KING EDWARD'S HOSPITAL FUND FOR LONDON

# Summary of Report

OF

THE COMMITTEE

APPOINTED TO INQUIRE INTO

# OUT-PATIENT METHODS

AT

LONDON VOLUNTARY HOSPITALS

AS AFFECTING

## SUITABILITY OF PATIENTS

AND

## TIME OF WAITING

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# Out-Patient Committee 1932.

In January, 1932, His Royal Highness the Prince of Wales, President of King Edward's Hospital Fund, appointed a Committee of Inquiry, consisting of the Earl of Onslow (Chairman), Sir John Rose Bradford, Bt., Lt.-Gen. Sir George Macdonogh, Dame Helen Gwynne-Vaughan, Sir Ernest Morris, Sir Francis Fremantle, M.P., Sir Isidore Salmon, M.P., and Mr. R. H. P. Orde, to inquire into and report upon out-patient methods as affecting the suitability of the patients and the time of waiting. The Committee reported in December, 1932.*

The general conclusions of the Committee were that, though part of the waiting was unavoidable with large populations, part was due to the treatment of excessive numbers of minor cases which could without detriment be dealt with elsewhere, and part was sometimes due to remediable defects in procedure or in accommodation.

On the first point, the Committee recommended that the present movement towards the more consultative use of the out-patient departments, except for emergencies, should be encouraged, provided that a patient desiring to attend a hospital, and unable to pay a consultant's fee, should have access, at least once, without a doctor's letter; and they also recommended that some of the minor cases should, after one treatment, be referred to appropriate alternative agencies described in the Report.

On the second point, they recommended that various time-saving methods of procedure or improvements in accommodation, already adopted or suggested at some hospitals and described in the Report, should be studied by all hospitals with a view to action where appropriate.

An Appendix to the Report contained a signed Summary, which is here printed separately.†

## Contents of Summary.




10 Old Jewry, E.C.2.
*June*, 1934.


* The Report is published for the King's Fund by Geo. Barber & Son, Limited, Furnival Street, Holborn, E.C.4, price 1s. 6d.; post free, 1s. 9d.

† The statements in the Summary are necessarily much condensed and many details are omitted. As printed in the full Report it contains, under each heading and sub-heading, marginal references to the paragraphs which give fuller particulars. See also page 19 below.

# Out-Patient Methods.

## SUMMARY OF REPORT.

### I. Introductory.

1. Subject-matter.—Our Report deals with methods affecting the suitability of the out-patients and the time they spend at hospital. Suitability depends partly on medical condition and partly on financial circumstances. It affects numbers and therefore time taken. Time taken includes time spent while receiving attention at each stage of the procedure, and also waiting, i.e., time spent between stages. Patients include out-patients proper and casualties, i.e., cases treated in the casualty department, which is commonly used both for emergencies and for minor cases.

2. Historical Note.—Out-patient departments were originally established for the treatment of the sick poor, when treatments were comparatively simple. There are now also numerous other agencies which provide the more simple forms of treatment for various classes; these agencies include the National Health Insurance system, the Public Assistance medical service, various public or voluntary clinics and dispensaries and the District Nursing Service. The specialised methods of diagnosis and treatment supplied only at hospitals have greatly increased both in number and in cost. Many changes have taken place in patients' circumstances. Those who can afford it now make a small payment; large numbers of wage-earners belong to contributory schemes; and many patients not formerly regarded as poor cannot now afford expensive modern medical services.

3. The Present Position.—The hospitals remain the most important centres for specialist and consultative services, and for medical education, and they also provide ordinary treatment for large numbers. They are popular and have the confidence of those

they serve. The number of patients fell after the Insurance Act, but has since increased.

4. General Description of Out-patient Procedure.—Our Report describes briefly the procedure in casualty and out-patient departments. Casualty departments are open day and night for the treatment of emergencies and trivial cases. They are sometimes used as a preliminary sifting place for all out-patients, retaining minor cases and passing on the more serious to the out-patient department. At the out-patient department the honorary visiting staff of consultant physicians and surgeons attend. The patients are divided into old and new, general and special. Sometimes they are sifted into major and minor, where this has not been done in the casualty department ; sometimes it is not done at all. They are registered, pass into the waiting hall and then into the consulting rooms. Their financial suitability is ascertained, unless this has already been done, and those needing supplementary assistance or after-care see the almoner for that purpose. They finally pass to the dispensary for their medicines.

5. Very few complaints have been reported, except those which suggest undue waiting, or overcrowding with unsuitable cases which could be dealt with elsewhere, and consequent difficulty in the treatment of suitable cases and overlapping with other agencies. There is, however, no recognised channel through which complaints could be made by patients.

## II. Evidence as to Time of Waiting.

### A. The Fact of Waiting.

6. Evidence as to the Fact of Waiting.—The chief evidence as to the existence of waiting is from common knowledge based on the experience of patients and those interested in them. More definite information comes from the contributory schemes such as the Hospital Saving Association, and from the District Committees of the Charity Organization Society. The hospitals themselves give the subject constant attention ; some report the existence of waiting or overcrowding ; some regard it as unavoidable ; some have reduced it by recent changes in procedure.

### B. The Question of Undue Waiting.

7. Alternative Theories of the Cause of Waiting.—Four common theories as to the cause of waiting have been brought to our notice :

(1) that it is inherent in the provision of medical treatment for large populations ;

(2) that it is partly due to inadequacy or unsuitability of accommodation capable of being remedied ;

(3) that it is partly due to defects in procedure capable of being remedied ;

(4) that it is partly caused by overcrowding due to the treatment of excessive numbers of minor cases, which could equally well be treated elsewhere.

Our Report discusses these, in the reverse order, beginning with the question of the suitability of the patients, since this will affect procedure, and procedure will affect accommodation.

## III. Methods affecting Suitability of Patients.

### A. The Question of Medical Suitability.

8. Different Definitions at Different Hospitals.—Different definitions of medical suitability are applied by different hospitals to patients other than emergencies. They result from different combinations of the " open access " principle, under which all the hospital facilities are open to both major and minor cases, and the " consultative " principle, under which part at least of the facilities are limited to major cases needing the services of the specialised staff and equipment of a hospital. The definitions range from those which include all sick poor ; through those which include all sick poor except certain specified classes, e.g., patients provided for by National Insurance or other statutory authorities, or patients whose treatment can be carried on by general practitioners ; up to definitions which include only cases needing specialised or consultative service; and finally, in the most extreme form of the consultative principle, only cases coming with doctors' letters.

Many hospitals are tending to move towards a more consultative definition, while rejecting this extreme form.

9. The Different Definitions as Applied in Practice.—The consultative principle is often applied to some of the facilities of a hospital though not to others. The visiting staff may see all cases and refer minor cases to qualified assistants, including old cases which no longer need specialist treatment. The minor cases may be sifted out and treated by the junior medical staff, perhaps in the casualty department as distinct from the out-patient department, the visiting staff seeing only major cases referred by the junior staff or coming with doctors' letters. The consultative principle may be applied to certain classes of patient, e.g., to insured patients or to those already being treated by a private doctor. Occasionally these limitations are applied partially in the casualty department itself.

10. Use of Doctors' Letters.—At some hospitals the bringing of recommendations from private or panel doctors is encouraged; at some they give access to the visiting staff without preliminary sifting; at some they are required in the out-patient department from all patients not referred from the casualty department; at some they are required from all insured patients; and at a very few they are required for all except emergencies. The Hospital Saving Association takes the view that hospitals are not intended for trivial cases, and recommends its members to bring doctors' letters.

11. Compulsory Doctors' Letters.—The British Medical Association advocates the extreme consultative system under which doctors' letters would be compulsory except in cases of emergency; patients without letters would be referred elsewhere after being seen once; for patients with letters the hospital would either advise the patient's doctor as to diagnosis and treatment, or, if necessary, would treat the patient itself. Our Report discusses the arguments for and against this proposal, including those based on the requirements of medical education, and expresses the opinion that all patients who cannot afford a consultant's fees should retain the power to go to a hospital for a second opinion without having first to get the consent of their general practitioner. This view, however, does not imply opposition to the development of partially consultative methods or to the reduction thereby of the numbers of minor cases,

provided that suitable alternative provision is available for them at a cost within their means. This involves the question of financial suitability.

## B. The Question of Financial Suitability.

12. **Definition of Financial Suitability.**—A maximum income limit of £4, £5 or £6 a week, according to size of family, was adopted at the foundation of the Hospital Saving Association, and has become nearly universal in London. More general definitions mention those unable to pay for the specialist services required, or those unable to pay consultants' fees or in certain circumstances the fees of a general practitioner.

13. **Patients above the Income Limits and the Very Poor.**—Patients above the income limits may be eligible if there is anything sufficiently exceptional in their financial circumstances, or in the cost of their treatment. Those who are too poor to benefit permanently by medical treatment alone are sometimes regarded as more suitable for the Public Assistance medical service.

14. **The Intermediate Class.**—Our Report discusses the evidence on the question how far patients within the income limits and suffering from minor ailments could obtain treatment elsewhere without financial hardship, e.g., from panel doctors or other statutory or voluntary agencies, or by paying a private doctor. A good many cannot even pay the usual 1s. or 6d. per attendance at hospital. With the others, the question is not now so much that of hospital abuse as of the best use of the out-patient departments as one of the alternative agencies for treating minor ailments.

## C. Alternative Medical Provision for Minor Cases.

15. Our Report describes and discusses the following alternative or supplementary agencies for the treatment of minor ailments at the hospitals and elsewhere :—

(*a*) **Hospital Consultants.**—These are the basis of the reputation of the hospitals and the claim that the poor have access to the highest skill. Our Report discusses the extent to which minor cases are treated by them personally or by qualified assistants working with them.

(*b*) Junior Medical Staff.—These range from newly-qualified men up to medical or surgical registrars or casualty officers with some years of experience. They treat large numbers of minor cases either in the casualty or in the out-patient department ; they sometimes sift new patients into major and minor, and may have power to refer minor cases elsewhere. Though their experience is sometimes limited, their knowledge is up to date, and they have behind them the visiting staff and all the resources of the hospital. But the treatment of minor cases by them may not relieve overcrowding.

(*c*) General Practitioners.—These often have long and wide experience and can know their patients' histories and circumstances. They provide most of the medical personnel for the other agencies treating minor cases.

(*d*) General Practitioners in Private Practice.—For the purposes of our Inquiry, these are an alternative agency only for such uninsured persons, including dependants of the insured, as can afford their fees.

(*e*) General Practitioners in Panel Practice.—From the National Health Insurance practitioners, insured persons suffering from minor ailments can obtain treatment without further payment. Our Report discusses the evidence on the question whether there is anything in panel practice which tends to make it less efficient or less desirable from the patient's point of view than private practice ; and also the extent to which hospitals refer to panel doctors insured patients suffering from minor ailments, and panel doctors refer suitable cases to hospitals for consultative diagnosis and treatment.

(*f*) Provident Dispensaries.—These provide similar treatment on a basis of voluntary insurance for those unable otherwise to pay for it. Their membership has diminished since the National Insurance Act, but they are a recognised alternative agency.

(*g*) "London Public Medical Service."—Our Report mentions evidence received from an association of general practitioners under this title. They provide dependants of insured persons and others with treatment on the basis of voluntary insurance, and refer them to hospitals if they need consultative diagnosis or treatment.

(*h*) **Non-provident or Charitable Dispensaries.**—These provide general practitioner treatment at the dispensary or in the patients' homes for those unable to pay private fees. Their work also has decreased in recent years. It has been suggested that they could be used or developed as auxiliaries to relieve the out-patient departments.

(*k*) **Voluntary Clinics**—These include the Red Cross clinic for the specialist treatment of rheumatic patients referred to it by medical practitioners, including hospital doctors ; and also various other clinics and centres for special treatments.

(*l*) **Medical Services of Public Assistance Authorities.**—The London County Council provides out-door medical treatment, at relief stations or in their homes, for patients who are in receipt of public assistance ; and through this agency other patients who are too poor to profit by medical attention alone can obtain non-medical assistance as well. The Council also has, at some of the hospitals transferred to it from the Guardians, out-patient departments which provide consultative diagnosis and treatment for public assistance cases, and deal with other specified classes of patients under the care of the Council. Our Report suggests that the hospitals should consider the desirability of referring to the Public Assistance Authorities, in this and other parts of the King's Fund area, such cases at all events as are already in receipt of non-medical public assistance.

(*m*) **Public Clinics and Centres for Special Classes.**—The London County Council has medical treatment centres for school children suffering from certain classes of ailment. A small charge is made except to necessitous parents. The Council also has venereal disease clinics open to all patients without charge. The Metropolitan Borough Councils have various centres for maternity and child welfare, and clinics for tuberculosis and certain other diseases.

(*n*) **District Nursing Service.**—The District Nursing Associations can and frequently do provide home nursing for minor cases which are sent away by hospitals as not needing out-patient treatment, or which, though still under the care of the hospital, only need nursing or dressings, and have difficulty in going to the hospital for them. This agency is therefore open to hospitals where the definition of medical suitability includes all minor cases, as well as to those

where it does not. Its use by the hospitals could be greatly extended. This would involve the associations in expense, and our Report discusses the question of a fair payment to the associations for work done by them for the hospitals in the nursing of patients who are members of contributory schemes, and for whom the hospital is receiving payment.

## D. Co-operation between Hospitals and other Agencies.

16. Co-operation would mean, not the mere exclusion of minor cases, but their reference to suitable agencies, most of which would themselves refer to the hospitals cases needing consultative diagnosis or specialist treatment. This involves co-operation between hospital consultants and general practitioners, with resulting benefit to the whole medical service.

17. Co-operation with General Practitioners.—To be fully effective the consultative side of out-patient work requires recommendations from general practitioners giving useful particulars, not merely visiting cards, and reports by the hospital consultant stating the diagnosis and giving advice. Methods have been suggested for facilitating this inter-communication, including the use of standard forms ; and also methods for assisting doctors to tell patients the right days and hours for particular consultants or special departments, and for discouraging the reference of unsuitable cases to hospital, or the retention by hospitals of cases which were only sent for a consultative opinion.

18. Some General Considerations.—Co-operation would mean additional work, but against this there would be the consequent reduction in numbers. Co-operation with the agencies themselves as well as between their medical staffs might be found useful, and the almoners' departments provide machinery for this. Reference of cases to other agencies in preference to mere exclusion will affect the methods employed by hospitals for determining which cases are suitable.

## E. Methods of Determining Medical Suitability.

19. Alternative Methods of Sifting.—At hospitals where patients are sifted into major and minor this may be done (i) in the out-patient

department by the visiting staff or by their assistants working with them ; (ii) in the out-patient department by junior medical officers ; (iii) in the casualty department by junior medical officers throughout the day or at a prescribed hour ; (iv) in the casualty department at a prescribed hour by the visiting staff or by their assistants. Our Report describes each of these methods. Where minor cases are referred elsewhere this may take place after one examination or one treatment, or at some later stage. Sometimes a great reduction in numbers, especially of panel patients, has resulted.

## F. Methods of Determining Financial Suitability.

20. Almoners and Inquiry Officers.—Inquiries are made either by inquiry officers or by almoners, sometimes only in doubtful cases. The same officers often decide whether a patient can afford the usual contribution. Almoners are concerned also, or sometimes solely, with inquiries in connection with supplementary assistance or after-care ; and sometimes with the reference of minor cases to other agencies.

21. Certificates from Outside Agencies.—Vouchers from contributory associations are often accepted in lieu of inquiries, and occasionally doctors' or subscribers' letters are accepted as evidence.

22. Relation to Minor Cases.—The difficult problem of inquiry into the large number of minor cases has been affected by the introduction of income limits and contributory scheme vouchers. Its aspect is also changed if it is no longer a question of hospital abuse but of whether patients who are considered medically suitable for other agencies can be referred to them without financial hardship. The latter question would arise only with uninsured patients, and might be regarded as within the positive sphere of the almoner.

## G. Minor Cases and Medical Education.

23. It is essential for medical education that a sufficient number of minor cases should reach the out-patient department either direct or through the sifting process or with doctors' letters, and should receive the whole of their treatment there, to enable students to be taught how to distinguish them from major cases and how to

treat them. But it does not follow that the present numbers could not with safety be considerably reduced.

## IV. Waiting as affected by Methods of Procedure.

24. Our Report describes in outline different methods of procedure and their effect on waiting, especially where time-saving changes have been proposed or successfully adopted, and suggests that the King's Fund should assist the hospitals to study these in more detail. This summary mentions the more important.

### A. Procedure at Separate Stages.

25. Arrival.—Hospitals either fix a single hour at which patients should arrive, or announce a narrow range of hours. The interval before the visiting staff begin varies from an hour and a half to half an hour, to give time for the registration and other preliminaries either for all the patients or only for those first treated. Our Report discusses under general procedure methods involving different hours for different patients.

26. Registration Stage.—This stage includes taking detailed particulars of new patients and issuing papers to old patients. Waiting has been reduced by registering these two classes at separate desks or at different times, by the adoption of modern systems of filing and card indexing, and by other changes.

27. Examination and Treatment Stage.—This stage comes next unless inquiry comes during the interval. Our Report deals under a separate heading with methods of sifting. Patients may wait partly in the main hall or partly in ante-rooms or in the consulting rooms themselves. If different cases can without detriment be treated simultaneously—e.g., new or major or teaching cases by the consultant, and old or minor cases by assistants—the preceding wait is shorter and the flow of patients to the dispensary more even.

28. Dispensary Stage.—This comes next unless inquiry comes after treatment. Waiting is reduced if more stock mixtures are

ordered and fewer special prescriptions ; or if fewer patients come at rush hours and more in a steady stream, resulting, e.g., from the simultaneous treatment of major cases and minor cases in the consulting rooms, or from a larger number of sessions during the day.

29. **Almoner or Inquiry Officer Stage.**—Inquiries are made by two kinds of officer and for two purposes and at two different stages. Different combinations of these produce three main types of inquiry, viz. :—(A) by inquiry officers for financial suitability before treatment, and by almoners for after-care following treatment ; (B) by almoners both for financial suitability before treatment and for after-care following treatment ; (C) by almoners for both purposes following treatment. Type B is less common, and type C rather more common, than type A. All patients are not affected : financial inquiry sometimes only supplements registration particulars in doubtful cases, contributory scheme members are often exempt, and only about 10 per cent. need after-care. Our Report discusses the reasons urged on behalf of each type from the points of view of policy and of relative time taken, and mentions some minor variations.

30. **Time Saved or Lost by Sifting.**—The sifting of minor cases from major cases saves time later on for both, but itself takes time. If done in the out-patient department the time taken is short, but overcrowding is not reduced, except at the later stages as a result of the speedier departure of the minor cases. If done in the casualty department, overcrowding is also reduced at the earlier out-patient stages ; but there may be a little duplication of procedure unless all the registration of new major cases is done with the sifting ; and there will be an interval between attendance at the two departments, necessitating a wait or a second visit, unless sifting takes place just before the out-patient session. The effects of the different methods could hardly be ascertained except by counts of hours.

## B. General Procedure.

31. **Additional or Separate Sessions.**—Pressure on the general out-patient departments is often relieved by transferring specialties to separate departments or to different times of day, or occasionally

by holding additional general sessions. Special sessions are sometimes held or suggested for discharged in-patients, for special consultative cases, and, in the evenings, for young people between 14 and 16—i.e., between school age and National Insurance age—or for other patients working throughout the day.

32. **Different Hours of Arrival within the Same Session.**—Various methods have been adopted or suggested for spreading the times of arrival within each session, by fixing different times for different classes or by making appointments for individual patients or groups of patients.

(*a*) **For Different Classes : New and Old, Men and Women, etc.**—As old patients usually take less time than new they are often given a later hour of arrival. Different hours are sometimes given to men and women and occasionally to one or two other special classes.

(*b*) **For Individual Patients or Groups : The Appointments System.**—It is frequently suggested that patients should not all attend at the beginning of the session, but that separate appointments should be given to individuals or to groups at regular intervals. This is already often done for old patients at several special departments, largely those providing lengthy treatments not applied by doctors. It is also done very occasionally for new general patients after first attendance in a sifting department. Three difficulties are commonly mentioned—that patients would not keep to their times, so that there might be gaps with no patients to treat, or none suitable for teaching ; that, unless all the patients are present at the start, the visiting staff cannot sort their cases or plan out their work ; and that the system would involve considerable administrative expenditure. A partial form has been tried whereby some of the old patients come at the beginning and the rest at half-time, and the same method has been suggested for new patients in limited numbers after preliminary sifting.

33. **Limitation of Numbers.**—Since there are limits to the number of major cases which each consultant can treat, some hospitals with a sifting stage place a fixed limit on the numbers referred to the next session of the out-patient department. Elsewhere it is left to each consultant to plan out his own work at the time.

34. **General Organisation and Amenities.**—A few points of interest have been mentioned in evidence, e.g., the employment of out-patient supervisors; voluntary services of V.A.D. nurses, at one hospital, to assist the movements of patients; electric sign-posting for the same purpose, with differently coloured lights; prevention of cold and draughts in waiting rooms; avoidance of waiting between undressing and seeing the doctor; provision of canteens; personal interest by members of the Ladies' Committees of hospitals. The increasing interest of hospital managers in the out-patient question is much to be welcomed; some means of making complaints known would be desirable.

35. **Total Time Taken; Counts of Hours.**—A few estimates have been received of the time at which out-patient sessions begin and end, or of the average time spent by individual patients. A few hospitals have made definite counts of hours for sample periods for each patient, either from arrival to departure, or for certain stages of the procedure, or for all the stages. The King's Fund might assist hospitals to make simple but valuable tests in this way of the results of different methods of procedure.

## C. Summary on Procedure.

36. **The Question of a Fixed Time of Arrival.**—Let it be granted that with a fixed time of arrival a good deal of waiting is inevitable on the part of the patients seen last; that a complete appointments system would theoretically abolish this form of waiting, but is impracticable; and that some hospitals have reduced this waiting by giving some classes or groups of patients different hours from others. Then it seems to follow that the question of a fixed time of arrival may be found to deserve concentrated attention in connection with procedure, as does the question of the numbers of minor cases in connection with suitability. At the very least, the question needs more study before the waiting is declared to be unavoidable.

37. **Improvements at other Stages.**—Meanwhile, the time-saving changes that have been made in other items of procedure should be studied by hospitals, and the King's Fund might help them by placing at their disposal the detailed information in our records, by assisting with counts of hours, and by other methods.

## V. Waiting as affected by Adequacy of Accommodation.

38. Inadequate accommodation is only one cause of waiting, and waiting has often been reduced by increases in accommodation either for general purposes or for specific purposes.

39. **General Accommodation.**—Some out-patient departments have been recently enlarged ; others are inadequate and out of date, and extension is deferred owing to the financial crisis, though good work is done in them under great difficulties.

40. **Accommodation for Specific Purposes.**—Waiting has been reduced by alterations and additions for specific purposes, such as registration facilities for old and new patients separately ; additional consulting rooms for the simultaneous treatment of major and minor cases ; extra dressing rooms to avoid delay between one patient and the next ; a separate dispensary for a special department, or an additional hatch in the general dispensary. The provision of separate accommodation for one or more of the special departments may greatly relieve the general out-patient department. Temporary occupation of neighbouring premises may sometimes be possible during the financial stringency. Casualty accommodation tends to become larger and more elaborate if used as a sifting place for all out-patients ; it should always be close to the out-patient department, and accidents should be kept separate from ordinary patients.

## VI. Conclusions and Recommendations.

41. The principal conclusions and recommendations of our Report may be summarised briefly as follows :—

(*a*) That there is a considerable amount of waiting in the out-patient departments proper, but that most of the very long periods are due to medical and surgical circumstances affecting the patients concerned.

(*b*) That part of the waiting is unavoidable with large populations, but that part is due to the treatment of excessive numbers of minor cases, which may also render more difficult the treatment of major cases, and part is sometimes due to remediable defects in procedure or in accommodation.

(*c*) That the movement towards the more consultative use of out-patient departments, except for emergencies, should therefore be encouraged, though patients who desire a second opinion and are unable to pay consultants' fees should continue to have access without doctors' letters; that minor cases should be sifted from major cases and referred to appropriate alternative agencies, including general practitioners in private or panel practice and the various voluntary, provident or statutory agencies described in our Report, so far as this can be done without hardship to the patients or detriment to their treatment or to medical education; that the other agencies treating only minor cases should, in their turn, send patients to the out-patient departments for consultative opinions or specialist treatments; and that various improvements should be made in the procedure for doctors' letters and hospital replies.

(*d*) That the time-saving methods of procedure already adopted or suggested at various hospitals should be studied by all hospitals with a view to action where appropriate, including improvements at separate stages such as registration, examination and treatment, dispensary, interviews with almoners or inquiry officers, and sifting, and improvements in general procedure such as additional sessions, separate sessions for special classes of patient, or different times of arrival for different classes or for such patients or groups of patients as can be given appointments.

(*e*) That, where extension of premises is at present impracticable, minor time-saving improvements may be possible in accommodation for specific purposes.

(*f*) That among the subjects which seem most to call for concentrated study are the question of minor cases, and the question of the fixed time of arrival.

(*g*) That these recommendations should be so applied as to promote the discovery and adoption of a common policy, while maintaining the individuality and freedom characteristic of the voluntary system.

(*h*) That the King's Fund should consider to what extent it can help to carry out the recommendations by making available the detailed information accumulated during the Inquiry, and by such other methods as may be relevant.

ONSLOW, *Chairman.*
JOHN ROSE BRADFORD.
G. M. W. MACDONOGH.
H. C. I. GWYNNE-VAUGHAN.
E. W. MORRIS.
FRANCIS FREMANTLE.
ISIDORE SALMON.
RODEN H. P. ORDE.

H. R. MAYNARD, *Secretary.*

## Out-Patient Arrangements Committee.

His Royal Highness the President, in order to carry out the last recommendation of the Report, has appointed a Committee with the above title, to consider, in consultation with the hospitals, what steps it would be practicable and advisable for the King's Fund to take, and to take such steps as the General Council or the Management Committee should approve. The Committee consists of Sir John Rose Bradford, Bt. (Chairman), Dame Rachel Crowdy, Sir Ernest Morris, Sir Isidore Salmon, M.P., Dr. Morley Fletcher, Mr. Eric Pearce Gould, Lt.-Col. A. P. Irwin, Mr. R. H. P. Orde, and Lt.-Col. W. Parkes.

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The Out-patient Arrangements Committee have published memoranda on the following subjects mentioned in the Summary or in the full Report* :—

Standard Forms for Doctors' Letters and Hospital Replies (cf. Summary, par. 17) ;

Hospital Out-patient Time-Tables (par. 17) ;

and are now considering the following subjects :—

District Nursing Associations (par. 15 (*n*) ) ;

Dispensary Stage of Procedure (pars. 24 and 28).

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* See note † on page 2 above.

The memoranda mentioned above are as follows :—

Memorandum on Standard Forms and Hospital Out-patient Time-Tables, September, 1933 ... Price 1½d. post free.

Hospital Out-patient Time-Table at London Voluntary Hospitals, revised issue, June, 1934 ... ... Free.

and may be obtained from Messrs. Geo. Barber & Son Ltd., Furnival Street, London, E.C.4.