is the question of time. (*Mr. Souttar*): I think the interest of the General Practitioner should be enormously stimulated and educated; I think it would be of very great value both to him and to us.

1193. Sir JOHN ROSE BRADFORD: I do not think that I have very much to ask after what Lord Hambleden has asked. I only want to be quite clear about one or two points. As far as I understand the Memorandum and your evidence you advocate that, we will call them paying patients for the sake of simplicity, might be admitted either to the Wards of the Hospital or to a Nursing Home established by the Hospital ?—Yes.

1194. In the former case the present rules as regards attendance you think should still continue to apply, but in the latter case the patient should have complete free choice as regards the Consultant who attends to him ?—That is the ideal position.

1195. That is what your Association recommends ?—Yes.

1196. Now as regards the Nursing Home side of the question, does that involve, in your opinion, fresh buildings; I mean, you do not contemplate a portion of the existing Hospital being labelled "Nursing Home,"; do you contemplate the building of a new institution ?—In general. It occasionally happens that a portion of the Hospital is empty and would be used as a separate building; it might be re-opened as a separate paying block; that circumstance could arise in London.

1197. I do not want to confuse the issue; you see paying block may mean one of two things. I was limiting it to your classification, and in your classification one of your categories is what you call the Nursing Home ?—Yes.

1198. That is what I want to clear up. Would you advocate a portion of an existing Hospital being allocated to the purposes of a Nursing Home ?—Yes, that is quite a possibility.

1199. Of course it introduces difficulties, does not it ?—I do not see that it is difficult if the whole Wing is allocated as a Nursing Home; I do not think it makes much difference whether you use the existing building or put up a new one.

1200. Well, it opens up the question as to how the funds were procured for the existing building; that is the difficulty I had in my mind ?—Even that difficulty could be got over actuarially.

1201. I want your views as a whole ?—By a Nursing Home we mean an institution which is financially independent of the Hospital.

1202. Then at the same time you do not advocate, what I may call bluntly, competition with existing Nursing Homes, do you ?—No, we think that their claims ought to be considered in any position.

1203. Such a policy as that would involve very serious interference with existing Nursing Homes, would it not. I mean if it was at all largely followed, if the various Hospitals in London instituted what one might call Nursing Homes ?—I think that in London the provision for patients of the class that was envisaged, the professional classes who find it very difficult to pay large fees, the provision for them is so inadequate at present that I do not think you would——(*Mr. McAdam Eccles*): Both inadequate in number of beds and inadequate in the proper provisions.

1204. I think that is common ground; I think we all realise that, but I do not think our Inquiry is limited to that, I think the inquiry we are all concerned in here should be put on a wider basis than that, as far as I understand it. With reference to that I might perhaps ask you what the views of your Association are on the provision of accommodation of this kind for relatively wealthy people, for all classes of the community on what may be called simply the American plan ?—(*Mr. Souttar*): I do not think that, as far as I recollect, the Association has actually considered that, but there is no question that as individuals we all hold that Hospital accommodation should be available for everyone. I do not say the accommodation in our present Hospitals, but that type of accommodation; and one special feature that does not exist in the Nursing Homes, the presence of a medical officer, we regard as absolutely essential to modern medical treatment.

1205. I think I understand the position as regards what I call the Nursing Home side of the question. Now with regard to the other category, the provision of beds in the Wards of the Hospitals for paying patients; I understand that you agree that under those circumstances the treatment of the patient must be under the control of the staff of the Institution ?—Where they form an integral part of the Institution.

1206. That is what we started with—in the Wards ?—It was agreed that they must be under the charge of the medical staff of the Hospital.

1207. I think, in answer to a question of the Chairman, you expressed the desirability of keeping the General Practitioner in contact with his patients; I think that was the word that you used. How do you suggest that should be effected; how is he to be kept in contact with his patient ?—He may be allowed access to his patient at all reasonable times; he may be communicated with when anything is going to be done, an operation to be performed; he may be informed as to the patient's exact condition on discharge and he may get advice as to what should be done.

1208. And that would satisfy your Association ?—Entirely. (*Dr. Anderson*): The paragraph in these two categories is for the first one you mention.

1209. Yes, I know, but we must keep the two

categories separate for the moment ?—I only mean as far as the Association is concerned.

1210. I quite understand that if you have a separate Nursing Home you then lay it down as a fundamental proposition that the patient should have complete control in the choice of his medical attendant, and that he should be simply a registered Practitioner, I was going to say, and not necessarily what is called a Consultant for the other case. You would be satisfied with the Practitioner keeping what is called in contact with his patient ?—(*Mr. Souttar*) : That is all that is practicable I think.

Sir JOHN ROSE BRADFORD : That is all I wanted to elicit ; I think that is all I wish to ask.

1211. Mr. LOW : Mr. Souttar, just to follow up what Sir John was asking you, it is a fact that at present all the paying beds in London are really in connection with Hospitals, are really an integral part of the Hospital, St. Thomas's and Guy's and King's, for example ?—St. Thomas's does not apparently regard them as an integral part of the Hospital, because they do admit outside Practitioners.

1212. But still it is practically an integral part of the Hospital ; it is all part of the building ?—We should regard it as a Nursing Home.

1213. That is all I want to know, you would regard that as a Nursing Home ?—Yes, and those arrangements are carried out entirely in accordance with our views.

1214. Entirely ?—Yes.

1215. I will come back to that in a minute or two, if I may. They would not allow, for instance, a General Practitioner to take any active part in the treatment of the patient ; he may certainly go and see the patient, but only as a friend ; he can give no orders to Nurses ?—No, but the patient must be under the charge of some one individual ; it is quite impracticable that he should.

1216. Medically speaking a patient in a Nursing Home—take for instance a surgical case, as you and I have more to do with surgery than other things—is under the care of the Surgeon and the General Practitioner ?—But you would be very much surprised if one went in and altered your kind of treatment.

1217. We generally do it together ?—Yes.

1218. But not so at St. Thomas's ; the Surgeon looks after the patient, and the person who is in the position of the General Practitioner is the Resident Medical Officer ?—Yes.

1219. And the General Practitioner is eliminated there—I do not say he objects, but he is in fact eliminated ?—Yes.

1220. At Guy's it is even more so ; as a matter of fact, at Guy's an outside Surgeon may go and operate there ; I do not think it ever happens ?—I did not know it was even possible.

1221. Dr. Eason told us the other day that it is a fact that it could happen. When the question is asked of the responsible persons of such Institutions as to who would be the outside Doctor or Surgeon who could come in, they say a Consultant or a Surgeon or a Consultant Surgeon, and you ask what they mean by a Consultant Surgeon and they generally define him as one who is on the staff of another Hospital ; would that be the definition that the British Medical Association would give ?—They have never made any definition ; I think that would be rather a matter of the domestic policy of the Hospital, would it not.

1222. The difficulty arises in this way, that you and I know operative surgery in particular has a much wider zone of exponents than it used to have, and that lots of operations are done, and possibly very well, by gentlemen who would not be called Consultants, and who have not even the ægis of a Hospital behind them. I mean, as you admit yourself, the Hospital Committee has a certain amount of responsibility for patients under their charge ; what would be the policy there ; are they to allow any gentleman who claims to be able to do an operation to come in and do it, or is it to be limited to a class of people who by convention are thought to have better opportunities of operating than others ?—There would be certain criteria he would have to satisfy. We have laid down these criteria, and, just speaking from memory, they are that he must have special experience in the class of work that he is undertaking, or he must have taken a special course of studies in that class of work, or he must be recognised by Practitioners in the neighbourhood as being specially skilled in that class of work. You and I are a little too apt, I think, to think of them in the terms of the big teaching Hospitals and not to consider the Hospitals in the smaller centres where people on the staffs of the bigger Hospitals are not available at all. Those criteria that I have mentioned will, I think, cover the point.

1223. Except that it is a little difficult for a medical officer, for instance, say at St. Thomas's, to bear all that in mind on the telephone. It is much easier if he knows that the gentleman in question occupies a certain position, whether he is good or bad, in connection with the Hospital ?—Yes, but we consider that that would be largely a matter of domestic arrangement. At St. Thomas's certain rules would be laid down for his guidance and they would be entirely different from the rules laid down at Willesden.

1224. Oh, yes, I realise that, and there would have to be different arrangements for different Hospitals ?—Exactly.

1225. That would not, of course, mean free choice ; you could not possibly say that a Hospital, take St. Thomas's for instance, which restricted people—take surgery, because I know more about that—which restricted the operations done in the Home to Surgeons who were on the staff of a big general Hospital ; you could not probably call that free choice of Consultant ?—We mean free choice within reasonable limits ; I think that is so. (*Dr. Anderson*) : But you are looking at this, are not you, entirely from the surgical standpoint.

1226. I said I am looking at it from that standpoint. I am talking to a Surgeon and I am a Surgeon, and I am looking at it entirely from a surgical point of view. I want to get the criteria as regards surgery ?—I think if we say a free choice within reasonable limits that would meet it.

1227. Of course in the American system, to which some reference was made, they have no free choice of Consultant. Take a Hospital like Johns Hopkins, where they have enormous paying Wards, they restrict them entirely to their own staff, and then even only to certain members of their staff, even some of the junior members are not allowed to look after these paying patients ?—(*Mr. Bishop Harman*) : But I think reports recently obtained show that in New York 75 per cent. of registered Practitioners were attached to some Hospital in some capacity or other.

1228. I am talking about General Hospitals. I am only referring to one particular thing which we have had evidence about. Then to go back to an old question, to make something clear, the class of patients you referred to who are paying full maintenance fees in your ordinary Ward,

and who could also have paid medical fees, who were only put there owing to the class of case they were; it is, I think, the mere fact that the Hospital had not got paying beds to take them. That is what you mean by that?—Absolutely.

1229. It was not that they were not paying anything, but they were there because you considered the Hospital the best place for them, and there was no other accommodation for them?—Frankly, I considered that it was the fault of the Hospital system that they were there; it was not the fault of the patient.

1230. No, that is what I gathered. Then a small matter: you say that all these patients should be admitted on the recommendation of a Private Practitioner. I am told that in many of these paying Wards attached to Hospitals a large number of applications—especially for such operations as you suggested, hernias and so on—come from the Colonies and abroad—people who are coming over on purpose to have an operation done in London, and they are very much attracted by the fact that they can go to a Hospital, and they do so. I think a great number of these people go straight to places like St. Thomas's and then ask for a Surgeon. There would be no objection because they are not recommended by any General Practitioner?—Not at all, they have not got a General Practitioner.

1231. Their General Practitioner is somewhere in Singapore or somewhere like that?—Yes, they are a special class, of course.

Mr. LOW: I think that is all I want to ask.

1232. Professor WINIFRED CULLIS: May I ask with regard to your tariff patients here, whether you include only those who get their treatment and maintenance for the one fee, or would you include people who were allowed to pay something for their treatment to Practitioners, to the Consultants. Is it all paid to the Hospital, the whole tariff and the cost of maintenance and treatment?—(*Mr. Souttar*): The tariff patient is a man who pays entirely to the Hospital. Our idea is, I think, that the cost of treating a patient may be represented by a certain sum, of which he pays a portion to the Hospital, but at the same time for the most part the Hospital takes it all, but he is essentially paying for the treatment which he received, though in actual fact the Medical Practitioner gets nothing—(*Mr. Bishop Harman*): We include generally in this category the contributory scheme patients.

1233. I wondered whether you would include the patients who paid a very small sum to their practitioner outside, even though it was a very small payment indeed?—Yes.

1234. Then about the Nursing Home block. I suppose that you would like to have facilities in your block for medical cases where the need was special Hospital treatment, perhaps more than a special Consultant?—(*Mr. Souttar*): Certainly it is to include all classes.

1235. That is what I imagined. Where you want free choice of Practitioner, the General Practitioner should have access to his patient without consulting anyone else?—Yes; for example, it is obvious that cases of pneumonia would be better treated in Hospital than at home, and it is quite possible that the General Practitioner might be perfectly competent to deal with them.

1236. Then you would like that Practitioner to go on treating that case?—Yes, we would, definitely, quite definitely. (*Dr. Anderson*): We want to increase the institutional facilities for the ordinary Medical Practitioner; that is our object running through the whole thing.

1237. Sir BERNARD MALLET: Did I understand you to say there is a considerable number of patients at the London Hospital who pay full maintenance fees?—(*Mr. Souttar*): I did not say a considerable number; I said there is a certain number; there is only a small number.

1238. The policy of the London Hospital is not to have paying patients; they have not any scheme?—We have no paying wards at all, and, therefore, sometimes a well-to-do patient is admitted for some very special reason—I remember, for instance, one spinal case where the man paid five guineas a week, which was the full cost, but I could not grumble at his being there, because it was obvious that the cost of treating the man privately would be entirely prohibitive.

1239. Mr. LOW: Just one matter with regard to the provision of private Nursing Homes. It is generally held, I think we all admit, that in the Nursing Homes, and especially in the rather cheaper Nursing Homes, the accommodation and the facilities are nothing like what they would be in the paying part of a Hospital. It would be enormously to the advantage of a patient to go into a Hospital rather than into one of those Nursing Homes, especially the cheaper ones?—I do not know any Nursing Home in which the accommodation is comparable with the accommodation provided in the poorest Hospital in London.

1240. And in addition to that there are all sorts of facilities in the Hospital with regard to accessory examinations and so on which are more easily looked after, and much more economically looked after, in a Hospital than in a Nursing Home. Take X-ray examinations and pathological examinations. There are more facilities for those than ever the patient can afford to pay?—I do not think any comparison can be drawn between a Nursing Home and a Hospital. For one thing, you have no Resident Medical Officer. If you have an X-ray apparatus, it is an apology for an X-ray; you never have a laboratory.

1241. I only want to emphasise the fact that in competing with Nursing Homes it would be to the advantage of the patient?—Yes, there is no question about that at all.

1242. The CHAIRMAN: Is there anything else that any of you gentlemen would like to say?—(*Mr. McAdam Eccles*): I do not know whether you would like to ask Mr. Bishop Harman whether he can give us just a short description of the West London Hospital and its paying block and how it really comes into line with the policy of the Association.

1243. Yes, we had evidence, of course, from the West London Hospital, but we should be very glad to hear anything more?—(*Mr. Bishop Harman*): You hardly need it if you have had it already. You have probably seen all these regulations, but I can tell you from the inside. We have 26 beds there in a wing, which is, you may say, in the heart of the Hospital; it is more than an integral portion, it is right in the centre of the Hospital. There are a number of single rooms and double rooms. It is approached by the same corridor as the public wards. It uses the same theatre, the same laboratories and X-ray equipment; it has nothing independent, so it is really an integral part of the Hospital; they are pay beds almost in the Hospital. When the scheme was started, the money was given privately by Mr. Dan Mason's benevolence.

The practitioners of the district were rather fearful, but they were asked to come and look and they were shown everything, and they were quite satisfied that there was nothing which would conflict with the propositions of the Association. There has never been any case of difficulty. The charges are very low—5 guineas a week for single rooms, 4 guineas for those who are in a double room. The arrangements for the payment of the member of the staff who undertakes it is a double one. The Committee desired that the cost should be the total cost to the patient and that the Committee should allocate so much to the member of the staff who treated the patient, but several objected. In fact there was a strong minority that the doctor should be free to make his own arrangements privately with the patient, if he so desired, so both systems are running; 75 per cent. of cases are paid for by one charge covering everything, and in the other 25 per cent. the member of the staff makes his arrangements with the patient privately. Roughly you may say, when a patient cannot afford much it is left to the Secretary to assess. If you know the patient well and he says: I can afford to pay such a fee, the arrangement is accepted. But there is a reduction of 10 per cent., which goes into the pool, and that is used for paying the radiologist and pathologist, and so you get the full benefit of the scheme without any additional cost to the patient. It works very well.

1244. Do you find the General Practitioners are very glad to send their patients in?—We have no difficulty. Usually we have a small waiting list. Just now there happens to be three rooms vacant, but as a rule there are a few patients waiting. We never had any greater waiting list than 15, which is reasonable. Private Practitioners are allowed in to see their patients at any reasonable time; usually they come when they know the Resident Medical Officer is visiting the patients. We have consultations with outside doctors if we wish. The staff are at full liberty to bring in anybody if they wish to see one of their patients. I have never heard of any outsider operating: I do not think they would be permitted except under some special circumstances. It must be understood that we do not admit anybody or every patient. Patients have to sign a form which shows it is reasonable and fair that they should take a share in the really charitable facilities which we give, for they do not pay on a full scale. Five guineas a week is the charge. If there is anything you would like to ask me I should be pleased to answer you. So far the scheme has worked out very well indeed, and as far as the facilities are concerned it is infinitely preferable to a Nursing Home. I think Fitzroy House is one of the best Nursing Homes, but I would rather have a patient in the West London.

1245. Your beds, I gather, are for the most part occupied by people who we call border line, and who, if such beds did not exist, might quite possibly be taken into the general wards?—That is true. I should think the majority of them would go into the general wards.

1246. Professor WINIFRED CULLIS: Do you have a special Resident Officer for the paying block?—One of the residents is detailed for the pay block, but he has other work as well.

1247. The CHAIRMAN: You have a Medical Officer for that block?—Yes, it is part of his duty. (*Mr. McAdam Eccles*): I wonder whether I can ask a question which has been troubling many of us a very great deal. Does the maximum, which I understand is 5 guineas a week for a single bed, really cover all the cost to the Hospital of that patient other than medical fees?

1248. I will put that question, but as I gathered, in the case of the West London Hospital, there are no extras. (*Mr. Bishop Harman*): The rule is as follows: "This payment entitles the "patient to accommodation, board, drugs, surgical "dressing, the use of the operating theatre, and "all routine nursing as ordered by the medical "attendant. Further consultative advice or "treatment, special nurses, massage, patho-"logical or radiographic examinations or any "other expensive or unusual remedies ordered "will be charged for in addition by arrangement "with the patient." Then there are certain extra charges in the case of massage and electrical treatment and so on. (*Mr. McAdam Eccles*): Of course the difficulty, you know, with a question of contributory schemes in connection with this matter is to know what is really the minimum which covers the total cost of maintenance.

1249. We are hoping—we have not arrived at it but we are hoping—to arrive at some figure which will be very near it, but it will vary, of course, in different Hospitals to a certain extent, because the ordinary beds do vary in cost.

1250. Professor WINIFRED CULLIS: I did ask that very question from the representatives of the West London Hospital because their fees seemed rather low, and they told us that it really did actually cover the cost.—(*Mr. Bishop Harman*): But you must remember the fabric is provided free of charge, and that is a heavy item.

The CHAIRMAN: If you had to put up a building of this kind I do not think it would be really possible to do it for 5 guineas, even if you had open wards.

1251. Mr. LOW: Does the arrangement under which these patients are looked after in the West London Hospital satisfy the Association's definition of free choice of Practitioner?—Yes, it was discussed at the last meeting of the Hospital Committee and it was agreed it does; it is an integral part of the Hospital and they could not detach it from the Hospital, and every part is a part of the Hospital, and, therefore, they are pay beds in the Hospital.

1252. It does not satisfy the definition of free choice of Practitioner?—But it is the definition; if they are beds in the Hospital then it is not anticipated that anybody except the Hospital staff would attend them. Of course we prefer that this should be a separate Nursing Home and then there would be a wider application, but we cannot have everything in this world (*Mr. McAdam Eccles*): I hope this is quite clear to the Committee, that the Association by all its policy and all its discussions are really in favour of a block system separate from the rest of the Hospital, which is a very important point, and that the block should be run so that none of the charitable money of the Hospital should in any way be expended upon it, either for capital or for current expenses.

The CHAIRMAN: Yes, I understand that.

We are very much obliged to you gentlemen for giving so much time to us.

(The Witnesses withdraw.)

(Adjourned.)

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

WEDNESDAY, 12th OCTOBER, 1927.

PRESENT :

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW.

LORD SOMERLEYTON and MR. LEONARD L. COHEN (*Honorary Secretaries*), and MR. H. R. MAYNARD (*Secretary*), also being present.

Transcript of the Shorthand Notes of MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.2.*)

SEVENTH DAY.

SIR HOLBURT WARING, F.R.C.S., Surgeon, St. Bartholomew's Hospital, and MR. THOMAS HAYES, Clerk to the Governors, called and examined.

1253. The CHAIRMAN : Sir Holburt Waring, you are Surgeon of St. Bartholomew's Hospital, and Mr. Thomas Hayes is the Clerk to the Governors ?—(*Sir Holburt Waring*) : Yes, that is correct.

1254. At the present time the Hospital has not beds of this nature ?—We have no paying beds in the true sense. What happens is this, that patients who are admitted to the Hospital are asked if they can contribute towards the cost of their maintenance up to a maximum of two guineas per week, or such lesser sum as their pecuniary circumstances will allow.

1255. That, of course, does not cover the full cost of maintenance ?—I believe the King's Fund have worked it out and they find it is much more, about £4, but I have forgotten what it is. (*Mr. Hayes*) : £4 13s. 0d. in 1926. (*Sir Holburt Waring*) : And the maximum we are able to charge is 2 guineas.

1256. I suppose sometimes patients will give donations after they leave the Hospital ; it is not unknown ?—Well, it is not unknown, but from the point of view of the Hospital and its staff I do not think it is advisable to encourage the practice that patients should come

to the Hospital and receive the benefits of the Hospital and its staff merely by giving a donation to the funds of the Hospital. Take for example many of the medical staff of a Hospital like St. Bartholomew's—they receive for their services to the Hospital an honorarium of 50 guineas per annum. That is a fixed sum which they receive as, call it, an honorarium or what you like. Under those conditions, we, the staff, do not think we ought to be called upon to treat any patient except the necessitous suffering poor. We do it because the conditions of affairs in this country are such that patients of all kinds can come to a Hospital, and this principle of payment has recently been recognised to be necessary to enable the Hospital to carry on their work. As I say, at St. Bartholomew's the Hospital may receive 2 guineas per week from each in-patient. As the result of this levy, if you like to call it such—I think also you have before you a statement as regards the charges which are made to out-patients — the Hospital receives approximately from patients and their contributory associations the sum of £30,000 per annum. I speak now as an individual, and I have found that in recent years there is an increasing number of patients who are able to pay various fees for their Hospital maintenance and treatment. As I say, there is an increasing number of patients of practically all kinds.

Sir Holburt Waring and Mr. Thomas Hayes.

1257. By treatment there, to get it quite clear, you mean what is necessary to support them in the Hospital treatment in the shape of fees?—(*Sir Holburt Waring*): Yes, I am constantly being asked if I can take into St. Bartholomew's patients who will pay for their Hospital accommodation and also pay for their treatment. We have no provision for this class of patient. I have noticed this a great deal of recent years, and I have no hesitation whatever in saying that, as a fact, it is becoming much more recognised by the suffering rich and the suffering middle classes that the treatment which they can get now in our voluntary Hospitals is far superior to what can be got practically anywhere else. That is the reason why sensible people are beginning to turn to Hospitals for their treatment.

1258. And that experience has led the Governors to suppose that there is a growing demand for that class of accommodation?—(*Sir Holburt Waring*): That is the experience of the members of the staff. The Governors themselves, of course, I do not think have any direct experience as regards that. (*Mr. Hayes*): Yes, I think there is a very distinct demand for pay beds for people who can pay an inclusive sum of anything from 5 to 10 guineas. There are a number of people who could pay 5 or 6 guineas, but I do not think they would be able to pay, in addition, a substantial fee, say for X-ray or other special examinations and treatments.

1259. Not a substantial fee, but I think a fee very often?—(*Sir Holburt Waring*): I do not quite agree with Mr. Hayes about that. (*Mr. Hayes*): No, we are not in agreement.

1260. Perhaps I may tell you that as a result of evidence, I think I may say that we have found that those who pay 5 guineas a week sometimes pay nothing in the way of fees for medical treatment, but very often desire to, and do, pay something?—(*Sir Holburt Waring*): As a fee.

1261. As a fee, but a small fee?—(*Sir Holburt Waring*): But what happens is that a great many of those patients come into the Hospital in the ordinary way and contribute 2 guineas.

1262. I will put it briefly; do you think if you had pay beds it would relieve the General Wards of a considerable number of patients who are taken in now because there are no beds?—I have no doubt it would relieve the charity beds of a great deal, because there are quite a number of patients who get into a Hospital in this wise. They go to the General Practitioner. He finds that they have got something serious the matter with them which is rather beyond the physician, and says: "You had better go to the Hospital "or a Specialist." The patient says: "I cannot "afford it" and the General Practitioner says: "I will get you into a Hospital," and very often the General Practitioner is misled as regards the pecuniary position of the individual. The latter has no qualms whatever, he has given a sixpence somewhere or other to some charity and he thinks he is entitled to the full benefits of the Hospital, and he goes on the recommendation of the General Practitioner. I do not think he does it wittingly in the majority of cases, but he gets in and receives all the benefits of the Hospital at 2 guineas per week.

I have taken a very great interest in this question for many years. When I first began to take an interest in it I was on the staff of the Metropolitan and afterwards on the staff of St. Bartholomew's, and more recently I have visited a large number of the Hospitals in this country and in other parts of the world. I think there is no question, but if you admit the principle of payment by patients in a General Hospital, which is supported by what you call contributions from the public, contributions from the King's Fund and otherwise, if you once take in patients who are going to pay for what they get, you have got to grade them; you cannot say that they are all going to be 2 guineas or 5 guineas or 7 guineas, because you find that they are different classes. One is perfectly satisfied in a small room where his operation or treatment can be carried out, and another man says: "No, "I cannot have a place like that; I want a large "room, and I am prepared to pay for it."

1263. It is the general experience that a certain amount of grading is necessary?—(*Sir Holburt Waring*): I think it will be very unwise to lay down the law in connection with all Hospitals. I can speak only in relation to St. Bartholomew's. I am saying that a Hospital which provides accommodation for paying patients in paying Wards must have graduation. You must provide for the suffering rich as well as for the suffering poor.

1264. Graduation in fees and maintenance?—Graduation in fees and maintenance.

1265. There would be a small number of 5 to 10-guinea patients. I suppose the 10-guinea patients would be equal to the class of patient who now goes into a fairly good Nursing Home?—(*Sir Holburt Waring*): Oh, quite, yes.

1266. Is there any feeling on the part of the staff as to whether they are prepared to deal with patients of that kind who would pay a highish fee for maintenance and also probably a high fee for treatment?—(*Sir Holburt Waring*): I do not know that I can answer that, but although our Medical Council have not passed a formal resolution on that matter, what I can say is this, that they, as a body, are strongly in favour of the provision of accommodation for paying patients of different grades provided it does not interfere with the beds which are allocated to the suffering and necessitous poor. The general question I can answer you; they are very anxious to have the paying department where different grades of patients can be taken, but they do not wish that that paying department should encroach upon the accommodation we have for the necessitous poor. If it can be done without any interference they would have it. It is a very valuable work, and they desire it.

1267. Do you know whether they have considered the rather burning question as to whether treatment of patients should be limited to those who are on the staff already?—(*Sir Holburt Waring*): Well, they have discussed it, but it has not been regarded as urgent until our rebuilding scheme has been fully worked out. We have got accommodation for a paying department in the scheme. We have not passed any resolution on that point. Would you mind stating your point again?

1268. I do not know whether I have stated it quite clearly; whether outside Consultants should be allowed to come into the Home?—(*Sir Holburt Waring*): Yes, we have discussed it in this way. We have talked it over and there were two principles, I think, which governed our discussion. One was this; that if a paying department of that kind is created, in the main and preferentially it ought to be for the patients of the staff of the Hospital who are treating the necessitous poor; but if, for example, it is found that there is more accommodation than the staff of the Hospital

require then that accommodation ought to be open for patients of individuals who are not on the staff of the Hospital. There must, however, be this proviso, that there will have to be some kind of a panel upon which are the names of Consultants who will be recognised for the purpose. I take it that if this did not exist and patients were allowed to be brought into a Hospital such as St. Bartholomew's or wherever you like, under the care, shall I say, of General Practitioner or Practitioners who have not got a first class professional position in connection with another establishment it opens the way to the General Practitioner of what I might call a second class category. He may take a patient into a paying department of a Hospital, and he may there, under the auspices of that Hospital, do operations which in a certain number of instances are illegal, and in many cases are very unjustifiable, and very often he is not competent to undertake either. So I think, without passing any formal resolution —I am not talking for the Medical Council of the Hospital because we have not formally considered this—we should not advise the Governors to have a paying department which was open to every patient under whatever Doctor they like to choose; but we should like a paying department of a suitable size graduated, which is available first of all and preferentially for the patients of the staff of the Hospital, and secondly, if accommodation is available, for the patient of every recognised General Practitioner. It is rather difficult to put it in so many words, but I would suggest Specialists such as Radiologists, Electrologists and those who have a recognised standing.

1269. I will put it this way; you are prepared to allow other Practitioners to come in to treat their patients, provided that the Hospital has approved of them, broadly speaking?—By the Hospital, you mean?

1270. Well, the Governors?—The Governors on the advice of the medical staff. I want to be quite clear; I do not want any misunderstanding. I think if we are not a little careful we might get into slight troubles. I do not think the Governors of St. Bartholomew's would ever make any regulations of that kind without consulting their Medical Council, but I am rather talking of the general principles and I want that to be perfectly clear; the panel is not to be merely on the approval of the lay body.

1271. Perhaps Mr. Hayes will be able to answer this question better. I see the Charity Commissioners have expressed an opinion as to the possibility of building upon the present site. Has a question been addressed to them by the Governors?—(*Mr. Hayes*): Oh, yes. We approached them before we could undertake it, and we have a scheme which has been in existence about seven years, authorising us to take paying patients. We thought at first we could not do it, but the Commissioners agreed that so long as we set aside not less than 100 beds for the necessitous poor, we may charge up to 2 guineas a week for in-patients, not exceeding 5s. for out-patients. They stipulated that we could set aside a certain number of beds for patients who could pay from 4 to 6 guineas, but the medical staff did not think our Wards were suitable for treating cases of that kind, and therefore we never availed ourselves of this permission; we merely receive the 2 guineas as a maximum. At one time 18 to 20 per cent. of the in-patients contributed the full 2 guineas a week, but since the Hospital Saving Association and the Saturday Fund have made definite payments on behalf of their members, that number is reduced to about 5 or 6 per cent.—(*Sir Holburt Waring*): May I supplement Mr. Hayes' answer. The point is this, that when the Medical Staff discussed this particular question, what had considerable weight with them was first of all, as Mr. Hayes has stated, that our Wards are not very suitable for that particular class of case; and secondly, they were very loth to allocate any Wards which at the present time were used for the necessitous poor for this purpose. They did not wish to curtail the advantages to the necessitous poor and they did not want to interfere in any wise whatever with the facilities of the education of the medical staff.—(*Mr. Hayes*): It was assumed that paying patients of that class would not be available for educational purposes.

1272. I think I shall be correct in stating the case, so far as those are concerned, if I say that you are quite clear that there is a class in the community which is not insured against sickness and which requires accommodation for ailments which can only be treated properly in an institution of some kind, and that the greater number of any beds provided for such a class of the community would probably be upon a rather low scale of payment. That is to say that the larger number of people who come to you would be ready to pay from 5 to 8 guineas?—(*Mr. Hayes*): I think that is the demand at the present moment.

1273. But that there is no objection in principle to providing for those patients who can pay a higher charge for maintenance and in many cases perhaps the full fee?—(*Sir Holburt Waring*): In a certain number of cases, I would not like to say the majority, but they would be naturally a small proportion.

1274. But as far as you know in principle there is no objection?—(*Sir Holburt Waring*): In principle we strongly advocate it, and I see no difficulties of differentiation when once accepting the principle of payment.

1275. Sir JOHN ROSE BRADFORD: Sir Holburt, as regards the panel question, just to come back to that for a minute. Do I understand that what your Council suggests is that this panel should be one approved by the medical staff? (*Sir Holburt Waring*): Approved by the medical staff and the Governors. I mean to say it should be approved by the Governors after consultation with the medical staff on the subject.

1276. I quite understand. What I want to ask you is whether in addition to that you would have the panel limited, to put it shortly, we will say, by professional status. Would you limit the panel to so-called Consultants, or would you admit on the panel General Practitioners?—(*Sir Holburt Waring*): We have not discussed that very point and it is only a personal expression of opinion that I can give you.

1277. It is rather an important point?—(*Sir Holburt Waring*): I do not think that we should welcome General Practitioners having total charge of patients in the Hospital.

1278. I mean total charge, I am considering only total charge?—(*Sir Holburt Waring*): I do not think we should welcome that.

1279. In other words this panel then would be one not only approved by the medical staff, but it would also be one that would be limited to the attainment of some professional position. That is what it amounts to?—(*Sir Holburt Waring*): That is what it amounts to.

1280. Then do you see any difficulty in allowing access to patients by the General Practitioner ?—(*Sir Holburt Waring*) : None.

1281. You see no difficulty ?—(*Sir Holburt Waring*) : I see no difficulty, no.

1282. Mr. LOW : I think Sir Holburt has made the position very clear by his answers, but there is just one point I should like to ask about and that is this. I understand that there is a demand at St. Bartholomew's for paying beds for what I may call patients who are prepared to pay 5 guineas, but not anything for their medical treatment, and there does seem to be a demand for the class of patient who can pay fully for his maintenance, and also fully for his professional treatment ?—(*Sir Holburt Waring*) : No, I do not think that there is a certain demand.

1283. Because of course one sometimes has wondered whether that is due to the geographical position ?—(*Sir Holburt Waring*) : There is no doubt about it there is a demand, but I think it is due mainly to the individual members of the Staff, and not the administration of the Hospital.

1284. Yes, it would not be due to the administration ?—(*Sir Holburt Waring*) : No.

1285. Of course, quite apart from the question of expense, it has been suggested to us that there is an enormous advantage in patients going to a Hospital over going to a Nursing Home, inasmuch as a Hospital has Resident Medical Officers ?—(*Sir Holburt Waring*) : That is one, but I think the other point, which is a stronger one, is that we should not get a complete equipment in a Nursing Home for the treatment of patients, and should not get the resources of the various accessory departments existing in a Hospital (X-ray, electrical, pathological, and so on), where you have those on the spot and they are available for the patients.

1286. We have already heard that there are enormous advantages ?—(*Sir Holburt Waring*) : And the general public are beginning to realise it, they are beginning to find that it is almost impossible for many of them at the present day to go to, say, a Physician for treatment and then to find, after going to the Physician, that it is necessary to go to the Radiologist or the Electrologist. The fees which are charged in many cases are two or three times what the Physician charges.

1287. Then you think there is a demand at St. Bartholomew's for a paying department under the administration of the authorities of St. Bartholomew's ?—(*Sir Holburt Waring*) : I do, strongly.

1288. In starting that Nursing Home you think it would be of great advantage if that were run by members of the staff of the Hospital ?—(*Sir Holburt Waring*) : You mean the medical staff ?

1289. I am talking of the surgical and medical staff plus what you call a panel of people of equal standing. I gather that panel would not be a personal panel, it would be composed of men like members of the staff of a teaching Hospital ?—(*Sir Holburt Waring*) : I think it would probably be both.

1290. You think it would have to be a panel not merely defined by saying any staff of a teaching Hospital, but in addition to that you would have certain names ?—(*Sir Holburt Waring*) : Yes.

1291. You explain the General Practitioner ; I do not want to go into that, but there is a difficulty in defining the Consultant rank. There is a large class of people nowadays who sometimes define their own position as Consultants, and they might not be accepted by the Hospital ?—(*Sir Holburt Waring*) : No. I do not think we should be prepared to accept a self-definition of the Consultant who is not on the staff of any recognised Medical Institution. I do not think we should turn him down, but we are not prepared to adopt the self-definition of Consultant.

1292. There is only one other question ; have you got any idea as to what would be the cost—I do not know whether you have gone into this at all—of building such a Nursing Home so as to take everything into consideration, so that you would know exactly what it costs the Hospital in arranging, say, fees for patients and maintenance for patients ?—(*Mr. Hayes*) : We have a scheme for a Home which is estimated by the architect to cost £150,000.

1293. How many beds ?—(*Mr. Hayes*) : About 80 to 95 beds.

1294. What does that work out at a bed ?—(*Sir Holburt Waring*) : £1,600 a bed. (*Mr. Hayes*) : It is a very rough estimate and the plans prepared were not complete drawings, they were merely sketch plans of what could be done on a certain site, and the provision on that site of accommodation for 80 to 95 beds.

1295. The CHAIRMAN : That was a complete unit divided into administrative quarters, etc. ?—(*Mr. Hayes*) : Yes, entirely separate from the Hospital, and the calculations of the maintenance of patients were based on an average payment of 7 guineas per week. The auditors showed that on that charge the thing would not be a paying proposition if we had to pay interest on the capital outlay.

1296. Mr. LOW : How much ?—He based his calculation on 7 guineas a week.

1297. The CHAIRMAN : An average of 7 guineas a week ?—(*Mr. Hayes*) : Yes.

1298. Mr. LOW : If this were a Nursing Home you would charge much more than 7 guineas a week. I am not talking about a medical fee, but the maintenance. The maintenance would be much higher than that. You would charge a patient much more than 7 guineas a week ?—(*Mr. Hayes*) : Yes, but that is the figure he took, because we had in mind that we were probably providing for patients coming out of the ordinary class of patient. I think it was felt primarily they would be the people we should make accommodation for.

1299. The CHAIRMAN : Was it designed for private rooms or wards ?—(*Mr. Hayes*) : Private rooms. (*Sir Holburt Waring*) : All of them private rooms. That is £1,600 a bed. I rather assume that it was nearer 100 beds than 80.

1300. There would be no objection to your taking 5-guinea patients who do not really pay for the whole of their maintenance ?—(*Sir Holburt Waring*) : We might have wards so arranged that they could have actually the conveniences of a private room and yet not be private rooms ; there might be two, or four-bedded cubicles, a small ward which is divided ; and then, of course, the expenses of both maintenance and building would be less. (*Mr. Hayes*) : It was proposed to nurse this with fully certificated Nurses. It is practically a Nursing Home on those lines. There would be 35 Nurses at £80 a year each, one Matron and six Sisters, two Resident Doctors and the necessary domestic staff. The ground rent of the site was estimated at £3,200 per annum.

1301. Mr. LOW : Is that included in the estimate ?—Yes, it included the ground rent—the

£3,200 per annum which would be paid to the Hospital. (*Sir Holburt Waring*): In connection with that particular point one might say something which might perhaps make that ground rent a little less. Perhaps you will say I am trying to push a point on behalf of the members of the staff and what is requisite for them. Part of the proposal is that the lower basement of this building should be cut off and should be available as a garage for cars of the members of the staff. At the present time we have to "park" in the Hospital square. The question has not been gone into in detail. I think if this were done it would make it something less. Of course, as to what could be done for a Hospital on those lines, what I think about it is this; if we could only find some philanthropic individual, who realises that the suffering rich and the suffering middle classes require assistance in the same way that the necessitous poor do; if we could only get him to build us an establishment, it could be run in such a way that there would be a substantial profit to the Hospital. I know of a Hospital in Boston which was built on those lines, and where they make a profit of approximately 50,000 dollars a year for the Hospital out of the building which was given to them by a generous donor.

1302. Just to supplement that, you do not think you could make a profit to the Hospital if you had to pay capital cost? You do not think you could make a Nursing Home pay in a Hospital?—(*Sir Holburt Waring*): On the calculations so far made, no.

1303. Mr. COHEN: I only want to ask on a financial question whether the calculation includes the provision for Sinking Fund in accordance with the requirements of the Charity Commissioners to replace that capital within a number of years?—(*Mr. Hayes*): No.

1304. The CHAIRMAN: Is there anything you would like to say?—(*Sir Holburt Waring*): I should like to put on evidence that what we think is requisite for St. Bartholomew's is a private portion of the Hospital or a private Hospital for the treatment of different grades of patients which shall contain accommodation for approximately 100 patients, and which we think would approximately cost £150,000. I should like that to go down so that if some philanthropic and well-meaning member of the community with more money than he knows how to spend would like to provide for such a thing it might be done. As regards this question of the panel, I am merely giving you the results of conversations with members of the medical staff. It has not been officially sent to the Governors by the Medical Council; we have not got so far as that.

1305. The CHAIRMAN: Well, we are very much obliged to you for coming and giving us so much time.—(*Sir Holburt Waring*): I hope I have succeeded in making myself clear.

The CHAIRMAN: Oh, yes.

(The Witnesses withdraw.)

DR. J. HUGH THURSFIELD, M.A., M.D., F.R.C.P., Royal College of Physicians, called and examined.

1306. The CHAIRMAN: Dr. Thursfield, you are here from the Royal College of Physicians?—Yes.

1307. May we assume that the College has given any consideration to this subject, or that the evidence that you give is from conversations?—The evidence that I give is from conversations with friends generally. I do not think the College as such has considered the question at all.

1308. But you have discussed the matter with the representative members of the College?—Yes.

1309. And you are prepared to give the result of those conversations?—Well, on certain points only; it is quite impossible to cover the whole ground.

1310. Quite so. First of all, can you say at all what class of patients might be expected to avail themselves of pay beds?—Yes, I think so. There is undoubtedly a considerable class in the community who are not prepared to pay the expenses of the ordinary Private Home, and are very ill-equipped in their own homes for necessary medical or surgical proceedings, and who yet are not in the class who are entitled to charity beds pure and simple, and are prepared and ready to pay certain sums, anything, I should say, from 3 to 7 guineas a week upwards. Above that I should doubt if there is any considerable class. I think the majority of people included in that class would desire to include a certain proportion of fees which ordinarily are paid apart, that is to say, fees for necessary pathological and X-ray examination. The class that I have in mind is the class who wish to be able to calculate the total expense of a month's illness and to see whether they can possibly afford it.

1311. You put the upward limit at 7 guineas?—Yes, I think so. If you take the ordinary stay in a Nursing Home as three weeks to a month, which I think is the average, that would run from 21 to 28 guineas for the illness quite apart from any fees that would be paid to the Doctor or the Surgeon.

1312. The reason that I asked the question was that you do not think that there is any demand by people who are prepared to pay more. What leads you to that conclusion?—I think that is wrapped up in another question, the exact site of the Home. For example, I think there is a class which is prepared to pay very much more heavily for accommodation in an up-to-date Nursing Home attached to a Hospital, and I think, for instance, a Hospital, taking London, like St. George's, is favourably situated for that, but a Hospital like the London is not favourably situated.

1313. It depends very much upon the situation of the Hospital?—Very much. I think it is extremely unlikely that a patient who is prepared to pay 15 or 20 guineas a week would be prepared to go for a month to Whitechapel.

1314. But you have no objection in principle?—Oh, none.

1315. Would a Hospital accept patients in its paying department who are prepared to pay the full Nursing fees and, of course, who would also be expected to pay the full fees for treatment?—That brings in the other question of the self-support point of the Home. If you can induce that class to patronise such a Home largely, obviously your financial problem becomes very much easier.

1316. And you might be able to provide the lower-priced beds in a larger number at a lower figure?—The higher the figure you could possibly charge, the lower the figure you could possibly charge.

1317. Or, alternatively, you might be able to provide a profit for the parent Institution?—I very much doubt the profit altogether. That is wrapped up in the charge which I think would have to be made. I mean, if I may enlarge on

that a little, I think that a Nursing Home attached to a Hospital, say, at Hampstead, is quite able to make a profit, because the rent at Hampstead for the ground on which it stands is comparatively low compared with the economic rent, say, of the building of St. George's Hospital, and, obviously, you have got to make a very much larger profit on your actual turnover, receipts and expenditure, in order to pay an economic rent at St. George's Hospital than you have at Hampstead.

1318. Quite true. So that you rather incline to the opinion that if the parent Institution is to be greatly benefited, the paying department should be provided by charity. I will put it this way that somebody might be prepared to confer a permanent benefit by providing it with a department which would produce a permanent profit for the Hospital?—Certainly, if such a benefactor were forthcoming and prepared to endow such an Institution substantially, then I think you could make a profit on quite a moderate fee charge, but the economic rental at my own Hospital, for instance, St. Bartholomew's, would be so very heavy, that without such aid I cannot see how you could expect to make a profit.

1319. The economic rental would be likely to be heavy in the case of all the Hospitals which are favourably situated for the high priced patients?—Yes, it would. Well, all the Hospitals attached to Medical Schools, with Medical Schools attached, but I do not know that that follows at such a Hospital as the Hampstead General Hospital, for instance.

1320. But that would be rather exceptional. Take St. Thomas's?—And Dollis Hill. I do not know, some of you probably know much more about the financial position of St. Thomas's than I do, but I understand that there is no economic rental paid there.

1321. No, there is not, but I think the value of the ground rent would not be quite so valuable as the rent across the river at Westminster?—No, probably not.

1322. Then you suggest that you would be prepared to deal with the demands of this particular class, what this particular class wants?—Yes.

1323. I do not know whether you would like to develop that any more?—Well, I find that very anxious inquiries are made by patients who are prepared to go into Nursing Homes as to the extras. If they are going to be X-rayed, for example, a series of X-rays for stomach complaints, is going to add very materially to their costs in an ordinary Home. If it is done at a Hospital with the staff and appliances and capital expenditure already laid out by the Hospital, it is obvious that the paying Home of the Hospital would have to pay at least maintenance charges to the X-ray department, and I think the class that I have in mind would like that to be included in their total charge, their maintenance charge. It makes the thing extremely complicated, of course.

1324. Of course, in any case the charges made in a Hospital would be very much smaller than the charges made in a Nursing Home?—They would be smaller—well, I understand from my X-ray friends that it is quite impossible to produce a complete series of intestinal X-ray photographs at a cheap rate. For instance, the outlay for films alone is about 5 guineas.

1325. I do not like to contest that statement straight off, but I think it is rather excessive?—Well, perhaps I ought to put it rather, overhead charges, plates, and the salary of the man who develops and the chemicals and so on.

1326. However, you are quite clear that there are great advantages for a patient who goes into a Hospital because he gets the benefit of all the auxiliary services which the Hospital provides on the spot?—Oh, certainly.

1327. In dealing with this question as to whether it is advisable for Hospitals to provide pay departments of this sort, you suggest that there might be differences between a Hospital with a Medical School and one without?—The difference that I had in mind is again twofold. A Hospital with a Medical School attached must necessarily keep, so far as one can see at present, the total number of its beds available for teaching purposes, and therefore pay beds must be an addition to the services of such a Hospital. In a General Hospital without a school attached, I think it is perfectly feasible to detach a certain number of the existing beds and make them an adjunct to the Hospital, a self-maintaining adjunct. Then again, there comes in the question of site. All the Medical Schools are situated upon sites which are valuable. Again, the question of the economic rental crops up.

1328. I do not know what your opinion would be as to the admission of outside Practitioners for the treatment of patients in these pay beds?—Before I answer that may I point out one other difference which escaped me for the moment between the Hospital with Medical Schools attached and the Hospitals without a Medical School attached? I rather hesitate to say this, it sounds perhaps a little conceited on the part of the man who is attached to a Medical School, but I think it is generally admitted that the standard of treatment on the whole is higher at Hospitals with Medical Schools attached than at Hospitals without Medical Schools attached, and that feature is reflected very largely in the additional expenditure per head on a patient at a Hospital with a Medical School attached. The standard of examination and investigation remains continually higher, because the Hospitals with Medical Schools are compelled, in the interests of teaching, constantly to exploit new methods. With regard to the question of who is to be admitted to the Pay Home, I think that must depend on the individual Hospital. There are various practices in the existing Homes. At St. Thomas's, as you know already, those qualified according to the terms that have been drawn up are at liberty to have patients in St. Thomas's Home. At certain other Hospitals the privilege is limited to members of the staff, and in such cases they have generally laid down certain limiting propositions as to the fee which those Doctors shall charge in the Homes. For example, I believe I am right in saying that if a Surgeon admits a patient to St. Thomas's Home he could, if he liked—there is nothing to prevent him—charge 100 guineas for his operation; there is nothing in the terms. At St. Peter's Hospital for Stone, where only the members of the staff have the privilege of treating patients, they have I understand limited the fee which any member can charge to 30 guineas.

1329. That is by agreement among themselves?—That is by agreement among themselves, and I think it is important, because if you limit the admission or the right of admission and the right of attention to the members of a particular staff and leave them with an unlimited charge, of course the rest of the Profession at once say that

they are creating a monopoly. The only way in which that would be corrected, I think, would be general competition with the other Homes.

1330. I do not know whether there is anything else you would like to add to what you have said. As far as I am concerned I have asked all the questions that arise to my mind.

1331. Sir JOHN ROSE BRADFORD: Dr. Thursfield, supposing there were a Nursing Home attached to a large Hospital, would you have any limitation imposed as regards the qualification of Practitioners who came to treat patients there? I mean, supposing the treatment of patients was not limited to the staff of that Hospital?—I think you would have to have some limitation, because otherwise you would be open to invasion by what the Profession would generally call cranks.

1332. And how would you impose the limitation; how do you suggest it should be imposed?—Well, I am afraid I have not considered that question, but off-hand the St. Thomas's arrangement seems to me to work very admirably. There you must be attached to the staff of a recognised London Hospital in order to have the right to go and treat patients.

1333. You would not be in favour of allowing a patient to be attended by any Practitioner he or she liked to select; that follows, does it not?—I think so. I do not think you could open it as freely as that.

1334. In other words you would not allow General Practitioners to have free access for the sole treatment of their patients?—I should like to do it, but I do not think you could do it at the moment without introducing a great many difficulties.

1335. You know it has been suggested that that should be done?—Yes.

Sir JOHN ROSE BRADFORD: I wanted to know what your opinion on the matter was.

1336. Mr. LOW: I should like to thank Dr. Thursfield for the very clear and useful evidence he has given; it has been of great assistance. There is just one question I would like to ask; I think you admit that, quite apart from the expense, there are certain advantages, there would be certain advantages even for the richest patient to go to a Nursing Home which was administered in connection with a Hospital?—I have no doubt about it.

1337. Dealing with emergencies, there would be someone to deal with emergencies on the spot?—Yes.

1338. It seems a little hard that wealthy people should not get those advantages?—I think it is very hard. It is a common phrase that the poorest man gets very much better treatment on the whole than the wealthiest, or than, I will not say the wealthiest, the ordinarily wealthy.

1339. I think you say that you do not think such a Nursing Home in connection with a Hospital could possibly make any profit?—I think I qualified that.

1340. I know, having regard to the economic rent, I recognise that. Of course, Nursing Homes, even situated in the Provinces, apart from London, where they do have to pay big rents, do make profits?—But they do not charge such small fees as the Hospital.

1341. Would you say that a Nursing Home in connection with a Hospital would probably be more economically run with all the advantages of buying and so on than a Nursing Home run by private people?—I should imagine it would be; that is a point I have not considered.

1342. Then the other question that you talk about, the geographical position of Hospitals; do not you think that sometimes the attraction to certain members of the staff might overcome those considerations. For instance, there might be in Whitechapel a gentleman that people will come from all over England to be dealt with by him?—Yes, but I do not think you could count on that at any particular time.

1343. It would be sporadic?—You have got to consider the life of an Institution, not merely for the lifetime of one member of the staff, but for a considerable period. If you are going to mention names, take Sir Frederick Treves at the London Hospital, no doubt that would occur, but I think you would recognise that that does not happen more than once in a generation.

1344. No, but do not you think once a habit was established the appetite would come with it. For instance, in America people go a considerable distance to go to Mayo Brothers, but they will disappear and people will still go to Rochester. I do not know whether if a habit of that sort were established in England you would think it possible?—I have never been in Rochester, but I imagine that Rochester is a great deal more pleasant place to be ill in than New York.

1345. Yes, it is a long way to go. I was thinking of geography rather than the actual surroundings?—You have mentioned America. Of course, the obvious way out of all our difficulties here is the American plan, which would make the wealthy man, whom you can charge in English money five-and-twenty guineas a week, pay for the man who can only afford 3 guineas.

1346. That was in my mind, and that is what I was trying to ask your opinion about?—Certainly, but can you establish that in the crowded areas of Central London?

1347. Mr. COHEN: Do you think that the experience of Guy's, where they have had a paying Ward for the last three or four years of 25 beds, where I understand they could provide probably 25 more beds, rather neutralises your experience about situation, because no one would say that Guy's is situated in a very eligible quarter?—I am afraid I know very little about Guy's Home; I do not know the charges there at all.

1348. The charges are 5 to 7 guineas, I think?—If that is so I should have said that 25 beds at an average charge of 5 to 7 guineas could not possibly be a profitable undertaking.

Mr. COHEN: I do not think the question of rent enters into it, economic rent, for instance?

1349. The CHAIRMAN: We are very much obliged to you. Is there anything else that you want to tell us?—I do not think there is anything else.

1350. Your evidence will be of great help to us—Of course, there is one other matter which I have not mentioned, but which is, to our minds at Bart's, very important, and that is the question of the attitude of the Charity Commissioners. You probably know very much more about it than I do, but I imagine that it would be quite impossible for St. Bartholomew's, for instance, to establish a pay Ward on any portion of the present Hospital site and charge fees without very considerable dealings with the Charity Commissioners.

1351. That, I think, is probably true and would be true of a good many other sites?—Yes.

The CHAIRMAN: Yes. Thank you very much.

(The Witness withdraws.)

(Adjourned.)

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

THURSDAY, 13th OCTOBER, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair,*
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
PROFESSOR WINIFRED CULLIS,
MR. LEONARD L. COHEN and MAJOR WERNHER (*Honorary Secretaries*), and
MR. H. R. MAYNARD (*Secretary*), also being present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.2.*)

EIGHTH DAY.

Dr. S. S. Goldwater.

DR. S. S. GOLDWATER, M.D., Director of Mount Sinai Hospital, New York, called and examined.

1352. The CHAIRMAN: First of all, I should like to thank you, Dr. Goldwater, for being so kind and liberal in giving your time to come here and see us over this question, which, comparatively speaking, is new to this country. By comparatively speaking, I mean compared with the United States. You have been good enough to send us certain papers over here which some of us have had the opportunity of reading, and if I may I would like to ask you one or two questions?—I should be very glad to answer them if I can.

1353. I understand from what you say, that in the United States you would find in practically all Hospitals, certainly in all the big ones, three classes of patients, charity patients, middle class patients and private patients?—That is quite true generally in Voluntary Hospitals. It is not true with Public or Municipal Hospitals, but it is beginning to be true even of those.

1354. Something comparable to our Voluntary Hospitals in this country?—Quite so.

1355. When you speak of charity patients, would they as a rule give anything towards the cost of their maintenance?—We speak of free beds in the States in this way, that the bed is available for any one who is unable to pay, but quite regularly, patients who enter the public or free Wards, so called, are invited to pay according to their means. Actually the amount of payment varies considerably according to the means of the individual. Very remarkable things are happening in the States at the present time. I happened to be in Cincinnati recently, where a project was on foot for the development of a Voluntary Hospital having a mixed service, and I was invited to assist in the formulation of a programme for this Hospital. Near by, there was a large Municipal Hospital offering very generously a very high grade of free service. The Voluntary Hospital of which I speak had had, during the previous year, 75 free beds available. Quite regularly throughout the year the number occupied was very small; the average number of free patients for the entire year was only 16. All that time there was a large waiting list of private and semi-private patients, made up for the most part of members of the artisan class, who were declining the free service that was available for them, because they were prepared to pay, and wished to choose their own Physicians and accommodation.

1356. I heard you mention the artisan class. Did you include those amongst the middle class

in the States ?—They are now so classifying themselves with respect to Hospital services.

1357. And they would be anxious to choose their own Physician or Surgeon ?—Their disposition is to choose their own physician or surgeon and to get accommodation superior to that which is offered in the common or public Wards.

1358. Would the members of the staff of the Hospital to which they were going be very much opposed to that ?—As a matter of fact, there is in the older and more representative Hospitals in the East, except in the teaching Hospitals, a tendency to become more "open." In some mixed Voluntary Hospitals in the East, the private Wards only are open to the medical profession at large. The tendency as one goes West is to open the free Wards also to the Medical Practitioners of the community.

1359. With regard to the middle class patient, what, as a rule, would he be prepared to pay for maintenance. I am not speaking now of fees for medical attendance but for maintenance ?—Broadly speaking, he is prepared to pay less than the cost of the service he is seeking. He is demanding really a higher grade of service than he is able to pay for. He is striving to lift himself out of the charity class in not taking anything which is free, but it is really beyond his means.

1360. What would the average cost of a charity bed be ; take the New York Voluntary Hospitals ?—In the General Hospitals it would be from 4 to 6 (or 6½ dollars in some instances) a day. In my own Hospital the cost of maintaining a ward patient is approximately 6 dollars a day. It has risen to 6 dollars from a dollar and 60 cents a day 20 years ago. That is due of course to the general change in price level but I think more particularly to the radical change in the character of Hospital service.

1361. That is about £8 10s. a week. I suppose that in comparatively recent years—here one is rather inclined to use the phrase "since the War" —but in recent years, I suppose salaries have risen proportionately to other costs ?—Almost proportionately I should say. That is certainly true of the salaries of industrial workers, but perhaps not so true of clerical workers.

1362. So that the middle class patients you have would pay on the average something less than £8 or £9 a week in our money ?—Yes. Let me give you a specific instance, the case of our own Hospital. We have semi-private Wards especially for the class of patient we are talking about. Our public Ward costs being 6 dollars, our estimated semi-private cost for a middle class patient's service is something in excess of 7 dollars. So that if a patient pays 5 or even 6 dollars a day, really there is a gift on the part of the Hospital of the difference. These patients pay reduced medical fees in some Hospitals—less than are paid by private patients. The professional fees are sometimes limited by Hospital Rules ; I am speaking now of the intermediate class ; but in most Hospitals there is simply a tacit understanding that the fees shall be reduced as compared with private room fees.

1363. Is that generally a scale which has been adopted by the Hospitals ?—As a rule not. As a rule there is a voluntary reduction of fee on the part of the staff. In some instances certain charges are made by the Hospital itself, for professional services. I speak particularly of the laboratory services, various biological tests and so on, where the work is done by salaried medical officers.

1364. There are extra charges for all ?—Almost always, yes, and the rule generally speaking is that those charges are reduced by approximately one-third as compared with the full charges which are made to private patients. To illustrate that, I have brought with me some schedules from my own Hospital, showing the fee rates charged for private and semi-private patients. I think those may be of some interest to you. I have here, also, some notes prepared for me at the last minute before my departure by the Hospital Information Bureau of the United Hospital Fund, giving specifically the rates charged for semi-private patients in various New York Hospitals.

1365. I am afraid I am ignorant of the rate of pay which artisans get in the U.S.A., but I take it that the pay would be at least twice as much as English wages ?—Well, in the building trades in New York City, wages now run from 8 or 9 to 14 dollars a day, 8 or 9 dollars for helpers, 10, 12 and 14 dollars for skilled mechanics.

1366. Over 6s. an hour ?—Of course building is more or less a seasonal trade, so that a reduction would have to be made in calculating annual earnings.

1367. Sir BERNARD MALLET : That would work out at something like £9 a week ?—Nine dollars a day would be paid, for instance, to a plumber's helper.

1368. The CHAIRMAN : I suppose these beds would also be occupied by the less well paid professional classes, small shopkeepers ?—Yes, shopkeepers and office workers.

1369. Who do not probably in proportion get a higher salary than the artisans ?—Probably less. The skilled artisan now in our country gets about as much as the ordinary college professor.

1370. Those would be the classes who occupy these beds ; the better paid working man, put it that way, and the lower paid professional classes and the small shopkeepers ?—Yes.

1371. People of that sort ?—Yes. If I may go back for a moment to the question of rates, I have here a list of 24 Hospitals in New York, all of which have semi-private beds, the number varying from two or three up to 40 or 50 ; a total of 648 beds is listed here, and the rate per day which is charged by these various Hospitals varies from 4 dollars as a minimum to 7 dollars as a maximum.

1372. Sir BERNARD MALLET : Those are not municipal Hospitals ?—Those are really Voluntary Hospitals. The Municipal Hospitals in New York do not receive patients of the class that we are speaking of. There are some Municipal Hospitals in the States, however, that are opening their doors to semi-private and private patients.

1373. Do they play a great part, the Municipal Hospitals ?—A very small part, as yet, in the case of private patients.

1374. The CHAIRMAN : Then you would say, as a rule, that the middle class patients do not pay for the cost of their maintenance ?—No, and the general sentiment I think amongst experienced Hospital administrators in the States is that it is useless to ask them to do so.

1375. At any rate I take it that those who are known as private patients pay a great deal more than the cost of their maintenance ?—That is, unfortunately, not uniformly true ; for Hospital interests, however, it ought to be. I should say that it is the accepted doctrine in the States that private patients ought to pay a rate equal to full maintenance cost plus interest on capital. That can be done and is done in certain Hospitals in the larger centres of population where there is, in

certain seasons of the year, actual competition for Hospital accommodation, and where the Hospitals therefore control the situation.

1376. But it is quite the fashion, is not it, for rich people to go into Hospitals ?—Yes.

1377. They do not go to Nursing Homes. We know that there are certain clinics which have been produced which they go into ?—Let me illustrate. Mount Sinai in New York, something like 25 years ago, had about 200 beds. It was not planned for private patients at all, but a few odds and ends of spaces were converted for private patients, and the administration succeeded in finding accommodation for 12 private patients. The Hospital was rebuilt in 1904 for 500 patients with accommodation in the private pavilion for 57. Within a year that department was overcrowded, and a new private pavilion, erected in 1921, included 131 rooms, 90 per cent. of which last year were occupied for the entire year. The earnings were about 180,000 dollars over and above operating expenses, which of course paid liberally on the capital investment. The building is tax exempt. We are now planning a separate pavilion for semi-private patients of 100 beds, and it is my firm belief that we shall require at least 200 beds of that class. This case is typical of the present tendency in the States. The Massachusetts General Hospital at Boston has a project for a semi-private pavilion of 200, eventually 300 beds. The Massachusetts General Hospital has also a private pavilion which accommodates, I think, something over 100; I think it was only 15 or 18 years ago that the Massachusetts General Hospital, as a matter of principle, like some of your Voluntary Hospitals here, adhered to the old traditions and firmly refused to receive any private patients who would pay fees to the staff for professional services.

1378. Then would it be true to say that all these paying patients, if taken together, assisted the funds of the Hospital or otherwise ?—I should say that the drift is decidedly in that direction.

1379. The Hospital is better off for having them ?—I am afraid I cannot make that statement as a general thing, and if you will allow me a moment I will explain why. Hospital rates were established before the war on the basis of what was then presumed to be the cost. I find in many cities a conflict between the Hospital and the staff, and generally speaking the influence of the staff is exercised against what the Hospital administration would regard as a suitable and reasonable readjustment of rates to meet present conditions. I think the public is gradually getting the idea that they ought to pay the full cost of any private Hospital service.

1380. I think it is rather the general idea in this country that those whom you specify as private patients have been in the habit of paying quite large sums, even larger sums than are paid in England at Nursing Homes for accommodation in Hospital; but I rather gather that that is not quite your opinion ?—Well, our own private pavilion at Mount Sinai the maximum room rate is 15 dollars a day, and the average room rate is 11 or 12. The actual average payment made by patients altogether, including extra charges, probably would run up to 15 dollars a day. There are Hospitals in New York that charge as much as 20 dollars for similar accommodation, and there are a few private Nursing Homes that charge as much as 30 dollars for accommodation which is not superior to what General Hospitals offer for 15 or 20 dollars.

1381. That would be £3 a day, 15 dollars ?—Yes.

1382. That is no more than you would have to pay with extras at a first-class Nursing Home in London ?—No, probably not. The Nursing Homes in New York charge for everything. They have not the same accommodation as the General Hospitals, but for such accommodation as they are able to offer, they charge higher rates than are charged in the Voluntary Hospitals.

1383. I think we are all agreed that the accommodation which can be offered in Voluntary Hospitals is better, for many reasons that you have already mentioned, than can be given in Nursing Homes. They have not the auxiliary services which the Hospitals can give. Have you any knowledge of the maximum cost of a private Nursing Home ? Have you come across it, including the extras which would mount up in the Hospital to 15 dollars ?—It is some years since I last studied intimately the operations of a Home of that sort. It was one that was then being built in New York and has since been discontinued. At that time they were barely making both ends meet, at rates similar to what Hospitals then were charging. Very recently there has started in the West, and is drifting East, a movement for the creation of rather large scale Nursing Homes. "Real estate" interests are taking them up as a form of investment, and are securing the support of Doctors who are not connected with Hospitals. I think this movement arises chiefly out of the fact that private service in Voluntary Hospitals is not yet adequate to meet public demand. Such Homes are being provided quite rapidly in the middle West, and there have been one or two of moderate size recently built in New York. There is one of 300 beds projected in New York, which really would be a fully equipped Hospital, but conducted on business lines by business men for business purposes.

1384. Sir JOHN ROSE BRADFORD: Have you any idea of their charges ?—Their charges must be in the nature of the case higher than the charges at Voluntary Hospitals, because they have to meet interest charges and taxation charges as well. The highest price that I have ever heard quoted for rooms in Nursing Homes in New York is 30 dollars a day, and the highest for any single private room at a Voluntary Hospital is 20 dollars a day with extras.

1385. The CHAIRMAN: Do you, as a rule, put your middle class patient into accommodation which gives him privacy ?—Yes and no. There are two types of provision that are commonly met with. Several years ago there was quite a wave of enthusiasm for the construction of small private rooms, which were presumed to be built at low cost and maintained at low cost. I think that movement has proved a failure. Those rooms have become more and more elaborate as time has gone on, and, as a matter of fact, they are being supported now at a rate which is away beyond the means of the semi-private patient. The other type of semi-private Wards have individual cubicles like some I saw at Guy's Hospital and, I think, St. Thomas's, many years ago. But I should say that at least three-quarters of all the buildings which are being planned and built now for semi-private patients, are divided into small Wards of two and three and four beds' capacity.

1386. They like the idea of a four-bedded Ward better than a big Ward ?—Oh, yes.

1387. Did they have any system of grading the condition of the patient ? Supposing you have several four-bedded Wards, would you have one for the worst cases, one for those that were not quite

so bad and one for convalescents?—From the standpoint of Hospital planning, what I am recommending and providing for is separation rooms in connection with semi-private Wards, just as one would provide separation rooms in connection with public Wards. I think the need is the same.

1388. One knows that in the great majority of surgical cases, convalescence is pretty rapid?—Yes.

1389. Patients have found it troublesome sometimes. When other patients come back from the Theatre recovering from anæsthesia, some of them do not like the noise, some of them do not mind it a bit. Do you make any special provision for that?—The separation rooms that I speak of are used for any condition that calls for separation of a patient, either for his own good or for the comfort of his neighbours. It requires a rather firm and consistent attitude on the part of the Hospital Administrator to retain for these specific uses the separation rooms that are provided in that manner. These rooms should be kept at the Hospital's disposal for the good of all. One finds, however, a tendency on the part of the staff to seek the use of those rooms for private patients who wish to rent them at reduced room rates.

1390. If it is true to say, as you stated, that you cannot make a high enough charge to the semi-private patients to pay for the services which they obtain, how is the capital money for this service to be found if you are going to develop the building?—By voluntary subscription.

1391. Then is it also true to say that this class of people do not mind the idea that they are depending on charity?—Well, they do not think of it in those terms, if the accommodations that are offered them are not called Wards, and if they have choice of Physician, and if they have all or most of the privileges that are commonly accorded to private patients. I have never heard of a private patient refusing to accept the service, and I should say that, in 50 per cent. of all the nearly 200 Hospitals that I have been associated with in the last 20 years in an advisory capacity, I have found the established rates to be below actual cost, and with the full knowledge of the staff, and with the full knowledge of the patient, patients are quite willing to accept hospital service on those terms.

1392. And people are ready to contribute charitable funds to those purposes?—Appeals are being made quite openly for Hospital provision on those terms. I can recall very vividly the character of a financial campaign in the City in the State of Michigan recently, where Hospital money had never been raised previously by appeal to the public. They made an appeal to the community at large; it was desired to enlarge and modernise one of the Hospitals, and representations were made to the well-to-do of the community that it was incumbent upon them to subscribe, because they and their families were using Hospital facilities which they had not previously paid for, and they must provide a building for their own use which would then be maintained at cost. In other words they were appealed to, to make provision for themselves, and they did it.

1393. Sir JOHN ROSE BRADFORD: I gather from what you said that the amount paid by the semi-private patient, the middle-class patient, does not meet the cost?—That is often true.

1394. What I want to ask you is this; can you tell us roughly what the cost of the free beds is? I mean I want to make a comparison, you see, with the cost over here?—Yes, in New York City the cost of free service runs from $4\frac{1}{2}$ to $6\frac{1}{2}$ dollars in the General Hospitals.

1395. $4\frac{1}{2}$ to $6\frac{1}{2}$ dollars per diem?—Yes.

1396. And the semi-private you said 6 or 7, did you not?—The actual cost; in most Hospitals, it would be from a dollar to a dollar and a half more per day than the cost of free Ward service, according to the method of administration.

1397. I wanted to make a comparison between the cost per day in the States and the cost that we are more or less familiar with here. So $4\frac{1}{2}$ to 6 dollars a day is the minimum cost for the free patient?—Yes. Of course I am speaking of New York City. There are smaller towns where different conditions prevail.

1398. Mr. LOW: I understand that it is a fact that you do provide for the very wealthiest class in Hospital?—Yes, quite so.

1399. And you make a profit on it?—Fortunate Hospitals do, but not all Hospitals.

1400. You mentioned taxation. Is it taxed by your State?—No.

1401. You are free from taxation?—Yes.

1402. So that the Nursing Home or private clinics that would be in opposition to them would have to stand the added cost of taxation?—Yes, the difference in principle being that the earnings of the Nursing Home might be appropriated to private use, whereas the earnings of the private pavilion of the General Hospital would have to be used for public service.

1403. It would go to the Hospital funds?—Yes.

1404. With regard to a Municipal Hospital; does that correspond to our Infirmary?—Yes, I should say so.

1405. That is to say, where any old or weakling person who is not actually ill would have to be taken if he was poor?—The classification is not quite the same, there are a few communities (fortunately very few) in the States that have no Voluntary Hospitals. Usually in the larger cities Voluntary Hospitals and Municipal Hospitals of the same general grade are carried on side by side, the chief distinction being that the Municipal Hospital does not, as a rule, make any provision for private patients. But there are exceptions, for some Municipal Hospitals do make provision in a small measure for private patients.

1406. They would not be supported by voluntary subscription but by the State?—By taxation.

1407. Then you said that in the Eastern part of the States, the service of the private pavilion was a close service, that is to say, only run by the staff of the Hospital?—Yes.

1408. Are they a paid staff? Is it a paid staff or a voluntary staff?—As a rule a voluntary staff.

1409. And they, of course, can charge fees to the patient in the paying part of the Hospital?—Quite so.

1410. And no outside Practitioner is allowed to come and treat the patient there?—Generally speaking that is true.

1411. And there is no feeling in the general profession in New York against that?—Oh indeed, there is, decidedly.

1412. They consider to a certain extent these other gentlemen are being put into a privileged class?—Quite so.

1413. What is the tendency, towards opening it or still keeping it closed?—The tendency, I think, is to increase, wherever practicable, the number of men who are attached to the Hospital,

and who therefore acquire private pavilion privileges.

1414. In the Western States it is not quite the same, is it, they are the more open services ?—Yes.

1415. Does that mean that any registered Medical Practitioner can go in and treat a patient in the Hospital ?—That is probably true of many Hospitals in the West, and of very few in the East.

1416. There is only one other little point, and that is, about the planning of these Hospitals as regards the small Wards. Does this apply to the very wealthy patients, that you find that three-quarters of the accommodation is for three or four-bedded Wards ?—No, single rooms are demanded by the very wealthy.

1417. What we should call the Nursing Home class of patient would have single rooms, and the three or four-bedded Wards are for those patients who, although they are paying for their treatment and for their maintenance, are still not paying for the full amount of either ?—That is the general character of the service.

1418. They are to a large extent getting a certain amount of charity ?—Yes, though it is concealed in many instances. It is not often publicly stated, but it is a fact that charity is indirectly given.

1419. But the patients who do not get charity would demand a room for themselves ?—Yes.

1420. Sir BERNARD MALLET: I think you imply that the number of people in semi-private Wards is increasing very much, the demand for them is increasing ?—Yes.

1421. And it is being met by new buildings and so on ?—Yes, and by the adaptation of old buildings; it was an unheard-of thing for a Voluntary Hospital 20 years ago to pay its way. There are many Voluntary Hospitals now that are practically paying their way, that is to say, the plant being given free and clear and the Hospital being exempt from taxation, it is able to earn out of its varied services, enough or nearly enough to keep it going. Of course this would not be true where the beds were preponderantly free beds; but the tendency is to substitute pay and part-paying beds for free beds.

1422. It is rather a recent development then ?—Yes.

1423. The CHAIRMAN: Now you might go to the second part of your paper, upon planning for the middle class of patient, that is the actual planning and the cost of building. The dimensions that you give are all limited to the actual Ward and its immediate surroundings ?—Yes, I so limited it for the sake of clarity.

1424. So that we do not include any administrative premises ?—In the figures given they were specifically excluded.

1425. In general, I want to ask do they include the cost of sanitary work, and heating and lighting, or merely building work ?—Not the cost of the central heating and lighting plant. So far as the patients' section of the building is concerned, the figures cover the cost of the building with all its fixed equipment. It is that part of the Hospital which is occupied and which immediately serves the patient, with all of its complete mechanical equipment—plumbing, heating, ventilating, and electricity.

1426. I think you come to the conclusion that accommodation can be provided, per bed, for the semi-private patient at a sum of 2,000 dollars ?—Yes.

1427. I think it is right to say that that would be a great deal less than we could do it for in England at the present time ?—Well, do we understand each other ?

1428. That is what I want to know. I have figures here of a Hospital which I hope to show you this afternoon, which was actually completed during the war, but the most part of it was built before the war, and the comparable figure to this figure of 2,000 dollars amounted then at that time to round about £300; I cannot say exactly, but just round about £300 then. Your figure is £400 now ?—My figure is the figure for providing bed accommodation only, it does not include operating theatres, kitchens, administration blocks, and so on.

1429. Neither does mine; mine merely includes the Ward block and its sanitary adjuncts and small rooms attached to it, a section of corridor and the pipes, electric light leads and so forth, which are required for the ordinary services. That runs up to about £300, and I think it is fair to say to-day that that would cost at least £600. I think if you ask an architect to do that building now, it would cost about two and a third times as much as it did before the war; I think I am correct there. So that that figure, if I may say so, a little bit surprises us ?—If we come to the actual analysis of plans, I think the figure would explain itself. In formulating a programme for a mixed Voluntary Hospital in any industrial city in the States to-day, where the required accommodation would run approximately one-third private patients, one-third semi-private patients, and one-third Ward patients, where there would be a moderate-sized out-patient department, and where the scientific service would be adequate, and where the Nurses would be provided for in the proportion of one Nurse to two in-patients, and where a certain proportion of the domestic servants would be provided for within the Hospital grounds, I find it necessary to provide about 10,000 and frequently 12,000 cubic feet of construction for all purposes for each in-patient. This is something quite different from 2,000 or 2,500 dollars a bed; it means that the average bed cost for the entire Hospital is likely to be 7,000, 8,000 or 9,000 dollars a bed.

1430. So really, as regards building the Hospital outside the mere Wards, it would cost about three times as much as the mere Wards ?—Yes, about.

1431. So that there we should agree ?—My figures were 2,000 to 2,500 dollars for semi-private Wards alone, according to the details of the arrangement.

1432. Just to make it clear, the total cost would be three times as much ?—It would; it is a very easy thing of course to manipulate figures. I have here a scheme for a little Hospital of 50 beds. This would perhaps be a simple illustration. I remember presenting these plans to the community that was expected to pay for it and they said: "This bed cost is frightfully high; you are asking "us to pay 6,000 dollars a bed for this little 50-bed "Hospital; it is much too much." I said: "Let me have that plan and I will alter it." I re-marked the plan with other figures, and there was now a 70-bed Hospital and the cost per bed was much lower. It was the same Hospital; I had simply appropriated 3 solaria, which were intended for convalescents, and put beds in those spaces. I had not the slightest doubt that, after this Hospital was put up, that would happen anyway. I did not mean the Hospital to be used in that way, and therefore I said I was preparing plans for a 50-bed Hospital. There are ways of crowding a Hospital of course. I happened

to be a few months ago in a Hospital in Michigan built by the State and conducted for teaching purposes; in Wards designed for 25 children I found 50 cribs. That was not what was intended; it does not add to the comfort of the patient when Hospital service is thus degraded. But in that manner, bed cost can be reduced.

1433. These costs that you suggest are based upon estimates from your experience?—They are based upon actual experience.

1434. And on a building being a more than one-storey building?—One-storey Hospital buildings are now exceptional in the States. Generally speaking there is no such thing as a new one-storey Hospital except in Southern California, and except throughout the States for orthopædic cases.

1435. Where you have got that class it is cheap construction comparatively?—Yes.

1436. And have they always been of a permanent type of building?—The practice is to build for permanent use.

1437. What materials do you use?—Brick is mostly used, brick walls. As a rule the framework is steel for tall buildings, or reinforced concrete for buildings up to three or four stories in height, steel beyond that with a brick curtain-wall; commonly reinforced concrete floors.

1438. And usually painted walls?—Painted walls, with a very liberal use of hard glazed tile for service rooms, operating rooms, kitchens and utility rooms.

1439. If you would give us the figure per cubic foot, it would make it very much easier to compare the cost here and in the States?—Well, figures which are most accurate are those running from 70 to 80 cents a cubic foot. In some few instances more than that is being spent.

1440. That is about 3s. or 4s. roughly?—Yes, nearer 3s. than 4s. in most cases. Within the last two months I can recall three contracts actually let in the City of Philadelphia where the figures were 66, 72 and 81 cents respectively; that is actual Hospital construction.

1441. Seventy cents would be rather above than below the average?—No; this happened to be a particularly low market. In Pittsburg and the vicinity shortly before, contracts were let at 68, 70, 82 and 85.

1442. About 3s., that would compare with ours?—We have just finished a Nurses' Home in New York comprising two million feet of construction, and the cost was 75 cents a foot; a million and a half dollars in round figures.

1443. I should be interested to know, if the figures are at all comparable, whether you are able to say whether your form of building is more economical?—I think a comparison of plans can show it more easily. I think you may be using your spaces more freely than we do. In the States there is a tendency to crowd patients closer together than you customarily do.

1444. I see in one place you suggest giving 80 superficial feet per bed?—That is being done quite commonly for semi-private rooms and small Wards. Rooms 10 by 16 are often occupied by 2 beds.

1445. I think it would be true to say that in the new buildings in the public Hospitals in England, that would be a great deal less than they have got?—Where the public authorities intervene with regulations—as a rule the public control is rather lax—but where they do intervene they frequently set a minimum space of 800 cubic feet for a patient in a Ward, but 1,000 cubic feet is more frequently used.

1446. Sir JOHN ROSE BRADFORD: The public authorities will accept 800 cubic feet?—They will in New York State. They have passed plans which provide no more than 800 cubic feet per patient in the Wards.

1447. The CHAIRMAN: You think 120 superficial is too liberal, so liberal as to be extravagant?—Well, I am participating in the planning of 30 Hospitals just now, and in most cases the money that is available would not permit of the use of space as generously as that.

1448. Of course you cannot exactly say that money spent in that way is extravagantly spent, because it gives the best conditions?—No, we just haven't the money to spend, that is all. I will say that I have seen in many instances patients occupying less space, and where the Nursing service was carefully provided for, and where proper precautions were taken to isolate suitable cases, I have seen no epidemics arise.

1449. Of course, during the war, Wards which were designed for 24 patients were very often used for 50?—Yes.

1450. I got some figures from King's College Hospital, and the figure there was 122 feet per bed and 1,575 cubic feet—Yes.

1451. Of course that may have been rather extravagant?—The first section of my own Hospital, built in 1904, provided 1,800 cubic feet per bed. The ceilings were 17 feet 6 high, but in the next construction we dropped the ceiling height of the Wards to 11 feet 6. Now we are using a ceiling height of 10 feet for private rooms and small Wards.

1452. And of course that does make a large saving?—Yes.

1453. Professor WINIFRED CULLIS: How many beds would you have in a Ward 10 feet high?

(The Witness demonstrated plans to the Committee; the Wards were generally small Wards—4 to 12 beds.)

1454. Of course it is true, is it not, that if you have practically all single rooms it increases the cost of certain services a great deal, Nursing especially; you must have more Nurses?—It increases the net cost of Nursing unless the patients pay the difference. They often provide individual special Nurses at their own cost. It is not uncommon to find that, out of 100 private room patients, 50 or 60 are employing at their own cost, day and night Nurses in addition to the staff Nurses supplied by the Hospital. Under those conditions the Nursing cost to the Hospital does not increase; the total or actual Nursing cost does, however.

1455. Do the middle class patients do that?—The middle class patients can hardly afford to do it.

1456. But the better-off patient?—Yes.

1457. Do you graduate your scale at all? I see you put 5,000 dollars a bed for the very best class of accommodation?—Yes, I know Private Hospitals have been built and are still being built far more expensively than that. Take the case of our own private pavilion, where we spent 10,000 dollars a bed.

1458. Does that provide a sort of private suite?—No, single rooms. Certain of them have private baths and private toilet, but there is much more that the 10,000 dollars includes. It provides kitchen, rest-rooms and dining-rooms for the Nurses, solaria, operating theatres, reception rooms, resident staff quarters, and many but not all the other features of a General Hospital.

Dr. S. S. Goldwater.

1459. You say bathrooms are sometimes attached to the rooms ?—Yes, hotel practice is influencing Hospital planning. No Hospital is considered up to date in the States nowadays which does not have private baths attached to a certain number of rooms, and while we do not need a bath for every room in a Hospital, people rather expect to see them, so a great deal of money is being wasted in the construction of private baths which are not used.

1460. It is possible to construct a bath between two rooms ?—It then ceases to be private.

1461. I do not know whether the question has been asked before I came, but have you any idea of the total all-in cost for a patient at the Hospital ?—Yes, I have already presented some figures.

Major WERHNER : Not exactly that.

1462. Professor WINIFRED CULLIS : What it actually works out at ?—You mean the total Hospital cost ?

1463. To the patient ?—Are you including medical charges ? I am sorry to say there are no reliable statistics to show that ; one can get estimates of course, but we do not have access to the Doctors' books and so I am afraid we cannot tell you ; fees are arranged between the Doctor and the patient entirely.

1464. Apart from medical charges have you any idea what the cost per week would work out at ?—You are speaking of ?——

1465. Mount Sinai.—Private or semi-private ?

1466. Semi-private.—Our semi-private patients pay between 5 and 6 dollars, which covers all extras except Doctors' fees. We charge them only 4 dollars as a regular day rate and their extras amount to a dollar or a dollar and a-half a day.

1467. The private room costs vary a great deal ? —Oh, certainly. Where private patients employ special day and night Nurses, costs run into hundreds of dollars a week.

1468. Could patients in the Hospital have in Physicians from outside ?—Most of the Hospitals in New York do not allow that.

1469. Sir JOHN ROSE BRADFORD : I am sorry, but I forgot a question which is rather an important question. Would you mind telling us whether the three categories, the Ward, semi-private and the private, are provided for in the Hospitals at which there are medical schools ?—I am not quite sure about uniform provision for semi-private patients, but all of the more recently constructed medical school Hospitals make provision for private patients, and, I think, it is reasonable to assume that they have provision for semi-private patients. In other words, so far as their Hospital accommodation is concerned, they are conducted precisely like the ordinary Voluntary Hospital, with the possible distinction that the number of private rooms which are permitted is perhaps smaller, but that is not uniformly true by any means. The limitation of private services is generally desired by those interested in medical education ; it is desired to keep the attention of the staff concentrated as much as possible on the free service which is essentially, but not always exclusively, the teaching service.

1470. Is there no Hospital with a medical school as far as you know with semi-private patients ?—I should say they either have, or feel the need of, semi-private accommodation.

1471. Are the semi-private patients available for teaching purposes ?—In some places, yes, in other places, no. There is no uniformity about that.

1472. Are the private patients available ?—They are frequently used with their own willing consent, not by rule or right.

1473. So it would be correct to say that there are teaching Hospitals in which both semi-private patients and private patients are available under certain conditions for teaching purposes ?—Quite so.

1474. That would be a correct statement ? —Yes.

1475. Professor WINIFRED CULLIS : How do you settle which patients are to be classed as private and semi-private ?—It is a question of the location of the patient in the Hospital, and a question of the rate he pays.

1476. He may choose himself ; it has nothing to do with his financial position ?—Well, that is true with reservations. There are some Hospitals which demand a showing on the part of a semi-private patient that he is not able to pay for private room accommodation. As a rule such inquiries cease where the free Ward service ends, and the semi-private patient is not obliged to make a financial declaration.

1477. Who makes such inquiries as to the financial standing of private and semi-private patients ?—The Hospital administrative staff.

The CHAIRMAN : Thank you very much, Dr. Goldwater, you have given us great assistance in the question we are dealing with.

(The Witness withdraws.)

(Adjourned.)

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

WEDNESDAY, 19th OCTOBER, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
PROFESSOR WINIFRED CULLIS.

LORD SOMERLEYTON and MR. LEONARD L. COHEN (*Honorary Secretaries*), and MR. H. R. MAYNARD (*Secretary*), also being present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.*2.)

NINTH DAY.

MR. E. L. PEARCE GOULD, F.R.C.S., Dean of Medical School and O-P. Surgeon, Middlesex Hospital, and MR. S. R. C. PLIMSOLL, B.A., Secretary, called and examined.

1478. The CHAIRMAN: Mr. Pearce Gould, you are, I understand, the Dean of the Medical School of the Middlesex Hospital?—(*Mr. Pearce Gould*): Yes.

1479. You are here to represent the Hospital to-day, and Mr. Plimsoll is the Secretary of the Hospital?—(*Mr. Plimsoll*): Yes.

1480. You were kind enough to send us a memorandum in answer to some questions. The Hospital has drawn up certain regulations which they propose shall govern the proposed Nursing Home which it is desired to erect in the new Hospital?—(*Mr. Pearce Gould*): Yes. (*See* page 85.)

1481. May I ask you whether all this information which you give us here and the answers which you give to our questions to-day are public in the sense that you have no objection to their being published in our evidence?—(*Mr. Plimsoll*): In your evidence, no.

1482. The evidence, of course, is available subsequently, and it might get into the Press subsequently, not for some time, because it will not be published till next year?—From the medical point of view there is no objection to that, apart from the point of view of policy. (*Mr. Pearce Gould*): In fact it is possible that before next year we may be contemplating even letting this be known on our own account.

1483. To take the scheme, the paper headed: "Private Ward Scheme." I see that the Governors have laid it down that there should be no profit made upon these private beds. I assume that that means that they are to pay their way but that you will not take into consideration the capital cost of construction?—(*Mr. Plimsoll*): No.

1484. Then you propose to obtain the cost of construction from charitable funds?—Yes, from public appeal.

1485. The members of the consulting staff and of the honorary medical staff, I see, have power to introduce cases into the Hospital but only on the understanding that such cases will be paying reduced fees?—(*Mr. Pearce Gould*): Yes.

1486. And in certain instances it will be within the right of the member of the medical staff to settle with a patient what that fee shall be before they come to the Hospital?—In certain instances, but it was found by the Medical Committee when they considered this that the happier arrangement would be that all cases which members of the honorary staff thought suitable for admission should be referred in the first instance to the Almoner's department and that the arrangements

of the fee should be effected by the Almoner's staff, as I think is set out.

1487. That is the general practice. The practice would be that the Almoner would see the patient first, ascertain his or her wants, and then settle on some scale the total fee which the patient is capable of paying and that is not to exceed 50 guineas ?—Yes.

1488. I want to be quite clear about that 50 guineas. Is that 50 guineas the total, or is it the maximum fee to be paid possibly to the medical staff ?—It is to be paid to the medical staff. That limit of 50 guineas is quite separate from what we call our full rate charge for the services provided by the Hospital as opposed to treatment provided by the medical staff.

1489. Would that include any fees which would be allocated or might be allocated to junior members of the staff ?—Yes, and to an Anæsthetist and to a Physician if he was called in in consultation with a Surgeon, or vice versa.

1490. While we are on that point, as I understand, the house man attached to a particular member of the staff who introduces the patient would look after that patient for him in his absence. You do not propose to have a Medical Superintendent in that department of the Hospital ?—(*Mr. Plimsoll*) : No.

1491. I notice that you place upon the Hospital the responsibility for the collection of all fees and you hope to get payment in advance. Does that apply to payment for maintenance as well as to payment for fees ?—We hope to get the maintenance payments weekly in advance and the medical or surgical fee in advance. We believe from our experience, the Almoner's experience, that that can generally be arranged without hardship.

1492. Then I see you limit the choice of medical attendance to members of the honorary staff of the Hospital ?—(*Mr. Pearce Gould*) : Yes, that is so. The control of patients should be limited to them, but it is in the discretion of the member who is controlling the treatment of the patient whether other doctors come in and see them.

1493. That is to say they would have no objection to the General Practitioner coming in to see a patient while in Hospital ?—One would expect and look for that, but he would not be allowed himself to prescribe treatment.

1494. He would not be in a position to give orders to the Nurses or anything of that sort ?—No.

1495. Is it your intention to have a completely trained nursing staff ?—(*Mr. Plimsoll*) : Yes.

1496. That is to say all the Nurses would be certificated Nurses ?—Yes.

1497. Does the Board intend to assume the same responsibility for the treatment of these patients as it does in the case of ordinary patients ? —Yes.

1498. So that if anything goes wrong they are quite prepared to accept all responsibility ?—The full responsibility.

1499. The scheme at any rate in the first instance is for 51 beds ?—That was based on the assumption that we had a certain building for the purpose. We have plans of that building which is a building planned for paying patients' Wards as we see them, but when we had the King's Fund's criticism of the position of that building at Mortimer Street, we considered the possibility of an alternate site.

1500. I assume that you have kept the charges for beds, whether in Wards or in rooms, as low as you can, consistent with the number which might pay their way ?—We believe that we have a good margin on which we may be able to make reductions after six months' experience.

1501. Is your object to keep them as low as possible ?—Yes, and any balance that we may get, profit balance, would go to reducing charges.

1502. Could you tell us whether the Board or the Medical Committee have ever discussed the question of admitting patients who are able to pay a higher charge for maintenance and also the full fee for medical attendance ?—That is mentioned in the last paragraph.

1503. I was not quite clear about that ?—Our present scheme is a development of the work of the Hospital, that is to say, we aim at a class which is not able to provide a similar service for itself outside.

1504. That is the only class ?—Yes.

1505. You do not propose to permit the admission of people who are able to pay more ?—(*Mr. Pearce Gould*) : Not as part of *this* particular scheme. We believe that we shall be able to fill the number of beds that it is possible for us to provide in the near future with patients of this class who, we think, are the most deserving class for the moment of this service. The well-to-do can obtain by payments all that they require. This class for whom we are catering are faced with very real difficulties in obtaining as good services as their poorer brethren who go into Hospitals without expense.

1506. I quite agree, I only ask the question because I rather wanted to know whether particularly the Medical Committee had any objection on principle to providing accommodation of that sort for the better class patients. If you do not want to answer please do not ?—I do not know that the Medical Committee has expressed an opinion on that subject. Once this class is adequately catered for, I think it would be a very legitimate extension of the Hospital services, as a whole, to extend it to most other people, but that I think is a more remote thing than what we are trying to meet.

1507. Can you give us any figures of the probable capital cost ?—(*Mr. Plimsoll*) : Yes, we have a building here for 51 beds at about £92,500. It is a new building fitted exactly as we should like to have it. It is possible that we may, in considering another site, only have to adapt a building which will cost us less but then perhaps it might not give us what we hoped to get.

1508. Is that including any separate administrative offices or services ?—Yes, but those are small. The general control as the Board assumes responsibility will be in the administrative offices of the Hospital. There will be the Matron's room, in this building, her secretary's room, waiting rooms, Consulting rooms, but not stores.

1509. It will be very interesting to the Committee to know whether in your experience a building of this kind is likely to cost more per cubic foot than a building for ordinary beds ?—Yes, we think it would.

1510. Were they 4-bed Wards you provided ?—We plan three four-bed Wards, one for men and two for women.

1511. And the remainder would be separate rooms ?—Separate rooms.

1512. Sir JOHN ROSE BRADFORD : I am not quite clear about the 50-guinea fee, if you do not mind my asking questions about it. I understand that the fee is, so to say, going to be more or less fixed by the Almoner, and that 50-guinea fee is, so to say, a maximum. Is that irrespective of the length of stay of the patient ?—(*Mr. Pearce*

Gould): Yes. Our own feeling was if patients were able to pay a bigger fee than 50 guineas to the Surgeon or Physician looking after them they would hardly fall into the class for whom we are primarily catering.

1513. It is very largely a time question?—Hardly, I think it is a question of the capacity of those people to pay and, if they could pay a larger fee than 50 guineas, they would presumably be able to pay the ordinary Nursing Home charges and would go there. It was simply to give the Almoner some guidance and to give the members of the staff some guidance as to the upper limit of the class we had in mind.

1514. What was passing through my mind was that I did not quite see how it was going to work because you might have a case of such a character, as to spread over a very considerable length of time either on the surgical or the medical side, and I only want to know whether that point has been considered, whether the 50 guineas was irrespective of the length of stay of the patient. You say that that has been considered and the answer is Yes?—Yes, I think the point is this, that with that class of people the actual amount they have to spend in their illness is very important. In that class of case the one important factor is that they should know at the beginning what the total outlay will be and make up their minds if they can meet it. We have to take the rough with the smooth.

1515. I am only thinking of the difficulties that might occur. Then the Almoner, I suppose, would have some scale to work on. Has all that been thought out of how it is going to be done?—I think that at any rate at the inception of the scheme the Almoner will confer with the members of the honorary staff, and it will be a question of mutual arrangement as to what the payment would be, and as time goes on the Almoner will get a very good idea as to what Surgeons expect for certain treatment.

1516. Your Committee, I assume, has considered the question as to whether the whole question of the fees payable to the medical staff should be a matter of arrangement between the patient and a member of the staff. Have they considered and rejected that?—They have considered it but only formally. I happen to be one of those who was in favour of that idea, because that is the point of view I adopted; but my colleagues wished to be relieved of what they thought was the rather unpleasant task of discussing fees with patients. (*Mr. Plimsoll*): There is another point that is urged for that course; the Almoner would be able to achieve some scale of uniformity, whereas members of the staff would not know, naturally, what their colleagues were charging. We wished to avoid any differences between fees.

1517. I do not wish to be misunderstood; I am not criticising the scheme; I only want to know whether you have considered the very obvious difficulties involved in the question of the length of stay, which itself, would depend on the nature of the case, that is all?—Yes.

1518. I only wanted to be certain about that. I forget the exact word you used, but you used a word saying that people who had means could go to a Nursing Home. Do you think that there is any Nursing Home in London which provides facilities comparable to those obtainable in a Hospital?—(*Mr. Pearce Gould*): I think there is a certain limited class of case which can be most efficiently treated only in a General Hospital or an Institution. On the other hand, the free expenditure of money can get over almost all the difficulties even in respect of a very limited class of case.

1519. You think that, even the very wealthy can get in a Nursing Home services comparable to those that the poorest patient in the Hospital can get?—For the moment, no case occurs to me in which they could not, by the expenditure of money without limit.

1520. There is the question of the Medical Officer always being on the spot, is there not, in the one case and not in the other?—Yes, but that is only a question of payment.

1521. Yes, well that is true, and I gather that your Committee and your Board, at the present time, do not propose to embark on a scheme which provides a Nursing Home for all classes of society?—At the present time, no.

1522. Would you yourself be in favour of that view at all?—Yes, quite definitely.

1523. Under those circumstances, I suppose the question of medical fees would have to be arranged between the patient and the Practitioner?—Oh, clearly, but I think that would be a third class of accommodation provided in the Hospital.

1524. Do you think that a Nursing Home on those sort of lines might add to the financial resources of a Hospital?—From the little I know of the profits of those who run Nursing Homes as a private enterprise I should say yes.

1525. You think it would be to the advantage of a Hospital, when I say a Hospital, I mean the general charitable work of the Hospital, to have a Home of that description isolated and apart?—I doubt it. I doubt whether for a Hospital to embark upon a money-making enterprise would altogether be to the advantage of the Hospital.

1526. Mr. LOW: I only want to emphasize one point. I imagine that, as the Hospital undertakes entirely, shoulders the responsibility for the patient, that is the reason why you limit it to your own staff. The Hospital would be entirely responsible, undertake the responsibility of the treatment of those patients, they take that responsibility only if the patient is treated by a gentleman that they select themselves?—Yes, that is the real reason.

1527. Of course if this sort of thing were to grow, it would make a very considerable difference to Practitioners. A class of patient, who at present pays the practitioner, would go into hospital?—Of course, of necessity, I look at it from the surgical point of view. Surgical cases can only get the treatment they require by being admitted to some Institution, where they get treatment of the kind we have contemplated.

1528. Then you do not anticipate any friction in regard to the exclusion of the Practitioner?—I know that there has been a little trouble of that kind at another Hospital that I am connected with, but there was a great deal more trouble when, at that particular Institution, certain Practitioners were allowed to come in and treat cases while they were in Hospital. There was confusion then in the treatment.

1529. There is a feeling in an important medical body, the British Medical Association, that Practitioners should still have to a certain extent some sort of control in the treatment of those patients?—Yes, just as when we operate on a patient and leave him afterwards to the care of his medical Practitioner.

1530. I only want to know what your view is?—I am afraid our view is as expressed here quite

definitely, that the Practitioner must be allowed to visit a patient.

1531. Of course that visit does not really mean anything; he cannot charge a fee for it, he only calls as a friend and he does not control, he cannot order a Nurse to do anything and he cannot even advise. He may advise the Surgeon privately, but he cannot tell him what to do?—He does a little more than that. He gives him an idea of what subsequent treatment is required when the patient is fit to leave.

1532. Is it in your scheme that these patients in those Wards should be available for the teaching of the Hospitals?—No.

1533. There is one little point: in your Committee you have, I imagine, members of the staff on your Committee of Management?—No.

1534. Not at all?—No.

1535. So that this scheme here is only in keeping with the present practice?—Yes, the present practice.

1536. Professor WINIFRED CULLIS: In regard to the payment of £50, does that include any payments to the Resident Medical Officer?—There will not be a Resident Medical Officer.

1537. Not for that special block?—No, not for that special block, and the question whether the Surgeon or Physician in charge makes a payment to his House Surgeon or House Physician is left entirely to the honorary staff.

1538. I thought possibly there would be one Resident Medical Officer?—No. That question was I think asked by the Chairman, and we have decided that it would be better not to have a Resident Medical Officer for that block so that each member of the staff could have the Resident Medical Officer with whom he was accustomed to work looking after his private cases as well.

1539. And as for the cost, are you going to ask for funds or have you obtained them?—(*Mr. Plimsoll*): We have already been given £12,800 which is earmarked for this purpose in the course of our general appeal, and we have one or two people and firms of importance interested but no more than that at the moment.

1540. So that you are contemplating trying to raise the whole of that money?—Between now and Christmas we hope to have evidence of sufficient interest from people and institutions that we are approaching to justify us early in the year, raising whatever difference there may be between that and the total estimated cost by public appeal. That is our scheme at the moment.

1541. Does that charge of £92,500 include the cost of the site, or is that the actual building?—No; we have a 999 years' lease of that site, provided it is used for Hospital purposes only, and we could let it to the paying patient block.

1542. So that you have to pay rent?—Yes; that was included in my costs.

1543. That works out at nearly £2,000 per bed?—Yes.

1544. Could you tell us what other accommodation besides actual Wards would be included?—We have a plan here of the building, and, as I told the Chairman, we are considering another possible site which might alter it considerably. There would be a small theatre in the first plan where lesser cases would be dealt with: the majority of the cases would be dealt with by members of the staff in the theatres in which they were accustomed to work.

1545. What bathroom accommodation have you arranged for?—That I think you will find in this plan is adequate. We have bathrooms and all sanitary offices to eight rooms.

1546. One bath to eight?—Yes.

1547. The CHAIRMAN: Could you give me the dimensions of a small Ward?

(The Witness explained the plan)

1548. Could you say what it works out per cubic foot?—I am afraid I have not got that. One could not ask the architect to go very much further with this as we had already put him on to plans for the conversion of another building.

1549. The cost seems rather high compared with other Hospital buildings; it works out at about £1,000 and four-fifths per 1-bed?—£1,850 per 1-bed.

1550. Professor WINIFRED CULLIS: You spoke of firms being interested. Have you any evidence that this would be a comparatively easy purpose for which to raise money?—I feel sure it would be a comparatively easy thing; it would appeal to a class which it is difficult to interest in the main Hospital project.

1551. Supposing you do not get all the money, would you contemplate putting the interest for the residue on to the cost of the beds?—You mean raise the balance?

1552. Supposing you only raise two-thirds of the money you want, the remaining one-third would have to be borrowed?—The Board has considered that and in fact it has decided that it would not go forward with this building until it held the balance in hand.

1553. But have you evidence that such a thing would be really popular?—From the enquiries we have made so far we believe it would be popular. It has been enthusiastically taken up by one or two people who are interested in Hospital work.

1554. Do you not think that 7 guineas will be too great a sum to be paid by the class that you really want?—We should like to lower it, but in view of the complete services which it is proposed to give in every department and with all extra possible work we do not see how at the beginning, we can lower it.

1555. And for those who could not pay the 7 guineas I suppose it means they would come into the ordinary Wards of the Hospital?—(*Mr. Pearce Gould*): No, they might go into the private Wards of this block at 5 guineas.

1556. Into the four-bedded Wards?—Yes, into the four-bedded Wards. May I say I have experience of rooms where the flat rate charge is 6 guineas, and I found that there is a very large class of person to whom that kind of accommodation at reduced Surgeon's fees is a god-send.

1557. The charge that interested me so much was the flat rate one; that would appeal to the patient to know what he had to cover?—The thing they want to know is what is the total cost going to be.

1558. Have you ever contemplated being able to reduce the charges to those private patients by taking into these Wards a class that could pay considerably more?—(*Mr. Plimsoll*): We believe that we have evidence that we can fill and more than fill these beds from the class we immediately want to assist, so that this question would not arise.

1559. The CHAIRMAN: Is it your opinion that when these beds are provided a certain number of cases which do now find their way into the ordinary Wards will become paying patients?—There are very few of that kind in our ordinary

Wards. They get there sometimes as casualty cases which must be admitted; you cannot stop them but they are moved on afterwards.

1560. There would not be many but there are probably some border line cases which go there because they cannot send them anywhere else?—(*Mr. Pearce Gould*): Well, as Mr. Plimsoll said, there are people who are brought in by the Police who frequently ask for private accommodation. They cannot be sent out immediately and have to go into the General Ward.

1561. You spoke of the Hospital having a 999 years' lease. I suppose it is quite understood that you are able to use it for this purpose?—Yes, that has been definitely settled.

The CHAIRMAN: Thank you very much; we are much obliged for your information. It is very helpful.

(The Witnesses withdraw.)

MR. G. E. MEAD, Chairman of the House Directors, London Fever Hospital, and MR. H. J. SAY, Secretary, called and examined.

1562. The CHAIRMAN: Mr. Mead, you are the Chairman of the House Directors of the London Fever Hospital, and Mr. Say is the Secretary?—(*Mr. Mead*): That is so.

1563. And you have at the Hospital a certain number of paying beds. Are all the beds paying beds to a certain extent?—Yes, the patients are all paying.

1564. But they pay in some cases according to their means but not always a fixed charge?—We have two classes of patients, Ward patients and private room patients. Of course the private room patients pay on a larger scale according to the capacity and the position of the rooms.

1565. And I take it that the charges made to the private patients would always meet the cost?—Well, yes, I suppose they would. (*Mr. Say*): Approximately, yes.

1566. In this Hospital you only take in people who are suffering from infectious diseases?—All infectious diseases except smallpox.

1567. And as a result it is common to have quite a considerable number of your beds unoccupied?—Yes.

1568. That is what one would expect; it depends on epidemics?—There are epidemics and the pressure comes in cycles generally. There are some periods with a few patients and periods of pressure as well.

1569. Have you any figures to show what the difference in the cost is between the private room patients and the ordinary patients?—No, the cost is worked out for the whole of the patients. The private patients are comparatively few in comparison with the General Ward patients.

1570. What number of private beds have you?—We have 24 beds in private rooms, and at the present time I suppose we have about 16 or 17 of those beds occupied.

1571. Then you give these patients a different dietry I understand?—That is so.

1572. Patients can only be attended by your own medical staff, that is to say, a General Practitioner is not admitted to the Hospital?—Not in an advisory capacity. (*Mr. Mead*): As a visitor only.

1573. Then you do not charge your patients any fees for medical attendance, or rather you do charge an inclusive fee?—(*Mr. Say*): Yes.

1574. In the case of the private patients, how do you settle the fees?—According to the class of accommodation they require. We have two grades, large rooms and the small, and that is arranged before the patient is admitted to the Hospital.

1575. In this case it is all medical attendance, not surgical?—Not surgical, well, with rare exceptions.

1576. You can perform operations in the Hospital?—Yes, we have a Surgeon on the staff for cases of emergency, but speaking generally operations are not carried out there except they are of an aural character. (*Mr. Mead*): They very seldom arise.

1577. They are mostly medical of course?—Yes.

1578. I do not think you work out the cost of beds per week here, do you, in the figures which you give?—£5 2s. 6d.

1579. That £5 2s. 6d. includes and covers all the cost of the private rooms as well as the others, they are not separated?—(*Mr. Say*): No, they are not separated at all.

1580. Were these private rooms provided in 1914?—Yes, before that there were private rooms.

1581. Do you know whether they were provided after the Hospital was built or were they added to the Hospital?—I should think when the Hospital was built, but I am not quite certain about that.

1582. When was the Hospital built, do you know?—About 1846 or 1847 on its present site. (*Mr. Mead*): Of course, the building has been re-adjusted from time to time.

1583. You have no figures to show what the cost of the private rooms was?—(*Mr. Say*): Not independently, no.

1584. And so far as this class of case is concerned, the infectious case, you think the demand is met by the accommodation which you have?—I think so, with the exception of epidemics.

1585. It is pretty clear from your figures you have a largish number of beds vacant as a rule?—We do during the year, yes.

1586. Do you always keep a full staff in the Hospital?—Oh, yes; if we only had three or four patients in the Hospital the whole staff have to be maintained.

1587. You cannot close a Ward?—We could close a Ward but not reduce the staff. (*Mr. Mead*): The staff is fully-trained.

1588. Of course, they are all trained nurses. Are they specially trained?—They have experience of fever, and if we part with them we cannot very well secure them again.

1589. Sir JOHN ROSE BRADFORD: May I ask as regards the cost, I gather it is somewhere about £5 a week?—(*Mr. Say*): Yes, £5 2s. 6d.

1590. And that is inclusive of everything?—That is, yes.

1591. Are the visiting medical staff paid; do they receive any remuneration?—They receive an honorarium.

1592. They do not receive individual payment from each patient?—No, nothing from the patient at all; none of the medical staff receive anything from a patient.

1593. Nor indirectly?—Nor indirectly, no.

1594. They simply receive an annual honorarium?—The amount is nominal really.

1595. Mr. LOW: That includes those 24 pay beds?—Yes.

1596. They only get the same honorarium?—Yes, just the same.

1597. For what was the Hospital intended, was it intended for the necessitous poor or for paying patients ?—Originally, it was formed in 1802 for the whole of London for infectious diseases for necessitous cases. It was afterwards converted into a Hospital for middle class patients who were called upon to pay a fee which was varied from time to time.

1598. Did you have to go to the Charity Commissioners or any body of that sort in order to get permission to do that ?—I am not in a position to say that.

1599. Are you under Charter ?—No, we are not.

1600. Then I understand that you have, in connection with this Hospital, a certain contributory scheme ; do not some of the big firms of London pay you something and send their employees there ?—(*Mr. Mead*) : All Governors have the privilege of sending one of their employees suffering from fever free of charge, and for a higher subscription that extends to any member of the family apart from the dependants.

1601. Of course, yours is quite peculiar, but what sort of contribution would enable, say, a firm to send any of their employees ; I suppose it would have to be *pro rata* for a number of employees ?—(*Mr. Say*) : It is on this basis.

1602. What sort of contribution would enable a firm to do that who have got 200 or 300 employees ?—Ten guineas would entitle them to six employees in one year, and so on, in multiples of ten. Of course, there again, it is governed by the amount of infectious disease in London. One year we may not get an infectious case from one firm, and another year we may get a number of them. (*Mr. Mead*) : We have a number of subscribers who are in the soft goods trade with assistants and clerks and warehousemen, especially round St. Paul's Churchyard, and they are very good supporters and they appreciate it.

1603. They pay a rate of 10 guineas to have six employees in any one year ?—(*Mr. Say*) : Yes.

1604. And if they had more they would have to pay for it ?—Yes. (*Mr. Mead*) : And the private subscriber can send one dependant for a guinea subscription, and, in addition to that, one of his family for another guinea.

1605. Into one of those private beds ?—No, in the Wards, not in the private rooms.

1606. Mr. COHEN : I notice that the admissions were 810 last year, and approximately about 10 per cent. of that number 78, were treated free in virtue of Governors' subscriptions You know, I suppose, what the income is from this class of subscriber ?—(*Mr. Say*) : Yes, from the whole of our subscriptions. We might get an individual person who had a patient this year and ran 10, 12 or 15 years before he had another patient.

1607. Lord SOMERLEYTON : You said in reply to the questionnaire as to the demand for this kind of accommodation in London that the accommodation meets the demand. I understand from that that in spite of the growth of London which I suppose is extending in population very largely you still have enough beds to provide for the needs of this class ?—Yes.

1608. Professor WINIFRED CULLIS : Have you any evidence as to the proportion of patients in the private rooms and in the public Wards ?—No, I have no figures before me.

1609. You said that the private Wards were not used so much ?—They are not used so much as the General Wards, but, of course, the fees are higher. It depends on the nature of the disease ; some are kept for one disease. We have a certain number of rooms for scarlet fever, measles, and so forth. If there is an epidemic of diphtheria, the diphtheria block would be, probably, full and the scarlet fever block practically empty. We have an isolation block of 20 rooms which are for various diseases. One time it may be typhoid and one time erysipelas, and so on. There is a good deal of erysipelas about just now.

1610. How many patients have you in the General Ward ?—42.

1611. At the present moment the proportion of beds in use in the Private Wards is about the same as in the General Ward ? — It is really for the number of beds, yes, at the moment.

1612. Sir BERNARD MALLET : I heard you say that you could do with a good many more private rooms ?—It was suggested that we might have more rooms for scarlet fever, because they are much smaller in number than they are for other diseases. Out of those 24 rooms, four only are for scarlet fever

1613. The CHAIRMAN : What class of disease do you get most of ?—It varies. We may get what we call a spreading disease, diphtheria and mumps. Scarlet is just coming along now, it is really the season for scarlet. Of course the medical profession will tell you, as a rule, what time to expect the cycles of epidemics, and it should be about this time of the year that it is due.

1614. Well, the spring ?—The disease is more prevalent in autumn and winter.

1615. You do not take influenza I suppose ?—Yes, into the private rooms.

1616. Sir BERNARD MALLET : Is there the same explanation with regard to the Metropolitan Asylums Board Hospitals as in your Hospital ?—Yes.

1617. Sometimes they are comparatively empty?—Yes, quite so. (*Mr. Mead*) : Of course, the difficulty is really in dealing with so many diseases. In the case of infection, you are obliged to keep the rooms distinct, otherwise we should have patients coming in with one complaint and catching another while under treatment. That is what we have to guard against.

The CHAIRMAN : Is there anything else you would like to say further to us.

Sir BERNARD MALLET : I suppose you are satisfied that there is a demand for this accommodation ?

1618. The CHAIRMAN : Yes, but you think as a whole, it is met ?—Yes.

1619. Mr. LOW : The Metropolitan Asylums Board do not provide paying accommodation, do they ?—No, none whatever.

1620. So that all patients are in exactly the same position. You do make a difference between the patients who can pay and the patients who cannot ?—Patients who can pay a small sum and patients who can pay a smaller sum.

The CHAIRMAN : Well, thank you very much ; we are much obliged to you for coming and giving us your time.

(The Witnesses withdraw.)

MR. E. MACPHERSON, Charity Commissioners, called and examined.

1621. The CHAIRMAN : Mr. Macpherson, we are much obliged to you for having sent in a memorandum expressing the view of the Charity

Commissioners upon the point of paying patients. I suppose some applications have been made to the Commissioners comparatively recently ?—Yes. We have got two or three schemes going on at the present moment, but they are in fact, only renewals of existing schemes in which the time has run out. (*See* page 87.)

1622. The kind of case where you have allowed Hospitals to make use of Wards for paying patients because they could not use their other Wards for the purposes of the Trust strictly ?—Strictly that was the origin of the Scheme. I rather fancy with a case where we are continuing it now the Wards are full. They have had this scheme for a great many years, and we are in fact continuing the time, as they still need the fees.

1623. Of course, I can quite understand the impossibility of your answering hypothetical questions, but it is a little difficult to put any question like this which is not to a certain extent hypothetical ?—Of course, all I meant by that was that if anybody had a particular Hospital in mind and they know they are likely to apply to us, I did not want that point put. We have had to refuse one or two applications in the course of the last two or three years.

1624. I do not know if you would care to say whether the meaning attached to the phrase "necessitous poor" has been varied at all in recent years ?—So far as I know, in the Law Courts it has never been varied at all. There are one or two cases of "poor" without the word "necessitous," which suggest that the Courts might take a rather wider view than they used to take, but I do not think there is any decided case that gives really any help for this particular purpose.

1625. Of course, the class of Hospital patient, as most of us know here, has, in some districts at any rate, changed very much during the last 25 years, so that you see really comparatively few of the kind of necessitous poor you used to see in those days ?—I know; I am quite aware of the difficulty.

1626. Most people who come into hospital now can afford to make some provision, or a very large number of them can, and I think it is true to say that quite a number who do not, who cannot, go to the Poor Law Infirmary ?—Yes, quite.

1627. But even there, of course, they are nearly all charged something ?—Yes.

1628. Unless they are so necessitous as to be without any funds at all so that I suppose you might be prepared to give a rather wider interpretation to that phrase ?—We give it as wide an interpretation as we can. It is only really in the cases where it is perfectly clear that the Trusts are for gratuitous treatment that we have refused, except in one case which was rather different.

1629. I suppose the difficulty is where the Hospital is on a site the ground of which cannot be used for any other purpose ?—That is the real difficulty, but, of course, there is the same difficulty when the greater part of the endowments, have been settled on similar Trusts, but, as I said, we have got round that in several schemes we have made by putting in a provision, when we authorise paying patients, that free accommodation shall be provided for say 100 or 200; that is the number which the original Hospital was capable of holding.

1630. Yes, I was thinking more of a Hospital which had its ordinary Wards full and had room on the site which might have been given for the purpose of the necessitous poor, or to provide gratuitous treatment, or some purpose of that sort, which could not be used because they have no money to develop it for ordinary patients, but they might have raised it for the purpose of putting up beds which would pay their own costs ?—I do not think there is any objection to that, but I think they would have strictly to get, either the authority of the Court, or from us. We have done that often.

1631. I rather gather from what you said that you would not admit that a portion of a Hospital already in existence would be permanently alienated for the purpose of providing paying beds. In the cases where permission has been given, I gather that it has been given for a term of years ?—No, we have done it permanently, at the same time making a condition that there shall be free beds in the future Hospital, free beds to the number that existed in the old Hospital. That is to say where there was a hospital of 200 beds and they have converted it into a 400 bed Hospital we have said they may have paying patients in the new Wards provided that 200 beds are kept for free patients.

1632. That would mean that the same number of beds would be provided for free patients as in the past ?—Yes.

1633. And the others would be in addition ?—Yes.

1634. What I meant was assuming the possibility of a Hospital finding it impossible to keep going with its ordinary beds, you might, for a term of years, allow it to use some of the beds vacated through lack of funds for paying patients, but that would be for a term of years only ?—That would be for a term of years with power to extend, and so far as I know it has always been extended.

1635. If the same conditions existed ?—Yes, I think substantially the same conditions.

1636. You say at the end of your memorandum: "When financial difficulties were the ground for "the scheme authority to take in paying patients "has often been given for a limited number of "years" ?—That was really because we felt we had not power to give it for ever when it was due to a failure that might be temporary.

1637. I take it, under those circumstances the class of paying patients would not interest you. Of course, we have been told that there is a very great demand for the patient who cannot afford to pay high fees, but is just in the position to pay the cost of maintenance. On the other hand, there is also a demand, so some people say, for accommodation of this kind where the patient is ready to pay for luxurious accommodation and the highest fee of medical attendance. It would not matter from your point of view, which class was provided for ?—Do you mean accommodation and the very highest fees ?

1638. Yes, quite ready to pay for the highest fee ?—I have had one application of that sort, and that we felt we had to turn down.

1639. You make a distinction ?—That was a Hospital which was admittedly for free treatment, and the proposal was to put up a paying patients' block on what you might call a free site at full West End nursing home fees, 30 guineas a week if necessary, and that we did not see how we could justify; it was not poor in any sense; it was admittedly to provide for the richest if they wanted to go there. But we suggested it might be done in another way, and as far as I know they did not adopt the other suggestion.

Mr. E. Macpherson.

1640. I do not know whether you can answer this question: did they put forward the argument that the provision of this accommodation at higher fees would help to provide funds for the hospital as a whole?—Yes, that was put forward. The Hospital as far as I know was full, and, as I say we thought there was another way in which it could be done legally, and we felt extremely doubtful whether we had the power to sanction it directly. We, in fact, suggested if they did not want that particular site, that the Hospital would let them the site and they should run it as a separate body, a separate body inside the Hospital.

1641. I am going to ask you another question altogether, not really in connection with this particular matter from the Charity Commissioners' point of view. From your experience, your office experience, do you think that a combination of this kind is wanted in the hospitals?—I should say it is.

1642. Amongst your colleagues and others in the Civil Service that is the opinion?—I am afraid that is only my general knowledge as a private individual.

1643. It is a little difficult to get what I should call lay evidence from an organised body about a matter of this kind?—Well, as a matter of fact besides doing all the medical charities in London, I am responsible as far as our office is concerned, for the endowed medical charities for the whole of the south of England, and it is pretty clear from the repeated applications that we get there is a great need for this.

1644. What kind of Hospitals have applied to you for schemes or for information?—We make quite a number of schemes for amalgamations and for paying patients during the year. At the moment there is rather a tendency for schemes for amalgamating smaller Hospitals with bigger ones. But we make a few every year in different parts of the year authorising the addition of paying patients, and of course people stroll into the office who are thinking of founding a small charity, something in the nature of a Cottage Hospital. Whenever they do come and ask me I say "For Heaven's sake do make provision "for paying patients, you will want it sooner or "later," and many of them have adopted it. We always do it if we can.

1645. At any rate you consider it is a matter of general knowledge that this sort of accommodation is required?—Certainly.

1646. Have you knowledge, or do you know anything about the Civil Service scheme?—Yes I know about it.

1647. Mr. LOW: So long as a Hospital pays a rent, or rather supposing they want to make a Nursing Home with accommodation of this sort they would be allowed to do that so long as they paid a sufficient rent to themselves for the site?—Certainly, if they said they did not require the site.

1648. If you are taking in patients of that kind who are paying full fees they must not use a site unless they pay a sufficient rent for it?—No; I thought that was the simplest way of authorising it.

1649. But that would not extend to the other class of patients who are paying probably maintenance but not paying full fees for treatment; they are still getting a certain amount of charity. Would that apply exactly in the same way?—Certainly; you could do it in the same way.

1650. They would still have to pay rent for their site?—Well, I think it will be very difficult to say.

1651. I only want to know whether you made a distinction between the two classes. One is, what shall I call it, an effort on the part of the Hospital to make money by a Nursing Home and also to provide certain advantages for sick people; the other is a partially charitable effort to provide accommodation for a certain class of people who cannot afford to pay the full amount?—Yes; I distinguish it for another reason really, that the Hospital being for the poor, we can vary those trusts by a scheme to admit what you call a new class of poor, but you can hardly vary the trust in order to admit the rich. That is too wide an extension.

Mr. LOW: That answers my question; thank you.

The CHAIRMAN: Well, thank you very much I am afraid we have brought you down a long way for a short time.

(The Witness withdraws.)

(Adjourned.)

Note to Questions 1480–2. *The following Memorandum was handed in by* MR. PEARCE GOULD *and* MR. PLIMSOLL.

MIDDLESEX HOSPITAL: PRIVATE WARDS SCHEME.

Approved by the Board, 13th July, 1927.

DEFINITION OF SCOPE.

Admission shall be confined to the class immediately above the Hospital class, for which no adequate provision in the English system of Hospital and Nursing Home treatment exists, and the scheme, therefore, in its inception, is a development of the work of the Hospital.

No profits shall be made and the beds shall be limited to the class just above the present Hospital class, embracing such cases as members of the Honorary Medical Staff are satisfied cannot afford full fees nor expensive Nursing Home treatment, and yet are ineligible for free treatment in the Voluntary Hospitals. Members of the Consulting Staff and of the Honorary Medical Staff shall only introduce cases to the paying wards to whom they are conceding reduced fees. Such members shall, however, only introduce patients to whom they are charging a fee for treatment, except in special cases, and the fee charged shall include all fees of other members called in consultation or for special treatment, and shall not exceed a maximum of 50 guineas.

The Hospital Almoners shall assess the fee which the patient is to pay, and collect and distribute to members concerned with the cases in proportions according to a Schedule to be laid down. Any member who so desires may intimate the fee he is prepared to accept in any given case.

A flat rate charge shall be made to cover maintenance, operation costs, X-ray diagnosis, examinations, and all other services of the Hospital, as provided for the ordinary patients of the Hospital. The flat rate maintenance charge shall be, for a trial period of six months, £7 7s. for a single room, £5 5s. for a bed in a ward.

The treatment fee and the flat rate charge shall be the only two charges made to patients. They shall be arranged, where practicable, between the Almoners and the patient, subject to any arrangement made by the member of the Staff as above, and shall, where possible, be collected weekly in advance.

The Hospital shall accept full responsibility for the collection and payment to members of the Staff of the treatment fee so arranged.

Working arrangements may be entered into with any Insured Groups whereby a proper fee for members of the Honorary Staff can be guaranteed. Such Groups may be informed that, though no priority of admission can be offered, a Schedule with a maximum fee not exceeding 50 guineas may be conceded to insured persons whose incomes are within an agreed limit.

Theatres.

Private patients requiring operations shall be dealt with, at the discretion of the member of the Honorary Staff in charge of the case, in the Ground Floor Theatre Group ; or in exceptional cases in the Theatre in which he is accustomed to operate, upon his normal operating day, after his ordinary Hospital list shall have been disposed of.

The Ground Floor Theatre Group shall consist of the New Theatre, a second large general operating Theatre, and a small additional Theatre, capable of being darkened.

Normal Hospital sessions in any Theatre shall take precedence of private patients' operations.

Ancillary Services.

X-Ray.—1. There shall be an X-Ray Diagnostic Department on the ground floor of the Private Ward Block to serve also as an X-Ray Annexe to the Ground Floor Theatre. This must be regarded in the first instance as temporary accommodation until it is known whether the department in the New Hospital can provide adequate waiting rooms, etc., for private patients.

2. For the use of the Private Wards this department shall be staffed by an half-time qualified radiographer, who should have no other duties in the Hospital. He shall be engaged either for the first or for the second half of the week, and at a commencing salary of £300 per annum.

3. The radiographer shall be provided with a whole-time trained female assistant, preferably living in.

Radium.—The use of Radium for patients is covered by the flat rate charge.

Treatment—(Electro-Therapeutic, Light Services, etc.)—For X-Ray treatment, Massage, Radiant Heat, Violet Light, etc., no special provision shall be made, the cost for patients in the Private Wards being included in the flat rate charge.

Pathological Service.—The first section is limited to patients to whom the staff is prepared to concede reduced fees, and the Scheme is an extension of the philanthropic work of the Hospital. No additional fees shall be paid for Pathological and other examinations, but an adequate return to the School for additional work placed upon its full-time paid officers shall be charged to the Private Wards, and included in the flat rate weekly charge for maintenance. If it is found that the School Departments are being overworked heads of departments shall ask for more paid assistants, when an adjustment will be made in the Contra Account.

The charge for such Pathological Services shall be included in the flat rate charge to be made for maintenance, the actual charge to be ascertained by the Medical School Finance Committee in conjunction with the Finance and Contracts Committee of the Hospital.

Patients.

Patients shall be admitted only through the recommendation of members of the Consulting and the Honorary Staff, under whose treatment they will be.

Maternity cases and Infectious cases shall not be admitted, and such other cases shall be excluded as the Medical Committee may from time to time advise.

The length of stay of any one patient shall be restricted to two months, any extension to be reported, with the explanation of the member of the Honorary Staff concerned, to the Board.

Treatment.

Treatment shall be provided exclusively by the Honorary Medical Staff of the Hospital.

The Board will hold members of the Honorary Staff directly responsible for the treatment of cases admitted, members arranging with General Practitioners whose patients may be under treatment, for such access as may seem to them advisable.

Members of the Honorary Staff may utilise the services of their Housemen.

Nursing.

The Nursing Staff shall not be a separate entity to that of the Hospital, but a development of the Nursing Service.

The Nursing Staff shall consist of :—

1	Sister-in-Charge.
1	Assistant to ditto (linen, letters, patients' friends, etc.).
1	Night Sister.
6	Charge Nurses (one to each floor).
12	Nurses.
9	Night Nurses.
30	

For special Nursing, special arrangements shall be made.

A Nurses' Institute shall be established as soon as possible to enable Nurses to be employed either in the Private Wards or on Private cases.

ADMINISTRATION.

The Administration shall be under the direct control of the Board as a development of the present philanthropic work of the Hospital.

The Committee of Control shall consist entirely of laymen.

All questions of finance, and of the relation of the Private Ward Block's finances to the Hospital finances, shall follow the present Hospital practice.

MEMORANDUM OF ESTIMATED COSTS AND INCOME OF THE PRIVATE WARDS SCHEME.

Under the Scheme, as adopted by the Board, using the Mortimer Street site, there are 39 single rooms and 12 beds in three small wards, a total of 51 beds.

The bed wastage in the Hospital has varied between 7 and 12 per cent. since the War. Although on the Medical Committee discussions it seemed reasonable to expect that these beds would be kept even better filled than the Hospital's beds, since several Surgeons were of opinion that they could easily fill twice the number which they could reasonably claim out of 51, and there is very little risk of infection closing any part of the Private Ward Block, since the majority of cases are in separate rooms and no ward has more than four occupants, nevertheless, a bed wastage of 20 per cent. has been allowed for when estimating income. This will amply cover slack periods and loss of time between cases, since patients cannot be admitted as quickly on each other's heels as is the case in General Wards.

Allowing 20 per cent. bed wastage, we have 31 single rooms at £7 7s., and ten beds in wards at £5 5s., giving a total income on 41 beds throughout the year of £6 16s. 9d. per occupied bed=£14,578.

This for the reasons given is believed to be a conservative estimate.

EXPENDITURE PER OCCUPIED BED.—The following table shows the various items of estimated expenditure as compared with the actual costs of these items for the General Wards for 1926. It should be remembered that the cost of 1926 was higher than normal Hospital expenditure owing to causes discussed by the Finance Committee in the Autumn, when planning the budget for the present year.

	£ s. d.		£ s. d.
Provisions	0 13 10.7 + 6/-	... ...	0 19 10
Surgery	0 11 4.84+ 3/6	... ...	0 14 10
Domestic	0 18 0.07+ 2/-	... ...	1 0 0
Salaries	2 0 2.02+14/-	... ...	2 14 2
Miscellaneous	0 2 8.49	... ...	0 2 8
Administration	0 3 3.9	... ...	0 3 3
Special Insurances		... ...	0 2 0
Renewals and Repairs	0 3 0.64	... ...	0 3 0
Finance	0 7 6.5 — 1/6	... ...	0 6 0
	£5 0 1.2	... ...	£6 5 9

The fractions of a penny are ignored, since in every case the increase and particularly the new cost for Special Insurances leaves a considerable margin.

Provisions.—" Ordinary Diets " will not be supplied. " Special Diets " mean, in Hospital experience, increased prices for food and a certain amount of wastage. There is ample margin to cover the provision of cream, fruit, special vegetables, etc., and these we shall buy at Hospital rates.

Surgery includes a charge for Pathological examinations at the rate of £9 per occupied bed per annum, which is believed to be an over-estimate. It includes also provision for a generous supply of champagne, brandy, etc.

Domestic includes provision for better class of linen, crockery, etc.

Salaries includes provision for the Radiographer, Radiographer's Assistant, increased cost of Nursing per bed (*see* Analysis).

Miscellaneous.—No addition. This is probably over-estimated.

Administration.—The Hospital figure is retained although several services will not be required. The balance will provide a Clerk to the Sister-in-Charge, and, if needed, a Hall Boy.

Special Insurances.—This figure is put in to cover any insurances which the Legal Committee may consider desirable.

Renewals and Repairs.—Whilst the better type of building and finish will not require the attention necessary in the old buildings, it is thought wise to retain this figure to meet the additional cleaning and decorating which the higher standard of the Private Wards requires.

Finance.—Under this head is taken the rent and rates on the Mortimer Street buildings.

July, 1927.

Note to Question 1621. *The following Memorandum was handed in by* MR. MACPHERSON.

1. The provision of beds for paying patients is primarily a matter for the Trustees of the Hospital, and the Commissioners are only concerned when the provision of accommodation for paying patients is not authorised by the Trusts under which the Hospital is administered and the Trustees apply to the Commissioners for a variation of the Trusts.

2. To make the position clear, I may say that the Commissioners have always looked upon such proposals with sympathy, and so long ago as 1875 they urged the great need for meeting the lack of accommodation for patients who could afford some payment but whose means were quite inadequate to pay the full fees of the ordinary Nursing Home.

3. From time to time the Commissioners have made schemes varying the Trusts of certain Hospitals so as to enable paying patients to be received.

4. These observations are only offered with a view to assisting Trustees, since from various proposals which have been submitted to the Commissioners it appears that many Trustees are under the impression that Trusts can be varied merely because the variation would extend the utility of the Hospital. That is not the case.

5. Property settled on charitable trusts can be used only for the object specified in the Trust Deed or other Instrument of Foundation.

6. Any Trustee permitting the use of such property for a purpose not authorised by such deed is committing a breach of trust, and may therefore incur serious liabilities.

7. Many Hospitals are held on Trusts which do not allow the admission of comparatively well-to-do patients paying fees for treatment, e.g., Hospitals founded to provide " Free " or " Gratuitous " treatment or to provide for the " Necessitous poor."

8. In such cases the Trustees cannot provide wards for paying patients until the Trusts have been varied. This can be done in certain conditions by a Scheme established by the Court or the Commissioners, whose power to make a Scheme is the same as that of the Court.

9. The Court has repeatedly held that neither the Commissioners nor the Court itself can vary Trusts merely because the variation would increase the utility of the Charity. To give jurisdiction to make a Scheme altering Trusts, there must be a genuine failure or partial failure of the original Trust.

10. Further, a Scheme must provide for the application of the endowment cy près, i.e., to purposes as similar as altered circumstances allow to the original object.

11. Accordingly Schemes have usually been made—

(i) where there has been a partial failure of the class for which the Hospital was originally intended so that the wards were not full ; or

(ii) where, owing to lack of funds, it was found impossible to keep all the wards open.

12. In such cases the Commissioners have felt justified in varying the Trusts so as to enable the Hospital to take in paying patients, as by such means full use could be made of the accommodation without interfering with the class originally intended to benefit, and in some cases the admission of paying patients to some wards has enabled more beds to be kept open for free patients than would otherwise have been possible.

13. When financial difficulties were the ground for the Scheme, authority to take in paying patients has often been given for a limited number of years, with power to extend the period with Commissioners' sanction.

14. In view of the legal difficulties, the Commissioners have been obliged, after considering some applications made to them, to say that they had no power to alter the Trusts, though they have sometimes been able to suggest that the object aimed at might be attained in other ways.

15. An appeal to the public for funds to provide wards for paying patients raises the same difficulty when the Hospital land is settled on Trusts which do not authorise the reception of paying patients unless additional land settled on wider Trusts is also obtained.

16. The difficulty is substantially the same whether a Hospital is administered under a Charter, Trust Deed, Memorandum and Articles of Association or an Act of Parliament—though the Hospital governed by an Act of Parliament is probably in the worst position as regards this particular point, as if the Act does not authorise provision for paying patients a further Act of Parliament must be obtained.

17. The Commissioners have power in suitable cases to vary the Trusts even if declared in an Act of Parliament by a Scheme made under the provisions of Sections 54–60 of the Charitable Trusts Act 1853.

KING EDWARD'S HOSPITAL FUND FOR LONDON.

MINUTES OF EVIDENCE

TAKEN BEFORE THE

PAY BEDS COMMITTEE

AT THE OFFICES OF THE FUND,

7 WALBROOK, LONDON, E.C.4,

ON

WEDNESDAY, 26th OCTOBER, 1927.

PRESENT:

VISCOUNT HAMBLEDEN, *in the Chair*,
SIR JOHN ROSE BRADFORD,
SIR BERNARD MALLET,
MR. V. WARREN LOW,
PROFESSOR WINIFRED CULLIS.

LORD SOMERLEYTON and MR. LEONARD L. COHEN (*Honorary Secretaries*), and MR. H. R. MAYNARD (*Secretary*), also being present.

(*Transcript of the Shorthand Notes of* MESSRS. GEORGE WALPOLE & CO., *Portugal Street Buildings, Lincoln's Inn, London, W.C.*2.)

TENTH DAY.

VISCOUNT KNUTSFORD, Chairman of the London Hospital, called and examined.

1652. The CHAIRMAN: Lord Knutsford, I will take your memorandum and ask a few questions upon it?—Do, please. (*See* page 95.)

1653. First on page 1, you say that it is quite certain that if beds or wards for paying patients are provided that they ought to be in addition to the existing beds?—Yes.

1654. For the reason that from your own knowledge all the existing beds are needed for the class which now uses them?—More than needed. All Hospitals have got a large waiting list.

1655. Then you comment later on about the permission which the Charity Commissioners have given to St. Bartholomew's Hospital to set aside a certain number of beds for patients to whom they are allowed to charge 6 guineas a week?—I do not think that means that St. Bartholomew's intended to do so. I have learned since they had to get leave to do so, because under the Charity Commissioners they have to do so. I do not know that they intend to do so.

1656. Later on in your memorandum you do suggest that both at the London and at other Hospitals, a class of person does occasionally get in who can afford to pay more than 2 guineas a week which the better class poor patients

themselves pay?—Yes, I think some do get in, certainly.

1657. That is to say people who are on the border line who cannot afford to pay the Nursing Home fee?—Yes, I think some do get in.

1658. Who do want Institutional treatment?—Yes, I think a certain number do get in. Very often Doctors and Surgeons have very interesting cases which they cannot possibly treat outside and they have asked us to take them in, and we do.

1659. I do not know whether you can answer this question; is it your practice then to ask them to pay rather more than 2 guineas or 3 guineas a week?—I really do not know. They are generally very poor, these people. It is generally pressing on them very hardly.

1660. I think you mention the sum of £400 as a maximum?—I can send you the actual proportion, I ought to have it here, the actual proportion of those who cannot pay and those who pay less and then a few pay more; just a few pay more.

1661. I asked the question because we have had a good deal of evidence to show that there are in all Hospitals, well, quite a proportion of people like those who would, if they were given the opportunity, go into a 5-guinea bed and be glad to pay, and those Hospitals which have beds of that description have stated quite clearly

Viscount Knutsford.

that the beds in the other Wards have been relieved of a good many of that class of patient ?—I do not think that is so at the London, because we are in a poorer district. I do not think that is so.

1662. I do not say that it is a large proportion ?—No, quite a small number.

1663. And especially casualties ?—Of course, casualties are getting into a rather serious thing in these days of motoring, especially in country Hospitals, but in a big Hospital like the London casualties do not interfere very much ; we are prepared to meet them ; but in small Hospitals it is a serious matter. I had a letter from Maidstone the other day saying the Hospital is full of motor accidents, but I do not think there is any large proportion of people in the London, quite a small proportion who could pay or who do pay anything like that.

1664. I do not think it is a large proportion but quite something to be reckoned with ?—I could send you to-night, or Mr. Morris could answer you by telephone now, the number who pay exactly if you like, who could pay more, and who did.

1665. I suppose they never pay anything to the staff ?—No, never, the staff get no payment at all from any patient.

1666. Of course, if paying beds are not provided that would be the natural course. Then it is your belief that it would create a very bad impression if the number of beds in Voluntary Hospitals for poor patients was reduced ?—Yes, I do. Of course people who have got to beg for Hospitals, like you and me, know that sentiment goes a long way, and if the impression was that Hospitals were being run as a business and treating a better class of person at the expense of diminishing the beds of the others I think it would create a very bad impression. It might die out, but at the present moment most people who give money to Hospitals are helping the sick poor, however much you extend that word.

1667. We have had quite a good deal of evidence suggesting that the provision of beds not for the well-to-do but for the people who are just over the ordinary Hospital class would be rather good propaganda, and is said to be by some Hospitals who have provided these beds, quite good propaganda ?—Well, every hospital must settle it for itself ; I do not think it would be.

1668. It might, of course, depend to a certain extent on the neighbourhood ?—Yes, I do not know where you are to stop if you once begin. Are you going to stop at £1,000 a year ; why not £2,000. Is a poor fellow with £2,001 going to be stopped going into a Hospital. You must have it for everybody.

1669. It might be necessary, perhaps, to have a certain proportion of accommodation, but the need you would agree, would not you, is for the poor patient who is ready to pay the full maintenance fee and a small fee for medical attendance but who cannot possibly pay the large fees of a Nursing Home. The rich man or woman are able to look after themselves ?—I do not really know how much that need exists.

1670. We have had very strong evidence to show that it does exist.—Well, I am a Director of a Company with a great number of clerks in the Insurance world, and I asked them yesterday : "What do you do when you are ill ?" they said : "We shove along as best we can and we get into "a Hospital." Well, that is the class that do come into Hospitals.

1671. You would not admit them over £400 ?—Yes, I think we should, if they could prove that they really were poor and deserving. We are obliged to have a limit.

1672. But there might be quite a number of clerks earning £400 a year or even £300 unmarried ?—And married ?

1673. No, unmarried, who really ought to be prepared to pay something for their Hospital treatment and pay their Doctor something too ?—Well, they would be assessed on a certain scale at the London.

1674. Then of course, they would not pay anything to the doctor ?—No, they would not pay a great deal ; I do not know why they should.

1675. Are not they in fact, if you accept patients of that sort, keeping out the poorer class, the really poor class ?—We consider that they are among the poorer class now. I mean we consider, and we always have admitted, the clerk as poor people. In all Hospitals it is the same, I am sure. The class we are out to help are those who cannot afford to get well.

1676. I think I shall be right in saying that the evidence we have received from quite a considerable number of Hospitals now, which have a certain number of pay beds, is, that that class of patient pays 4 to 5 guineas a week where they have got the pay beds ?—What, a man with £400 a year married ?

1677. Quite likely, yes, it depends on his circumstances, of course.—We have got at the London Hospital a very sympathetic woman ; we got her, because she was that, who goes round and assesses these patients, and I think it might be worth while for you to see her and she would tell you how far she could assess them.

1678. You see we have got the Hospital Saving Association limit at £6, the upward limit of the Hospital Saving Association is £6 a week, that is only £300 a year with a family ?—That is people who are allowed to belong to it ?

1679. That was agreed by all the Hospitals in London as being the upward limit of a man who is married and has children ?—Yes, we were obliged to fix that because of trouble with the doctors. They are admitted without inquiry because they are members of the Hospital Association ; they are admitted without inquiry as to means, and that was really to satisfy the Doctors as much as anybody else, that we were not cheating them out of fees they would otherwise get. I do not think anybody on the staff of the London Hospital would say there are people in there who can afford to pay a Surgeon or Doctor anything like his normal fee.

1680. No, I should think probably that is true, but of course it is also true to say that these people who go into Hospitals where they pay 5 guineas or 4 guineas a week do not pay anything like the normal fee for a Surgeon. Surgeons there are prepared to accept something very much smaller ?—I suppose all Surgeons would accept as much as they could get, like a barrister. I do not know what a normal fee is considered to be. A normal fee is as much as you can get.

1681. I think I will leave that to my professional brethren. Would you draw any distinction in your own mind between the provision of beds for the class we have been discussing, that is to say those above what we call the Hospital class, and the provision of beds for wealthy people ?—What do you mean, draw any distinction ?

1682. Would you think one was less advisable than the other ?—From what point of view ?

From the demand point of view or what point of view ?

1683. From the General Voluntary Hospitals point of view ?—I am sorry I am so stupid, but I do not understand the question. Do you mean, do I think we ought to provide for the other people ?

1684. There is a general consensus of opinion, I think, that somehow or other this middle class, if you like to call them so, must be provided for, that they require Institutional treatment, that they are either getting it for nothing somewhere where they ought to pay, or that they do not get it at all. There seems to be a general consensus of opinion that that class must be provided for, but there is not the same unanimity about providing for the wealthy class, who can go to a Nursing Home, and pay perhaps not always the full fee, but a considerable fee for medical attendance. The argument for providing for those is that in most Nursing Homes you cannot give the services which a Hospital can give with all its concomitant arrangements, X-rays, laboratories and so forth. Do you think there is more objection to providing for the rich sick than for the comparatively poor sick ?—Yes, from the Hospital point of view, I do not think it is our business.

1685. You would object to anything like the adoption of the American system ?—Well, that is such a wide thing ; I do not quite know what the American system is. The American system is the Surgeon gets as much as he can from anybody in his own Nursing Home, and everybody uses these clinics, do not they ?

1686. Perhaps not quite ; there may be such, but when I mentioned the American system I meant the system which has been adopted by certain American Hospitals which have always had so far as we know a large number of pay beds graduated from the quite comparatively poor up to the very rich ?—My answer is, I dare say it is quite a good system, I do not know, but we do not learn much from what is done in other countries. The whole feeling, the whole sentiment towards the Hospitals, towards the profession, is so utterly different, that you would have to tear up our present system, you cannot start the American system unless you tear up our present system.

1687. You feel that if these beds were provided in our Voluntary Hospitals it would alienate sympathy ?—Yes, I think it would. I am assuming you mean taking them away from the present beds.

1688. I think we are all agreed you cannot use these beds for teaching ?—Then you must add beds to the present beds out of new money.

1689. Yes, I think that would be agreed ?—Raised for the purpose. Then you might just as well start a paying Hospital.

1690. That might lead us into a rather long inquiry, but if you have got the ground and you have got sufficient administrative offices all ready, you might be able to provide the beds a great deal cheaper than you could if you had to build a whole Hospital ?—As you say, that is a very big thing ; I do not think that one could express an opinion about that.

1691. Your experience is that this class of patient if they go into the General Ward do not mind it ?—Not the slightest. It may sound exaggerated, but I never have heard of a case of a patient complaining. I had great difficulty in persuading a friend of mine, who is very poor, to go into the General Ward. He said : " I " cannot go in there, it is impossible with the fellow " next door making a row." He was quite different when he came out. I have had two or three Members of Parliament and of borough councils and they were quite happy there.

1692. There is one other question I should like to ask about Nursing Homes. You say on page 7, about the middle, that you doubt the fairness of using the Voluntary Hospitals to compete with Nursing Homes. Of course it would depend very largely upon the Medical profession whether patients were sent to Voluntary Hospitals instead of to Nursing Homes. I take it that a patient as a general rule asks his medical adviser where he advises him to go ?—Yes, I should think he does, certainly, but you see I do not think there is very much in that argument. You would be using charitable money at present to compete with people who have put their money into Nursing Homes.

1693. That is on the assumption that you use existing buildings ?—Yes, or raising money by charity at all, like voluntary donations.

1694. Unless it was given specifically for that purpose ?—Then you are competing with people who have not had that advantage.

1695. Yes, quite, you are competing with people in the same way, but you would not think it unreasonable I suppose to eliminate the bad Nursing Homes even by that process ?—No, I do not know whether the complaint is not very much exaggerated of bad Nursing Homes. They are not convenient but I think it is rather a strong word for them.

1696. You think it would be unfair on the Medical Profession if the patients in these proposed pay beds are only to be attended by the staff of the Hospital in which the Wards are. I suppose it would be generally the staff of the Hospital who would fill the beds, would not it ?—No, not necessarily. If you are going to have these pay beds open to the public then it would be very unfair that patients should only be admitted to them through the staff of the Hospital itself. They must be open to every member, like they are at St. Thomas's, of the whole profession. It would be a very unfair advantage—it is not for me to fight for the profession, but already members who are not on the staff of Hospitals know how awfully handicapped they are compared with those on the staff. If you are going to add to that a pecuniary advantage to them I think it would be a very serious handicap ; I think it would be very hard.

1697. You might leave that perhaps to the Medical Profession ?—I do not want to lower the standard of men and the ideal of the men of the staff of the Hospital ; you yourself know how high it is.

1698. Oh yes, certainly.—And they have been rather proud up to now that they have never taken money from patients.

1699. Sir JOHN ROSE BRADFORD : Lord Knutsford, I only want to be clear on one or two points. You would admit that there is at the present time a great demand for Hospital treatment by those whose financial position is somewhat above that of the average Hospital patient ?—Yes, I think so certainly, but I do not know that the demand has increased. I think it has come into the limelight more. I do not know that it has increased except that treatment is more expensive.

1701. Yes, that is one of the reasons, is it not. Then you think that that would be met by the

provision of paying Hospitals independent of existing Hospitals. That is your position ?—Yes.

1702. Do you think that the accommodation and amenities and so on afforded by the Nursing Homes are really comparable to those afforded by a good Hospital ?—I think some are. There are two just started quite as good, I think, and I have visited a great number of Nursing Homes which I think are just as good as some of the Hospitals.

1703. But they have not got the provision of what we call the accessories that a Hospital has, have they, in the way of laboratories and X-ray equipment and so forth ?—I do not know that you want all that for one illness, so to speak. The laboratories and so on are working on preventive medicines and research.

1704. Yes, but they are also urgently required in routine, the diagnosis of ordinary cases, are they not ?—Yes, but in any Nursing Home the Doctor or Surgeon who sends a patient there gets that done elsewhere.

1705. We have had a good deal of evidence given to us that speaking broadly Nursing Homes cannot afford the facilities which are open to the poorest patient in a General Hospital ?—I am sure that is so, but my experience is that somehow or other if you go to a Surgeon he says : " Yes, I shall " want this examined," and he takes a bit from you and he sends it somewhere ; I do not know where he gets it done, probably privately, but it is done.

1706. But you would admit, would you not, that speaking broadly a man with a small income, we need not fix the limit, but a man with a small income who is attacked by illness cannot get at the present time the facilities for his adequate treatment that are afforded to the poor in a Voluntary Hospital ?—I think he comes now into the proper definition of the " sick poor " treated in the Voluntary Hospitals.

1707. He cannot get it unless he goes to a Hospital ?—No, that is so.

1708. You would admit that ?—Yes, it always has been so.

1709. But it is more so, is it not ?—No, I do not think it is.

1710. But surely it is more so, is it not, as the result of the last 30 or 40 years' changes that have taken place in medical and surgical treatment. Nothing on this scale was required 30 or 40 years ago ; I think I can speak from my own experience ? —You know better than I do.

1711. I thought that was one of the reasons of the increase in expenditure in Hospital administration ?—Yes.

1712. But anyhow you would meet this problem by having paying Hospitals independent of the existing Voluntary Hospitals ?—Yes. I think it might be seriously urged that people should insure against the liability of an operation or a long illness. I know my own Company is considering it, and I know the Prudential do it, and I think it would be quite possible in a business proposition that they should insure.

1713. The CHAIRMAN : To cover all the costs of treatment and maintenance ?—Yes, limited, say to £100 or whatever you like. That is a business proposition which I cannot think would not be solved. It seems to me the duty of people as they know they are likely to have some illness or some operation in the family, it seems almost necessary they should provide for this in advance. They provide against fire, they provide against burglary and insure their lives ; why should not they insure against an almost certain incident ?

1714. Sir JOHN ROSE BRADFORD : Yes ; that is another question of course, is not it, but anyhow your main position is that this provision or attempted provision for those beds in a Hospital should be provided in separate Institutions and not in the main Hospital ?—Yes, for every possible reason, for sympathetic reasons, for Nursing reasons, for medical reasons, the whole of the work for teaching and everything I think would be better if we had any such provision, provided it was in a separate establishment.

1715. I would like to ask you on that, would your objection to the associations of these pay beds with a Voluntary Hospital be limited to the teaching Hospitals. I mean would your objection be limited to the teaching Hospitals or would it apply to all the Voluntary Hospitals ?—I had not thought that out. I do not think the ones which are not teaching Hospitals have got all these facilities you mention, or very few of them.

1716. I think some of them have them on a certain scale at any rate ?—No, I do not think so, but you know and I do not. I know Hospitals which I know have not got them ; Poplar has not got them, and Shadwell has not got them.

1717. I do not say they have got them on the scale of the teaching Hospitals, but they are on a different plane to most Nursing Homes at any rate ? —I really do not know.

1718. What I want to know is whether your objection to these pay beds being associated with Voluntary Hospitals would be limited to the Voluntary teaching Hospitals or to other Hospitals generally ?—No, I think I would rather it applied to all. It is a separate job and a very popular job if you do start it.

1720. Would you object to developments of this kind taking place on a large scale in connection with so-called Cottage Hospitals ?—No, I do not think I should.

1721. Mr. LOW : I have not much to ask ; there is only one point you mentioned about insurance. They would have to have a very rigid medical examination for an insurance of that sort, which would be very difficult ?—In any new scheme one always sees difficulties at first, but the only reason for difficulties is to get over them ; there is nothing without difficulties, and you can be quite sure that Insurance Companies who undertake this business will take care of themselves and they will get over the difficulties. They now insure against certain illnesses.

1722. But a very limited number ; all the illnesses you are not likely to get, like Plague ?— That depends on the Surgeon's point of view.

1723. All sorts of things. I looked at a list a short time ago, and it struck me that one was not likely to get any of the complaints in that list.— I think appendicitis is getting out of fashion.

1724. Then the question of setting up these paying beds for the poorer class of patient—I am not talking about the very poor but the 5 to 7 guineas a week type of patient, Sir John Rose Bradford has mentioned many disadvantages which Nursing Homes suffer from, but there is one of course, and that is the Resident Medical Officer. There are various emergencies that arise which cannot be dealt with except by somebody on the spot. You never know when they are going to arise, and people who use Nursing Homes are at a disadvantage in that respect ?—So is a millionaire who does not have a Resident Medical Surgeon ; that is a common thing in all

illnesses, that you have not got a resident man.

1725. But the millionaire can pay for one ?—He would not dream of doing it ; he never does.

1726. But a poorer man could not do that ?—I have never heard of a Resident Doctor in a private case.

1727. Sir JOHN ROSE BRADFORD : I have.—I have had operations myself ; most parts of me have been operated upon at different times and I have never had a Resident Doctor.

1728. Mr. LOW : I am not suggesting in every case.—I have never heard of one in all my life ; you have, I dare say. I have never heard of anyone having one.

1729. I have raised the question with Resident Doctors, and in the case of a Hospital there is a distinct advantage in having a man on the spot for emergencies which may arise. That is one of the advantages of being in a Hospital ?—Yes.

1730. In such a Hospital as you suggest, do you think that could be worked as economically if it stood on its own basis as if it were formed in connection with an already existing organisation in which, for instance, they would have a call on the Resident ?—I suppose you could run it cheaper in connection with a General Hospital. It would alter the whole work of the General Hospital and I think we have got enough to do. I dare say it could be run cheaper, but I think you ought to be able to run a paying Hospital, by having it of a sufficient size, economically.

1731. And you think it would be a pity to make use of existing organisations rather than to set up an entirely fresh organisation of this sort ?—Very strongly, I feel it is better to set up a separate one.

1732. Lord SOMERLEYTON : You say in your evidence, and you said I think to-day, you do not know of a case of any man who went into a General Ward who did not get over his dislike of being in a General Ward ?—Yes, I think so.

1733. Would that apply to women ?—Oh yes, certainly.

1734. As much ?—Yes, as much.

1735. I had an idea in my mind that women did not like the public Wards at all ?—No, every bit as much, only they object more before and less afterwards almost certainly. It is much easier to satisfy a woman than a man ; they are more grateful.

1736. Professor WINIFRED CULLIS : You agree that there are very large numbers of people who cannot afford a fee for a Nursing Home which would give them anything like the facilities that they would get in a Hospital for the same money, but who yet would wish to pay their medical adviser ?—Yes, I think they might like to pay their medical adviser, certainly.

1737. I think there are a very large number who would wish to pay something, but who are barred from going into Nursing Homes at present, because they are so expensive, and yet who must have Institutional treatment ?—I admit there are some, but I think perhaps it is exaggerated. I think there are people, of course, who could pay more than they do in a Hospital.

1738. I think there are many who could not pay much more than they do pay for Institutional treatment in some of the Wards of the Hospital, who would very much like to pay something for the medical services ?—To the staff of the Hospital ?

1739. Yes, if the work is done by the staff. They cannot go to a Nursing Home for 4 guineas or 5 guineas a week.—Yes, I dare say.

1740. Do you not think it is a very urgent matter to provide for this large number of people who want Institutional treatment and who yet would like to pay something for their medical treatment ?—Yes, I think it is quite likely.

1741. And your solution would be to build separate Hospitals for those ?—Yes.

1742. We have met in begging for Hospitals the very widely expressed feeling that it is high time something was done for those people. Have you not come across that at all ?—No, I really have not. I think those people get the help. What do they do now, do they die without help ?

1743. No, they either go to Hospital where they can get the help as far as the Institution is concerned which bars them from paying.—They can always subscribe.

1744. No, I do not mean to the Hospital only, but to people who treat them.—To the Surgeons and Doctors ?

1745. Yes, or they stay at home and are nursed under very bad conditions.—Yes.

1746. I think it is an urgent need, and I am just wondering if you had any experience of this attitude. We meet a great many people, I mean people who subscribe to Hospitals, who complain that nothing is done for that group, and wish that something could be done for them.—I have found that amongst the people who subscribe to Hospitals lots do it. I have urged it in "The Times" and other papers over and over again. I want to have a Hospital with the menu put up and you can order what you like off the menu ; you can have your appendix taken out, your kidneys operated on, and know what the whole thing will cost, and any person going there would know exactly what the cost of his illness would be.

1747. You do not think that provision of such accommodation would be a solution to some of the difficulties of the Hospitals ?—Oh dear no, I do not think it would ; I do not think it would help us at all ; I think it would muddle our work. I think we have got quite enough to do in every Hospital, and I do not think it is our job at all.

1748. Sir BERNARD MALLET : You said just now, that you knew two new Nursing Homes that have been opened. Would they be run on commercial lines like the Empire Hospital we have heard about ?—Yes, but cheaper.

1749. Not belonging to some Doctor or Surgeon ?—No. A very very rich man has opened one of them, I cannot remember his name, but it is very good. There are two in the same street.

1750. Were the houses built specially for them ?—Yes, one in Dorset Square that I know of ; that is run as an ordinary speculation by those to whom it belongs.

1751. That is not so convenient ?—No, but fairly convenient.

The CHAIRMAN : Thank you very much for coming.

(The Witness withdraws.)

DR. C. McMORAN WILSON, M.C., M.D., F.R.C.P., Royal College of Physicians, called and examined.

1752. The CHAIRMAN : You have been good enough to send us on behalf of the Royal College of Physicians, a memorandum, but I understand that you are at liberty to speak, or rather to give your own views, and that you have not, in fact, any means of knowing the collective opinion of the College ?—No.

Dr. C. McMoran Wilson.

1753. I do not quite understand the second paragraph: "The College, I think, would wish the "question examined from a wide educational "angle." Would you mind elaborating that a little?—I meant as it would concern the General Practitioner from the educational angle, rather than a medical one, and as it would affect the teaching schools.

1754. Because such pay beds, if provided, would not be available for teaching?—Yes, that is one aspect.

1755. I take it to be your experience and to be the experience of your colleagues in the profession, that you do find there is a large class of people who require medical treatment or surgical treatment and whose homes are unsuitable for treatment of that kind, and who cannot afford the ordinary Nursing Home fees?—Yes.

1756. And who do in fact now find their way very largely, I will not say very largely, but to a certain extent, into the ordinary Wards of General Hospitals?—Yes, I think so, certainly.

1757. Have you any actual experience yourself of a Hospital with paying beds?—No.

1758. So the first paragraph on page 4 is evidence of what you have heard said?—Yes, based upon existing Institutions with such beds.

1759. And the same would apply to propaganda value on the same page; that is what you believe to be the general opinion from what you have heard from other people?—Yes.

1760. Now at the bottom of that page, you say you think that so long as this class goes unprovided for, the general whole position cannot be satisfactory, and I gather that you think it may affect the future Voluntary Hospitals if some provision is not made?—Yes.

1761. So that in your opinion, the Voluntary Hospitals are likely to stand to lose rather than to gain in sympathy if they do not take some steps to provide beds for this class of patient?—Yes.

1762. Have you ever heard yourself in your experience amongst your own patients, of their difficulty in finding treatment?—Do you mean the middle class?

1763. Yes.—Yes, I have pretty constantly. We are always faced with people who want to have certain things done and they cannot afford Nursing Homes; people who can afford really more than existing Hospitals, but cannot afford Nursing Homes. It is not only occasional: I think it is a common experience.

1764. And who I suppose might be able to afford modified fees for medical attendance?—Yes.

1765. You have made some systematic inquiries, as I understand, about the Nursing Home accommodation in London?—Yes. It may be put in a sentence really. The total number of Nursing Homes is 410; that is got from the buff telephone book, there is no register at the present time, and inquiries have been made of 191 consecutively, and in those 191 Homes there were 1,770 beds, so working on an average, the number in London would be about 3,500. Of those 1,770 beds, three-fourths or 77 per cent. have no lift, 49 per cent. have no theatre, and only two were fitted with X-rays, and not one of which I inquired had a Medical Officer. That is really what the thing came to in brief.

1766. You say 49 per cent. had no theatres?—Yes, the exact numbers were these; of 1,770 beds, 905 had a theatre fitted, that is 51 per cent. and the remainder of those 1,770, that is 49 per cent. had no theatre, so it is really half.

1767. Did you ask what the practice was?—Yes, apparently the practice is they clear a Ward, that is their almost invariable answer, if they have got no theatre they nearly always, when asked, say they clear a Ward when it is necessary for an operation: I suppose a small Ward, a single room really.

1768. And they have operating tables and so forth, I suppose they could get them in, they could hire them?—Yes, I suppose they could hire them.

1769. That information of course is interesting. Those two that had X-ray apparatus, were they recently built?—I could not say that; they were the larger ones.

1770. You have had some experience, I see, of working for the Guardians?—Yes.

1772. I am not quite sure whether I have drawn the right inference from what you say about the possible relation which might exist in the future between Voluntary Hospitals and Infirmaries, but it seems to me that it might be this, that in the case of St. Mary's Hospital a certain number of pay beds would be provided and that their loss in the Hospital would be made up by finding more beds for the poorer class of patient in the Paddington Infirmary?—Well, I was rather making this point: if there was a large Municipal Hospital indistinguishable from a Voluntary Hospital in point of efficiency, and another large paying Hospital not the Voluntary Hospital, then the position of this Voluntary Hospital sandwiched between these two would become very difficult.

1773. Would you suggest that a Voluntary Hospital is ever likely to become a paying Hospital only, because in that case it would be very difficult to find, certainly in a certain class of Hospital, sufficient room for teaching?—No, that was not the point I was making, otherwise it would be like Copenhagen.

1774. You do contemplate the possibility, I do not know that it has got much to do with this inquiry, of the Municipal Hospital and Voluntary Hospital being in closer relation than they are at the present time?—Yes.

1775. Supposing that relation did exist, you do not suggest that Voluntary Hospitals should on that account give up to pay patients beds which are now devoted to poorer patients?—No.

1776. What is your opinion about the rather vexed question of the medical men who are to be allowed to attend patients in Hospitals, that is to say whether the Hospital is to limit those who attend patients to members of their own staff?—My feeling is that it is impossible to express an opinion without a trial on a more extensive scale than at present, but I thought the best scheme would be that Hospitals should be more or less allowed their head in this respect to work it out by trial.

1777. It would be very difficult for a Hospital, the staff of which is all of the standard of Fellows of both Colleges, to allow General Practitioners to come in and treat?—Yes, I think difficulties might arise, but if you are really going to draw in the whole of the middle class, if you do not do that you practically prevent the General Practitioner treating the middle class when they are seriously ill. That would be the ultimate logic of it, and I do not know that that is a practical proposition.

1778. You could not allow a General Practitioner to come in and do a serious operation?—No, I take it they would be barred from the surgical point of view. I think the question really would

boil down to what would happen in medicine. I think it is difficult; experience, however, would suggest, no doubt, a working compromise.

1779. Would it be true to say that at least 75 per cent. of these cases would be surgical cases, not because they are not medical cases, but it is because, on the whole, it is easier to treat medical cases in a patient's own home ?—Oh, I think it is quite impossible for me to answer that, because I only see the medical side. I think the only way would be to get figures from existing Nursing Homes.

1780. Of course all Hospitals are more pressed for surgical beds now than medical ?—Yes, but there are long waiting lists on the medical side also.

1781. You would be prepared to say, as a general rule, it is easier to treat a sick man who does not require an operation in his own home than a sick man who does require an operation ?—Yes, I think the answer to that is, it is almost impossible to treat in many homes surgical cases; you have got noise and you have got children about; but I think in the average middle class home the treatment of severe medical cases is extremely difficult too for reasons that are less obvious, but I think they are equally potent.

1782. Sir JOHN ROSE BRADFORD: Dr. Wilson, would it be correct for me to say that your position, speaking generally, is that there is a demand for paying beds of this character ?—Yes.

1783. And that they should be associated with existing Voluntary Hospitals ?—Yes.

1783A. And not as independent institutions ?—No.

1784. And lastly that the question of the medical attendant should be left to the Governing Body of the Institution ?—For the time being, yes, I think so.

1785. That is the summary of your position ?—Yes.

1786. Professor WINIFRED CULLIS: Would you contemplate the Infirmaries being available for teaching the medical students ?—Yes, we use, of course, Paddington, as it is.

1787. Sir BERNARD MALLET: Do you know, with regard to any of these Nursing Homes, are they regular commercial companies like the Empire, or are they merely private concerns ?—I am afraid I do not know.

1788. The CHAIRMAN: Is there anything else you would like to say ?—No.

The CHAIRMAN: We are obliged for your memorandum; it will be very useful.

(The Witness withdraws.)

Note to Question 1652. *The following Memorandum was handed in by* VISCOUNT KNUTSFORD.

The Terms of Reference to the Committee are :—

> " To inquire and report upon the question of Hospital accommodation in London for persons
> " prepared to pay more than ordinary Voluntary Hospital patients; and to report the
> " conclusions at which they may arrive."

But in Mr. Maynard's letter to me of August 8th, he writes :—

> " The Committee have to consider the general question whether (and if so, to what extent)
> " pay beds for those prepared to pay more than ordinary Voluntary Hospital patients
> " should, if provided on a largely extended scale, be so provided in association with the
> " Voluntary Hospitals or in separate Institutions created for the purpose."

This goes a good deal beyond the terms of reference.

I assume, therefore, that I am asked to give evidence, not on the question of whether it would be a paying proposition for Voluntary Hospitals to open what are called Paying Beds or Paying Wards, or a separate paying annexe, such as at St. Thomas's Hospital, but whether it is a step which should be generally adopted on a large scale by the Voluntary Hospitals, or in connection with them.

If this is done, I am sure these wards or beds should be in addition to the present beds, because all the Hospitals which I know of are more than full to-day; that is to say, that the accommodation which they are providing is not sufficient to meet the wants of the class of persons whom they are to-day catering for. As a result, all Hospitals have long waiting lists.

In this connection, I note that the Treasurer of St. Bartholomew's reports (the Charity Commissioners have some say over the expenditure at St. Bartholomew's, because till lately the Hospital lived on its endowments) :—

> " The following authority has been obtained from the Charity Commissioners :—
> " The Governors may set aside not more than 100 beds in the best wards in the Hospital
> " and may charge each patient occupying any of such beds at such rate, not being more
> " than £6 6s. a week, as the Governors may from time to time fix."

I do not wish to criticise the action of any other Hospital, but I feel that if this be done, it must mean that the class below the £6 6s. a week class will be deprived of beds which are to-day not sufficient in number to meet their needs. To allocate 100 beds for this purpose would mean about one-seventh of the total number of beds at St. Bartholomew's. And this would mean that these people will have to seek help from other Hospitals already overtaxed for accommodation.

I do believe that it would create a very bad impression, and would put the public out of sympathy with the Voluntary Hospitals, if the idea got abroad that they were reducing their number of beds hitherto used by a poorer class of patients so as to accommodate a richer class. I repeat again that it is not as if there were not enough of the poorer class clamouring for admission.

If this premise is admitted, i.e., that any paying-bed accommodation should be in addition to, and not in place of, the present beds, then we are left with the question whether it is the duty or the business of the Voluntary Hospitals to provide additional accommodation to meet the wants of people who are able to pay more than the small weekly payments now generally made for maintenance.

I do not like the idea of doing this.

If we were to scrap all our methods of helping and treating the sick poor and were to begin again, perhaps we should adopt the American system. Professor Berry, Dean of the Faculty of Medicine, University of Melbourne, lately wrote in the " Daily Telegraph " :—

> " In the United States all the leading Hospitals are now staffed by a full-time and paid medical
> " service, the members of which do not, as a general rule, engage in any private practice
> " whatsoever. The Hospital beds are open to all, rich and poor alike, who contribute for

"their maintenance and treatment according to their means. Every Hospital is thus "largely self-supporting, and when, or where, it falls short, the deficiency is made good "by the necessary contribution from the public purse of the State or City, and at times "from the private one of the wealthy benefactor."

But we have to get the best out of our present system, which on the whole has worked very well. It is trusted by the General Public everywhere, and the Hospitals have been generously, if not sufficiently, supported. The highest ideals and standard of treating the sick has been common amongst them all. Great training schools for Doctors and Nurses have grown up under this system—probably the finest schools in the world—and the leaders of the Medical Profession have given their services to the Hospitals free. Nothing like it in any other country.

I dislike the idea of making the Hospitals into a business. To do so would alter the whole spirit of the work.

There is a good deal of talk just now about the "sick poor" being treated better than the "white-collar" class—the clerk, the small tradesman, the poor gentleman class, and so on, *ejusdem generis*. But is it not the experience of all Hospitals that there is no obstacle placed in the way of anyone belonging to these classes to get into Hospitals, provided they are willing to go into a general ward?

At the London Hospital our official limit for in-patients is £400 a year; that is to say, that anyone up to that income is admitted without question. Above that limit, inquiry is made as to the patient's suitability, from a pecuniary point of view, to receive the benefits of so cheap a road to recovery as the Hospital can give. But the exceptions made are numerous. The practice is to admit a patient if the answer is negative to the question "Having regard to the treatment you require, can you afford to have it carried out privately?" If the answer is "No," and if satisfied that that answer is true, then the patient is admitted.

I have seen every class of patient in the general wards of the London Hospital. Our students are often in them. I have seen in them clergymen, many retired officers, any number of clerks and small tradesmen, and men connected with the press. I have seen Labour M.P.'s in our wards, and the Mayor of a London borough has lately been an inmate. I can recall many who might be called "lady" patients. All of these were "sick poor" in the sense that they could not possibly have afforded to get the help they needed without the Hospital, nor to have been ill in their homes.

They got to their destination by the same train as the rich, but because they were poor they travelled third class instead of first. Is it a great hardship to them to have travelled third when they were ill, as they had travelled third when they were well? Is it a great hardship that if they wish to receive the very best doctoring and nursing in sickness for practically only the cost of maintenance, that they should receive this on a somewhat lower plane of comfort than the richer folk?

My experience is that the objection to being in a general ward is usually made by those who have never been in one. I have never heard any objection from anyone who has been in one, and I say this with a long experience of visiting patients. As a matter of fact, the interest taken in what goes on all round a patient in a general ward is very often a help to recovery by taking his thoughts off himself.

Now, we are told that there is a large number of people who are anxious for Hospital help, ready to pay for it, but who are above, socially or pecuniarily, the class for whom the Voluntary Hospitals were endowed, or are supported, and we are asked to embark on the business of catering for these people.

I admit the want of a cheaper means of recovery than can be got from the present Nursing Homes and the present fees of Surgeons and Physicians.

I admit the impossible accommodation at most middle-class (pecuniary middle-class) homes for any operation or long illness necessitating nursing. I am left wondering where they go now, unless it be to the Voluntary Hospitals? To put the question in its extreme aspect, do the people of this class die because they cannot obtain adequate treatment? I do not think they do.

I admit that if better accommodation than the general wards is provided, it will be fully occupied.

But is it the business of the Voluntary Hospitals to provide this? I think not. Very certainly not out of their present funds, given to help a different class of person.

I have admitted the *want* of a certain number of people above the present class of Hospital patients to have a cheaper road to recovery than they can get outside the Voluntary Hospitals. But because a want exists it does not follow necessarily that the Voluntary Hospitals should meet it. No one can deny that there is a want for more accommodation for chronic and dying cases, for tuberculosis, for long illnesses, for nervous diseases, for orthopædic cases, for the after-care and watching of patients who have now to be discharged to make room for more urgent cases. Child welfare work and pre-natal work is developing. New discoveries are constantly being made which the Voluntary Hospitals must try.

But the accommodation of the Hospitals, and their funds, are limited, so they are obliged to be content to do what they can and leave to others what they cannot.

On the question referred to the Committee, I doubt the fairness of using the position of Voluntary Hospitals to compete with Nursing Homes, many of which are good, many bad, but all started out of private capital. I think there is a movement towards improving Nursing Homes owing to the new Nursing Home Registration Act.

Then I think it would be certainly unfair on the Medical Profession if the patients in these proposed Pay Wards or Pay Homes attached to Hospitals are only to be attended by the staff of the Hospital in which the wards are, or to which the homes are attached. This is generally the case now.

As it is, the members of the staff of a Voluntary Hospital have a very great advantage over Doctors and Surgeons not fortunate enough to be on the staff of a General Hospital. And, if you are going to add to this the pecuniary advantage of their being able to get fees from patients in Wards or Homes erected at the cost of voluntary subscriptions which are denied to other members of the profession, you are still further handicapping the less fortunate members. It is clear that it would be no inconsiderable advantage for a Surgeon to have one or two operations a week at 10 to 25 guineas each, in the routine of his Hospital work, with all the extraneous help of a House Surgeon and skilled nursing provided by the Hospital.

To-day all the in-patient work of a Hospital is closely linked up and allied with the out-patient work and with the departments dealing with Special Diseases, such as those of the Heart, Eyes, Nose and Throat

and Skin; and also with what may be called the Scientific Departments—Bacteriological, Clinical Pathological, and Pathological, and so on. All these are fully employed, and have no spare force to give to increased work. Investigations, Researches and Teaching are carried out right through a Hospital on the in-patient material. If more work is put on the workers it would mean, I fear, that the output would suffer in quality and value. I have seen the effects of over-pressure on medical and scientific workers.

I think also that there would be a danger that too large a portion of time and work might be diverted to the paying patients, as constituting a very important part of the Hospital.

I am dealing with the proposition on the supposition that it is proposed to have a very large addition to the Voluntary Hospitals' work by making it possible for all big Hospitals to have a really good paying Home attached to them, or a considerable number of Pay Wards in them, as part of the Hospital's organisation.

It must be remembered that some of the most important functions of a big Voluntary Hospital are Investigation, Research, Preventive Work, and training Doctors and Nurses. Curing the present sick is of course its first duty, but it is not from the Nation's point of view the most important of its many responsibilities. No training of Doctors or Nurses could be done, or is done to-day, in any of the Pay Wards or Homes attached to Hospitals.

I think it ought to be possible to raise the money to build a Pay Hospital of say 100 to 150 beds to start with.

But I repeat I do not think it is the duty of the Voluntary Hospitals to embark on such a speculation, and I feel that it would alienate a great deal of sympathy with them and would be liable to considerable misconstruction if any of the money given to Hospitals, or subscribed to the King's Fund, to help the sick poor was diverted to helping a different class of person than it was meant for.

Sometimes it is said "Surely if you have beds closed because you have not the money to keep them "up with, surely it would be better to open them for people who could pay rather than to keep them empty?" This question assumes that a sufficient profit could be made from these beds to make it worth while. From the experience of those Hospitals which have these beds, I doubt if the profit is sufficient to relieve a Hospital to any material extent.

In March, 1926, the House Governor of the London Hospital reported on this:—

At the Royal Free there are 9 pay beds in separate wards. The Hospital received £1,200 from the weekly payments in the year. But it was not known how much was profit.

At the West London they have 26 beds in a block, the gift of a special donor. The charges are £5 5s. a week for a single room, and £4 4s. for a 2-bedded room. This pays, but only just pays, and it is not intended to make a profit.

At Westminster there is a special department of 14 beds for paying patients; small 4-bedded wards charge £6 6s. a week, and single rooms £10 10s. a week. A profit was made of £1,600 in the year. The Secretary reports that the profit was only possible by working the wards in conjunction with the rest of the Hospital.

At St. Thomas's there is the well-known separate Home consisting of 40 beds. The charge is £6 6s. a week, and some extras have to be paid for, such as X-rays and Anæsthetist. It does not pay, or only just, and cannot be considered a financial asset to the Hospital.

At Guy's there is a pay ward of 26 beds. The beds are in separate cubicles. The charge is £5 5s. a week. The profit to the Hospital is round about £500 a year.

There are six other Hospitals which have pay beds or wards, but in March, 1926, the figures from these were not available.

But in all the above instances I doubt whether the increased work put upon the officials of the Hospital, the House Governor, the Matron, the Accountant, etc., was calculated in the cost.

Anyhow, I think we may safely assume that, from the money point of view, having Pay Wards or Pay Homes is not going to make it worth while for the Voluntary Hospitals to embark on this new speculation.

I have already given my opinion on the question from the other point of view.

MEMORANDUM by EARL OF SCARBROUGH, *Chairman, Empire Hospital for Paying Patients.*

1. The Empire Hospital, Vincent Square.

(*a*) This Hospital was built in 1912 in order to provide all the equipment of a modern institution, including two operating theatres together with skilled nursing and home comforts for persons of moderate means. It is in no sense used as a convalescent home.

(*b*) It was formed into a Limited Company with an authorised capital of £25,000 (since increased to £35,000), which was privately subscribed.

(*c*) There are 42 patients' bedrooms. The charges before the War were 3 guineas to 10 guineas per week according to the size and position of the room. Theatre fees and special nurses, if required, are extra. These charges since the War have been increased to 8 guineas and 18 guineas. Patients are attended by their own Doctors and Surgeons. The Hospital is open to all the profession. There is no Resident Doctor or Surgeon. There is an Honorary Advisory Medical Committee appointed from members of the profession who use the Hospital.

(*d*) We aim at paying 5 per cent. interest to our shareholders, which we have been able to do since the War, and at building up an adequate reserve fund which under certain conditions may in part be used towards the reduction of fees in the case of necessitous patients. During the past year we have been able to admit 42 necessitous patients at from 3 guineas to 6 guineas per week.

(*e*) The number of patients treated in the year 1926–27 was 716, of whom 668 were surgical cases and the daily average of beds occupied was 34 out of 42 available. The holiday seasons bring down the average considerably, while in the month preceding the holidays we usually have to turn applicants away: but in any case necessary cleaning and painting mean that a few rooms are generally out of action, which prevents the occupation of all the rooms together for any length of time.

(*f*) The varying scale of fees, based on the size, furnishing and outlook of the rooms, is not only required to meet the wishes of patients, but is essential to the financial success of this Hospital—the well-to-do patients in effect helping to pay for the poorer class who can only afford the lowest fees. We adopt this principle because we insist on a very high standard of nursing, food and home comforts.

(*g*) If the Hospital had been designed for all the rooms to be of a small and uniform size for the use of poorer patients only, the standard of cooking and comforts would have to be substantially reduced to enable it to pay its way.

II. The Question of the Provision of Pay Bed Accommodation at Voluntary Hospitals or at Separate Hospitals.

(*a*) I contend that the Voluntary Hospitals for the poor, and Pay Hospitals for those who can afford to pay, are two entirely different problems which should not be mixed up. To attempt to cater for the latter *on anything like an adequate scale*, even if practicable, might easily tend to alienate public support from the proper work of Voluntary Hospitals when that work is urgently in need of extension in every Hospital in the country—a need estimated by the Voluntary Hospitals Commission at 10,000 additional beds for England and Wales. Apart from this possibility, there is the question of the additional accommodation which would be required. This would presumably have to be provided in one of two ways :

(1) By building new rooms or wards. This would mean the acquisition of additional space adjoining the Hospital which, if obtainable, it is submitted should be utilised for the much-needed expansion for the purposes for which the Hospital was originally established ;

(2) By allocating part of the existing accommodation to pay patients, thereby depriving the poor of a number of beds provided for them by public subscription and for whom there is already insufficient provision.

(*b*) For Voluntary Hospitals to obtain small contributory fees from those who can afford to pay is right and proper, but that only touches the fringe of the problem.

(*c*) There are other objections.—For a large proportion of pay patients the cooking arrangements in a Voluntary Hospital would be quite unsuitable. Again, this class would demand to be nursed by fully trained nurses only : the staff of a Voluntary Hospital includes probationers undergoing training. Pay patients are very particular and expect everything of the best.

(*d*) It is probably true that to-day, speaking generally, the highest skilled attention and treatment are only available for the rich and the very poor, and that the huge intermediate class have to be content with a much lower scale of efficiency. In order to give them the same advantages, it is submitted this can only be done by the institution of Pay Hospitals. These could be formed as separate annexes to our Voluntary Hospitals, and under their control, which would have certain obvious advantages, or as separate institutions on the lines of the Empire Hospital and others. In either case the initial capital for building and equipping institutions of this character should be found by the class of people for whom they would be provided. If this were done it should be practicable to maintain them on business lines at a low uniform fee and pay interest on the capital employed, with this vital reservation—that everything depends on efficient administration and management.

MEMORANDUM by MISS CUMMINS, *Almoner at St. Thomas's Hospital.*

THE DEMAND FOR PAY BEDS.

1. From an examination of our records of recent date, it would appear that paying wards, at an inclusive weekly fee, should be in fairly constant demand. For the purpose of this inquiry a period of three weeks, taken at random during 1927, has been scrutinized. Excluding those patients treated in the Maternity, Tuberculosis and Venereal Wards, there is left a total number of 467 persons. Nine of these patients, or relatives and friends who were responsible for payments, would have been ready and able to manage a weekly inclusive fee of from £3 10s. to £5. Thus one might fairly conclude that out of all the patients treated in the general wards of St. Thomas's, we could count upon, roughly speaking, 150 per annum who would apply for admission to a moderately priced paying ward. This would represent not less than ten beds.

2. This number of patients would presumably be augmented from the class of patient who have just sufficient savings to meet the present cost of nursing home and surgeon's fee in an emergency, but which suffer in after years from this sudden depletion of a very small capital. One is a little uncertain as to whether or not there would be a temptation to use the paying ward when the income or capital of the patient applying might be sufficient to meet the ordinary present cost of a nursing home as well as a surgeon's fee. But no doubt this danger could be guarded against by the consideration of each individual case, as at present.

3. Interviewing patients who come for treatment to our special departments, particularly those treating throat, nose and ear complaints, reveals a small steady demand for admission to a Nursing Home or Hospital for a certain composite fee. The removal of tonsils, tonsils and adenoids, and the surgical treatment of deflected nasal septum usually entails a stay of not more (sometimes less) than a week. Special provision for this type of case would have to be made in thinking out a scheme for a paying ward. My experience is that a fair number of people are prepared to put down £20 to £25, if certain that the

total expenses of nursing and operation will not exceed this sum. The patient is not incapacitated for long after the operation, and is not likely to be an expense to relatives during a convalescent period, as is the case usually after an illness. Therefore a weekly rate would not fairly meet the case.

4. There is yet a very urgent need which I meet many times in the course of a month, and that is a moderately priced Maternity Hospital. More and more, in the professional world, at all events, when starting out in life people are obliged to curtail their expenses on domestic servants; a great many, indeed, start life with only daily help. When the first baby comes they do not want to go into the wards of a Voluntary Hospital, and, so far as I know, there is very little accommodation for such cases in the one or two London Hospitals with such a ward, but I think I can quite certainly say that there is a large and growing demand. For a good many years I have felt worried at having to say that I have little to offer them in the way of private homes, and regret that at the most important time in their young married lives, there is no place where they can get the accommodation, etc., which they need. The municipal authorities are, I believe, realizing and beginning to meet the needs of cases in certain parts of London, but my impression is that there is a great deal more to be done.

5. In reference to the provision of homes for chronic and incurable cases, I should say it is fairly easy to find accommodation for those whose complaints do not (*a*) render them offensive to other patients, or (*b*) require constant nursing and night attention. That is to say, when relatives are in a position to pay a minimum of 3½-guineas a week. But for members of the professional and educated classes who are suffering from any form of illness which involves much constant nursing care over a prolonged period, there is no adequate provision at such a price. This is quite understandable, as a privately-run house out to make even a small profit cannot provide the necessary staff to care for such patients. For middle-class patients suffering from any physical illness which is fairly certain to have a fatal termination within six months, there are, of course, beds in the various homes for the dying.