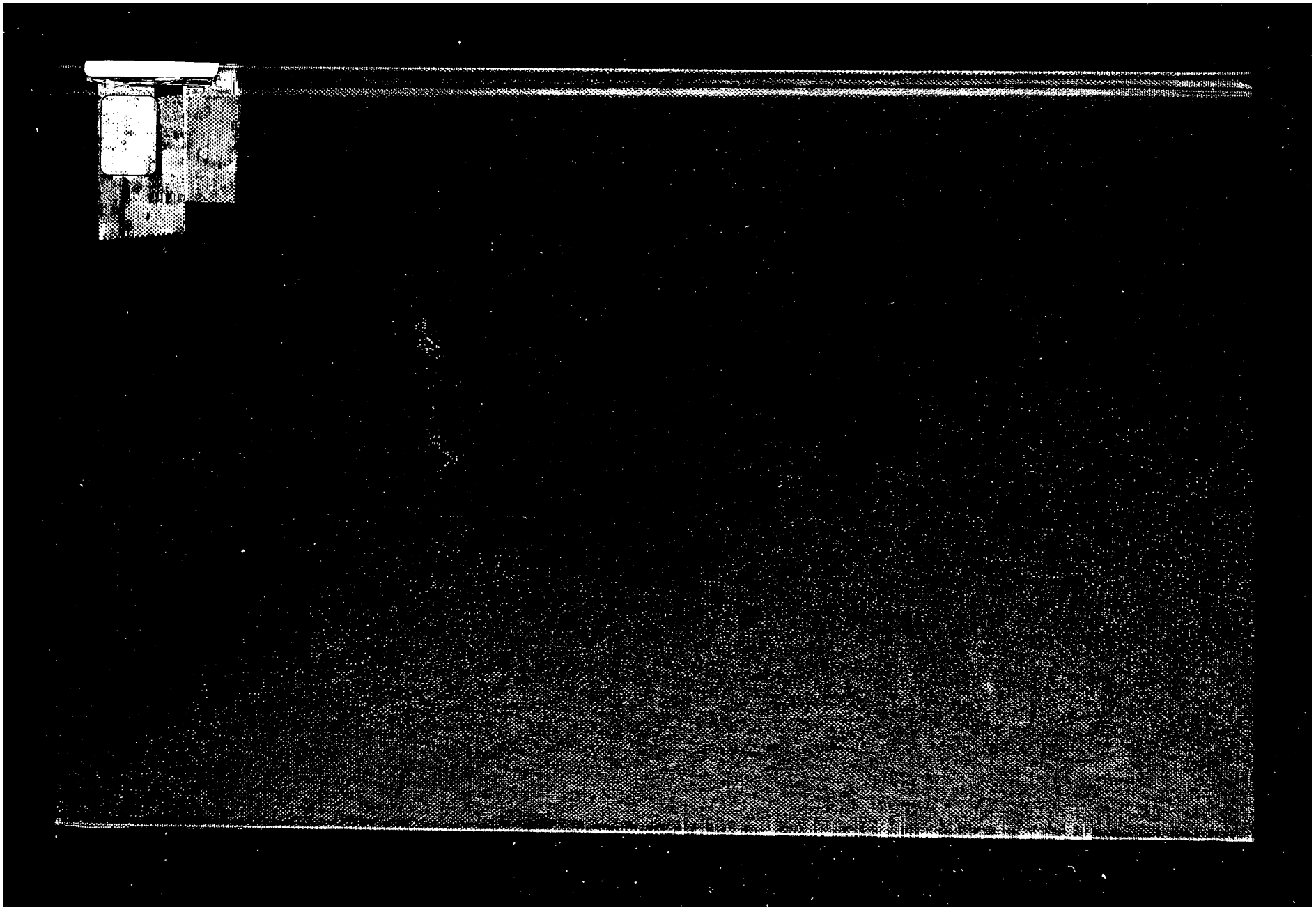


KING EDWARD'S HOSPITAL FUND FOR LONDON.

REPORT

OF

THE COMMITTEE

APPOINTED TO INQUIRE INTO

OUT-PATIENT METHODS

AT

LONDON VOLUNTARY HOSPITALS

AS AFFECTING

SUITABILITY OF PATIENTS

AND

TIME OF WAITING

DECEMBER, 1932.

LONDON:
PRINTED AND PUBLISHED FOR KING EDWARD'S HOSPITAL FUND FOR LONDON BY GEO. BARBER & SON LIMITED, FURNIVAL STREET, HOLBORN, E.C.4, AND CURSITOR STREET, CHANCERY LANE.

Price 1*s.* 6*d. net.* *Post free* 1*s.* 9*d.*

KING EDWARD'S HOSPITAL FUND FOR LONDON.

REPORT

OF

THE COMMITTEE

APPOINTED TO INQUIRE INTO

OUT-PATIENT METHODS

AT

LONDON VOLUNTARY HOSPITALS

AS AFFECTING

SUITABILITY OF PATIENTS

AND

TIME OF WAITING

DECEMBER, 1932.

LONDON:
PRINTED AND PUBLISHED FOR KING EDWARD'S HOSPITAL FUND FOR LONDON BY GEO. BARBER & SON LIMITED, FURNIVAL STREET, HOLBORN, E.C.4, AND CURSITOR STREET, CHANCERY LANE.

Price 1*s.* 6*d. net.* *Post free* 1*s.* 9*d.*

ORDER OF APPOINTMENT.

I hereby appoint the following persons to be Members of the OUT-PATIENT COMMITTEE 1932:—

EARL OF ONSLOW, *Chairman*,

SIR JOHN ROSE BRADFORD, BT.,

LIEUT.-GENERAL SIR GEORGE MACDONOGH,

DAME HELEN GWYNNE-VAUGHAN,

SIR ERNEST W. MORRIS,

MAJOR ISIDORE SALMON, M.P.,

LIEUT.-COLONEL F. E. FREMANTLE, M.P.,*

MR. R. H. P. ORDE,

of whom three shall be a quorum.

EDWARD P.,
President.

5th January, 1932.

* NOW SIR FRANCIS FREMANTLE.

DELEGATION OF POWERS.

Resolution of General Council, 11th December, 1931:—

That, until the General Council shall otherwise direct, the Out-patient Committee 1932 shall have the powers of the General Council with respect to the following matter, that is to say:—

To inquire into and report upon the methods in use in the London Voluntary Hospitals regarding the attendance of patients in the out-patient and casualty departments, and the effect of those methods upon the suitability of the patients treated and on the length of time during which patients wait before or after treatment; and to make such recommendations thereon as may seem to them desirable;

and such powers are hereby delegated to them.

GENERAL SCHEME OF REPORT.

CONTENTS.

*

Contents

on Motions as affecting Sch...
Overcrowding and Delay ...
...ing
...ent of the Inquiry ...

...IV. Matters to be Decided by Magis...

...SEPARATE STAGES ...
...
...ation Stage ...
...ation and Treatment S...
...Summary Stage ...
...Adjournment for Inquiry (Short S...
...Cases Stayed or Lost by Side ...

...Cases to Proceed ...
...Additional C...
...Different Hours of Attendance ...
...New Matters as to Jurisdiction ...
...Sick and Witnesses ...
...Other Special Cases ...
...Appearances ...
...Limitations of Numbers ...
...General Organisation ...
...Total Time Taken ...

...CONCLUSIONS ON THE FACTS ...
...The Question of a Fixed Time for Attendance ...
...Improvements in other Courts ...

...SECTION V. MATTERS TO BE DECIDED BY ...

...General Accommodation ...
...Accommodation for Specific Purposes ...
...Witnesses on this Part of the Inquiry ...

...SECTION VI. CONCLUSIONS ...
...
...

KING EDWARD'S HOSPITAL FUND FOR LONDON.

Out-Patient Committee 1932.

REPORT OF COMMITTEE.

SECTION I. INTRODUCTORY.

1.—We were appointed in January, 1932, by H.R.H. the Prince of Wales, President of King Edward's Hospital Fund for London, to be a Special Committee, the following being the terms of reference :—

> " To inquire into and report upon the methods in use in the London Voluntary Hospitals " regarding the attendance of patients in the out-patient and casualty departments, and " the effect of those methods upon the suitability of the patients treated and on the length " of time during which patients wait before or after treatment ; and to make such " recommendations thereon as may seem to them desirable."

2.—We have held 13 meetings and have received oral evidence from 87 witnesses representing 20 hospitals and 9 other agencies and associations, and also from 2 witnesses giving personal evidence.

3.—A questionnaire was issued to 78 hospitals.* In the case of hospitals from which oral evidence was received the replies were taken as a written précis. The other replies have been used in the preparation of this Report. Written statements of evidence were received from 5 associations and public bodies and from 2 other witnesses, and these have also been used.†

A. THE SUBJECT-MATTER OF THE INQUIRY.

Suitability of Patients and Time of Waiting.

4.—The subject-matter of the Inquiry, as defined in the terms of reference, falls into two parts, (i) methods as affecting the suitability of the patients treated, (ii) methods as affecting the time spent by out-patients attending hospital. These two parts cannot be kept wholly distinct. The amount of time spent by patients will depend partly on the numbers attending, and this in turn will depend partly on the definition of suitability adopted by the particular hospital ; while the amount of time required may itself affect the question whether suitable patients are or are not deterred from attending.

5.—The question of suitability itself falls into two parts : medical suitability and financial suitability. These also cannot be kept wholly distinct, since financial suitability will depend not only on the financial circumstances of the patient, but also on the cost of the diagnosis or treatment which he requires.

6.—The time spent by an out-patient at hospital also falls into two parts : the time spent in receiving attention at one or other of the stages of procedure, and the time spent in waiting between one stage and the next. These again are not distinct, since the time spent by patients in receiving attention affects the time spent by other patients in waiting either before that stage or before some later stage. The Inquiry will thus cover both periods, though the term " waiting " should always be reserved for the time spent between stages, or between arrival and the first stage.

Out-patients and Casualties.

7.—The out-patient organisation of a general hospital usually itself consists of two parts, commonly known as the Out-Patient Department proper, and the Casualty Department. The question of waiting, and still more the question of suitability, may be different in these two departments.

* For a list of 114 hospitals with out-patient departments in the King's Fund area, which extends to a radius of 11 miles from St. Paul's, *see* Appendix I. For the Questionnaire, *see* Appendix II.

† A list of the witnesses is given in Appendix III. The whole typescript of the evidence is on record at the office of the King's Fund.

8.—The primary object of a casualty department is, or was, to provide immediate treatment for casualties, in the sense of accidents or other emergencies which come to the hospital outside out-patient hours, or which are better treated without interrupting the out-patient work. Such a department naturally comes to be used also for minor cases which arrive at odd times and are treated immediately by the resident staff, without being required to wait till the honorary visiting staff next attend to see out-patients. If and when the out-patient department is developed as a place primarily suited for the elaborate diagnosis and treatment of the more serious cases, the casualty department, since it is already being used for the treatment of casual minor cases, tends to be developed as a secondary department for the treatment of all minor cases by the resident or other junior staff, as well as for casualties in the original sense. Finally, if and when it is decided that access to the out-patient department shall only be through a preliminary department, where minor cases are sifted out and only major cases are passed on, the casualty department is frequently used as the place both for the sifting process and for the retention and treatment of the minor cases.

9.—All the cases treated in such a department, for any of these three reasons, are frequently still called casualties, and the term thus comes to include large numbers of cases which have no connection with its original meaning. Even where some other term, such as surgery, receiving room, or sorting room, is applied to the department itself, as better representing one or other of the three functions, the term casualties is still often used for all cases treated in it. On the other hand, if sifting takes place in the out-patient department itself, and if minor cases are treated there and are not sent to the casualty department, they may not be called casualties. The use of the term may thus depend more on administrative methods than on any principle of classification.* No conclusion as to the function of the casualty department can therefore be deduced directly from its title.

10.—It remains to add that the term out-patient is used sometimes for patients attending the out-patient department as distinct from the casualty department, and sometimes (as, for instance, in the title of this Committee) for all patients other than in-patients. The difference is often important. Where it is not sufficiently indicated by the context, the phrase out-patient department proper will be used when the casualty department is excluded.

B. HISTORICAL NOTE.

Original Objects of Out-patient Departments.

11.—Generally speaking, the out-patient departments of the voluntary hospitals were originally established for the treatment of the sick poor, and sometimes specifically their free treatment, at a time when the available forms of medical treatment were comparatively simple and inexpensive, but nevertheless could not be obtained by the patients through any other agency at a cost within their means

Development of other Agencies.

12.—Since that time a number of changes have taken place. Various agencies outside the voluntary hospitals have been established to provide the more simple forms of medical treatment for particular classes. These have included the Poor Law Medical Service, available for those who are unable to afford not only medical treatment but even the ordinary necessaries of life; the National Health Insurance Service, established to enable large classes of wage-earners to obtain from general practitioners, by means of weekly payments during health, supplemented by contributions from employers and from the State, the treatments which general practitioners can supply; and various kinds of clinics established out of public funds for dealing with ailments for which statutory authorities of one kind or another have, in the interests of public health, undertaken more or less complete responsibility. A recent important development has been the transfer, under the Local Government Act, 1929, of the Poor Law Medical Service from the local Boards of Guardians to the County Councils and the County Borough Councils,† and its consequent close association with other Public Health Services. There are also numerous provident and charitable dispensaries and clinics and District Nursing Associations. A good many firms have also provided clinics for the treatment of their employees, and large numbers of voluntary medical clubs have been established in works and warehouses.

Changes in Cost of Treatment and in Patients' Finances.

13.—In the meantime, the developments of medical science and of public health have increased the supply of, and the demand for, more numerous, more elaborate and more costly methods of diagnosis and treatment. Services which can be provided only by institutions of hospital standard are therefore

* For these reasons the Revised Uniform System of Hospital Accounts does not attempt any definition of Casualty. Our questionnaire asked each hospital to give its own definition of the way it used the word; and it has been found impossible to draw any conclusions from the different numbers of casualty patients, casualty attendances, or attendances per casualty patient, as compared with the corresponding figures for out-patients proper.

† *See* note on page 25.

required by whole classes of the community who would not for other purposes be commonly regarded as poor. At the same time, as the result of social and financial changes, especially since the war, some classes who could not previously afford to contribute towards the cost of hospital services are now able and willing to do so; while certain other classes find it more difficult than before to pay the fees of private specialists for themselves, or to contribute on any large scale towards the provision of hospital facilities for others. These changes, combined with the increased cost of hospital work, have led, first, to the development by the hospitals of a system of voluntary payments by patients when attending hospital, based on what they can afford at the time towards their cost, whether they belong to the classes for which hospitals were originally founded or to others which formerly had been regarded as unsuitable; and, second, to the establishment of contributory associations of wage-earners, whose members make regular weekly payments when in health, out of which the association pays to the hospital a fixed amount representing what is agreed to be the share of the cost which such wage-earners can fairly be expected to pay if they make provision in advance by this method.

Growth of Patients' Contributory Schemes.

14.—The largest of these contributory schemes in London is the Hospital Saving Association, founded in 1922. Its members, whose income must not exceed the prescribed limit of £4, £5 or £6 a week, according to the size of family, make a fixed contribution of 3d. a week. When accepted as medically suitable for treatment at a co-operating hospital they are exempted from inquiries into their financial suitability and also from further contribution, and the Association makes to the hospital, in respect of the treatment of each contributor treated, a payment on an agreed basis. The members also obtain, in return for their weekly contributions, certain non-hospital benefits. The membership is now over 1,000,000.

15.—The Hospital Saturday Fund, which is a much older institution, has recently developed a somewhat similar form of hospital contributory scheme, with a less definite and usually smaller contribution. The latest available figures give its membership as between 200,000 and 250,000.

Changes in the Functions of Out-patient Departments.

16.—One result of all these changes has been that the function of the out-patient department of the voluntary hospital has gradually changed. It may be possible still to describe it as being for the treatment of the sick poor, i.e., of such persons as are unable to obtain elsewhere the services they need, at a price within their means. But the persons included in this definition will depend on which of the numerous services now available they require, and on the present day facilities for obtaining it elsewhere.

17.—If all that is wanted is the ordinary treatment of a minor ailment, the patient may be able to obtain it for himself through the National Insurance scheme, or by some other provident method, or from some public clinic for the service of which he is eligible; or, if he is destitute, it may be provided for him by the Public Assistance Authority. Before deciding, therefore, what classes of patients are suitable, whether medically or financially, it is necessary to decide how far it is desirable for out-patient departments to supply the more simple kinds of service which are now provided, in a rather different form, for many of the patients for whom the hospitals were once the only resource. If, on the other hand, what is needed is a "consultative" opinion, or an expensive form of diagnosis or treatment, the patient, though able to obtain ordinary medical services by one or other of the methods just mentioned, may not be able to afford more than part, if that, of the cost of the special service, and he may therefore, in relation to that service, come within the meaning of the phrase " sick poor." No conclusion, therefore, as to the proper function of an out-patient department, or as to the most useful definition of the suitability of patients, can now be drawn directly from the use of that phrase.

Questions arising out of these Events.

18.—In order to arrive at such a conclusion in present conditions, it will be necessary to consider which of the numerous forms of medical services can be, and are, provided efficiently by the various existing agencies, and at what cost in relation to the means of the patients; and which of these services should be performed by the out-patient department if the best use is to be made of the facilities which they afford, associated as they are with all the highly specialised resources, material and personal, of a modern hospital.

19.—It is necessary also to consider the possible reactions of any decision on the efficiency and development of the hospital as well as of the other agencies, including, in the case of a teaching hospital, the effect on medical education.

C. THE PRESENT POSITION.

Importance of Out-patient Departments

20.—Generally speaking it may be said that during all these changes the out-patient departments of the voluntary hospitals have continued to hold a leading place amongst the public agencies for

treating the sick, as distinct from the services of the medical profession to those who are able to pay private fees. They are the principal centres for the supply of the more highly specialised forms of diagnosis or treatment. As the number and complexity of these continually increase, it becomes more and more difficult to supply them except at a hospital equipped with expensive apparatus, possessing numerous special departments, and staffed by physicians and surgeons of the highest skill. The great increase in the facilities elsewhere for supplying the poor with the simpler forms of examination and treatment by general practitioners renders these specialist or consultative functions of the out-patient departments all the more important, and increases the demand for them. But, although this is the part of their work which seems to be increasing most rapidly, the hospitals are still attended by large numbers who are suffering only from minor ailments, and they are still amongst the largest centres for simple treatments, often of a kind closely resembling those supplied by the other agencies.

21.—There are various reasons for this. One is that the hospitals have to keep their doors open to all comers, so as to be able to deal with emergencies. If it is held that some kinds of case are not suitable for a hospital but should obtain their treatment elsewhere, either these must be kept away by some method which will not exclude emergencies and other suitable cases, or they must, after they come, be sifted out and told to go elsewhere. The latter method cannot be applied without at least one examination and, in many cases, one treatment. Both methods are contrary to the instincts and traditions of medical charities and of medical men, and require the deliberate adoption and consistent application of the comparatively modern principle of co-ordination. There is a natural tendency to keep the door open and to allow patients, once admitted, to come again and again.

Popularity of the Hospitals.

22.—Another reason is that the hospitals are undoubtedly the most popular of medical institutions. This is shown by the large numbers that seek their services in preference to those of the other available agencies, even when their attendance involves long waiting, and when the hospital considers that it would be better for them to go elsewhere. It is also shown by the readiness of patients and prospective patients to pay their fair share of their cost either directly or through weekly contributions on a provident basis, as well as by the remarkable way in which voluntary gifts, amounting in 1931 to over £2,400,000 in London alone, have continued to increase even during the recent years of financial difficulty. The popularity of the hospitals is due largely to the faith of their patients in hospital diagnosis and to the feeling, based on experience, that everyone will receive at a hospital thorough examination and treatment, either from physicians or surgeons of the highest standing or from juniors who are under their supervision and can refer any patient to them if necessary. At a large general hospital, moreover, there are available for diagnosis or treatment all the resources of the special departments, the number and importance of which are continually increasing. The evidence confirms the concluding words of the statement by the Hospital Saving Association: "One thing is common to all the hospitals—they have the confidence of the working class population."

Numbers of Attendances.

23.—The following figures will give some idea of the scale on which the out-patient departments of the hospitals were used in 1931, as compared with 1911, which was the year of the previous King's Fund Inquiry by Lord Mersey's Committee and was also the year before the passing of the National Insurance Act, and with 1921, which may be regarded as the first normal year after the war. The figures of the twelve teaching hospitals, taken together, are selected as a sample, and casualties are included:—

	Out-patients.	Attendances.
1911	886,000	2,649,000
1921	672,000	2,857,000
1931	761,000	3,809,000

24.—The changes in these collective figures are doubtless the combined result of several different factors. It will be noticed on the one hand that after the National Insurance Act the number of out-patients decreased and has not yet reached its former total, and on the other hand that the number of attendances has increased. This may indicate an increase either in the average seriousness of the cases treated, or in the number of special treatments that involve numerous attendances, or in both. One large hospital, which has retained on principle the widest possible definition of medical suitability, and whose figures therefore reflect the movements of patients unaffected by any restrictions adopted by the hospital, gave us an account of the changes in its numbers. In the surgery there was an immediate drop after the passing of the National Health Insurance Act, presumably because many insured persons found it convenient to be attended by their panel doctors. After the war there was a fairly rapid rise until 1923, since when the numbers have diminished. The attendances are now lower than before the Insurance Act, being about 72,000 in 1930 as compared with more than 100,000 in 1911. In the out-patient department proper, medical patients reached a peak in 1912. A large decrease followed the passing of the Insurance Act and continued until 1917. Since then the numbers

have shown a gradual increase, and this is attributed to the demand for complex methods of diagnosis which are not available from general practitioners. The numbers of surgical out-patients have not been affected by the Act. It will be interesting to compare these figures later on with those of another large hospital which has, also on principle, placed certain restrictions on its definition of medical suitability. pars. 241

D. GENERAL DESCRIPTION OF OUT-PATIENT PROCEDURE.

25.—No general description of out-patient procedure will apply accurately to the methods at any one institution. Each voluntary hospital is an independent body, free to develop along its own lines. Even within any one hospital, each physician or surgeon has to some extent his own methods. This freedom has many advantages in such matters as the treatment of the sick, medical education and the advancement of medical science, and it is one of the sources of some of the valuable features which the voluntary hospitals contribute to the medical service of this country. It may be useful, nevertheless, to attempt to give some general picture of the procedure in the out-patient and casualty departments, before discussing the details of the methods in use and their effects on the suitability of patients and the time of waiting.

Out-patient and Casualty Departments.

26.—The casualty department is usually open all day and all night for emergencies and minor cases, and is staffed by residents or junior medical officers. The out-patient department proper is open at certain hours for cases requiring the attention of the visiting staff, frequently in the afternoon, though some of the special departments are often open at other specified times.

27.—At the casualty department, therefore, patients are passing in and out in small numbers all day, including the times when the out-patient department is open. At the out-patient department large numbers come at particular times.

28.—The two departments may be structurally separate ; they may be closely adjacent ; they may use, in part at least, the same premises at different times, or different parts at the same time.

29.—For each there will usually be required a waiting hall or room, consulting rooms and a minor operation room, and, for the out-patient department at all events, an almoner's or inquiry officer's room, and a dispensary. In the out-patient department there may be smaller waiting rooms attached to the dispensary and to various special departments, and there is usually a canteen at which patients can get tea.

30.—New cases may or may not be medically sifted before any of them reach the visiting staff, according to the definition of medical suitability adopted by the hospital. If there is sifting, this may be done, usually by junior medical officers, either in the out-patient department or in the casualty department, and either at a special time, or shortly before the hour of opening of the out-patient session, or, if in the casualty department, indiscriminately throughout the day.

Procedure at Casualty Departments.

31.—At the casualty department every patient sees a casualty medical officer, who treats him once and either discharges him cured or tells him to come again on another day at whatever is the fixed time for the attendance of old casualties ; or, if he needs the attention of a consultant, sends him to the out-patient department or tells him to attend it at the proper time. There may or may not be inquiry into the patient's circumstances by an almoner or other inquiry officer. The casualty officer may or may not be empowered to send a minor case away to a private doctor or to some other agency after one examination or treatment.

32.—Where the casualty department is also used as the sifting ground for the out-patient department, it is larger and more elaborate. Patients come in considerable numbers at the appointed time of day. They are sorted first into old casualties and new cases of all kinds. The new cases are sorted into medical and surgical, and are seen by the medical officers on duty for the purpose. From them are selected the cases which are to attend the out-patient department. If the appropriate out-patient session is at another time of day, the patients thus selected either wait, or go away and come again. The rest are treated by the casualty medical officers, and may possibly go through the successive stages of seeing the almoner, seeing the casualty medical officer, and getting their medicine at the dispensary, all inside the casualty department itself.

Procedure at Out-patient Departments.

33.—In the out-patient department proper the visiting out-patient staff attend at fixed times. Sometimes the out-patient department is open to all comers. Sometimes it is open only to the patients who have been selected for it by the casualty department, with the addition of those coming

direct with introductions from private doctors for a consultant's opinion or for special treatment. In addition to the new out-patients there will usually be old out-patients, often in much larger numbers.

34.—If not already registered in the casualty department, the new out-patients have to be registered, and they then wait in a part of the hall adjacent to the consulting room where they will be seen. They may pass into the consulting room one by one after the doctor or surgeon arrives. They may be admitted several at a time. If it is a teaching hospital, they may there be seen first by students, who take preliminary particulars. The consultant may have various clinical assistants working under him, and one of these assistants may sift the cases for him and deal with the minor ones in his presence. The procedure differs at different hospitals and with different consultants. Patients may require special X-ray or other examinations.

35.—Old patients may be seen by the consultant himself, or they may be seen by a house physician or house surgeon or other junior officer except where the consultant has indicated that he wants to see particular patients himself. They may be seen before the new patients, or after them, or simultaneously with them but by different doctors.

36.—At some stage or other the new patients, and perhaps some of the old patients, go to see the almoner or other inquiry officer, unless they are exempt under a contributory scheme. The almoner ascertains in what ways the hospital treatment needs to be supplemented by after-care, and may also be the officer who decides on financial suitability and assesses what is a fair payment towards the cost where that method of inviting contributions is in force.

37.—The patient finally goes to the dispensary, receives his medicine and leaves the hospital.

Small Number of Complaints Reported.

38.—We have received but few complaints of the methods followed in the casualty or out-patient departments. Allowance has to be made for the facts that patients have no ready means of making grievances known, even when they exist, and that they recognise the value of the services they receive from the hospitals and the difficulties under which those services are rendered, and are reluctant to make much of the discomforts or even hardships which they may have experienced. We were told, also, that there was sometimes an impression that it was not to the advantage of a patient to become known to the hospitals as a complainer. Those who have tried to distinguish between the real grievances of invalids and their imaginary ones will realise the difficulty of entirely preventing the existence of such impressions. While expressing no opinion as to how far such complaints are justified we think that it is important, in the interests both of the patients and of the hospitals, that channels should be readily available whereby complaints can be made with the assurance that they will be sifted and the resulting information utilised for the introduction of improvements, wherever these are desirable and practicable.

39.—To some extent the existence of contributory associations such as the Hospital Saving Association has provided large numbers of patients with an agency to which they can report any grievances. Their group or workshop secretaries and their central officials can usually form a very fair idea of the amount of substance in the complaints, and it is their experience that the hospitals are usually ready to inquire into the circumstances and are able to give an explanation which is accepted by the patient. It is largely from the statements of evidence from the Hospital Saving Association and from the Hospital Saturday Fund that we have formed the impression that the actual causes of complaint are not numerous ; and this impression is confirmed by the evidence from the Charity Organisation Society, based on the experiences of its local Committees, who are in touch with considerable numbers of individual patients.

40.—The principal complaints on which a material amount of evidence has been received from patients or from persons or bodies interested in the general subject relate to two subjects :—

(i) waiting ;

(ii) overcrowding with unsuitable cases which could be provided for elsewhere, and consequent difficulty in the treatment of suitable cases, and overlapping with other medical agencies.

Since overcrowding, from whatever cause, is closely associated with waiting we do not propose to treat these two subjects separately. We shall deal first with the fact of waiting, then with the question of the suitability of patients, and finally with waiting as affected by methods of procedure and by adequacy of accommodation.

SECTION II. EVIDENCE AS TO TIME OF WAITING.

41.—Two questions arise under this head :—what evidence there is of long waiting on the part of patients ; and what evidence there is of undue waiting, i.e., of excessive and avoidable waiting. The evidence on these questions is of several kinds. pars.

A. THE FACT OF WAITING.

Evidence from General Sources.

42.—In the first place there is the evidence derived from common knowledge. There is undoubtedly a general impression in the minds of the public, of hospital patients themselves, of employers, of private doctors, of district nurses, and of others interested in patients, that attendance at a hospital takes a long time, that the time ought if possible to be shortened, and that it probably could be shortened if enough attention were given to the subject by those responsible for hospital organisation. This opinion suffices, we think, to justify the holding of our inquiry ; but it needs to be tested from more authoritative sources before any useful conclusions can be drawn.

Evidence from Contributory Associations and from Employers.

43.—In the second place, we have put the question directly to the contributory associations of patients already mentioned, the Hospital Saving Association and the Hospital Saturday Fund. The replies were not very conclusive. 14–5

44.—The Hospital Saturday Fund submitted reports from 62 patients, and from 5 honorary collectors in various works. Of the 62 patients, 46 made no complaints at all, while 8 referred to waiting. Of the 5 honorary collectors, 3 spoke of a general feeling on the subject of the time of waiting, combined with an impression that in most cases it could not be avoided. The Hospital Saving Association wrote to 54 of its group secretaries, asking if it was the general experience that patients had to wait an excessive time. Of these, 30 replied in the negative, and though some of them referred to periods of from 3 to 5 hours spent on a visit, they spoke of such periods as inevitable. One of them added that all good things were worth waiting for. Of the other 24, some mentioned periods (which they sometimes called delays) of from 3 or 4 hours up to 5 or 6.* A good many of those who mentioned long periods suggested possible causes, occurring at some stage or other of the procedure, some of which they thought could be remedied. These we shall discuss when we come to details. The secretary of the Association himself had a strong general impression that members attending out-patient departments would expect to have to give up half a day for the purpose ; that they would probably think it worth while to wait rather than not to have the opportunity of seeing a hospital consultant ; but that there was reason to believe that time could be saved at some stages. 268

45.—Somewhat akin to the experience of associations of workpeople is that of those employers who, in order to avoid the loss of time on the part of their employees attending out-patient departments, have established in their own works clinics such as those to which we have already referred. This again is not necessarily a criticism ; but it is evidence of the existence of a problem, and illustrates on a small scale one of the common suggestions for solving it, namely, the development of other agencies for certain types of cases.

Evidence from the Charity Organisation Society.

46.—In the third place, we had evidence from the Charity Organisation Society, whose Medical Advisory Committee, after considering reports from the District Committees of the Society, had already submitted to the King's Fund a resolution calling attention to long waiting at the out-patient departments of many of the London voluntary hospitals. The Society submitted particulars of 51 instances, not as having been obtained by any intensive inquiry, but as having come to the notice of the District Committees in the ordinary course of their work. Out of 45 cases where times were given 16 mentioned periods of from 2 hours to 4 hours, 22 of 4 hours to 6 hours, and 7 of over 6 hours ; and one Committee added that delay of 5 or 6 hours was of quite common occurrence. The Society referred to a common impression in some quarters that patients did not mind the long wait, but they expressed the view that, although many patients took the waiting as a matter of course (a fact which accounted for the comparatively small number of complaints) the loss of time involved caused hardship and, in particular, made it difficult for mothers to take their children to hospital even in cases of necessity. 352 376

Evidence from the Hospitals.

47.—In the fourth place, we have received much evidence from the hospitals themselves. The questionnaire asked each of the 78 hospitals whether there was either overcrowding or excessive

* It is often difficult to be quite certain whether figures of hours refer only to actual waiting or to the whole period spent at the hospital.

pars. waiting. An analysis of the replies in so far as they are capable of classification shows that, on the first question, 21 hospitals report overcrowding generally, 3 more experience it in one department or on a particular day of the week, and 42 state or imply that there is none. On the second question, 9 hospitals report long or excessive waiting and 8 others imply it by speaking of their efforts to avoid it, making 17 in all, while 36 consider that there is no excessive waiting, and 10 others that it is not excessive in view of the service rendered and the unavoidable fluctuations in numbers.*

48.—At some of the hospitals the evidence points to the absence of any serious problem of prolonged waiting. In some cases the numbers attending are not large compared with the available accommodation, and the department is normally cleared within a comparatively short space of time. On the other hand, at some hospitals, especially where the out-patient accommodation is antiquated and has not been extended for many years, there is obvious congestion and consequent delay. At many hospitals the time taken differs with the day of the week or even with the weather, owing to the fact that the numbers attending fluctuate to a degree which cannot be compensated for by any variations in staffing or in procedure.

49.—Some of the hospitals which recognise the fact of waiting definitely express the view that it is inevitable. They hold that it results from the time taken by the various stages of procedure through which patients must necessarily pass ; from the fact that where large numbers attend some must be dealt with after others ; and from the different speeds at which different individuals attending on patients can best do their work. They endorse the view that the patients think the delays worth while because of the value of the service received, and they point to the large attendance as evidence of this. Finally they claim, as one reason why waiting cannot be cured, that where any hospital has substantially reduced the time of waiting, either by improvements in procedure or by the provision of new and enlarged premises, this very fact, when it has become known, has attracted additional patients in such large numbers that the previous conditions of crowding and waiting have been speedily re-established.

50.—Some hospitals report that unusually long periods of waiting are almost always due to some exceptional circumstance connected with the individual patient, such as the need for X-ray or
205, 275 other special investigations. Other long periods are attributed to the attendance of patients at a time when the particular department whose services they require is not in session. We are also told that at some hospitals patients frequently arrive before the official time for the opening of the doors, either because it suits them better—as, for example, when they come by workmen's trains—or because they hope to receive earlier attention. In such cases the hospital naturally claims that it is not responsible for the additional time spent.

51.—Nevertheless, the fact that many of the hospitals themselves (including some which take the more lenient view which we have quoted) have given, and are giving, serious and prolonged attention to the problem, is itself evidence that it is a real one. At quite a number of hospitals special sub-committees have recently been holding inquiries into their own methods, and comparing them with the methods at other hospitals, in the hope of discovering ways of speeding up the procedure without reducing the efficiency of the work. Some of these inquiries are still going on, and their results should help to indicate how much of the waiting is preventable and how much is inevitable.

52.—We have also the statements received from various hospitals which, as the result of such special inquiries, have recently introduced changes in procedure by which they claim to have effected definite reductions in the time taken. Amongst examples mentioned are half an hour saved by improved methods of registration ; the introduction of arrangements whereby two sets of patients, e.g., old patients and new ones, can be seen simultaneously ; considerable saving at the dispensary stage ; waiting reduced by 50 per cent. for a large number of cases by a series of improvements introduced by a special out-patient medical officer. It is therefore hardly too much to say that no hospital can claim that all its waiting is unavoidable unless and until it has studied its procedure in the light of the experience of the hospitals which have actually achieved reductions such as these.

268 53.—We shall refer to improvements of this kind in more detail when we come to discuss the separate stages of procedure. And we shall also have occasion to consider whether the amount of waiting is influenced by certain more fundamental differences in the types of out-patient
65, 217 organisation, based on differences in the definition of medical suitability and in the methods of sifting adopted for the purpose of distinguishing between the suitable and the unsuitable.

54.—We have also a certain amount of evidence derived from the figures which the hospitals have submitted to us either of the amount of time taken on the average by the work of an out-patient session taken as a whole, or of the time spent by individual patients, or on the average by all the
374 patients during or between the different stages of the procedure. These figures are discussed in a later section.

* Out of the 12 teaching hospitals the numbers included in these figures are respectively : on the subject of overcrowding 4, 2 and 3 ; on that of waiting 1, 2 and 3. The 24 hospitals which report overcrowding in one form or the other represent about 3,000,000 attendances : the 42 which report none represent about 3,750,000. The 17 which report or imply excessive waiting represent about 2,700,000 attendances ; the other 46 represent about 3,800,000.

Conclusion as to the Fact of Waiting. pars.

55.—On the question of the fact of waiting, the general opinion which we have formed is as follows :—

(*a*) that, although the direct evidence on the question is rather scanty and vague, there is no doubt that there is a considerable amount of waiting in the out-patient departments, though not much in the casualty departments ;

(*b*) that most of the very long periods of waiting which form the subject of comment are due to medical or surgical circumstances affecting the patients concerned ;

(*c*) that there is little evidence of long waiting in special departments (except possibly those for eye and ear) as distinct from sessions for general medical and surgical out-patients ;

(*d*) that, although there are a good many complaints of waiting for medicines at the hospital dispensary, dissatisfaction amongst patients arises chiefly when a long delay occurs before the stage of examination or treatment, and that, when once the process of " seeing the doctor " has begun, the patient is more ready to accept delays as being a necessary part of the time spent in actually obtaining the service for the sake of which he has come to the hospital.

B. THE QUESTION OF UNDUE WAITING.

56.—The further question whether, if there is waiting, there is undue waiting, i.e., excessive or avoidable waiting, requires a good deal of consideration. It is necessary first to inquire into the causes of waiting, and then to ask how far those causes are or are not removable.

Alternative Theories of the Cause of Waiting.

57.—Four general theories as to the cause of waiting have come under our notice during our Inquiry :—

(i) that it is inherent in the institutional provision of medical treatment for large populations, and could therefore be remedied only by a practically unlimited increase in the available accommodation and staff ;

(ii) that, while it is caused by overcrowding, the overcrowding itself is partly due to inadequacy or unsuitability of accommodation capable to a great extent of being gradually remedied ;

(iii) that it is partly, at all events, due to defects in procedure which are capable of being remedied ;

(iv) that, while it is caused by overcrowding, the overcrowding is primarily due to the treatment of excessive numbers of patients suffering from minor ailments who do not require the services of the highly specialised staff and equipment of a hospital out-patient department, but for whom the necessary treatment could be efficiently provided elsewhere ; and that waiting would be remedied if the hospitals were to specialise more than they do now on what is commonly called the specialist or consultative part of their present work.

58.—The arguments used in favour of the theory that long waiting is unavoidable, and results 49
from the necessity of providing for large numbers, have already been quoted from the hospitals that hold it. These hospitals consider, logically enough, that the only remedy would be such an increase in the staff, medical and lay, and consequently in the accommodation, as would reduce the waiting to whatever was regarded as unobjectionable. It is, therefore, in their view wholly a question of finance, with the implication that the expenditure involved, even if practicable, would not be justified.

59.—It is clearly impossible to form a judgment on the theory that waiting is irreducible without first considering the alternative theories which suggest methods of reducing it. It is equally impossible to come to a conclusion about accommodation without first considering procedure, or about procedure without first considering how far different methods should be applied to " major " cases and to " minor " cases.

Connection with question of Suitability of Patients.

60.—It follows that, although the four theories have been set out above in the order in which they naturally arise, they can best be discussed in the reverse order. In other words, we cannot form a final opinion on the question of waiting as affected by methods of procedure until we have discussed the other part of our reference, the question of methods affecting suitability of patients.

SECTION III. METHODS AFFECTING SUITABILITY OF PATIENTS.

pars. 61.—We have already referred to the fact that the suitability of a patient for attention, in an out-patient or casualty department, depends on a combination of his circumstances and his medical need for the kind of services provided by a hospital.* Throughout our Report the term medical suitability refers to the medical side of this two-fold definition, and the term financial suitability to its financial side; and although, for convenience, each side is dealt with separately, and without frequent cross-references, the other side has constantly to be borne in mind.

A. THE QUESTION OF MEDICAL SUITABILITY.

Alternative Principles: the "Open Access" and the "Consultative."

62.—From this point of view, the definition of medical suitability may be said to depend on the extent to which the hospital acts on one or other of two alternative general principles, the extreme forms of which may be roughly expressed as follows, viz.:—

(i) that access to the facilities of the hospital should be open to all the sick poor;

(ii) that access should (except for emergencies) be limited to patients who need the specialised consultant services or expensive equipment which are provided by a hospital and which are not obtainable by those patients elsewhere.

The first alternative may be provisionally called the "open access" principle: the second the "consultative" principle. Either of them may be advocated, or even adopted, in the extreme form here set out. But there are a number of possible definitions intermediate between the two.

63.—Under the first principle the hospital treats all cases, whether major or minor. Under the second principle, to the extent to which the consultative idea has been introduced, the hospital confines itself more or less to major cases, and prefers that minor ones should be treated elsewhere.

64.—Where the second principle is adopted at all, there are differences in the extent to which it influences the definition of suitability, not only at different hospitals, but also in the out-patient and casualty departments of the same hospital. Whatever the degree in which the consultative principle may be applied in the out-patient department, access to the casualty department must be open at all times to all comers, who must receive attention from a qualified medical man at least sufficient to enable him to decide whether a case is an emergency or not. After this, the extent to which treatment is continued in the casualty department will depend on the extent to which the open access principle or the consultative principle is applied by the particular hospital to that department as distinct from the out-patient department proper.

Different Definitions at Different Hospitals.

65.—Our questionnaire asked each hospital what its definition of medical suitability would be. It was found that the written replies represented a considerable number of possible gradations between the open access definition and the purely consultative definition, and in the course of our further inquiries it became more and more clear that many of the present definitions were the result of a gradual movement towards the latter principle, frequently accompanied, however, by an emphatic rejection of its more extreme forms.†

66.—Historically speaking, the earlier definition of medical suitability may, as we have already
11 suggested, be expressed in the words "all sick poor." This still remains as the summary of one of the present main types of definition, retained and defended by some of the most important hospitals. In considering the exact meaning and merits of this definition in present-day circumstances, regard must be had to the various developments, already described, in the nature and cost of hospital work,
12–3 in the establishment of alternative agencies for providing the simple forms of treatment, and in the relative financial positions of different classes of the community.

67.—Next to these come the hospitals whose definition may be summarised as "all sick poor, except" certain specified classes. The first of such classes to be mentioned are usually those specifically provided for by statutory agencies, e.g., "insured patients"; "children eligible for treatment at L.C.C. school treatment centres"; "venereal disease patients provided for elsewhere"; or, more generally, "cases provided for elsewhere by legislation." This may be regarded, by those who would welcome such a movement, and also by those who would deprecate it, as a first step in the

* We are not concerned with the purely technical question whether the disease from which a patient is suffering is one which comes within the scope of the particular hospital, or with cases which are merely passing through the out-patient or casualty department on their way to a bed.

† All the more or less consultative definitions are commonly applied only after either a first examination or a first treatment. A phrase often used in evidence is "seen once," and the ambiguity may correctly represent the facts.

direction of a system of co-ordination under which the hospitals would specialise in a greater or less degree on the provision of consultative services. pars.

68.—Other definitions of this kind include some explicit qualifying phrase which is probably implied in those just mentioned. Some describe as being unsuitable " insured patients whose treatment is within the scope of a general practitioner," a form of definition which leaves the decision to the hospital. Sometimes, on the other hand, the definition leaves the decision to the panel doctor by excluding, e.g. panel patients without a doctor's letter.

69.—Rather more consultative are the definitions which limit suitability by the character of the case without specific reference to alternative statutory provision, e.g., those which mention, as unsuitable or as being discouraged from attending, " cases whose treatment can be carried on by general practitioners " ; " trivial cases," especially where these are discouraged in the casualty department as well as in the out-patient department proper ; " chronic cases which do not require specialised treatment."

70.—Similar to these in their emphasis on a consultative function, though with significant exceptions based on poverty, are the positive definitions which mention, as suitable, " cases which cannot be dealt with by general practitioners and cannot afford a specialist " ; " those unable to pay for specialist service " ; " consultative cases and those who cannot afford general practitioners' fees " ; " cases needing specialised treatment and with no panel or private doctor available." Definitions of this kind raise questions of financial suitability which we shall have to discuss under 92
that heading.

71.—One step further in the consultative direction is a definition which reads " cases requiring a specialist opinion or expensive treatment and recommended by a general practitioner for the purpose." The teaching hospital which gives this last definition is careful to state that it applies only to the out-patient department proper. The same is probably true with most of the other definitions. It is a common practice that, where doctors' letters are required in an out-patient department, a reference from the casualty medical officer gives access to the visiting staff equally with a letter from a private practitioner.

72.—Finally, there are a few hospitals, particularly in the suburbs, which have adopted the strictest form of the consultative definition of medical suitability, and require all out-patients, other than emergencies, to bring a letter of recommendation from a doctor. There appear to be seven such hospitals, besides one which does not apply the rule except to panel patients and to those who have already been under a private doctor. Some, if not all, allow exceptions in cases which cannot consult a private doctor owing to lack of means, and, like hospitals with other less strictly consultative definitions, allow all comers one examination if not one treatment ; and one of them has an open access clinic in another part of its district.

The Different Definitions as applied in Practice.

73.—It would be a mistake to suppose that these definitions embody rigid rules, formulated by the hospital committee and binding on all the lay and medical staff. In many cases, possibly in most, the question is the subject of frequent discussion ; the definition represents the stage which had been reached at the moment of our inquiry, and the actual practice may differ with different members of the medical staff. By certain hospitals which have a somewhat consultative definition we were told that it had been adopted quite recently ; in some cases we gather that no actual definition has ever been formulated, and that the reply to the questionnaire indicates rather the direction in which the collective opinion of the hospital is moving. In one case at least we understand that the lay Board has come to be in favour of a fairly consultative definition, but that the medical staff, though not disputing the principle, are reluctant to apply it in practice when the individual patient is before them. Other medical witnesses have spoken to us of the great difficulty they find in sending elsewhere a patient who is obviously unsuitable, but who persists in continuing to attend. At another hospital, where the open access principle is advocated in its most extreme form, as applying both to the casualty department and to the out-patient department proper, though with some preliminary sifting of patients before they reach the consulting rooms of the medical staff, it has become the practice of the visiting physicians themselves only to see such patients as bring doctors' letters or are referred to them by their assistants. Even these patients they rarely see more than once, but send them back with a report to the doctor who sent them. They have, in fact, so many of these cases that they have no time for anything else, and their assistants treat the ordinary cases. This illustrates the way in which, as the result of the increase in specialist methods of diagnosis and treatment at the hospitals on the one hand, and of the provision of general practitioner treatment on the other, the consultative side of out-patient work is developing.

74.—There is, of course, a fundamental difference between the practice at a hospital such as this and the extreme consultative definition which would confine the work of a hospital, apart from emergencies, entirely to the examination of cases coming with doctors' letters, and to their treatment

pars. only when they need something which a general practitioner cannot supply. At a hospital which consistently followed the latter practice, minor cases would not be seen at all except at a first attendance. In all other hospitals, even if minor cases did not see the visiting staff, they would be attended at least for a time by assistants or junior medical officers, often of high qualifications, possibly in the out-patient department, but at all events in the casualty department. In such cases the consultative principle is being applied to part of a hospital, although it would be regarded as highly undesirable and impracticable to apply it to the whole.

75.—In the light of these various examples, the methods of applying the open access principle and the consultative principle in varying degrees in actual practice may be more fully summarised as follows :—

A. At one end of the series, access to the facilities of the out-patient department as well as of the casualty department, including diagnosis and treatment to a conclusion by the visiting medical staff, may be unlimited, i.e., may be open to all the sick poor ;

B. Access to the visiting staff may be open, but the visiting staff may refer minor cases to assistants or junior medical officers for treatment, retaining only the consultative cases for themselves: members of the visiting staff may even attend in the casualty department for the purpose ;

C. The whole of the services of the visiting staff may be consultative, i.e., access to diagnosis and treatment by the junior medical officers may be open to all the sick poor ; but access to diagnosis and treatment by the visiting medical staff may be limited to those referred to them for the purpose either by the junior medical officers or by outside doctors: the services of the junior staff may be provided either in the out-patient department or in the casualty department, the effect in the latter event being that the open access principle is applied to the casualty department and the consultative principle to the out-patient department proper ;

D. Access to the visiting staff may be open to some classes of patient, but the consultative principle may be applied to others ; e.g., to insured patients, or to other patients for whom statutory provision has been made, or to those which have a private doctor or to those who have been receiving treatment from a general practitioner for the particular ailment ;

E. Access to the visiting staff may be open as regards the first attendance of all sick poor, but may be consultative as regards subsequent attendances, i.e., access may be open to all sick poor for a first attendance, but minor cases for which the necessary treatment can be obtained from other agencies may subsequently be referred to those agencies. The reference to other agencies may take place either :—

(i) at first attendance, after diagnosis but before any treatment ; or
(ii) at first attendance, after diagnosis and one treatment or prescription ; or
(iii) at some subsequent attendance, after the more serious stages of the illness are past, and the case has thus come within the scope of a general practitioner ;

F. The consultative principle in one or other of the two last-mentioned forms may be applied in some degree also to the treatment of patients by casualty medical officers in the casualty department, subject of course to the universal proviso that no form of limitation affects cases of emergency ;

G. Finally, at the other end of the series, the whole of the out-patient work of the hospital may be strictly consultative, i.e., all its facilities may (except for emergencies) be open only to those who come with an introduction from a medical practitioner indicating a need for diagnosis or treatment by a hospital consultant, or for the use of the specialised services or expensive equipment of the hospital.

So far as our evidence goes, the actual procedure at most hospitals corresponds in part at least to one or other of the intermediate alternatives B, C, D and E, or to some combination of them. Alternative A is still largely held in theory, though usually with some modifications in practice. Alternative G has been adopted only by very few hospitals, and then only with a sufficient amount of latitude as regards first attendances to cause it to approximate to a combination of E and F. The
231, 234 use of the casualty department on the lines either of B or of F is rare, though examples are to be
241 found at important hospitals, and will merit our serious consideration later on.

Use of Doctors' Letters.

76.—The consultative use of an out-patient department, as the term is commonly employed, consists of two parts : consultations by general practitioners who desire a second opinion on the diagnosis of a case or advice as to the best method of dealing with it, and the provision of specialist treatments which require the continued services of the equipment or staff of the hospital. For both purposes one of the indications of the extent to which a hospital aims at being consultative is to be found in its rules and practice in connection with letters of introduction or recommendation from general practitioners.

77.—An inquiry on the subject was included in the questionnaire. We shall discuss in our next sub-section the rule which requires doctors' letters from all patients except emergencies, and which has been adopted at seven hospitals. The following are examples of rules at other hospitals :— * pars. 82

(*a*) not required ;
(*b*) not required but desired, or preferred, as a guide and help ;
(*c*) not required but desired, to facilitate reference back ;
(*d*) not required but encouraged ;
(*e*) not required but encouraged and facilitate procedure ;
(*f*) not required but encouraged and give direct access to the out-patient department proper ;
(*g*) encouraged, but hospital committee now considering some stricter rule ;
(*h*) required for new cases where a general practitioner has been treating the case, but exceptions allowed : and give access to out-patient department ;
(*k*) required in out-patient department except from cases referred from casualty department ;
(*l*) required in out-patient department except from cases referred from casualty department or bringing other forms of recommendation ;
(*m*) required from insured patients ;
(*n*) required from insured and private patients, but discretion allowed to casualty officers.

It is obvious that these rules, in proportion as they become more strict, are designed to encourage the consultative side of the work of the hospital.

78.—The numbers of patients who actually come with doctors' letters or cards of introduction, addressed either to the hospital or to individual members of the visiting staff, differ widely. Examples quoted in evidence include such estimates as a very small number, about 10 per cent. ; a minority, 35 per cent. ; 40 per cent., of whom about one-half came from panel doctors. At one teaching hospital with the open access definition of suitability about 36 per cent. in the general out-patient department come with letters, while the numbers in the special departments range from 17 per cent. to 66 per cent. At another, where the out-patient department proper is consultative, more patients come with recommendations from outside doctors than from the casualty medical officers.

79.—We have received a good deal of evidence on the experience of hospitals in connection with the communications they receive from doctors and the procedure they adopt for making reports to doctors in reply. We shall discuss this subject later on. At present we are concerned only with the bearing of these rules on the application of the consultative principle as distinct from the open access principle. 199

80.—It is significant in this connection that the Hospital Saving Association, which is by far the largest association of contributing patients or prospective patients, circulates the following instruction to its group secretaries and its members :— 14

> " Hospitals are not intended to deal with trivial cases or cases which can be equally well dealt with by private doctors. A patient cannot get full value out of a consultation at hospital unless the consultant is in full possession of such information, with regard to the condition of the patient and previous treatment, as only the patient's doctor can supply. Contributors applying for hospital treatment are therefore strongly recommended to obtain a letter from their doctor."

The Association states that, as a result, the proportion of its out-patients is below the average and is falling ; although the hospitals frequently treat, and apply for payment for, a contributor who is prima facie not a hospital case and has been told by his group secretary that he must get a doctor's letter before a voucher is issued to him. Sometimes a hospital tells us that it asks for a letter but that the patient is unwilling.

81.—We say that this action by the Hospital Saving Association is significant of the movement for the development of the consultative side of hospital work, because the members of the Association have contributed in order to be exempted from further payment when accepted for hospital treatment according to the rules in force at the hospitals. It does them great credit, therefore, that they should be willing themselves to advocate a principle which sacrifices the benefit of treatment for minor cases for the sake of the less immediate advantage of better and quicker treatment for serious cases.

Compulsory Doctors' Letters—The Scheme submitted by the British Medical Association.

82.—The consultative principle in its extreme form has been advocated by the British Medical Association for many years. Its proposals had recently been formulated in a report on the problem of the out-patient, and witnesses from the Association gave us evidence on the subject. The principle was also supported by evidence from the London Panel Committee and the Medical Practitioners' Union.

* Although the proviso is only occasionally mentioned, it is possible that all these rules apply to patients who are within the usual income limits but who are considered to be able to obtain a doctor's letter and, if uninsured, to pay the legitimate charge.

pars. 83.—The principle is thus expressed in the conclusions to the recently published report of the British Medical Association :—

> "No person, except in cases of emergency, should be accepted for treatment as an out-patient at a voluntary hospital unless he brings a recommendation from a private medical practitioner, a provident or other dispensary, a public clinic, or a public assistance medical officer of a local authority."

We propose to summarise briefly the arguments for and against this proposal.

84.—The Association bases its recommendation on the contention that a large amount of the present work of the out-patient departments consists of the treatment of patients with minor or chronic ordinary ailments which could be dealt with by general practitioners ; that the volume of unnecessary work thus created prevents the best use being made of the services of the hospital staffs ; and that for this reason, and because of the overlapping with other agencies which is involved, it produces a waste of public funds and of the money of hospital subscribers. It is argued that the out-patient departments should be used only for three types of case :—casualties or emergencies for first attention, but not for more if suitable help can be got elsewhere ; discharged in-patients ; and consultation cases, including those retained for special treatment, though in many instances all that would be necessary would be the one consultation, the patient being referred back with the diagnosis and with suggestions as to the line of treatment. It is recommended that minor cases, whether with or without letters, should be examined, but that no treatment should be administered unless it is not available elsewhere, the treatment of such cases being regarded as no part of hospital work. It is argued that the resulting reduction of numbers would lead to the greatly enhanced benefit of the patients who were admitted, and that the out-patient departments would, as centres for emergency treatment and for the provision of consultation and specialist opinion, fall into their right place as a most valuable part of the medical service of the community. These arguments were supported in oral evidence by eight medical witnesses from the Association, of whom five were hospital consultants, including three surgeons on teaching hospitals. One of these was also on a suburban hospital where the system was first adopted, and where he said that it worked perfectly well. It was admitted, however, that this hospital
108 was not a very large one and that patients excluded by the rule might go to out-patient departments elsewhere.

85.—Various objections to the scheme have been mentioned to us in evidence, and, indeed, some of these are referred to in the British Medical Association report itself.

86.—One question that has been raised is whether the panel doctors and other general practitioners are really fitted to be the agency which would decide which cases are suitable for the hospital out-patient departments and which are not. The British Medical Association itself admits that the general practitioners' outlook will have to be changed before they can play their part in the scheme. But it attributes this to the tendency to look on the out-patient departments as competitors, and it considers that the scheme would result in close co-operation between hospitals and outside doctors which would be of immense advantage to the patients of the latter.

87.—Another objection mentioned to us is that patients are often reluctant to ask their own doctor to obtain a second opinion, and that, the less the confidence they feel in him, the greater often is the reluctance. This is a difficult question on which to express an opinion. The reluctance may be reasonable or unreasonable : there seems to be no doubt that it exists. Representatives of general practitioners have assured us that, whether in private practice or under the National Insurance Act, a patient who has lost confidence in his doctor need have no difficulty or hesitation in changing to another. But here again the hesitation undoubtedly exists. These are strong arguments in favour of retaining for the patients the power to go to a hospital for a second opinion without having first to get the permission of their general practitioner. This view has been taken by most of the hospital witnesses, and also by representatives of the Incorporated Association of Hospital Officers, and we ourselves emphatically hold the same opinion.

88.—Another difficulty is that many patients may not have a doctor and would not know how to get a letter of recommendation. There is also the objection, already referred to, that some may have a difficulty in paying the fee which may be asked, especially if the giving of the recommendation is, as it should be, preceded by a careful examination and accompanied by a statement for the information of the hospital consultant. In the case of panel patients it may be a sufficient answer that there is no charge for the services of the doctor : but this does not apply to uninsured patients, including the dependants of the insured. The British Medical Association considers that, under present conditions, there are not many who are not provided for by the panel doctors, or by private doctors either directly or through some form of contract practice, or, if they are very poor, by the public assistance medical officers.

89.—Another objection which has been put to us arises out of the possible effects of the scheme
255 upon medical education. The arguments on both sides of this question will be discussed later on. We found that as a rule the views of witnesses from teaching hospitals were against the proposal, although sometimes opinion even amongst the medical staffs was divided.

90.—The arguments that render us unable to recommend the adoption of the scheme must not, however, be taken as evidence against the continued or increased use of doctors' letters in the ways

described in the previous sub-section. Similarly, it is quite possible to dissent from the extreme view that the treatment of minor cases is no part of the work of a hospital, and to regard their attendance, even in considerable numbers, as essential to medical education, and yet to be in favour of the general adoption of partially consultative methods and of a consequent reduction in the numbers of minor cases, as affording the best prospect of solving the problems of overcrowding and waiting.

The question of Minor Cases as affected by their Financial Position and by the Alternatives Available.

91.—Before reaching any conclusions on the question of the suitability of minor cases, it is necessary to discuss two subjects with which we have not yet dealt, viz., the financial position of the patients concerned, or, in other words, the question of financial suitability, and the alternative forms of medical provision which would be available for them, at a cost within their means, if any considerable proportion of them were excluded from the out-patient departments.

B. THE QUESTION OF FINANCIAL SUITABILITY.

92.—The question of the financial suitability of patients for treatment by the hospitals, with the aid of charitable funds and the voluntary service of physicians and surgeons, falls into three parts :—

(i) Are the hospitals treating patients who, being major cases, could obtain efficient specialist or consultative diagnosis and treatment elsewhere at a cost within their means ?

(ii) Are the hospitals treating many patients who, being minor cases, could obtain elsewhere, within their means, the kind of diagnosis and treatment they need ?

(iii) Are the hospitals treating many patients who, whether major or minor, are so poor that their condition cannot be efficiently remedied without the provision of non-medical aid from the Public Assistance Authorities; and, if so, is it desirable that the hospitals should treat such cases ?

The second and third of these have a direct bearing on the question whether it is desirable and practicable for the hospitals to reduce overcrowding and waiting by referring minor cases to other agencies.

Maximum Income Limits and other Definitions of Suitability.

93.—The definition of financial suitability, as regards the hospitals taken as a whole, has been considerably simplified by the general adoption of a scale of income limits above which a patient is not normally regarded as suitable. The usual scale is the one agreed upon by the hospitals when the Hospital Saving Association was founded in 1922, viz. : £4 a week for a single man, £5 for a married couple, £6 for a married couple with children under 16.*

94.—Patients whose income does not exceed the prescribed maxima are accepted by the hospitals without further inquiry. Where the voucher of a contributory association is, by mutual agreement, accepted as proof that the member's income is within the limit, no inquiry is made at all. This fact has done much to establish the scale as the general standard.

95.—The more general definitions of financial suitability include such phrases as " those unable to pay for the specialist services required," or, still more general in wording, " those needing investigation or treatment which they cannot get within their means except at a hospital," " those unable to pay consultants' fees, or, in certain circumstances, the fees of a general practitioner." These definitions, and particularly the one last quoted, illustrate the difficulties that arise in judging solely by a definite income limit, in view of the differences in the elaborateness and cost of the various services provided by the hospital and the equally numerous differences in the circumstances of the individual patients.

Patients above the Income Limit.

96.—Where the income of a patient is above the scale, the question of suitability will depend partly on his domestic commitments, the expenses of his illness, and his other financial circumstances, and partly on the nature of the medical service which he needs. If all that is necessary is the treatment of a minor ailment no question arises : the scale excludes him. But he may require some consultative or specialist diagnosis or treatment, and he may not be able to pay the private cost of both, or perhaps not even of either.

97.—In such cases the hospital may, according to its view of the circumstances, supply the service and ask him to contribute to the hospital funds his fair share of the cost ; or it may advise him to obtain what he needs privately, or it may refer him to some physician or surgeon, perhaps a member of its own honorary staff, who will see him for a reduced fee. If he comes with a

* This scale is known alternatively as the Hospital Saving Association scale, the British Hospitals Association scale, and the British Medical Association scale, having been adopted by all these bodies, or as the Hospital Patients' Standard. A very small number of hospitals prefer different scales for their own guidance, e.g., £5 to £7; or for labour class 37s. 6d. to 87s. 6d. ; for clerks 50s. to £5.

pars. recommendation from his doctor the hospital will be guided largely by the information supplied from this source; we are sometimes told that greater latitude is allowed in such cases, or that a doctor's recommendation is accepted as being in itself sufficient evidence of suitability. Sometimes the hospital will only treat such a patient if he brings a doctor's letter, and will, if he has no doctor, advise him how to get into touch with one.

98.—An alternative method has recently been growing up whereby consultations at reduced fees on some standard scale are available, in suitable cases, for patients who are slightly above the income limit, or who are willing to pay extra for the service, or who, as insured persons or members of a contributory scheme, are entitled to receive a limited sum to cover the cost. Special clinics have recently been established in this way, at the ophthalmic hospitals and elsewhere, for persons entitled to ophthalmic benefit; a few hospitals have provided facilities for general consultations at reduced fees; and, outside the hospitals, the principle of a general list of consultants who are willing to see suitable cases on this basis has been agreed upon between the Hospital Saving Association and the British Medical Association. It is anticipated that such arrangements as these will relieve the out-patient departments to some extent. It has been suggested that they may at all events provide an alternative for some of the patients who are least tolerant even of the most unavoidable amount of waiting. But the number of out-patients likely to be affected by any of these methods is said to be small.

The Very Poor.

99.—At the other end of the financial scale come the patients whose incomes may not be able to provide them with the necessaries of life even when in health. All hospitals now have, through their almoners or other officers with a similar function, the means of putting patients into touch with charitable agencies. But it has often been urged that where the patient is so poor as to need more non-medical aid than can be supplied in this way the treatment received from the hospital can produce no permanent benefit, and that he had better be dealt with by the Public Assistance Authority, which can supply both medical treatment and any other form of relief required in order to make the treatment effective. This argument is applied with special emphasis to cases which are already receiving public assistance either for themselves or for their families.*

100.—This view has been adopted by some hospitals, and applied in individual cases through the almoner and the hospital doctor acting in co-operation. It is approved by some in theory but carried out leniently in practice, in view of the requirements of medical education and the difficulty arising out of the element of deterrence traditionally associated with the Poor Law. By some it has been definitely disapproved as being inconsistent with the object for which they were founded, which was the treatment of the sick poor. In accordance with the principle to which we referred in our historical section, we shall not ourselves express any opinion until we have considered the nature of the
158 alternative provision which has gradually been developed for such cases, first under the Boards of Guardians and more recently under the County Authorities.

101.—The decision on this point will affect the question of the extent to which hospitals could, without detriment, reduce the attendance of minor cases by referring them to other agencies; though, judging from the experience of hospitals which have adopted the principle, the numbers who would be affected by the decision might not be very large compared with the present totals of out-patients.

The Intermediate Classes.

102.—The problem of the hospital patients who are below the maximum income limit but are normally self-supporting is a much larger one than either of the others, and it has a much more important bearing on the question whether there is any excessive number of minor cases which could,
80 without financial hardship, be referred elsewhere. As we have already seen, the Hospital Saving Association, for whose members the income limit as certified by the Association's vouchers is conclusive evidence of financial suitability, has, on the question of medical suitability, officially advised its members that they should not regard the hospitals as places for the treatment of trivial ailments, but should first consult their own general practitioner. But the question how far this policy could be generally carried out by the members of the Association, or be adopted and applied to all patients by the hospitals, involves the question how far those who now attend the out-patient departments with minor ailments could obtain elsewhere the services they need.

103.—On the question whether any large proportion of hospital out-patients within the income limits could afford to obtain treatment from general practitioners, the evidence we have been able to obtain is not conclusive. Large numbers, of course, can do so through the panel system of the National Insurance Act, but this does not apply to their dependants, nor to other uninsured persons.

104.—The witnesses from the British Medical Association were positive that large numbers of these could obtain general practitioner treatment, either by direct payment or by making use of some

* In the whole of our discussion on this subject we must be regarded as referring to average conditions, and not to periods of exceptional industrial depression when large numbers of patients who are normally in regular work may be in receipt of public assistance

form of voluntary insurance such as that provided by provident dispensaries. The scheme for strictly consultative out-patient departments presupposes in fact that the vast majority of patients will have access to outside doctors either by one of these methods, or through non-provident dispensaries, or through the Public Assistance Authority. It was recognised at the time of the previous King's Fund inquiry in 1911, that any scheme for effecting a substantial reduction in the numbers of minor cases would require a considerable development of provident agencies. This difficulty has been partly met by the National Insurance system ; and we have had described to us a new form of provident agency designed to provide uninsured persons, in return for voluntary weekly contributions, with all the benefits received by those who are compulsorily insured under the National system. We shall refer to these agencies in more detail later on. pars. 145

105.—On the other hand, we have received a good deal of evidence that, under present conditions, there are large numbers of uninsured persons who are above the class of applicants for public assistance and yet cannot pay the fees of general practitioners. The Hospital Saving Association mentions, as one of the difficulties in applying the principle of the doctor's letter, the fact that the charge made by the doctor, which covers, or should cover, an examination as well as the letter itself, is a serious burden on some of the members who have already paid, by their weekly contributions, their share of the cost of the hospital treatment itself. These charges are stated to range from 1s. 6d. to 4s., though in very poor districts they may be as low as 3d. or 6d. for dependants of panel patients. Some, at least, of the small number of hospitals which have adopted the strictly consultative scheme find it necessary to make exceptions for patients who cannot afford a doctor. Some of the large general hospitals have given us evidence of the numbers of patients who are unable to pay the 245 contribution which is asked at each visit from those who can afford it. At one of the teaching hospitals 16 per cent. of those coming without either doctors' letters or contributory scheme vouchers were excused the usual 6d. a visit. At another, 50 per cent. paid 1s. per visit, 10 per cent. came with vouchers, and 40 per cent. were treated free. Even when allowance is made for the fact that the free cases would include patients who might, in a fully co-ordinated system, be regarded as more suitable for the Public Assistance medical service, there seems no doubt that there is a considerable number who, at all events in the absence of any comprehensive provident scheme for uninsured persons, cannot pay the ordinary fees of general practitioners. This view is supported by the witnesses from the Charity Organisation Society.

106.—This does not necessarily mean, however, that a substantial proportion of the patients whose incomes are within the prescribed maxima could not obtain for themselves the treatment necessary for minor ailments if this was not supplied by the hospitals. The income limit, though a most useful guide in connection with the specialist services of the hospitals, is only an approximate test of the financial suitability of minor cases ; and it has long been recognised as one of the difficulties of out-patient organisation that a complete inquiry into the circumstances of all the 253 patients in the casualty and out-patient departments would be a practical impossibility. We have no evidence that there is at present any considerable amount of what used to be called hospital abuse. Witnesses representing general practitioners spoke of it as unfair that people who could afford to pay by provident methods should get treatment from hospitals for nothing. But the British Medical Association did not, as they did at the time of the inquiry in 1911, bring any general charge against the out-patient departments of competing with the livelihood of private practitioners. The problem as now stated is rather one of making the best use of the hospitals as well as the other agencies and of avoiding overlapping, and the question whether any considerable number of minor cases can afford to pay arises mainly as part of the question whether, if it were thought desirable on other grounds to reduce the numbers of minor cases, the patients who would have to be excluded could, without financial hardship, obtain the necessary treatment elsewhere.

The question of Alternative Agencies.

107.—We must now proceed, therefore, to consider what alternative agencies exist from which minor cases could obtain the whole or part of the necessary treatment at a cost within their means, what kinds of service these agencies supply, and on what terms and conditions.

C. ALTERNATIVE MEDICAL PROVISION FOR MINOR CASES.

108.—A complete list of the existing agencies for treating minor cases will include those provided at the hospitals and those available elsewhere. It will be convenient to set all these out in full so as to be able to consider what kinds of service each is adapted to supply.*

109.—It must be remembered that the term minor cases will include not only patients who never had anything serious the matter with them, but also old patients who were major cases at first but have reached a stage at which they no longer need the personal attention of the hospital consultants or the specialised services of the hospital. From the latter point of view the work of the other agencies is alternative only to the later stages of treatment, and is supplementary to the earlier stages.

* It must be recognised that, where different hospitals have widely different definitions of medical suitability, those with a more open-access definition may be regarded by patients as being themselves an " alternative agency " to those with a more consultative one. *See* pars. 84, 241 and 411.

110.—The provision at the hospitals includes diagnosis or treatment by the various different members of medical staffs, viz. :—

(*a*) the honorary physicians and surgeons, often called the consultant staff or the visiting staff ; and

(*b*) the assistant or junior medical staff, of various grades of qualification and experience,

these services being performed either in the out-patient department or in the casualty department.

111.—Agencies outside the hospitals include individual doctors and various kinds of provident, charitable or public institutions, e.g. :—

(*c*) the private practice of general practitioners ;

(*d*) the panel practice of general practitioners treating patients insured under the National Insurance Acts, commonly called panel doctors ;

(*e*) various medical agencies on the basis of voluntary insurance, including provident dispensaries, and also associations of general practitioners providing treatment on this basis ;

(*f*) non-provident dispensaries, voluntary clinics and other charitable medical agencies staffed by general practitioners ;

(*g*) the outdoor medical service provided by the County Councils and County Borough Councils for Public Assistance cases, including what were formerly called Poor Law Dispensaries, supplemented, in the County of London at all events, by certain consultative out-patient services at County Hospitals ;

(*h*) various public clinics or centres for particular classes of case, such as school children, tuberculosis, venereal disease, etc. ;

(*k*) the district nursing service, which supplies dressings and various forms of simple treatment in patients' own homes.

Hospital Consultants.

112.—For the purposes of this discussion the visiting staffs are of course the primary agency to which all the others are the alternatives ; and we have only to consider how far they are an appropriate agency for the treatment of minor cases, and how far they do under present conditions actually treat such cases.

113.—There is universal agreement on the subject of the ability and competence of the visiting physicians and surgeons. They are the basis both of the reputation of the hospitals and of the claim that through the hospitals the poor can receive when they need it the same skilled attention as the rich. It is the consultant that the patient wants to see and for whom he is willing, we are told, to put up with long waiting.

114.—These are amongst the reasons for maintaining the principle that patients desiring a second opinion should be able to go to a hospital without having first to get the consent of any outside doctor. But it does not follow that it is practicable, or even desirable in the interests of the patients, that an interview with a consultant should be the normal method of obtaining medical attention. It was hospital consultants who expressed to us the opinion, in support of the scheme for compulsory doctors' letters, that, as medicine and surgery became more and more specialized, the experience of the hospital consultant, however pre-eminent he might be in his own sphere, often tended to become comparatively limited, particularly in special departments, and that it was better as a rule for a patient to be in touch with a general practitioner and to go to him in the first instance. It was also submitted that in the numerous major cases where the services of the hospital consultant were required, his superior skill and experience were largely neutralised by the enormous mass of material with which he had to deal. It was another consultant who spoke of the visiting staff as being overburdened with people with very little the matter with them who ought to be treated by general practitioners.

115.—The extent to which the visiting staffs do in actual practice treat minor cases is difficult to ascertain. One argument used for the exclusion of such cases is that they take up the time of the highly-skilled consultants to the detriment of the more serious cases ; another argument used, in answer to the plea that they should be freely admitted for the purposes of medical education or in order to ensure that the best skill is available for them, is that they are usually treated by juniors and never see the visiting staff at all. Both these arguments cannot apply to the same place at the same time ; and the truth is probably between the two. The different hospitals, and even the different medical men, appear to have different methods, and these are not formulated in any rules.

116.—For example, in the out-patient department proper, the distinctive feature of which is the attendance of the visiting staff, it is a common practice for the consulting physicians and surgeons to be accompanied by qualified assistants of various degrees of experience and status—house physicians, house surgeons, registrars, resident medical officers, clinical assistants—all working under their immediate supervision, sometimes in the same room with them, sometimes in adjacent rooms in the same suite.* An assistant may treat patients after his chief has seen them all and has selected

* We discuss in the next sub-section the work of junior medical officers who see patients elsewhere, and not as personal assistants to a particular physician or surgeon whose patients they are.

those he wishes to keep for himself; or the assistant, if of appropriate status, may see them all first, pars.
except those who come with doctors' letters or with references from some other department, and the chief may confine himself to these and to such of the others as are referred to him by the assistant.
At some hospitals the consultant sees all the new patients in the out-patient department, while 223
leaving the old patients to his assistants except those that he specially reserves for himself.

117.—On the other hand, where all cases are sifted in the casualty department before they reach the out-patient department proper, a work usually done by juniors or assistants of suitable qualifications, we have already mentioned that there are important hospitals where members of the 75
consultant staff attend in the casualty department and themselves sort patients, referring the minor cases to juniors and keeping for themselves those which require their personal attention for the purpose either of treatment or of teaching. This method occurs in at least two different forms which 234
we shall describe when we come to deal with details of procedure.

118.—We have already referred to the fact that divisions of opinion on the question, how far the work of a hospital should aim at being consultative, exist amongst the members of the medical 73
staffs of different hospitals or even of the same hospital, as well as amongst the lay members of committees. It is certainly essential that, whatever line of policy on this subject is adopted by a hospital, it should be such as will secure the support and co-operation of the consultants, with whom it will largely rest to apply it in practice.

Junior Medical Staff.

119.—In so far as minor cases are not treated by the visiting staff of consultants there are practically only two alternatives: either they must be treated by the junior medical staff of the hospital, or they must be referred elsewhere to be treated by general practitioners. At every hospital a greater or smaller number of minor cases are in fact treated by the junior staff.

120.—The term junior staff is here used to include all the qualified medical and surgical officers except the visiting consultants. The juniors may range from recently qualified house physicians or house surgeons up to medical or surgical registrars or casualty officers with some years of experience and sometimes of consultant status.

121.—The duties allocated among the various grades of junior staff differ, like many other things, at different hospitals, but they usually consist of one or more of three functions. They may sift new patients into major cases who need the services of the visiting staff and minor cases who do not, unless this is not done at all or is done by the visiting staff themselves; they may treat on their own responsibility minor cases who do not need the services of the visiting staff, or old cases which no longer need them; and they may act as assistants to the visiting staff in the treatment of cases which have been referred to the latter or which have reached them direct. They may or may not have power to refer to other agencies such minor cases as do not come within the hospital's definition of medical suitability.

122.—The first of these, the sifting of patients into major and minor, will be discussed in a later 227
sub-section. It may be performed either in the casualty department or in the out-patient department 230
proper. The third, the work of the junior staff when acting as personal assistants to the visiting staff in their consulting rooms in the out-patient department, is closely bound up with the work of the hospital consultants, and has already been described in that connection. We are here concerned with 116
the second, in which the junior staff acts as an alternative to the visiting staff in the treatment of minor cases.

123.—The treatment of minor cases by the junior staff may be done either in the casualty department or in the out-patient department; or some patients may be treated in one and some in the other. Where the treatments are done in both, the more trivial cases are often seen in the casualty department, which is staffed for this purpose by comparatively recently qualified men, such as house physicians and house surgeons, perhaps under the supervision of a resident medical officer; while the less trivial cases are often dealt with in the out-patient department by more experienced officers, such as medical or surgical registrars. It is sometimes the rule that the casualty department staff may not see any case more than a limited number of times—perhaps once, perhaps three times—without referring the patient to the out-patient department. If the casualty department is a large one, and is used not only for the treatment of large numbers of casual patients and other minor cases, but also as the sifting place through which major cases without doctors' letters reach the out-patient department, it may itself have a large staff of comparatively experienced residents.

124.—The evidence which has been submitted to us on the subject of the efficiency of the junior staff has consisted chiefly of comparisons between their qualifications and those of general practitioners. It has been argued on the one hand that the junior medical staff have had a more limited experience than graduates who have worked both in hospital and in private practice; that they cannot know a patient's constitution and medical history as a family doctor can; and that their frequent changes of personnel make it difficult for the hospital to secure the carrying out of any

pars. consistent policy in the selection of patients. On the other hand, it is urged that they have the advantage of contact with the latest advances in medical science, that they are kept up to the mark by association with their colleagues, and that the brevity of their experience is more than balanced by the fact that they are under supervision and can, if occasion arises, call in the help of the highest experts and the other special resources of the hospital. To this extent the patient obtains the benefit of access to the visiting staff if he needs it, though he may not actually be seen by a consultant.

125.—But the question whether the junior staff of a hospital is the best agency for the treatment of minor cases is wider than the question of their efficiency for the purpose. A hospital might introduce a system by which the services of its visiting staff were limited to major cases, and all minor cases that presented themselves were treated by efficient juniors. Nevertheless, if this was done in the out-patient department, overcrowding and waiting might still remain; while if it was done in the casualty department, that department might become virtually a second out-patient department in which overcrowding and waiting might recur. It would therefore still be necessary to consider what alternative agencies there were to which a sufficient proportion of the minor cases could appropriately be referred.

General Practitioners.

126.—The typical function of the general practitioner is summed up in the words family doctor. He has received an all-round training at the hospital in medicine and surgery, and it has been supplemented by general experience outside. He is in a position to know a good deal about the medical history of his patient and about such of his circumstances, his home conditions, and his personal idiosyncracies as affect his health. He provides treatment at his surgery or in the patient's home as may be required.

127.—It has been submitted to us that, for these reasons, he is able both to know his patient better and to look at him from a wider point of view than is possible for the hospital consultant, that his experience is longer and more general than that of the junior medical officers, and that in ordinary circumstances he is often better able than either of these to give advice or treatment which is suited to the particular case.

128.—It is therefore urged that the medical service of the community should be so organised that minor cases should normally be treated by general practitioners, and should attend hospital only in exceptional circumstances, when the services of these are unavailable or when some special diagnosis or treatment outside their scope is required.

129.—It is submitted that the consequent closer co-operation between the hospitals and the general practitioners would increase the knowledge and experience of each through contact with the other, and would thus improve the whole medical service, to the great benefit of the patients.

130.—As all the agencies for the treatment of minor cases, except the hospitals, are staffed by general practitioners or by medical officers doing similar work, the arguments for and against these views will apply to all of them.

131.—Whatever the conclusions may be, so large a part of the medical service of the community must be carried out by general practitioners that it is highly desirable that in any plans for its better organisation their sympathy and co-operation, as well as that of the hospital staffs, should as far as possible be secured.

(a) In Private Practice.

132.—The question, how far the general practitioner in his ordinary individual private practice can be regarded as an alternative for the treatment of minor cases now attending as hospital out-patients, is merely another form of the question, how far these patients are in a financial
102 position to pay a doctor's fee at the time of their illness. We have already discussed this under the
252 heading of financial suitability, and shall refer to it again when describing the methods by which that suitability is ascertained. The proportion of hospital patients whom it directly affects has been greatly reduced by the introduction of the National Insurance System, though they still include all the dependants of insured persons.

(b) In National Insurance Practice: Panel Doctors.

133.—The National Health Insurance system provides insured persons with "all proper and necessary medical services other than those involving the application of special skill and experience of a degree and kind which general practitioners as a class cannot be expected to possess." These services are provided by National Health Insurance practitioners, popularly known as panel doctors. Each of these receives, out of funds provided by the contributions of the insured, their employers, and the State, a fixed annual payment for every insured person on his panel, irrespective of the amount of medical attention required. This service does not extend to the dependants of the insured.

134.—It is therefore submitted to us that all insured patients suffering from minor ailments have already a medical service at their disposal without charge, and that there is no need for treatment to be provided for them by the hospitals.

pars.

135.—We have found it impossible to estimate the proportion of hospital out-patients to which this argument would apply. Of the general practitioners in the County of London, 2,250, or about 70 per cent., are on the panel, and there are about 1,800,000 insured persons.

136.—On the question of the financial suitability of insured patients for hospital treatment when suffering from minor ailments, there is no doubt that they could without hardship be referred by the hospitals to their panel doctors, since they would not have to pay either for treatment or for a letter of recommendation to the hospital if need arose. On the question of their medical suitability the arguments are the same as those which apply to any other patients whose treatment is within the scope of general practitioners, except in so far as there may be anything in panel practice which tends to make it less efficient or less desirable than private practice.

137.—On this point we have had many arguments put to us on both sides. It has been suggested that some of the conditions of National Insurance practice do not make for efficiency : that the panel doctors, especially those in large industrial areas or those with considerable private practices as well, have too many patients and cannot give adequate time and attention to them ; that the examination their patients receive is too often perfunctory and the treatment mere routine ; and that this is why so many patients prefer the hospital, where, even if they have to spend time in travelling and in waiting, they are certain of thorough and careful attention.

138.—On the other side, we heard witnesses from the London Panel Committee, a statutory body consisting of representatives of panel practitioners and of certain other medical interests, including the consulting staffs of medical schools. They pointed out that each doctor's panel was limited to the maximum of 2,500 agreed to by the various bodies concerned as having been found by experience to be a number that could be satisfactorily dealt with in addition to private patients, since only a small percentage of the 2,500, of course, would be ill at any one time ; that the average panel was only about 1,200 ; that if patients were dissatisfied, and did not recommend newcomers in sufficient numbers to replace the annual wastage, the size of a panel would soon fall ; and that dissatisfied patients, moreover, could change their doctor either with his consent or after a very short delay. They had often heard the charge of perfunctory treatment, but they maintained generally that it was not justified, and that the attention given by panel doctors to their patients was if anything more than could be given at out-patient departments, in what they described, from their experience in their practices, as being the present overcrowded conditions in most of the big hospitals.

139.—Witnesses from the British Medical Association, including hospital consultants, said that all their experience showed that the great bulk of panel practice was carried out honestly and with very great skill. They thought that a patient's preference for hospital was often due to his not realising that the services rendered by the two were altogether different. They admitted that patients had some ground in history for thinking that they got the best treatment at hospital ; but said that there was machinery in the panel system for remedying any neglect of duty on the part of insurance practitioners and that it was better for this to be used than for the hospitals to do their work for them.*

140.—We do not feel called upon to pronounce an opinion on the merits of the panel practitioners. With so large a body of doctors and of patients there are certain to be some of all sorts. We can only set out the arguments as part of the evidence on the value of the panel system as an alternative agency for minor cases.

141.—Further evidence can be derived from the experience of hospitals in dealing with cases referred by panel doctors to the out-patient departments or by the hospitals to the panel doctors.

142.—The panel doctor is under an obligation to advise his patient how to obtain any further advice or treatment which is required, and he frequently carries this out by sending him to hospital for a second opinion. It is said that large numbers are so sent ; that there are more than used to be sent by clubs or private practitioners, though some hospitals find that the numbers from panel doctors and from private doctors are now about equal ; that many panel doctors write detailed letters giving excellent information about the case, thus rendering the consultant valuable assistance and saving the patient's time ; but that many others send their cases with only visiting cards or pieces of paper 199
which are of no use except by enabling the hospital to communicate with the doctors ; and that there are some who send cases to the hospital not because they are difficult but because they are troublesome, 208
sometimes even after the hospital has already referred the case back.

143.—The London Panel Committee said that they were satisfied that most panel doctors sent only cases needing a second opinion : there was only a small percentage of exceptions and they would talk straight to them if they found them. They considered that the great majority would be prepared to give the desired particulars, especially if forms were agreed upon for the purpose. They suggested that the development of a consultative system depended largely on the hospitals, who now treated many patients who might be referred to their panel doctors, and even retained cases which had been sent up for diagnosis and report. The insurance practitioners suffered, of course, no financial loss by this ; their reason for making the complaint was that they desired the satisfaction of doing their

* There is a body sitting fortnightly to hear complaints. It consists of three doctors, three representatives of Approved Societies, and a neutral chairman.

pars. full duty by the patients ; they objected on public grounds to duplication and overlapping as a waste of charitable funds, and they believed that co-operation on consultative lines would be better for the patients, better for the panel doctors, and better for the hospitals.

144.—There seems to be no doubt that this kind of co-operation is increasing. We shall
199-213 discuss later on certain detailed suggestions that have been made for improving the procedure. On
67 the general question we have already mentioned that various hospitals have adopted definitions of medical suitability which exclude insured persons, at all events after one attendance, and some of the largest of these now display notices in their casualty departments to the effect that insured patients
241 will not be treated unless they bring a letter from their panel doctor explaining why the help of the hospital is desired, though in special cases a discretion is left to the medical staff. Evidently the experience of these hospitals goes to show that considerable use can be made of the National Insurance service as an alternative agency for the treatment of minor cases, and that the numbers attending the out-patient and even the casualty departments can be reduced thereby.

Agencies on a Basis of Voluntary Insurance.

145.—Before the National Insurance Act, general practitioner treatment was provided on a fairly large scale either by private doctors through some form of contract or club practice, or by means of provident dispensaries.

(i) Provident Dispensaries.

146.—Members of a provident dispensary pay a weekly subscription and receive ordinary treatments either there or in their homes from the doctors attached to it, special or consultative cases being referred to hospital out-patient departments. The dispensary is sometimes partly financed by voluntary subscriptions, and it is usually managed by a committee which may represent members and subscribers and which appoints the medical staff.

147.—A great deal of the work for which provident dispensaries were established is now done by the National Insurance System, and the number of dispensaries and of members has greatly declined. The Medical Advisory Committee of the Charity Organisation Society has recently held a conference on the subject and has given us figures which show that in 1910 there were 53 and in 1929 only 16, and that the membership had fallen from 86,000 to 25,000 and the numbers treated in the year from 28,000 to 5,000. This decline is attributed mainly to the Insurance Act, but partly also to the establishment of public clinics for certain classes of case, and partly to the rapid growth of the Hospital Saving Association, which was founded for the assistance of hospitals, and whose contributors are therefore excused further payment at a hospital but not at any other institution. Some dispensaries also have suffered from movements of population away from their neighbourhoods.*

148.—In some areas, however, the provident dispensaries still remain active, and they have been mentioned to us as one of the alternative agencies for the provision of general practitioner treatment for uninsured persons who are not in need of public assistance but would have difficulty in paying doctors' fees if they did not make provision in advance. We gather that some of the hospitals are quite prepared to refer such cases to a provident dispensary if there is one in the neighbourhood, and if the patients are willing to join it. One large teaching hospital recently gave the secretary of the local provident dispensary facilities for interviewing the patients in the out-patient department, but without effect, the patients being apparently quite satisfied with the conditions at the hospital. The medical staff of the hospital have, however, recently passed a resolution in favour of the principle, and the efforts are to be continued. Most hospitals report that there is no strong dispensary near by.

149.—We think it desirable that wherever an efficient provident dispensary exists its use should be encouraged as a method of providing general practitioner treatment for patients who can afford its weekly subscription but cannot afford more expensive methods.

(ii) " London Public Medical Service."

150.—New agencies for the provision of general practitioner treatment on somewhat similar lines have recently been established under the title of " Public Medical Services," and we received evidence from the " Public Medical Service for London." This aims at supplying medical attention of a good general practitioner type to the dependants of insured persons and to others in similar economic positions. We are informed that 425 doctors are now members and that there are 13,500 subscribers. The weekly subscription ranges from 4d. to 1s. 1d. according to the size of family, and has been fixed on an economic basis with the idea that this would enable a better service to be supplied. A subscriber has free choice of doctor amongst the members willing to attend him, and there is freedom of change on either side at short notice. Certain special services are the subject of extra charges. An introduction to a hospital consultant is given when necessary, and a special form is used for this purpose. The service is governed by central and local committees of doctors, which provide subscribers with a channel for complaints.

* Particulars of these institutions in the County of London will be found in a Survey of Medical Services in London, now being prepared by the London Voluntary Hospitals Committee and the London County Council with the co-operation of the Metropolitan Borough Councils.

151.—The witnesses representing the service submitted that it provided a suitable means of treating, on family doctor lines, very large numbers of those who at present crowded the out-patient departments by attending for minor ailments, but who could afford to pay for their treatment by making provision in advance. They wished for an arrangement with the hospitals by which the hospitals should, for the treatment of minor ailments, refer such patients to the Public Medical Service, the service referring its subscribers to the hospitals when consultative treatment was required.

152.—While we are not in a position to express an opinion about the merits of any particular association of medical practitioners, it seems to us that these witnesses presented a strong prima facie case, and that their suggestion deserves full consideration by the hospital authorities.

Non-Provident or Charitable Dispensaries.

153.—There are a number of dispensaries which are not on a provident basis but which aim at providing, largely out of endowments or charitable subscriptions, the medical treatment of patients who are suffering from minor ailments and who cannot afford to pay private doctors. They are independent institutions and vary in their constitutions and methods. At some of them the patients are treated free, at some they are assessed for voluntary payments, and at some the subscriber's letter system is in operation. They are usually staffed by local doctors, though there are sometimes whole-time medical officers as well. Unlike the hospital out-patient departments, they do not, as a rule, provide consultative services, though there are one or two which have a staff of consultants and elaborate equipment. Nor do they command access to beds. On the other hand, their medical officers attend patients in their homes when necessary.

154.—The figures supplied by the Charity Organisation Society show that the work of these dispensaries also has decreased considerably in recent years. There were 21 in 1929 as against 31 in 1910, and the number of patients had fallen from 188,000 to 84,000. The Society told us that there were several that were very efficient and quite well known in their own districts ; and suggested to us that use might be made of them to relieve the out-patient departments of part of the crowd of minor cases.*

155.—We gather from the hospital evidence that where there is an active dispensary in the neighbourhood cases are sometimes referred to it. One hospital sends cases that need only repeat medicines, the dispensary referring them back if any special diagnosis or treatment is required. Another refers cases to a local dispensary only if they are uninsured, if they live near it, and if they are unable to come to the hospital. In this case the hospital and the dispensary had discussed the question, but had been unable to arrive at any suitable arrangement for more general co-operation.

156.—We should have to make a considerable extension in the scope of our inquiry before we could form any opinion as to the suitability of the various dispensaries as alternative agencies for the treatment of out-patients suffering from minor ailments. So far as we could ascertain they are not represented by any central association which could give us information on the subject. It is quite possible to conceive of a scheme of co-operation by which each hospital should refer some of its minor cases to local dispensaries, where they could be treated by general practitioners either at the dispensary or in their homes, or where they could receive simple dressings or be supplied with medicines while still under the care of the hospitals. If there are, or could be established, an adequate number of efficient dispensaries in the confidence of the hospitals, and if there are a sufficient number of patients who cannot afford to join any provident agency and yet cannot be appropriately referred to the Public Assistance Authority, a scheme for decentralising the treatment of appropriate minor cases in this way might well be worth considering. But we have not the information to enable us to form an opinion on these two points; and possibly no such information could be available until the co-ordination of medical agencies has made more progress, or at least until the possibilities of the provident method have been more fully tried, and until more is known of the effects of the recent changes in the district medical services now under the Public Assistance authorities.

Voluntary Clinics.

157.—The British Red Cross Society has a clinic for rheumatism which provides treatment for all classes of adults, but not for children. Patients must send or bring a recommendation signed by a doctor, and the medical officer of an out-patient department can therefore send a patient with a letter. All consultations are by appointment, which can be made by interview or by post. All recognised methods of physical, medicinal, vaccine or immunisation treatment are provided. There is a minimum fee of 4s. per attendance, subject to arrangements with the almoner for patients unable to pay that amount.

158.—There are a few other voluntary clinics for sunlight, orthopædic or other special treatments, particulars of which will be contained in the Survey.*

* *See* note on p. 22.

pars.

Medical Services of Public Assistance Authorities.

99 159.—We have already referred to the conflicting arguments, from the side of the voluntary hospitals, on the question whether patients who are suffering from minor ailments, and are so poor that they need non-medical public assistance, should be treated by voluntary hospitals or should be referred to the medical service provided by Public Assistance Authorities. We have now to consider the light which is thrown on this question from a study of the character and conditions of that service. By far the most important of these authorities in the King's Fund area is the London County Council, which has kindly furnished us with a written statement on the subject.

(i) London County Council.

160.—The London County Council provides or arranges for three medical services for out-patients : (i) a small number of hospital out-patient departments used for certain specified kinds of case, including consultative cases sent by the Council's own medical officers ; (ii) outdoor medical relief ; (iii) medical treatment centres for certain kinds of patients for whose treatment the Council
173 has some direct responsibility. Of these services we shall discuss the third later on. Only the first and second are concerned with the public assistance patients. These patients, if major and needing a consultative opinion or treatment, are dealt with by the first. Minor cases, which are our primary interest at present, are dealt with by the second. Nevertheless, to avoid misapprehension, it will be well first to explain what is provided by the London County Council out-patient departments and, consequently, what is not.

161.—As a result of the Local Government Act, 1929, the London County Council has taken over from the late Guardians a number of general hospitals, and has placed them under the control of its Central Public Health Committee, not of the Public Assistance Committee. Of these hospitals, 28 are to be used largely for acute cases, including patients in receipt of public assistance, but including also other patients.

162.—Of these 28 hospitals, 9 have definite out-patient departments, although the others deal with casualties and also with continuation treatment for old in-patients. There is also a small amount of after-care out-patient work at a few of the Council's special hospitals.

163.—The out-patient work of the hospitals is limited strictly to six definite kinds of cases, which may roughly be grouped under the following three heads : (*a*) emergencies ; (*b*) cases for which the London County Council has already taken responsibility, such as former in-patients and maternity cases ; (*c*) consultation cases referred by medical officers of the Council, including the district medical officers who administer the outdoor medical relief. Any patient presenting himself at one of the Council's out-patient departments on his own initiative, whether with or without a doctor's letter, is examined, and if necessary treated. He will not be treated again unless he comes within one of the above-mentioned classes. If he has no private or panel doctor and cannot afford one, he is advised to apply for outdoor medical relief from the district medical officer, who can, if necessary, refer him to the out-patient department for consultative or specialist treatment.

164.—So far as concerns the treatment of public assistance cases suffering from minor ailments, the service supplied by the London County Council does not consist primarily in the provision of out-patient departments attached to hospitals, since these out-patient departments treat only cases which cannot be adequately dealt with by the district medical officers. It consists of the outdoor medical relief administered at centres which used to be called poor law dispensaries, but are now known as outdoor medical relief stations. There are 70 centres of various kinds in the Administrative County.

165.—These outdoor medical relief stations are staffed partly by whole-time officers of the Council who are also assistant medical officers in the Council's hospitals, but mainly by general practitioners. Most of the latter are part-time officers in general practice, some having panel patients. The Council is bringing them more and more under the supervision and control of the medical superintendents of the Council's hospitals and into close touch with the consultative service provided at these hospitals. If necessary the medical officers attend patients in their homes, and nursing at home, if needed, is supplied by arrangements which the Council has made with District Nursing Associations.

166.—Persons needing medical relief may apply to the relieving officer on their own initiative, or the relieving officer, in the course of administering non-medical public assistance to an individual or family, may discover the need for medical relief and himself call in the district medical officer or may direct the patient to him. Patients who can afford to pay are assessed at an appropriate amount.

167.—One of the changes resulting from the transfer of the Poor Law Medical Service to the London County Council is that, so far as major cases are concerned, the necessary consultative out-patient service is now supplied by the Council. If, therefore, minor cases needing public assistance are referred by the out-patient departments of the voluntary hospitals to the outdoor medical service provided for them by the Council, there will no longer be, as there often was under the Guardians, any reciprocal reference of consultative cases by the district service to the voluntary hospitals. From the point of view of overcrowding in voluntary hospital out-patient departments this might mean that the relief would be two-fold.

168.—As the London County Council is prepared to deal with all cases in receipt of public assistance through their district medical service, supplemented by their consultative out-patient departments, we think that the hospitals should consider the desirability of referring to the County Council all cases which are already in receipt of non-medical public assistance.

169.—The question of out-patients who are too poor to benefit by hospital treatment unless supplemented by non-medical public assistance but who are not actually receiving it, is more difficult.* As described to us by the witnesses from the Charity Organisation Society, the old objection to the Poor Law is still very strong, in spite of the change of authority and of name. Where this objection deters the sick from obtaining the assistance which they need, and which they cannot get from any other source, its removal is to be welcomed. But where it is the result of a desire for independence and an expression of self-respect, and where the voluntary hospital, with the help of its almoner's department, can give effective aid in such a way as to foster these qualities, then the hospital may well be reluctant to exclude the patient. This argument would not, however, apply to cases which are already in receipt of public assistance or which cannot be effectively helped in any other way, and of such cases there are probably a considerable number.

(ii) Other Public Assistance Authorities.

170.—We have not made any similar detailed study of the facilities provided by the other County Councils and County Borough Councils the whole or part of whose districts are included in the King's Fund area.† Each of these affects only a small number of hospitals in that area, and most of them affect a much larger number outside. It seems to us better, therefore, that, if any inquiry is needed, it should be made locally by the hospitals affected. The general facts as to the nature and conditions of the facilities available for minor cases are not likely to differ very much from those here described.

Public Clinics or Centres for Special Classes.

171.—Public medical treatment centres or clinics have been established in the County of London by the London County Council and by the Metropolitan Borough Councils to provide certain kinds of treatment for special classes of persons resident in their respective areas. As we have already seen, a good many hospitals regard as unsuitable those patients who are already thus provided for at a cost within their means.

172.—Some of these centres or clinics are held at hospital out-patient departments, though the work is generally kept distinct from the ordinary out-patient work of the hospital and is done at different hours.

(i) London County Council.

173.—The London County Council provides medical treatment centres for school children, and clinics for the treatment of venereal disease, and there are also psychiatric centres at three of the County hospitals. The tuberculosis dispensary service for the County is part of the Council's tuberculosis scheme, but is provided by the Metropolitan Borough Councils.

174.—The school treatment centres are open to all children between the ages of 5 and 14 attending London County Council schools, and suffering from enlarged tonsils and adenoids, dental defects, refraction, ringworm and minor ailments, including such conditions as impetigo, discharging ears, conjunctivitis, and such other ailments as require daily treatment by nurses. Children do not use the centres until the Council is satisfied that the parents are unable to obtain treatment privately. Charges are made to the parents on a definite scale, though for necessitous children the charge may be reduced or remitted. Most of the cases treated at the Council's "minor ailments" centres are of a kind for which children would not in any event be brought to a hospital out-patient department.

175.—The venereal diseases clinics are open to any patient at any time without charge.

(ii) Metropolitan Borough Councils.

176.—Metropolitan Borough Councils provide various medical services under the Maternity and Child Welfare Act, 1918, the Tuberculosis Regulations of 1912 and 1930, and the Public Health (London) Act, 1891.

177.—For maternity and child welfare there are in London between two hundred and two hundred and fifty centres which are either municipal institutions or in receipt of subsidy from the Borough Council in whose area they are situated. Patients usually attend in the first instance at the suggestion of the health visitors for the Borough. Treatment is normally given only for minor conditions, and cases requiring continued medical care are referred in the first instance to their own medical practitioners, or, if they have not got one, to special clinics or to hospital out-patient departments. The provision of special centres such as sunlight, electrical, and massage clinics is increasing. Advice is generally free, and medicines are usually supplied at cost price.

---

* *See* note on p. 16.

† The King's Fund area includes the County of London, such parts of Middlesex, Herts, Essex, Kent and Surrey as are within 11 miles of St. Paul's, and the County Boroughs of West Ham, East Ham, and Croydon.

pars. 178.—Tuberculosis dispensaries are provided in every Borough. A practitioner diagnosing tuberculosis must notify the Borough Medical Officer of Health, whose health visitors will then investigate and bring the dispensaries to the patient's notice. Many patients, however, having no practitioner, drift to the hospitals; but the latter can always refer such cases after diagnosis to the T.B. dispensaries. Recourse to hospital out-patient departments for consultative purposes is only rarely necessary. No charges are made in connection with this service.

179.—Various centres and clinics have been provided by the Borough Councils under the Public Health (London) Act, 1891, for residents in the respective Boroughs. These include at least one example of each of the following, namely: centres for orthopædic, cancer, foot, dental, and bronchial inhalation therapy cases. The treatment in most of these might be described as semi-consultative. There are also provided certain rheumatism and other specialist services and a supply of insulin for diabetics. Home nursing is also provided by district nurses paid for by the Borough in connection with these services as well as with maternity and child welfare. Patients may reach these centres on their own initiative or directly or indirectly through the Medical Officer of Health or the health visitors. The Act gives power to provide a temporary supply of medicine and medical assistance for the poorer inhabitants of the Borough, but a charge of some sort within the means of the patient is made in some cases.*

(iii) Other Local Authorities.

180.—We have not collected any particulars of clinics or centres in the parts of the King's Fund area outside the County of London, for the reasons already stated in the section dealing with
170 Public Assistance medical services.

The District Nursing Service.

181.—The District Nursing Service provides skilled nursing in their own homes for patients unable to pay for private nurses. It is carried on in greater London by voluntary bodies known as District Nursing Associations. There is a Central Council of District Nursing in London to which 57 associations are affiliated. The number of visits paid by these in 1930 for general nursing, apart from maternity and midwifery, was over 1,260,000. This work was performed by about 380 nurses, of whom 214 belonged to associations in affiliation with the Queen's Institute of District Nursing, 92 were Ranyard nurses, and 72 belonged to other associations. There are also a small number of parochial nurses in individual parishes. Each association has its own area, and between them they cover practically the whole of Greater London, this co-ordination of their work having been facilitated by the assistance of the Central Council.

182.—The Associations derive their funds partly from voluntary subscriptions and donations, partly from grants from the Central Council, partly from payments by public bodies whose cases they nurse, and partly from contributions from patients who are asked to give what they can afford. With some of the newer associations, the patients' contributions are on a provident basis, whereby those who make regular payments of, e.g., 1d. a week obtain their nursing free. All these contributions go to the associations; the nurses are whole-time salaried employees.

183.—District nurses may be called in by doctors, by clergy or by social workers, and a considerable number of cases are referred to them by hospital almoners. The cases referred by hospitals include in-patients who can be safely discharged if they can receive some amount of nursing at home. But they also include out-patients who require only dressings or similar attention which can be supplied by a nurse. In this way the District Nursing Associations can relieve the out-patient departments of some part of the treatment of minor cases.

184.—The extent to which this takes place in practice depends partly on the hospital's definition of medical suitability as applied to such cases, and partly on the extent to which the almoner system has been developed by the hospital. Sometimes a hospital regards as unsuitable any case needing only minor dressings which can be thus supplied; at one large teaching hospital some 400 cases a year are sent away from the casualty department for this reason. Sometimes the hospital, through its almoner, arranges for the district nurse to carry out, in the patient's home, dressings or treatments which have been ordered by the hospital doctor and which would be applied by a nurse at the hospital were it not that the patient is not physically fit to make frequent journeys or cannot leave home for the necessary length of time. The case is thus regarded as being still under the care of the hospital, and when the patient next attends at the out-patient department the nurse will furnish the hospital with a report.

185.—The actual procedure for the reference of cases is that the almoner arranges by telephone for the District Nursing Association which serves the street in which the patient lives to send a nurse to the patient's home on a given morning or afternoon. The almoner then tells the patient that she has done so.

* Particulars of the number of patients treated in each Borough under the various headings in pars. 176–9 will be found in the Survey. *See* note on p. 22. For the above information we are indebted to the Metropolitan Branch of the Society of Medical Officers of Health.

186.—Witnesses representing the District Nursing service told us that where the almoner system was in full operation a large number of cases were referred in this way, but that many more might be sent from hospitals where the almoner did not see all the patients, and especially from casualty departments where the almoner might not see any patients at all. Even where the almoner system was well developed gaps frequently occurred, and this the witnesses attributed to the constant changes in the junior medical staff, since a house physician, for example, who had learned the value of the services of the district nurse might soon be replaced by one who had not yet done so. They gave us instances of patients whose condition had been made worse by frequent journeys to hospital for treatment by a nurse which could equally well have been applied at home.

187.—They submitted, therefore, that a considerable increase in the number of minor cases referred to the District Nursing Associations, for treatment of this kind, would both prevent hardship to patients and reduce the overcrowding of out-patient and casualty departments. The Central Council said that they had recently addressed a circular to the hospitals advocating increased co-operation, and that the replies showed that the suggestions had been approved and appreciated.

188.—The following are the kind of case which the witnesses regard as being most suitably dealt with at home :—

(i) Patients who have been discharged from the wards still needing treatment, and who are unfit or too far removed from the hospital to attend;
(ii) Any cases of dressing, e.g., leg or foot cases, where walking is detrimental to the condition, and where a doctor's advice is not necessary every day ;
(iii) Any child whose mother has to bring him to hospital every day, thereby leaving the rest of the family at home uncared for ;
(iv) Any mother who has to come for treatment for herself and has to bring one or more children with her because they are too small to be left at home ;
(v) Any mother who has to be dressed for a breast abscess or other ailment following confinement and is not in a good state of health ;
(vi) Carcinoma cases needing dressing, who are often very exhausted with the journey and with waiting for their turn ;
(vii) Gynæcological cases, especially where the woman or her home is not likely to be clean enough for her to be able to do the treatment properly at home by herself;
(viii) Eye and ear cases.

189.—The witnesses agreed that if it became the general practice at all hospitals for suitable cases from all the out-patient departments, general, special and casualty, to be referred to district nurses, this would mean a considerable increase in the work of the Associations. But they were confident that they would be able to cope with the increase so far as the supply of the additional number of specially trained nurses was concerned. The only problem would be the financial one of obtaining the necessary increase in funds

190.—In connection with the financial question they mentioned one difficulty which has already arisen. The Associations rely partly on voluntary payments from such of their patients as can afford to make them. But an ever-increasing proportion of their hospital patients subscribe to contributory schemes such as the Hospital Saving Association, which exempt them from further payment for hospital treatment. As their contributions would thus cover treatment by a nurse, including the necessary dressings, if given in the out-patient or casualty department, they expect them equally to cover exactly similar services if the hospital arranges for them to be given by a nurse in their homes. The view of the District Nursing Associations naturally is that, as they supply the service, they should receive the payment made on behalf of the patient for it.

191.—In order to form an opinion on this question it is necessary to take into account the following considerations :—

(*a*) The Hospital Saving Association was established to help the hospitals, and its members' contributions to it are, apart from the proportion allocated to non-hospital benefits, made definitely to cover their fair share of the cost of their hospital treatment when they are accepted by a hospital as suitable for treatment.
(*b*) Hospital Saving Association money is therefore not regarded by the Hospital Saving Association as available to pay the cost of treatment provided by other institutions for cases which are not regarded as suitable by a hospital : the Hospital Saving Association itself has adopted the principle that a hospital is not intended for trivial cases within the scope of a general practitioner.
(*c*) Hospital Saving Association money would therefore not be regarded by the Hospital Saving Association as being available to pay for the treatment of a minor case by an agency to which the hospital had sent that case away as not requiring hospital treatment, either because it had always been unsuitable, or because it was so far recovered as to be no longer suitable.
(*d*) The agency supplying such treatment for minor cases thus sent away would therefore have to obtain payment direct from the patient in so far as it relied for its funds on payments

pars. made by its patients, and the patients could be asked and expected to contribute towards the cost of such non-hospital treatment, irrespective of whether they had or had not contributed to the Hospital Saving Association in respect of hospital treatment.

(*e*) Some of the cases referred by hospitals to the District Nursing Associations are thus sent away by the hospital as being unsuitable.

(*f*) A large proportion, however, of the cases referred by the hospital almoners to the District Nursing Associations have not been sent away as being unsuitable or as being capable of being treated by a general practitioner, but are regarded by the hospital as being still under its care, and as being treated by the district nurse under the orders of the hospital doctor.

(*g*) As the Hospital Saving Association pays the hospital so much per out-patient and not so much per attendance, the hospital receives from the Hospital Saving Association in such cases the full payment for the patient, just as if the hospital supplied the whole of his treatment and his dressings; whereas in fact part of these, and perhaps a part representing the great majority of the attendances, is supplied by a District Nursing Association. Thus, to take an extreme instance, a hospital might receive 7s. for a patient who attended ten times and was seen by a doctor on the first and tenth attendance and by a hospital nurse on the other eight. If these other eight treatments were given by a district nurse in the patient's home, the hospital would still receive 7s.

192.—The following alternative suggestions have been made for meeting the difficulty so far as it affects patients who are regarded as still under the care of the hospital, i.e., such cases as those described under (*f*) and (*g*) :—

(i) that the hospital should pay over to each District Nursing Association a share of the Hospital Saving Association payment proportionate to the share of the work done by the nursing association, as representing the patient's fair share of the cost of the work of the nurse ;

(ii) that the hospital should itself bear the cost of the work of the nurse, or at least of some part of it, e.g., the supply of dressings : we are told that the supply of dressings to a nursing association to be applied by a nurse, instead of their issue to the patients themselves, sometimes proves a great economy; and this might, under this alternative, be itself an argument in favour of the reference of more cases to district nurses ;

(iii) that the Hospital Saving Association should include this form of home nursing amongst its non-hospital benefits, should make to the District Nursing Associations a payment corresponding to the patient's fair share of the cost, and should make a smaller payment to the hospital proportionate to the work actually done by the hospital ;

(iv) that the King's Fund should set aside each year a sum for grants to District Nursing Associations, or to the Central Council, on the basis of the work done by the district nurses for all the hospital cases taken together, and should, in apportioning the resulting reduction in the amount available for grants to hospitals, take into account the amount saved to each hospital by the work done for its cases by the district nurses ; or, alternatively, should earmark for this purpose a proportionate amount of its grant to each hospital.

There seems to us to be much to be said for each of these suggestions, though their relative advantages may depend on practical considerations known only to the parties concerned.

193.—The evidence which we have received on the subject of District Nursing points to the following conclusions :—

(i) that it affords a very useful alternative for the treatment of minor cases of the kinds described ;

(ii) that it can be advantageously employed for such cases, not only when the hospital has decided that the individual patients are unsuitable and can be sent away as not needing hospital treatment, but also when the hospital regards them as being still under its care and the nurse as treating them on its behalf ;

(iii) that it is therefore particularly useful as a method of reducing the numbers of minor cases of the kinds mentioned, because it can be employed by hospitals whose definitions of
65 medical suitability would include these cases as well as by hospitals whose definitions would exclude them ;

(iv) that a considerable increase in the numbers referred to district nurses, from casualty departments and special departments as well as from general departments, would be advantageous both to the patients and to the hospitals ;

(v) that such an increase would involve the District Nursing Associations in considerable increased expense, and that additional funds for the work of the Associations would be required ;

(vi) that the parties concerned should therefore make a serious effort to find a solution of the particular financial difficulty described in the preceding paragraphs, either by one of the methods there suggested, or by some other method, so that a fair payment may be made to the District Nursing Associations for work done by them.

D. CO-OPERATION BETWEEN THE HOSPITALS AND THE OTHER AGENCIES.

194.—If it be granted that these outside agencies could be so developed as to provide between them the medical services required by a large number of the minor cases at present treated by hospitals, and that it would be desirable that the hospitals should be relieved of some of these cases, then the further question arises whether the procedure for this object would consist in the hospitals merely excluding the patients as being more suitable for treatment elsewhere, or whether there should be more systematic co-operation between the hospitals and the other agencies. If such increased co-operation is desirable and practicable, it would clearly be an important further step in the co-ordination of the medical services of the country.

195.—From the point of view of the provision of treatment for individual cases, co-operation naturally takes the form of the reference of such cases by the hospitals to agencies providing general practitioner treatment, and the reference of cases by such agencies to the hospitals for consultative or specialist services. This applies to all the alternative agencies which we have discussed, except the outdoor medical service of the London County Council or of any other Public Assistance Authority which itself provides consultative diagnosis and treatment for its own cases; the District Nursing Service, in so far as this deals with patients who are still under the care of the hospital; and some of the clinics for special diseases.

196.—It follows therefore that the form of co-operation in question amounts to co-operation between hospitals and general practitioners, whether these practitioners treat the minor cases in their individual capacity or as the medical officers of some institutional agency.

Co-operation between Hospitals and General Practitioners.

197.—The development of the consultative side of an out-patient department, whatever form it might take, and whatever proportion it might bear to the other activities of the department, would necessarily involve more and more of this kind of co-operation between the hospital and general practitioners. Its advocates claim that this would be one of its great advantages. The general practitioners would benefit by being brought into more frequent touch with the visiting staff and with the latest improvements in medical science. The visiting staff would not approach the patient as if the occasional visits to hospital were the only kind of medical attention he received, and as if his dossier in the hospital registry contained the whole of his medical history, but would take into account the family doctor as part of the environment affecting his past, present and future condition. The medical students would realise more clearly the relation between the science of medicine and its application to everyday life, and, when qualified, would regard the hospital, not as a place of education which they had left behind, but as an important part of the available facilities for the efficient conduct of their practice.

198.—If these benefits are to follow, the consultative side of the out-patient work must include consultation as the term is used in private practice; that is, as involving mutual communications between the general practitioner and the hospital consultant, whereby each obtains the information which he requires and which only the other can supply.

(i) Introductions from Doctors and Reports from Hospitals.

199.—In this connection the hospitals complain that general practitioners often send patients with only a visiting card or a scrap of paper which gives no information about the case. The Hospital Saving Association also states that doctors frequently regard the giving of a recommendation as a mere formality. On the other side, witnesses representing general practitioners have suggested that doctors are deterred from sending patients for consultation because it has been found by experience that the hospitals keep them as out-patients until they are well, without making any communication to the doctor who has sent them.

200.—At the same time, it is clear that in a large number of cases the general practitioner does send a letter giving more or less adequate information as to the history of the case and of the reasons why he considers that it requires a second opinion or possibly some specialist treatment; and that the hospital consultant replies by sending a report to the general practitioner indicating the results of his examination and giving advice as to further treatment either by the general practitioner or by the hospital, according to the circumstances. This is particularly likely to happen when the introduction from the general practitioner is addressed to a member of the visiting staff and not merely to the hospital. If the consultant wishes to retain a case for teaching purposes, he often asks and obtains the consent of the general practitioner.

201.—The procedure followed by members of visiting staffs in sending reports to general practitioners varies. Sometimes this is done only when the patient has brought a letter, and not merely a visiting card. Sometimes it is done only when the case is referred back to the general practitioner and is not retained for treatment at the hospital. Some consultants write the reports

pars. themselves, either at home from their notes or while actually at the hospital. They prefer this as the most personal method of keeping in touch with the general practitioners. At some hospitals shorthand writers are placed at the disposal of the visiting staff for the purpose. Sometimes the report is drafted by a medical clerk or other student, and this is said to be excellent educational practice. Sometimes it is written by a registrar or other qualified assistant. Sometimes printed forms are provided which reduce the amount of writing to a minimum.

202.—The use of printed forms has been recommended by several witnesses, not only for the reports by hospitals to general practitioners but also for the recommendations by general practitioners to hospitals. Some hospitals provide them for the latter purpose when writing to a doctor about some patient who has come without a letter. They have the great advantage that they contain a space in which the doctor is invited to give information about the case, and they thus emphasise to him the importance of this information to the hospital. The London Public Medical Service has a form in two parts for the use of its members ; one part is filled in by the doctor and kept by the hospital, and contains the history of the case and the treatment already given ; the other is filled in by the hospital and returned to the doctor, giving the consultant's diagnosis and stating whether he advises treatment as an in-patient or as an out-patient or at home. The London Panel Committee were at one time proposing to draw up a form, and we understand that the British Medical Association, which includes representatives both of hospital consultants and of general practitioners, has a model form in preparation.

203.—We are strongly of opinion that a standard form would be of great value. A good deal of experience has been gained by hospitals and general practitioners who have used the various alternatives already in existence. We suggest that the King's Fund might well co-operate in securing
207 the adoption of a form which will be acceptable to all concerned, and which could also be used for the purpose which we suggest in the next sub-section.

204.—We are also in favour of the provision of shorthand or dictaphone and typing facilities by the hospitals for the use of such of their consultants as would be glad of them. We anticipate that the need for this will increase as the consultative work of the out-patient departments continues to grow.

(ii) Doctors' Letters and Hospital Time-tables.

50, 275 205.—Another source of trouble arises from the fact that patients often arrive at a hospital with a doctor's letter intended for a particular consultant who is not there at the time or even on the day, or for a department which is not in session. This means that the patient has either to wait or to come again, unless of course the needs of the case can be met by his seeing someone else. We are told that this is a frequent cause of unnecessary waiting.

206.—This can only be avoided if some method can be devised for enabling the general practitioner to know, at the moment when he needs the knowledge, the hours at which a patient should be at the hospital in order to see a particular consultant or to attend a special department or a session for general medical or surgical out-patients. The difficulty is that there are so many hospitals, so many consultants and so many departments that no doctor could know them all, or even consult all the lists which are to be found in the reports, gazettes or leaflets of the separate institutions.

207.—Three remedies have been put forward during the course of our inquiry. One is that each hospital should supply time-tables to all the general practitioners in the district it serves. This is done by some hospitals once or twice a year, with good results. But it is rare in London for a hospital to have anything approaching a monopoly of any particular area, even its own immediate neighbourhood. Another suggestion is that teaching hospitals can at least notify their old students, who are likely to send up a good many cases. A third is that a suitable reference to the subject should be printed on the suggested standard form for doctors' letters and hospital replies. This would do much to ensure that the doctor would realise, at the moment when he was giving the introduction, the importance of telling the patient to go at the right time. He could then telephone to the hospital or consult its list if he had one. Possibly it would be practicable, if the particulars do not change too rapidly, for a kind of Bradshaw's Guide to be compiled containing the time-tables of all the hospitals in London. If the lists of every hospital were to be printed on a uniform size of leaflet, so that they could all be bound up or clipped together, some kind of collective volume or file might perhaps be formed in which each doctor could include all the hospitals which he was likely to use.

(iii) Reference of Unsuitable Cases to Hospitals.

208.—Some hospital witnesses seem to fear that under any organised system of co-operation there might be an increased tendency on the part of some panel doctors to refer patients to the
142–3 out-patient departments because they were troublesome rather than because they needed consultative treatment. The suggested standard form of reference with the space for a statement of the doctor's reasons would, we think, act as a check on any such tendency. As a further safeguard it has been

suggested that each hospital might keep a record of the number of patients referred to it by each panel doctor, and that, if any particular doctor was found to be sending up a disproportionately large number, especially if his forms gave no evidence that they were serious cases, the hospital should make a report to the local Panel Committee on the subject. We think it quite possible that an arrangement of this kind might be useful. pars.

(iv) Retention by Hospitals of Cases sent for Consultation.

209.—From the other side the complaint is made that, when cases are sent with doctors' letters, the hospitals often keep them and treat them themselves, when they should have returned them to the general practitioner with a report. Sometimes the case has never required specialist treatment as distinct from a consultant's diagnosis or advice, and has thus always been a minor case. Sometimes hospital treatment was required at first, but the patient is kept by the hospital long after he has reached a stage when he could safely and properly be returned to his own doctor. This time it is the hospital that is said to be regarding the doctor's letter as a mere formality.

210.—From the point of view of the general practitioner, as we understand from witnesses on behalf of panel doctors who have no financial interest one way or the other, this is regarded as a serious obstacle to the use of hospitals as consultative centres, since the doctor not only loses the advantage of the consultant's opinion and advice, but also sees nothing of his patient during a specially important period in his medical history. This has a deterrent effect on the very doctors who are most interested in their professional work, and would be most likely to send useful information with their cases.

211.—The disadvantage to the hospital is that the out-patient department adds, unnecessarily and by its own act, to the number of minor cases which it retains but for whom treatment is available elsewhere ; and it may even, if the process is continued long enough, acquire an additional supply of chronic patients.

212.—The reason suggested for this action on the part of the hospital is that it takes longer to make out and send a report on a case than it does to repeat the prescription and tell the patient to come again ; and that, under the pressure of numbers, the hospital must do whatever takes least time. Where it is the custom, also as the result of numbers, for patients after their first attendance to be seen by juniors, the consultant may himself have lost sight of the case and the junior may not remember the doctor's letter, or may not realise the importance of fostering the consultative element in out-patient work. The hospital may also be affected by its experience of doctors' letters which do not imply any desire for true consultation, and of patients who need a good deal of persuasion before they will go back from the out-patient department to the private consulting-room.

213.—It has been suggested that this difficulty might be partially removed by an extension of a process already in use to some extent, namely, a periodical examination of the record papers of all the old patients and a review of their cases by the consultants. This would enable the hospital to refer to their general practitioners any patients who could be adequately treated by them. Such a review might, in fact, include not only those who had originally come with doctors' letters but also those who had not. The method would thus have a two-fold effect in encouraging the use of the hospital for consultative purposes and in reducing the numbers of the more obviously unsuitable of the minor cases.

(v) Some General Considerations.

214.—It will have been noticed that several of the difficulties in the way of co-operation between hospitals and general practitioners contain, on both sides, an element of the vicious circle. The difficulties which hamper the development of consultations are due to causes which that development would reduce. The remedy is that, on both sides, the value of the consultative function of the hospital should be realised and a deliberate effort made to develop it in practice, even if this means more work at the outset for all concerned. If it were once developed, the argument is that the additional time taken by each case would be balanced by the reduction in the number of cases.

215.—The question remains whether co-operation should take the form solely of communications between hospitals and general practitioners, arising out of private practice, out of panel practice, or out of the work of medical officers of institutional agencies ; or whether there should be co-operation which should include the various agencies themselves. The need for the co-ordination of the various medical agencies was strongly urged in evidence from the London Council of Social Service. As we shall see later on, the hospitals possess, in their almoners' departments, a possible machinery for this kind of co-operation. 249

The Sifting of Cases for Reference to Suitable Agencies.

216.—Any system of medical organisation which regards some cases as suitable for hospital treatment, and some as more suitable for other agencies, will require the establishment of some procedure by which the patients are sifted on this basis. From the point of view of the hospital,

pars. however, the best method of determining suitability may well depend, not only on the definition of suitability, but also on the question whether cases regarded as unsuitable are merely to be refused or are to be referred to some appropriate outside agency. The next step in our study of the question of co-operation with other agencies, and consequently of the whole question of the possible ways of dealing with minor cases, will be to consider the various methods by which hospitals do at present determine the suitability of patients, both from the medical point of view and from the financial.

E. METHODS OF DETERMINING MEDICAL SUITABILITY.

The Sifting of Cases into Major and Minor.

217.—If the definition of medical suitability adopted by a hospital includes all sick poor, the only medical question it has to decide for this purpose is whether an applicant is sick. But if it confines any of its facilities to patients needing consultative or specialist services it must have some method of sifting major cases from minor cases.*

218.—In any event, patients will have to be sorted to some extent, e.g., into medical, surgical and special. This is sometimes done in the first instance by porters or other lay officers, or even by the patients themselves. We shall use the term sifting for the process of separating major cases from minor, even if the medical officers who do this also do the other kind of sorting. In other respects, the function of the sifting officers may be merely to decide which cases shall be referred to the visiting staff and which shall be treated by juniors. But it may also include power to refer cases to outside agencies for treatment by general practitioners.

Doctors' Letters as a Method of Sifting.

82 219.—Under the strictly consultative scheme advocated by the British Medical Association, the general practitioner outside the hospital would be the recognised sifting agency. Patients sent by him, either as a private doctor, as a panel doctor, or as the medical officer of a dispensary or other institution, would be seen by the hospital staff. No others would be treated by the hospital at all, except in cases of emergency. This principle, as we have already mentioned, has been adopted only by six or seven hospitals in suburban districts.

220.—At most hospitals, however, doctors' letters, when brought by patients, are accepted as prima facie evidence of medical suitability. Frequently they give the patient direct access to the visiting staff, being thus regarded as a sieve equal in value to the sifting procedure applied by the hospital to other patients. Sometimes this privilege attaches only to letters addressed to individual members of the visiting staff, and not to those addressed merely to the hospital. Sometimes all patients with doctors' letters, however addressed, have to pass through the same sifting procedure as patients without any letter at all. We see no objection to doctors' letters being accepted as evidence, or even as conclusive evidence, if the hospital so decides. But we consider that the power to decide whether a case is major or minor should be kept by the hospitals in their own hands.

Alternative Methods of Sifting at the Hospital.

221.—The principal methods in use in the large hospitals for sifting patients into major or minor may be roughly grouped into the following types :

(*a*) Sifting in the out-patient department by the visiting staff or under their immediate supervision.
(*b*) Sifting in the out-patient department by junior medical officers.
(*c*) Sifting in the casualty department by junior medical officers.
(*d*) Sifting in the casualty department by the visiting staff or under their immediate supervision.

These different methods are usually found at different hospitals, though occasionally more than one may be in use at the same hospital.†

222.—We are at present concerned with these methods only in connection with medical 327 suitability. We shall discuss in a later section their effects on the time of waiting.

(i) By Visiting Staff in the Out-patient Department.

223.—Where the first method is in use, sifting is done in the out-patient department proper by members of the visiting staff, or by their personal assistants working with them, as part of their

* *See* notes on page 10.
† For a general comment on our method of dealing with details of hospital procedure, *see* par. 267.

examination of the patients. The question which cases are to be treated by consultants and which by assistants is decided in the consulting rooms themselves. pars.

224.—This method is associated with the principle of open access for all the sick poor to all the facilities of the hospital. All patients reach the consulting rooms of the visiting staff, though it does not follow that the consultants personally attend to every case.

225.—The procedure at one large teaching hospital may be taken as a specimen. The patients see no medical man till they arrive at the consulting room, where sit a medical or surgical registrar and a visiting physician or surgeon. They are first seen by the registrar. If they are suffering from minor ailments or are old cases not specially reserved by the consultant, the registrar can either treat them or refer them to one or other of the alternative agencies which we have described. If they are major cases, he will pass them on to the consultant at the next table.

226.—At one of the special hospitals, to take another example, the consulting room has tables for the consultant and three clinical assistants. A resident medical officer at the entrance to the out-patient department sorts the patients and refers them to the consultant or to a registrar, according to the character of the case. They are thus all treated either by the consultants or in their presence. At one of the non-teaching general hospitals all patients, except minor cases amongst the insured, see the consultant, who may refer some to his clinical assistant, and some to a minor medical clinic for treatment by a casualty officer.

(ii) By Junior Staff in the Out-patient Department.

227.—By the second method patients are sifted in the out-patient department proper by junior medical officers of appropriate status, as a separate stage in the procedure of an out-patient session, before the patients reach the consulting rooms of the visiting staff. The juniors may be registrars attached to the particular consultants who will subsequently treat the major cases. 119

228.—This represents open access to the out-patient department but not to the visiting staff, whose services are reserved for consultative cases.

229.—Thus at one teaching hospital new out-patients receive a preliminary examination from medical or surgical registrars before the visiting staff arrive. The registrars either treat them or refer them to the consultants. At another the sifting is done in the same way by the resident medical officer. At a large non-teaching hospital it is done by an out-patient medical officer who can himself treat minor cases only for a limited number of times without reference to a consultant. With this method minor cases retained by the hospital are usually treated in the out-patient department, but are sometimes referred to the casualty department.*

(iii) By Junior Staff in the Casualty Department.

230.—By the third method all new out-patients pass through the casualty department, where they are sifted by junior medical officers of appropriate qualifications and experience, and are either referred to the out-patient department to be seen by the visiting staff or retained for treatment by the juniors in the casualty department, at all events for a time. There is open access to the casualty department, the out-patient department proper being confined to consultative cases.*

231.—The medical officers in the casualty department may or may not have power to refer cases elsewhere for treatment by general practitioners after one treatment at the hospital; in other words, the consultative principle may or may not be applied in some degree to the casualty department.

232.—The casualty department may be used for the sifting process equally at all hours, in which case patients will drift in all day long. But there may also be some particular hour, usually in the morning, which is announced as the time for the attendance of new out-patients, and at which, therefore, large numbers will arrive simultaneously.

233.—There is no need to give typical examples of this procedure. They are all covered by the general description.

(iv) By Visiting Staff in the Casualty Department.

234.—By the fourth method members of the visiting staff, or others of consultant status acting as their deputies, attend in the casualty department and themselves sift the new patients into those whom they wish to treat personally, those whom they will leave to the junior staff, and those who can

* As explained in par. 9, the casualty department may be called by some other name, such as receiving room, surgery, or sorting room, though the minor cases treated in it are still counted as casualties. Occasionally the sifting by juniors is done in the out-patient department at a different time of day from the general out-patient session. It must be remembered that considerable numbers of patients with doctors' letters will be exempt from the sifting process, especially in the casualty department. *See* par. 220.

pars. be referred elsewhere. The cases they keep for themselves may be chosen because of their seriousness or difficulty or because of their value for teaching purposes.

235.—Under this alternative there must of course be a fixed hour at which new patients must attend in the casualty department for the sifting process, though the department will also be open all day for casual comers, who will then be seen by a junior casualty officer, and may be told to come to see the consultant at the next sifting time.

236.—There are two examples of this method amongst the large hospitals. At one a visiting surgeon attends in the casualty department in the morning and selects the cases which he wishes to see in the out-patient department in the afternoon, while a resident physician with consultant qualifications, acting as deputy for the visiting physician who will attend in the afternoon, does the same with the medical patients. The cases not so selected are either treated by juniors in the casualty department or are referred to other agencies, though no patient is referred to his own doctor without that doctor's consent. The out-patient department here is purely consultative, all the patients coming either with doctors' letters or through the casualty department, which is itself partly consultative.

237.—At the other hospital, the visiting physician and the visiting surgeon both attend in the casualty department in the morning. They sift the new cases, though, in view of the large numbers, part of the sifting is done by assistants working with them. They select the cases they require for teaching and send them at once to the out-patient department. They, or their assistants, treat the more serious of the others on the spot, and leave the rest to the junior staff of the casualty department, trivial cases amongst insured patients being referred to their panel doctors. They then proceed to the out-patient department and treat the cases they have reserved for teaching.

238.—This method seems to combine some of the characteristics of all the different alternatives. There is open access to the consultant staff in the casualty department, while at the same time the out-patient department is wholly consultative and the casualty department partially so.

Some Effects on the Numbers of Minor Cases.

239.—The arguments for and against reducing the number of minor cases by reference to other agencies are affected by the method of sifting. The more competent and experienced the doctors who sift the cases, the less the risk of mistake, or of dissatisfaction on the part of patients who had wished to have the advantage of the special facilities provided by a hospital.

240.—The arguments are also affected by the stage at which the reference to other agencies takes place. This, as we have seen, never takes place before at least one examination by a hospital doctor, even if the patient could have obtained attention elsewhere from a panel doctor or from any other source. The rules of the hospital may require that every patient who comes should have not only one examination but also at least one treatment. The practice may be, as we have also seen, that patients are treated as long as they are ill enough to need the care of the hospital, and are then referred to their own doctor or to some agency providing treatment by general practitioners; in other words, when a case originally major or doubtful has become definitely minor.

241.—All these differences will affect the degree in which the hospital is in practice consultative and the extent to which the sifting process does actually reduce the number of attendances. But the most striking evidence on this point came from one of the hospitals where experienced junior officers sift patients in the casualty department, where these casualty officers have discretion to refer minor cases elsewhere, and where notices are exhibited stating that insured persons must bring letters from their panel doctors. At this hospital the number of out-patients proper has remained almost stationary at 70,000 since 1927, though in 1911 there had been 90,000. But the number of patients attending the casualty department fell from about 140,000 in 1911 to about 42,000 in 1927, when the notices about insured patients were put up, and has since fallen to about 11,000. During the whole period the average number of attendances per patient has increased from less than 3 to more than 6, which shows that the seriousness of the cases treated has increased. At this hospital, therefore, it may be said that the adoption of partially consultative methods has resulted in the exclusion, before even a first attendance, of large numbers of minor cases for whom statutory provision has been made elsewhere through the National Insurance Act. It is interesting to compare these figures with those quoted in
24 an earlier section from another large hospital where the open access definition of medical suitability has been retained on principle, and where it has thus been left to the minor cases to decide whether they will attend or not. We have no evidence to show whether the patients excluded from the first
108 hospital obtain their treatment from their panel doctors or go to other hospitals. Different students of the subject may draw different conclusions from the figures. But at all events they form part of the evidence which has to be taken into account.

242.—The sifting officers here described are all doctors. But at many hospitals the almoner's department is an important part of the machinery for the reference of patients to the most

appropriate agency, in cases where the patient might otherwise be in difficulties. That department is in touch with the hospital doctors, with the officers who inquire into patients' means, and with all the agencies outside which provide medical or non-medical assistance. It represents in practice the connection between medical suitability and financial suitability and will be more fully described in connection with the latter. pars. 246

F. METHODS OF DETERMINING FINANCIAL SUITABILITY.

Inquiry Officers and Almoners.

243.—There are two main types of officials who carry out inquiries into patients' means—inquiry officers who may be employed for that purpose only, and almoners, usually ladies, who also arrange for any supplementary assistance or after-care which patients may need in addition to medical treatment. The same hospital may have both, the inquiry officer making inquiries in order to determine the financial suitability for hospital treatment, while the almoner deals only with the patients' circumstances as affecting their need for supplementary assistance and their power to contribute towards its cost. At small hospitals the work is sometimes done by other officials. Whatever the method, no patient is sent away without seeing a doctor.

244.—The procedure for inquiry into financial suitability has been considerably simplified since the general introduction of agreed maximum income limits. The necessary information is often noted by officers who register the patients on their arrival, only doubtful cases being referred to a special inquiry officer, or to an out-patient superintendent or organiser who has general supervising functions in the whole department, or to the doctor. Sometimes doubtful cases are referred to the almoner; or the inquiry officer may be one of the staff of the almoner's department. 93

Collection of Patients' Payments.

245.—The determination of financial suitability is also often associated with the collection of patients' payments, from those who can afford them, towards the cost of their hospital treatment. These payments are voluntary, but it has become the custom nowadays at most hospitals for patients to be expected to contribute their fair share, unless they have already done so by subscribing to a contributory scheme. For this purpose a rough assessment may be made by the inquiry officer or almoner, according to the patient's means. But it is frequently the practice to ask each patient for a flat rate contribution of, e.g., 1s. or 6d., on each attendance, and to refer for further inquiries into means those who say they cannot afford it. Some hospitals still take the view that no patients should be asked for anything but a voluntary contribution on or after leaving the hospital, but even these may make a small charge for medicines to those who are not too poor. 105

The Special Functions of Almoners.

246.—Where there is an inquiry officer as well as an almoner the reason usually is that the almoner's work in connection with supplementary assistance or after-care is considered so important that it is better to make a complete separation between inquiries for this purpose and inquiries for the purpose of excluding the unsuitable. As one hospital witness put it, the almoner is a person who provides benefits for the patients, while the inquiry officer is looked upon as a sort of policeman to stop people coming in who are not eligible.

247.—This special after-care work of the almoner includes making arrangements for supplementary medical assistance such as convalescent home or sanatorium treatment, or the supply of surgical appliances, artificial teeth, spectacles, or special foods for invalids or children; paying visits to patients' homes at the request of the hospital doctor to see to the carrying out of his instructions; providing other forms of assistance such as help with fares to and from the hospital, the finding of lodgings for patients coming from a distance for special treatments, or the provision of clothes for necessitous children; or, where possible, endeavouring to remove or alleviate conditions which are unfavourable to the patient's recovery, such as unsuitable occupation or housing. In all these activities the almoner co-operates as far as possible with other agencies, decides how much the patient can fairly be asked to contribute, and arranges for the balance to be provided from some other source. Sometimes the hospital itself has a Samaritan Fund from which a limited amount can be granted in special cases.

248.—For many of these purposes the almoner must know the doctor's diagnosis and the treatment prescribed; and it is therefore a common custom, though not a universal one, for patients to see the almoner after seeing the consultants, the inquiries into financial suitability having often taken place at an earlier stage. Sometimes only the patients that need after-care see the almoner. The differences in the practice on this point, and the arguments for or against each method, will be better discussed when we come to the section dealing with the time taken by the different stages of procedure. 308

pars. 249.—At some hospitals the almoner's department is also the channel through which patients are referred to other agencies, including sometimes their panel or private doctors. For this purpose also, the almoner must know the diagnosis of the hospital doctor, whether it be the consultant or a junior sifting officer. She is regarded as the best officer for this purpose because of her knowledge of the other agencies. This means that exclusion by reference to other agencies, based on the idea of a co-ordination of the different medical services of the community, is different from exclusion merely on the ground of financial circumstances, and requires a different kind of skill and outlook from that of the policeman or detective. This is another of the ways in which changes in the definition of medical suitability may gradually come to modify conceptions of procedure.

Certificates from Outside Agencies.

250.—It is a common practice for a hospital to enter into an agreement with a contributory
14, 316 association whereby the hospital grants exemption from inquiries into means to all patients who present vouchers certifying that they belong to the scheme, and therefore come within the agreed income limits. As the result of the rapid growth of the Hospital Saving Association the number of patients so exempted is now very considerable.

251.—It is also a common practice to accept doctors' letters as evidence of financial suitability, or at least to give the benefit of any doubt to patients who bring them. At some hospitals subscribers' letters are still accepted for this purpose, though sometimes the form of letter provides that it shall contain a medical certificate as well.

Inquiry Methods in Relation to Casualty Departments and to Minor Cases.

252.—At the majority of hospitals the inquiry system, whether by inquiry officer or almoner or both, applies only to the out-patient department proper, and there is no inquiry in the casualty department other than the inspection of patients by the registering clerks and the casualty medical officers. At a few hospitals, however, including some of those whose casualty departments have become important sifting and treatment centres, an interview with the almoner is a regular stage in the procedure of that department, while at others the casualty registering clerk is a member of the almoner's staff; or patients are referred to the almoner if they cannot pay the usual 1s. One large teaching hospital stated that it had made occasional inquiries in its casualty department and had discovered no abuse.

253.—The problem of determining the financial suitability of minor cases, i.e., of ascertaining
106 whether or not they can afford to pay a general practitioner, has always been a difficult one because of their numbers. It has been changed, rather than solved, by the introduction of income limits and of contributory schemes. It is comparatively easy to determine whether or not a patient comes within the income limit, and to exclude those who do not and have nothing exceptional about their circumstances or the treatment they need. It is therefore frequently considered that there is no hospital abuse in the old sense of the word. At the same time it is often held that large numbers of minor cases are treated which could, without hardship, be referred to general practitioners; and that this does not apply only to insured persons. It is not suggested, so far as we know, that these minor cases are outside the income limit. Yet any further general inquiry into means would be almost impossible and, in the case of members of a contributory scheme, is often ruled out by the terms of the scheme, because it is regarded as unnecessary when once the patient is known to be within the income limit.

254.—But the whole aspect of the problem is changed when it is approached from the standpoint of the co-ordination of medical services, and the question is one not so much of the exclusion of minor cases as of their reference to the most appropriate agency. What the hospital then desires to know is whether the patient, if referred elsewhere for treatment by a general practitioner, will suffer financial hardship. This question would only arise in the cases which had been judged to be medically unsuitable, and it would be one which might be regarded as coming within the
250 sphere of the almoner, subject, of course, to the agreements with members of contributory schemes. Along these lines it might be possible to reduce the problem to manageable dimensions, especially as a large number of minor cases come within the sphere of the National Insurance system and not of private doctors, and would not have to be taken into account in considering the question of financial hardship.

G. MINOR CASES AND MEDICAL EDUCATION.

255.—Medical education is so important a function of the voluntary hospital system that no question affecting the organisation of the great teaching hospitals can be considered without taking into account the possible effects on this part of their work. We have accordingly received a good deal of evidence on this aspect of the suggestion that the number of minor cases retained and treated by the hospitals could with advantage be considerably reduced.

256.—In reply to the argument of the British Medical Association that hospital out-patient departments should, apart from emergencies, be strictly consultative, and that the treatment of minor cases is no part of hospital work, it has been submitted to us that the total exclusion of such cases would deprive the medical student of an essential part of his education, since he must be taught to distinguish between a major case and a minor case. We are told, indeed, that this is one of the most difficult things either to learn or to teach, especially in connection with medical cases, surgical being more obvious. It must be taught in the out-patient department, because in the wards the student knows beforehand that all the cases are serious or they would not have been admitted. pars. 84

257.—Some witnesses from teaching hospitals go further than this and argue that it would be difficult even to reduce the attendances of minor cases without adversely affecting medical education, since large numbers of such cases are needed in order that students and newly qualified house physicians and house surgeons may get enough experience. Others are in favour of reducing the number of trivial cases but would deliberately keep some for teaching purposes.

258.—The answer of the British Medical Association witnesses, who included members of the staffs of teaching hospitals, was that, as things were, minor cases were usually treated by juniors and did not reach the visiting staff at all. Other witnesses representing general practitioners said that experience showed that students did not learn minor cases until after they had left the hospital; that the out-patient departments were too congested and the conditions too unlike those met with in general practice. It was also argued that the out-patient department could be made consultative without any risk since the casualty medical officers could always pass on enough minor cases; while even if the whole hospital was purely consultative a sufficient number of such cases would still be included amongst those coming with doctors' letters. Although the fact that such cases do come is supported by the experience of hospitals in present conditions, this last argument would not remove the objection to the scheme described in the report of the British Medical Association, since under that scheme such cases would not be treated except possibly once, whereas it is urged that for efficient teaching there should be a large number of cases of all kinds, including even trivial and chronic cases, the whole of whose treatment should for this purpose be carried out at the hospital.

259.—Our own opinion is that, while there can be no possible doubt as to the great importance of medical education, there is a certain amount of exaggeration in the more extreme of the arguments which we have quoted on either side. We should be inclined to say that the attendance of a reasonable number of minor cases is essential to medical education, but that a considerable reduction in the present numbers, if desirable and practicable on other grounds, could be effected without any danger. We have seen that some of the teaching hospitals have adopted more or less consultative definitions of medical suitability for their out-patient departments proper, and that at least one has placed limitations on the work of its casualty department which have led to a great falling off in the number of patients. Yet we have no evidence that their schools have suffered. 65-72 241

260.—The net result, therefore, of our study of this part of the question is to confirm us in the opinion that access to the hospitals should not be closed to minor cases, but that it does not follow that schemes for reducing the present numbers cannot safely be entertained, if found to be desirable for other reasons.

H. SUMMARY AND CONCLUSIONS ON METHODS AS AFFECTING SUITABILITY.

Relation between Waiting, Overcrowding and Medical and Financial Suitability of Minor Cases.

261.—The principal questions which we have been discussing in this section of our report may be summarised as follows:—

(*a*) Is waiting caused by the attendance of excessive numbers of minor cases who are medically unsuitable for treatment by hospitals with expensive equipment and highly skilled staff, but who could be dealt with by agencies providing simpler forms of treatment?

(*b*) What are the arguments for and against the exclusion of such minor cases?

(*c*) Are the financial circumstances of any considerable number of them such that their exclusion would cause hardship, unless they can be referred to alternative agencies which will treat them at a cost within their means?

(*d*) What alternative agencies are there which can provide on an adequate scale efficient treatment for minor cases, and on what terms and conditions do they provide it?

(*e*) What methods are used by the hospitals to determine, from the point of view of medical suitability and financial suitability, which cases should be treated at the hospital and which cases could without detriment or hardship be referred to other agencies; and what have been the effects of those methods?

(*f*) What would be the effect on medical education of reducing the number of minor cases retained and treated at teaching hospitals?

We have considered the available evidence on all these points.

pars.

262.—In doing so we have quoted from time to time the opinions expressed by witnesses representing the alternative agencies or advocating their use, to the effect that there is overcrowding of the out-patient and casualty departments by minor cases which could without detriment or hardship be dealt with elsewhere, and that this is one of the causes of long waiting.

263.—We have also seen in an earlier section of our Report that, while some of the hospitals consider that there is no overcrowding in their out-patient or casualty departments, others report that there is.

264.—The theory that the admission of unlimited numbers of minor cases is one of the main causes of overcrowding and waiting was supported by the evidence of witnesses from the Hospital Saving Association and the Hospital Officers' Association, though the latter laid stress on the importance of retaining the freedom of the patient to come to the hospital on his own initiative for a second opinion, and of making sure that there were adequate alternative agencies for the treatment of those whom it was desirable to exclude in the interests of the efficient working of the out-patient departments.

Conclusions on this part of the Inquiry.

265.—Our own conclusions on the whole of this part of our subject-matter are that part of the waiting is due to overcrowding caused by the treatment of excessive numbers of minor cases which could without financial hardship obtain the treatment they need from other agencies such as those we have described; and therefore that the present movement on the part of a large number of the hospitals towards the more consultative use of their facilities (except in cases of emergency) is, generally speaking, a movement in the right direction and should be encouraged, subject to the
403 various considerations which we set out in our final conclusions. These include the provisos that patients who desire a second opinion, and who cannot afford a private consultant, should continue to have access to hospital out-patient departments for the purpose, without having first to obtain the consent of a general practitioner, that no hardship should be caused to patients, and that a sufficient number of cases of all kinds should, at teaching hospitals, be available for the purposes of medical education. With this end in view, the different methods of procedure described in this section are well worth the careful study of all concerned in hospital administration.

SECTION IV. WAITING AS AFFECTED BY METHODS OF PROCEDURE.

266.—We have already mentioned, as evidence on the subject of the fact of waiting, that pars. several hospitals have reported recent changes in procedure which have resulted in a saving of time. We have now to consider the evidence as to the ways in which time is spent during or between the different stages in the procedure, and the methods which have been suggested or adopted for reducing the time to a minimum. This evidence relates partly to the procedure at each separate stage, and partly to general procedure the effects of which are not limited to any particular stage.

267.—It would be impossible in the time at our disposal to prepare a complete account of the methods in use at all the hospitals, especially as different methods are often followed in different departments or even by different medical men. We propose, therefore, to describe briefly the various types of procedure in use or suggested, especially those which appear to have a direct effect on the time taken. We have been obliged to omit special departments and special hospitals altogether except where they have been mentioned to us in connection with particular points of procedure; and also the question of the relative numbers of patients and of staff, medical or lay. We recognise, however, that a good deal of the detailed information which we have collected might be of assistance to hospitals in comparing their own methods with those of others, and the King's Fund might well consider whether it could usefully help by rendering some of the additional details available in the form of supplements to our Report, or in some other way.

A. PROCEDURE AT SEPARATE STAGES.

268.—The principal stages of procedure have already been briefly described. They may be 25 grouped under the following heads :—

(*a*) Arrival;
(*b*) Registration;
(*c*) Examination and Treatment;
(*d*) Supply of medicines, etc., at hospital Dispensary;
(*e*) Interview with Almoner or Inquiry Officer either for determining financial suitability or for after-care or supplementary assistance. This may not apply to all patients and may take place either before or after examination and treatment.

Some of these are common to all medical agencies, including the private doctor and the chemist's shop; the rest are essential for the efficient institutional treatment of large numbers.

269.—There are other items of procedure which affect some or all of the patients at some or all of the hospitals. These include preliminary sorting into medical, surgical and special; sifting into major and minor; and special examinations, sometimes by the X-ray, pathological or other special departments. These may be carried out during or between some of the stages just tabulated, or they may themselves include a shorter series of somewhat similar items.

270.—Some stages may occur both in the out-patient department proper and in the casualty department, others only in the out-patient department.

271.—It must not be supposed that the number of stages necessarily affects the time taken. Before each stage there must be some waiting period for all patients, except the first comers, and during this period another stage can sometimes be taken, thus actually reducing the time during which the patient is doing nothing but wait.

272.—In studying the evidence it is necessary to distinguish between time spent on a stage and time spent between stages, and between the total time required for dealing with all the cases during a stage and the time spent by an individual patient. The term waiting, as we have pointed out, is properly applied only to the periods spent by an individual patient between one stage and another. Each period of waiting depends largely on the time taken by the next subsequent stage and will usually be discussed under the heading which relates to that stage. It may, however, be affected by the extent to which some preceding stage has or has not produced a steady flow of patients.

Arrival.

273.—For attendance at the out-patient department proper, or at a casualty department where sifting is done at a particular time of day, the hospital always announces the hour or hours at which, or the hours between which, patients should arrive. Sufficient time must be allowed between the time of arrival and the time when the visiting staff begin their work. During this interval patients must be registered and sorted, and, to some extent at all events, their financial suitability ascertained. Allowance has to be made for wide fluctuations in the daily numbers.

pars. 274.—The length of this interval between arrival and seeing the doctor is often mentioned as a subject of complaint. Hospital opinions differ as to the minimum required in an out-patient department for all the patients taken together. Some hospitals allow half an hour, some one hour, some an hour and a half, including the sorting of patients between various clinics. A good deal may depend on whether it is thought desirable to complete the registration of all the patients, or only of enough to enable the doctors to begin, i.e., on whether it is considered that the registration and sorting stages and the consulting room stage should or should not overlap. The first method has been estimated to require an interval of an hour, the second only of half an hour. An intermediate course is to announce the earlier time but not to close the doors until the later. Something may depend on the methods of registration, and on whether there is a sifting stage before patients reach the consulting room.

275.—One of the difficulties in fixing a minimum interval between arrival and seeing the doctor
50, 205 is that patients often do not keep to the prescribed hours. We have already discussed some aspects of the problem of getting the hours known, and some of the possible solutions. But even when the patients know the right time they often come late, and this compels the hospital to fix the hour unnecessarily early ; or they come too soon, perhaps by some hours, either for their own convenience or in order to get taken earlier. In the latter event, especially if the second is the reason, the extra time of waiting may be made an additional subject of complaint, though the hospital naturally disclaims responsibility. Some hospitals provide a waiting room for such early comers ; at others they wait outside. We have been told that if a range of hours is announced it is best to make it a narrow one, since patients are sure not to keep within it. One hospital which used to say 12 to 3 now merely says 1.30, the prescribed time of arrival thus becoming more than ever a fixed hour.

276.—A method that has been widely introduced of late in order to reduce waiting after arrival has been the fixing of different times for different classes of patient, e.g., for new patients and old patients, or for men and women. A method often suggested is the adoption of a system of appointments for individual patients or groups of patients. We shall discuss these departures from the fixed hour of
345 arrival in the sub-section dealing with general procedure.

277.—The procedure at this stage may have an important effect on the minds of the patients
55 because, as we have already said, many of them complain more of waiting before they see the doctor than of waiting afterwards.

Registration Stage.

278.—The registration stage in an out-patient department includes taking down particulars of new patients and giving them cards or other documents for the use of the hospital at subsequent stages, and giving old patients the documents used on previous visits. It may also include a certain amount of
316 inquiry into financial circumstances. Occasionally, the registration officers are part of the almoner's staff. Registration may take place after a preliminary sorting by a lay or medical officer.

279.—The amount of individual waiting before this stage begins depends, of course, partly on the numbers attending as compared with the size of the staff, but partly also on the procedure. Periods quoted by different hospitals have ranged from 6 minutes at normal times, up to 20 minutes or half an hour on busy days. Some hospitals have a special waiting room in front of the registration windows or tables, others have no space for this.

280.—The time taken in registering a new patient will depend on the number of different cards or papers that are needed for him, and the amount of handwriting required. There must usually be at least two—one to form the basis of his medical record, to be retained by the hospital when he leaves* and one for him to keep and produce for identification purposes when he comes again. One or other of these or some third document must link him with the department he will attend or the doctor he will see, unless these are not known at this stage.

281.—The time taken in dealing with an old patient will depend largely on the way in which his papers are filed. Some methods render them much more accessible than others, especially if there has been an interval since he last attended. On this point the practice varies. Some hospitals keep a patient's medical record longer than others. Another difference in procedure is that some hand the papers to the patient and he takes them with him, while at others they are put in charge of the nurses so that the patients cannot read them. The waiting will also depend on whether old and new patients are taken separately, or whether the old, whose records can be produced rapidly, have to take their turns with the new, whose papers have to be written up. This latter practice is said to be fairly common.

282.—The importance of procedure is shown by the time saved through recent improvements at several hospitals. One of the chief of these is the separation of old patients from new, either by
346 providing a different though adjacent place or by fixing a slightly different hour. Sometimes one

* Amongst the titles for these papers are : out-patient books, history sheets, record papers, prescription papers, medical notes.

of the modern systems of filing and card indexing has been introduced. One hospital by these methods, and by arrangements which have allowed more space and more staff, claims to have reduced the waiting from 30 minutes to 6 minutes. Another has saved half an hour. The registration of women patients by women clerks is said to save time by facilitating their immediate reference to the right department. One hospital where all new out-patients are first sifted in the casualty department has recently saved a good deal of time in the out-patient department, where all the patients attend at a fixed hour, by transferring most of the registration procedure for new patients to the casualty department where they come singly throughout the day. At the hospital where the visiting staff do the sifting in the casualty department at a fixed hour, immediately before the out-patient session, the registration takes place in that department after the sifting, each of the three classes into which the patients are divided being registered in a separate part of the hall. At the one where the visiting staff sift in the casualty department in the morning and the out-patient session is in the afternoon, the cases treated by the casualty officers are registered after the sifting; the out-patients not until they reach the out-patient department. pars.

283.—In most casualty departments the registration is very simple. Sometimes it is not a separate stage at all; such records as are needed are kept in a book by the casualty medical officer.

284.—The methods of registration to which we have here referred seem to us to be well worth careful study, especially if it is true, as we have been informed, that rather old-fashioned methods are still in use at many hospitals. The time taken by this stage affects the minimum length of the interval between the time the patients arrive and the time the doctors begin, and the procedure should therefore be as rapid as possible.

Examination and Treatment Stage.

285.—At a good many hospitals the next stage in the out-patient department after registration is the interview with the almoner or inquiry officer for inquiries into means. But as inquiries into means, where not combined with registration, often take place after the patient has seen the doctor, we propose first to discuss the stage of examination and treatment and to take the inquiry stage at the end. Another reason for doing this is that, where inquiries are made before the doctor is seen, they often take so little time that they are done while the patients are waiting for the doctor, and do not add to the length of that wait.* This, however, is not always the case, since at least one large teaching hospital considers that the waiting could be reduced by speeding up the inquiries if enough money could be spent on additional staff and accommodation. 308

286.—With any considerable numbers attending at a fixed hour, there must be an interval between the time when any particular patient arrives and the time when he goes into the consulting room, and this is necessarily longer for those who see the doctor last than for those who see him first. With any given fixed hour of arrival and any given number of patients, the difference between the shortest wait and the longest will depend on the time taken for each patient by the stage of examination and treatment, and will be reduced if the average of this time can be reduced.

287.—It is difficult to make any generalisation about the actual length of this period of waiting. As we have already seen, the numbers fluctuate widely on different days, and, as we shall soon see, the time taken by the examinations and treatments of patients also varies widely. The intervals which we have mentioned for all patients when discussing the hours of arrival give some idea of the minimum for the first patient at some hospitals, if the time spent on registration is deducted. One teaching hospital estimated the interval for individual patients between arrival and examination at from 10 minutes to 30 or possibly 40 minutes for those with doctors' letters giving the correct time, and rather longer, perhaps 60 minutes, for others. A large non-teaching hospital put it at anything up to 60 minutes after registration and sifting. At one teaching hospital a count of hours, for the period between registration and entering the consulting room, gave an average for the general medical and surgical out-patients of about 1½ hours, and an analysis of the figures showed that this average was made up of large numbers of periods between half an hour and 2 hours, with small numbers above and below. At a large children's hospital a count showed an average of about 2¼ hours. At both hospitals the periods included interviews with the almoner. We shall discuss these extremely useful counts later on. 274 374

288.—In considering the procedure of the examination and treatment stage as affecting the time of waiting, we shall postpone to a later sub-section any preliminary sifting of patients that takes place before they reach the consulting rooms. 327

289.—During the wait before seeing the consultants, the patients usually sit on benches in that part of the out-patients' waiting hall which is nearest to the consulting room of the doctor who will see them. From these benches they may be shown direct into the consulting room, perhaps one at a time, perhaps two or three, perhaps as many as six. Where the building is large enough and modern enough, there may be ante-rooms attached to each consulting room suite, and the patients may be

* Presumably the arrangements are such that patients who go through the inquiry do not lose their places in the queue. We have heard of patients not being seen in strict rotation, and one hospital reported that numbered tickets had been adopted to avoid this.

pars. moved forward into these several at a time. Some doctors prefer that the interview with a patient should not be in the presence of other patients. Some consider that this is unobjectionable if the room is large enough for the conversation not to be overheard, and that there is a slight saving of time between each patient, which mounts up in the course of the session. Some doctors wish to begin by having a look at all their patients so as to select those who require their personal attention and those who are suitable for teaching. No complaint on this score has been reported by witnesses from the patients' side. We have been told that they sometimes prefer waiting in the doctors' room to waiting outside.

290.—While the patients are in the ante-room or on the back benches of a large consulting room, they may be having their temperatures taken by a nurse, or by students, clerks or dressers if at a hospital with a medical school, and notes may be made which may save time later on in diagnosis and treatment. This may take place before the hour for the arrival of the visiting staff.

291.—When the patient reaches the actual interview with the visiting physicians or surgeons, the time taken will depend not only on the nature of the case, but also on the methods of the particular consultant and his natural speed of working, and may not be unaffected by the number of patients he has seen that day and the number he has yet to see. Undue pressure on the doctor is amongst the evil results of overcrowding. One teaching hospital witness estimated the time required per medical case at from a few minutes up to half an hour, with an average of 15 minutes ; another gave the same average for new medical cases ; while another suggested a minimum of 20 minutes, a maximum of an hour, and an average of 30 minutes. A suburban hospital on a strictly consultative basis gives the average at 7 minutes. Medical witnesses who have held posts both in teaching hospitals and in non-teaching say that in the former the doctor takes longer over each case, but that he has so many more assistants to share the work with him that there is very little difference in the total time required.

292.—Where the consultative side of out-patient work is being developed, the writing or
201 dictating of reports to general practitioners will add to the time taken, unless it is done afterwards either in the hospital or at the consultant's home.

293.—It frequently happens that a patient requires a special examination by the X-ray or pathological department. If the information is needed at once, the patient may return to the hall till the result is known, and then see the doctor again. This is a frequent cause of long but unavoidable waiting on the part of individuals. Sometimes the treatment will include a minor operation, or, as at one large children's hospital, a consultation between physician and surgeon.

294.—With patients who have to be undressed either before their examination begins or before it can be completed, much depends on the number of dressing rooms or cubicles available, and on their planning. When the doctor has finished with one patient the next must be ready ; and yet no patient should have to wait long after undressing. At one teaching hospital, for example, with a large and fairly modern out-patient department, each examination room attached to a consulting room has four dressing cubicles. One medical witness expressed the opinion that much waiting would be saved if every consulting room had from four to six dressing or examination rooms attached, instead of only one or two. One special hospital reports that it has saved much time by having two dressing rooms instead of one ; they are used alternately, so that no patient has to wait for a room.

295.—One of the most important factors affecting the time of waiting is the extent to which the work can, without loss of efficiency, be shared between the consultants and their assistants, so that more than one case can be dealt with simultaneously. This method of speeding up is especially important where the numbers reaching the consulting rooms have not been already reduced by a preliminary sifting and the treatment of minor cases elsewhere. It applies particularly to old patients. If the same doctor sees both old and new, either the old, who will take only a short time, must wait for the new who will take a long time, or the new who may be urgent must wait for the old. It is therefore becoming more and more the practice for the old patients to be treated by assistants, except those specially noted by the consultant for his personal attention or referred back to him by the assistant. The consultant may also refer to his assistants some of the less serious cases among his new patients. One large teaching hospital has, during our inquiry, considerably developed this part of its procedure. Formerly, consultants often first treated their new cases, including those suitable for teaching, each of which would take a long time, since minor cases would already have been sifted out in the casualty department. They then treated the old cases, which would take a shorter time. The result was that the dispensary staff had only a small number of patients during the early part of the session but had to cope with a rush of cases later on. Each consultant now makes it a settled practice to treat only the new cases suitable for teaching, while simultaneously other new cases are treated by his first assistant and old cases by his second assistant. This has had an immediate effect
304 on the amount of waiting both before this stage and subsequently at the dispensary stage. It is a common practice for old cases to be treated by assistants after their first or perhaps second attendance, unless they have been specially marked by the consultant for his personal attention. At one hospital the consultant sees his special old patients while the histories of his new patients are being taken.

296.—Simultaneous treatment of course requires space. At the teaching hospital whose accommodation we recently mentioned each consulting room suite has three examination rooms each with

its four dressing cubicles. Where space is not available, old cases or minor cases, if treated separately, must be seen at a different time, e.g., by the consultant's assistants before he arrives. pars.

297.—Amongst the subjects of comment are delays due to the absence of a doctor at the appointed time or to occasional interruptions by the claims of emergency cases or ward cases. The former may be caused by weather conditions or by the unexpected length of an operation elsewhere. Avoidable unpunctuality would be a serious matter and would be disclosed to the hospital authorities by the attendance book. Incidents of this kind can hardly be wholly prevented ; the extent to which their effects can be mitigated will depend on the number and qualifications of the available substitutes.

298.—Examination and treatment is the essential part of the out-patient procedure, and the effects of any avoidable loss of time during this stage are far-reaching. The different methods will therefore repay careful study, especially such recent changes in procedure as have produced a reduction in waiting, due regard being had to the maintenance of the conditions which the various members of the medical staffs require in order to do their best work.

Dispensary Stage.

299.—After examination and treatment, the patients take their prescriptions to the dispensary, though at a good many hospitals it is the practice for some or all of them to see the almoner between these two stages

300.—At the dispensary there tends to be some waiting, especially on certain days or at certain times of the day. This is one of the subjects most often mentioned by the group secretaries of the Hospital Saving Association, and one of the District Committees of the Charity Organisation Society reported that there was more complaint about this than about the time spent before seeing the doctor. The waiting periods mentioned from the patients' side ranged from one hour, said to be general, up to as much as two hours. Estimates from hospital witnesses include 3, 5, 10 or 15 minutes ; 30 minutes or up to one hour on busy days or very busy days.*

301.—At some hospitals there is a small waiting room as part of the dispensary unit ; at others the patients sit on special benches in the part of the waiting hall next the hatches, which are of course near the exit ; in some of the older buildings patients may stand in a queue with at most only a bench or two available. Sometimes a separate part of the special waiting room is railed off opposite each of the hatches, the benches being so arranged that no patient can get out of his turn.

302.—The number of hatches and of dispensers bears no uniform relation to the total number of out-patient attendances. Among the teaching hospitals the smallest number of hatches mentioned to us was 2 and the largest 8, of which one was reserved for cases marked by the doctor as urgent : at this hospital the dispensary waiting room holds 200 patients. The number of dispensers engaged on out-patient work also ranges from 2 to 9, though the differences often do not correspond with those in the numbers of hatches. The number of dispensers attending and of hatches open may be changed from time to time with the number of patients present.†

303.—The time taken by the dispenser in dealing with the individual patient will depend, apart from considerations of space, planning and organisation, mainly on the nature of the medicine, lotion or ointment to be issued, which may be a stock mixture made up beforehand or even put up in the usual quantities, or a stock mixture with some additions, or a special prescription. Estimates of the relative time taken range for this reason from 6 or 10 minutes up to 16 or 20 minutes. If there is a large proportion of special prescriptions there will thus be increased waiting, not only for the patients concerned but also for those who follow them. Examples of estimated proportions are : mostly stock ; 35 per cent. stock with additions ; two-thirds stock, one-third special. The differences depend partly on the practice of different doctors, even at the same hospital. The prescribing of stock mixtures is encouraged ; if medical officers other than visiting physicians write special prescriptions to any extent their attention may be called to it.

304.—Apart from this, the amount of waiting will depend on the relation between the number of hatches and dispensers and the number of patients attending at the time. The hospital with 8 hatches estimates that 200 patients can be cleared in an hour. The number present at a time will depend on the extent to which there is a steady stream of patients or a succession of rush hours and peak loads. This in turn depends mainly on the extent to which each consulting room discharges its patients at fairly equal intervals during the session, or deals with them slowly at one time and rapidly at another. We have described one example of the way in which delay at the dispensary from the latter cause can sometimes be reduced ; namely, by arranging that old patients, each of whom takes a short time, do not wait till after the new patients, each of whom takes a long time. The total pressure on the dispensary will be affected by the number of separate consulting room 295

* At the dispensary stage, of course, patients wait outside not only before receiving attention but while receiving it. This adds to the difficulty of knowing for certain whether a reported time of waiting refers only to the former period or includes also the latter. *See* note on page 7.

† The same dispensary is often used for in-patients as well, though mostly at a different time of day. We have received complaints that the work of the dispensers is sometimes held up at tea-time ; but we were always assured by hospital witnesses that arrangements were made to avoid this.

pars. 340 units which are working simultaneously. Other remedies adopted or considered by hospitals are, therefore, the fixing of different times for different special departments, or even the holding of additional sessions in the day for general out-patients, all with the object of distributing the patients more evenly. At one suburban hospital we are told that repeat medicines are now dispensed on special days at specially reserved times. Sometimes the number of dispensers has been increased or part-time officers appointed to cope with peak loads, though the possibilities of this are of course limited by considerations of space and expense. Occasionally, a separate dispensary is provided for one or more of the special departments.

305.—The casualty department sometimes has its own dispensary, though the more common practice is for such casualty patients as need medicines to go to the same dispensary as the out-patients, there being sometimes a special casualty hatch.

306.—We have come across instances where one hatch is used for handing in prescriptions and another for handing out the medicine. We have mentioned the hospital where one hatch is kept for urgent cases. We have not been told of any dispensary with separate hatches for patients needing stock mixtures and for those with special prescriptions; though at one hospital we found different hatches, together with the waiting spaces opposite them, reserved for the patients of different doctors, because of their different methods of prescribing, though one dispenser would help another if the pressure was unequal.

307.—There is undoubtedly a tendency for a pool to form outside the dispensary, and for this reason the various remedies to which we have referred have been receiving, and should continue to receive, special attention from the hospital authorities.

Almoner or Inquiry Officer Stage.

308.—This stage is discussed last, not because it comes last, but because it comes at different times in different hospitals. It may come before the examination and treatment stage, after that stage, or partly before and partly after.

309.—The fundamental reason for this difference in procedure is that this stage includes two different kinds of function, often carried out by different kinds of officer, and often applying in part to different groups of patients.

243 310.—The differences between the two functions have already been described. One is inquiry into means in order to determine financial suitability for treatment in an out-patient department; the other is inquiry with a view to the provision of supplementary assistance or after-care. The first function is now also associated with the assessment of the patient's ability to contribute towards the cost of his treatment, and often with the collection of the contribution.

246 311.—The differences between the two kinds of officer, the inquiry officer and the almoner, have also been described: the term inquiry officer being associated more with the detective side of inquiry work, and the term almoner more with its friendly benefit side. But it does not follow that every hospital always has both. The original object of inquiry was to prevent hospital abuse: the almoner system was subsequently suggested as being a better method of inquiry, combining the exclusion of the unsuitable with a more efficient service to the suitable. Some hospitals retained inquiry officers, some substituted almoners, some kept the inquiry officer and added the almoner; and these differences have sometimes continued to this day.

312.—As the result of different combinations of these three factors there are three main types of procedure:

(A) Where patients see an inquiry officer before the examination and treatment stage for inquiry into financial suitability, and those who need after-care also see an almoner for that purpose after that stage;

(B) Where patients see an almoner before the examination and treatment stage for inquiry into financial suitability and those who need after-care also see the almoner for that purpose after that stage;

(C) Where patients see an almoner after the examination and treatment stage both for inquiry into financial suitability and for after-care.

If the hospitals from which we received oral evidence can be taken as a sample, type A is more common than type B, but less common than type C; the proportions being approximately as seven, four, and eight.

313.—From the point of view of the kind of officer who carries out the respective functions it will be seen that type A employs inquiry officers for inquiries into financial suitability, while types B and C employ almoners for this purpose, the proportions on this basis being approximately as seven to twelve. All the types employ almoners for after-care purposes.*

* Staff returns for all the hospitals to which the questionnaire was sent show that for out-patient work 23 employ inquiry officers only, 14 have both inquiry officers and almoners, and 38 have almoners only. Almoners are also employed for work in connection with in-patients. The same almoners may give part of their time to each, or there may be a separate staff, according to the size of the hospital and the method of organising the departments.

pars.

314.—If classified according to the time at which the inquiry into financial suitability takes place, types A and B have this before the examination and treatment stage and type C has it after, the proportions being eleven to eight. In all the types the after-care inquiry follows that stage.

315.—Considered from the point of view of the time taken by the patients, the effects of the respective methods depend partly on the number of patients who in actual practice are interviewed for the different purposes. If there were no exceptions, the effect would be that with either type A or type B all patients would pass through the stage of inquiry into financial suitability, while such patients as were afterwards found to need after-care, estimated by the Hospital Officers' Association at about 10 per cent., would pass later on through a second inquiry for after-care purposes. Under type C all patients would pass through only one inquiry, which for 90 per cent. would be only for financial suitability, while for 10 per cent. it would be also for after-care.

316.—In actual practice, however, there are a good many exceptions. In the first place, it must be remembered that large and increasing numbers of patients are exempted by membership of a 250
contributory scheme from inquiries into means, though in some cases investigation of the circumstances of the home may be needed for the guidance of the medical staff, and the almoner is, of course, prepared to interview such patients for the purposes of supplementary assistance or after-care. In the second place, at hospitals with type A or type B, it may be only for the doubtful cases that there is any special inquiry into financial suitability, whether by inquiry officer or by almoner, separately from the registration stage. For many patients, therefore, these methods may not mean a separate early stage, 278
but only that the registration stage is somewhat lengthened. In the third place, even with type C, it may be the practice that the number of patients who see the almoner for inquiry into financial suitability is limited to those who have been already regarded by some previous observer as doubtful; the almoner stage being thus confined to the doubtful cases and to those needing after-care. This is, at all events, the practice at one of the large teaching hospitals. At another it is only the medical cases which all see the almoner.

317.—The different types of procedure are strongly defended by the respective hospitals. The arguments involve questions of policy, besides the questions of the relative time taken. It will be convenient to take these separately.

318.—With all three types the hospitals are agreed that after-care inquiries should be made by almoners, and should take place after the patient has seen the doctor, so that the diagnosis and method of treatment will be known. The differences arise on the two questions—by whom, and at what stages, the inquiries into financial suitability should be made.

319.—On the question whether inquiries into financial suitability, and into capacity to contribute, should be made by an almoner or by an inquiry officer, we have already seen that a majority of the hospitals which gave oral evidence entrust it to the almoner. The minority are, however, 313
supported by the evidence given on behalf of the Hospital Officers' Association. The reasons include the desire to separate the detective side of inquiry from the after-care side, the fear that the after-care patient may otherwise associate the almoner too much with the collection of contributions, and the 246
feeling that the almoner, as a trained social worker, should not spend her time on routine inquiries which are considered not to need the kind of interview for which she is specially qualified. On the other side it is argued that during the financial inquiries the almoner gets to know the patients, gains their confidence, and obtains information which saves time in the after-care inquiry. Sometimes a hospital aims at combining the advantages of both; the inquiry officers' notes are placed at the disposal of the almoner, or the officers are themselves attached to the almoner's department.

320.—On the question whether the inquiries into financial suitability should be made before the examination and treatment stage or after it, the majority prefer the former. Apart from 314
considerations relating to time-saving, which will be discussed separately, it may be argued, on the one side, that the patients who are financially unsuitable ought to be excluded before they gain the advantage of an interview with the consultant; and, on the other side, that until the diagnosis has been made and the cost of the treatment can be estimated it is impossible to say whether they are suitable or how much they should be asked to contribute.

321.—There remains the question how far these arguments on matters of policy are affected by the difference in the time taken by the respective methods. Type C methods mean that, after examination and treatment, more patients see the almoner, since they will not be limited to those needing after-care; the interviews will be longer, since no financial information will have been obtained beforehand; and patients that do not need after-care may have to wait longer because they follow those that do. On the other hand, type A or B methods mean that the patients needing after-care have to go through two different interviews at two different stages, though against this has to be set off the time saved by the shortening of the second interview and of the wait before it.

322.—Another argument affecting the relative time taken is that the purely financial inquiries are often so short they they can be completed during the inevitable interval between the registration stage and the examination and treatment stage, and therefore do not add to the total period spent at the hospital, especially if they are partly included in the registration itself; whereas inquiries

pars. between the treatment stage and the dispensary stage will frequently cause delay in the patient's progress.

323.—Apart from these questions affecting the types of procedure, three modifications of the usual methods have been adopted or suggested. One large hospital which believes in type C methods has nevertheless decided to save time by arranging for surgical cases to see the almoner before they see the doctor, and medical cases after. At another, a special sub-committee has recommended that the out-patient sister should have discretion to arrange for some patients to see the almoner after the dispensary and some before they see the doctor, thus spreading the work on occasions when there would otherwise be congestion. The Hospital Officers' Association, which advocates type A, suggested that, except where the medical officer desired the contrary, after-care patients might see the almoner, not on their first visit but on their second, when their other stages would take less time.

252 324.—In casualty departments there is usually no inquiry stage, except that, at some of the
324 hospitals where that department is used as a sifting place for out-patients, financial inquiries by registration officers, or even an interview with members of the almoner's staff, may take place there.

325.—Old patients do not as a rule go through any inquiry stage, except that a few special cases may have to see the almoner. Patients' contributions are, however, commonly made at each visit.

326.—Our own attitude towards the subject of the different types of inquiry procedure is that, where there is such a wide difference of opinion among the hospitals, and amongst the officers who are dealing every day with the problem at first hand, we are hardly in a position to pronounce a judgment on the questions of policy which are involved. The question of the relative amount of time taken by the different methods is, however, very relevant to our subject. It is difficult to make any real comparison of the respective times without further information of the kind which would
374 be supplied by counts of hours, such as we have already mentioned and shall refer to again later on. But we think that the hospitals concerned might well consider, first, whether time could be saved by the adoption of one or other of the alternative methods, and, second, whether the advantages of any such saving could be secured without any countervailing disadvantages.

Time Saved or Lost by Sifting.

221 327.—The object of sifting out minor cases, by any of the methods described in a previous section, is to reserve the consultative and specialist facilities of the out-patient department for the major cases which really need them ; and one of the advantages claimed for this policy by the hospitals which have adopted it is that it reduces overcrowding and saves time. But the sifting is itself an additional process, and the time it takes has to be compared with the time it saves.

328.—The direct saving of time due to the sifting out of minor cases must be very considerable. The minor cases can receive their treatment from junior officers either at once or simultaneously with the major cases. The major cases will not have to wait their turn with minor cases to see the consultant, and he will have more time to give them. The flow of cases to the dispensary will be more even

329.—Where sifting is done in the out-patient department, the additional time taken for each individual patient is probably small. Whether the sifting comes immediately before or after registration, or whether it is part of the examination and treatment stage, this is one of the questions that could hardly be decided except by comparative counts of hours.

330.—Sifting in the out-patient department will affect overcrowding only indirectly as a result of the saving of time. It will not reduce the number of patients who will arrive at a fixed hour and will pass through the registration stage. They will, moreover, all pass through the later stages, except in the rare instances where minor cases are referred to the casualty department. But overcrowding in the later stages will be reduced or prevented by the speedier departure of the minor cases.

331.—Where sifting is done in the casualty department there is a direct reduction in the numbers arriving at the out-patient department, and therefore a direct saving of time at the registration stage in that department, as well as the saving at the later stages. The minor cases will perhaps be dealt with even more rapidly, especially if the sifting is done continuously with small numbers coming throughout the day. The dispensary especially benefits by this arrangement.

332.—On the other hand, the major cases will have to attend in two departments instead of one, and the effect of this on the time taken needs to be carefully considered There are two factors: the extent to which any of the stages of procedure are duplicated, and the interval between attendance at the casualty department, which may or may not be at a prescribed time of day, and attendance at the out-patient department, which always is at a prescribed time.

333.—If the sifting in the casualty department is done continuously throughout the day, the major cases may be registered and have financial particulars taken before they see the casualty officer who does the sifting. But this will not usually involve much waiting, because the patients are only

present in comparatively small numbers. If they happen to come just before the hour for the out-patient department, they will go there without delay. If not, time must elapse before they can go there, and it may not be possible for them to go till next day. There is thus the risk of having either to wait or to pay two visits to the hospital. pars.

334.—The amount of additional waiting from these causes could be reduced by applying remedies which we have already mentioned. Advantage can be taken of the duplicate machinery of registration to carry out in the casualty department, for each of these patients singly, the complete registration which would otherwise have to be done in the out-patient department during the peak load period at the fixed hour of arrival. The risk of waiting or double journey through coming at an unsuitable hour would be reduced if information about the hospital time-table could be more widely diffused. We have already discussed some ways of doing this. 278 205

335.—If the sifting in the casualty department is done mainly at a prescribed time of day, patients both major and minor will arrive in comparatively large numbers. So far as we know, the sifting by the doctor, whether consultant or junior, is always the first stage, after the necessary preliminary sorting, and waiting in the casualty department before the sifting is thus reduced to a minimum. The registration procedure will then be carried out subsequently either in the casualty or in the out-patient department, duplication being thus at a minimum.

336.—The risk of loss of time between the two departments will then depend on the interval between the respective hours of opening. If the hour for sifting is only a short time before the hour for the attendance of out-patients, the waiting here also may be very small. If the sifting is, say, in the morning and the out-patient session in the afternoon, the patient may have to choose between waiting and going away and coming back. There is, however, at least one way of compensating the patient for this. At one of the large teaching hospitals, where the consulting surgeon sifts cases in the morning and sees the major ones in the afternoon, he gives them appointments for definite hours. The amount of waiting in the out-patient department is thus reduced to a minimum. 236, 356

337.—It remains to mention that, as a doctor's letter addressed to a member of the visiting staff usually admits the patient direct to the out-patient department, the increased use of such letters by general practitioners in suitable cases would reduce the numbers who have to run any of these risks of waiting, especially if the doctor also tells the patient the proper hour to attend. 219

338.—We are of opinion that an accurate comparison between the time saved by the sifting out of minor cases, and the time taken by the different methods of sifting, can hardly be made except with the aid of some form of counts of hours. But if there are any considerable differences in the time required by different methods, this fact should be taken into account, along with the other arguments for or against each method, in deciding which is best suited to the circumstances of any particular hospital. 374

B. GENERAL PROCEDURE.

339.—Several remedies for overcrowding or waiting have been suggested or adopted which do not come under the head of any particular stage, or which affect all the stages. These include additional sessions for general or special out-patients, different hours of attendance for different classes of patient, appointments for individual patients or groups of patients, and limitation of the number seen on any one day. Under this general head it will also be convenient to consider questions of general organisation, the provision of what may be called amenities, and the time taken by the whole procedure made up of all the different stages added together.

Additional or Separate Sessions : Special and General.

340.—It is becoming more and more the practice to reduce the pressure on the out-patient department, where possible, by arranging for different classes of patients to attend at different places or to come at different times. The most obvious as well as the most common way of doing this is to have separate departments or separate sessions for patients suffering from special ailments which can be treated by specialist members of the medical staff. This is done partly by providing separate suites of rooms, and partly by using the same rooms at different times of day.

341.—Separate accommodation is highly desirable, if not essential, for some kinds of specialities, but in itself it does not relieve the peak load pressure at such stages as registration and dispensary, unless the special departments have separate accommodation for these or unless these parts of the general out-patient department are enlarged. It is therefore often more economical for some at least of the special departments to meet at different times of day ; and this is frequently mentioned by hospitals as a means by which overcrowding and waiting have been reduced.

342.—Another proposal, mentioned to us as being under consideration by a large non-teaching hospital, was that on the days of the week found by experience to be the most crowded there should be two sessions for general out-patients in the morning and two in the afternoon instead of one each

pars. as now. This is more difficult to carry out, since it would require an additional staff of general consultants, whereas the special departments already have their separate staffs. At one large teaching hospital surgical patients are seen in the morning and medical in the afternoon.

343.—Separate sessions have also been mentioned in connection with different classes of patient. Hospital Saving Association witnesses have suggested evening sessions for workers employed in the daytime, and one large hospital has provided them in its casualty department. Another has an evening clinic for massage, at a special charge of 2s., with a separate appointment for each patient, but finds it not much used. Some hospitals arrange for special clinics at which members of the senior visiting staff see discharged in-patients, or consultative cases specially referred to them by general practitioners.

344.—Special evening sessions have also been suggested for young people between the ages of 14 and 16—i.e., between the time when they pass out of the care of the school medical service and the time when they qualify for treatment under the National Insurance system. This is one of the most important needs, though there is the difficulty that the mere seeing of patients is often of little use unless the ancillary services such as the X-ray and bacteriological departments are available.

Different Hours of Arrival within the same Session.

345.—Another kind of remedy adopted or suggested aims at spreading the times of arrival within each session, either by providing that different classes of patient shall arrive at different times, or by making appointments for individual patients or groups of patients. The principal classes mentioned under the first head are new patients and old patients, and men and women.

(i) New Patients and Old Patients.

346.—In the case of new patients and old patients the question arises because of differences in procedure which we have already described in connection with the separate stages of registration, examination and treatment, and almoner's inquiries. These result from the differences in the needs of the two classes, and from the fact that the needs of the old patients can usually be supplied in much less time than those of the new. If the new are taken first because they are more urgent, then the old will have a long period of waiting in order to receive a short period of attention, especially if there happen to be exceptionally large numbers of new patients. Hence we receive through the Hospital Saving Association the two complaints : first, that the new patients are seen before the old, and second, that they are both required to attend at the same time.

347.—There are two remedies for this. One is to arrange for new and old patients to be dealt
281-2 with simultaneously in different places. We have mentioned examples of this at the registration
295 stage and at the examination and treatment stage. The other remedy is to arrange for new and old patients to arrive at different times. A good many hospitals have already adopted a later hour for old patients than for new. Among the hospitals which gave oral evidence on the subject, seven have the same hour, and six have a later hour for old patients. The intervals mentioned are usually half an hour or an hour. At one large teaching hospital about half the old medical out-patients are seen in the morning before the arrival of the new patients, and about half in the afternoon after the new patients have been seen, and by this means the waiting has been diminished. At another teaching hospital the consultants tell such old patients as they wish to see personally to attend two hours after the usual time of arrival ; but about half of them nevertheless still come at the earlier hour.

(ii) Men and Women.

348.—The question of different hours of attendance for men and women patients sometimes arises because at some hospitals men are treated first, with the idea of enabling them to return to work. Some hold, on the other hand, that it is important to let the women go home as soon as possible to look after their children. Whichever sex is treated first the question arises whether the other sex need arrive at the same time. But the fixing of a different time for men and women may also be adopted merely because waiting will be reduced if the patients do not all come at once, and the distinction between men and women is an obvious one to make. Sometimes all the patients of one sex are treated first because the dressing room accommodation is limited. At one hospital where both sexes come at the same time the physicians see men first and the surgeons see women first.

349.—Whatever may be the reason, different times have been fixed at four out of the hospitals which gave oral evidence. Sometimes the rule applies to general out-patients, sometimes only to certain special departments. In each case the hour for women is later than that for men, the intervals including half an hour, one hour, and an hour and a half.

(iii) Other Special Classes.

350.—Special arrangements are occasionally made for other classes. At one large general hospital a separate bench and treatment cubicle are provided for workpeople who arrive not later than one hour after the opening, with a written request from their employers for early treatment. At

one of the smaller general hospitals rheumatic children are told to come late in the afternoon when the other patients will have been cleared off. A large ophthalmic hospital reports that patients who have already had drops in their eyes, and can therefore be dealt with rapidly, are instructed to attend punctually next time and are treated in a special room. pars.

(iv) Appointments for Individuals or Groups.

351.—It is frequently suggested that a great deal of waiting would be obviated if different patients were given appointments to attend at different hours, as is done in a consultant's private practice, instead of all coming at the fixed time for the opening of the session. It is recognised that this could not be easily applied to the first attendance of new patients, and that the appointments would have to be given to patients in groups or batches at regular intervals.

352.—This idea is certainly very much in the air at present. It is said to have been tried successfully in a general hospital in the North of England. It was suggested in the evidence from the Hospital Saving Association and from the Hospital Saturday Fund, and it was specifically mentioned in the resolution of the Medical Advisory Committee of the Charity Organisation Society to which we have already referred. This ended by expressing the hope that the King's Fund would urge upon the hospital authorities the desirability of taking steps to ease the present situation, either by some form of group appointments or by any other means that might be found practicable. The subject was also mentioned by a good many hospitals in reply to the section of the questionnaire relating to remedies recently considered or adopted. The Hospital Officers' Association also referred to it in their statement of evidence. We therefore made a point of discussing it with most of the witnesses giving oral evidence. 46

353.—The general tenour of the hospital evidence was that the appointments system could be applied successfully in certain of the special departments, but that it was not thought possible to extend it to general medical or surgical out-patients.

354.—We have been told of fourteen kinds of special departments at which the group appointments system for old patients is in operation, the number of hospitals reporting experience of this kind being fifteen. The departments, arranged in the order of the frequency with which they are mentioned, are massage, electrical, dental, children's, maternity, varicose veins, and, in alphabetical order, diabetes, ear, genito-urinary, gynæcological, neurological, physico-therapy, and radium, besides casualty dressings and minor operations. Individual appointments have been mentioned in connection with children's and neurological departments. One large teaching hospital reports that, out of a total of 558,000 attendances a year, 197,000 are made by appointments at five special departments.

355.—It will be noticed that among the departments mentioned there are several at which the treatment of each individual patient takes a fairly long and fairly constant and predictable time, and is not necessarily carried out by the medical staff.

356.—Occasional instances have been reported where it has been possible to make appointments for new patients. This is sometimes done by one hospital for dental and maternity cases. At a suburban hospital with a purely consultative out-patient department at the hospital and an open-access auxiliary department in the poorer part of its area, all the consultative patients are given appointments. We have already mentioned a large teaching hospital where the visiting surgeon sifts his general surgical cases in the casualty department in the morning and gives appointments at fifteen-minute intervals to the patients whom he decides to see in the out-patient department in the afternoon, in addition to those coming with doctors' letters addressed to him. If any of the selected patients come late they have to wait till last. Witnesses from this hospital, which has long paid special attention to out-patient organisation, expressed the view that the appointments system could gradually be extended from the special departments to the whole hospital, and that, though it would not be easy with large numbers, it was hoped that the difficulties would not prove insuperable. 336

357.—The difficulties mentioned in evidence in the way of extending the group appointments system to general medical and surgical out-patients are of three kinds.

358.—In the first place, we are told that it would be difficult to secure the attendance of the right number of patients to occupy the successive periods. It is said that patients cannot be relied on to keep the appointments: they either come too early or too late. At a children's hospital which made counts of hours for a sample month, it was found that, of the patients who were given appointments for certain special departments, about one-third arrived late. At a hospital where the system was introduced for casualty dressings only one in twenty-five kept to the time. If this were the result the visiting staff might have intervals during which no patient was present. Gaps might also be caused by exceptional numbers of cases taking only a short time. Even if this could be prevented by making the groups large enough, it might still happen at a teaching hospital that there were no cases present which would be of value for teaching, and the work of the students would be interrupted. On the other hand, the arrangements might be upset by the arrival of urgent cases 382

359.—In the second place, it has been represented to us that great difficulty would be caused to the visiting staff. If all the patients allotted to a consultant at a session are present when he arrives

pars. he can decide which he wishes to treat himself, which are useful for teaching purposes, and which he can leave to his assistants. He can thus plan out his work and go away when it is finished. But if patients come in small numbers throughout the session he must always stay till the last group arrives, perhaps only to find that they do not need his personal attention. It has also been suggested that, 365 as the time required by each patient is so uncertain, the consultant could hardly make appointments for as many patients as he now actually sees in the time. In any event appointments could only be made for a limited number of patients at one session.

360.—In the third place, it is suggested that the system would require considerable expenditure and much clerical labour, especially in the large hospitals. The appointments would have to be spaced out and cards given to the patients. At one large hospital this is done for the children's department twice a week by two volunteers. Registration would take place at intervals during the session instead of being concentrated at the beginning. But our evidence does not show whether these items would be serious.

361.—In order to judge of the force of these objections it is necessary to consider whether it is proposed to apply the system to new patients or only to old patients. If it is to be applied to new patients, then it involves some prior communication between the hospital and each patient or the doctor sending the patient, unless it is done when the patient is attending for a preliminary sifting. If it applies only to old patients the arguments are affected by the fluctuations in the daily numbers of new patients, and by the fact that, except in the special departments already mentioned, the treatment of an old patient takes a comparatively short time and is often done by an assistant and not by a member of the visiting staff. So far as the latter are concerned the appointments would apply only to the patients marked by him for his personal attention.

362.—A partial form of the appointments system has been recommended by a sub-committee at one of the teaching hospitals, whereby the patients would not be summoned for a series of group appointments but only in two batches, one at the usual time of arrival and the other at a time half way through the session, the size of the first batch being determined by the average time taken by their treatment. This is based on an experiment by one of the visiting staff with his old patients, and is 365 suggested in connection with a system of sifting new patients and allotting only a limited number to each consultant ; but it does not follow that the method of two groups per session would not be worth considering as a general alternative.*

363.—An alternative method which has been suggested for spreading the attendances of patients is that each consultant, when telling a patient to come and see him again, should mention a particular day and should, by keeping a simple record of the allocations, limit the number of old patients who would come on any one day.

364.—We noticed during our inquiry that, while the evidence which spoke of the success of the system in special departments was based on experience, the objections to its extension to general out-patients were largely anticipations of what would happen and not reports of what had happened. 388 For a reason which we shall mention when we come to our conclusions on this part of the inquiry, we think that the hospital world and the public generally are right in having paid so much attention to the question of different times of arrival for different patients, since it has a direct bearing on the question how much of the waiting at hospital out-patient departments is inevitable and how much is not. We are of opinion, therefore, that the problem should still be the subject of discussion and, if possible, of experiment, in order to ascertain whether the difficulties, which are clearly very real, are or are not wholly insuperable.

Limitation of Numbers.

365.—The plan of limiting the number of patients to be seen by any one consultant at any 359 one session has been mentioned by witnesses as a necessary condition of a practicable system of 362 appointments for general out-patients. But it has also been suggested as being in itself a desirable method of preventing such excessive pressure on the time of the consultant as might militate against the efficient diagnosis and treatment of serious cases. At one hospital it has recently been recommended by a sub-committee who state that the consultant may now have 20 new cases averaging at least 15 minutes each.

366.—It has in fact been in operation for some years at a small number of hospitals where sifting is done in the casualty department. The medical officer selects the cases which are the most suitable to be seen in the out-patient department up to the prescribed number for each consultant. Examples of the prescribed numbers are 12, 15, 18 or 25 usually not including patients coming with doctors' letters addressed to the particular consultant but occasionally including them. By the latter

* *Cf.* pars. 275 and 358. It is interesting to compare the arguments about appointments with the experience of hospitals which have a fixed time of arrival with a wide range (e.g., 12–30 to 2–30). This enables patients to choose their own time within the prescribed limits. Other things being equal, the result is that those who come first will be seen first and those who are seen last will have come last. In order to keep this within bounds, some hospitals have found it necessary to narrow the limits, or even to prescribe a single fixed hour in between (e.g., 1–30). The appointments system would prescribe single fixed hours at more or less distant intervals (e.g., 1–30, 2–0, 2–30, 3–0, etc., or, in this partial form, 1–0 and 3–30).

method the consultant's whole quota is fixed, by the former it is limited, though still partly dependent on the number coming with letters. pars.

367.—The patients who are in excess of the prescribed number may be either treated on the spot, or given priority for next time. At one women's hospital they may be added to the quota if serious or may be advised to go to a neighbouring general hospital. We were informed by one of the teaching hospitals that limitation had been tried and had been discontinued many years ago because of the dissatisfaction caused amongst those sent away. It should be noted that the method is closely associated with the sifting of patients by a doctor. Where the sifting itself is done by a consultant this difficulty will be at a minimum.* If it be once admitted that there is a limit to the number of patients which a consultant can treat efficiently at a sitting, there are not many alternatives open. Either he must attempt the excessive number, which is probably his natural instinct, or the number must be limited. The first of these alternatives might compel rapid work towards the end of the clinic, resulting in pressure on the dispensary at a late hour. Under the second alternative there are two courses open: either the number may be limited at a sifting stage, whether that takes place in the casualty department or in the out-patient department, or, where there is no preliminary sifting, the consultant himself must keep his maximum number in mind when he decides which cases he will deal with personally and which he will leave to his assistants. The term limitation of numbers is, however, usually applied only to the fixing of a specified quota at a sifting stage.

General Organisation and Amenities

368.—We have not received much evidence to show that the amount of waiting is materially affected by differences in general organisation, but a few points of interest have been brought to our notice.

369.—Some hospitals have lay supervisors in charge of the general administration of the departments, and the duties of this office may include that of deciding on the financial suitability of doubtful cases.

370.—A good deal may depend on the arrangements for regulating the movements of patients, grouping them, marshalling them and helping them to find their way about. This was mentioned in the evidence of the Hospital Saving Association, and occasionally by a hospital which had effected an improvement by increasing the staff of porters. One teaching hospital has secured the voluntary services of V.A.D. nurses from the neighbouring branch of the British Red Cross Society. They supplement the ordinary nursing staff by telling patients which way to go and giving them friendly assistance. Some hospitals have adopted a system of electric sign-posting, similar to that on the Underground Railways, with differently coloured lights to mark the routes to the various departments. This facilitates the giving of verbal directions if it does not take their place. It was recommended in the evidence from the Hospital Officers' Association.

371.—On the question of amenities, almost the only complaints reported to us related to two subjects. One was that the waiting accommodation at some hospitals was said to be cold and draughty, especially when patients had to wait an extra time to attend special departments and the main waiting-hall was the only place for the purpose. Sometimes the fact of having to stand in queues is mentioned. The other subject of complaint is the time sometimes spent by patients after they have undressed and before they are examined by the doctor, and we certainly consider that this should be avoided wherever possible.

372.—We have already referred to the question of the medical examination of patients in the presence of others. We gather that some patients do not like this, while others do not mind. There is the same difference on the question of the presence of students.† 289

373.—It is the common practice to provide a canteen in the out-patient department, though it appears from the Hospital Saving Association evidence not to be universal. The Hospital Officers' Association suggest that members of the Ladies' Committee of the hospitals should interest themselves in the working of the canteens and generally in the welfare of the out-patients, as a method of making the atmosphere more congenial. So long as the present hours of waiting continue, there is much to be said for this. The feelings of patients on the subject of amenities depend largely on what they are accustomed to in ordinary life. It used to be brought up against the out-patient departments that they attracted numbers of patients who regarded them as pleasant places in which to spend an afternoon and have tea. We are told that this kind of patient is still to be found. But there is an increasing number of a different kind, of whom the regular wage-earner who subscribes through a contributory scheme is a type, who value the hospital for the quality of the service it provides. They

* At one hospital the methods include three special features: preliminary sifting by consultants in the casualty department, appointments for the patients selected for the out-patient department, and limitation of their numbers. 236, 356

† In this connection we may quote what the Pay Beds Committee of the King's Fund said in 1928, with reference to a particular scheme where it was a condition of certain special facilities that, unless the patient raised objection, the member of the honorary staff attending him would be accompanied by his students: "The patient who objects is placing himself in the position of being willing to benefit by all the knowledge gained in the past from the cases of other patients, but of refusing to permit any future patients to benefit by anything that might be learned from his own case."

pars. appreciate many of the real difficulties of out-patient organisation for large numbers, and readily accept explanations which have that basis. On all grounds the signs of an increased interest in the out-patient department on the part of the voluntary workers on the hospital committees are much to be welcomed. We have already expressed the opinion that it is important, in the interests both
38 of the patients and of the hospitals, that channels should be readily available whereby complaints could be made with the assurance that they would receive due attention.

Total Time Taken: Counts of Hours.

374.—It is not possible to give any accurate or comparable figures of the time taken at different hospitals by the whole of the procedure. We know the time at which each session opens, and we sometimes have estimates of the time at which the dispensary is clear on normal days and on exceptionally busy days. This would not give the time for any separate patient unless all the patients arrived at once, and then only for the last one treated. Occasionally a witness has been able to estimate the average time taken by individual patients, or the maximum time, and at a few hospitals definite counts of hours have been made during a sample period by the timing of each patient at definite stages in the procedure.

375.—The following are examples of the time taken by the whole of a session for general medical or surgical out-patients at teaching hospitals: hour of arrival 1 p.m., dispensary normally clear by 4–30; arrival 1 to 1–45, dispensary usually clear by 4–45; arrival, new cases 12–30, old cases 1–30, dispensary usually clear by 5; average for three months for commencement and termination of clinics, medical 12 to 4–30, surgical 9 to 12–30 or 1, followed in each case by attendance at the dispensary; at a non-teaching hospital, arrival 12–30, dispensary usually finished by 3, but sometimes not till 5.

376.—For the average time spent by an individual patient we have practically no evidence except that given by counts of hours. Apart from this we have a few estimates given verbally by hospital witnesses, of which two hours may be taken as a sample. Several of the complaints forwarded
46 by the Charity Organisation Society mentioned times spent at hospital, but it is sometimes difficult to know what these include.* One hospital witness had made the interesting calculation that the minimum time for a single average patient who had the place to himself would be 33 minutes.

377.—Counts of hours have been reported to us by three teaching hospitals and one large children's hospital. These counts were made on the initiative of the hospitals concerned, three of them after our inquiry began. They differed widely in their scope, and this must be borne in mind in comparing their results.

378.—In these counts the very long times may have been due to special circumstances or to examinations, such as X-ray or pathological, particularly where the patient waited for the result

379.—The first teaching hospital recorded, for one week, for each patient, in several departments, the time when his registration stage ceased, and the time when his examination and treatment stage began. The average interval for all patients came out at about 1 hour. The average time for general medical and surgical patients alone was 1½ hours: 5 per cent. of these patients waited less than half an hour and 2 per cent. more than 3 hours, the minimum being 12 minutes and the maximum 3 hours 14 minutes. This did not include registration or seeing the doctor or getting medicine, but did include seeing the almoner during the wait for the doctor.

380.—The second teaching hospital recorded, for one teaching day, for medical out-patients in the out-patient department both new and old, after preliminary sifting, the time of arrival and the time of departure. The average interval for these patients came out at 1½ hours; 19 per cent. waited less than half an hour and 14 per cent. more than 3 hours, the range being from 5 minutes to 4 hours 35 minutes. The count did not include time previously spent in preliminary sifting in the receiving room, nor that spent by after-care cases in seeing the almoner, but it did include registration and getting medicine at the dispensary.

381.—The third teaching hospital made a sample count, for one week, for each patient, whether new or old, of the time of registration and the time at which the medicine was dispensed. The average for general patients was 1 hour 17 minutes. This included for new patients the taking of registration particulars and any wait beforehand, but not the issue of record papers to old patients; nor did it include the sifting of new patients in the casualty department just previously.

382.—The children's hospital recorded, every day for four weeks, for each patient, old and new separately, the time of the beginning and end of each stage, including special examinations, from the time of arrival for the preliminary sifting out of very minor cases in the casualty department to the

* It is sometimes difficult to be sure what is included in a hospital's own estimates. The terms used are different. The opening of a clinic is the hour of arrival; its closing may be the time when the examination and treatment stage is over. Occasionally a hospital does not regards its dispensary as being part of its out-patient department at all. The word session is here used to cover the whole.

time of departure. A sample average viz., for new patients on Mondays, was : from arrival to end of seeing casualty officer for sifting, 20 minutes ; wait and get letter at registration stage in out-patient department, 18 minutes ; wait and see almoner, 45 minutes ; wait for doctor, 42 minutes ; see doctor, 37 minutes ; wait and get medicine, 24 minutes ; total from arrival to departure, 2 hours, 58 minutes.* The range was from three-quarters of an hour to 5½ hours. This covered all stages The counts also showed what percentage of the patients that were given appointments kept to their times. pars. 358

383.—In order to get the best results from counts of hours they must be made on a uniform plan for at least two hospitals of similar type, so that the times taken by their different methods of procedure may be compared. It was not possible for us to follow up this subject without unduly delaying our report. But we consider that the hospitals would find it a useful way of testing the value of different methods from the point of view of the time taken, and perhaps the King's Fund could assist them to do this, with the help of the information we have collected, and possibly by the loan of recording clocks. So far as our study of the subject has gone it has suggested to us the following tentative conclusions :— 52

(i) that a simple timing at arrival and departure would be useful for a first comparison between the results of different types of procedure at different hospitals ;

(ii) that timing at every separate stage would involve great labour, particularly if special examinations were included ;

(iii) but that the following method might prove both simple and useful :—

(*a*) that a time-record might be made for each individual patient on arrival and departure. Each patient could be given a numbered card which would be time-stamped on arrival and on surrender at exit, e.g., the porter at the entrance could have a supply of numbered cards ; he could time-stamp each in turn and hand it at once to the incoming patient, the patient's name being added later on so that there should be no waiting in a queue before the first timing ;

(*b*) that, in order to enable cases of exceptionally long time to be explained or omitted from the average or tabulated separately, the patients' time-cards could be stamped at each intermediate stage or department, not with times of arrival and departure, but merely with a sign that the patient had been there, e.g., A for almoner, X for X-ray, P for pathological, etc. ;

(*c*) that, if this simplest form of count showed any considerable differences in the total average time for patients who had not been to special departments, it might be possible to tell, from subsequent observation at each hospital, at which stages of the procedure the additional time was taken, and then to test this by similar counts taken for those stages ; in making such counts it might not be necessary to identify the times with the names of the patients ;

(iv) that, alternatively, simple counts at particular stages might be useful independently of counts of total time taken, provided that it was remembered that one stage might affect another, so that extra time at one stage might not mean a longer total time.

384.—We put these suggestions on record not as being final but only for consideration. In the meantime we are grateful to the hospitals which made the experiments, especially to the children's hospital, where a great deal of time and thought was given to the problem of timing all the stages and all the departments.†

C. CONCLUSIONS ON THIS PART OF THE INQUIRY.

385.—The evidence summarised in this section, on the question of waiting as affected by methods of procedure, has shown that a certain amount of time has been saved at different hospitals by the adoption of particular methods, either at different stages or in matters of general procedure. It follows that no hospital can be quite sure that the waiting in its out-patient department has been reduced to a minimum, unless it has considered how these methods compare with its own or how far they are suited to its circumstances. The evidence also contains a number of suggestions which appear to us to be worthy of consideration by the hospitals.

386.—It is difficult to make any definite estimate of the amount of time that can be saved at any particular stage. A few minutes saved on each case will make a great difference to the patients at the end of a queue. The saving effected by a new registration system has been put at half an hour. If it should prove possible for the same hospital to effect improvements at more than one stage, the combined saving might be considerable.

* Each of these averages was based on the papers that happened to contain the necessary particulars, and these were not always the same papers : hence the difference between the details and the total.

† Perhaps we may here depart from our rule of not mentioning the names of individual hospitals. They are the Middlesex, the London, University College, and the Hospital for Sick Children, Great Ormond Street. It must be remembered that, owing to the different methods, the results are not directly comparable.

pars. 387.—The methods of general procedure on which evidence has been received are mainly of two kinds: different sessions and different times of arrival at the same session. Methods of the first kind produce a reduction in the numbers attending at any single session; the claims made for methods of the second kind suggest that considerable importance may attach to the question of a fixed time of arrival.

The Question of a Fixed Time of Arrival.

273 388.—We have already discussed the fixed time of arrival as one of the routine items of procedure, sometimes capable of improvement in details. The more fundamental question which we propose now to consider has been stated in two ways, from opposite points of view. On the one hand it is argued, as a reason why waiting is unavoidable, that if a number of persons wish to interview the same person at the same hour, the later ones must wait longer than the earlier, the length of the waits depending on the numbers and on the time taken by the interviews. This argument, when applied to out-patients, clearly presupposes a more or less fixed hour at which they all arrive and from which, after allowing for the preliminary stage of registration, all the waits begin. On the other hand it is asked why all the patients should come at a fixed hour so early that, when the doctors are ready to begin seeing the first of them, all the others, or a large number of them, will be ready and waiting. Since the doctors, it is asked, can only see them a few at a time, why need the patients be ready more than a few at a time; or, in other words, why should they not arrive a few at a time, so that each group will have approximately the same short interval of waiting before the doctor is ready to see them? If only such a procedure, which is virtually the appointments system, were practicable, then clearly it would do away with the greater part of the waiting between the hour of arrival and the time of seeing the doctor.

357 389.—We have quoted a number of reasons, laid before us in evidence, why such a procedure is often thought to be impracticable, except in certain special departments. But it does not follow that there is no middle course between a fixed hour of arrival for all patients, and the impossible ideal of a complete system of individual appointments. The hospitals are already making several departures from the fixed hour. As we have seen, the prescribed time of arrival sometimes takes the 275 form of a range of hours, so that some patients who will be treated after others will have come after those others, though it is said that even this amount of elasticity, unless very limited, sometimes 346 leads to trouble. Then there are the growing numbers of hospitals where old patients come later than 348 new, and those where women come later than men; and there is the hospital whose sub-committee 362 recommends a partial two-shift appointments system by which only some of the patients would be summoned at the opening time and the rest at an hour half way through the session, and where consultants already do this with old patients whom they wish personally to see. And these may not exhaust the possible experiments.

390.—We may perhaps put it this way. Let it be granted, first, that with a fixed hour of arrival a long wait is inevitable on the part of the patients seen last; second, that an ideal, though quite impracticable, appointments system for individuals would theoretically reduce all the longer waits to the level of the shorter; and, third, that in various partial ways hospitals have been able, for some groups of patients, to depart here and there from the fixed hour, in the direction of an adjustment between the times of arrival and the times of seeing the doctor. If all this is true, it seems to follow that, in connection with waiting as affected by methods of procedure, the question of the fixed hour of arrival may be found to deserve concentrated attention, just as the question of the numbers of minor cases has been shown to deserve it, in connection with waiting as affected by the suitability of patients.

391.—Until the subject has received a good deal more study, it is impossible to say whether it would be found practicable to make such departures from the fixed time of arrival as would solve the problem of waiting before the examination and treatment stage. There would undoubtedly be great difficulties in carrying out some of the suggestions. We would not go further than to say that, until the question has been thoroughly studied, no one can be sure that waiting before that stage has been reduced to a minimum.

Improvements at other Stages.

392.—In the meantime, and because even this would not directly affect waiting at later stages, there is every reason for studying the experience of the hospitals which have saved time by improved methods in other parts of the procedure. Here again we think that the King's Fund might well find itself able to help the hospitals by rendering available for their use some of the detailed information which has come before us in the course of our inquiry, by studying the question of counts of hours, and by various other methods.

SECTION V. WAITING AS AFFECTED BY ADEQUACY OF ACCOMMODATION.

pars.

393.—We have now discussed the evidence on the question whether there is avoidable waiting caused by the treatment of large numbers of unsuitable cases, or by defects in procedure. We have now to consider the question whether there is avoidable waiting caused by inadequacy of accommodation.

394.—According to one argument the prevention of waiting is wholly a matter of the expenditure of a sufficient amount of money on increases in accommodation and staff, and is therefore a question of finance. This argument is used as a proof that the present amount of waiting is unavoidable. It certainly cannot be denied that if unlimited increases were practicable all waiting could be abolished. It is equally undeniable that unlimited increases are wholly impracticable. But it does not follow that no reduction in the present amount of waiting is possible. The witnesses from the Hospital Officers' Association regarded inadequate accommodation as a fruitful source of delay, but only one of the sources, and not the most important. We have quoted a good deal of evidence to show that substantial reductions have been effected by changes in connection with suitability of patients and with procedure. There is also evidence that reductions have been and can be effected by structural extensions and alterations which are not outside the range of practicable finance in normal times.*

General Accommodation.

395.—A good many hospitals report that there is overcrowding and waiting due to general inadequacy in accommodation. At some of these the departments were built many years ago when out-patient treatment and organisation were very much more simple. Premises of this kind have long been inadequate not only because of increases in the numbers attending, but also because of the development of special treatments and of new methods of administration, needing not only more space but the provision of special accommodation for numerous different purposes. At some hospitals the department has been rebuilt and enlarged in comparatively recent years, but has again been rendered inadequate by later developments of the same kind. In the old days the out-patient department even of a large general hospital might have had only one waiting hall, with a registration desk near the entrance, one or two consulting rooms with a single dressing and examination room attached, and a dispensary hatch or two near the exit. The waiting hall of a modern out-patient department will often have a number of consulting room suites, each containing four or six rooms, and perhaps an ante-room for patients waiting their turn. There may also be a separate registration unit with its waiting room, a dispensary unit with waiting space, and perhaps a separate almoners' department; and parts of this elaborate accommodation may be reproduced on a smaller scale elsewhere for each of several special departments.

396.—Amongst the present out-patient departments there may be found numerous grades intermediate between these two extremes. Of the hospitals to which we sent the questionnaire, 24†, including 5 with schools, mentioned inadequacy of accommodation as one of their difficulties. Eighteen of these have schemes of extension in a more or less advanced state of preparation, though progress with most of them is at present held up owing to the financial crisis. The amount and quality of the out-patient work that is done in these conditions reflects the greatest credit on the staffs concerned, both medical and lay.

Accommodation for Specific Purposes.

397.—Apart, however, from the question of the general extension of an out-patient department as a whole, we have received evidence to show that it is often possible to reduce waiting by structural alterations or additions for specific purposes. Sometimes a small increase in the accommodation may relieve the congestion at a critical point, while even a slight structural re-arrangement may help to produce more rapid or more regular progress on the part of the patients.

398.—The examples of this have usually been mentioned already in connection with the stages of procedure at which they occur. Improvements in the registration facilities have sometimes been effected by the moving of a few partitions, sufficient to enable old and new patients to be dealt with separately. In the consulting room suites additional examination or dressing rooms have been provided. One hospital reported that a slight internal re-arrangement had produced two dressing rooms instead of one and greatly expedited the work by enabling a second patient to be prepared while the first was being treated. The provision of one or two doctors' rooms may enable old patients to be

282
289
294

* As evidence of the capacity of the voluntary hospital system for expansion, it may be mentioned that voluntary gifts for extensions and improvements of all kinds in London alone amounted in 1929 to £859,000, in 1930 to £863,000, and even in 1931, when a good many schemes were necessarily deferred, to £453,000.

† These 24 hospitals represent about 3,000,000 attendances out of about 9,000,000.

pars.
296 seen simultaneously with new, or minor cases with major cases, and we have seen that this may reduce the waiting before treatment and may regularise the subsequent flow of patients to the dispensary.
341 The provision of a separate dispensary for a special department, or even a slight re-arrangement of the
302 dispensary to enable another hatch to be opened, may greatly shorten the final stages of the procedure. At one large teaching hospital where a scheme for a new out-patient department has had to be deferred, great improvements have twice been effected by finding space elsewhere to which the whole work of one or more of the special departments can be transferred, considerable relief being thereby produced in the general out-patient department for a comparatively small expenditure. Opportunities might occur for reducing congestion in these or similar ways, during the period of financial stringency, by the temporary occupation of outside premises

399.—Casualty department accommodation varies widely in amount. Where the department deals only with minor cases coming in small numbers throughout the day, it can be small and simple in plan. All general hospitals must, however, contain adequate provision for serious accidents, either in connection with the casualty department or elsewhere ; and it is highly desirable that these should not have to be brought into or through any place where ordinary patients are waiting or receiving attention. Where the casualty department is also used as a sifting place for out-patients at a fixed hour, much more space is required. At the hospital where consultants sift cases in the casualty department, treat some there, send some to the out-patient department for teaching and leave the rest to the junior staff, the casualty department might almost be described as, structurally speaking, the central feature of the plan, the out-patient department proper being in this case one of the special departments, though of course by far the most important of them. The Hospital Officers' Association in their evidence urged that the casualty department should always be close to the out-patient department.

Conclusion on this part of the Inquiry.

400.—It would not be within our power, even if it were within our province, to make a complete survey of the out-patient accommodation in London in relation to the demands upon it. We have mentioned the instances which have been brought to our notice in order to show that here and there appreciable reductions in waiting have been produced, with ingenuity and favourable circumstances, at a comparatively trifling cost, or for an expenditure which in normal times would be well within the range of what is practicable.

SECTION VI. CONCLUSIONS AND RECOMMENDATIONS.

401.—Our conclusions on the general subject of our Inquiry are— pars.

(i) that the out-patient departments of the voluntary hospitals are popular and have the confidence of their patients; 22

(ii) that there are very few complaints except on the subject of waiting and overcrowding, and of overlapping with other and more recently established agencies which are now available for the treatment of minor cases. 40

402.—On the question of the fact of waiting our conclusions are— 41–60

(iii) that, although the direct evidence on the question is rather scanty and vague, there is no doubt that there is a considerable amount of waiting in the out-patient departments, though not much in the casualty departments, or in most of the special departments;

(iv) that most of the very long periods of waiting which form the subject of comment are due to medical or surgical circumstances affecting the patients concerned;

(v) that, although there are a good many complaints of waiting for medicines at the hospital dispensary, dissatisfaction amongst patients arises chiefly when a long wait occurs before the stage of examination or treatment;

(vi) that the further question whether there is undue waiting, i.e., unnecessary and avoidable waiting, depends on—

(*a*) whether the present amount of waiting is inherent in the provision of medical treatment for large populations; or

(*b*) whether it is partly due to inadequacy or unsuitability of accommodation capable of being remedied; or

(*c*) whether it is partly due to defects in procedure capable of being remedied; or

(*d*) whether it is partly due to overcrowding caused by the treatment of excessive numbers of minor cases, i.e., to the methods affecting suitability of patients.

403.—On the question of the suitability of the patients treated, and the effect of this on waiting, our conclusions are— 61–265

(vii) that the retention and treatment of large numbers of non-urgent minor cases which could be efficiently and appropriately treated, at a cost within their means, by other agencies such as those described in our Report, conduces to overcrowding and excessive waiting, and may render unnecessarily difficult the speedy and efficient diagnosis and treatment of major cases;

(viii) that, consequently, the present movement on the part of a large number of the hospitals towards the more consultative use of their facilities is, generally speaking, a movement in the right direction;

(ix) that this is particularly true of the facilities provided in the out-patient department proper, including the services of the visiting staff and the elaborate equipment for special methods of diagnosis and treatment;

(x) that it is nevertheless important that patients who desire a second opinion, and who cannot afford a private consultant, should continue to have access to the hospitals and, if necessary, to the out-patient departments proper and to the visiting staffs, without having first to obtain the consent of a general practitioner;

(xi) that it is important also, for the purposes of medical education, that a sufficient number of cases of all kinds should attend at teaching hospitals, to ensure that the visiting staff are able each day to select those cases which they need for the instruction of their students;

(xii) that it is desirable that patients should bring doctors' letters, provided that there is also a channel by which patients without doctors' letters can obtain access to the hospital;

(xiii) that there should be, as part of the hospital procedure, some stage at which patients, at all events those coming without doctors' letters, should be sifted into major cases and minor cases, i.e., those who require the consultative or specialist services of the out-patient department and those who do not; and that the different methods of sifting adopted by different hospitals, whether by members of the visiting staff or by juniors, and whether in the out-patient department or in the casualty department, are well worth careful study;

pars.

(xiv) that the practice of referring minor cases, after one examination and if necessary one treatment, to whichever of the various alternative agencies is most appropriate should be encouraged and extended; provided that care is taken not to cause hardship to patients who would not know of this procedure, or for whom alternative agencies may not as yet be available;

(xv) that the co-operation between the hospitals and the alternative agencies which treat only minor cases should be mutual, these other agencies referring to the hospital out-patient departments such of their cases as need consultative diagnosis and specialist treatment, but cannot afford to pay for it;

(xvi) that such co-operation would be facilitated by various improvements in the details of procedure for mutual communications between general practitioners and hospital consultants;

(xvii) that co-operation on these lines would encourage the development of efficient alternative agencies, and the movement for the co-ordination of the medical service of the community and the avoidance of waste and overlapping; whereas the general retention and treatment of minor cases by the hospitals would have a discouraging effect;

(xviii) that the almoners' departments, working in conjunction with the medical staffs, are a most valuable part of the machinery for co-operation with other agencies, and for the reference of cases to such agencies, either for medical treatment or for supplementary assistance or after-care, especially where questions of the financial and other circumstances of the patient are involved.

266–392 404.—On the question of waiting as affected by methods of procedure our conclusions are—

(xix) that at several hospitals part of the waiting has been reduced by improvements in procedure at different stages in the progress of the patients through the out-patient departments, and therefore that similar reductions could probably be made at some at least of the other hospitals;

(xx) that, although the procedure for sifting minor cases from major cases takes time, it produces a great saving of time at later stages;

(xxi) that at some hospitals time-saving improvements have also been made in general procedure, especially by the provision of separate sessions for special departments, and by the fixing of different hours of arrival for different classes of patients within the same session, such as new patients and old patients, or men and women;

(xxii) that a system of appointments for individual patients or groups of patients has been applied successfully by many hospitals to old patients in certain special departments, although difficulties have been reported to us in the way of its extension to general medical and surgical out-patients;

(xxiii) that, since a fixed hour of arrival for all patients must produce an inevitable wait for those who see the doctor last, great importance attaches to the question how far and in what ways departures can be made from the principle of a fixed hour.

393–400 405.—On the question of waiting as affected by inadequacy of accommodation our conclusions are—

(xxiv) that waiting and overcrowding are caused at some hospitals by inadequate and old-fashioned accommodation, but that many out-patient departments have been enlarged and brought up to date at a cost which is not beyond the resources of the voluntary hospital system in normal times;

(xxv) that waiting has been reduced at some hospitals, at a comparatively small cost, by minor structural additions and alterations in the accommodation for specific purposes, designed to relieve congestion or obviate delay at particular stages in the out-patient procedure.

406.—We accordingly recommend—

(*a*) that hospitals should be encouraged to develop the consultative side of their out-patient work and the reference of non-urgent minor cases, after first attendance, to suitable agencies which provide general practitioner treatment, subject to the following safeguards:—

(1) that patients who desire a second opinion but cannot pay the fees of a private consultant should have access to the hospitals at least for one medical examination without first having to obtain the consent of any medical practitioner;

(2) that a sufficient number of cases of all kinds should, at teaching hospitals, be available for the purposes of medical education;

(3) that the reference of minor cases to other agencies should not be made a rigid rule, but should be introduced only gradually and applied only with

gradually increasing strictness; except possibly where, as in the case of insured persons, an alternative agency has already been established, the services of which are immediately available at no further cost to the patient; pars.

(*b*) that for this purpose co-operation between hospital consultants and general practitioners should be facilitated by the following methods amongst others:—

(1) by the adoption of standard forms for the use of general practitioners in referring patients to hospital for consultative diagnosis and advice and treatment if required; the forms to contain space for the necessary particulars of the case; 199–204

(2) by the adoption of standard forms for the use of consultants in reporting to the general practitioners on the cases so sent; and

(3) by the provision by the hospitals of secretarial or clerical assistance for such consultants as may desire it; 201, 204

(*c*) that the standard forms should draw attention to the importance of patients being sent to hospital at the proper times either for the general out-patient department, or for seeing particular consultants or for attending special departments, and that the hospitals should keep general practitioners informed as far as possible of the proper times; 205–207

(*d*) that co-operation between the hospitals themselves and the other agencies treating minor cases should be developed, so that such cases should not be merely excluded but should be assisted to obtain treatment elsewhere, and that the almoners' departments of the hospitals should, as far as possible, be utilised for this purpose; 214

(*e*) that the junior medical officers of the out-patient and casualty departments should, during their terms of office, be kept informed of the available alternative or supplementary agencies and of the procedure for co-operation with them; 124, 186, 212

(*f*) that the consultative use of the out-patient departments for insured patients should be regarded as a specially desirable form of co-operation, and as likely to conduce to the efficiency both of the National Insurance medical service and of the hospitals; 133–144

(*g*) that patients who are in receipt of public assistance in normal times should be referred to the medical service of the Public Assistance Authority when suffering from minor ailments; and that the question should be considered whether this practice should extend also to other patients who need public assistance in order to benefit by medical treatment; 159–170

(*h*) that more use should be made of the District Nursing Service for out-patients who need only such dressings or treatment as can be supplied by nurses; and that, where such patients are regarded as still under the care of the hospital, arrangements should be made whereby the District Nursing Association should receive a fair share of the payments made on behalf of contributory scheme patients towards their hospital treatment; 181–193

(*k*) that all hospitals should be encouraged to study the experience of those which have adopted time-saving methods at various stages of their procedure; 266

(*l*) that, in connection with methods of procedure, the following subjects should receive particular attention:—

(1) if there is a fixed time of arrival, the fixing of a time as near as possible to the time when the visiting staff begin work; 273–277

(2) the fixing of different times for old and new patients;

(3) the registration of old and new patients separately;

(4) registration by means of modern systems of filing and indexing; 278–284

(5) the simultaneous treatment of new cases or serious cases by the visiting staff and of old cases or minor cases by assistants, so far as this is consistent with the efficiency of the medical service; 285–295

(6) the promotion, by this and other methods, of an even flow of patients to the hospital dispensary instead of an alternation of slack periods and rush hours; 299–307

(7) the discouragement of the unnecessary use of special prescriptions in preference to stock mixtures, wherever the former are not required for the welfare of the patient; 303

(8) the consideration of the alternative methods of inquiry by almoners or inquiry officers, at the alternative stages of the procedure, from the standpoints of greatest efficiency and of least expenditure of time; 308–326

(9) the consideration of the alternative methods of sifting minor cases from major cases, from the standpoint of greatest efficiency, and also from 327–338

pars.

that of the loss of time caused by the sifting process as compared with the saving of time at later stages ;

340–343 (10) the holding of different sessions for different departments, where this would relieve pressure and would not be disadvantageous ;

344 (*m*) that, so far as possible, there should be special evening sessions for patients employed during the day time, and also for young people between the ages of 14 and 16, i.e., between leaving the care of the school medical service and qualifying for National Health Insurance ;

345–364 (*n*) that special attention should be given to the question how far waiting before the examination and treatment stage is the result of a fixed hour of arrival, and how far this waiting can be reduced by departures from the principle of a fixed hour, such as the adoption—

(1) of a range of hours ;
(2) of different hours for different classes of patient ;
(3) of an appointments system for individual patients or groups of patients in special departments or in general departments ;
(4) of a partial appointments system, e.g., one whereby some of the patients would come at the beginning of the session and the rest at half-time ;

due regard being had to the conditions which must be maintained in order to enable the medical staffs to do their best work ;

371–373 (*o*) that every effort should be made to avoid, wherever practicable, the necessity for waiting in cold or draughty rooms, or between undressing and seeing the doctor ; for lengthy standing in queues ; and for the medical examination of patients in the presence of others instead of in separate cubicles ;

373 (*p*) that there should be a recognised and easily accessible channel through which complaints could be made with the assurance that they would be considered by the hospital authorities with a view to the discovery and removal of avoidable causes, if any, for reasonable dissatisfaction ;

397–400 (*q*) that hospitals where the out-patient or casualty accommodation is inadequate or defective, but where a comprehensive extension scheme is not possible in present financial circumstances, should consider whether the procedure could be facilitated by minor additions or alterations at a practicable cost, or by the temporary occupation, during the financial crisis, of outside premises for special purposes ;

267, 383, 392 (*r*) that the General Council of King Edward's Hospital Fund should consider to what extent and in what ways it could help to carry out these recommendations, by making available, to the hospitals and to others concerned, the detailed information accumulated in the course of our Inquiry, and by such other methods as may be relevant to the particular recommendations.

407.—We are convinced that, while part of the present waiting in the out-patient departments is inherent in the provision of hospital treatment for large populations, part of it could be saved by the methods which we have indicated. These are largely based on the experience of hospitals where waiting has actually been reduced by recent changes. It follows that, until the methods here described and suggested have been thoroughly studied with a view to action where desirable and practicable, no hospital can say that the whole of the waiting in its out-patient or casualty department is unavoidable.

408.—Some of these time-saving changes have been made in the procedure at different stages, and some by structural alterations and additions. But the subjects which seem most to deserve study in the search for remedies for waiting are, first, in connection with the suitability of patients, the extent to which it is possible to reduce the number of minor cases by developing the consultative part of out-patient work, though not to the undue exclusion of the other parts ; and, second, in connection with methods of procedure, the extent to which it is possible to depart from the principle of a single fixed hour of arrival for all patients. Both of these questions we have accordingly discussed at some length.

409.—We regard it as essential that, when any measures are contemplated for improving the methods in use in the out-patient or casualty department of a hospital, the concurrence of the honorary visiting medical and surgical staff should be secured at each stage in the consideration and adoption of the proposals.

410.—We have been impressed by the evidence of the popularity of the hospitals, by the confidence felt by the patients and their friends in the thoroughness and efficiency of the examination and treatment provided by their medical staffs, and by the amount of attention which their committees and officers have been giving to the problem of the prevention or reduction of waiting and overcrowding in the out-patient departments.

51

411.—One noticeable feature in the evidence has been the variety in the procedure of different hospitals and even of different consultants within the same hospital. We consider it important that these qualities of individuality and independence should be maintained if the voluntary hospitals are to continue to make their special contribution to the hospital service of the community and to the progress of medical science. The numerous recent improvements in out-patient organisation which we have described have been due to this freedom of initiative on the part of individual hospitals. The prospect of a general improvement in out-patient organisation will, however, depend largely on the extent to which the hospitals are able to pool their experience and to move together in the same general direction towards the discovery and adoption of a common policy. It has always been the aim of King Edward's Hospital Fund to encourage common action combined with independence and variety, and its traditional method is to collect information from all the hospitals and to place this at the disposal of all. These are among the reasons why we suggest that the King's Fund should assist the hospitals in the further study of the subject with a view to definite action of the kinds which have already been found useful.

412.—For the benefit of those who would like to have a guide to the full Report, or who would not have time to read the whole of it, we have prepared a short summary, which is printed as an Appendix.

413.—The Committee were assisted by the presence of the senior Honorary Secretary of King Edward's Hospital Fund, Lord Somerleyton, who occasionally attended our meetings, and we should like to record our sense of gratitude for the help that he gave us.

414.—We also desire to express the deep sense of obligation under which we are to our Secretary, Mr. H. R. Maynard, to whom we are in particular grateful, since on his shoulders the heavy load of drafting the Report mainly devolved. Mr. Maynard's great knowledge of the subject, and of all cognate matters, was of much assistance to us, and we feel deeply indebted to him.

We would also like to express our thanks to Mr. A. G. L. Ives, Assistant Secretary, Mr. P. W. Burton and other members of the staff of the King's Fund, who have rendered us able and valuable assistance in collecting and sifting the evidence, and arranging for the examination of witnesses.

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.*
7 Walbrook, London, E.C.4.
December, 1932.

APPENDIX I.

STATISTICS OF 114 HOSPITALS WITH OUT-PATIENT DEPARTMENTS WITHIN 11 MILES FROM ST. PAUL'S.

Hospital.	Beds.	New Out-patients.	Attendances.
I.—TEACHING HOSPITALS.			
Charing Cross	291	26,843	129,763
Guy's	648	122,867	554,606
King's College	386	49,364	322,086
London	839	81,389	492,645
Middlesex	473	51,210	238,888
Royal Free	280	51,700	296,310
St. Bartholomew's	715	95,121	472,801
St. George's	337	37,934	183,788
St. Mary's	356	45,827	140,497
St. Thomas's	640	96,664	575,687
University College	540	77,289	273,500
Westminster	257	25,163	128,909
II.—OTHER GENERAL HOSPITALS—100 Beds or more.			
Bolingbroke	121	13,495	52,900
Connaught (Walthamstow)	100	11,186	50,201
Croydon	130	30,328	126,655
Dreadnought	250	12,186	85,841
East Ham	100	8,169	38,271
German	160	10,114	79,155
Hampstead	138	25,397	94,832
King Edward Memorial (Ealing)	109	11,960	51,739
King George (Ilford)	130	14,143	61,685
London Homœopathic	171	15,549	63,549
London Jewish	108	15,481	64,391
Metropolitan	150	30,588	149,387
Miller	151	28,282	177,541
National Temperance	140	12,078	61,541
Poplar	122	32,069	110,447
Prince of Wales's (Tottenham)	201	27,981	113,557
Queen Mary's (West Ham)	216	43,805	150,369
Royal Northern	371	61,416	339,579
St. John's, Lewisham	102	20,056	113,155
West London	234	37,722	361,384
Willesden	106	12,094	46,969
Woolwich	112	4,795	17,121
III.—GENERAL HOSPITALS—Under 100 Beds.			
Acton	62	7,223	31,610
Albert Dock	53	5,913	39,397
Anti-Vivisection; Battersea	75	13,205	55,808
Beckenham	45	2,351	8,754
Blackheath and Charlton	30	1,358	7,132
Brentford	27	1,619	13,267
Catholic Nursing Institute	15	457	12,113
French	70	8,209	25,049
Hornsey	48	1,077	6,708
Italian	42	3,876	13,690
Mildmay Memorial	46	102	4,180
Mildmay Mission	56	15,386	49,930
Nelson (Merton)	83	3,237	25,046
Phillips Memorial (Bromley)	18	345	2,148
Princess Beatrice	78	7,460	39,052
Putney	52	2,803	15,822
Royal, Richmond	97	8,312	29,784
St. John's (Twickenham)	34	1,231	7,164
Weir	30	4,917	24,345
Wembley	25	1,942	4,614
Wimbledon	72	1,294	7,218
IV.—SPECIAL HOSPITALS.			
All Saints' (Gen.-Ur.)	31	1,448	14,575
Babies', Kensington	34	1,682	16,033
Belgrave (Children)	76	13,206	61,098
Bermondsey Medical Mission (Women and Children)	20	8,389	49,825
British for Mothers	42	1,521	11,274
Cancer (Free)	169	1,512	32,720
Central London Ophthalmic	51	12,626	34,473
Central London Throat, Nose and Ear	76	11,042	50,621
Chelsea (Women)	100	3,085	9,555
City of London Heart and Lungs	186	10,326	42,907
City of London Maternity	71	2,779	17,142
Deptford Babies'	14	208	1,404
East End (Maternity)	56	527	12,668
Elizabeth Garrett Anderson (Women)	105	7,492	51,648
Evelina (Children)	80	15,144	58,281
General Lying-in	45	3,994	38,151
Golden Square (Throat, Nose and Ear)	101	14,786	55,114
Gordon (Fistula, etc.)	34	1,589	10,339
Grosvenor (Women)	45	1,064	4,436
Hospital for Consumption	339	4,725	40,800
Hospital for Epilepsy	87	4,037	29,063
Hospital for Sick Children	252	32,206	112,923
Hospital for Tropical Diseases	76	930	2,320
Hospital for Women	81	3,823	10,375
Infants'	50	2,591	11,845
Institute of Medical Psychology	12	470	6,463
Jewish Maternity	34	70	1,247
London Lock	68	5,984	143,429
Marie Curie (Radium)	30	272	1,294
Medical Mission of Good Shepherd (Babies)	10	1,361	10,202
Metropolitan Ear, Nose and Throat	22	4,377	15,593
Mothers', Salvation Army	90	4,841	50,974
National Heart	46	4,323	29,467
National, Queen Square (Nervous)	195	3,742	48,799
North Islington Infant Welfare	18	3,252	31,168
Ormond Maternity	7	167	820
Paddington Green (Children)	42	11,234	42,182
Plaistow Maternity	60	15,218	158,897
Princess Elizabeth of York (Ch.)	135	15,298	60,246
Princess Louise (Children)	50	10,734	80,018
Queen Charlotte's Maternity	130	6,669	64,729
Queen's (Children)	160	29,525	142,002
Royal Dental	10	18,207	65,031
Royal Eye	46	23,340	68,086
Royal London Ophthalmic	152	44,282	146,156
Royal National Orthopædic	170	6,941	120,563
Royal Waterloo (Women and Children)	127	16,338	79,102
Royal Westminster Ophthalmic	76	13,523	53,252
St. John's (Skin)	40	11,971	54,327
St. Mark's (Fistula, etc.)	71	1,962	10,404
St. Mary's, Plaistow (Women and Children)	71	8,521	52,151
St. Paul's (Gen.-Ur.)	33	4,018	145,469
St. Peter's (Stone)	32	1,509	20,361
Samaritan Free (Women)	69	3,999	10,049
South Eastern (Children)	72	7,946	35,999
South London (Women)	119	13,540	59,319
Victoria Children	138	11,826	77,427
West End (Nervous)	78	4,286	41,256
Western Ophthalmic	35	11,949	37,441
Total	14,911	1,815,009	9,386,093

In addition to the above hospitals some of the other hospitals in the King's Fund area, although having no regular out-patient departments, treat a number of casual out-patients.

An analysis of the out-patient attendances at the Teaching Hospitals, showing the attendances at different special departments, will be found on page 51a of the "Statistical Summary of the Income, Expenditure, Work and Costs of One Hundred and Forty-two London Hospitals for the year 1931" (published by King Edward's Hospital Fund for London, 7 Walbrook, E.C.4), price 1/– net, 1/5 post free), and a similar analysis for Hospitals in the County of London in the Survey referred to in the note on page 22).

APPENDIX II.

QUESTIONNAIRE ISSUED TO 78 HOSPITALS.

1. Name of Hospital.....

I. STATISTICS, ETC.

2. (as on Statistical Tables for 1931)
   (i) Bed Complement, December 31, 1931.
   (ii) Total number of new out-patients, 1931.
   (iii) Total number of out-patient attendances, 1931.
   (iv) Number of casualty patients included in (ii) above.
   (v) Number of casualty attendances for 1931 included in (iii) above, if known.

3. If the hospital makes a distinction between casualties and other out-patients, what is the hospital's definition of a casualty ?

4. Please give a list of the accommodation for out-patients (e.g., number of waiting halls or rooms, with approximate area and seating accommodation, number of consulting rooms, etc., etc., for general out-patients, different kinds of special out-patients, and casualties, respectively.)

II. METHODS AS AFFECTING SUITABILITY OF PATIENTS.

5. What would be the Hospital's general definitions of the classes of patients (other than emergencies) who are at present considered suitable and unsuitable, respectively, for out-patient treatment at the Hospital, as regards medical suitability and financial suitability. (Please quote any rules as to income limits or other criteria. If any classes otherwise suitable are excluded because provided for elsewhere by public authorities or other agencies, please give particulars.)*

6. Are out-patients (other than emergencies) required to bring doctors' letters, subscribers' letters, or other introductions, as evidence of medical or financial suitability ? (If so, please give particulars, stating whether they refer to all out-patients other than emergencies or only to particular classes of out-patient ; and enclose specimens of any forms supplied for the purpose.)*

7. Is medical and financial suitability ascertained by examination or inquiry, as distinct from or in addition to introduction from outside ? (If so, please state by what officers, medical or lay, the examinations or inquiries are made.)*

8. Are patients who are considered unsuitable, medically or financially, or otherwise, referred to any other agencies ? (e.g., general practitioners, etc., etc. If so, please give particulars.)*†

III. METHODS AS AFFECTING TIME OF WAITING.

9. Please give a list of the successive stages of the procedure during the day from the arrival of patients to their departure : (Indicating at which stages any considerable period of waiting may occur before or after treatment ; stating the time at which the Department opens and closes ; and, if practicable, giving some indication of the time taken by the different stages, and also of the numbers attending, as compared with the number of staff, medical and lay.)*

10. If the Hospital Committee consider that there is either overcrowding or excessive waiting, do they attribute this wholly or partially to anything special in the circumstances of the Hospital or the neighbourhood ?*

11. Has the Hospital Committee (*a*) adopted, (*b*) considered, any changes specifically designed to reduce recent or present overcrowding or waiting ? (e.g., enlargement or alteration of premises ; restrictions on the kinds of cases treated ; limitation of numbers treated in any one day ; different hours of attendance for different patients or groups of patients ; changes in the staffing arrangements, medical or lay ; changes in procedure ; or other methods. If so, please give brief particulars, and indicate the result of the adoption or consideration, and any expression of opinion which the Hospital Committee desire to add.)*

N.B.—The mention in this Questionnaire of any particular alternative method must not be taken to imply that the Out-patient Committee have formed any opinion favourable or unfavourable to that method.

If more space is needed for the answers to any of the Questions, or if it is desired to add any general remarks, the back page can be used for the purpose, or additional pages can be attached.

---

* Please give, where relevant, any material differences in the rules or procedure (*a*) as between Casualties and other Out-patients, (*b*) as between new Patients and old Patients, (*c*) as between general Patients and special Patients.

† If there is any system of reporting on cases to general practitioners or other agencies, even if the cases are not actually referred but are retained for further out-patient treatment, please mention it here.

APPENDIX III.

LIST OF WITNESSES.

This list includes Hospital witnesses interviewed at Hospitals.
*The asterisk * indicates a written statement only.*

ALDERTON, Miss A. Irene, Royal Free Hospital.
ANDERSON, Dr. G. C., M.D.Ed., British Medical Association.
AULT, Miss O., Hospital for Sick Children.
BALDIE, Dr. A., M.B., Ch.B.Ed., Panel Committee for the County of London, and Public Medical Service for London.
BALL, Mr. W. Girling, F.R.C.S., St. Bartholomew's Hospital.
BAMFORD, Mr. D. St. John, Victoria Hospital for Children.
BARLOW, Mr. D. M., M.S., F.R.C.S., West London Hospital.
BATTESON, Dr. C. L., M.R.C.S., L.R.C.P., Panel Committee for the County of London, and Public Medical Service for London.
BEATTY, Dr. C. C., M.C., M.B., B.S., M.R.C.P., Royal Northern Hospital.
BEDWELL, Mr. C. E. A., King's College Hospital.
BEWSHER, Mr. James, M.A., West London Hospital.
BONE, Mr. Harry A., Miller General Hospital.
BRENNAN, Miss M., Miller General Hospital.
BROAD, Mr. J. Vickers, M.B., B.Ch., Victoria Hospital for Children.
BRUNNER, Lady, Elizabeth Garrett Anderson Hospital.
BUCKLE, Mr. J. Gerald T., University College Hospital.
CARDALE, Dr. H. J., M.B., C.M.Ed., Panel Committee for the County of London.
CHASE, Dr. R. G., M.B., B.Ch., M.R.C.S., L.R.C.P., Panel Committee for the County of London.
CHURCHFIELD, Mr. James M., St. George's Hospital.
COHEN, Dr. J., M.R.C.S., L.R.C.P., Panel Committee for the County of London, and Public Medical Service for London.
COLES, Dr. D. A., M.D., L.R.C.P., M.R.C.S., L.S.A.
COX, Dr. Alfred, M.B., British Medical Association.
CROOK, Mr. E. A., M.Ch., F.R.C.S., Charing Cross Hospital.
DICKSON, Mr. W. Muir, M.B., Ch.B., F.R.C.S., Willesden General Hospital.
EASON, Mr. Herbert L., C.B., C.M.G., M.D., M.S., Guy's Hospital.
EAST, Dr. Terence, M.D., F.R.C.P., King's College Hospital.
ECCLES, Mr. W. McAdam, M.S., M.B., F.R.C.S., British Medical Association.
ELLIOT, Mr. F. B., C.B.E., Hospital Saving Association.
ELLIOTT, Capt. Arthur G., O.B.E., M.C., London Hospital.
EVANS, Dr. Geoffrey, M.D., F.R.C.P.*
GARRATT, Mr. Reginald R., Royal Free Hospital.
GIBSON, Dr. A. Keith, M.B., Ch.B.Ed., British Medical Association, Panel Committee for the County of London, and Public Medical Service for London.
GOSSE, Dr. A. Hope, M.D., B.Ch., F.R.C.P., St. Mary's Hospital.
GOULD, Mr. E. L. Pearce, M.A., M.D., M.Ch., F.R.C.S., British Medical Association.
GRAHAM, Dr. George, M.D., F.R.C.P., St. Bartholomew's Hospital.
GRAY, Dr. A. Charles E., O.B.E., M.D., C.M., Charity Organisation Society.
GRAY, Dr. A. M. H., C.B.E., M.D., F.R.C.P., University College Hospital.
GREEN, Dr. Margaret K., M.R.C.S., L.R.C.P., Public Medical Service for London.
GREGG, Dr. L.R.C.P.I., L.R.C.S.I., L.M., Panel Committee for the County of London, and Public Medical Service for London.
GREGORY, Dr. J. C., M.R.C.S., L.R.C.P., University College Hospital.
HALDIN-DAVIS, Dr. H., M.D., F.R.C.P., F.R.C.S., Royal Free Hospital.
HAMER, Sir William H., M.A., M.D., F.R.C.P., Charity Organisation Society.
HAMILTON, Miss J. M. A., St. George's Hospital.

HARMAN, Mr. N. Bishop, M.A., M.B., B.Ch., F.R.C.S., British Medical Association.
HAWTHORNE, Dr. C. O., M.D., F.R.C.P., British Medical Association.
HAYES, Mr. Thomas, St. Bartholomew's Hospital.
HEARNE, Mr. R. J., Willesden General Hospital.
HENLEY, Hon. Mrs. Anthony, King's College Hospital.
HOSPITAL SATURDAY FUND.*
IRWIN, Lt.-Col. A. P. B., D.S.O., M.A., St. Thomas's Hospital.
JONES, Mr. George J., Charing Cross Hospital.
KAYE, Miss L., University College Hospital.
LEDLIE, Mr. R. C. B., M.B., B.S., F.R.C.S., Miller General Hospital.
LEVICK, Dr. C. B., M.B., St. George's Hospital.
LINDSAY, Mr. D. H.
LONDON COUNCIL OF SOCIAL SERVICE.*
LONDON COUNTY COUNCIL.*
LUPTON, Miss Joan, Royal London Ophthalmic Hospital.
MADGE, Mr. H. A., West London Hospital.
McKAY, Mr. James, Hospital for Sick Children.
MAITLAND, Mrs., Charing Cross Hospital.
MARRIOTT, Dr. H. L., M.D., B.S., M.R.C.P., M.R.C.S., Middlesex Hospital.
MARSHALL, Dr. G., O.B.E., M.D., Guy's Hospital.
MEDICAL PRACTITIONERS' UNION.*
MELLOWS, Mr. H. W. B., Charity Organisation Society.
METROPOLITAN BRANCH of SOCIETY OF MEDICAL OFFICERS OF HEALTH.*
MILSOM, Capt. H. L., London Hospital.
MITCHENER, Dr. P. H., M.D., M.S., F.R.C.S., St. Thomas's Hospital.
MOLLISON, Mr. W. M., C.B.E., M.Ch., Guy's Hospital.
MORRIS, Miss C., St. Thomas's Hospital.
MURRAY, Mrs. Jean R., Elizabeth Garrett Anderson Hospital.
NICHOLL, Miss F. M. C., A.I.H.A., University College Hospital.
PANTER, Mr. Gilbert G., Royal Northern Hospital.
PARKES, Col. W., D.S.O., M.C., Incorporated Association of Hospital Officers, and St. Mary's Hospital.
PAXTON, Dr. J., L.R.C.P., L.R.C.S.Ed., L.R.F.P.S.Glas., Panel Committee for the County of London, and Public Medical Service for London.
PEAKE, Miss C. M., M.D., B.S., Elizabeth Garrett Anderson Hospital.
PERFECT, Miss M., Westminster Hospital.
PLIMSOLL, Mr. S. R. C., M.C., Middlesex Hospital.
PONSONBY, Lt.-Col. C. E., London Hospital.
POWER, Mr. Charles M., Westminster Hospital.
PRINGLE, Rev. J. C., Charity Organisation Society.
RICHARDSON, Miss A. I., Central Council for District Nursing in London.
RIDLER, Miss M. E., Incorporated Association of Hospital Officers.
SIMPSON, Sister, R.R.C., Ranyard Nurses.
SOUTTAR, Mr. H. S., C.B.E., M.Ch., F.R.C.S., British Medical Association.
STOTT, Dr. Arnold W., M.A., F.R.C.P., Westminster Hospital.
STOWELL, Dr. T. E., M.D., F.R.C.S., L.R.C.P.*
TARRANT, Mr. Arthur J. M., Royal London Ophthalmic Hospital.
THOMPSON, Miss E., St. Bartholomew's Hospital.
THURSFIELD, Dr. J. Hugh, M.A., M.D., F.R.C.P., Hospital for Sick Children.
VOELCKER, Miss W. M., A.I.H.A., Royal Free Hospital.
WHEEN, Mr. Francis T., Miller General Hospital.
WHITBREAD, Mr. F. P., Guy's Hospital, and Hospital Saving Association.
WILDING, Mr. L. W., London Hospital.
WILLIS, Lt.-Col. Arthur, M.B.E., J.P., Royal Northern Hospital.
WILMSHURST, Miss M., Metropolitan District Nursing Association (affiliated to the Queen's Institute of District Nursing).

APPENDIX IV.

SUMMARY OF REPORT.

I. INTRODUCTORY.

pars.
4–6 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
7–10 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.

11–12 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
13–19 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.

20–24 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.

25–37 4. *General Description of Out-patient Procedure.*—Our Report describes briefly the procedure
31–32 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.
33–37 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.

38–40 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.

41–42 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
43–45 information comes from the contributory schemes such as the Hospital Saving Association, and from
46 the District Committees of the Charity Organization Society. The hospitals themselves give the
47–55 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.

57–60 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 ; pars. 57–60

(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. 62–72

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. 73–76

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. 76–81

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 patients' 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. 82–90

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. 91–95

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. 96–98, 99–101

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 102–106

pars.
102–106 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.

108–111 15. Our Report describes and discusses the following alternative or supplementary agencies for the treatment of minor ailments at the hospitals and elsewhere :—

112–119 (*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.

119–125 (*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.

126–132 (*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.

132 (*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.

133–136 (*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
136–140 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 ;
141–144 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.

146–149 (*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.

150–152 (*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.

153–156 (*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.

157 (*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.

158–169 (*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
170 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.

171–175 (*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
176–180 without charge. The Metropolitan Borough Councils have various centres for maternity and child welfare, and clinics for tuberculosis and certain other diseases.

pars.

(*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. 181–189 190–193

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. 194–196

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. 198–204 205–207 208 209–213

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. 214–216

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. 219–238 239–241

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. 243–244 245 246–249

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. 250–251

22. *Relation to Minor Cases.*—The difficult problem of inquiry into the large numbers 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. 252–254

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. 255–260

IV. WAITING AS AFFECTED BY METHODS OF PROCEDURE.

pars. 268–272 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.

273–277 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.

278–284 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.

285–298 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.

299–307 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.

308–326 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 comparatively rare, 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.

327–338 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.

339–344 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.

345 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.

346–350 (*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.

pars.

(*b*) *For Individual Patients or Groups : the Appointments System.*—It is frequently suggested 351–364
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 365–367
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 368–373
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 374–384
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 388–391
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 392
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 393–394
reduced by increases in accommodation either for general purposes or for specific purposes.

39. *General Accommodation.*—Some out-patient departments have been recently enlarged ; 395–396
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 397–399
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.

pars. 401-411

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.

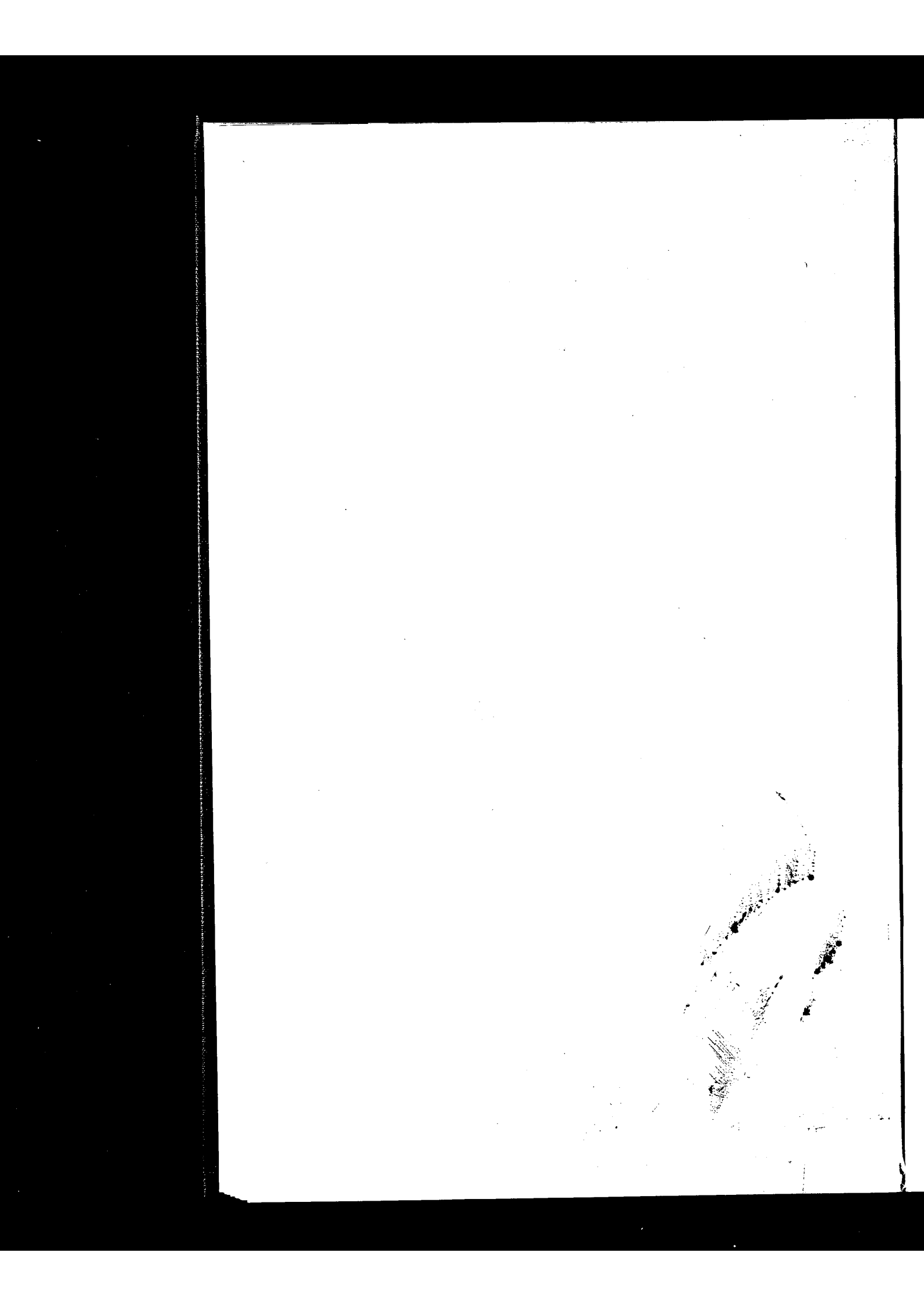
H. R. MAYNARD, *Secretary,*
7 Walbrook, London, E.C.4.
December, 1932.

INDEX.

Note i.—Roman figures I. to VI. and the initial S. indicate Sections of the Report and the Summary, viz. :—

Note ii.—Figures in italics indicate the principal descriptive passages dealing with the subject.

Note iii.—Figures in small type refer to the Summary of the Report in Appendix IV.



Bound By
Blissett Bookbinders
020 8992 3965