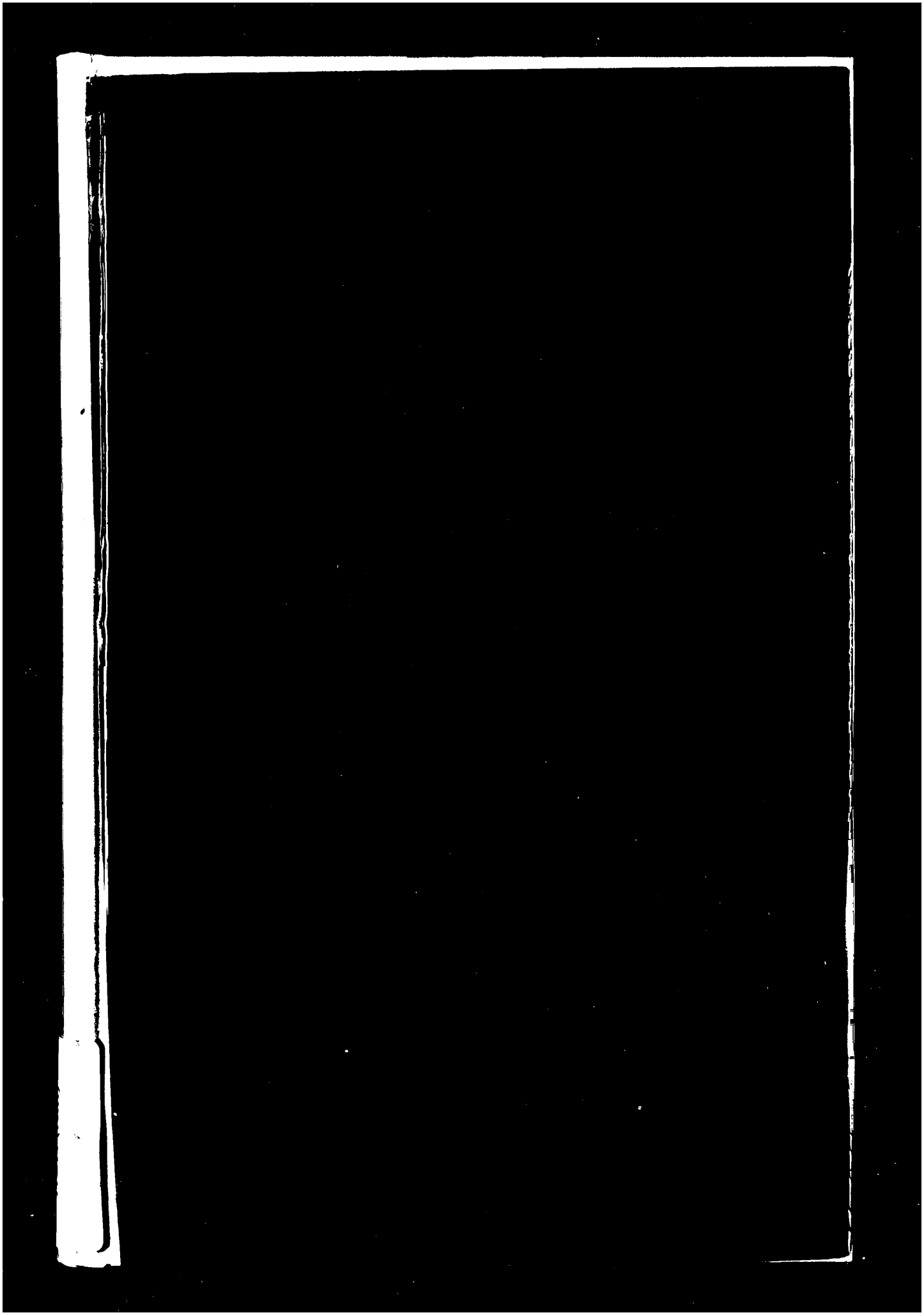

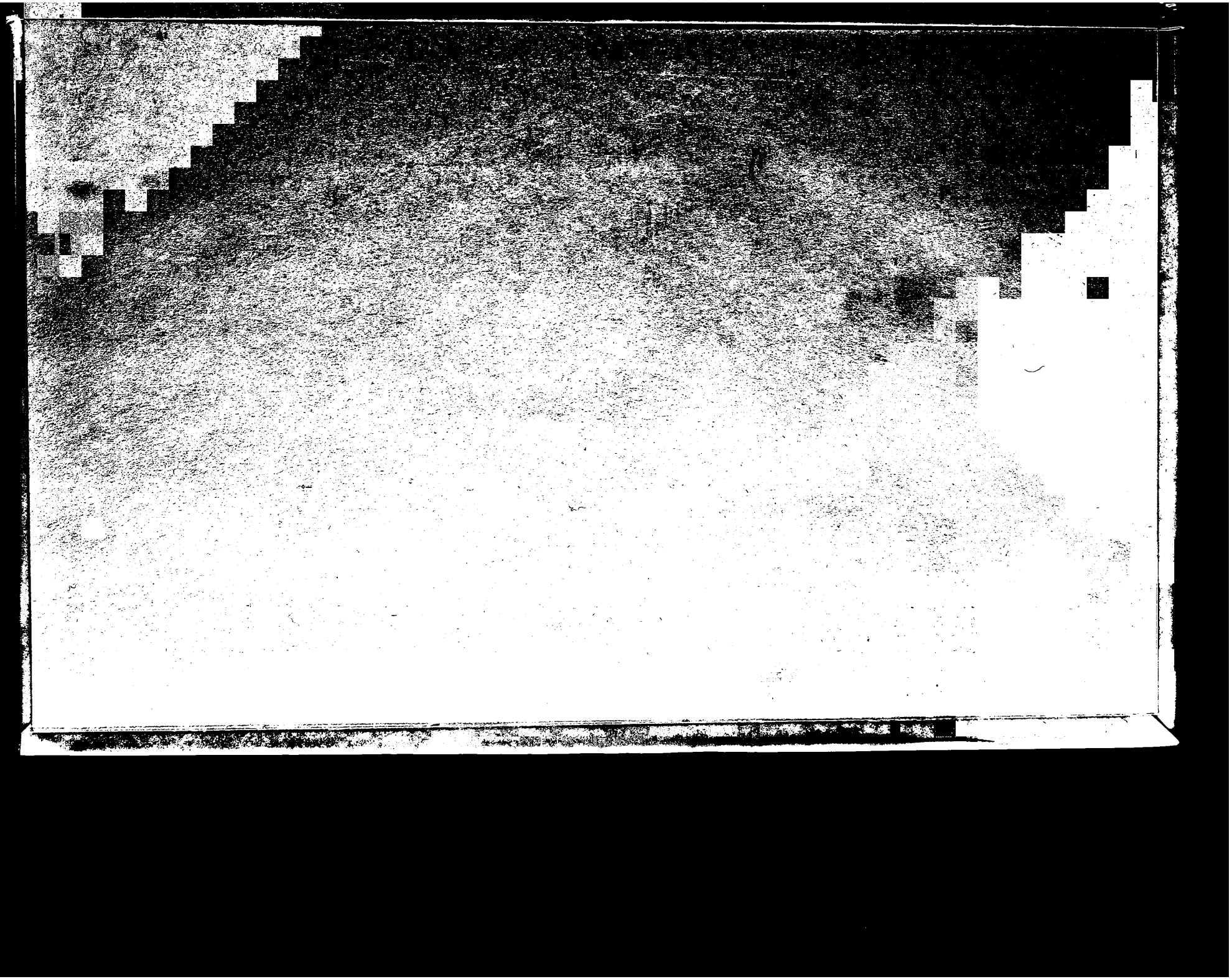

SOME ASPECTS OF THE POST-WAR HOSPITAL PROBLEMS IN LONDON and THE HOME COUNTIES

Issued by the Joint Committee of -
KING EDWARD'S HOSPITAL FUND FOR LONDON and
THE VOLUNTARY HOSPITALS COMMITTEE FOR LONDON

CO-ORDINATION OF HOSPITAL SERVICES

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* *Drafting Sub-committee*

10, OLD JEWRY, E.C.2.
July, 1945.

PREFACE

In the Autumn of 1941, King Edward's Hospital Fund and the Voluntary Hospitals Committee for London established a Joint Committee to consider post-war problems of the Hospitals of London, with a view to maintaining and improving the standard of services which they render to patient Representatives of the voluntary hospitals in the Home Counties and of the British Hospitals Association have attended the Committee's meetings since January, 1943.

The Joint Committee invited the voluntary general hospitals and the various groups of voluntary special hospitals to consider and report on the part they desire to play in the future hospital service. In addition it appointed a Medical Sub-Committee under the Chairmanship of Sir Hugh Lett, Bt. Reports drafted by the Medical Sub-Committee have provided a great deal of the material for the present Report, which also incorporates many of the views expressed in the Memoranda put forward by the General Hospitals Committee and by the different groups of Special Hospitals. Steps have already been taken in certain of the Home Counties to survey their present position and assess their future needs. The Joint Committee has taken note of the bodies which have been formed in the Home Counties for securing co-operation and exchange of information as between the local authorities and the voluntary hospitals. These joint bodies have provided a means for studying future needs and for preparing suggestions whereby the hospital services may be co-related and expanded. Much useful work has been done, notably in Surrey, where the Joint Divisional Council has published a constructive and comprehensive Report.

Two Reports with an important bearing on the London problem have made their appearance within recent months. The Report of the Inter-Departmental Committee on Medical

Schools which sat under the Chairmanship of Sir William Goodenough, Bt., and the Survey of the Hospital Services of London and the Surrounding Area by Dr. A. M. H. Gray, C.B.E., M.D., F.R.C.P., and Dr. A. Topping, M.D., M.R.C.P., D.P.H., appointed by the Minister of Health. The Goodenough Committee Report appeared in time for its conclusions to be taken into account and a series of references to its findings will be found in the sections concerned with the Teaching and Special Hospitals.

The Report of the Survey Officers was not available until the drafting of this Report was completed. The work of the Survey Officers and the present Report must therefore be regarded as parallel contributions to the problem. Its publication came too late to allow any detailed comparison between their findings and those of the Joint Committee, but it may be noted that many of the conclusions reached are substantially the same.

The Committee is acutely conscious of the difficulty of handling the various large subjects included in such a way as to satisfy all shades of opinion and it must not be assumed that every member of the Committee is fully in accord with every opinion here expressed. Many matters mentioned are dealt with in a sketchy manner which does less than justice to their importance and much clarification will be needed before a truly co-ordinated service can emerge.

It is, of course, recognised that the success of the future hospital service must largely depend on the quality of the medical and nursing staff, and that its expansion must depend upon the extent to which staff becomes available in numbers adequate to maintain the quality of the service. These matters are, however, outside the scope of this Report.

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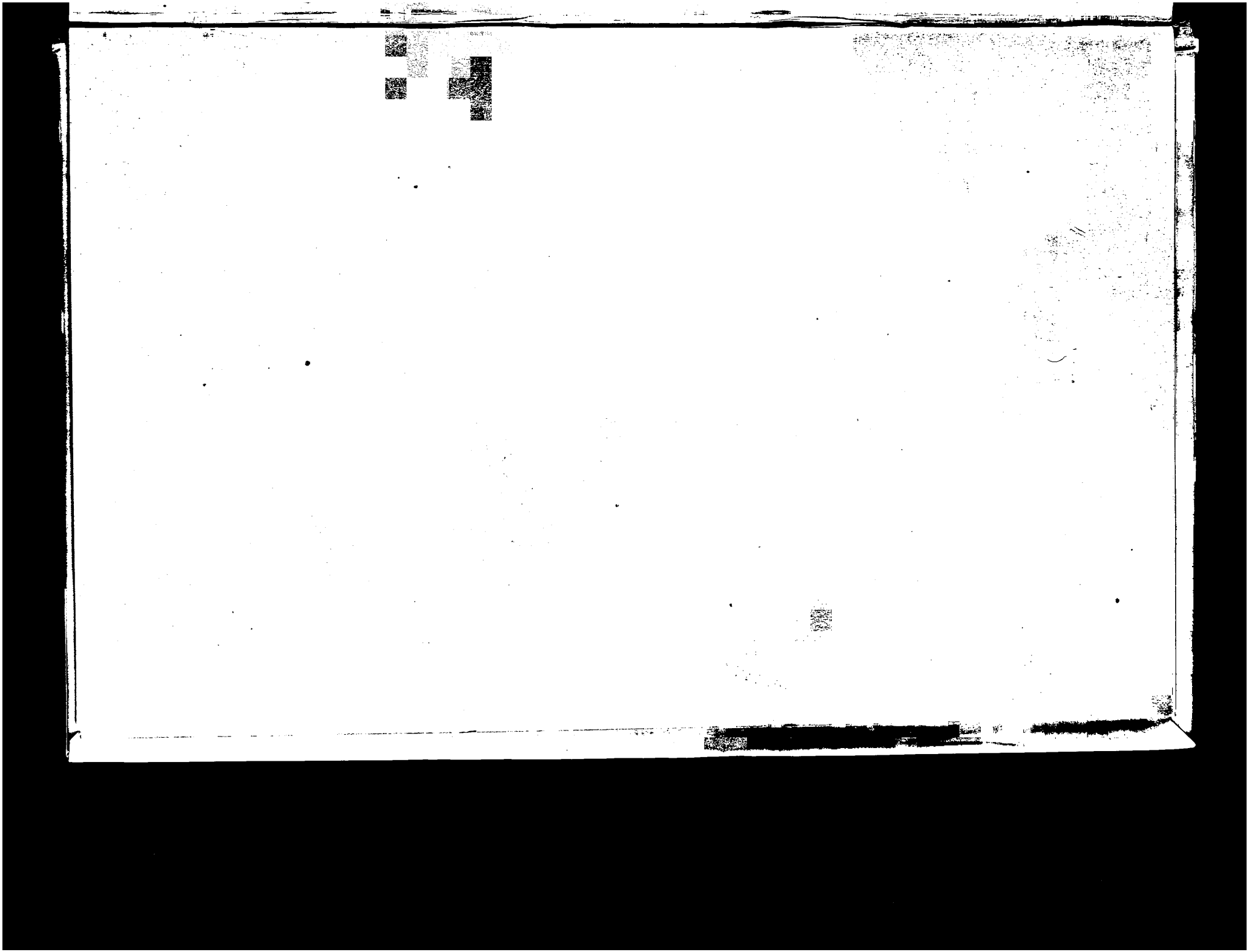

PART I.—THE PRESENT SITUATION

I. CRITICISMS AFFECTING THE CO-ORDINATION OF HOSPITAL SERVICES

No criticism of the hospital service has been repeated more frequently than that of lack of co-ordination. Thus, in the Report of the Medical Planning Committee of 1942 we read

> "there is general agreement that the present unco-ordinated hospital services should give way to a unified hospital system."

The White Paper is more specific :—

> "The hospital and specialist services have grown up without a national or even an area plan. In one area there may be established a variety of hospitals. Another area, though the need is there, may be sparsely served . . . . Moreover, even though most people have access to a hospital of some kind, it is not necessarily access to the right hospital . . . . no one hospital can be equally equipped and developed to suit all needs, or to specialise equally in all subjects." (Page 7.)

And further on :

> "The plan must ensure that the various special treatments are concentrated in centres competent and convenient to provide them, and not dispersed haphazard in uneconomic and overlapping units ; that proper linking of services is secured by relating the work of special and general hospitals ; that arrangements are at hand for the transfer of patients to the hospitals best suited to their medical needs ; and that the skill of the consultant staffs of the various hospitals taking part can be used to the maximum advantage of the area as a whole." (Page 22.)

It is, of course, comparatively easy in commenting upon a rapidly expanding hospital service to point out directions in which further improvement may be made. What is not so easy is to distinguish between criticisms which are valid, and of which full account ought to be taken in any re-organisation of the hospital services, and criticisms which upon closer investigation may be found to derive from a failure to appreciate the underlying principles upon which the service must be based. An attempt therefore to list those criticisms which relate to the organisation of the hospital service, and which, therefore, fall properly within the scope of a report upon co-ordination, may be of value.

The criticisms of the present hospital services most commonly made may be classified under three broad headings :—

1. Those which relate to the distribution of hospital facilities.
2. Those which are mainly concerned with the staffing of the hospitals.
3. Those which relate to the work and functions of voluntary and municipal hospitals respectively.

There are, of course, other criticisms such as those relating to the internal organisation of hospitals both voluntary and local authority, and to the methods of appeal sometimes adopted by the voluntary hospitals, with which this Report is not directly concerned.

1. Distribution of Hospital Facilities

(*a*) *That there is an uneven distribution of hospital facilities ; overlapping in the urban centres together with a lack of facilities in the more sparsely populated outer areas*

It is true that the individual voluntary hospital is a law unto itself and that there is little or no central control or

supervision to ensure that overlapping does not occur. It is easy to pass from the premiss—the independence of the voluntary hospital—to the seemingly all but inevitable conclusion that the services of the individual hospitals must commonly overlap. In an area like London, with upwards of 200 hospitals, voluntary and municipal, it would seem unavoidable that, in the absence of centralised direction and control, collision should occur. It is but a short step from such a conception to the view that "the time has come" when the independence of the voluntary hospital should be curtailed, and from this to the further conception that this independence is something that may be contrary to the public interest. How far is this true? The measure of truth in the contention that this independence has led to an uneven distribution of facilities can only be ascertained by an examination of the demand in relation to the actual facilities available in the different areas, and a great deal of the present Report discusses the hospital provision of London and the Home Counties from this angle.

(*b*) *That there are no arrangements for ensuring that the existing accommodation and services are used to the best advantage*

This criticism differs from the foregoing in that it carries far-reaching implications as to the methods by which inequalities and deficiencies may be made good. It is usually to be inferred that if the critic could have his way it would prove a simple matter to devise arrangements—*e.g.*, by means of bureaux controlling admission of patients and the staffing of the hospitals—whereby patients awaiting treatment could be directed to beds remaining empty under present arrangements. Such a conception is in some ways attractive, and there are traces of this attitude to be found in the White Paper, but at any rate in its cruder form it involves a failure to appreciate the fundamental importance of retaining the

free choice of hospital. It often involves also a misunderstanding of the problem of waiting lists. It is important that those concerned with the planning of hospital facilities should realise the trap that lies in wait for them should they pursue this path. The subject is discussed at length in Sections III and XII.

(c) *That special departments and services, particularly in the case of voluntary hospitals, are located in small and uneconomic units*

This criticism relates to the small special hospitals of London as well as to the smaller general hospitals which provide a disproportionate number of special departments in relation to their total bed complement. With regard to the former, the question is discussed fully in the section dealing with special hospitals.

So far as the smaller general hospitals are concerned, the subject is one of wider import than is at first sight apparent, since a sweeping generalisation of this kind may easily lead to a verdict in favour of the large all-purpose general hospital of some 800 or more beds on the assumption that it contains within its curtilage a wide range of specialist facilities. It is very necessary that the merits and defects of this form of hospital provision should be better appreciated before plans are laid for the future hospital service. Since the case for this form of hospitalisation depends very largely upon the alleged economy, it is important to realise that the problem is distorted if pride of place is given to the familiar examples of the apparent extravagance of providing such items as X-ray equipment at two or more centres where one might perhaps at first glance suffice. The true factors between which a balance must always be struck are, on the one hand, the best use of the limited amount of specialist skill available, and, on the other hand, the convenience of access on the part of the public. In the

discussion of the provision of general hospital facilities (see Section VI), an attempt is made to give due weight to both these factors.

2. Staffing of the Hospitals

(*a*) *That there are no arrangements for ensuring that the maximum use in each area is made of the skill of the consultant staff available*

It is true that for many years past consultants have been and still are concentrated in the Harley Street neighbourhood, and they are often on the staff of a number of different voluntary hospitals which may be and often are situated at different ends of London and even out in different parts of the Home Counties: consequently it is undoubtedly true that they spend an undue proportion of their time travelling from one hospital to another. While it is clear that there are not at present sufficient consultants to provide a complete consultant service for all hospitals, voluntary as well as those owned by local authorities, some improvement would be effected if the number of hospitals to which a consultant is attached were limited, and if they were reasonably adjacent to each other. Machinery for co-ordinating appointments, particularly in the outer areas is desirable, providing always that such machinery does not interfere with the ultimate responsibility of each hospital for the appointment of its own staff (see pages 24–26).

(*b*) *That there is no machinery to prevent a hospital from admitting cases for whose treatment it possesses neither the suitable staff nor the necessary equipment*

This is a criticism directed primarily at the small general and cottage hospitals, staffed as they often are by local general practitioners with no arrangements for regular supervision by consultants. It must be admitted that these hospitals do, on occasions, admit unsuitable cases. The question as to whether

they should be referred elsewhere, or whether a consultant should be called in, depends on whether the local general practitioner feels that the case is one that he may or may not be able to undertake. This is a defect inherent in the present arrangement and must be guarded against in the future (see pages 41–45).

(c) *That in many of the smaller hospitals there are no adequate arrangements for providing a 24-hour service for dealing with emergencies*

It is said that the present method whereby voluntary hospitals are staffed by honorary part-time consultants does not provide an efficient 24-hour service for dealing with emergencies. It is argued that emergencies are constantly dealt with by resident officers, or in smaller hospitals by one of the local general practitioners, and that the anæsthetic may be administered by a house officer who does not possess adequate experience. So far as the larger general hospitals are concerned, there is little substance in the criticism. Such hospitals appoint as resident surgical officers men of considerable experience and ability, and before undertaking an operation they can be relied upon to get in touch with the appropriate consultant, who is always willing to attend if the need arises. Moreover, they have a resident anæsthetist and a radiographer on call.

In the case of the smaller voluntary general hospital outside London there is more truth in the criticism. Staffed partly by consultants from London and partly by local general practitioners, it may not be feasible to make arrangements whereby consultants in general medicine and surgery and each of the main specialties, as well as an experienced anæsthetist and radiographer, are available day and night to deal with any emergency. Availability of medical staff which is discussed fully on pages 42–44, will go a long way towards overcoming these difficulties.

3. Unequal Distribution of Clinical Material

That the selection of cases by voluntary hospitals is an obstacle to the organisation of a comprehensive hospital service

As the result of the stages by which the present hospital services have been developed we find a situation in which we have, on the one hand, the voluntary hospitals accustomed to exercise their discretion over the admission of patients ; and, on the other hand, a local authority service required by statute to provide for all those who seek its services. This inequality of circumstances underlies much of the sense of dissatisfaction with the present arrangements expressed by the local authorities, and is reflected in the pressure for a " comprehensive " service. There is, of course, no difficulty in understanding how it has arisen ; but there is room for a closer examination of its present practical results, especially in so far as it raises the question of the treatment of the chronic sick. The case for the voluntary hospitals is that their special facilities, their highly-skilled medical and nursing staff and special equipment would be wasted if the chronic sick were to be admitted to their wards. In so far as this contention means that it is uneconomic and wasteful to admit for an unlimited period chronic sick to accommodation classified and staffed as acute, it is certainly a valid objection. But this is not to say that there may not be good reasons in the interests of the service as a whole for a revision of the entire plan whereby particular hospitals are devoted only to the acute sick, and full weight ought to be given to this contention. From the local authority side it can quite properly be urged that such segregation, whatever its historic origin, leads to grave difficulties in the recruitment of medical and nursing staff for their hospital service which has to deal both with the acute and chronic sick. The subject is discussed fully in Section IX.

II. A SINGLE SYSTEM?

To what extent would a single hospital system help to overcome the defects of the present hospital service which we have been considering in the preceding section? If the standard of the municipal hospitals is to be raised and the valuable elements of the voluntary system are to be largely incorporated in the municipal hospitals, why, people ask, should not the voluntary hospitals be gradually absorbed into a single system combining the merits of the voluntary and municipal hospitals of to-day? It is no answer to such a question to reply with a dissertation upon the long history, past achievements and present pre-eminence of the voluntary hospitals.

In the first place, it is necessary to distinguish between two different senses in which the phrase "single system" is used in this connection. It may mean two quite different things. It is quite true that it *is* desirable that there should be a single hospital system in the sense that overlapping should be avoided, but it is a different matter if one passes from this idea and postulates that it is desirable that there should be a single system in the sense that all hospitals should be of the same type and dependent upon the same form of control to secure adaptation to the public need.

Used in this latter sense the contention amounts to a failure to appreciate the fundamental importance of the maintenance of standards of quality and of the machinery by which such standards are at present maintained, not only in the hospital sphere but also in other spheres where economic considerations play only a minor part, and where public opinion is but a paper check. In the hospital world there is no absolute standard by which it is possible to say that a hospital is "good"; it cannot be measured in terms of money, and public opinion is almost entirely dependent for its judgment in

regard to a particular hospital on what is known of other hospitals. Were there but a single hospital system with all the hospitals at a uniform level, how would the public know whether the service it was receiving was good or bad ? The fundamental problem lies there : and the true justification for the deliberate preservation of the voluntary hospital system within the framework of a national system lies, not in voluntary gifts or ancient history, but in the fact that the voluntary hospitals provide an independent standard against which hospitals provided by the public authority can be judged.

The public hospital system cannot rid itself altogether of one handicap—it is implicit in a " public " hospital system that control of policy should be at several removes from the immediate contact with the patient. Policy must be settled, not at the individual institution but at the centre. Such a system has its advantages. In many instances voluntary hospitals have been stimulated by the good services done at the local authority hospitals. It also has its disadvantages—the question is whether the disadvantages are serious. So long as there are voluntary hospitals which do not suffer from this particular handicap, we can have some idea whether that handicap is serious or not : but take away the voluntary hospitals and we have no means of knowing. Again, so long as there are voluntary hospitals the local authorities will keep their eye upon this handicap, they will seek to counteract it, and they may be successful—and, indeed, there are signs that some local authorities are likely to be very successful in this endeavour : but, again, take away the voluntary hospital and its direct impact of patient upon management without intermediary, and there is no telling to what lengths remote control may go nor how deadening that handicap may become.

It is not suggested that the voluntary hospitals as a body will be better than their local authority counterparts of the future. But whether better or less good they will provide a

counter-check, a measure, and a standard upon which the service, as a whole, can be judged. It is upon its flexibilities, its simple direct machinery for bringing together patient and medical staff and management, that the voluntary hospital of the future will have to rely for its power to keep abreast and, in some respects at least, a little ahead of its municipal partner with all the advantages that large-scale organisation can give. For it is in this respect that it possesses something inevitably denied to the public hospital system.

III. FREEDOM OF CHOICE

The above arguments are, of course, based on the assumption that the doctor and the patient should have the right to choose the hospital to which the patient will go, provided the necessary facilities are available thereat.

This is a fundamental principle; should this freedom be lost the index of the relative efficiency of neighbouring hospitals will disappear, for the popularity of a hospital is an expression of the regard in which it is held by the doctors and the general public in its area, and it is a useful guide to the general standard of its services. Apart from its professional efficiency, a number of other factors influence the doctor and the patient in their choice of hospital. One of the most important of these factors is that the doctor knows, either personally or by reputation, the staff of the hospital to which he sends his patients, and is thereby enabled to convey to them his own confidence in the treatment that will be given. There are also other influences of a psychological character which are far from negligible, and the effect they may have on the patient and his easy convalescence should not be disregarded. It may be that he has an illogical aversion to a particular hospital, or that he has had unhappy associations with it, arising perhaps from the death of a relative there or from some other experience. On the

other hand, the patient may be anxious to go into one hospital rather than another because of what he knows and has heard of the skill and sympathy of its medical and nursing staff; he may have worked for it and contributed to its funds, and he may have an affection for it. The mental effect of all these factors, and the confidence with which he enters the hospital, must be borne in mind. They can be appreciated at their real value only by the patient's doctor with his knowledge of all the circumstances, and he should be able to secure his patient's admission to the most appropriate hospital.

The planning of the hospital service must ensure this freedom of choice; while patients would ordinarily wish to go to a hospital within the region in which they live it should not be compulsory for them to do so.

No arrangements, financial or otherwise, must be made which would have the effect of restricting the patient to a particular area or region.

PART II.—AGENDA FOR A REGIONAL ORGANISATION

IV.—THE NEED FOR A REGIONAL APPROACH

Since the publication of the White Paper the King's Fund and the British Hospitals Association have submitted to the Minister of Health the views of voluntary hospitals concerning the type of administrative structure which would, in their opinion, be most likely to lead to the development of a comprehensive hospital service and a true partnership between the voluntary hospitals and the local authorities. Both bodies have emphasised their sense of the importance of two main principles : first, of securing that the responsibility for planning the hospital services should rest upon bodies upon which both the voluntary hospitals and the local authorities are represented ; and, second, of ensuring that London and the Home Counties be regarded as a single region for hospital purposes. Discussion of the means by which the former of these objectives is to be achieved lies outside the scope of this Report, but the case for including the Home Counties within the London region is inseparable from any discussion of the post-war problems of the hospital services of London. Although the subject has been dealt with elsewhere (*e.g.*, the Goodenough Report), the principle is so closely bound up with the questions under discussion in this Report that a brief resumé of the case is essential to the argument.

It is now generally recognised that the hospital services of London cannot be planned without taking into account :—

(1) the extent to which the Home Counties look to London for hospital facilities, and

(2) the importance of extending the university influence.

(1) *The extent to which the Home Counties look to London for hospital facilities*

Before the war approximately 40 per cent. of patients treated in the voluntary hospitals of London came from outside the county boundaries.* There is a comparatively large number of beds within the County of London which, in addition to the London County Council hospitals and the voluntary general hospitals, contains the teaching hospitals and the most outstanding special hospitals in the country. These hospitals were originally founded on sites where they were most needed and the concentration of consultants in the neighbourhood of Harley Street has undoubtedly encouraged extensions and the provision of special services in the central area. On the other hand, during the last 50 years the tendency has been for great numbers of the London population to move outwards. Old industries have migrated, new ones have developed, means of transport have improved out of all knowledge, and housing estates on most parts of the periphery of London have developed on an unprecedented scale; but hospital provision in these areas both voluntary and local authority has, generally speaking, lagged behind the needs. In the less prosperous areas the small voluntary hospital has often been faced in recent years with great difficulty in finding the funds for extension. The King's Fund has done what it could but the financial support which it has been able to give these hospitals has not been on a scale sufficient to meet all their needs. Local authorities, while they have effected a substantial increase in their hospital accommodation in recent years, have also been quite unable to keep pace with the greatly increased demand for hospital accommodation and services. Hitherto no machinery

* Statistical Tables are not given here as the Hospital Survey has recently been published and provides comprehensive statistical data.

has been devised that ensures the adequate provision of hospital facilities in rapidly growing areas.*

The provision of additional accommodation in the peripheral areas will meet a real need but it will not mean that the Home Counties will cease to look to London for hospital facilities. In the interests of economy and efficiency, as well as of investigation and research, highly-specialised treatment should continue to be concentrated in a relatively small number of selected hospitals. The Home Counties and, to a varying extent, other parts of the country look to the great hospitals of London for the provision of highly-specialised services. It is to the advantage of patients and doctors alike that these services should continue to be provided at hospitals in the central area.

(2) *The Importance of Extending the University Influence*

The King's Fund and the British Hospitals Association, in their memoranda commenting on the White Paper, put forward strong arguments in favour of each planning area being based on a university centre, wherever that is practicable. The Goodenough Committee on Medical Schools also stress the importance of extending the influence of the university. They are satisfied that :—

> " there is convincing evidence that the care and treatment of the sick reaches the highest standard when it is associated with the conduct of teaching and research, and when every step in treatment must be fully and openly discussed . . . ." (page 42)

and they urge that :—

> " every practicable means should be sought to bring every hospital into association, directly or indirectly, with a teaching centre " (page 74).

We are in full agreement with these views. The extension

* The London Maternity Services Joint Committee in their Report on London's Maternity Services also drew attention to the inadequate provision of hospital accommodation in the peripheral areas.

of the university influence, in our opinion, can become the most important factor in effecting improvement in the general standard of hospital treatment. Only if the influence of the universities can be made to permeate the hospitals, both voluntary and municipal, throughout the length and breadth of the country can the most effective development of a comprehensive hospital service be anticipated.

Advantage must be taken of the unique position of London University and its twelve medical schools, and the aim should be to extend its influence until it meets the areas of influence of other universities. The sphere of influence of the University of London cannot be easily defined, but the association which already exists between the London teaching hospitals and hospitals in the neighbouring counties should be so developed and extended that ultimately all hospitals within easy reach of London will be in close touch with the teaching hospitals (associations which should exist are discussed on pages 26–29).

(3) *Conclusion*

We are, therefore, of opinion that the London Region should comprise the County of London and the Home Counties. The area must be planned as a whole, in view of the concentration of the teaching and special hospitals in the centre, the extent to which the surrounding areas are and will continue to be dependent on the centre, and the need to extend the influence of the universities and its medical schools. This is the area we have had in mind in this Report.

It is, of course, recognised that different parts of this large area present very different problems. It can be roughly divided into three zones :

(i) the central area of London with a comparatively heavy concentration of beds and a declining residential population,

(ii) the industrial and dormitory areas, both inside and outside the County of London, with a shortage of beds and a rapidly increasing population,

(iii) the more rural areas centred on a local town.

We discuss these areas separately (see pages 36–44), as varying conditions apply, but they must be inter-related in the service they provide.

V. THE RECOMMENDATIONS OF THE GOODENOUGH COMMITTEE ON MEDICAL SCHOOLS PARTICULARLY AFFECTING CO-ORDINATION

(1) *Teaching Hospital Centres*

The Goodenough Committee's recommendations have a substantial bearing on the future distribution of hospital accommodation in London. Starting from the basis that :—

> " properly planned and carefully conducted medical education is the essential foundation of a comprehensive health service." (Page 9) ;

they are of the opinion that :—

> " the two most pressing London problems are :—
>
> (i) to secure adequate facilities for the existing undergraduate schools, and
>
> (ii) to organise better and develop intensively the exceptional facilities of London for post-graduate medical education." (Page 128.)

They draw attention to the concentration of teaching hospitals in the centre and recommend that St. George's, Charing Cross and, possibly, the Royal Free should transfer to the outer areas : " the hospital service in London would greatly benefit, since a better distribution and linking of hospitals could be effected in the inner area and the stimulating effect of Teaching Centres could be brought to the health services in the populous outer areas." (Pages 115–118.)*

* The Goodenough Committee also suggest that the possible advantages of a local authority general hospital becoming the parent teaching hospital of one of the existing medical schools, perhaps removed to a new locality, should be investigated. (Page 129.)

We are in agreement with this recommendation* for it will not only facilitate the extension of the university influence but it will also help to provide that additional hospital accommodation which is so badly needed on the periphery.

> In addition, the Goodenough Committee recommend that a medical school should have access to between 950 and 1,000 beds† in addition to beds for patients suffering from tuberculosis, acute infectious diseases and mental diseases. They suggest that medical schools will have to depend on groups of hospitals for clinical facilities, each such group, or Teaching Hospital Centre, would comprise the parent teaching hospital and one or more associated teaching hospitals. Invariably local authority special hospitals‡ would be included. The inclusion of local authority general hospitals would need to be settled in the light of local resources, but their inclusion as associated teaching hospitals would have certain advantages, provided they were suitably administered, staffed and equipped. They are, however, satisfied that it is essential that the medical school and its 1,000 general hospital beds should occupy the same or immediately adjoining sites and that the aggregation of two or more geographically separated hospital units into a Teaching Hospital Centre should be regarded as a short term policy. (Pages 69–71.)

We are also strongly of the opinion that to obtain the maximum of efficiency for teaching and research the medical school and its 1,000 general hospital beds should be on one site.

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* So far as Charing Cross and St. George's are concerned, it appears likely to be put into effect. The former has already bought a site in Middlesex and the latter had seriously considered selling their present site at Hyde Park Corner even before the war.

† Estimate based on the admission of 100 students a year to the clinical part of the course, as they consider that such a rate of admission should be the aim of most medical schools.

‡ i.e., hospitals for infectious diseases, mental diseases and tuberculosis.

The geographical separation of the units constituting a Teaching Centre must result in a weakening of the close linkage of departments which is such an important, healthy and progressive feature of the modern teaching hospital, and would militate against the intimate association of clinical and non-clinical departments which is essential for team-work in research.

However, to obtain access to 1,000 beds some medical schools may have to depend on groups of hospitals, but it is probable that several of the teaching hospitals will be able to arrange to increase their accommodation to 1,000 beds, and there is no doubt that this is the ideal at which to aim.

It is likely that the additional beds provided by the parent teaching hospitals in the centre will exceed the total number of beds provided by Charing Cross, St. George's and the Royal Free before the war. If the total number of hospital beds in this central area is not to be excessive, it may ultimately be necessary in the interests of medical education for some of the smaller non-teaching general hospitals to move out from the centre in order to ensure the provision of sufficient teaching material for the teaching hospitals. The future of the small general hospital in the centre of London is discussed fully on pages 37 and 38.

(2) *Machinery for Selecting Staff*

The Goodenough Committee are of the opinion that the factor of prime importance in the Teaching Hospital Centres of the future is linkage of staff, and they give detailed recommendations as to how this should be brought about. (Page 71.)

They also state that " there has been complete agreement among our witnesses on the need (i) for suitable advisory machinery for the selection of the medical staff of the school, hospitals and services comprising a

> Teaching Centre, and (ii) for arrangements to secure that posts are filled from the widest possible field of candidates."
>
> They suggest that in London there should be a joint advisory selection committee, including external experts in the subject or department to which the appointment relates, for each Teaching Hospital Centre, and that this committee (with its constitution slightly modified) might be used for the selection of senior staff in non-teaching hospitals in the zone of influence of the centre. All appointments should be advertised and they should be filled from the widest possible field. (Pages 88–90).

We strongly support the view that advisory appointments boards should be established for the selection of the senior staff in all hospitals, but we do not think that they should be so closely related to one Teaching Hospital Centre as the Goodenough Committee's suggestion would imply. We hold the view that the boards should be truly representative and that the influence of one particular medical school should not predominate. In all probability London and the Home Counties would need several advisory appointments boards, but the number and their exact constitution and composition is a matter which can be determined at a later date. Their purpose would be (*a*) to ensure that senior staff appointments are made in a strictly impartial manner, (*b*) to assist hospital boards to secure the most suitable candidate.

We consider that the hospital should advertise the vacancy and the applications received should be submitted to the advisory appointments board for consideration. The board should advise on the merits of the candidates, select those competent by training, experience and academic qualifications to perform the duties entailed, and indicate those who, in their opinion, did not reach the necessary standard. The hospital concerned should be invited to nominate representatives to

attend the meeting of the board, so that the medical committee of the hospital could be supplied with first-hand information of the board's opinion of the merits of the candidates before submitting a recommendation to the governing body, with whom the final appointment would rest, as it does now.

In many instances in the Home Counties (see pages 42–44) the visiting staff would have to be considered in relation to the needs of the area. In these cases machinery would have to be devised for consultation between the interested hospitals with reference to the appointment.

(3) *Extension of University Influence—Associations which should exist*

We have already stressed the importance we attach to the extension of the influence of the university, and the teaching and other hospitals associated with it, to all hospitals throughout the region, large and small, voluntary and municipal.

The university of a region should do more than put the stamp of its approval on a man's academic standard at the outset of his career. It should lay upon him, in whatever hospital(s) he may serve, the obligation of keeping the standard of his performance up to current university level.

It may be assumed that a metropolis will usually attract the exceptionally able man, and hitherto it has been generally true that, with exceptions, the quality of medical work falls off with increased distance from the university centre. In the future it is hoped that men of every standing from senior consultant to house officer, but more particularly those of registrar or chief assistant rank, wherever they may be employed, will continue to keep in touch with the university or teaching hospital.*

There are many consultants in London and the Provinces who are not attached to any teaching hospital, undergraduate

* See page 28, Senior Resident Officers, and Appendix.

or post-graduate. The atmosphere of a teaching hospital undoubtedly acts as a stimulus and helps to keep the members of the staff in close touch with modern medical thought. It would, therefore, be an advantage if all consultants were in contact with one and in some way associated with it.

The Goodenough Committee have gone fully into the best methods of securing the extension of the university influence and the following is a brief summary of the associations which they suggest should exist.

> Although in their opinion it would be impracticable for the staff of teaching hospitals to undertake regular duties in other hospitals (with the exception of special institutes*), they would be available for consultation and advice in respect of the care and treatment of individual patients. Such consultations should, whenever practicable, be conducted in the hospitals of the teaching centre.
>
> The medical school and teaching hospitals of the centre would develop a series of informal educational associations with all the major hospitals in a wide area around ; they would evolve in part out of the arrangements made in respect of pre-registration house-appointments† and in part out of the provision for refresher courses for general practitioners, hospital appointments for intending specialists and other forms of post-graduate education. (Page 75.)
>
> " Although organised by the universities, refresher courses would, in general, be conducted elsewhere than in institutions comprising undergraduate teaching centres, and the teachers would not be those engaged in the training of undergraduate students, but would be

* For special institutes see Section VIII.

† See Appendix.

> approved by the universities specially for these courses . . . . the more widespread the distribution of refresher courses among suitable hospitals, the better from the point of view of the hospital service." (Page 222.)
>
> "In so far as these major hospitals may be linked by means of their specialists with the outlying 'General Practitioner' hospitals, there will be a measure of contact between the teaching centre and all hospitals in its zone of influence." (Page 75.)

The recommendation that it would not be practicable for a teaching hospital consultant to undertake regular duties with other hospitals, with the exception of special institutes, fails to take account of the fact that in certain departments it would not allow the consultant concerned to have a sufficiently large department (*a*) to widen his experience, (*b*) to train his first assistants, (*c*) to keep pace with his waiting-list, and (*d*) to occupy his time fully. In addition, with the present shortage of consultants it will be many years before it is feasible—even if desirable—for this recommendation to be implemented. While the Goodenough Committee recognise that :—

> "Until there are sufficient specialists to meet the needs of the health service it may be necessary as an interim measure for specialists on the staff of teaching centres to serve also in non-teaching hospitals." (Page 75.)

they do not appear to have given this aspect of the question due weight.

Otherwise we are in agreement with all the above suggestions. The majority of them are in line with conclusions reached by our Medical Sub-Committee some two years ago. In addition, we are of the opinion that further useful links would be provided : (i) by the appointment of a new type of Senior Resident Officer* to the larger general and special hospitals ; (ii) if the specialists who take an active part in post-graduate

* See Appendix.

instruction referred to above could be recognised as teachers by the university ; (iii) if occasional exchanges of personnel could be arranged, so that from time to time those who conduct post-graduate courses in one hospital could be invited to give lectures or demonstrations in the courses held at another hospital ; (iv) if clinical meetings were held more frequently than at present in the university teaching hospitals and in other large hospitals in London and elsewhere, consultants from other hospitals being invited to attend.

It is probable that Teaching Centres will form close associations in matters of staffing and of services with particular hospitals. Those situated near Waterloo and Victoria will tend to form associations with hospitals in Surrey and Sussex, while those near Euston and King's Cross will have the majority of their contacts with hospitals in Hertfordshire. But mobility of staff, freedom and flexibility are fundamental to the voluntary hospital system, and the associations between hospitals are most likely to flourish if based on natural inclination rather than on a cut and dried plan.

VI. GENERAL HOSPITALS

(1) *Acceptance of Responsibilities*

General hospitals, both voluntary and municipal, are more numerous than any other type, and they will, therefore, be the backbone of the future hospital service. In London and the Home Counties there is great variety in the size and function of hospitals which are included in the classification "General Hospital." On the local authority side we have a number of large, up-to-date and well-equipped hospitals side by side with old-fashioned and unhygienic institutions still administered under the Poor Law, while on the voluntary side we find hospitals ranging from three or four of the largest, giving a service approximating to that found at the teaching hospitals,

to small hospitals of some 60 beds or so, which have been classed as " general " rather than as " cottage " hospitals.*

The most critical stage in the development of the voluntary general hospital is the transition from the small local cottage hospital of some 20 to 60 beds to the general hospital of 100–200 beds and upwards ; it may be gradual or it may be comparatively clearly defined.

Since many—and, indeed, the majority—of the voluntary hospitals with which we are concerned are at some such stage of development, it may be useful to trace the process of development in the light of the broad considerations of accessibility and function to which reference was made in Section I. Only too often the essential factors are obscured by the adoption of a piecemeal process of extension. The provision of additional beds, new nurses' accommodation, new theatres, and so forth, in response to local needs, has been limited as a rule by the amount of money which the hospitals have been able to raise from voluntary sources. Whilst no one would wish to belittle the value to the community of small hospitals and the enterprise and public spirit shown by those responsible for their management, it remains true that extensions are often effected in such a haphazard way that the smaller general hospital finds itself uncertain as to its proper place in the scheme of the hospital service of the locality. Only in the light of some clear conception of development of function is it possible to proceed to the " grading " of the general hospitals with its implied standards for hospitals of different categories.

The transition from cottage to general hospital should imply a full acceptance of the fact that henceforth the hospital lays itself out to cater, with certain exceptions, for the whole range of acute work likely to arise in its locality. When this responsibility is accepted the hospital must be prepared to provide all those

* For Cottage Hospitals, see Section VII.

adjuncts which are logically involved in offering a comprehensive service. They may be listed as follows :—

(1) So far as is practicable a consultant staff should be made available with clinical responsibility for the patients under their care.

(2) The staffing arrangements must be such that the hospital is able to deal with all types of cases (excepting the most highly specialised), including emergencies, throughout the 24 hours. A resident medical staff is a necessity and an experienced anæsthetist and a radiographer must be available at all times.

(3) A nursing staff competent to deal with all types of cases, including acute and difficult cases.

(4) All the appropriate ancillary services, including radiodiagnostic and pathological departments and such other facilities as become necessary or desirable from time to time.

(5) Out-patient clinics.

(6) The commoner in-patient departments, such as ear, nose and throat, gynæcological, etc., *i.e.*, those which are most commonly needed and should therefore be readily available to everyone.

If due account is to be taken of these factors, it is clear that some minimum standard and size must be laid down for a general, as distinct from a cottage, hospital. Whilst no one of the above factors taken by itself establishes a minimum number of beds, it is increasingly coming to be recognised that efficiency demands a bed complement somewhere in the neighbourhood of 150*. Thus, for example, the General Nursing Council has indicated its intention of requiring a minimum of 100 occupied beds for recognition as a training school. There may, indeed,

* Apart from considerations advanced in Section IX concerning the chronic sick.

be other ways of securing efficient nursing, but there is little doubt that for some time to come the possession of a training school will be regarded as offering the best means of attaining that end. A hospital of 150 beds affords sufficient work to warrant the employment of at least three resident medical officers, in addition to one or more registrars. Whilst hospitals have in the past sometimes employed only one or two residents, there is no doubt that a team of three can work in more easily and with less difficulty in ensuring that one is always on duty throughout the 24 hours. The provision of the necessary ancillary services also indicates a minimum of some 150 beds, if the radio-diagnostic and pathological departments are to be reasonably economic and efficient units, staffed by whole-time technicians and visited regularly by pathologists and radiologists. It will be noticed, too, that in-patient beds for at least the commoner special departments are mentioned, and this in itself implies a total bed complement sufficient to permit the allocation of beds to the consultants concerned.

The special in-patient departments to be provided must depend on the facilities available in the district and the facilities for transferring patients from out-patient clinics to other hospitals. So far as possible the small departments which necessitate the provision of special equipment and which are bound to be uneconomic and may prove inefficient should be avoided,* although in rural districts where accommodation for a particular specialty is not readily accessible this may not be practicable.†

* The aim should be to transfer patients seen at the out-patient clinics who are in need of special in-patient treatment.

† There are those who hold the view that all special departments should be of sufficient size to employ full-time specialists, that the experience to be gained in such departments is of great value and provides the maximum opportunities for research. We do not hold this extreme view as we feel that the experience obtained by being on the staff of more than one hospital can be of even greater value.

In hospitals suitably staffed and equipped to deal with all the commoner specialities as well as general medical and surgical cases, it is apparent that the number of beds needed may well reach 250 or more; especially if separate pay bed accommodation and a maternity unit are included.

Acceptance of the foregoing principles implies that there is no appropriate halt for the developing hospital until the standard indicated has been reached. In present circumstances it would be a mistake to apply too rigidly any such standard, but it should be made clear to all concerned that "extension" must be viewed primarily as an acceptance of greater responsibilities rather than as a matter of bricks and mortar. It would, however, make for progress if it were recognised that a hospital with less than 150 beds—other, of course, than the cottage hospital staffed by general practitioners—is unlikely to be able to provide a complete service and should, therefore, be regarded as being in a state of transition, and as not yet having fully attained to the status and responsibilities of a "general hospital."* This is essential if the voluntary general hospital is to prove itself capable of active and fruitful co-operation with the hospital services provided by the local authorities.

We appreciate that in the smaller general hospitals, and even in some of the larger hospitals in the Home Counties, some if not all of the staff are engaged in general practice. It is not yet practicable to propose that all the members of the staffs of these hospitals should be consultants, giving their whole time to general medicine or surgery or a specialty, but it is desirable that in future such appointments should be restricted to practitioners who have served for a period of not less than two years in a hospital or unit devoted to the special work they

* Misunderstanding would be avoided if the term "general hospital" were restricted to hospitals approximating to this size.

propose to undertake. They should also hold the relevant diploma or higher degree.

Every hospital, no matter how small it may be, should have consultants on its staff and should be visited by them at regular intervals—not less frequently than once a week.

(2) *The Larger General Hospital: Is there an Economic Size?*

The transition from the small general hospital to the general hospital of the largest size offers no clear-cut line. It often happens that no sooner has the cottage hospital extended into a small general hospital than the need is felt for largely increased accommodation, and the hospital accordingly undertakes extensions to meet the need. The increase of beds carries with it the opportunity to increase the size and character of the consultant staff, and in this sense the hospital naturally begins to offer a service extending in many directions beyond that offered by the smaller hospitals, and, in a few cases, approximating to that offered by the teaching hospitals. In this sense the larger general hospitals act as key hospitals to their neighbours, and often draw patients from a relatively wide area.

This leads to the question whether it would be wise to encourage the ultimate development of voluntary general hospitals to a size approaching that of the average local authority hospitals? Or can considerations be adduced which would indicate a smaller number of beds? In other words, is there any indication of the "economic" size of the general hospital?

There has grown up in recent years a belief that the large hospital (*i.e.*, 700–800 beds and over) is *per se* more efficient than the small hospital. In the sense that a hospital of several hundred beds is large enough to warrant a full range of ancillary services—radio-diagnostic, pathological, and so on—to warrant sub-division into specialised units, to warrant the

appointment of senior resident staff and to provide a full-time service with experienced physicians, surgeons, anæsthetists and radiographers always available, the belief is justified. It is also true that the larger unit is better able to take advantage of modern methods of management, of all those economies in expenditure on the essential services of food and equipment that are open to any large institution as compared with the small unit. No one would wish to deny this ; but there lurks here a very real danger that the argument in favour of the large hospital may be carried too far. The problem of the best means of providing hospital services for any given population is much more complicated than it may seem to the critic who relies on the foregoing considerations alone, and the case for the small general hospital rests on much firmer ground than appears at first sight.

The size of a general hospital must depend upon the population of the area it serves and the work it is called upon to undertake ; the services which it provides must depend on the needs and the resources of the area served. Even if it were desirable, it would not be practicable for all general hospitals to have at least 700 beds ; sparsely-populated areas cannot conveniently be served by hospitals of this size ; patients would find themselves 30 or 40 miles away from the nearest hospital.

We are not, however, convinced that it is desirable that general hospitals should have at least 700 beds : smaller hospitals possess certain advantages over larger units. They serve a more local population ; well known to their patients, they can more easily ensure that friendly and personal atmosphere, which means so much to the sick person. The larger the hospital the harder it is to preserve this friendly informal relationship between staff and patients. Very large hospitals often appear formidable to those who do not know them ; they can easily become the coldly efficient kind of institution

which is so terrifying to the sensitive. The following extract from an article by Helen Rees on " Some Aspects of Regional Hospital Planning "* emphasises this aspect :—

> " Almoners who have seen the response of the nervous patient to the small, friendly hospital and know how hard it is to reconcile certain patients to the idea of entering a very large institution, will want to put up a plea that these regional centres for investigation and specialist treatment should not be allowed to become too big . . . . Long experience of hospital patients suggests that to most of them the atmosphere of the hospital or ward, the friendliness of the staff, and the feeling of security which some hospitals manage to convey so much better than others, matter far more than whether the medical or surgical treatment provided is the last word in efficiency."

Considerations of large-scale economies are, and ought to be, secondary. We do not believe that the voluntary hospital is called upon to compete with the local authority hospital in size, and we think there would be a real danger of voluntary effort failing to make its special contribution in terms of quality of service if too ambitious a programme were to be undertaken with the help of public monies.

The point is worth stressing, since there is evident a tendency on the part of officialdom throughout the country to accept the case for the large unit as already proven.

(3) *Geographical Considerations—The Central London Area*

The foregoing considerations need to be borne in mind when we come to examine the general hospital position in the London region.

As has already been noted, London and the Home Counties can be divided into three distinct areas, each with its own hospital problems. These areas need to be considered

* Published in " Social Work "—April, 1942.

separately from the point of view of availability, efficiency and economy.

The central area of London, from which the population is now tending to recede, contains most of the teaching and special hospitals, as well as several voluntary general hospitals and a number of London County Council hospitals, with the result that it is comparatively well provided with hospital beds.

There are 10 voluntary general hospitals* in this area with less than 100 beds, but most of them, while they are general in the sense that they deal with all the usual types of case, are special in the sense that they mainly confine their admissions to a particular category—they may have a religious foundation, they may be for people of a particular class or of a particular nationality. These hospitals, while they may not be the last word in medical and surgical efficiency, provide for special classes of the community who prefer to have their own hospitals, even at the loss of some of the advantages attributable to size. So long as they continue to serve a special section of the community, they cannot be included in the general hospital pattern. Some of them, however, no longer confine their activities in this way; apart from their name few signs remain of the special purpose for which they were founded. While we have welcomed the White Paper's proposal to make use of good existing facilities, there is little justification for general hospitals with less than 100 beds in central London. They rarely conform with the minimum standards discussed on pages 30–34, and the majority are on cramped sites with out-of-date buildings, which have been developed piecemeal with no clear conception of their ultimate aim, and they are deficient in many of the features which are now considered essential in modern hospital planning.† The

* Including general hospitals for women.

† This also applies to many of the municipal hospitals, and, in some cases, even more so.

money, energy and hard work needed to turn them into reasonably efficient and economic units would be out of all proportion to the result likely to be obtained.

The question of easy accessibility—of such importance in the outer areas—hardly arises, and looking at the problem of the hospital system as a whole, the ideal would be a long-term policy whereby these hospitals would join forces with each other or with a larger neighbour, with the ultimate object of a physical amalgamation, either on one of their existing sites or, if it should prove desirable, further out towards the periphery. Such amalgamations should result in increased efficiency and economy and the larger general hospitals thus obtained should be of a size and standard to justify a claim for recognition by the university as being suitable for pre-registration house appointments (see page 27 and Appendix).

At present the small general hospitals are kept fairly busy, but it must be remembered that the existing pressure on hospital beds in central London is likely to be relieved :

(*a*) by the expansion of the teaching hospitals,

(*b*) by the expansion of the special hospitals to form special institutes,

(*c*) by the provision of additional accommodation on the periphery.

Of course the future hospital plans of the London County Council have a very direct bearing on the picture. But making every allowance for the great improvements made by the Council since 1930, it is probable that it will take them many years to provide the number of beds they had before the war in hospitals of the desired standard, in view of the severe damage that several of their hospitals have suffered from enemy action and the need for re-building some of their older units.

(4) *Geographical Considerations—Industrial and Dormitory Areas*

The area extending from the outer edge of the County of London towards the boundaries of the Metropolitan Police District is largely an industrial and dormitory belt.

This is the area referred to on page 19, where hospital provision, both voluntary and municipal, has failed to keep pace with the rapidly increasing population.

At present these areas are served by the large all-purpose general hospital owned by the local authority and by a number of voluntary general hospitals ranging in size from 50 to 250 beds, apart from the Royal Northern with 398 beds which is in a class by itself. The pressure on hospital accommodation is heavy and the general hospitals concerned are in practically every case conscious of the need for material expansion. There are in the industrial periphery of London some hospitals (including Connaught, East Ham, King Edward Memorial (Ealing), King George (Ilford), Memorial (Woolwich), Prince of Wales's, Queen Mary's for the East End, Willesden, of considerable local importance, where pressure on the existing accommodation is marked, and where an ambitious programme of development should be encouraged even after full allowance has been made for the development of the local authority services.

The justification for such expansion must be viewed in the light of the overall need for the development of hospital services in these areas and the possible alternative provided by the further development of the large general hospitals provided by the local authorities. If these hospitals are to play their appropriate part in the future hospital structure of London, the problem of their development by appropriate stages within their financial capacity must be solved. We have already noted that this should be viewed primarily as a matter of staffing (medical, nursing and technical). The errors of the past whereby additions to the number of beds have not been accompanied by appropriate arrangements, *e.g.*,

the provision of accommodation for nurses, etc., must not be repeated.

There remain to be considered the small hospitals of some 75 beds which at present regard themselves as general rather than as cottage hospitals. Dealing with the central area we have committed ourselves to the view that there is little justification for the continued existence of these small hospitals as separate entities. But in central London there is no serious overall shortage of hospital accommodation, nor does the factor of local interest apply to the same extent as in the outlying areas.

A recommendation that the smaller hospitals in the outlying areas should cease to function would be quite impracticable in view of the serious shortage of hospital facilities. In addition, their elimination would be a serious loss to the life of the communities concerned in view of the pride and interest which the industria centres take in their local hospital. Further, it is likely that in the course of time the demands of the district they serve will result in their ultimate development into hospitals of 200 or more beds, providing a comprehensive service. In the meantime, arrangements for close co-operation with neighbouring hospitals, either voluntary or local authority, will help them to provide an efficient service. Joint staffing arrangements are likely to ensure the most useful result, and such associations are discussed fully in the next section, which deals with the residential and rural areas.

It is probable that the local authority hospitals will also expand their services to meet the exceptional demands created in these areas, and every encouragement should be forthcoming to enable them to do so.

(5) *Geographical Considerations—The Home Counties outside the Industrial Zone*

We have been concerned so far with the inner London area and with the industrial and dormitory belt. When we pass to

consider the hospital services of the Home Counties outside this belt we find ourselves confronted by a very different series of problems calling for quite different treatment. The problems differ in that the hospitals are mainly located in towns of medium size serving comparatively thinly-populated rural and semi-rural areas, and geographical considerations play a correspondingly more important part. It is fortunate that in several of the counties concerned, most notably in Surrey, progress has already been or is being made towards working out a skeleton plan for the hospital services (see Preface). The draft plans already prepared or in course of preparation provide in each case for the existing hospitals to be classified in two or more categories, and will, no doubt, prove to be a useful foundation for future collaboration between the voluntary and the local authority services.

It is, however, clear that whatever terminology is eventually adopted, the only hospitals in these areas which can expect to conform to the standards suggested in this Report for the general, as distinct from the cottage, hospital are the (very few) large local authority general hospitals,* and the voluntary units of 100 beds and upwards situated in the larger towns. The majority of the voluntary hospitals are of the cottage hospital type, though a great many have, through force of circumstances, functioned as general hospitals in the past, and have sometimes undertaken work beyond their proper capacity. The fact that the latter in some cases do not even approximate to the minimum standards discussed on pages 30–34 either as regards staffing or equipment presents one of the major problems of hospitalisation, which the Home Counties share with a large part of the rest of the country.

The following suggestions would, we think, go a long way towards solving the problem :—

* Apart from one or two outstanding exceptions like St. Helier's many of the municipal hospitals are in obsolete buildings and some are still administered under the Poor Law.

(*a*) a full acceptance of the distinction between a general hospital and a cottage hospital,

(*b*) the up-grading of all those units where the circumstances justify the development into a general hospital; and such circumstances must perforce include availability of appropriate consultant staff,

(*c*) an overhaul of the present distribution of consultant medical staff in such a way as to bring a regular system of visiting of cottage hospitals by consultants into the realm of practical politics.

It would be impracticable within the limits of this Report to embark upon an examination of all the factors involved in these suggestions, but it may be worth while to offer certain comments which should be read in conjunction with the next section on "Cottage Hospitals."

Districts outside the centres of population must continue to be served by cottage hospitals, if hospital accommodation is to be within easy reach of everyone; it is, therefore, of the utmost importance that the distinction between a general hospital and a cottage hospital should be clearly defined so as to ensure that the latter do not undertake work outside their capacity.

While the density of population in certain of the middle-sized towns as well as of the larger towns would justify the provision of one large general hospital providing a full range of special departments (except the most highly-specialised), in practice most of these towns already have at least two hospitals, one voluntary and one local authority. Broadly speaking, while the latter have a greater number of beds the former provide the out-patient consultant clinics and special services. The up-grading of these hospitals must mean working arrangements between the voluntary and local authority hospitals. This would be greatly facilitated if they shared, to a certain

extent, the same consultant staff. There would then be little difficulty in (*a*) referring patients from the out-patient clinic of the voluntary hospital for admission to the local authority hospital, (*b*) ensuring that the provision of special departments needing expensive equipment should not be duplicated, (*c*) making arrangements whereby one or other hospital would be able to deal adequately with any emergency, day or night.

The institution of advisory appointments boards already recommended would greatly facilitate the appointment of joint consultant staffs, but, in addition, it would be essential for local authorities (where they have not already done so) to review their staffing arrangements so as to give their consultant staff full clinical responsibility for a number of beds, as distinct from the existing arrangement whereby the consultants are called in for consultation at the discretion of the medical superintendent.* Unless some such change is effected the consultants concerned will have little interest in the municipal hospitals; they will continue to pick and choose the cases which they keep at the voluntary hospital and the present disbalance of clinical material, to which we have already referred, will be likely to continue.

There is another aspect from which joint consultant staffs would be of mutual advantage. The appointment of the same consultant to two or more hospitals in the same area would probably provide him with sufficient work to make it worth his while to live in the neighbourhood. Availability of medical staff is one of the most important factors of an efficient hospital service. The present dearth of consultants living in the country

* The Goodenough Committee on Medical Schools recognise the disadvantages of this system so far as teaching is concerned. They say (page 67): "A parent teaching hospital must have a governing body personal to the hospital. A medical superintendent should cease to be the chief clinician of the hospital . . . . essential for members of the medical staff to have complete individual responsibility for the clinical management of their patient."

towns undoubtedly helps to explain why the Home Counties have looked to London to such a great extent for hospital provision.

VII. COTTAGE HOSPITALS

> "Large local government hospitals have some administrative advantages. Patients regard them as institutions, while they look on our little cottage hospitals almost as they do on their own homes. They think as little of going into them as of moving from one bedroom to another in their own homes. They are happy in them. They know that they are easily accessible to their friends, and these are important factors in shortening their convalescence . . . . The small hospital within easy access of the patient's home and friends will suit his convenience and will meet his wishes."*

The cottage hospital has all the advantages of being small and homely; patients usually come from the immediate neighbourhood, and therefore the hospital and its doctors are well-known to them; the staff and the patients are under the direct and immediate personal supervision of the Matron; they are free from the problems of institutional management.

They probably inspire as much local enthusiasm, interest and affection as any other class of hospital, and yet many of the criticisms which we considered in Section I. are particularly directed at these hospitals.

The reason is not far to seek. It is because many of them admit and treat cases which they are neither equipped nor staffed to deal with satisfactorily. This may be due to force of circumstances, *i.e.*, difficulties of transferring such cases to another hospital owing to a lack of suitable available accommodation—or it may be due to ignorance or misplaced confidence, *i.e.*, where the general practitioners staffing the

* James Murphy, "British Medical Journal"—October 14, 1944.

cottage hospital have not appreciated the need for more expert treatment.

In future there must be proper safeguards to avoid the admission of unsuitable cases and their retention in cottage hospitals; it must be clearly realised that cottage hospitals are not general hospitals, and they should be classified in a separate category. Readily accessible to the general practitioner their purpose should be to provide him with beds in which his cases can be kept under observation, and may receive proper nursing care and suitable diet.

Machinery must be devised to facilitate the transfer to general hospitals of patients in need of more highly-specialised treatment and their re-transfer to the cottage hospitals under the care of their general practitioner when the need for general hospital treatment is past.

Improvement can best be effected through staffing arrangements; consultants in general medicine and surgery should be appointed to these hospitals with supervisory responsibility, and they should pay regular visits—not less often than once a week—instead of attending only when asked to do so. On these visits they should see patients in the wards and those sent by doctors for an opinion. It is most desirable that all the hospitals to which any particular consultant is attached should be in the same area—a matter to which reference has already been made—and this applies with even greater force to the cottage hospitals. In respect of patients in private wards the general practitioners should still be at liberty to call in a consultant who is not attached to the hospital.

In any cottage hospital with 50 or more beds there should be a resident medical officer.

The hospital service must be considered as a pattern, and the build-up ought always to be from the general practitioner to the specialist. The Committee of Management must be responsible for the appointment of the medical staff, but

subject to their approval, the beds at a cottage hospital should be available to all general practitioners in the neighbourhood. Unless the general practitioner is provided with a local hospital where he can himself attend his patient, the quality of the whole medical service will suffer, and there will occur a divorce between the work of the general practitioner and of the hospital services. Arrangements such as those advocated by the Goodenough Committee (pages 32–3 of their Report) and other bodies for those taking part in the work of the general and special hospitals, by means of clinical assistantships, etc., while highly desirable in themselves, are not enough. Close association with the visiting consultant in the care of his patient at the cottage hospital will be of real benefit to doctor and patient alike.

VIII. SPECIAL HOSPITALS

Following the birth of specialisation some 100 years ago, the special hospitals came into being owing to the limited facilities available for the treatment of specialties in the general hospitals. Their establishment provided opportunities for the intensive study of diseases affecting particular parts of the body, such as the eye, the ear, etc., and particular age groups, such as children and infants, and the resulting advances in knowledge created an increased demand for their services so that the special hospitals grew in number and size. The importance of the provision of facilities for the specialties soon became generally recognised, and, as a later development, special departments were instituted at most of the larger general hospitals.

Some of the larger special hospitals have played a predominant part in the development of their particular branches of medicine and surgery. The consultants by whom they are staffed are usually responsible for the conduct of a special department in the same subject at a general, often a teaching,

hospital so that the larger special hospitals bring together a group of consultants, all interested in the same specialty but also associated with a number of different general hospitals. The special hospital thus becomes a centre where ideas can be exchanged and compared. The benefits are two-fold. In the smaller special departments in the general hospitals the danger of isolation from the stream of progress is eliminated, and on the other hand any tendency to over-specialisation is corrected by contacts in the general hospitals with colleagues interested in other branches of medicine and surgery.

Those larger special hospitals which are able to provide all the appropriate ancillary services are in a position to take up and develop new methods of examination and treatment and, therefore, to function as active centres of investigation and research. Abundantly supplied with their particular variety of clinical material, they have the advantage of a staff of consultants all working in the same field but with different ideas and methods.

The Goodenough Committee recognise the important part played by special hospitals in post-graduate medical education :

> " In the case of most of the special branches of medicine and surgery it will be essential, as in the past, for the greater part of a trainee's period of service to be in one or more of the leading special hospitals concerned with the branch of medicine for which he is preparing . . . . As a rule, the special departments of the general hospitals used for the training of undergraduate students have not been large enough to provide post-graduate students with the range and variety of clinical material that they need." (Pages 215 and 216.)

We agree that general hospitals do not, as a rule, provide the same facilities as the special hospitals for post-graduate teaching in the specialties. The largest of these general hospitals are fully occupied with undergraduate teaching and, even if they

had the necessary clinical material, there are difficulties in connection with concurrent undergraduate and post-graduate instruction in the same institution. General hospitals which undertake post-graduate teaching cater more often for a type of post-graduate who does not need intensive training in any one specialty, but wishes rather to refresh his knowledge of medicine and surgery as a whole.

There are those who think that provision for specialties should be made only in special units at general hospitals and that there is no case for the separate existence of special hospitals. On the other hand, there are many who take the opposite view, namely, that a higher standard would be achieved if all work in connection with specialties were carried out in hospitals entirely devoted to them.

We do not give our support to either of these extreme views. We believe that a limited number of special hospitals are necessary in London, and we recognise that some of those which now exist enjoy a reputation which is international, and which has been earned by the high standard of their work, their progressive spirit and tradition, and by their contributions to the advancement of their particular specialty. Further, in view of the need for a greatly increased number of specialists of all kinds, it is essential that there should be sufficient training centres for them.

We endorse the Goodenough Committee's view that the exceptional resources of London as a centre for post-graduate education are not at present properly utilised, and we agree with their recommendation that :—

> "the British Post-graduate Medical School should be reconstituted as a federal organisation embracing not only the departments and teaching organisation which are attached to Hammersmith Hospital and which at the present time constitute the school, but also a series

of institutes in the various special subjects, each institute being based on the most suitable special hospital in its particular subject." (Page 227.)

They go on to say :—

"the aim should be to have . . . . one institute in each of the principal special subjects. Each of these institutes should be attached to an appropriate special hospital. . . . . As a first step, at least one special hospital in each major special subject should be brought up to university standard in respect of staffing, accommodation and equipment, and should be assisted to establish an institute for post-graduate education and research."* (Page 229.)

In some specialties two or more hospitals might take part in the establishment of an institute.

There are, however, a few special hospitals which are not of the necessary standard and size to take part in post-graduate education. The small special hospital probably owed its foundation to a feeling that that particular specialty was not receiving from the general hospitals the attention that was its due. When originally founded ancillary services did not play such an important part in medical treatment, and at that time it may have been a reasonably economical proposition to set up a unit of some 40 or 50 beds, and in several instances in London two or three small hospitals, devoted to the same specialty, are to be found within a mile of each other. In these days when ancillary services play such a prominent part in medical diagnosis and treatment, these units are possibly unduly extravagant. In the interests of efficiency and economy special hospitals should each provide not less than 100 beds, and there would appear to be good reason for encouraging such

* They suggest that the Maudsley Hospital, the Bethlem Royal Hospital, the Royal Cancer Hospital, the Royal London Ophthalmic Hospital, the Hospital for Sick Children and the National Hospital for Diseases of the Nervous System should be among the first to develop institutes and to federate them to the British Post-Graduate Medical School.

of these hospitals as do not already reach this size to achieve it by extension or amalgamation, or alternatively, to enter into a close association with a neighbouring general hospital.

As regards maternity work we are substantially in agreement with the Report which was prepared by the London Maternity Services Joint Committee on behalf of the maternity hospitals and maternity departments of general hospitals, in which it is clearly indicated that there is scope for maternity hospitals as well as for the maternity departments of the general hospitals. This Report has been circulated to all hospitals, and apart from certain matters of general interest the recommendations contained therein are not repeated here.

While we are of the opinion that it is desirable that general hospitals should have children's departments, we feel that there will be a need for two or perhaps three special children's hospitals associated with the Institute of Pædiatrics. As in the case of the maternity department, it is desirable that the children's department at the general hospitals should so far as is practicable be kept apart from the rest of the work of the hospital.

IX. THE CHRONIC SICK

Increasing interest is being taken in the care of the chronic sick, and it is recognised that provision for the treatment of these patients is at present totally inadequate. It is often difficult for general practitioners to find accommodation for patients who are suffering from an acute phase of a chronic condition.

Strictly the term "Chronic Sick" should be confined to those who have contracted a malady for which there is no adequate curative or palliative treatment, and which renders them incapable of looking after themselves; but, in practice, a wider interpretation is given to the term, and the following

rough classification gives the different types of case which are usually referred to as " the chronic sick."

A. Those which are remediable and can be materially benefited by treatment, *e.g.*, cardiac cases with temporary failure of compensation, chronic rheumatism and arthritis.

B. Those which are irremediable, *e.g.*, advanced carcinoma and the later stages of incurable nervous diseases.

C. Those cases of aged and infirm who would be more suitably housed in hostels than in hospitals.

While the question of adequate accommodation for the third group is outside the scope of this Report, it is a matter of extreme urgency that comfortable homes for these people—who, while they do not require skilled nursing, do need care and sympathetic understanding—should be included in the re-organisation of the National Health Service. The present unsatisfactory position has been recognised by the Nuffield Trust who have set up a committee to report on the care of the aged, and their findings will be awaited with interest.

But Groups A and B are the concern of the hospitals; patients in these groups require patient and careful nursing.

A small number of voluntary homes, the majority of them with a religious basis, were pioneers in providing care for the dying and the incurable, but apart from these special homes voluntary hospitals, while they have for long been conscious of the need for increased provision for the care of the chronic sick, have been unable to help owing to lack of accommodation. With their highly-skilled staff and costly equipment they have had to reserve their limited accommodation for acute cases, and even so the majority of them have lengthy waiting lists.

The public authorities have a general responsibility for the care of the chronic sick, but there is often severe pressure on their accommodation for these patients and the standard of treatment in the purely chronic sick institution leaves much to be desired. The staffing of these institutions—both medical

and nursing—presents real difficulties. When the psychological effect of looking after patients who are often incurable and who seldom show signs of improvement is taken into consideration it is hardly surprising that it is difficult to find the staff to look after these cases, and yet shortage of staff only aggravates the position by throwing a greater burden upon what staff there is, with the result that conditions in these institutions are often deplorable. They tend to become a backwater forgotten by everybody, with no outside contacts to bring in fresh ideas and fresh enthusiasms; the daily routine is performed with a minimum of energy and many chances of, at any rate, partial cures are missed.

In addition, the present practice, whereby voluntary hospitals exercise their discretion over the admission of these patients and having admitted them transfer them to municipal hospitals, deprives medical students and nurses of experience which is so necessary for general practitioners, district nurses and private nurses, a great proportion of whose work is spent in looking after chronic sick patients.

We, therefore, have two cogent reasons why the present arrangements for the care of the chronic sick need to be drastically reformed. (i) To improve the standard of treatment it is essential that the isolated chronic sick institution where it still exists should be abolished and that the necessary accommodation should be provided either at general acute hospitals or at institutions closely affiliated with them. (ii) In the interests of medical and nursing education all teaching and general hospitals should take a share of these cases.

We appreciate that, in view of the heavy pressure on their existing accommodation, few voluntary hospitals will feel able to admit an appreciable proportion of these cases immediately; but in the future hospital service general hospitals should make provision for a certain number (dependent on the needs of their area) of chronic sick patients, possibly in a separate

block. We realise the financial difficulties involved but feel that the matter is of such importance that these must be overcome, if necessary by special financial arrangements with the exchequer both as regards capital and maintenance expenditure.

While the past history of the two types of hospital service has led to this segregation of cases, it has been a source of friction and misunderstanding between the voluntary hospitals and the local authorities (see page 13); the above recommendation, in addition to being in the best interest of the future hospital service, will help to obviate unnecessary friction and will encourage that friendly partnership between the voluntary hospitals and the local authorities, which is an essential foundation of a comprehensive and efficient hospital service.

X. OUT-PATIENTS AND CASUALTIES

It is not possible to review all the different departments and services which are provided by the general and special hospitals and reference has, therefore, only been made to those which, in the opinion of the Committee, are particularly affected by plans of co-ordination.

(1) *Consultative Out-patient Departments.*—The White Paper says (page 20) :—

> " It will be the aim to restore the out-patient work of the hospitals as much as possible to its proper function of specialist and consultant care, when the existence of a general ' family doctor ' for all has been secured."

and " P.E.P. " in commenting on this state :—

> " the out-patient department will become a health centre at the level of the consultant and specialist. It will work in close co-operation with the G.P.s in the area, and, apart from former hospital patients and accident cases, it should be accessible only through them."

This is an over-simplification of the problem. While it is desirable that the movement towards the more consultative use of out-patient departments (for casualties see (3) below) should be encouraged—as that is their proper function—it must be recognised that there are some patients who are not in a position to bring a doctor's letter. For instance, they may not be able to afford a private doctor, or they may have lost faith in their own doctor and may therefore be anxious to have a second opinion. While the former difficulty will disappear under the proposed National Health Service, the latter will remain. The more complete the scheme the greater the danger of undue regimentation, and the more important it is to ensure that an alternative professional opinion is available for those who want it.

It is therefore recommended that no patient should be turned away from the out-patient department without being seen and if necessary treated by a medical man. But these departments are not intended for trivial cases, and patients attending without a doctor's letter should be seen by a medical officer who would sift the cases, referring the more complicated ones to the appropriate clinic and the minor ones to a general practitioner. Pending the establishment of the National Health Service, patients who could not afford a doctor's fee could be treated by the medical officer, providing the medical officer did not retain them under his care for more than three attendances without reference to the appropriate consultative clinic. It is, of course, understood that all patients sent by doctors should be seen by a consultant.

(2) *Appointments System.* — The White Paper (page 7) says :—

> " There is undue pressure in some areas on the hospitals' out-patient departments—in spite of certain experiments which some hospitals have tried (and which should

be encouraged), in arranging a system of timed appointments to obviate long waiting."

It is not perhaps realised that the voluntary hospitals do the bulk of the out-patient work; the reputation of the consultants on their staff attract ever-increasing numbers to their clinics, with the result that they have great difficulty in keeping pace with the growing demand for their services. As long ago as 1932 the King's Fund held an enquiry into out-patient methods, when they made various recommendations, including the following :—

> "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."

A great number of voluntary hospitals have instituted an out-patient appointments system, and many others are only waiting for the easing of the labour situation to do likewise. In addition, a number of voluntary hospitals have provided a canteen and other amenities for their out-patients, in spite of difficulties caused by the war—such as the removal of out-patient departments to temporary and often cramped and unsuitable quarters and shortage of staff. We are of the opinion that all hospitals, large and small, general and special, should make every effort to initiate an appointments system*

* The Out-Patient Time-table of London's voluntary hospitals circulated by the King's Fund to all doctors practising in the Metropolitan Police District facilitates the fixing of appointments.

and to provide other amenities, such as a canteen, more comfortable seats, etc.

(3) *Casualty Departments.*—In addition to an out-patient department there should be a casualty department, with casualty officers and nursing staff available day and night to deal with accidents and emergencies. In thickly-populated areas, where casualties are frequent, patients should only be seen once and then, if not in need of admission, referred to their doctor or to the out-patient department to avoid congestion and unnecessary waiting.

XI. AMBULANCE SERVICE

The importance of a well-organised ambulance service cannot be over-emphasised; it is an essential part of any hospital service. A first-class hospital service must include arrangements for ensuring that there is the minimum amount of delay in getting a patient to hospital; effective co-ordination between hospitals, voluntary and municipal, large and small, general and special, must depend on efficient arrangements for the transfer of patients.

At present arrangements vary in every county or borough; some ambulances are confined to their own districts; there is no uniformity in the charges; some local authorities provide free ambulances, others charge as much as 1*s.* 6*d.* a mile. In Outer London alone* there are over 120 different ambulance services. There is often difficulty and delay in getting an ambulance to convey a patient who resides in one borough to a hospital situated in another, particularly in a case where the patient is unable to pay. Even if it is not a matter of life and death unnecessary complications can be caused when a patient is kept waiting.

In addition to the need for uniform arrangements for the administration and operation of the ambulance service, it is

* i.e., the area outside the County of London and within the Metropolitan Police District.

equally important that arrangements should be made to ensure :—

(*a*) that ambulances are operated by properly trained staff ;
(*b*) that up-to-date and comfortable vehicles are used ;
(*c*) that there are adequate facilities for cleaning and disinfecting.

It would be outside the scope of this Report to give these matters the detailed and careful consideration which they need, but we have mentioned them here so as to emphasise the need for a uniform and co-ordinated scheme for re-organising the existing services.

XII. WAITING LISTS AND CENTRALISED ADMISSIONS

It is a natural assumption that in an ideal hospital service the waiting list would disappear, and from this assumption it seems to follow as a logical sequel that a central bureau should be established for controlling admissions and directing patients to hospitals which are able to admit them without delay. This we hold to be an undue simplification of the problem, and an illusory short cut which, if adopted, might do irreparable damage to the hospital system. Not only would it be contrary to the principle of free choice of hospital, the importance of which we have already stressed, but to suggest that the waiting list as such ought to disappear is to ignore the fact that the acquisition of a reputation by a hospital or by an individual member of its staff is bound up with progress in medicine. It is owing to the established reputation of certain hospitals, where the maximum ability and skill are to be found, that suitable cases are attracted to them ; with the decline of that reputation the patients gravitate elsewhere.

The root question is, after all, not what system will reduce the waiting lists to a minimum, but what system will, in the long run, ensure the highest standard of service. Only so long as we possess an index of efficiency can we be sure that public

opinion is not lulled into the acceptance of a hospital system less good than it might be, and that mediocrity is not passed off as excellence.

To argue thus is not to defend the excessively long waiting list. While " the anomalies of large waiting lists at one hospital and suitable beds empty at another " is not nearly such a common occurrence as this quotation from the White Paper (page 56) might lead one to believe, the lengths of waiting lists not only vary as between one hospital and another, but they show even greater variation as between one type of case and another. There is a lack of machinery for the systematic control and revision of waiting lists in relation to the need for additional accommodation for different categories of patient. In many cases, for example, a large part of the waiting list is composed of gynæcological and ear, nose and throat patients because the number of beds reserved for these cases is quite inadequate. It is also true that waiting lists are swollen by ignorance on the part of the patients of the possibility of obtaining treatment elsewhere. Administrative arrangements should certainly be devised to eliminate these factors. A good deal could be done by better organisation in the work of the hospital, including if necessary re-allotment of beds to the various departments. While any attempt to obtain uniform distribution of patients among the various hospitals by bureaucratic control would be a mistake, it would be useful if hospitals in an area could come to an agreement whereby patients could be transferred from long waiting lists to other hospitals, subject always to the patients' consent.

But the essential step is to raise the standard of medical and nursing care in those hospitals in which it is unsatisfactory. When the general efficiency of these hospitals has been improved their reputation will be enhanced, and as a result, they will attract more cases and unwieldy waiting lists will be proportionately diminished.

SUMMARY

I. Criticisms Affecting the Co-ordination of Hospital Services (page 7)

Some criticisms are valid but others derive from a failure to appreciate the underlying principles upon which a hospital service must be based.

The main criticisms may be classified under three broad headings :—

(i) Those which relate to the distribution of hospital facilities.

(ii) Those which are mainly concerned with the staffing of the hospitals.

(iii) Those which relate to the work and functions of the voluntary and municipal hospitals' respectively.

The criticisms under these heads are examined and reference is made to the relevant sections of the Report.

II. A Single System (page 14)

It is not desirable that all hospitals should be of the same type and dependent on the same form of control. Voluntary hospitals provide an independent standard against which hospitals provided by the public authority can be judged. The public hospital system cannot rid itself altogether of the handicap of " remote control."

III. Freedom of Choice (page 16)

It is a fundamental principle that the doctor and the patient should have the right to choose the hospital to which the patient will go. The popularity of a hospital is an essential guide to the general standard of its services and should the freedom of choice be lost, the index of the relative efficiency of different hospitals will disappear.

No arrangement, financial or otherwise, must be made which would have the effect of restricting the patient to a particular area or region.

IV. The Need for a Regional Approach (page 18)

The hospital services of London cannot be planned without taking into account :—

(i) the extent to which the Home Counties look to London for hospital facilities; and

(ii) the importance of extending the university influence.

The London region should therefore comprise the County of London and the Home Counties. The area must be planned as a whole in view of the extent to which the surrounding areas are and will continue to be dependent on the centre with its concentration of teaching and special hospitals, and in view of the need to extend the influence of the university and its medical schools.

V. The Recommendations of the Goodenough Committee on Medical Schools Particularly Affecting Co-Ordination (page 22)

(1) *Teaching Hospital Centres.* St. George's, Charing Cross and possibly the Royal Free should move out as recommended by the Goodenough Committee.

To obtain access to 1,000 beds some medical schools may have to depend on groups of hospitals, but the ideal at which to aim is for the medical school and its 1,000 general hospital beds to be on one site.

In order to ensure the provision of sufficient teaching material for the teaching hospitals, it may ultimately be necessary for some of the smaller non-teaching general hospitals to move out from the centre.

(2) *Machinery for selecting staff.* Advisory appointment boards should be established for the selection of the senior

staff in all hospitals. The boards should be truly representative and the influence of one particular medical school should not predominate.

In many instances in the Home Counties the visiting staff would have to be considered in relation to the needs of the area and machinery would have to be devised for consultation between the interested hospitals.

(3) *Extension of University Influence. Associations which should exist.* In the future it is hoped that men of every degree of seniority from senior consultant to house officer will continue to keep in touch with the university. It would be an advantage if all consultants were in some way associated with a teaching hospital—undergraduate or post-graduate.

Reference is made to the Goodenough Committee's suggestions for informal educational associations between the teaching hospitals and the major hospitals in a wide area around. Additional suggestions are submitted in this Report, with the same end in view. Associations are most likely to flourish if based on natural inclinations rather than on a " cut and dried " plan.

VI. General Hospitals (page 29)

(1) *Acceptance of responsibilities.* There is great variety in the size and function of hospitals which are classified as " General Hospitals."

The transition from cottage to general hospital should imply acceptance of responsibilities. A general hospital should accept responsibility, with certain exceptions, for the whole range of acute work likely to arise in its locality. Constructive suggestions are put forward indicating the provision that should be made.

It is probable that 150 beds (apart from beds for the chronic sick) is the minimum number that would enable the

provision of an efficient and economic comprehensive service, and if separate pay bed accommodation and a maternity unit are included the number may well reach 250.

It is not yet practicable to propose that general hospitals in the Home Counties should be entirely staffed by consultants, but where practitioners are appointed they should have served for a period of not less than two years in a hospital or unit devoted to the special work they propose to undertake, and they should hold the relevant diploma or higher degree.

Every hospital, no matter how small, should have consultants on its staff and should be visited by them not less frequently than once a week.

(2) *The larger General Hospital—Is there an Economic Size?* It would not be wise to encourage voluntary general hospitals to develop to a size approaching that of the large local authority hospitals. The case for the belief that the large hospital is more efficient than the small hospital needs careful examination. The larger the hospital the harder it is to preserve a friendly informal relationship between staff and patients.

(3) *Geographical considerations. The Central London Area.* The central area of London is comparatively well provided with beds, and there is little justification for general hospitals with less than 100 beds in this central area. In most cases the work of the small voluntary general hospitals is influenced by religious and other special considerations, but if they wish to function as general hospitals they should join forces with each other or with a larger neighbour, with the ultimate object of a physical amalgamation either on one of their existing sites, or further out towards the periphery.

(4) *Geographical considerations. Industrial and Dormitory Areas.* Hospital provision has failed to keep pace with the rapidly increasing population of the industrial and dormitory belt. The larger voluntary hospitals in these areas are conscious of the need for material expansion and in most cases

an ambitious programme of development should be encouraged, even after full allowance has been made for the development of the local authority service.

In these areas the smaller voluntary hospitals of some 75 beds will need to be retained as general hospitals in view of the overall shortage of hospital accommodation. The demands of the district they serve will probably result in their ultimate development into hospitals of 200 beds or more; in the meantime, arrangements for close co-operation with neighbouring hospitals will help them to provide an efficient service.

In these areas, too, local authority hospitals should be encouraged to expand their services.

(5) *Geographical considerations. The Home Counties outside the Industrial Zone.* Hospitals are mainly located in towns of medium size serving comparatively thinly-populated rural and semi-rural areas, and only a few large local authority hospitals and the voluntary hospitals of 100 beds and upwards situated in the larger towns can expect to conform to the standard suggested for the general hospital.

The majority of the voluntary hospitals are of the cottage hospital type, though many have, through force of circumstances, functioned as general hospitals and have sometimes undertaken work beyond their proper capacity. Suggestions are put forward to obviate this risk.

Many towns already have at least two hospitals, one voluntary and one local authority, and if they are to be upgraded they must have working arrangements with each other; this would be greatly facilitated if they shared to a certain extent the same consultant staff. If consultants were appointed to two or more hospitals in the same area, they would possibly have sufficient work to make it worth their while to live in the neighbourhood, and the more even distribution of consultants

which would thus be effected would facilitate a system of regular visits to cottage hospitals.

VII. Cottage Hospitals (page 44)

While cottage hospitals have all the advantages of being small and homely and probably inspire as much local interest and affection as any other type of hospital, they are often subject to criticism. This is because many of them admit and treat cases that they are neither equipped nor staffed to deal with satisfactorily. Suitable safeguards are proposed.

Beds at a cottage hospital should be available to all general practitioners in the neighbourhood, subject always to the approval of the committee of management.

VIII. Special Hospitals (page 46)

There are those who think that provision for specialties should be made only in special units at general hospitals, while others take the view that all work connected with specialties should be carried out in hospitals entirely devoted to them. Neither of these extreme views are supported. Special hospitals play an important part in post-graduate education and in research, and a limited number of special hospitals are necessary in London.

The British post-graduate medical school should be reconstituted as recommended by the Goodenough Committee to embrace a series of institutes in the various special subjects, each institute being based on the most suitable special hospitals. In some specialties two or more hospitals might take part in the establishment of an institute.

There are a few special hospitals which are not of the necessary standard and size to take part in post-graduate education. In the interests of efficiency and economy special hospitals should each provide at least 100 beds, and where

they do not reach this size they should achieve it by extension or amalgamation, or alternatively, they should enter into a close association with a neighbouring general hospital.

IX. The Chronic Sick (page 50)

The chronic sick can be roughly classified as follows :—

(a) Those which are remediable and can be materially benefited by treatment ;

(b) Those which are irremediable ;

(c) The aged and infirm who would be more suitably housed in hostels than in hospitals.

Groups (a) and (b) are the concern of the hospitals and there is often severe pressure on accommodation for these patients. Apart from a few special voluntary homes they have been mainly accommodated in local authority chronic sick institutions, where the standard of treatment leaves much to be desired. The staffing of these institutions presents real difficulties. The present arrangements for the care of the chronic sick need to be drastically reformed. All voluntary teaching and general hospitals should take a share of these cases. It will not be possible for them to take an appreciable proportion immediately, but they will have to make arrangements to provide the necessary additional accommodation in the future. The isolated chronic sick institution should be abolished, and the necessary accommodation should be provided either at general acute hospitals or at institutions closely affiliated with them.

X. Out-Patients and Casualties (page 53)

(1) *Consultative Out-patient Departments.* The movement towards the more consultative use of out-patient departments should be encouraged ; but there are some patients who are not in a position to bring a doctor's letter, and no patient

should be turned away without being seen and if necessary treated by a medical man.

All patients sent by doctors should be seen by a consultant.

(2) *Appointments system.* A considerable number of voluntary hospitals have instituted an out-patient appointments system, and this system should be generally adopted.

(3) *Casualty Department.* In a casualty department the casualty officers and nursing staff should be available day and night.

XI. Ambulance Service (page 56)

A well-organised ambulance service is an essential part of any hospital service. There should be uniform arrangements for the administration and operation of the ambulance service.

XII. Waiting Lists and Centralised Admissions (page 57)

A central bureau for controlling admissions has sometimes been advocated. The suggestion needs careful examination. It would not only be contrary to the principle of free choice of hospital, but it would ignore the fact that waiting lists are an index of efficiency.

It is true, however, that there is a lack of machinery for the systematic revision of waiting lists in relation to the need for accommodation for different types of cases. Administrative arrangements should be devised to eliminate this.

But the essential step is to raise the standard of medical and nursing care in those hospitals in which it is unsatisfactory : their reputation will then be enhanced, they will attract more cases, and unwieldy waiting lists will be proportionately diminished.

For Hospital Maps, see back cover.

APPENDIX

Resident Officers

Goode-nough Report Page Nos.

(a) *Pre-Registration House Appointments*

We are in agreement with the Goodenough Committee's recommendation that every student, after he has passed his final qualifying examination and before he is admitted to the Medical Register, should be required to serve as a junior house officer for a period of twelve months in one or more approved hospitals. 198

Most of these appointments will have to be found in associated teaching hospitals and in non-teaching hospitals. Any hospital that is used for this purpose outside a teaching centre should be specially approved by the University of London in consultation with the appropriate medical school. 201

It will not be possible or desirable to effect an exclusive link between a particular medical school and an approved hospital, though in the main an approved hospital is likely to develop a close attachment to a particular medical school. Responsibility for securing a pre-registration house appointment should rest with the student's medical school. In fairness to the non-teaching hospitals and in order that the house officers' experience should be as wide and varied as possible, where practicable, the aim should be to arrange for every student to hold an appointment in the teaching centre for half of the required period and an appointment in an approved non-teaching hospital for the other half. 202

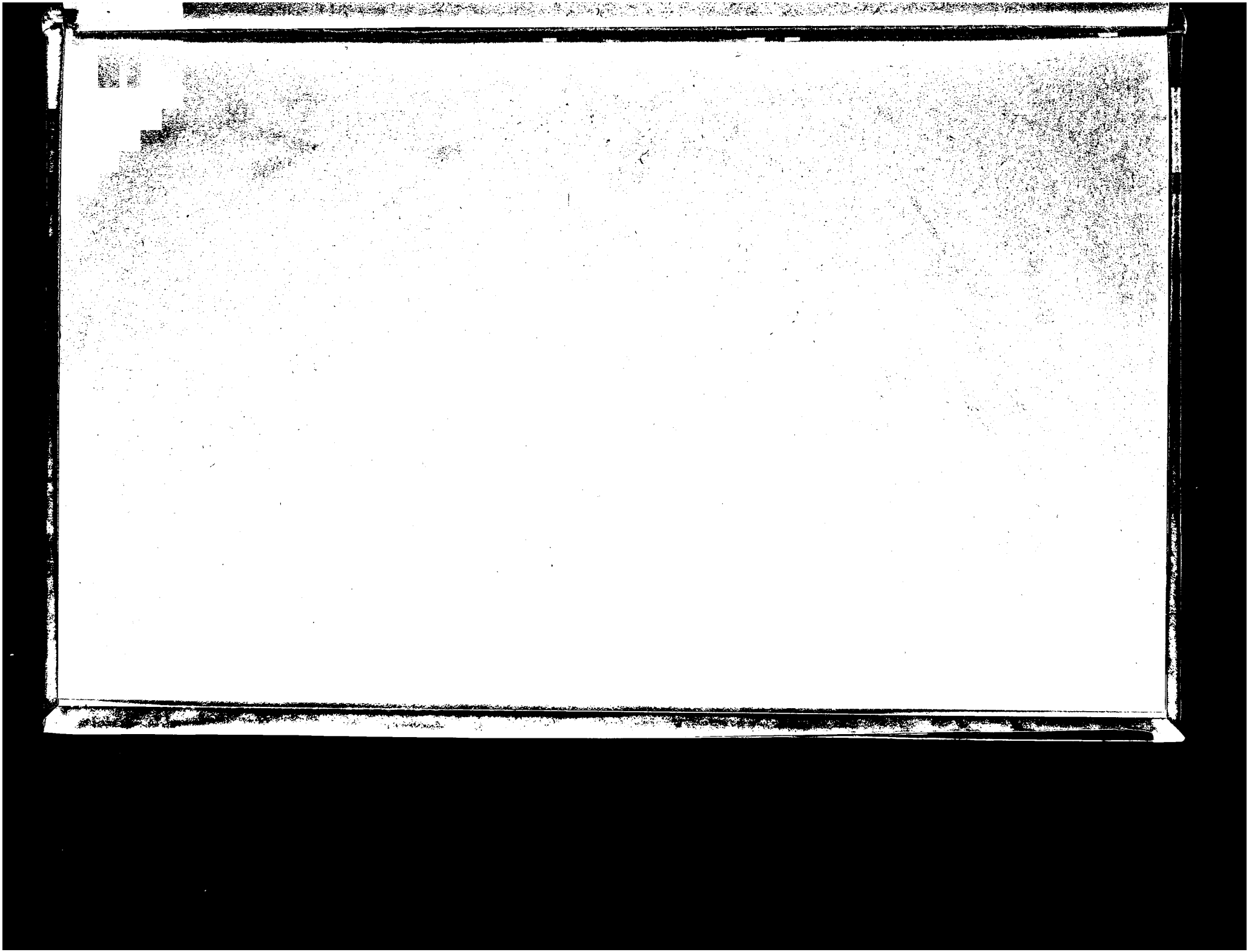
(b) *Senior Resident Officers (in Hospitals without Undergraduate Medical Schools)*

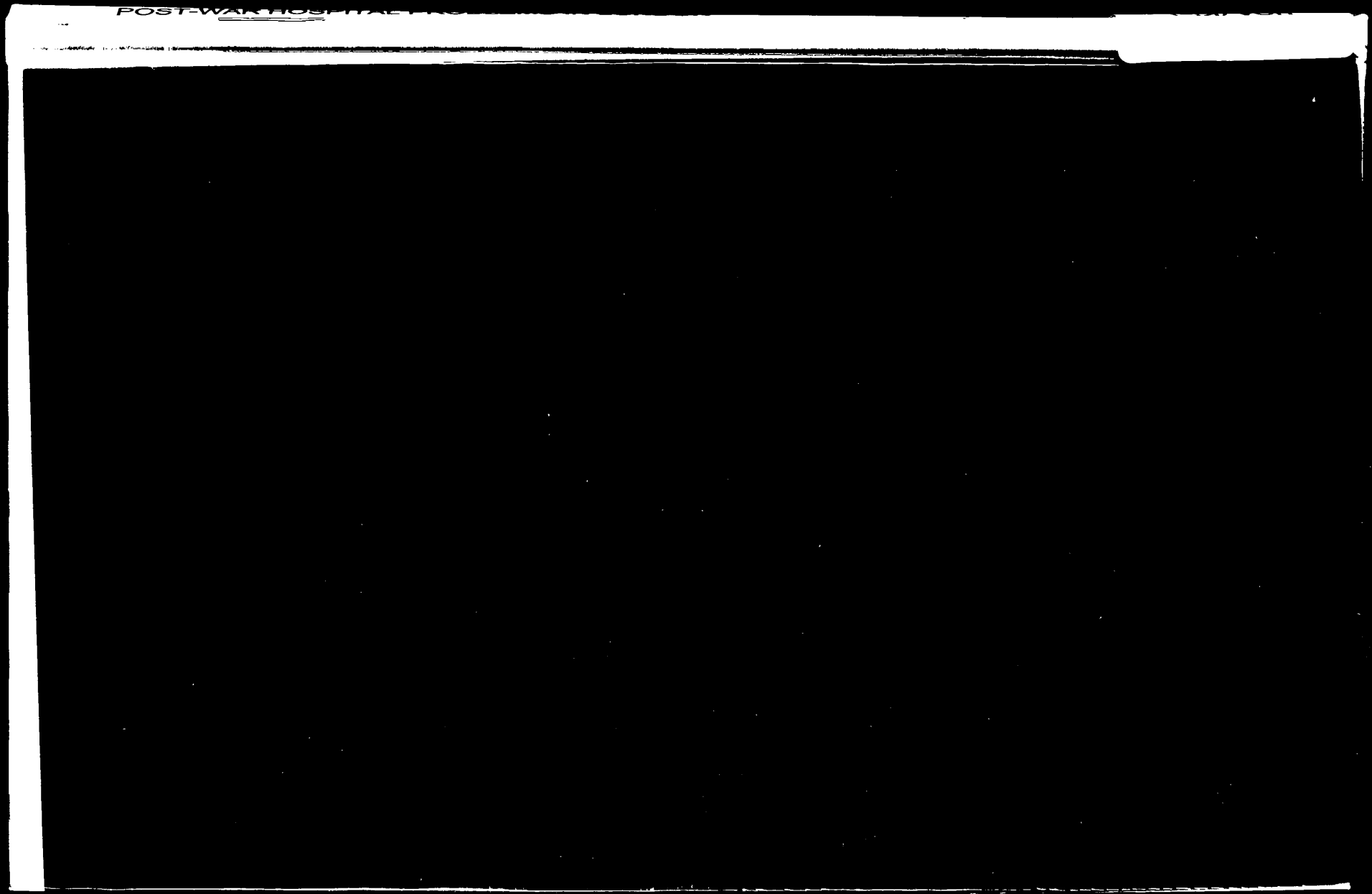
We have given this matter some careful consideration and are of the opinion that in addition to registrars covering the work of each department every hospital of sufficient size and importance should have a senior resident officer who has recently held the post of first assistant or its equivalent in a teaching centre. Such an arrangement would provide these hospitals with an officer of exceptional experience and would

at the same time increase the number of embryo consultants. For such an arrangement to become effective it would be necessary for all the teaching hospitals to agree that the tenure of the appointment of registrars should be restricted to not more than three years in a teaching hospital. First assistants and registrars could then pass on to these senior resident posts with the knowledge that the holding of such a post at an approved general hospital would give them an opportunity of proving their suitability for subsequent appointment as full members of the staff of another hospital in the area, or perhaps of a teaching hospital. The senior resident officers would be responsible for the general routine work and case records in their section of the hospital and, in addition, might devote themselves to some special branch, such as the accident clinic, children's department, and so on, after consultation between the staff of the hospital and the body which advises on the hospital services of the area. These men would have a greater degree of responsibility and independence than they had in their teaching hospital where they were under the immediate supervision of their professor.

It is most desirable that the liaison between the professor or director at the teaching hospital and the senior resident officer should be maintained at this stage of his career. If such men come from the sphere of another university, as they frequently should, they should regard themselves as potential candidates for any higher post in their own or any other university that may offer. But it is important that there should be no suggestion of divided responsibilities, for this would gravely embarrass the general hospitals to whom such men whilst in their service must always be primarily responsible.

All vacancies for resident appointments should be advertised and the appointments made by the hospitals concerned. Every encouragement should be given to men and women who have qualified in Dominion and Colonial medical schools to apply for appointments.




POST-WAR HOSPITAL