should use certain moneys released from their funds by the operation of the Act, towards providing medical benefit for women and children. The capital value of the amount so released is £5 per head. I would endorse that suggestion, and place the interest of that sum each year, automatically, whether there were illness or not, to the member's deposit account.

The deposit account should be the property of the member, held in trust by the Authority. If unexpended it should be returnable to his family at his death, or to the member himself if he left the country.

The broad principle of this scheme would, I think, result in the best features of private and family medical practice being preserved, whilst the irritating features, so far as they are financial, would be largely avoided. Doctors would be paid on a business footing, yet no patient would be liable for more than a moderate fraction of a week's wages at any one time. Therefore there would be no serious reason or excuse for not coming for medical assistance early in illness. A patient now frequently says, "I did not want to start doctoring because I was afraid of a big bill." That fear would be banished under this scheme. There would be deterrent enough to prevent vexatious claims, time-wasters of doctors, and malingering, that canker of friendly society funds; but it would be light enough to be no bar to early betakement to a doctor by women and children, as well as the employed person of whom the Act makes so much.

Further, the apportionment of payment for attendance on insured persons who constantly change their abode, which constitutes a very serious difficulty under the scheme assumed by the Act—namely, capitation—becomes a perfectly simple matter if each doctor is to be paid just what he does according to the tariff. A gipsy or a canal man will be as easy to provide for as the village blacksmith.

The cost of the greater part of the long and serious illnesses would fall on the insurance funds; that of short and trivial illnesses would be borne by the insured themselves.

Excessive attendance by a doctor would not be encouraged or accepted by the patient. Such, I apprehend, are some of the advantages.

Of course, I assume a £2 wage limit. That is necessary to bring the scheme into accordance with the policy of the British Medical Association; but really I cannot see why, were the whole tariff fixed proportionately, a higher wage limit should present any difficulty.

The difficulties are of diverse character, but I group them together chiefly because it seems possible that the solution of them all is to be sought in the same direction.

Difficulties of the Scheme.

(a) Malingering	} After the deposit has been exhausted.
(b) Excessive attendance	
(c) Excessive demands for attendance	
(d) Provision for consultations.	
(e) Provision for special forms of treatment.	
(f) Inspection, necessary under any insurance scheme.	

I make the following proposal for dealing with all these with the utmost diffidence. It is merely tentative, and does not necessarily bear an integral relation to the foregoing portions of the scheme.

The proposal involves the formation in each insurance area of a district medical staff, to consist of a body of consultants similar to the staff of a large general hospital. It would be, so to speak, "a hospital without walls," its sphere of work the patients who were referred to it by the doctors practising in the insurance area.

A practitioner would request a consultation with a member of the staff because he desired his assistance or advice in a difficult case, or if the patient was malingering.

Again, it might be the patient who desired a second opinion, and the ready means of obtaining a highly skilled and indubitably authoritative one which the district medical staff would supply, would obviate many of those cases in which one doctor is asked to supersede another at the present time on totally inadequate grounds.

Also, if the Authority suspected a doctor of over-attending a patient whose account had come on to the pool it might request a consultation. The illness would in that case be a long one, and the consultation would have a medical, as well as a disciplinary, value. The subject is unpleasant, but it has to be faced, as the advocates

of payment for work done have been taunted with the difficulty it refers to. May I here say, shortly, that the mere fact of the existence of a system of disciplinary consultations would check the need for their use.

I had hoped to bring into this paper some mention of provision for the higher and special departments of medical work; to suggest that, for instance, a skilled ophthalmic surgeon, as a member of the district medical staff, might hold an eye clinic in a convenient centre, such as a market town, once a week—say, on market day; that his clinical assistants should be two or three general practitioners from the neighbourhood, adequately paid for their afternoon's work; that the interest and efficiency which constant association in work with a colleague of undoubted distinction would bring into their professional lives would be reflected in the rest of their practice; that such arrangements might be developed in other departments of medical work; and that the expert work of school clinics would be more economically and better carried out by such arrangements.

But time does not permit. Still, let me say this, that any scheme requires the creation of a vast mass of machinery, both administrative and clinical, and it is surely in the interests of national economy that this machinery should not pick out merely the insured members of households, but that it should include the women and children. Only so can you begin at the beginning to secure the objects avowed in the title of the Act, "the prevention and cure of sickness."

THE REFORM OF HOSPITAL OUT-PATIENT DEPARTMENTS.*

BY A. STANLEY PARKINSON, M.D. LEEDS,
WAVERTREE, LIVERPOOL.

I HAD the privilege of working some eighteen months ago with a committee appointed by the combined Liverpool and Birkenhead Divisions whose duty it was to draw up a report on the working of the out-patient departments, with special reference to the Liverpool medical charities. It is therefore with pleasure that I incorporate in my paper the conclusions arrived at by that committee.

The Majority Report of the Royal Commission on Poor Law states that: The benefits of the voluntary hospitals are largely taken advantage of by the well-to-do classes (Conclusion 8, Part v, chapter i). The report of the Royal Commission on the Poor Law (Scotland), in reference to the city of Edinburgh, states that the low membership of friendly societies amongst a thrifty people can hardly fail to be connected with the large medical charities in Edinburgh. There is practically no attempt on the part of the inhabitants to provide medical aid for themselves on a provident basis.

These recent investigations clearly indicate that a good deal of abuse must be present, a fact to which every general medical practitioner can testify.

In preparing statistics of the seventeen large voluntary hospitals in Liverpool and Bootle, it was found that in the year 1908 the number of out-patients was over 228,000, and the number of attendances over 700,000. The total estimated population of Liverpool and Bootle was 821,644, so that the proportion of one person in every 3.6 (3½) of the citizens of Liverpool and Bootle sought charitable medical out-relief in 1908, and this was quite exclusive of over 77,000 cases treated under the Poor Law.

Naturally, in the distribution of such an enormous amount of medical charity there is ample room for abuse, and on inquiry as to the measures taken to prevent the abuse it was found that at some hospitals no special precautions were taken at all; at other hospitals it was left to the medical staff; and at other hospitals a clerk, an out-patient Sister, or a dispenser made some inquiries as regards each patient. To any one who has given special attention to the work it means that in Liverpool, I am sorry to say, very little is done to prevent abuse, and in my opinion the only people who think that no abuse, or

* This paper was read in the Section of Medical Sociology of the Annual Meeting at Liverpool, but owing to a misunderstanding was omitted from the report of the proceedings of the Section published in the JOURNAL on August 3rd.

very little, takes place are some of the members of the lay committees of the hospitals.

The out-patients can be divided into six classes :

1. A large number of cases for whose treatment the Poor Law authority are, or should be, responsible.
2. Persons suffering from chronic ailments.
3. Persons whose home conditions will not allow them to reap any commensurate benefit from such treatment.
4. Well-to-do persons who can afford to pay private practitioners.
5. Persons sufficiently well off to be able to join a provident institution or a public medical service.
6. The suitable persons for the out-patient department.

I have not included in this classification the children sent to the out-patient departments by the education authority because I have hope that before many months are over this gross abuse will be entirely swept away.

Class 1. The Poor Law cases ought always to be referred to the Poor Law authority.

Class 2. Persons suffering from chronic ailments ; and Class 3, Persons whose home conditions will not allow them to reap any commensurate benefit from such treatment, ought, I consider, to be referred to a reformed Poor Law authority.

Class 4 and Class 5, the well-to-do and persons able to join a provident institution or a public medical service, should also be excluded from the out-patient department.

Class 6 contains the suitable persons for the out-patient department—that is, patients who are not able to pay for adequate treatment—of course making exception for cases of serious accident and of severe sudden illness.

The next question is, What should be the character of the work undertaken by the out-patient department?

I think it is now fairly well agreed that it should be used almost exclusively for (1) casualties, (2) consultations, and (3) cases requiring expensive equipment for the treatment of special diseases and defects.

Under such conditions the work would be so limited as to prevent overlapping between its sphere and that of the Poor Law authority ; full scope would be left for private practice and provident effort ; the work accomplished by the department would be more valuable and more efficient ; it would not entail so arduous a task upon the medical staff ; and the funds of the hospital would not be wasted.

At present each hospital is an isolated unit acting without any co-operation with other hospitals. Also when a patient leaves the hospital and arrives home the only evidence that he has been to the hospital is the existence of the wonderful "bottle." These conditions ought not to exist. All the hospitals in any town or city ought to co-operate with one another and also with various outside societies. These outside societies would follow the case up, and would help patients unable to help themselves in securing both proper nourishment and any other assistance for their families that might be necessary. This would give a much better chance of a more speedy recovery for the patient, by ensuring that the advice given at the hospital was fully carried out.

In order to bring about these reforms it is obvious that there must be some official attached to the hospital for the purpose of thoroughly weeding out all the various unsuitable classes to which I have referred ; this official would co-operate with the various outside societies in following up the cases to their own homes, and would also help the patients, as far as opportunity allowed, to obtain surgical appliances, letters for convalescent homes, or any other such aid as the staff might consider them to need. Such an official is now known as an almoner, and a properly trained almoner is one who has been trained not only in the work of the out-patient department, but also in the work undertaken by the Charity Organization Society.

When the almoner is weeding out the various applicants for medical charity, she finds that no mere inquiry work, no fixed rate of rent, income, &c., is of much value ; every case must be treated on its own merits, and no patient can be considered as an individual alone, but as a member of a family and a part of the community. This entails a great amount of personal work, time, and expenditure ; but surely, if it is worth while for a physician or surgeon to devote long hours daily to the arduous task of the treatment of out-patients, it is only right to ensure that the treatment is not granted save to those who cannot afford to pay for it, and, moreover, that it is not rendered inadequate for want of help and care in carrying out the instructions laid down.

One or more almoners ought to be attached to each hospital ; in some cases of small hospitals possibly one almoner could serve two hospitals, and all the almoners in any city ought to work in co-operation with one another, so as to avoid overlapping.

Hospitals which do not adopt this system cannot help having their out-patient departments considerably abused, and in cities and towns with more than one hospital there is a great amount of overlapping and inco-ordination, whereby considerable sums of money are wasted or improperly applied and much effort is rendered useless.

I therefore think that it is the primary duty of all hospital committees to take the strongest measures possible to see that the funds entrusted to them for charity are spent for that purpose in the best possible way, and this can only be done by employing one or more almoners as the case may be, and limiting the scope of the work undertaken in the out-patient department to casualties, consultations, and to cases requiring expensive equipment for the treatment of special diseases and defects.

EIGHTIETH ANNUAL MEETING

OF THE

British Medical Association.

Held in Liverpool on July 19th, 20th, 22nd, 23rd, 24th, 25th, and 26th.

PROCEEDINGS OF SECTIONS.

SECTION OF STATE MEDICINE.

A. K. CHALMERS, M.D., President.

PRESIDENT'S INTRODUCTORY REMARKS.

AFTER a few initial observations, including a reference to the fact that the two first meetings of the Section had been held in conjunction with the Sections of Bacteriology and Medical Sociology respectively, Dr. CHALMERS said that he would like to take advantage of the occasion to enter a protest against the growing tendency to regard the work of preventive medicine as resulting only in flooding the population with inefficients. He could conceive no more grotesque or inaccurate description of the actual position. It was true that of recent years they had been afforded illustrations of much inefficiency, both mental and physical, and in a way these had been traced to certain groups of population and to definable circumstances. But these did not affect the population as a whole, nor even to a considerable extent, and once these conditions were more clearly understood, the remedy or avoidance might be possible. The whole movement, indeed, had been a forward one, and the future was full of hope. A second remark might be directed to the field of school medical inspection, which he thought was probably too great an extent pathological rather than physiological in its objective. It was a valuable contribution to knowledge to ascertain in what proportion their children were handicapped physically ; but they would reach higher levels if they endeavoured to group the mental equipment of the children, especially of those who were above the average. He hoped a time would come when in conjunction with the teachers the school medical inspector would be able to group children during their school life in accordance with their adaptability to and proficiency in certain forms of future work.

CHILDREN AND DENTAL DISEASES.

I.—R. J. ERSKINE YOUNG, M.D.,

Dental Officer to the Liverpool Education Committee.

THE deplorable dental condition of the poorer classes of society is already too well known to the dental profession, but it was only as recently as 1907 that certain municipal authorities realized this. After due consideration the