

## The Future OF THE HOSPITALS OF LONDON.

BY SIR JAMES KINGSTON FOWLER, K.C.V.O.,  
C.M.G., M.D. CAMB.

It is stated in the Final Report of Lord Cave's Committee that in 1920 40 out of the 113 hospitals in the metropolitan area had a surplus and each of the remaining 73 a deficit. I hope to show how it may be possible for some at least of those in the latter category to join those in the former.

With the measures of immediate urgency necessary in order to meet the financial crisis which has arisen from temporary and well-understood conditions, I am not now concerned.

### ANNUAL SUBSCRIPTIONS.

It is, I believe, generally accepted that the amount received from annual subscriptions forms "the backbone of hospital finance." I have before me a chart, begun in 1897 and continued up to 1921, which shows the income from annual subscriptions of all the London hospitals with medical schools, except St. Bartholomew's. This chart has to-day become a document of much interest and of great value. It is possible, almost from a glance at it, to differentiate four distinct types, which, so far as this single department of administrative effort is concerned, may be classified thus.

#### *Analysis of the Chart.*

1. In this class, which comprises eight out of the 11 hospitals, there is no evidence during the whole of this long period of any effort to increase the number of annual subscribers; in some cases the curve shows a slight rise, in others a steady decline is apparent. It is, however, only fair to state that as regards one of them there is evidence of a recent awakening. Let us hope that it will be of prolonged duration.

2. One hospital constitutes this class. For 16 years the curve shows a slight upward inclination, £2200 in 1897 having become £2822 in 1913. A new chairman then gets to work with the startling result that in 1917 £2822 has been increased to £10,351! At this hospital in 1921 there was no crisis, there was not even a deficit, but in its place a comfortable surplus!

3. One hospital starts in 1897 with an income of £11,000 from annual subscriptions, then follow some lean years, but by a vigorous appeal in 1903 the amount is raised in the next year to £16,400. It then, after two sharp rises, gradually declines in 1910 to £13,200 and again steadily rises to £16,780 in 1918. In 1921 the figure was £15,900. The result of these fluctuations is to produce an outline which reminds one of the peaks of the Himalayas. This is evidence of intermittent efforts which almost deserve the epithet "heroic." It was obviously impossible to maintain such efforts from year to year. Is it not clear that the burden was too heavy, and does it not suggest that in the future it should be lightened?

4. One hospital, but, alas, only one, shows a steady and almost continuous rise from £3600 in 1897 to £9609 in 1921. The rise would have been absolutely continuous, but for the diversion of energy needed to support a special appeal made at a festival dinner. From this appeal a very large addition to the funds of the hospital resulted, but in spite of this there was a temporary, but very slight, falling-off in the income derived from annual subscriptions with which, it may be well to repeat, we are now alone concerned. From this slight decline in the curve there is a lesson to be learned, but it is too obvious to need statement.

#### *Inferences from the Chart.*

The inferences which I suggest are to be drawn from the chart are as follows.

(a) That the policy of masterly inactivity, as regards obtaining new annual subscribers, accompanied doubtless by a hope that from some other source something would turn up, and the selling of stock or the issue of an appeal when the financial outlook was specially threatening, may in the past have sufficed to keep things going, but that such a policy is quite inadequate to meet the needs of to-day.

(b) That good organisation, hard work, and sustained effort are required from all concerned in hospital administration, if the number of annual subscribers is to be increased year by year, and that, in the long run, such a policy gives a better and more enduring result than intermittent periods of volcanic activity.

(c) That it is possible for a single individual, possessed of great energy and a clear vision, provided the load is not too great, to raise a hospital in a year or two from a financial morass to a high plateau of prosperity, but he will be wise if he takes all the steps necessary to ensure that his policy is continued when he is no longer at the head of affairs.

Having submitted the ideas contained in the scheme, which it is the object of this article to make known, to one who is competent to judge and having been told that the procedure recommended differs in no essential particular from the general methods which have been employed at the hospital referred to above under Class 2, I am disposed to think that it may be worthy of the consideration of those who are responsible for the management of the 73 hospitals which in 1920 showed an adverse balance in their accounts.

#### *Patients' Contributions.*

The suggestion to the patients that they should contribute something towards the cost of their maintenance in hospital has everywhere met with a generous response and this already very considerable source of income will undoubtedly increase from year to year. Is not this a sufficient reply to those who think that some sort of bribe is necessary in order to obtain money for the hospitals from the wage-earners? Surely they must have higher ideals than those who claim to know their minds, otherwise they would not so readily have recognised their duty to contribute according to their means towards the cost of their maintenance when in hospital.

I am sorry to have to correct the following very unfortunate mis-statement contained in the Final Report of Lord Cave's Committee (par. 38). "Some London hospitals, including the . . . . ., the Middlesex, and . . . . ., make a fixed charge (except in the case of poor people) as a condition of admission [the italics are my own], the charge for an in-patient being generally about 20s. a week and for an out-patient 6d. to 3s. per attendance, according to the nature of the case."

At the Middlesex Hospital each out-patient is asked for 6d. at each attendance, if he is willing to pay that sum. If he states that he is unable to pay anything at all, he is at once, and without further enquiry, given a "free ticket." No patient at the Middlesex Hospital has ever been charged any sum as a condition of admission to the wards. The procedure of admission to the wards is as follows: After admission the patient is visited by the lady almoner, who, from the patient's statements, fills in the "index card"—e.g., single; married; children; no children; weekly earnings, &c. Either the patient or the almoner suggests a sum payable weekly by the patient towards the cost of his maintenance. When they have come to an agreement that is the sum which becomes payable. If the patient states that he is unable to make any contribution at all he remains in the hospital free of any charge. No patient in a ward knows whether any other patient in the ward is paying part of the cost of his maintenance; nor does he know which patients, if any, are making no contribution at all. Moreover, the sister of the ward and the nurses are equally in ignorance of these facts; all patients are treated alike, whether they pay or do not pay.

# SCHEME FOR THE FUTURE SUPPORT OF THE HOSPITALS OF LONDON.

## Central Area.

1. That the whole of London now dealt with by King Edward's Hospital Fund be mapped out into *Spheres of Influence*, having relation to the existing hospitals or hospital groups.

2. That within its sphere of influence each hospital or group be advised to set up an organisation for the purpose of collecting money and that no neighbouring organisation be allowed to solicit support within that area.

3. That each hospital or group be free to accept voluntary gifts from any source apart from any question of the place of residence of the donor, or any other consideration.

4. That within its sphere of influence it should be the duty and interest of the organisation to create a local patriotism centred upon the hospitals. Such a local patriotism, but, of course, quite apart from the hospitals, exists in all large towns in the Provinces, but has hitherto been conspicuously absent in London.

5. That within its sphere the organisation should search out every possible source of voluntary gift, endeavouring especially to make such gifts annual.

6. That the sum annually collected within each of the central areas should be divided amongst the group of hospitals (where it is a group area) in accordance with any plan upon which they may mutually agree.

7. That, as at present, no hospital receiving support from King Edward's Fund be allowed to make a public appeal without previously submitting the scheme to the Council of the King's Fund and obtaining its approval.

8. That in the future every effort should continue to be made to compel the hospitals to recognise that their annual expenditure must be regulated, like that of any prudent individual or well-managed institution, by the income in sight, and that the King's Fund will continue its present policy and will not countenance expenditure upon buildings or extension of departments for the erection and maintenance of which there is no prospective income.

9. That the borough hospitals (late Poor-law infirmaries) should be developed as an integral part of the hospital system of London, and should be affiliated to the general hospitals of the area, to which they geographically belong.

10. That two important steps to attain this end would be (a) the appointment of a visiting staff (as in Marylebone), and (b) the appointment, as far as possible, on the resident staff of men educated at the medical school of the general hospital to which the borough hospital is affiliated.

11. When a system of transfer of patients from a general hospital to its affiliated borough hospital has been brought into operation, it would be possible to convert one or more of the ordinary wards of the general hospital into "diagnosis wards."

12. "Diagnosis wards" would be reserved for the diagnosis of obscure cases, a proceeding which with all the resources for the purpose possessed by a hospital well equipped with laboratories and all modern methods of recognising disease might take a few days, or a week or, of course, in some cases still longer. After the diagnosis has been arrived at the patient might be removed to one of the ordinary wards of the same hospital or, if the case was likely to require prolonged hospital treatment, to the affiliated borough hospital, where the treatment would be equally well carried on in a less expensively equipped hospital.

13. The number of patients passed through a diagnosis ward in a single year might easily be three times as many as it would have been had the ward been used as in the past, when it was supposed that hospitals existed solely for the treatment of disease, whereas in a very large number of cases the diagnosis is by far the more important factor in the case. It is not necessary to be a doctor to appreciate the fact that before the treatment is begun it is well to know

what is the matter with the patient. In many cases, once the diagnosis is made, any competent practitioner can carry out the treatment recommended, whereas he might not have had at his disposal the means whereby alone an accurate diagnosis was rendered possible.

## Application of the Scheme to the Outlying Areas.

1. That in areas upon the outskirts of London within which there may be no local hospital, or only a small cottage hospital, a voluntary hospital committee be set up, charged with the same duties as the organisations of the central area.

2. That the amounts collected by such committees be paid into a fund, to be called the Annual Fund, in order to distinguish it from King Edward's Hospital Fund and to indicate that its functions are fulfilled by annual payments to the hospitals. Such a fund should only retain a sum necessary for its working expenses. This annual fund should be managed by King Edward's Hospital Fund and distributed year by year upon a basis to be agreed upon.

3. It may happen that a resident in one of these outlying areas when appealed to for his support may say, "I don't see why I should be asked to subscribe to the hospitals, there is not one nearer here than three miles." He would be confronted with the fact that (say) 1000 in- and out-patients from his area made use of that hospital, distant more than three miles, during the last year, not to mention many who, for various reasons, attended at hospitals situated at a still greater distance. By the use of the card-index system, now almost universal at the hospitals, the place of residence of every patient is known and such figures could be produced without difficulty.

## The Scheme in Being.

It must not be thought that this is a merely abstract and paper scheme, born of an active imagination, as in two cases, to one of which I have already alluded, it is in actual operation in London, and has been so for more than a year. The story of the results obtained in the second of these "spheres of influence" is very interesting. One lady canvasser, assisted by two part-time workers, one of whom has been engaged only six months, has obtained by personal visits more than £1000 in voluntary annual subscriptions and a considerable sum from collecting boxes. In addition, one large business firm within the area, with the complete accord of its employees, has decided to divert the sum of 1000 guineas, collected for a war memorial, which it was intended to erect within the house of business, in order in lieu thereof to endow a hospital bed, over which a suitable inscription will be placed. Only factories, places of business, and shops have been visited, no private residences have been included in this branch of the collecting department of the hospital. What a commentary this is on the contention that "mass-contributions" can only be looked for if some quid pro quo is offered!

The area of the borough in question so far covered comprises, as I am kindly informed by the Surveyor, about one-twelfth of the total area, excluding such parts as are not built upon. As the visitation of each street is finished a blue pencil mark is made along it on a map of the borough, so that it is easy to see at a glance how little has yet been done and how much labour still confronts the far too few workers now engaged in the search for support of the hospitals situated within this sphere of influence.

The lesson that these workers have learned is that "personal touch" is the secret of success. No printed or type-written circulars or letters are of any use, every letter, whether of solicitation or of thanks, must be written by hand and signed by someone in authority. An occasional visit from such a person connected with the hospital to express the thanks of the governing body "acts like a charm." All this does not seem to prove that the voluntary system is a failure!

If the needs of the hospitals are to be brought home to the people the facts must be taken to the homes of the people and to the places where they work.

## CONCLUSIONS.

*Spheres of Influence.*

The principle of spheres of influence has been already accepted by King Edward's Hospital Fund. What is now necessary is for the Fund to appoint a committee to delimit these areas. Should there be any tendency to make exaggerated geographical claims in order to secure supporters, the impartial and quasi-judicial position of the King's Fund Committee would ensure an equitable decision.

*A Hospital Map of London.*

This map would constitute the report of the King's Fund Committee when their work was completed. It is urgently necessary, as it is the essence of this scheme, that every Londoner should know as soon as possible the number of his hospital area as well as he knows the number of the omnibus service which takes him to

his daily work. I can see such a map on a hoarding with the "legend" beneath, "Which is *your* area? What have *you* done for the hospitals?"

*The Voluntary System.*

There are some people who appear to think that the voluntary system should be likened to a decrepit old man tottering to his grave; there are others, with whom I am in complete accord, some of them men who have spent their working lives in hospital administration and who alone are entitled to be heard on this subject, who picture the voluntary system as a healthy infant just learning what wonderful things it can do if it tries. It is for London to decide which policy shall prevail. Shall it be that which represents the former view, a policy of despair, or the latter, a policy which is an expression of a continued belief in the generosity of the people of London, whether they work with their brains or their hands?

## Nettsonian Lectures

ON

### AMOEBIC LIVER ABSCESS:

#### ITS PATHOLOGY, PREVENTION, AND CURE.

BY SIR LEONARD ROGERS, C.I.E., M.D.,

F.R.C.P. LOND., F.R.C.S. ENG., F.R.S.,

LIEUT.-COLONEL, I.M.S. (RET.)

#### LECTURE II.\*—THE VARIETIES AND TREATMENT OF AMOEBIC LIVER ABSCESS.

In the first lecture I dealt exclusively with the ætiology and pathology of amoebic liver abscesses; I now have to treat of the varieties and treatment of liver abscess, in which important life-saving advances have been made during the last two decades. Before passing on to the clinical side there are still some points derived from my experience as a pathologist which have a practical bearing on treatment, and I will first complete what I have still to say on the varieties of liver abscesses.

##### FORMS OF MULTIPLE LIVER ABSCESES.

Davidson, in Allbutt's System of Medicine, divided suppurative hepatitis into the following classes: (1) pyæmic, now comparatively rare and forming only a part of a hopeless general infection with which I am not at present concerned; (2) porto-pyæmic or pylephlebitic, surprisingly rarely found complicating dysenteric ulceration of the bowel; (3) secondary pyoseptic, of which Davidson wrote: "It is always secondary to the opening—spontaneous or operative—of an abscess of the liver, and the consequent entrance of infective micro-organisms from without," an early and authoritative acknowledgment of the danger of septic infection of the large single tropical liver abscess, regarding which I shall speak presently; (4) tropical suppurative hepatitis, which is the large comparatively chronic amoebic abscess of present nomenclature; (5) suppurative cholangitis with the formation of pus in the dilated intrahepatic bile-ducts, concerning which I have something to say, and have also to add a still rarer variety I met with in Calcutta.

##### *Suppurative Cholangitis.*

I have been greatly interested in this rare disease ever since I met with three cases while demonstrator of pathology in my third year's studentship at St. Mary's Hospital, when I also collected and analysed 17 more cases in an unpublished paper read before the hospital medical society. Fourteen years later I recorded<sup>5</sup> a case I diagnosed and operated on at the Calcutta European Hospital, removing a mass of gall-stones from the hepatic ducts, but was a day too late, as unfortunately the suppuration proved to have already tracked up along the inferior vena cava and

opened into a bronchus with fatal results. In reporting this case I included from memory all the essential data of my early study, and suggested that a history of obstructive jaundice due to gall-stones with fever and leucocytosis, but in which the jaundice decreased at the same time that the general symptoms grew worse, formed a combination of signs indicating suppuration in the bile-ducts loosening the stones and allowing the bile once more to escape past them into the bowel, and one which should lead to opening and draining the enormously dilated bile-ducts of such cases as the only chance of saving the patients—conclusions which have since been endorsed by the high authority of Sir Berkeley Moynihan in his work on Gall-stones and their Surgical Treatment.<sup>6</sup> This condition is, however, so rare in India that among nearly 5000 Calcutta post-mortem records I only found one probable case, which is explained by the fact that although gall-stones are nearly as common in India as in Europe, in the former country most of them were of the soft pigment variety, the hard disease-producing cholestinine form being comparatively uncommon in Calcutta, as I showed in a paper on gall-stones in the tropics.<sup>7</sup> Suppurative cholangitis will, therefore, seldom give rise to difficulties in the differentiation of liver abscesses in the tropics on account of its great rarity and of the prolonged obstructive jaundice usually preceding it—a symptom which is not at all marked in the amoebic disease, except occasionally as the result of a large abscess bulging on the under surface of the right lobe of the liver pressing on the hepatic ducts, as in a case recorded by Moir in 1902,<sup>8</sup> and one reported in my Bowel Diseases in the Tropics, which I diagnosed during life, and verified post mortem.

##### *Diffuse Suppurative Hepatitis Produced by B. Coli Communis.*

The only case I have seen of this condition was in a Calcutta hospital patient with fever and acute hepatitis, in whom I found leucocytosis with over 90 per cent. of polynuclear leucocytes, which led me to express the opinion that it was not an amoebic hepatitis, in which I had never seen such a high polynuclear proportion, although I was at a loss to suggest its cause. I found post mortem a peculiar diffuse suppuration throughout the half of the liver supplied by the right branch of the portal vein, in which extensive clotting was present, while the remaining half of the organ was healthy. Cultures showed a pure growth of innumerable coli communis bacilli.

In all the foregoing varieties of multiple small liver abscesses the histories of the cases and the acuteness of the symptoms are quite different from those of the more insidiously forming large amoebic ones, while it is only the latter form usually which is amenable to surgical treatment. Further, I have already shown in the first lecture that multiple small amoebic abscesses are nearly always overshadowed clinically by the acute sloughing dysentery to which they are secondary, so they cannot as a rule be recognised during life and are also quite beyond the reach of surgical measures. The

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