negative in all the fluids. Sera of these cases gave negative results on agglutination with the leptospira of Weil's disease.

The patients were evacuated to base hospitals, where three of them made a complete recovery within two months. The other two cases developed sequelae, as described below.

Case IV

C.S.M. J., aged 32, was seen by Major A. D. Leigh, R.A.M.C., neurologist, in Dec., 1943, three months after the onset. The following notes are extracted from his report. The patient complained of weakness and numbness in the legs. There was no jaundice and the liver was not palpable. The pupils and cranial nerves were normal. There was slight weakness of both hand-grips, with exaggerated reflexes in both limbs. Blunting to cotton-wool and pinprick was present on both hands. Power in both lower limbs was diminished, more particularly in the right leg. Muscle tone was increased in both legs and the gait was mildly spastic. The deep reflexes were much exaggerated, except the right ankle-jerk, which was diminished. The plantar responses were flexor. There was diminished sensation on the outer side of both thighs and over the dorsum of the feet, with absolute loss on the toes. The cerebrospinal fluid was normal. The patient was invalided to the U.K.

Case V

On Sept. 2, 1943, Capt. R., aged 33, complained of sore throat. On the 9th he had a rigor, which recurred despite quinine. On Sept. 14 he was admitted to an M.D.S., where his urine was noted to be dark in colour. The next day he complained of pains in the calves and thighs, and these were followed by loss of power from the hips downwards. On Sept. 17 there was a complete flaccid paraplegia, with anaesthesia below the groins. The patient complained of pain in the right arm, and on examination weakness of abduction was noted. There was no complaint of headache. On Sept. 19 he was admitted to a C.C.S.; he vomited several times that day. The next day he complained of headache, pain in the back, and blurring of vision with the onset of fever. There was difficulty in emptying the bladder. Jaundice was now present and the liver was enlarged and tender. The C.S.F. showed no increase in cells and the protein content was normal. The white cells numbered 9,000 per c.mm. Improvement was noted during the next few days, and on Oct. 2, on arrival at a field hospital, a considerable return of power and sensation had taken place in the left lower limb and, to a less degree, in the right. By the end of October no weakness of the right arm could be detected. The abdominal reflexes were normal. There was weakness of flexion of the right knee and of dorsiflexion of the right foot. Tone was increased in the right leg, particularly in the tendo Achillis. There was no appreciable wasting, and sensation was normal. The deep reflexes were exaggerated in the lower limbs, more particularly on the right side. There was unsustained right-sided ankle clonus, and the right plantar response was equivocal, while the left was flexor. By the middle of November power had further returned in the right leg, and the plantar response was now flexor. The patient was evacuated to the U.K.

Discussion

In four of the five cases described above an abrupt onset of fever, generalized pains, and signs of a mild meningitis were quickly followed by blurring of vision, weakness, and paraesthesiae in the lower limbs. In the fourth case pyramidal signs were subsequently noted, while in the fifth case the signs were predominantly those of a myelitis. Jaundice associated with enlargement of the liver and spleen appeared in all cases between the 4th and 6th days of the illness. Recovery was rapid and complete in three of them. In the remaining two a mild residual spastic paresis of the lower limbs, with in one case sensory loss peripherally, was still present several months later.

In considering the aetiology of the nervous signs in these cases acute poliomyelitis need be considered only in Case V. In Sept., 1943, only a single case of this disease was reported from this part of the Burma front. Furthermore, the myelitic form is distinctly rare, and it is unusual in such cases for recovery to be so rapid and the sequelae so mild. The normal cerebrospinal findings on the fifth day of the disease are also unusual. Since another case with mild myelitic signs occurred in the series, and since there were features in Case V rarely seen in acute poliomyelitis, this has been included.

The jaundice appeared to be of the usual infective type, especially since other cases from the same area were seen at that time. Assuming that these men suffered from infective jaundice, the question of neurotropism of the virus causing this condition must be considered. It is known that, experimentally,

hepatotropic and neurotropic elements may coexist in viruses—e.g., yellow fever. On the other hand, taking into consideration the widespread distribution of infective hepatitis during the present world war and the extreme rarity of nervous complications, it is doubtful whether neurotropism of this virus can be accepted as the explanation in these cases. There remains the coincidental association of two diseases—a not uncommon event in the East. Encephalomyelitis, to which one case bears some resemblance, although not uncommon in peacetime, has been rare in the Army in India during the present war. We have not attempted to give a label to the neurological picture which these cases presented, but have indicated that meninges, spinal cord, and peripheral nerves were affected in varying degree.

Summary

A description is given of a small outbreak on the Burma front of a condition characterized by the association of jaundice with meningitis, peripheral neuritis, and, less constantly, myelitis.

The relationship of these conditions is briefly discussed.

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A SOCIAL STUDY OF HOSPITAL TREATMENT

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Anyone with experience of modern hospital work knows that facilities for in-patient treatment are limited. It is therefore important that they should be used to the best advantage. Also, all those who deal with the sick know something of the impact on family life made by a serious illness, but few realize how it is borne. The present study is an attempt to assess the value and efficiency of the in-patient service of a general medical ward, and to discover how such a misfortune as a hospital illness is met by the patient.

The Patients Studied

Contact was made with all the patients who had been admitted to Collier Ward during a period of six months to see how far medical and social care had been adequate to meet their needs. The period between Aug. 1, 1941, and Jan. 31, 1942, was chosen because during that time one of us (M.B.) had been house-physician.

Collier Ward is divided into accommodation for 10 men and 11 women. It is attached to the Nuffield Department of Clinical Medicine, and although when it was opened in 1938 it was mainly intended for scientific investigation and research, by 1941 it was also taking its share in the clinical teaching of students and the general work of the hospital. The ward was staffed with a sister, seven nurses, and a house-physician, and the bed costs for the six months under review were £2,280.

The follow-up was begun in Feb., 1943, and a letter was sent to each of the 156 patients explaining the nature of the investigation and asking for their co-operation. Wherever possible the social worker (F.C.C.) then visited the patients, discussed the social implications of their illness, and arranged for them to come up to hospital for a medical examination. Seventy-two patients were visited in their own homes; 51 attended for medical examination; 31 lived too far away for a visit, but sent a letter and report from their own doctor. Only 6 remained untraced, and of these one was an evacuee, one a tramp, and two were from a near-by construction camp. Notes were made on the medical and social aspects of each case, and when the record was complete the questionnaire shown in Table I was filled in. All but two of the patients were delighted to hear from the hospital and know the staff were interested in their progress. They gave us unlimited co-operation.

TABLE I.—*Questionary used in the Follow-up and a Summary of the Answers*

Total number of cases	156	
Dead	29	35
Untraced	6	
Number included in the questionary	121	
<i>Medical</i>		
	Yes	No
1. Is the patient still suffering from the disease which caused admission?	82	39
2. Is any present incapacity due only to a psychogenic overlap?	8	—
3. Did the follow-up visit end in a suggestion as to treatment or supervision?	31	90
4. (a) Is hospital treatment still necessary?	47	74
(b) If so, is it being given?	36	11
5. (a) Is other medical care still necessary?	35	86
(b) If so, is it being given?	29	6
6. Was patient seen by family doctor after discharge?	105	16
<i>Social</i>		
7. Is the patient now (a) employed in full-time work?	72	
(b) employed in part-time work?	30	
(c) totally incapacitated?	19	
8. Was the period of incapacity caused by the illness greater than three months?	98	52*
9. Was the stay in hospital longer than three weeks?	66	90†
10. Was the period of incapacity after discharge greater than three months?	73	48
11. Could this period (10) have been shortened by:		
(a) fuller co-operation of patient or family?	11	
(b) closer hospital supervision?	13	
(c) financial help?	5	
(d) occupational therapy?	6	
(e) other services?	19	
12. What were the sources of income during illness?		
(a) Wages paid by employer during illness	23	
(b) Insurance	64	
(c) Savings	32	
(d) Family funds	82	
(e) Public funds	16	
13. If the patient is not working full time now, what are the sources of income?		
(a) Pay from part-time work only	3	
(b) Insurance	6	
(c) Savings	6	
(d) Family	38	
(e) Public funds	2	
14. When the patient was a housewife, were reasonably adequate arrangements made for the care of the rest of the family:		
(a) during illness?	44	4
(b) during convalescence?	40	8
(c) at present time if still incapacitated?	21	3

* All the patients traced—i.e., 150—are included in the answer.

† All of the 156 patients are included in this answer.

All but 5 of the patients were civilians, drawn mainly from Oxford and the large rural area surrounding it. More than a third came from the country, and many of the Oxford townspeople have the outlook and attitude of country folk. Among those from the town 10% were evacuees from London. Eight per cent. of all patients were sent for diagnosis from considerable distances outside the usual area.

The housing conditions of patients, from both the urban and the rural areas, were good on the whole. The majority of our patients came from neat semi-detached houses with pleasant gardens and reasonable rents, or from country cottages with somewhat primitive sanitation but ideal positions and rents of a few shillings a week. There was little evidence of overcrowding or bad conditions.

Results of Treatment

Table I gives a summary of the medical and social status of the patients who were alive at the end of a year. Twenty-nine (19%) patients had died, 82 (55%) were still suffering from the disease which had caused admission, and another 8 (5%) were incapacitated because of psychogenic symptoms which remained after cure of their organic disease. Thirty-two (21%) patients had been admitted to other hospitals, 38 (25%) were still receiving out-patient care, and another 10 (7%) needed it. Almost as large a number required attention from their general practitioner. During six months the ward had cured only 39 (26%) of the patients admitted. For the majority of the patients the stay in hospital was merely an episode, sometimes a relatively brief episode, in a protracted period of disability and treatment.

A better impression is given if we show how many of the patients had returned to their occupations. Whereas only 39 (26%) could be considered cured in the strict medical sense, 72 (48%) had been able to return to full-time work, and 30 (20%) were doing part-time work. The group of patients with blood diseases did better than the others, while those with lung disease were much the worst.

For the purpose of this study the patients were divided into groups in three ways: (a) those under 45 years of age were

compared with those of 45 and over; (b) those whose stay in hospital was 21 days or less were compared with those who were in hospital for longer periods*; and (c) those whose total period of incapacity was 3 months or less were compared with those who were incapacitated for more than 3 months. The results showed that patients under 45 years have a better chance of returning to full work than those who are older, and that the patients who stayed in hospital less than three weeks and those whose entire illness lasted less than three months had a better chance of recovery than the others. These facts are not surprising, but their implications are important.

Use of Available Bed Space

If the services of a well-equipped diagnostic ward are to be used to the best advantage the patients must be selected for suitability for admission, and they must be discharged as soon as practicable after the diagnosis has been made and such treatment as can be given in this type of ward has been completed. Little fault can be found with the choice of patients for admission. In the present state of hospital waiting lists it would be more appropriate to comment on the many suitable cases which fail to gain admission than on the few unsuitable ones which do. Of the patients who were traced, 99 had been admitted from the waiting list compiled in the out-patient department, and the remaining 51 were admitted as emergencies on the days when the ward was "on take."

Of those from the waiting list 73% had returned to work at the time of the investigation, whereas only 55% of the emergency admissions were working. This difference is probably due to the type of illness rather than the method of selection. In cases of emergency no request for the admission of a patient was refused, so that the decision was solely in the hands of the general practitioner. Only two of the patients admitted in this way did not require special investigation or treatment. One was a patient with disseminated sclerosis whose home conditions necessitated removal, and the other was a mild case of gastro-enteritis. Only one case was clearly hopeless—that of a woman with carcinomatosis—and here there was some possibility that radiotherapy would alleviate her pain. The record as a whole justifies the choices of the general practitioners. It is clear, then, that faulty selection of patients was not the cause of much waste of bed space.

If, however, we turn to the circumstances which governed the discharge of patients we find that there were many defects. There were 25 (16%) whose discharge had been delayed beyond the time they needed special treatment, and this involved the waste of 680 bed-days. The chief cause of delay was the lack of suitable institutions for the care of patients who needed only general nursing and possibly a special diet. To such a hospital some of our patients with peptic ulcer, for instance, could well have been sent for a month and then readmitted for a review of their condition, and the old people with bronchitis and asthma would have done as well in simpler surroundings. The patients of this type who had to be kept in the ward long after they required the special services it provided are listed in Table II. There was a smaller group

TABLE II.—*Causes of Undue Delay in Discharge from Hospital*

Absence of an institution providing nursing care and/or diet:	
Peptic ulcer	3 cases
Bronchitis and asthma	2 "
Chronic emphysema	1 "
Chronic nephritis	1 case
Thyrototoxicosis; fibroids	1 "
Rheumatic fever	1 "
Meningitis	3 cases
Undiagnosed cases	1 "
Delay in supply of special services: radiotherapy, surgical specialists, etc.:	
Leukaemia and reticuloses	4 cases
Pulmonary Tb.	1 case
Carcinoma of lung	1 "
Renal stone	1 "
Essential hypertension	1 "
Delayed admission to another hospital:	
Psychoneuroses	2 cases
Tuberculous effusion	1 case
Diabetes; cataract	1 "
Estimated waste of bed-days: 680	

* Patients with diseases of the blood were not considered in the second analysis because they were usually studied for research purposes and were kept in hospital for observation longer than their condition demanded.

whose stay was unduly long because some special service was unavailable. It would be unreasonable to expect every facility to be available immediately it is required, and this has not been the standard. Rather, included in the group were those who had to wait two to five weeks for radiotherapy or who had to wait a fortnight or longer for the surgical specialist. A third group of cases was held up because it was impossible to arrange for their admission to a special hospital within a reasonable time. The war, with the crowding of hospitals which it caused in this area, was of course partly responsible for this, and in any event the group was small. All three of the causes of delayed discharge from hospital were beyond the control of those in charge of the ward, but an analysis of this defect in the general organization of hospital services gives an indication of the importance of the problem. The time required to treat the 83 (55%) patients who were in hospital for three weeks or less was 879 days, and 58 (70%) of them returned to full work. If the beds had not been blocked by the 25 patients listed in Table II it might have been possible to treat another 65 acute cases and so to increase by more than 50% the number of patients who returned to full-time work. If this had been possible it might have meant an increase in the staff both in the ward and in the laboratories, etc., but this would have been justified in order to make the special ward facilities available to a greater number of patients.

After-care Facilities

The after-care arrangements which were made for these patients were often inadequate. During the time that these patients were in the ward many of the convalescent homes were closed on account of the war or reserved for special purposes, so that the type of convalescence which was provided is not a fair sample of what might be arranged for a similar group in peacetime. Convalescence lasting from a few days to 12 weeks was arranged for 22 patients. The average stay was 4 weeks. The majority were sent to small cottage hospitals near their homes so that they could be under the care of their own doctors, but sometimes it was impossible to arrange this. Although full particulars were sent with each case, the link between the hospital and the local doctor seems to have been deficient. Many patients were only too aware of the break in the continuity of treatment, and felt on the one hand that the specialists were no longer interested and on the other that the convalescent hospital did not understand their illness. Three of the patients took their own discharge before their convalescence was completed. The absence in the small hospital of many of the concomitants of specialized medicine probably played a part in this feeling. It was impossible to tell how far the criticisms were really justified, but even their presence was disturbing. They point to the necessity for careful explanation of the circumstances before the patient leaves the key hospital and a closer connexion between the doctors concerned than is provided by a case sheet.

There was unrest on other grounds. A great difference existed between the quality of the food in the Radcliffe Infirmary and that in the smaller hospitals. Good diet—and rightly so—takes a high place in the patient's idea of convalescence, but the food in these smaller hospitals was often much inferior to that supplied at the Radcliffe Infirmary, and special diets were sometimes unobtainable. Younger patients sometimes found themselves in a ward full of the very old. For instance, a boy recovering from rheumatic fever spent three months in a room with six beds, of which only one was occupied by a young man during part of his stay; all the other patients were old and infirm. At first he was unable to read because he was flat on his back, but no attempt was made to provide any diversion.

There was often resentment if it was necessary to send a patient to a hospital far from his home, even when the stay in the Radcliffe Infirmary, almost as far away from relatives, had led to no discontent. Several times one met the argument from members of the Hospital Contributory Scheme that as contributors they had a right to a bed in the Radcliffe Infirmary and should not be sent somewhere else. On the other hand one patient who went to a seaside convalescent home was most enthusiastic about the care he received and the value of a real

change of surroundings. All of these are points of general application, some of which could be remedied by institutional reorganization, and some of which must be met and solved by a study of each case.

Six patients would probably have returned to work sooner if convalescent treatment had been provided. Two of these were women who refused to allow arrangements to be made because they were worried about their homes. Two men with peptic ulcer went home to unsatisfactory diets, partly the result of their poverty. A woman with a breast-fed baby was a contingency for which no provision could be made at short notice. Another woman, who was referred to the psychiatric clinic and needed a period of rehabilitation, returned home to be nursed by her mother, an over-possessive person partly responsible for her daughter's psychoneurosis. Thus the shortage of beds for convalescents was the cause of incomplete treatment in four of these cases, and lack of provision in the home when the mother was ill was the cause in the other two.

Time and facilities for closer follow-up, and financial help, would have aided the recovery of another sizeable group of patients (Table I, Question 11). For instance, some who did not follow instructions after discharge might have been persuaded to do so. In three cases poverty made proper care impossible. At least 12 patients would have been benefited if occupational therapy had been provided during their incapacity. In 6 of them the return to work might have been accelerated; others might have had their interest aroused in the ward, and the work could have been carried on at home to avert boredom. For some this would have been an activity which would have continued through years of incapacity.

Provision for housewives during illness and convalescence is a special problem. Several would have been helped by such services as residential nurseries for their children, home helps, and other forms of social care. Many expressed the wish that there was an insurance scheme for them. The husband's weekly wages often do not go far when he or a neighbour does the shopping, and the housewife in hospital worries about the family budget. All those who belonged to the District Nursing Association spoke most highly of the service. There seems no reason why a Home Help Service for the convalescent and semi-invalid housewife should not be run on similar lines.

Social Adjustments during Illness

When studying the social effect of illness involving admission to hospital it is necessary to know something of the make-up and background of the group of patients. Their occupations will give some indication of this. Of the 156 patients admitted, 91 were gainfully occupied; 28 of these were women employed in domestic, professional, clerical, and factory work. The remaining 65 patients in the series were housewives or children. The group of 91 workers was divided as follows:

Domestic workers..	..	..	..	11
Labourers ..	..	..	..	14
Clerks and shop assistants ..	..	..	..	15
Farm workers and gardeners ..	..	..	..	14
Skilled workers ..	..	..	..	21
Professional workers ..	..	..	..	11
H.M. Forces ..	..	..	..	5

Omitting the 5 Service cases, 66% were urban workers and 34% rural workers. Twenty of these patients died. Nineteen of them were men, of whom 10 were urban workers, 8 rural workers, and 1 in H.M. Forces.

On the whole the patients came from a stable population and, apart from those who had come to Oxford on account of the war, most of them belonged to families who had lived in the neighbourhood for several generations. Family ties appeared to be strong, and many patients relied upon their relatives to help them during their illness. The expense of hospital treatment had largely been provided for by membership of a hospital contributory scheme. Seventy per cent. belonged to the Radcliffe and Associated Hospitals Contributory Scheme or a reciprocal scheme, and while the funds obtained in this way did not completely cover the cost of treatment, contributors must be considered to have borne a major part of the expense. Only 8 patients were unable to pay anything or were on public assistance.

The means of meeting the expenses of medical treatment and the running of the home are listed in Table I, Question 12. Only 5 patients applied for public assistance; another 11 were eligible for special grants from local authorities. Other State funds, such as the N.H.I. benefits, were of course obtained in the usual way, although by themselves they were quite inadequate to meet the needs of a long illness. Only 32 had enough savings to tide them over the crisis, and in a great many instances other members of the family rallied round during the illness. This illustrates the strength of family ties, and it is significant that of the 5 who found it necessary to apply for public assistance, 4 were single persons with no family backing.

For those patients with a high standard of living the inadequacy of benefit is pronounced in spite of sick clubs and savings. But the most striking examples of the inadequacy of the benefit are the cases where the man with a young family is sick. One of our patients suffering from a peptic ulcer, who had a young child and whose wife was pregnant, had his benefit supplemented by the Public Assistance Committee. He felt ashamed of having to apply for relief, and although he felt ill, dared not go to a doctor for fear of being put off work. This abhorrence of obtaining relief through the Poor Law is deeply ingrained, and adequate provision should be made through insurance for the whole family when the bread-winner has the misfortune to be ill. Employers, particularly the farmers, were generous to their workers during their illnesses, and 23 were given their full wages throughout the entire period. Many others had generous allowances.

Examination of the sources of income for the 49 (40%) patients who were not working full time (Table I, Question 13) showed that the incapacitated also relied mainly on family support. There were only 2 (4%) patients on public assistance, but only 10 (20%) had adequate pensions, savings, or sufficient pay from their part-time work to maintain themselves. The great majority (76%) relied on assistance from relatives. One of those on public assistance—a young woman who had been ill since contracting infantile paralysis in childhood—had never been taught a craft, and although she could have done some dressmaking and had a sewing-machine, regulations would not allow her to supplement her allowance by earning, and so she preferred to leave her machine idle and be sure of her weekly grant.

Value of a Long-term Follow-up of this Type

The review of this group of patients led to some addition to treatment in 31 (25%) cases (Table I). There were a few instances where a new development in the patient's condition required direction. In others the treatment prescribed on discharge needed to be started again. Each patient was questioned to find the effectiveness of liaison with the general practitioner (Table I, Question 6). On the whole it was satisfactory, and the majority of our patients had been seen by their family doctor soon after discharge. Despite this a few major aberrations were discovered. For instance, one patient with auricular fibrillation who had been sent out on digitalis therapy was dismissed by her doctor in a few weeks, and was found to be so ill when she visited the hospital that her name was put down for readmission. Another woman, who had left Oxford—a case of pernicious anaemia—had not had an injection of liver extract for more than a year. Altogether, readmission to hospital was recommended in 3 cases, out-patient treatment in 9, a surgical consultation in 2, and 6 were referred to their own doctors.

There were equal opportunities, some of which have already been mentioned, to improve the social management of a number of cases. Because of ignorance of the arrangements some patients had not received benefits to which they were entitled—statutory benefits as well as those from voluntary agencies. Several men had not understood national health insurance, and gave up when they got muddled in the procedure of application. There was some acute need at the end of a year in 15 (12%) cases, and the steps taken to meet it included such things as the provision of dentures, the arrangement of meals for a child, reference to a mental welfare worker, and the direction to training centres of several patients who were fit but not employed.

When this group of patients was in the ward the Almoner's Department consisted of 3 trained almoners, 2 senior clerical assistants, and a shorthand-typist, and it had to deal with a 500-bed hospital as well as out-patient clinics. Under-staffed as it was, it gave help to 25 patients covered by this study. Looking back, it was clear that 36 more patients needed help which only the hospital could provide, and another 23 might have been referred to other agencies for assistance. Thus 70% of the patients required supervision if full use was to be made of existing social agencies and if recovery was to be as rapid and comfortable as possible.*

For purposes of clinical research it is probable that follow-up studies are of little value except when specific conditions are the subject of special investigation. This fact has perhaps made the hospital physician less conscious than he should be of the importance of the follow-up as a part of the patient's treatment. Our study has shown that only a small proportion of patients are completely and speedily cured as a result of admission to a medical ward. For the majority of them it constitutes a short episode in a long period of disability, and unless in-patient treatment and after-treatment are closely integrated, much of the benefit of the stay in hospital may be lost. Some of the defects we have noted would be remedied by an improved regional hospital organization in which the key hospital occupied a central position and the auxiliary and special hospitals, sanatoria, and convalescent homes took their places as equally important parts of the whole plan. The greater part of the patient's difficulties, however, would still remain.

It is our conclusion that the social problems which face patients who are admitted to hospital are so numerous and important that they demand attention. They are closely related to treatment, and unless patients are given adequate social care during the period of rehabilitation they may find it difficult once again to take their place in society. This care should be available at each stage of recovery until the optimum adjustment has been reached. It will involve liaison with many social agencies. A study of the type we have presented does not in any way take the place of this continuous care, but it serves several useful purposes. First, it draws attention to defects in hospital organization; secondly, it is an opportunity to discover patients' attitudes to the hospital service; thirdly, it reviews the correlation between the services inside and outside the hospital; fourthly, it enables individual patients to be helped where medical or social care has been inadequate; lastly, it indicates changes which can be made to benefit future patients.

Summary

150 consecutive patients who had been treated in a general medical ward in a teaching hospital were followed up 12 to 18 months later.

Only 26% had been cured, though 48% had returned to full-time work and 20% were doing part-time work.

Age over 45 and an illness of over three months' duration are bad prognostic signs.

Delay in discharge of patients from hospital because of the absence of suitable institutions for the care of long-term sickness is an important cause of wastage of bed space.

Arrangements for convalescent treatment and rehabilitation were defective, and, on the whole, cottage hospitals proved unsuitable for convalescence.

Contributory schemes and assistance by relatives are important factors in taking the financial strain of illness in this area.

In retrospect it is clear that 70% of the patients required supervision after discharge if full use was to be made of existing social agencies and if recovery was to be as rapid and comfortable as possible. This type of supervision could be given by an almoner, with reference of selected cases to medical officers.

Grateful acknowledgment is made to Mr. A. G. Sanctuary, administrator, Radcliffe Infirmary, for permission to make this investigation, and to Miss Helen Rees, chief almoner, and Prof. L. J. Witts for their interest and help.

* Since this study the Almoner's Department in the hospital has been augmented by 1 part-time and 4 full-time almoners and additional clerical assistance. An almoner is now attached as social worker to the Nuffield Department of Clinical Medicine. A voluntary worker skilled in handicrafts also visits the ward and guides those patients who are able to benefit by simple occupational therapy. It is hoped to carry out another follow-up of this type at a later date to discover what has been the effect of these changes.