éire

roinn riaġaltais áitiúil agus sláinte poiblí.

(DEPARTMENT OF LOCAL GOVERNMENT AND PUBLIC HEALTH).

coimisiún na n-ospidéal

An Ceathramhadh Tuarascáil Choitcheann

1938

THE HOSPITALS COMMISSION

FOURTH GENERAL REPORT

Baile Átha Cliath
DUBLIN
Foilsithe ag Oifig an tSoláthair le haġaid Coimisiún na n-Ospidéal
PUBLISHED FOR THE HOSPITALS COMMISSION BY THE STATIONERY OFFICE.

Le ceannach díreach ó
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A Thuine Uasail,

Iarrann an t-Aire Riaghaltais Áitiúil agus Sláinte Poiblí orm a rá leat go bhfuil fáth aige an Ceathrúnach Tuarasgabáil Coitcheann do'n tréimhse ón céad lá d'Eanair, 1938, go dtí an 31ú lá de Mhí na Nodlag, 1938, atá coimhthe ag an gCoimisiún do.

Mise, le meas,

Séamus Hurson,

Rúnaí.

An Cathaoirleach,
Coimisiún na n-Oispidéal.

Iúl a 26, 1939.

Do'n Aire Riaġaltais Áiteamhail agus Sláinte Poiblíde,
Tig an Custuim,
Baile Áta Cliaṫ.

A Thuine Uasail,

Tá sé d'onóir ag Coimisiún na n-Oispidéal é seo leanas do ċur i láṫair Aire Riaġaltais Áiteamhail agus Sláinte Poiblíde, an Ceaṫramaḋ Tuarascáil Coiṁisiúin faoi ṫéimhse na bliaḋna 1938 i n-a bruil faisnéis an ċúrsaí pé leiṫ a baineas le ceisteanna na n-Oispidéal i ríċ na ṫéimhse sin.

Is mise, le meas mór,

MÍCEÁL Ó DEORÁIN,

Cathaoirleaċ.

THE HOSPITALS COMMISSION

MEMBERSHIP OF COMMISSION

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(Secretary).

CONTENTS

PART I.

SECTION I.

SECTION II.

SECTION III.

SECTION IV.

SECTION V.

SECTION VI.

SECTION VII.

SECTION VIII.

PART II.

APPENDIX

TABLE OF CONTENTS.

SUPPLEMENT.

FOURTH GENERAL REPORT

PART I.

SECTION I. (Introductory.)

PERIOD COVERED BY REPORT.

This Report covers the work of the Hospitals Commission for the year 1938. It follows the general plan of previous Reports, being divided into two parts and an appendix. Part I contains observations on hospital and allied problems, whilst Part II is confined to the presentation of statistical data for the years 1937 and 1938 and their interpretation. The appendix brings particulars relating to the monies derived from Sweepstakes for hospital purposes and their utilisation up to date to the end of the year, contains a list of additional applications for grants, gives details of expenditure incurred by hospitals out of Sweepstake Funds received by them prior to the Public Hospitals Act, 1933, and the recommendations made to the Minister in respect of applications for grants dealt with during the year.

HOSPITAL SURVEY.

There was no general survey of hospitals during the year. An investigation was, however, carried out into the Ambulance Service throughout the country. Observations resulting from this investigation are contained in Section VI. Statistical data relating to hospital activity continued to be collected throughout the year and are given in tabulated form in Part II. The submission weekly of the daily bed occupancy in each of the general hospitals was continued throughout the year. From the returns, the graphs in this report showing the relationship between occupied, available and total beds have been prepared. During the latter half of the year the forms, in which bed occupancy and availability were submitted, were amended to show greater detail in respect of classification of the main types of disease. Two tables, one in respect of the first half of the year and the other of the second, are given in the appendix. These tables give an analysis of bed availability and bed occupancy for nine Dublin General Hospitals, as compared with ten for the previous year. The decrease is due to the refusal of the Adelaide Hospital, which does not participate in benefits from Sweepstake Funds, to furnish the Commission with the data required.

ADDITIONAL HOSPITALS AND INSTITUTIONS CLAIMING GRANTS.

During the year 63 new applications for grants were received, 35 on behalf of voluntary hospitals and institutions, and 28 on behalf of those controlled by Local Authorities, bringing the total number of applications received, to December 31st, 1938, to 333. A complete list of the additional applications received during the year is given in the appendix.

INSPECTION OF HOSPITALS.

During the year 48 visits of inspection to hospitals and institutions were made, and details of their claims for grants from the Hospitals Trust Fund were examined,

In addition the accounts of 56 hospitals for the year 1937 were examined, and recommendations in respect of payments of deficits incurred on maintenance for the year made to the Minister. The amount recommended to be paid from the Hospitals Trust Fund in respect of these deficits totalled £103,055.

BED OCCUPANCY AND AVAILABILITY.

Graphs similar to those published in the two immediately preceding Reports, showing the relationship between bed complement, beds available and beds occupied, are included in this Report in respect of the year 1938. In its Third Report the Commission was compelled to draw the Minister's attention to the fact that, notwithstanding that a request was circulated to all hospitals in March, 1937, to try to reduce the discrepancy between bed complement and bed availability, particularly in the summer months, the figures and graphs in that Report showed practically no change for that year, many hospitals having closed beds in the summer months to the same degree as they had hitherto been accustomed to do. In that Report also, the possibility of the Minister's being compelled to adopt a different policy in respect of deficit payments to hospitals, if no improvement in bed availability took place, was referred to. Whilst the figures for 1938 show an increase in bed availability over those of 1937 and 1936, this increase is so slight that it could hardly be said to constitute a definite improvement. In many of the Dublin hospitals over half their normal bed complement was not available for the reception of patients during certain periods of the summer months, and in the case of one large hospital almost two-thirds of its accommodation was closed down. A small number of these Dublin hospitals do appear to make a serious effort to keep a reasonable proportion of their beds open all the year round, whilst in the case of similar hospitals in Cork and Limerick the number of available beds is fairly constant throughout the year.

It is difficult to reconcile the demand for additional beds by some hospitals with the rather limited extent to which their existing beds are utilised. The capital cost of a large hospital is far too great to-day to permit of its being utilised to only 50%, and sometimes considerably less, of its full capacity. In respect of maintenance, the Commission considers that it may be necessary in the future to relate the maintenance payments that may, from time to time, be made to hospitals out of the Hospitals Trust Fund, more closely to the extent to which they utilise the facilities they possess, than has hitherto been the practice. It is to be regretted that the hospitals which show large discrepancies between their total bed complement and the number of available beds have not themselves made some more serious effort to remedy this defect, notwithstanding the attention that has been drawn to it in the Commission's various Reports, and by its circular letter on the subject in 1937. It ought to be obvious to any hospital that in the graphs dealing with the matter, the more the curves representing total bed complement, bed availability and bed occupancy approximate to each other, the greater is the argument in support of its claim for additional accommodation. If a hospital can close down half its beds for certain portions of the year, and if the graphs show that during these periods there is no abnormal occupancy of the remaining beds, arguments in support of increased bed accommodation are considerably restricted. If, on the other hand, they show that the demand on the reduced number of beds does not provide a reasonable margin for emergencies, indicating that sufficient beds were not kept available, it is difficult for any responsible authority to approve of extending the total accommodation in such a hospital, without an assurance that the additional beds would be fully utilised. It has been stated that the inability of some hospitals to provide more available beds, particularly at certain periods of the year, is due to shortage of nurses occasioned by insufficient nurses' accommodation, but, as pointed out in the Commission's First Report, the figures showing the ratio of beds to nurses do not support this contention, since they demonstrate that in comparable hospitals, where no complaint can be made in respect of the available beds provided all the year round, the ratio of beds to nurses is greater.

Subsequent figures given in the Commission's Third Report are still more unfavourable to those hospitals which close down a large proportion of their bed accommodation, and the Commission is of opinion that it is not shortage of nurses that is the real cause, but rather the system of organisation governing the holiday arrangements

In view of the failure of some of the Dublin General Hospitals to so reorganise their institutions as to permit of the provision of a larger number of available beds, the Commission would strongly urge on the Minister the desirability of his calling their attention to this matter, since the Commission's references to it do not appear to have altered the position, or to have convinced these hospitals of the necessity for improvement in the provision of available beds.

FINANCE AND MAINTENANCE.

In regard to the conditions which govern hospital finance and maintenance, the voluntary hospitals are passing through an abnormal phase. The success of the Sweepstake scheme for the past seven years, the regularity with which recurring annual amounts are made available for hospital purposes (as well, indeed, as the uncertainty of the period of their continuance), and the exaggerated anticipations of individual institutions in relation to the distribution of Sweepstake funds, have caused this abnormal situation. It is evident that, in view of the present unsettled world situation, the greatest care must continue to be taken to husband the available funds to ensure the realisation of the contemplated schemes, while making reasonable provision for the maintenance of existing and future extensions to hospital services.

In previous Reports the Hospitals Commission stressed the seriousness of the continuous rise in hospital expenditure, especially in regard to its influence on the deficit problem. That problem has now assumed such dimensions that urgent measures are required, either to limit the amounts to be paid annually in respect of maintenance deficits or, assuming that the upward trend of the deficits must be accepted as unavoidable, to postpone some of the proposed schemes of hospital building and development. At present it requires an invested amount of approximately £3,350,000 (set aside out of the Hospitals Trust Fund) to bring in an annual income sufficient to meet the approved deficits of the voluntary hospitals. Every increase on this sum must naturally mean a corresponding reconsideration of the amount available for development.

The growing gravity of the deficit problem is clearly illustrated in the following table relating to the deficits returned by those voluntary hospitals which benefit from the distribution of Sweepstake funds :—

Year	Total Deficits	Increase over previous year	Increase since 1933
	£	£	£
1933 ...	54,868	—	—
1934 ...	58,469	3,601	3,601
1935 ...	78,841	20,372	23,973
1936 ...	88,012	9,171	33,144
1937 ...	103,966	15,954	49,098
1938 ...	115,257	11,291	60,389

It will be seen from this table that the total amount of the maintenance deficits has increased by approximately 110% in five years. The principal increases occurred in the eight Dublin general hospitals included in the above figures, as may be seen from the following table.

DUBLIN GENERAL HOSPITALS.

Year	Total Deficits	Increase over previous year	Increase since 1933
	£	£	£
1933 ...	23,956	—	—
1934 ...	28,093	4,137	4,137
1935 ...	34,230	6,137	10,274
1936 ...	41,073	6,843	17,117
1937 ...	56,188	15,115	32,232
1938 ...	59,291	3,103	35,335

The increase in deficits for these Dublin general hospitals in five years is, therefore, approximately 147%. A corresponding table for the Dublin special hospitals shows an increase of approximately 71% for the same period.

DUBLIN SPECIAL HOSPITALS.

Year	Total Deficits	Increase (+) or Decrease (—) since previous year	Increase (+) or Decrease (—) since 1933
	£	£	£
1933 ...	20,865	—	—
1934 ...	16,390	— 4,475	— 4,475
1935 ...	30,562	+14,172	+ 9,697
1936 ...	30,926	+ 364	+10,061
1937 ...	32,120	+ 1,194	+11,255
1938 ...	35,737	+ 3,617	+14,872

Similar comparative tables are shown hereunder in respect of the provincial general and special hospitals :—

PROVINCIAL GENERAL HOSPITALS.

Year	Total Deficits	Increase (+) or Decrease (—) since previous year	Increase since 1933
	£	£	£
1933 ...	8,677	—	—
1934 ...	9,337	+ 660	660
1935 ...	12,928	+3,591	4,251
1936 ...	11,172	—1,756	2,495
1937 ...	12,393	+1,221	3,716
1938 ...	16,079	+3,686	7,402

The increase in five years in the deficits of the provincial general hospitals was approximately 85%.

PROVINCIAL SPECIAL HOSPITALS.

Year	Total Deficits	Increase (+) or Decrease (—) since previous year	Increase (+) or Decrease (—) since 1933
	£	£	£
1933 ...	2,370	—	—
1934 ...	4,659	+2,279	+2,279
1935 ...	2,121	—2,528	— 249
1936 ...	4,841	+2,720	+2,471
1937 ...	3,265	—1,576	+ 895
1938 ...	4,150	+ 885	+1,780

The increase in five years in the deficits of the provincial special hospitals was approximately 75%.

It must be remembered, too, that these deficits would be considerably larger were it not for the fact that the hospitals derive an appreciable amount of their income from invested Sweepstake funds in their possession. For instance, if the income from Sweepstake funds invested by the hospitals be excluded, the deficits in 1938 would reach the huge total of £166,362. It must, therefore, be accepted that the problem of the maintenance deficits should be regarded as of major importance, both as regards its own magnitude and in consequence of its effect on all schemes of hospital planning, by reason of the strain it imposes on the resources of the Hospitals Trust Fund.

It is argued that the maintenance deficits of the voluntary hospitals were bound to increase, owing to the improved standard of service and to the general rise in maintenance costs. Cognisance has always been taken of these factors, but the Commission considers that there is a definite tendency on the part of some hospitals to take advantage of the position and to depart from a reasonable outlook on maintenance expenditure. Where the Commission, in its examination of hospital accounts and in comparing the different yearly returns, as well as those of the separate institutions each year, has found cause for serious misgivings is in the inconsistency and disparity of the increases. Under the heading of provisions some hospitals have shown increases and others have returned decreases. Big increases in respect of drugs and medicines have been shown by some hospitals, while the expenditure of others under this heading has shown no appreciable change. The disparity is illustrated very forcibly in the following comparison between two Dublin general hospitals :—

Hospital	Total ordinary expenditure in 1933	Total ordinary expenditure in 1937	Percentage Increase
	£	£	
A ...	15,200	21,983	44·6%
B ...	33,116	36,078	9·0%

The Commission accordingly feels it necessary to reiterate its opinion that the managements of hospitals should exercise such internal control of expenditure as will ensure a rational maintenance cost. To effect this, the control of expenditure should not, as in most cases it apparently is, be confined to the monthly or quarterly examination of accounts presented for payment. Recently a few of the more

progressive hospitals have instituted a regular procedure for tabulating and comparing quantities and prices of provisions each month. It would be well if all the hospitals followed this excellent example. Quantity statistics are far more reliable for comparison purposes than the total amounts of expenditure expressed in terms of pounds, shillings and pence. In regard to renewals and repairs, some hospitals continue to disregard repeated admonitions not to include items of a capital nature under this heading, while others allow miscellaneous items of repair (effected with almost daily regularity) to be carried out with such lack of adequate supervision that the total thus expended at the end of the year is abnormally high. It is because hospital expenditure, even under the most stringent control, is at all times difficult to keep within economic limits, that hospital administrators should examine their maintenance problems with the maximum care, more especially because the large sums derived from Sweepstakes have tended towards an exaggerated sense of financial security among the hospitals themselves and have given rise to a false idea among the general public that unlimited funds are now available for hospital purposes.

Mental Deficiency and Epilepsy Investigation.

The investigation into the incidence of mental deficiency and epilepsy not associated with insanity, referred to in previous Reports, was completed in 1938 in respect of the Dublin selected area, and arrangements made to continue the investigation for the Cork area during the current year. It is planned to have this latter investigation concluded by the end of 1939.

National Health Insurance Statistics.

The Unified National Health Insurance Society has since its inception been collecting very important data relating to the types of disease responsible for incapacity for work amongst its members. This is the first time that any figures of such statistical value on this subject have been produced in this country, and it is believed that their publication will be welcomed by Hospital Authorities, the Medical Profession, Social Workers, and all interested in hospitals and Public Health matters. It was not possible for the Society themselves to publish this data and, on representation being made to the Commission, the latter body agreed, subject to the Minister's sanction, to include it in its present Report, in the belief that by making such data readily available to the public in general, and to all those specially interested in particular, it was contributing to general enlightenment on this important aspect of sociology. The Society's report is included as a supplement to the present Report.

SECTION II.

HOSPITAL DEVELOPMENT DURING 1938.

General Observations.

There has been a certain amount of criticism during the year of the delay in the furtherance of hospital schemes. Here we think the factors making for delay were not fully appreciated and some of the criticism either was not related to facts or, if so related, was presented in such form as to suggest a misunderstanding of such facts. Delay in the achievement of any object which is designed to confer a public benefit is, of course, a thing which everyone will regret. There are, however, many factors relating to hospital reorganisation and development which must inevitably occasion delay. Many of the recommendations of the Hospitals Commission contained proposals for development very far in excess of what hospital authorities had ever seriously thought out. So far did these recommendations go in this respect that they bore very slight, if any, resemblance to the schemes of development which the hospitals themselves had submitted to the Minister, either in respect of magnitude

or cost of development. It is hardly necessary to say that the more modest a scheme of development is, the more speedily is it likely to be realised. When, therefore, hospital authorities complain that the operation of the Public Hospitals Act, 1933, has had the effect of retarding rather than advancing hospital development, there is an apparent justification for the complaint, in the sense that it did retard the development which these hospitals contemplated at that time, a development which the Commission feels these authorities would now describe as far from adequate to the needs of the people, either in respect of bed complement or organisation. In all probability more accommodation and increased facilities in respect of hospital equipment would have been provided, but the development would have been haphazard, with each hospital attempting to progress along its own lines and bearing very little relation, if any, to a planned hospital system. It may be argued, and indeed has been argued in the criticisms referred to, that such development even if haphazard was preferable to the alternative planned system, since it at least provided some immediate amelioration of the disabilities under which many hospitals laboured. To reason thus, however, is to ignore the facts of human progress not only in hospital development but in practically all aspects of modern human activity. To-day, in practically every country, continued efforts are made to plan hospital progress, in complete contra-distinction to the practice obtaining in the last century where uncoordinated development was the rule. Such haphazard development inevitably created problems which every country has since found it necessary to deal with by some form of planned development. Irish hospitals can no more be divorced from this planning movement than can other human activities such as sanitation, pure water supply, etc., or industry itself. To plan a logical hospital system on virgin ground presents few, if any, difficulties other than financial. Where, however, it is necessary to reorganise a hospital system which has existed through several generations to enable it to conform to modern ideas and requirements, whilst the planning may not present insurmountable obstacles, the realisation of the plan evolved does. One of the most common criticisms of delay in development to-day is that, whereas little has been done for the voluntary hospitals in the cities, there has been continuous and steady development of the Local Authority hospitals throughout the country. There was, as everyone knows, only very indifferent hospital accommodation throughout the greater part of the country. There were, in addition, very few conflicting interests to be reconciled. It was in effect virgin soil, and delay in development did not occur in most counties since the main causes for delay were absent.

When we come to consider the voluntary hospitals we find a very different and more complicated situation. These hospitals, like voluntary hospitals elsewhere, had long been accustomed to operate without very much interference from any outside body. Their sturdy sense of independence, which for long was one of their greatest assets, had the effect of preventing any form of useful co-operation between themselves. Only when their existence was threatened by financial stringency did they really come together to find a solution. Just as it was inevitable that the State, which had rendered the holding of Sweepstakes legal, would be bound to legislate for the proper distribution of the funds realised, when these funds began to assume large proportions, so also was it inevitable that the voluntary hospitals would tend to resent such interference. One of the greatest causes of delay in the development of the voluntary hospitals has been the difficulty of reconciling the demands which the State, as trustee of the people's hospital rights, finds it necessary to make on the voluntary hospitals, with the tenacity with which those hospitals cling to their time-honoured claim for complete individual independence.

By virtue of the Public Hospitals Act, 1933, the Minister responsible for administering the Act is empowered to attach any conditions he deems desirable to any grant from the Hospitals Trust Fund which he may, from time to time, make to any hospital. The principle of the claim so asserted by the State—the right to intervene in the affairs of a hospital (with the solitary notable exception of any matters

governing the appointment or dismissal of staff)—has not been seriously contested by any body of opinion in the country, not excepting the voluntary hospitals themselves. In actual practice, however, it has met with considerable opposition by some of the latter. It is the efforts to reconcile the duties which the State has had imposed on it by law to safeguard the rights of those of its citizens, for whom the hospitals are primarily intended, with the claims of the hospitals for an independence of any State intervention that has been the main cause for delay in voluntary hospital development.

A satisfactory adjustment of the differences which exists on this question is of prime importance to hospital development. Particularly is this the case in the Dublin area, where the scheme of development recommended by the Commission and accepted by the Minister has increased rather than diminished the responsibilities of the State, in respect of the provision of hospital facilities for a large section of the population.

It is not always generally appreciated that voluntary hospitals are not, strictly speaking, under any obligation to admit any and every sick person, whether poor or otherwise, applying for admission to their wards. Under the voluntary hospital system, therefore, there was no legal guarantee that any sick person, and more particularly any sick poor person, needing hospital treatment would be admitted to a voluntary hospital. There was, however, a guarantee of another nature which, although without any legal sanction, was nevertheless fairly effective. It was that those hospitals depended to a very large extent for their existence on the measure of public support which they received by way of subscriptions and donations, legacies, and bequests of various kinds, public entertainments, appeals, etc., and this support was liable to be adversely affected, if these hospitals could not show that they were rendering in return a fairly complete hospital service for that section of the community which could not of their own efforts provide it. The advent of the Sweepstakes has largely negatived the effects of this latter safeguard.

It appears to the Commission that, when its recommendations for general hospital development in Dublin and the treatment of the poor in the voluntary hospitals, now accepted by the Minister, become fully implemented and the Hospital Bureau established, the right of inspection will ensure the efficient functioning of the scheme in its main essentials.

Apart from the delays in the realisation of major hospital schemes, there has been steady progress made in the improvement of facilities in a large number of hospitals during the year. The following are some of the more important developments in this respect.

Dublin General Hospital Situation.

Richmond Hospital.

Pending the realisation of the new hospital, temporary improvements will have to be carried out on the present site to meet the urgent situation created by the dangerous structural condition of the old converted convent building, which, known as the Old Richmond, for many years has served as an out-patient department. This building has been condemned by the Municipal Authorities and, as the expense of rendering it safe would not be justified by any future use to which it might be put, it has been decided to erect a temporary out-patient department which will also provide improved accommodation for the X-ray department. Plans for this new out-patient department are at present in course of preparation. The existing X-ray department is housed in a wooden structure which, whilst in good structural condition, is altogether inadequate in size for the radiological work of a hospital of over 300 beds. The physio-therapy department is housed in a small room off the entrance to the Whitworth Hospital. This room is so small that it does not permit of additional essential equipment required being accommodated there. The plans for the temporary out-patient department will provide for accommodation for an X-ray department sufficiently large to meet present day requirements. When this has been

accomplished, the physio-therapy department will be transferred to the building occupied by the present X-ray department. All the X-ray and physio-therapy equipment, including new equipment which is required, will be transferable to the corresponding departments of the new hospital when the latter will have been completed.

MATER HOSPITAL.

The reconstruction of the former chapel to provide new wards accommodating 29 beds is practically completed. Alternative schemes for utilising the site to the best advantage in realising the new 550 bed hospital are under consideration.

PROPOSED AMALGAMATED HOSPITAL.

Draft provisions for an Amalgamation Bill have been prepared and are at present under consideration by the hospitals concerned, and the early introduction of the necessary legislation is anticipated. An excellent site in the south-western area of the city is available for the new hospital, and it is to be hoped that the progressive lead already given by St. Vincent's Hospital in the selection of site will be followed by the amalgamating group. The available site considered in conjunction with the site for the new St. Vincent's Hospital at Elm Park would prevent possible overlapping, and would enable both hospitals to serve the needs of the south side of the city to the best advantage.

The temporary X-ray department at Sir Patrick Dun's Hospital has been completed and forms a considerable improvement to the hospital's existing facilities.

In general it may be said that the Commission has given every encouragement to hospital Authorities to incur expenditure on improvements which, though of a temporary nature, are justified by the necessity for minimising the deficiencies of the existing hospitals, pending the realisation of their reorganisation and reconstruction schemes.

DR. STEEVENS' HOSPITAL, DUBLIN.

The Minister having decided to accept the Commission's recommendations for the development of the Dublin general hospitals, the position of Dr. Steevens' Hospital in that scheme was given immediate consideration, with a view to enabling the necessary improvement programme to be initiated. As a result of discussions with the authorities of the hospital, a suitable improvement programme was prepared and recommended for adoption by the Minister. The existing hospital dates from 1720 and, while the main fabric is in an excellent state of preservation, considerable outlay had to be contemplated to bring the hospital services up to modern standards. A new out-patient department is being provided, and with this will be incorporated an extension of the existing nurses' home, to provide for nurses and maids for whom adequate accommodation does not exist at present. A new casualty block will link the out-patient department with the main hospital. Internal improvements include the replacement or re-surfacing of worn floors and corridors, transfer of the X-ray department to the ground floor, re-designing of the operating suite, and modernisation of the boiler equipment and kitchens. The cost of the improvement scheme is estimated at £110,511, to which must be added a sum of £5,363 previously recommended on interim schemes. The Commission's report and recommendations are set out in appendix IV, recommendation No. 19.

MONKSTOWN HOSPITAL, CO. DUBLIN.

The Board of Governors of Monkstown Hospital having notified the Commission that the terms of their lease precluded them from undertaking anything but General Hospital activities, a scheme of improvements to the hospital was prepared and recommended to the Minister. This scheme provides for improved accommodation for the nursing staff and an extension of out-patient facilities. The work is in progress. The Commission's report and recommendation in connection with the scheme are set out in recommendation No. 18, appendix IV.

Dublin Children's Hospitals.

Proposed New Children's Hospital.

The chief development to be recorded under this heading is the proposal to provide a new Children's Hospital in the Crumlin area. The proposal is based on the fact that large housing schemes are being carried out in this district, and that these schemes would provide for the transference of large sections of the population from the city congested districts. It is understood that the Crumlin housing schemes involve the provision of some 6,000 houses, which will provide a considerable addition to the 24,141 children who are at present enrolled in the primary schools in the adjoining south-western area of the city. With a view to providing for these developments, His Grace, the Archbishop of Dublin, acquired from the Dublin Corporation a site of approximately 16 acres for the building of a Children's Hospital. The proposed location, being on high ground on the outskirts of the city, is in accordance with modern hospital practice, and its proximity to main lines of communication makes it readily accessible. The original proposal submitted to the Commission provided for a hospital of 300 beds, but in view of the existing Children's Hospital provision and the fact that the new General Hospitals will also provide for a number of children's beds, it was decided to limit the immediate scheme to 125 beds. The new hospital will be under the management of a lay Board. It will be administered by a community of nursing sisters and staffed by lay nurses. Plans for the hospital are at present under consideration by the Minister. The report of the Commission on the project is given in the appendix.

National Children's Hospital, Harcourt Street.

The lack of observation wards in this hospital has been a source of anxiety to the Board of Management for some considerable time, and the consequent inability to suitably control admissions and segregate cases has resulted in outbreaks of infectious disease which have necessitated the closing down of the hospital at intervals. In 1937 the hospital was compelled to cease its activities for a period of 10 weeks on this account. In order to obviate a recurrence of such interruptions of the work of the hospital, the Board of Management consulted the Commission and with its concurrence purchased the adjoining premises of 89 Harcourt Street, known as the Wellington Hotel. These premises have since been remodelled internally and connected with the main hospital. By this extension the hospital has increased its bed complement from 53 to 73 beds, and has considerably improved its admission and observation facilities as well as providing for a rearrangement of staff accommodation. Towards the end of 1938 the Board notified the Commission that No. 86 Harcourt Street was in the market and could be purchased at an advantageous price. The Commission agreed with the Board that the acquisition of these premises would be of advantage in consolidating the services of the hospital at its existing bed complement. The premises have been acquired. Expenditure on these two items has been defrayed from the unexpended balance of Sweepstake funds held by the Board of the National Children's Hospital.

Children's Hospital, Temple Street.

The building of an emergency admission and observation block in connection with this hospital is practically completed. As in the case of the National Children's Hospital, Harcourt Street, the inadequacy of observation accommodation has been responsible for successive outbreaks of infectious disease in the wards of the main hospital. To remedy this position the authorities of the hospital developed a scheme for an admission and observation block of 15 beds and this scheme was proceeded with The scheme also provides for a new mortuary and post-mortem room and, as well as serving as a useful filter against the admission of infectious cases, will mark a considerable advance in the modernisation of the Temple Street Hospital. The cost is being defrayed from Sweepstake funds in the hospital's possession.

St. Ultan's Infant Hospital.

The authorities of this hospital have had in use during the year 10 cots provided as additional accommodation in order to deal with suspected cases of tuberculosis—a problem to which the hospital is devoting special attention. Two two-cot observation wards of temporary construction have also been added as a precaution for the exclusion of infectious cases. Considerable progress has been made by the Board in the acquisition of the site extension necessary for rebuilding the hospital and a tentative scheme for development has been submitted. This scheme visualises the utilisation of the Charlemont Mall frontage for hospital, out-patient department and nurses' home, and is also designed to permit the continued utilisation of the existing hospital during the reconstruction period. A report on the project has recently been submitted to the Minister.

Dublin Maternity Hospitals, General.

Comparative statistics covering the main activities of the three Dublin Maternity Hospitals are given in Part II. These are of interest as showing that the demand for increased maternity bed accommodation and maternity hospital facilities has kept pace with the gradual implementation of the maternity hospital improvement schemes since 1933. The combined bed complements of the Coombe, Holles Street and Rotunda Hospitals totalled 261 beds in 1933 and increased to 364 beds in 1938. The number of in-patients dealt with by these hospitals in 1933 was 7,014 and rose to 9,653 in 1938. The number of births which took place in the three hospitals was, in 1933, approximately 39% of the total births in Dublin City and County in that year. In 1937, the percentage had risen to approximately 46% and 1938 to 47·9%. The concurrent improvement in the maternity hospital out-patient department facilities is represented by the increase in out-patient attendances, which grew from 32,176 in 1933 to 60,375 in 1938. These figures are a clear indication of the needs which have been met by the Minister's implementation of the Dublin Maternity Hospital re-organisation programme.

National Maternity Hospital, Holles Street.

The second section of this hospital was completed during the year and enabled increased accommodation to be placed at the disposal of patients. The new out-patient department has also been put into operation and all services of the hospital, including X-ray and pathological departments, are functioning fully. A certain proportion of patients' accommodation is at present occupied by the nursing staff, as it has been found necessary to increase the number of nurses above the number originally provided for. A house adjoining the hospital has been purchased by the Board with a view to reconstruction as an annexe to the nurses' home.

Rotunda Hospital.

With the exception of the new students' quarters the reconstruction programme of this hospital is practically completed. Work on the students' quarters is well advanced and all departments of the hospital are functioning fully. An application for a grant to cover a programme of additional improvements, not contemplated in the original scheme, was investigated by the Commission and a further grant of £55,819 was recommended, bringing the total amount to be provided from the Hospitals Trust Fund for the improvement of the Rotunda Hospital to £163,283.

Coombe Hospital.

The temporary annexe to the Coombe Hospital was completed and put into operation during the year. The additional 26 beds which it provided have been fully availed of. Preparatory steps have been taken in connection with the eventual transfer of this hospital to the site of the Cork Street Fever Hospital, as recommended in the

Commission's First General Report. It is anticipated that progress on the realisation of the new Dublin Fever Hospital will make the Cork Street site available in the near future for the rebuilding of the Coombe Hospital.

St. Mary's Orthopaedic Hospital, Cappagh.

Pressure on the bed accommodation of this hospital has resulted in overcrowding, with a consequent demand for the completion of the Boys' Ward which was left in an unfinished position pending further consideration of the future extent of the institution. The need for the provision of improved X-ray facilities was also brought to the attention of the Commission. These matters have been examined by the Commission and recommendations have been drafted to deal with them as items in a considered plan of development for Cappagh. A financial recommendation disposing of outstanding loans not covered by previous grants is given in recommendation No. 8, appendix IV.

City of Dublin Skin and Cancer Hospital.

The financial position of this hospital was examined and a recommendation (see appendix IV) was made to the Minister, to make a grant of £3,430 to enable the bank overdraft to be cleared. The hospital had not participated in the Sweepstake distributions prior to the passing of the Public Hospitals Act, 1933, and had no resources with which to liquidate this debt, which represented an accumulation of annual deficits.

South Infirmary, Cork.

This hospital's out-patient department suffered from a number of defects, both in respect of accommodation and equipment, and a scheme for its improvement was dealt with during the year. The site of the existing out-patient department did not lend itself to easy extension, and considerable alterations in original plans were necessary. Most of the difficulties in this respect were finally surmounted and a scheme of extension and improvement, which it is considered possesses many advantages, was approved. The additional accommodation provided includes very necessary increase in waiting accommodation, separate medical and surgical consulting rooms and dental and ophthalmic departments. The hospital put forward a scheme for the provision of a very much larger ophthalmic clinic but, when it was pointed out that the general hospitalisation scheme for Cork was embodying a special eye centre elsewhere, it was agreed that the minimum accommodation for this service should be provided. The plans submitted by the hospital authorities have now been altered to provide one single entrance centrally placed in lieu of the double entrance which was at first favoured. In addition, by a reorganisation of the existing accommodation, great improvements can be effected in the facilities already offered. The cost, estimated at £10,000, will be defrayed from Sweepstake funds in the hospital's possession.

New Maternity Hospital, Cork.

A new site for this hospital has been acquired and the preparation of plans is being proceeded with.

District Mental Hospital, Cork.

To deal with continuous overcrowding at the Cork Mental Hospital, a scheme for the provision of two temporary pavilions was approved and recommended to the Minister. The proposed pavilions can be adapted for other purposes whenever contemplated permanent patient accommodation becomes available. A grant of 50% of the total estimated cost of £21,154 was recommended, in accordance with the details set out in recommendation No. 39, appendix IV.

LIMERICK HOSPITALS.

The Commission's recommendation, accepted by the Minister, for a regional hospital in or near Limerick City to serve the city and county and the adjoining counties of Clare, Tipperary and North Kerry, for cases needing a more advanced type of treatment not provided by the smaller hospitals in these counties, has been regarded by the existing hospitals in Limerick as a threat to their existence, and repeated representations for guarantees of financial support to these hospitals have been made to the Minister. As a result of these representations the Commission, at the request of the Minister, visited Limerick during the year and interviewed the Boards of the two Voluntary General Hospitals in Limerick, namely St. John's and Barrington's.

From these interviews it was evident that no objection was taken to the Commission's regional hospital proposals, but that the possibility of all grants from the Hospitals Trust Fund to St. John's and Barrington's Hospitals being terminated was occasioning considerable concern. It was admitted that the Commission's original proposals for a solution of the Limerick hospital situation, which envisaged the retention of the voluntary system in Limerick by an amalgamation of the existing hospitals and the provision of a new Central Hospital, were not accorded the consideration they deserved when they were made. Further information relative to these proposals is contained in the Commission's First Report.

The Commission pointed out at the interviews that its proposals for a regional hospital envisaged a hospital of 200 beds. The Minister had since increased the number of beds to be provided to 250 and, as this number was considered sufficient for the area, it would not be possible for the Commission to recommend to the Minister that he should give a guarantee to the remaining hospitals of financial support from the Hospitals Trust Fund, since they might prove redundant. That, even if the latter did not prove to be the case, it would be to the greater interests of efficient hospital development in the area to extend the new hospital than to expend large capital sums on reconstruction of the existing voluntary hospitals. The Commission further pointed out that there was no desire to victimise the staffs of the existing hospitals or to jeopardise their interests, and that the best way to safeguard these interests was for them to co-operate with the authorities of the proposed new hospital in making it a complete success in every respect.

There can be no doubt that the provision of a 250 bed hospital in Limerick will mark a distinct advance in hospital development in that area, and should place Limerick in a much more advanced position from a hospital point of view than any other part of the country, with the exception of the medical teaching centres. The objection to a hospital controlled by the Local Authorities, however modern in construction, equipment and staff, which was voiced to the Commission in Limerick, does not agree with the experience in other areas where new and less ambitious hospitals have been provided by Local Authorities. The complaint in these latter areas appears to be that the poorer people find difficulty in obtaining admission because of the demand for accommodation by the better-off classes. The further objection that a new hospital situated a mile or so from the city would impose too great a hardship on the poor because of its distance, is one that might have had weight twenty years ago, but under the conditions of modern transport can hardly be said to have application to-day, and in respect of out-patient services the greater distance of the hospital will help somewhat to prevent abuse of this department, by discouraging the attendance there of those suffering from trivial complaints which could be equally well treated by the Dispensary Medical service in the city.

Regarding the staffing of the hospital, the Commission is of opinion that, if the medical staffs of the other hospitals in Limerick were prepared to co-operate with the authorities of the new hospital, it might be possible to evolve an acceptable scheme whereby they could be incorporated in its medical staff.

DROGHEDA COTTAGE HOSPITAL.

A scheme for improvements to this hospital was examined by the Commission and recommended to the Minister for adoption. The scheme provides for an extension

incorporating a labour ward and maternity beds and involves a slight addition to the hospital site. The hospital holds sufficient unexpended Sweepstake funds to defray the costs of the project. The Commission's report on the proposal is given in appendix IV.

PROPOSED NEW HOSPITAL IN DROGHEDA.

A proposal to establish a new voluntary hospital in Drogheda under the management of the French Sisters of Charity was made the basis of a claim for financial assistance from the Hospitals Trust Fund. The Commission felt unable to recommend a grant towards the cost of the project, mainly on account of the hospital development programme which had already been recommended for County Louth. A report on the project is given in appendix IV.

ROYAL NATIONAL HOSPITAL FOR CONSUMPTION FOR IRELAND, NEWCASTLE.

A grant of £4,880 was recommended to be paid to the authorities of this hospital towards the cost of urgent improvements, including the provision of a new operating block. Particulars of the items covered by the grant are given in recommendation No. 38, appendix IV.

ST. AUGUSTINE'S COLONY FOR MENTAL DEFECTIVES, BLACKROCK.

The reconstruction programme initiated at this Colony for Mentally Defective youths included the building of new pavilions and workshops. The scheme is now nearing completion and the population of the Colony has been increased, according as sections of the new accommodation became available. Additional claims were made during the year for further financial assistance, to allow a new kitchen to be provided instead of the originally contemplated reconditioning of the existing kitchen, and also to vary the proposals in connection with workshop facilities. After investigation the Commission advised the Minister to approve of these variations as providing for greater efficiency in the work of the Colony. A claim for the provision of laundry facilities was withdrawn after discussion, but the proposal to install a disinfector was recommended. The cost of the proposed variations was mainly offset by savings on the original programme, as set out in recommendation No. 34, appendix IV.

HOSPITAL LIBRARIES.

The Hospital Library Scheme, which was inaugurated towards the end of 1937 by a grant of £10,000 from the Hospitals Trust Fund, has been greatly appreciated by the participating hospitals. The service is at present limited to voluntary institutions, of which 57 applied for registration under the scheme in 1938. Books have been allocated to these on the basis of three volumes per bed and 11,678 volumes were issued during the year. The Annual Report of the Hospital Library Council gives particulars of the working of the scheme which, in addition to the supply of books, provides an advisory service for the instruction of hospital administrators on library organisation within the hospital. The issued volumes cover a wide range of interests and are approved by the Council's Book Selection Committee before purchase. A special interchangeable book cover per bed is provided by the Council, to ensure length of life and hygienic safeguards. Hospitals which apply for registration under the scheme are required to (a) provide suitable accommodation for the books, (b) appoint a person who shall be responsible for the safe keeping of the books and (c) adhere to the simple methods prescribed for the issuing and recording of the books. The issued volumes remain the property of the Hospital Library Council.

The Commission regrets an apparent apathy on the part of the general public, to the value of the work which is being carried on by the Hospital Library Council. A wireless broadcast appeal for magazines and periodicals met with a very poor

response. The provision of varied and suitable reading matter for hospital patients should command widespread voluntary support here as in other countries. A service which has been welcomed by voluntary hospital patients would be equally appreciated in Local Authority hospitals and institutions which are not yet covered by the Hospital Library Scheme, and which represent a considerable financial problem beyond the present resources of the Hospital Library Council.

MEDICAL RESEARCH.

The Medical Research Council, set up in the early part of 1937, following a recommendation by the Commission, made further representations to the Minister respecting its future financial position. It was submitted that the grant of £10,000 from the Hospitals Trust Fund, allotted to the Council by the Minister, would be exhausted by about the middle of the year 1939, and a plea was made for a guarantee that annual grants, sufficient to meet the Council's commitments, would be forthcoming from the Hospitals Trust Fund. The Minister referred the application to the Commission for investigation and report.

Regarding the request for a continuity of annual payments in perpetuity—for this is what the representations of the Research Council amount to—the Commission was compelled to have regard to the financial requirements of the hospital reorganisation schemes recommended by it and already accepted by the Minister, and also to the additional schemes not yet finally decided on, and the ability of the Hospitals Trust Fund to satisfy these requirements. Notwithstanding the fact that the fund had increased considerably since its first report on Medical Research was submitted, so also had additional applications for grants. The added factor that the cost of building operations had increased considerably had also to be taken into consideration. The net result of these two latter factors was that the resources in the fund were not sufficient to satisfy the minimum recognised claims on it.

On the other hand, the case put forward by the Medical Research Council for a guarantee of continuity of financial support was already recognised, and the question resolved itself into one of trying to see how its claim could be reconciled with the limitations of the resources of the Hospitals Trust Fund. Could there have been any guarantee of continuity of the success of the Sweepstakes for a considerable number of years to come, it would have simplified the problem of recommending a similar guarantee to the Medical Research Council of annual grants.

Having considered the question in all its aspects, the Commission came to the conclusion that a period of approximately eight years would elapse before the major schemes of hospital development which it had recommended would be realised or, if not completely realised, would have progressed sufficiently to enable a more reliable appreciation of the financial position of the Hospitals Trust Fund to be arrived at, when the question of providing permanent endowment of Medical Research could be more fully dealt with. It, accordingly, recommended to the Minister the granting to the Medical Research Council for a period of eight years of an annual sum of £5,000. Following on further representations to the Minister by the Research Council, the latter made a grant of £25,000 payable at the rate of £5,000 per year for the five calendar years 1939 to 1943, on the understanding that the matter would be again reviewed at the end of two years. The detailed recommendation is contained in the appendix.

Of twenty-nine applications for grants during the year, the Medical Research Council made eighteen awards. There were at the end of the year twenty-one holders of grants engaged on research work, as compared with eleven at the end of the previous year.

SECTION III.

GENERAL OBSERVATIONS AND RECOMMENDATIONS ON PARTICULAR ASPECTS OF HOSPITAL DEVELOPMENT.

ORTHOPAEDICS.

Further consideration has been given to the question of providing suitable facilities for the prevention and treatment of orthopaedic conditions. The subject was fairly exhaustively dealt with in the Commission's Third Report. During the year efforts were made to bring about a more closely co-ordinated orthopaedic hospital system in the Dublin area, where there exist two special hospitals dealing with the problem, namely the Incorporated Orthopaedic Hospital situated in the city (Merrion Street), and St. Mary's Open-Air Hospital which is situated some 4 miles from the city at Cappagh.

The Incorporated Orthopaedic Hospital authorities, in their application for a grant for improvements in the facilities they at present provide, stressed the importance of adding to these facilities by providing an open-air auxiliary hospital in the country somewhat similar to the Cappagh Hospital. Since they also required hospital facilities in the city to replace those now provided at their hospital in Merrion Street, the lease of which was shortly due to expire, the possibility of evolving a combined orthopaedic scheme for the Dublin regional area was examined.

The authorities of St. Mary's Open-Air Hospital were approached, in order to secure their consent to the provision of open-air hospital facilities for the authorities of the Incorporated Orthopaedic Hospital. Provided certain conditions respecting administration were agreed to, the Cappagh authorities were prepared to provide the required facilities adjoining their existing hospital. The conditions stipulated were on the whole reasonable, and necessary for the preservation of discipline in administration.

The authorities of the Incorporated Orthopaedic Hospital were next approached and expressed themselves as favourably disposed to the scheme for the provision of open-air hospital facilities for them at the Cappagh Hospital. They, however, stipulated that in addition to these facilities they should be given facilities in the city practically equivalent to those at present possessed by them in the Merrion Street Hospital. They further stipulated that these latter facilities be provided in a special Orthopaedic Hospital rather than as special orthopaedic sections in the General Hospitals.

It is conceded that for a considerable number of orthopaedic cases, and also for the follow-up of post-hospital cases, convenient out-patient facilities are necessary, and that the provision of such facilities in an open-air hospital, situated some distance from the city, does not fulfil the essential condition of convenience. The Commission, however, holds that such facilities can be better provided by the principal General Hospitals rather than by a hospital provided specially for this purpose. The authorities of the Orthopaedic Hospital hold, however, that orthopaedics is too special a subject to be satisfactorily dealt with in a General Hospital. They argue that in a General Hospital orthopaedics will not be accorded the attention it deserves, and that it will be swamped in the general activities of the hospital. This is a perfectly understandable objection if the practice obtaining in practically all the General Hospitals in Dublin to-day is to continue, but it does not take cognisance of the changes that are either actually taking place or are foreshadowed as fairly immediate developments in these hospitals. It is furthermore not supported by other orthopaedic surgeons in Dublin who have had considerable experience of the working of open-air orthopaedic hospitals. If it were a question of continuing the activities of the Incorporated Orthopaedic Hospital in their existing hospital in Merrion Street and providing for them open-air facilities at Cappagh, whilst it is not a solution that commends itself to the Commission, it might be permissible to

recommend its acceptance as being in the nature of a compromise. The lease of the Merrion Street Hospital, however, will shortly expire and, as these premises are required by the lessors for other purposes, the possibility of continuing orthopaedic treatment there for any considerable time is remote. The proposals of the authorities of the Orthopaedic Hospital, therefore, if accepted, would necessitate the provision of a new Orthopaedic Hospital in the city and of open-air facilities, also new, in the country. The Commission cannot see its way to recommend to the Minister the adoption of a plan of this nature, of which it does not approve in principle and which has the additional disadvantage of necessitating a greatly increased expenditure for its realisation. To the argument that orthopaedics cannot be properly treated in a General Hospital it is submitted that far from such being the case, it is fast becoming the solution of choice in most countries where hospital development has reached a comparatively high degree of perfection.

There does not appear to the Commission to be any sound reason why orthopaedics could not be as well treated in a General Hospital as in a Special Hospital for the purpose, always provided of course that there exists in the General Hospital a sound system of administration for the various specialities that such hospital may be called on to provide. Such specialities as ophthalmology, gynaecology, oto-laryncology are provided for to-day in almost every big General Hospital and it has never been seriously suggested that the treatment of such specialities has suffered by their being located in a General Hospital. Certain essential conditions do undoubtedly require to be fulfilled by the orthopaedic department of a General Hospital so that this speciality shall be effectively treated. One of the most important is segregation whilst another is the provision of trained medical and nursing staff. The orthopaedic department of a General Hospital should form as distinct a unit as, for example, does the ophthalmological or gynaecological department, both in respect of internal and external facilities. The staff should be composed of trained orthopaedic surgeons, with a specially trained orthopaedic nursing staff. If such a department were to be created in each of the four major General Hospitals in Dublin it is submitted that the orthopaedic facilities required in the city, in addition to those provided for in the open-air hospital, would be a distinct improvement on those provided in one special city Orthopaedic Hospital, as advocated by the authorities of the Incorporated Orthopaedic Hospital.

There is just one other aspect of this situation to which the Commission considers it desirable to draw attention. It is what precisely is meant by the term orthopaedics. This is considered all the more necessary, since from discussion, correspondence and public utterances it would seem that attempts are often made to distinguish between some physical deformities and others, and to classify the former under the heading of orthopaedic conditions and the latter under some other heading definitely not orthopaedic. The definition of the term orthopaedics as used in this Report is that given by the late Sir Robert Jones of Liverpool, a world recognised authority on this subject. It is as follows :—"The treatment by manipulation, operation, re-education and re-habilitation of the injuries and diseases of the locomotor system."

If this definition is accepted it will be seen that there are certain conditions treated in General Hospitals to-day which should be included under the heading of orthopaedics. The most important of this group are fractures, they being pre-eminently the result of injuries to the locomotor system. Similarly there appears to be a tendency to regard tuberculosis of the bones and joints as a condition not to be classified as distinctly orthopaedic, but since bone and joint tuberculosis is a disease of the locomotor system it is difficult to see how it can be excluded if the definition of orthopaedics just quoted is accepted. A child suffering from a tubercular hip or an un-united fracture ought to be regarded as a crippled child, just as much as one suffering from some congenital deformity, such as club foot, or acquired deformity, such as infantile paralysis. It is true that some of these conditions can be treated successfully by operative or manipulative procedures, whilst others, notably tuberculosis, require prolonged open-air treatment, but this is not peculiar to the orthopaedic disease group.

The definition of orthopaedics above quoted should, the Commission considers, be accepted. Where an orthopaedic department is created in a General Hospital, this department should embrace the treatment of all the conditions of the locomotor system covered by this definition, the special open-air hospital working in conjunction with these special orthopaedic departments for the treatment of orthopaedic conditions requiring open-air treatment. With such a system in operation the Commission considers that greater encouragement would be offered for the advancement of orthopaedic surgery in the country, and the present shortage of orthopaedic surgeons and qualified nursing staff remedied to a considerable extent. It would have the further advantage of providing more convenient out-patient orthopaedic facilities than would one special orthopaedic hospital, since the four major hospitals would be strategically situated to each serve the city more fully than could one out-patient institution.

HOSPITAL ACCOMMODATION.

Probably the most outstanding feature of hospital activity during the past few years has been the greatly increased demand for accommodation, both intern and in the out-patient departments. It was, of course, inevitable that the publicity incidental to the conduct of the Sweepstakes would have the effect of considerably reducing, if not altogether abolishing, the traditional reluctance on the part of the public to enter a hospital for treatment of any save the most serious illness. It must, however, not be forgotten that the old workhouse hospital had ceased to exist in practically every part of the country long before the new source of hospital income had been thought of and, if the accommodation and facilities provided in the reconstituted hospitals that emerged from the operation of the Local Government (Temporary Provisions) Acts of 1923 and 1926 left much to be desired, there can be no doubt that these hospitals constituted a notable advance on the workhouse system. The hospital consciousness of the people, therefore, had been steadily increasing during the decade before the Sweepstakes were initiated. The improved facilities which this source of income made possible, whilst they have done no more than to quicken this movement, have, however, created fresh problems in respect of accommodation and administration. There appears to be no end to the demand for more and more hospital accommodation, not only in the case of hospitals in cities, but also in the county hospitals. Greater still is the steadily increasing demand for additional facilities for out-patients. In Dublin alone this latter demand is represented by an increase from 627,236 attendances in 1933 to 874,749 in 1938. Where to draw the line that will limit this demand without imposing hardship is a vitally important question from several points of view.

One of the most facile deductions that might be drawn from the enormously increased demand for hospital facilities is that the health of the population has so deteriorated that such increased accommodation is imperative. This was undoubtedly to a large extent the explanation of the intense hospital activity that characterised the latter part of the eighteenth and the beginning of the nineteenth centuries, when such pestilences as enteric, typhus, smallpox and cholera awoke such a healthy fear in the people that action to combat them was essential and urgent. To-day, however, if we except tuberculosis and cancer, the situation is not analogous. In fact the exact opposite is the case. The death rate was never lower, and the expectation of life has increased substantially over what it was half a century ago. Unprecedented advances have been made in the prevention of diseases which a few years ago made enormous demands on hospital accommodation, whilst in treatment many of the diseases responsible for chronic illness have been got well under control, if not completely conquered. For a considerable number of years now, front rank medical scientists have been forecasting the early approach of the time when less and less hospital accommodation will be required for many of the purposes for which it is to-day being utilised. Some go so far as to say that in the designing of such new institutions as those for tuberculosis and acute infectious disease, serious consideration

should be given to the possibility that long before their lives are ended they will be converted for use to altogether different purposes, and a new fever hospital in Glasgow has recently been planned and erected with this end in view.

Why is it then that side by side with the prognostications of those who it must be conceded are competent to make them, that hospitals as we know them to-day will cease within a comparatively short time to be required, there is an ever increasing demand for an increase of such hospitals not only in this country but throughout the world? It may help us to understand better the apparent paradox if we try to ascertain the possible causes and to arrive at some conclusions as to which are the most probable explanations.

Increase of Population.

In a country where the population is increasing, it obviously will be necessary to provide increased hospital accommodation just as it is necessary to provide increased housing accommodation. Even if the decline in demand for hospital accommodation forecast by the leaders in the field of preventive medicine actually occurred, unless the decline was equal to or greater than the increase in population, increased hospital accommodation would still be necessary. Taking Ireland as a whole, increasing population offers no explanation of increased demand for hospital accommodation. It does, however, explain in some degree the Dublin demand where the population has shown a rapid increase in the past two decades, at the expense of the rural community.

Increased Hospital Consciousness.

There can be no doubt that the reluctance to enter hospital for treatment which obtained in the past has now practically disappeared. Not only has it disappeared amongst the poorer sections of the community, but even the comparatively well-to-do people, who formerly were treated at home or hospitalised in private nursing homes, now have no hesitation in accepting treatment in a public hospital, whether voluntary or controlled by Local Authorities, and in fact demand it. This latter development has tended to create still greater difficulties in respect of accommodation. It is obvious that the more the hospital accommodation and facilities provided, whether by Local Authorities or voluntarily, are improved, the greater will be the demand for accommodation by the well-to-do or paying patients, and there is likely to be a danger that the accommodation which was primarily intended for the necessitous poor and the destitute will be seriously encroached upon by this class of patient. Indeed in some areas already, where new and up-to-date hospitals have been provided, complaints in this respect have been publicly ventilated. Yet another development that may be anticipated from the increase in hospital consciousness, coupled with improved hospital facilities, is that patients will demand hospital accommodation for complaints that could equally well be treated at home. In one large hospital in the country, the surgeon in charge recently reported to his Board that there was serious overcrowding and that a large number of the patients were not suitable for hospital treatment. He requested the Board to advise all dispensary doctors to send to the hospital only genuinely suitable cases. A tendency to send non-paying patients to hospital, irrespective of their suitability medically, is not a modern development. On the other hand if a hospital possesses a large number of paying patients the temptation to retain them longer than is necessary, if they are willing to stay, is ever present.

Social Conditions.

The social conditions of the patients do influence somewhat the demand for hospital accommodation. Bad housing conditions often render it imperative that patients who could otherwise be treated at home be transferred to hospital. Similarly, destitution, rendering it impossible to provide even the simplest nourishment necessary

for treatment, renders hospitalisation necessary. If, however, these and other defects in the social system are being dealt with energetically, as they are at present, should the present demand for hospital accommodation for such cases be altogether conceded, when it is obvious that, when the causes are removed, such accommodation will not be so necessary ? This is an aspect of the accommodation problem that is only too frequently lost sight of, when arguments are put forward in support of increased hospital beds.

ISOLATION.

Certain infectious diseases require to be hospitalised for both prevention and treatment. Here again it is extremely difficult to arrive at definite conclusions as to precise requirements, since a proportion of such cases could be as effectively isolated at home if the conditions are suitable as in a hospital, where the danger of cross infection is greater. Moreover, the diseases to-day requiring isolation are all preventable and, with the progress in this branch of medicine, may be expected to show a decrease. It would appear that either the accommodation to be provided for such cases should be of a temporary nature or that, if permanent, it should be so planned as to be readily converted to other uses when no longer required.

CHANGING METHODS OF TREATMENT.

Many conditions previously requiring hospitalisation no longer do so, owing to the introduction of newer methods of treatment, or merely to the discarding of methods previously adopted. Many of the acute infectious diseases are affected by the former, whilst in respect of surgical operations like tonsilectomy and nasal pharyngeal operations, opinion has become more and more conservative. A considerable number of gynaecological conditions previously frequently met with are preventable, particularly those resulting from child-birth, and are on the decrease. On the other hand, however, conditions hitherto considered incurable and therefore not suitable for hospitalisation are now being effectively treated in such institutions. Yet again, conditions hitherto treated in general hospitals now require, owing to the changed methods of treatment that have evolved, special hospitals or special sections in general hospitals. Tuberculosis (Chest Hospitals), Cancer (Radio-therapeutic Institutions), Orthopaedics and acute and chronic rheumatism are examples.

Respecting increasing demand for out-patient facilities, this has grown to such an extent in recent years as to create serious problems concerning accommodation. As in the case of in-patients, this increase cannot be explained by general deterioration of the health of the people. Increasing population offers only partial explanation in the Dublin area, since the rapid increase in out-patient attendances during the past three years is much greater proportionately than the population increase. To the provision of better facilities by the provision of new out-patient departments in some hospitals and equipment in others, coupled with increased hospital consciousness, must be ascribed the main cause for the increase.

The foregoing are some of the principal considerations affecting hospital accommodation, and it remains to consider objectively some of the effects created by the increased demand and to try to estimate their advantages or disadvantages.

The machinery existing for the prevention and treatment of disease is partly Governmental and partly a development of private enterprise. The former consists of two distinct systems, one relating to the Poor Law and the other to the health of the public generally. The backbone of the former system is the dispensary medical service, whereby the country is divided into dispensary districts, usually not excessively large, and each such district is provided with the services of a doctor whose duty it is to provide free medical service, including drugs, to the poor. This officer is employed on a part-time basis and is free to engage in private practice for his own financial benefit. Supplementing the dispensary service is a hospital system, also under the Poor Law. This is usually composed in each county health area of a General Hospital for general medical, maternity and surgical cases, one or more District

Hospitals for medical and maternity cases, and a County Home for the aged and infirm, epileptics and chronic illness, and Fever Hospitals for acute infectious disease. The Public Health system provides for a County Medical Officer of Health with one or more assistants. There is a considerable amount of activity common to the two systems.

The dispensary medical officers are also medical officers of health for their dispensary districts. Their services are being availed of more and more for purely Public Health activities as distinct from Poor Law activities, as for example in operating schemes for diphtheria immunisation. In the Poor Law Hospitals, County Surgeons engage in public health activity such as the removal of tonsils under School Medical Service Schemes. They also treat tuberculosis, mainly non-pulmonary.

The voluntary or private machinery for dealing with disease consists of private practitioners holding no public appointments, who are scattered throughout the country, and those holding appointments in voluntary hospitals, mainly in the cities. These practitioners are not obliged to treat any patients free of charge (excepting, of course, those treated in hospitals). In the absence, however, of a complete State Medical and Hospital Service, they constitute an important factor in the prevention and treatment of disease. Excepting somewhat those holding hospital appointments, who are usually classified as specialists, they, in association with the dispensary doctors, are to a large section of the community what is known as "family doctors," and as such are usually in a singularly favourable position to play a very important part in any measures that require to be taken to preserve the health of the nation.

Now, if hospital development is to be encouraged to proceed to an extent where all but those suffering from the most trivial complaints will become hospital patients either intern or extern, it is certain that the private practitioner and dispensary medical officer will find it increasingly difficult to earn even a modest income from private medical practice, and the income usually derived from private patients by these practitioners will be diverted to the hospitals and their medical staffs. This must inevitably lead to the disappearance of the private medical practitioner and to a demand by the dispensary medical officers for either whole-time employment at commensurate salaries, or for such an increase in their part-time salaries as to make their posts virtually whole-time from the salary point of view, but not from any other. The position could arise, where the hospitals, if permitted unlimited expansion, would be supplying practically all the medical service needed, whilst the dispensary doctors would require to be paid more to compensate for loss of income from private practice, and the private general practitioner would disappear altogether. Dispensary districts might, of course, be enlarged, but is it desirable that the "family doctor," with the unique opportunities he possesses for securing confidence and for disseminating health propaganda, should disappear or be reduced in number? Medical opinion seems to be unanimous that the general practitioner is the most essential factor in the existing medical service, and is equally emphatic that a complete State Medical Service is not desirable. When, however, the question of hospital accommodation crops up, opinion is not so unanimous. Those attached to hospitals hold to the view that much more hospital accommodation than that outlined in the Reports of the Commission is urgently needed. The general practitioner, however, whilst equally of opinion that existing hospital accommodation is inadequate and not of the best quality, is becoming mildly alarmed at the prospect of seeing the greater portion of his practice diverted to the hospitals. The increasing tendency of the better informed, to avail of the facilities for investigation afforded by the hospitals, will inevitably cause considerable reduction in the numbers seeking medical advice from the private practitioner. The irony of this position, if created, would be that at a time when the standard of general medical practice was higher than ever before, fewer people would be availing of it, owing to the attraction of the hospitals. Hospitals, undoubtedly, do possess advantages over the general practitioner in many respects, whilst in many others, the latter is the more important. There does not, therefore, appear to be any good reason why the hospital service should be extended to a degree that would constitute a menace to the continued existence of the family doctor.

SECTION IV.

NURSING.

Nursing Pension Scheme.

Following the passing of the Public Hospitals Act, 1933, one of the earliest applications for a grant from the Hospitals Trust Fund was that made by the Irish Nurses' Union (later changed to Irish Nurses' Organisation) to enable a pensions scheme for nurses to be provided. Following examination of this application the Commission concluded that a scheme of the nature proposed did not come within the terms of the Public Hospitals Act, 1933, and that accordingly no grant from the Hospitals Trust Fund could be recommended in respect of it.

In 1937 the Irish Nurses' Organisation made application to the Minister for a grant to enable investigations into the number of nurses practising in the country to be made. Since such an investigation was related directly to the survey of nursing facilities provided for in the Act, the Commission recommended that a grant of £100 be made to the Irish Nurses' Organisation to enable it to carry out its investigation. This sum was paid directly in 1938 by the Commission with the sanction of the Minister.

The results of this investigation cannot be considered satisfactory. Of a total of 10,000 nurses to whom a questionnaire was sent, replies were received from 3,027 or approximately 30%. These latter were grouped as follows :—

Nurses and midwives in miscellaneous positions	330
Nurses and midwives in non-pensionable positions	266
Nurses in private practice	520
Nurses and midwives 65 years and over	119
Nurses who state no position	208
Invalid nurses	52
Unregistered nurses and midwives	37
Nurses and midwives 65 years and over in pensionable positions	52
Pensioned nurses and midwives	99
Queen's Nurses	94
Midwives in private practice	574
Dispensary midwives	403
Religious Orders	104
Details incomplete	97
Mental nurses	25
Candidates in training	47
Total ...	3,027

It is to be regretted that an investigation which was related so intimately to the welfare of nurses in their old age did not receive a greater response, as it is doubtful if the data collected will prove of value for actuarial purposes, should a Pensions Scheme for Nurses be finally decided on.

District Nursing.

A new District Nurse under the Lady Dudley Nursing Scheme was provided during the year at Barna, Co. Galway, and a grant in respect of her installation and maintenance for the year, amounting to £230, was recommended. In addition grants of £167 7s. 11d., £64 17s. 3d., £200, £47 14s. 6d. and £70 for the maintenance of nurses at Cape Clear Island, Inishmaan, Inishmore, Inishere, and Adrigole respectively were recommended.

SECTION V.

FINANCE.

From the initiation of the Sweepstake scheme in 1930 up to 31st December, 1938, there were twenty-five Sweepstakes held. It will be seen from the financial statement that the position as at 31st December, 1938, was as follows :—

(1) HOSPITALS' PORTION OF SWEEPSTAKE FUNDS—CASH ACCOUNT, 1930–1938.

	£ s. d.	£ s. d.
Total received for all hospitals (including interest)		13,017,379 9 6
Disbursements were made as follows :—		
Direct to Participating Hospitals ...	2,762,501 5 6	
To Minister for Local Government and Public Health for Local Authority Hospitals	1,159,184 6 5	
To Hospitals Trust Fund	9,046,837 1 5	
Leaving a balance (portion of proceeds on Cesarewitch Sweepstake, 1938) not paid to Hospitals Trust Fund till March, 1939	48,856 16 2	
		13,017,379 9 6

(2) THE HOSPITALS TRUST FUND—CASH ACCOUNT FOR THE YEAR ENDED 31ST DECEMBER, 1938.

	£ s. d.	£ s. d.
Receipts from Sweepstakes during 1938 ...		1,386,158 12 3
To this must be added :—		
Dividends and Refunds of Income Tax ...	240,239 4 8	
Profit on Sale of Investments ...	6,026 14 2	
		246,265 18 10
		£1,632,424 11 1
Deduct Disbursements :—		
Capital grants to Voluntary and Semi-Voluntary Hospitals	127,067 5 1	
Grants in respect of deficits	103,055 0 0	
Grants to Local Authority Hospitals ...	340,207 12 4	
Grants to Nursing Institutions ...	579 11 9	
Expenses of Hospitals Commission ...	9,423 1 10	
Expenses of Hospitals Trust Board ...	1,537 14 1	
		581,870 5 1
		£1,050,554 6 0
ADD Balance on hands at 31st December, 1937		7,022,286 3 5
Leaving a balance in the Hospitals Trust Fund at 31st December, 1938 ...		£8,072,840 9 5

The foregoing statements were prepared on the Cash Account basis, in order to show readily and in the most convenient way the monies which accrued from

the proceeds of Sweepstakes for hospital purposes, and the amounts paid in grants and incidental expenses out of the Hospitals Trust Fund. The amount of £8,072,840 9s. 5d. shown as the balance in the Hospitals Trust Fund at 31st December, 1938, is accounted for as follows :—

	£	s.	d.
Investments at cost	7,594,531	2	5
Cash at bank—Deposit Account ...	470,000	0	0
Current Account ...	29,350	19	0
	£8,093,882	1	5
Less :			
Current Account overdraft at bank	21,041	12	0
	£8,072,840	9	5

TOTAL AMOUNT AVAILABLE FOR HOSPITALS AT 31ST DECEMBER, 1938.

To the balance of £8,072,840 9s. 5d. there must be added the sum of £6,330 7s. 6d. in respect of income tax recoverable not collected at 31st December, 1938, and the sum of £48,856 16s. 2d. not paid into the Hospitals Trust Fund until March, 1939, which would make available for hospital purposes the total amount of £8,128,027 13s. 1d. at 31st December, 1938. On the basis of calculation hitherto adopted of two-thirds for voluntary hospitals and one-third for the Local Authority Hospitals, and allowing for the monies already distributed to each, the allocation would be as follows :—

	£	s.	d.
Available for voluntary hospitals at 31st December, 1938	6,255,684	7	0
Available for Local Authority hospitals at 31st December, 1938	1,872,343	6	1
	£8,128,027	13	1

TOTAL GRANTS PAID TO DATE.

The total amount of grants paid to hospitals from Sweepstake Funds up to 31st December, 1938, was £5,760,377 1s. 3d., of which the sum of £3,669,013 7s. 0d. was paid to voluntary hospitals and nursing institutions and the sum of £2,091,363 14s. 3d. was paid to Local Authority hospitals.

HOSPITAL DEFICITS.

The maintenance deficits of the voluntary hospitals continue to increase. The Special Purposes Fund of £2,000,000, which had been set aside for the purpose of yielding an annual income to meet the approved deficits, was increased during 1938 by the addition of securities valued at cost at £596,861 16s. 2d., but the augmented Fund was not able to yield sufficient income to meet the 1937 deficits. The auditors now state that it will be necessary to transfer to the Special Purposes Fund a further sum of about £750,000, which would increase the total amount of the Fund to £3,346,861 16s. 2d.

AMOUNT AVAILABLE FOR VOLUNTARY HOSPITAL DEVELOPMENT.

The amount available in the Hospitals Trust Fund for voluntary hospitals at 31st December, 1938, was £6,255,684 7s. 0d. Deducting the sum of £3,346,861 16s. 2d., as being the amount of the Special Purposes Fund set aside to meet the annual approved deficits, there remains the sum of £2,908,822 10s. 10d. for schemes of voluntary hospital development.

(1) SWEEPSTAKE FUNDS—HOSPITALS' PORTION.

Cash Account for Period 1930–1938.

Receipts.	£	s.	d.	Payments.	£	s.	d.
To Total from Sweepstake Funds, including Interest (25 Sweeps)	13,017,379	9	6	By Amount paid direct to Participating Hospitals ...	2,762,501	5	6
				„ Amount paid to Minister for Local Government and Public Health for Local Authority Hospitals ...	1,159,184	6	5
				„ Amount paid to National Hospital Trustees and Hospitals Trust Board (Hospitals Trust Fund)	9,046,837	1	5
				„ Balance of Proceeds on Cesarewitch Sweepstake, 1938, not paid to Hospitals Trust Fund until March, 1939	48,856	16	2
	£13,017,379	9	6		£13,017,379	9	6

(2) THE HOSPITALS TRUST FUND.

Cash Account for the year ended 31st December, 1938.

Receipts.	£ s. d.	£ s. d.	Payments.	£ s. d.
To Sweepstakes:—				
Cesarewitch, 1937, Sweepstake, per published account	493,366 5 5		By Capital Grants to Voluntary and Semi-Voluntary Hospitals	127,067 5 1
Add—Interest on Deposits up to date of payment to Hospitals Trust Board	655 19 2		„ Grants in respect of Deficits to Voluntary Hospitals ...	103,055 0 0
	494,022 4 7		„ Grants to Local Authority Hospitals	340,207 12 4
Less—Received on account before 31st December, 1937	450,000 0 0		„ Grants to Nursing Institutions	579 11 9
		44,022 4 7		570,909 9 2
Grand National, 1938, Sweepstake, per published account	503,485 12 10		„ Expenses of Hospitals Commission including Mental Deficiency Investigation	9,423 1 10
Add—Interest on Deposits up to date of payment to Hospitals Trust Board	650 0 5		„ Expenses of Hospitals Trust Board	1,537 14 1
		504,135 13 3		
Derby, 1938, Sweepstake per published account	437,511 12 2			
Add—Interest on Deposits up to date of payment to Hospitals Trust Board	489 2 3			
		438,000 14 5		
Cesarewitch, 1938, Sweepstake—Payment on account		400,000 0 0		
		1,386,158 12 3		
„ Dividends and refund of Income Tax ...		240,239 4 8		
„ Profit on Sale of Investments—*Less* premiums paid against redemption of bonds ...		6,026 14 2		
Total Receipts ...		1,632,424 11 1	Total Payments ...	581,870 5 1
„ Balance on hands at 31st December, 1937		7,022,286 3 5	„ Balance on hands at 31st December, 1938*	8,072,840 9 5
		£8,654,710 14 6		£8,654,710 14 6

* To this Balance there should be added the sum of £6,330 7s. 6d. Income Tax recoverable, not collected at 31st December, 1938, and the sum of £48,856 16s. 2d. not paid to the Hospitals Trust Fund until March, 1939 (See Account No. 1).

SECTION VI.

MISCELLANEOUS.

Hospital Administration.

Reference by the Commission in its Reports to deficiencies in hospital administration has evoked adverse criticism by some hospital authorities. This criticism would appear to be mainly dictated by a desire on the part of these authorities to defend the administrative systems in their hospitals, and the staffs which operate them. It should be stated at the outset that there was never any intention on the part of the Commission to single out individual hospitals or individual administrations for adverse criticism. It has been its experience since its inception that hospital authorities and their administrative staffs have spared no efforts to assist it by every means in their power in its investigations, often at very considerable inconvenience to themselves. The Commission's comments, therefore, should be regarded as an effort to stimulate a greater interest in the growing importance of hospital administration amongst all those associated with the conduct of hospitals, rather than an indictment of individual hospital administrators, whose difficulties are fully appreciated.

Few hospitals, the Commission feels, will deny that, up to comparatively recently, only very scant attention was paid to hospital administration in comparison with that given to their purely medical activities. There were two principal reasons for this attitude, one the expense involved in providing adequate trained administrative staff and the other the fairly widespread opinions that, once a competent medical staff was provided in a hospital, its smooth and efficient running was assured. Naturally there was no great desire to provide the former, when its importance in the life of the hospital was not fully appreciated. It should be clearly understood that this was an attitude towards administrative problems in hospitals that was by no means confined to this country. It is only in comparatively recent times that hospital authorities in other countries have come to realise the importance of up-to-date administrative methods in their institutions. In Great Britain and the United States of America scant attention was paid to the importance to the hospital of a well organised and efficient administrative department. The change in outlook that has taken place in these countries is almost exclusively due to the initiative and enterprise not of the hospital Boards but of the officers of the administration departments themselves. These men, from their daily contact with the intimate administrative life of a hospital, had little difficulty in appreciating the many defects in administrative methods which obtained and the economy and efficiency of service which would result from remedying them. In England the Association of Hospital Officers was created, whilst in America a somewhat similar organisation, the Association of Hospital Administrators, came into being. The first task these organisations set themselves was the improvement in the standard of efficiency of all those employed in an administrative capacity in hospitals. This was achieved by the laying down of a definite curriculum, with examinations, and the granting of a diploma to successful candidates. The next great step was to persuade hospital Boards of the importance of insisting on a minimum standard of efficiency when recruiting an administrative staff. This was no easy task and the reason is not difficult to seek. As previously stated, hospital Boards were accustomed to regard the provision of a competent medical and nursing staff as the only staff problem that deserved any serious consideration. These staffs, themselves, the medical in particular, engrossed fully in their own special activities, did not appreciate the importance of a sound administrative department or, if they did in a general fashion, being without business training themselves, they did not fully understand the various requirements of such a department. The medical staff will inevitably have more influence in a hospital than will any other group, by reason of the nature of their work. It does not detract in the slightest from their unselfish interest in the welfare of the hospitals, to which they give their services free, to say that, not being conversant with the details of hospital administration, they could

not be expected to use the great influence which they possessed in the hospital to bring about a radical change in administrative methods. The more progressive hospital administrators, therefore, in their efforts to improve the standard of administrative efficiency, were often confronted with open opposition from their Boards, and general apathy from the medical staffs. It was only with the greatest difficulty that they were able to persuade these Boards of the value of the standards of efficiency they had brought about, and of the necessity for having regard to the qualifications which were required when recruiting staff for the administrative departments. They were helped considerably by the financial difficulties which hospitals in both countries have experienced since the war. As has been the experience in ordinary commercial life, when hospitals could show each year a sound financial position the happy-go-lucky administrative methods in operation were not questioned. When, however, many hospitals found themselves, as they did, in the gravest jeopardy of complete extinction, and when at the same time increasing attention was focussed by progressive minds on the outworn methods of administration in operation, hospital Boards could not afford to ignore the importance of the administrative department, and even the medical staffs were roused from their understandable apathy. The result was a vast improvement in hospital administrative methods in these countries. Notwithstanding this improvement, progressive hospital administrators still maintain that there is yet much leeway to be made up, before hospitals can claim to be in any way in step with the advances made in the commercial and industrial world. In the United States of America a further step has been taken to advance the standard of hospital administration, by the creation of colleges devoted exclusively to the training of hospital administrators. The University of Chicago has, in addition, actually created a special course on this subject.

When we turn to this country, we are faced with the situation that no such developments as above outlined have taken place. It is no detraction from the work which most hospital administrators in this country have been doing, particularly in the past few years, to say that unless their importance in the life of the hospital is recognised by hospital authorities and by the medical staff, which nearly always exercise such considerable influence in the hospital, they can never be expected to discharge their onerous duties with complete satisfaction. Since efficient hospital administrators are indispensable to the economical and efficient conduct of the hospital there should be no reason why hospital Boards should not exercise the greatest care in their selection, and once they are given a position of responsibility they should as a matter of right and justice be given authority commensurate with that responsibility. In the purely medical sphere it should be realised that the hospital statistician is as essential an adjunct to assessing the achievements of the medical activities of the hospital as are the individual medical men who are primarily responsible for these achievements. In the sphere of medical research he is no less indispensable.

There is another aspect of hospital administration, particularly in its relation to recruitment of staff, to which the Commission desires to call attention. There are in this country two distinct hospital systems, the hospitals controlled by Local Authorities and the Voluntary Hospitals. Owing to developments in recent years the former system is beginning to assume an importance in the hospital life of the country it did not hitherto possess. The hospitals operating under this system are in many respects comparable in accommodation and equipment to the best voluntary hospitals. In some centres they may be expected to outstrip the voluntary hospitals in this respect. Under Local Authority administration, the recruitment of staff to the more important positions is achieved by a method of selection which has met with widespread approval, namely the Local Appointments Commission. It behoves voluntary hospital authorities to have serious regard to the manner in which staff is recruited, lest they find themselves in a position of inferiority in this respect to Local Authority Hospitals, which up to a few years ago were not regarded in any too flattering light. The Public Hospitals Act, 1933, under the terms of which voluntary hospitals receive capital and maintenance grants from the Hospitals Trust

Fund, does not empower the Minister to attach to such grants any conditions governing the appointment and dismissal of staff. Where, however, such large sums of money are involved, the Commission considers that the Minister should have an interest in the standard of administrative efficiency obtaining in any particular hospital when releasing the grants he may, from time to time, make to such hospital. The degree to which hospitals themselves are successful in improving their administrative machinery will, the Commission considers, be a measure of their interest in realising a really efficient hospital service.

Apart from the importance of a competent internal department for the normal administration and co-ordination of a hospital's activities, there is the added necessity at the present time for such a department to cope with the unusually abnormal developments that most hospitals are contemplating. Developments involving the expenditure of vast sums of money will, it is hoped, shortly be under way and it is of the highest importance that such hospital administrative departments should be competent to deal with the numerous problems which are incidental to considerable capital expenditure. Hospital authorities should therefore be advised to see that this department is fully capable of dealing with the large scale developments which are contemplated. The Commission is not satisfied that the administrative machinery in many hospitals to-day is capable of undertaking efficiently any but the simplest administrative duties but that, if called upon to cope with the complicated tasks that will be encountered in such future developments as the complete reconstruction of a hospital, they will be unable to do so, with the result that considerable difficulties and perhaps financial loss will eventuate. In some instances, where considerable development has already taken place such difficulties have occurred, necessitating the most arduous and complicated investigations subsequently. There are, furthermore, numerous examples where a considerable number of developmental activities are conducted by agencies not directly related to the administration department. Architects, for example, often carry on all the correspondence, interviews, etc., incidental to some particular aspect of hospital development. In such cases it is obvious that the hospital secretary and the administration department generally can have no exact knowledge of what is actually happening in respect of such development. It would, therefore, be unfair to blame them for the difficulties that may subsequently result, and the responsibility for such must be borne by the hospital authorities who permit such unbusiness-like methods in their institutions. A hospital secretary or superintendent should be intimately acquainted with every matter relating to his hospital. If a hospital Board permits activities to be undertaken by all and sundry, without the knowledge of the secretary or superintendent, it must accept the responsibility for the resulting chaos.

It has been contended, in reply to criticisms of hospital administration in previous Reports of the Commission, that hospitals do not possess adequate administrative staff, and that any attempt to remedy this defect is resisted by either the Commission or the Minister on the grounds of the expense involved. It is well, therefore, that the Commission's attitude on this question be clarified. In its criticisms on rising expenditure in hospitals, no specific reference has ever been made by the Commission to extravagance on personnel in administrative departments of hospitals. Its criticisms have been mainly directed to what it considers are the main defects in administration, namely absence of adequate supervision of the activities of the hospital, mainly responsible for increasing expenditure. It believes that the cost of remedying the defects in the administrative machinery in a hospital, so as to procure proper supervision of expenditure, would be repaid many times over by the savings which such supervision would show, and would accordingly strongly advise the Minister to consider sympathetically any schemes for improved administrative methods, which the hospitals may from time to time submit to him.

From what has already been said it will be clear that, having provided proper administrative machinery for the routine conduct of a hospital in all matters relating to its primary function, namely the accommodation and treatment of the sick, the

next most important function of such an institution is the efficient control of income and expenditure. A secretary or superintendent, however efficient, cannot be expected to adequately cope with the many and varied factors governing income and expenditure in a hospital of average size, since by far the greater portion of his time is occupied with day to day matters relating to the accommodation and treatment of the sick. A qualified hospital accountant is, the Commission considers, an essential adjunct in the administration department of such a hospital. Dealing exclusively with the financial aspect of the hospital's activities, this officer would be in an ideal position to supervise expenditure, to suggest ways and means for economy without detracting from efficiency, to devise methods for increasing income without inflicting hardship, and to render numerous other financial services of utility to the hospital administration department.

Reference has already been made to the steps that are being taken in other countries to improve the standards of hospital administration, and University educational interest in this subject is evidenced by the initiative shown by the University of Chicago in promoting facilities for the training of hospital administrators. It is a subject of such great importance that the Commission does not consider it too much to hope that our own Universities will develop an interest in the subject sufficient to provide facilities of a similar nature. The experience gained in the short time that hospital administration has been taught in Chicago University has demonstrated that the subject is more complicated than even the most progressive protagonists of its importance were disposed to believe.

The relationship of the medical staff of a hospital to the administration aspect calls for a few comments. It goes without saying that the more efficient is the general administration of a hospital, the better will be the all-round treatment of the patient, if we use the word treatment in its broadest sense and not in the purely medical sense. This must inevitably prove of considerable assistance to the medical staff in their treatment of the patient. They will not be so worried with complaints regarding food and the manner in which it is served, complaints of discourtesy on the part of any of the hospital's officers, or of the numerous other often trivial matters which tend to make a sick person irritable and to play some part in retarding recovery. The medical staff will naturally also be interested in having a sound system of medical recording in their hospital, to aid them in their work and enable them to study their cases more thoroughly. No record system, however perfect, will succeed in the absence of a competent administration department. It is to be regretted, however, that there is sometimes to be observed—and here again it may be stated not only in this country—a tendency on the part of members of medical staffs of hospitals to resent any suggestions being made to them by lay men respecting possible improvements in administrative procedure. Fortunately, such an attitude is not widespread and the Commission feels that, with the rapidly growing sense of appreciation of the importance of the administrative aspect of hospital activity amongst that section of the medical profession associated with hospitals, the latter will use the great influence they possess with hospital authorities to promote efficient administrative departments. In promoting measures for the training of suitable hospital administrators their influence would also be very great, and their co-operation in this respect invaluable.

To conclude on the subject of hospital administration, the Commission again desires it to be understood that its remarks are not intended to cast any reflection on the hard working and conscientious men and women who staff the administration departments of the hospitals. Rather is it its wish to help these officers by focussing attention on their importance in the hospital field. If it refers to defects in administration, it is aware that often such defects are rather the result of general indifference to the subject on the part of hospital authorities than of any lack of ability or responsibility in administrative officers. If it makes suggestions for remedying such defects and for raising the standard of administrative efficiency, it is solely from a desire to impress on hospital administrators the necessity for strengthening the claim they possess, to be regarded as being as essential to the proper conduct of a hospital

as any other department of service in that hospital. In a previous Report it welcomed the formation of an Irish Hospitals Officers Association, as it is keenly conscious of the extent to which such a co-ordinating body can influence hospital administration in this country in the future.

HOSPITAL RECORDING.

Hospital recording in Irish Hospitals was confined to the keeping of simple medical records until the advent of the Sweepstakes, when the necessity for furnishing more detailed particulars of their activities compelled them to enlarge the scope of their record departments. The first legislation which authorised the promotion of Sweepstakes made it an essential condition for a hospital, in order to benefit from such Sweepstakes, that it should treat at least 25% of its patients free of charge. It, therefore, became necessary for hospitals to keep records of their free patients. Later legislation, under which the funds accruing from Sweepstakes were distributed to hospitals by a Committee of Reference in accordance with the needs of each hospital, made it necessary to furnish to this Committee still more detailed particulars, and a further step in the development of hospital recording was registered. The Public Hospitals Act, 1933, under the terms of which the Hospitals Commission was created, called for still more detailed records, since the Commission was charged under the Act with "surveying generally the existing hospital facilities, the needs of the people for such facilities and the adjustment of such facilities to such needs." The hospital survey, made necessary by this legislation, called for the furnishing by the hospitals of details of their activities which they had not hitherto been called on to provide. They, naturally, experienced considerably difficulty in supplying the data requested of them but, on the whole and considering the backward state of hospital recording, the response may be considered to have been fairly satisfactory. Thus a still further advance in hospital recording resulted. Notwithstanding such advances however there is yet much leeway to be made up and, strictly speaking, hospital recording is still in a very elementary stage in most of our hospitals.

The greater the demand for increased hospital development the more necessary does it become to have detailed information respecting actual hospital activity and the precise needs of the people for increased hospital facilities, so that the extent of additional requirements can be assessed with some degree of accuracy. A hospital may have all its beds continuously occupied and in addition have a long waiting list, and yet such a position may not indicate that there is a need for additional accommodation. If a large proportion of the patients are of the chronic type who should not be in the hospital at all, or if patients are admitted for trivial complaints, or if an undue proportion of paying patients are catered for, it is obvious that a hospital can deceive itself and others that its accommodation is insufficient for the needs of the population it serves, unless a more detailed analysis based on accurate records is made of these and other factors.

The expenditure of colossal sums of money on hospital development is another very cogent reason for improving hospital recording. When hospitals were leading a more or less hand to mouth existence and when they were small in size and relatively easily managed, whilst it may not have been good practice, it was at least understandable that the necessity for detailed recording of their activities was not considered so important. To-day, however, no authority responsible for the disbursement of such relatively large sums of money to hospitals can do so without insisting that a detailed account of the uses to which such money is put shall be rendered regularly. Before the hospitals can fulfil requirements in this regard their recording systems must be brought more up to date.

Hospital recording falls under two main headings, medical and administrative. Most hospitals have been accustomed for many years to the keeping of medical records of patients treated. There has, however, been a noticeable lack of uniformity in the types of medical records kept by the hospitals, those kept in some being of a very detailed nature, whilst in others only the minimum amount of information appears

to be recorded. It would be very desirable if hospitals would themselves combine for the purpose of evolving a standardised primary medical recording system.

Administrative records in hospitals were, as previously stated, of the most primitive kind until comparatively recent years. They are still far from satisfactory. When it is realised that a hospital administrator, however efficient, cannot hope to conduct the business affairs of such a large and important institution unless he has the most intimate contact with every activity therein, the need for an efficient recording system will be appreciated. Obviously he cannot personally attend to every detail of his hospital's daily activity. It will be necessary to delegate duties and powers to sub-ordinates. When he does this he will inevitably lose touch and control, unless he has a system whereby he can keep check on how the duties and responsibilities he has delegated to others are being performed. Nor will he be able to satisfactorily fulfil the demands that will be made on him for detailed information respecting the activities of his hospital, if his records of such activities are not systematically compiled. Hospital Boards should not be satisfied with such methods and should realise that when applications for grants from the Hospitals Trust Fund are under consideration, mere statements of what a particular hospital is doing, unsupported by detailed and systematized records, cannot be accepted in their entirety, where the disbursement of considerable sums of money is concerned.

The Commission would again here like to emphasise that its criticisms of hospital recording, like those respecting administration generally, are not meant to be destructive. It fully appreciates the difficulties which prevented hospitals from being as up-to-date in this respect as is desirable. Its remarks are primarily intended to be helpful to hospital authorities by stressing the importance of good records of day-to-day activity. Whilst it is no part of its function to perform duties which are the prime function of the hospitals themselves, or to interfere in their internal administration, it is prepared to be helpful where it can. In this respect it has suggested to one hospital the desirability of experimenting with a system for the better and simpler utilisation of hospital records, and this system is at present under trial and appears to be of considerable assistance to the administrative staff. If found satisfactory it is intended to suggest to the other hospitals the desirability of adopting a similar system. From the nature of its work the necessity for some such system is perhaps more apparent to the Commission than to any other Body. In the many hospital problems that confront it from day to day the desirability of having a record of the different kinds of diseases treated in the hospitals is very great. All the general hospitals, for example, treat cancer, tuberculosis and orthopaedic conditions. Yet there is a strong demand for special hospitals for these conditions, as in the case of the proposed radium therapeutic institute for the treatment of cancer, and chest hospitals for that of tuberculosis. It is extremely difficult to estimate with any degree of accuracy what accommodation is required in such special hospitals, in the absence of detailed information respecting the activities of the general hospitals in treating these diseases. Aagin the number of short term patients, or the number of patients admitted for examination only, are all factors which play a large part in estimating hospital requirements. Hitherto the Commission has been reluctant to impose on hospitals the task of supplying it with detailed information of this nature, in view of limitations in their administrative machinery and the large demands it has been making in respect of other hospital activities. The information, however, is necessary if the dangers of haphazard development are to be avoided, and it was with a view to making the task of supplying such information as light as possible for the hospitals that the system above referred to was suggested. If it proves to be successful in this respect in the trial it is now undergoing, it is to be hoped that the other hospitals will adopt it, as an aid to their existing recording systems.

In previous Reports the Commission referred to the services that could be rendered to hospitals in the matter of records by the proposed Bed Bureau. The centralisation of recording permits of the economic employment of methods of detailed recording which are not so feasible if applied by each individual hospital. It has the further advantage that it enables greater uniformity in recording to be maintained.

No matter what system of recording the multitudinous activities of a hospital, and tabulating the results in useful form, may be finally evolved, it cannot be successful unless every one associated with the hospital's activities accords to the subject the consideration it deserves. If the preliminary recording, whether purely medical or administrative, is not performed in a satisfactory manner no system, however perfect in other respects, can compensate for the defective records that will result. It is, therefore, of the utmost importance that great care be exercised to ensure that the original records are as complete as it is possible to have them. In the case of the medical record, it is usually the practice in this and other countries to place the responsibility for complete medical records on the senior surgeon or physician responsible for the patients to whom such records apply. Busy staff men do not usually themselves complete the record. If, however, the staff man does not fully appreciate the necessity for complete records, and as a result does not take sufficient pains to see that they are kept in the manner prescribed, it will become quite impossible to utilise such records for any but the most elemenetary statistical purposes.

Hospitals and Emergency Precautions.

The intensive efforts which are being made in all European countries today to minimise the effects of aerial bombardment of the population include special attention to the part to be played by hospitals. Where the possibility of such bombardments is great, and where they may be continuous over a lengthy campaign, it is obviously necessary to take elaborate precautions in ensuring continuity of hospital service, particularly in areas of dense population. In common with other buildings, hospitals may be called upon to withstand the effects of high explosive bombs, aerial gas and incendiary bomb attacks, but while the interruption of general commercial activities may be anticipated with a degree of equanimity, the time of crisis must inevitably involve an intensive demand on hospital services, which must be planned to function continuously and to the best effect under such adverse circumstances. Emergency schemes to enable this to be done include :—

(1) Plans to evacuate patients in order to make beds available for casualties.
(2) Fire precautions to minimise the effects of incendiary bomb attacks.
(3) Provision for excluding gas from hospital buildings.
(4) Storage of emergency water supplies and safeguards against breakdowns of electrical supplies.
(5) Provision for controlling lighting as a precaution against night attack.
(6) Provision against interruption of essential medical supplies.
(7) Provision against interruption of food supplies.

The degree of attention to be paid to safeguarding these services depends, of course, on the degree of risk of air bombardment and the intensity and suddeness of attack to be anticipated. These factors can be assessed only by the competent authorities and therefore, in view of the comparatively isolated position of this country, it would be extremely injudicious of individual existing institutions to take any steps involving financial outlay, except in accordance with considered plans which may be evolved by the authorities responsible for promulgating Air Raid Precaution schemes. This is particularly important in the case of hospitals which it is intended to replace by amalgamation, transference to new sites, or rebuilding to a considerable extent. It is obvious that air raid precaution expenditure on such hospitals for an interim period should be kept at a minimum, unless it can be efficiently related to schemes for the permanent utilisation of the sites or buildings for hospital purposes.

The minimum precautions which should be taken in existing hospitals should provide for the training of personnel to deal effectively with emergency fire outbreaks and the allaying of possible panic consequent thereon. Apart altogether from air raid precautions, this service should be regarded by all hospitals as a routine precaution,

as urged in the Commission's Third General Report. Periodical inspection of fire-fighting equipment, test drills, and instruction of staffs in emergency procedure under trained supervision should have a definite place in the organisation of each hospital. This is particularly necessary in the case of old or adapted buildings, to enable an emergency to be dealt with promptly and efficiently and so minimise danger to life and property.

The extent to which the design and location of new hospitals should be affected by air raid precaution considerations is a matter for serious thought. Proximity to centres liable to attack involves a risk which cannot be altogether disregarded in designing a new hospital. The special technique which has been developed in more seriously threatened countries for dealing with war contingencies is available for study in this connection, but it is obvious that a due sense of proportion must be observed in applying this technique to hospitals in this country, if building costs are to be kept within reasonable limits. Here again the advice of the competent authorities should be sought in assessing the degree of risk which might reasonably be provided for.

Hospital Planning.

It is again necessary to stress the importance of close collaboration between hospital authorities and their technical advisers in the preliminary stages of reconstruction programmes, so that essential requirements may be efficiently provided for in planning and the cost of realising them closely approximated. There is still evidence that hospital managements do not yet fully realise the necessity for this methodical approach to the development of their schemes. In many cases the supporting particulars which accompany claims for grants from the Hospitals Trust Fund are of a most general nature, particularly in regard to financial implications and, even when the initial information has been subsequently elaborated, omissions or extras have been made the basis of additional financial claims and have caused considerable delays in the completion of approved schemes. To avoid difficulties of this nature, the preliminary requirements of each scheme should be closely examined by the hospital architect in conjunction with the medical staff and the heads of the various departments concerned, and the sketch plans and estimates prepared as a result of these consultations should be as complete a presentation of the contemplated scheme as possible under the circumstances. Supplementary claims in connection with sanctioned schemes have in some cases been due to lack of attention on the part of technical advisers to matters which should have been the subject of the initial survey made of the problem—particularly in the case of necessary improvements to existing institutions. Unauthorised variations in the carrying out of sanctioned schemes have also been made the basis of post factum claims on the Hospitals Trust Fund. Such looseness makes for delay and can be avoided only by the completeness of the technical advice afforded to hospital authorities in preparing their improvement schemes.

Ambulance Services.

An investigation into the ambulance services provided in the country was carried out during the year. Questionnaires were sent to all Local Authorities responsible for the provision of ambulance services, to voluntary agencies, and to certain hospitals which provide ambulance facilities. A table showing the number of ambulances in each area is given in Part II, together with one showing the cost of operation, the receipts from paying patients, number of patients carried, public and private, total mileage covered and the mileage covered by the transport of patients to main hospital centres.

The latter figures are interesting as showing the proportionately large mileage and the great variations in this mileage covered by ambulances operating in different Local Authority areas. They help to illustrate two features of hospital practice in this country. The first, namely the proportionately large mileage, is a reflection of

the practice whereby a considerable proportion of the hospital work of the rural areas is performed in hospitals outside the area. These latter are in the main the hospitals located in the principal hospital centres, Dublin predominating. The variations in the mileage are to some extent due to the greater proximity to the main hospital centres of some areas as compared with others. This, however, is not a complete explanation since some of the areas near the main centres show much greater mileage than comparatively remote ones, as for example the County Carlow with an ambulance mileage of 18,934 and the County of Cavan with only 6,506 miles. It will be noticed by those who are conversant with hospital development in the rural areas that, in those in which a good internal hospital service exists, the ambulance mileage for transport to external areas is much less than in those where the standard of hospital service is not so high. This feature is of considerable importance, inasmuch as it constitutes a factor that it is necessary to take into account in estimating the degree of accommodation required in the main hospital centres, particularly in Dublin. In practically all County Authority areas, schemes of hospital development have been sacntioned, which will have the effect of bringing these areas up to the standard now enjoyed by but a few counties. This development will have the effect of reducing the demand from rural areas for bed accommodation, and in the case of Dublin in particular it is questionable whether the demand for further increased bed accommodation, owing to increase in population, will not be more than offset by the decrease in the demand from rural areas, when the hospital schemes contemplated for these areas have been realised. Since a considerable portion of the income of city hospitals is derived from the payments made by Local Authorities in respect of patients treated in these hospitals, a diminution in the income from this source has to be anticipated. It would, therefore, be desirable to proceed cautiously in the matter of deciding on further increased bed accommodation in the main hospital centres until the effects on demand by rural areas can be more accurately estimated, since not only is there the risk of too liberal accommodation being provided but a considerable source of income will be lessened, with consequent additional demand on the Hospitals Trust Fund for the maintenance of accommodation that may not be really required.

SECTION VII.

SUMMARY OF SPECIFIC RECOMMENDATIONS OF THE HOSPITALS COMMISSION TO THE MINISTER FOR LOCAL GOVERNMENT AND PUBLIC HEALTH DURING THE PERIOD 1st JANUARY—31st DECEMBER, 1938, REGARDING APPLICATIONS FOR GRANTS FROM THE HOSPITALS TRUST FUND.

(I) Applications Recommended to be Granted.

Name of Hospital or Institution	Purpose for which Grant was required	Amount applied for	Amount recommended
		£ s. d.	£ s. d.
VOLUNTARY AGENCIES.			
DUBLIN :			
Catholic Children's Hospital (proposed) ...	Erection of new Catholic Children's Hospital	Not specified	Grant recommended—not specified.
Catholic Institution (St. Mary's) for the Deaf and Dumb, Cabra	To meet extra expenditure due to Conditions of Employment Act and tariff duties on materials	3,273 7 1	3,273 7 1
City of Dublin Skin and Cancer Hospital ...	To provide a Contact Therapy X-ray apparatus	460 0 0	460 0 0
	To liquidate bank overdraft	3,430 9 3	3,430 0 0
Rotunda Hospital	To convert existing X-ray apparatus into an efficient shock proof installation	681 10 0	681 10 0
	For improvements, repairs and equipment	39,626 0 0	55,819 0 0
	To provide Mortuary table, mahogany cots, etc.	91 18 0	See Recommendation 2.
Rotunda and Coombe Hospitals ...	To provide for the appointments of two anaesthetists	Not specified	Grant recommended—not specified.
Royal Victoria Eye and Ear Hospital ...	For improvements to main entrance and railings	1,000 0 0	924 0 0
Steevens' (Dr.) Hospital	To provide for the replacement of ward equipment, etc.	455 15 1	455 15 1
	To provide for general improvements and endowment	304,061 0 0	110,511 0 0
DUBLIN CO. :			
Monkstown Hospital	To improve and recondition the hospital	3,715 6 8	1,977 0 0
St. Augustine's Colony for Mental Defectives	To erect new kitchen, laundry and disinfector	5,350 0 0	415 0 0
St. Mary's Open-Air Orthopaedic Hospital, Cappagh	To liquidate outstanding loans	16,629 0 0	8,000 0 0
St. Michael's Hospital, Dun Laoghaire ...	To purchase adjoining house property	Not specified	Grant recommended—not specified.
LOUTH :			
Drogheda Cottage Hospital	To provide increased accommodation and general improvements	Not specified	Scheme concurred in.
WICKLOW :			
Royal National Hospital for Consumption for Ireland	For the general development and improvement of hospital	5,457 0 0	4,880 0 0
MEDICAL RESEARCH COUNCIL	For furtherance of the work of the Medical Research Council	10,000 0 0	5,000 0 0 (per annum, for 8 years).

(I) Applications Recommended to be Granted.—*continued.*

Name of Hospital or Institution	Purpose for which Grant was required	Amount applied for	Amount recommended
		£ s. d.	£ s. d.
Lady Dudley's Nursing Scheme	To provide part maintenance of nurse on Cape Clear Island for the year ending September, 1939	167 7 11	167 7 11
	To provide part maintenance of nurse at Inishmaan, Aran Islands, for the year ended February, 1938	64 17 3	64 17 3
	To provide for the establishment and maintenance of nurse at Inishmaan and Inishmore, Aran Islands	Not specified	200 0 0
	To provide part maintenance of nurse at Inishere, Aran Islands, for the year ending September, 1939	52 8 3	47 14 6
Queen's Institute of District Nursing ...	To provide part maintenance of nurse at Adrigole, Co. Cork, for the year ending August, 1939	120 0 0	70 0 0
	To provide for the establishment and maintenance of a nurse at Barna, Co. Galway	Not specified	(To 31/12/38) 230 0 0
LOCAL AUTHORITY HOSPITALS.			
Cavan :			
County Surgical Hospital	Part cost of installation of X-ray apparatus	504 6 0	⅓ of cost
	Part cost of purchase, new Operating Table	Not specified	⅓ of cost
Clare :			
Clare Board of Health	To provide a Public Health Clinic at Ennis	Not specified	2,500 0 0
Cork :			
District Mental Hospital, Cork	To provide for the erection of two temporary structures to cope with overcrowding, and levelling of required site	Not specified	10,577 0 0
District Hospital, Kinsale	To provide for general improvements	306 11 0	½ of cost
Dublin :			
Pelletstown Auxiliary	To meet increased building costs not provided for	929 9 4	619 12 0
Kerry :			
District Mental Hospital, Killarney ...	To improve main entrance, enlarge tradesmen's shops, etc.	Not specified	50% of cost
Meath :			
County Hospital, Navan	To meet part cost of installation of X-ray apparatus	Not specified	⅓ of cost
Tipperary :			
Tipperary (N.R.) Board of Health ...	To provide a Public Health Clinic at Nenagh	Not specified	Grant recommended—not specified.
Wexford :			
Wexford Board of Health	To provide Public Health Clinics in Co. Wexford	8,000 0 0	Grant recommended—not specified.

The Commission's separate Reports and Recommendations regarding these applications will be found in the Appendix.

(II) Applications Recommended to be Refused.

Name of Hospital or Institution	Purpose for which Grant was required	Amount applied for
		£ s. d.
VOLUNTARY AGENCIES.		
Dublin :		
Catholic Institution (St. Mary's) for the Deaf and Dumb, Cabra	Alterations to workroom and refectory	860 0 0 (approx.)
Rotunda Hospital	To provide additional X-ray equipment	100 0 0
Sancta Maria Rescue Society	To purchase additional premises and to extend the social work of the Society	3,500 0 0 (approx.)
Dublin Co. :		
St. Michael's Hospital, Dun Laoghaire ...	To extend hospital to provide 20 additional children's beds	Not specified
Louth :		
New Voluntary Hospital, Drogheda (proposed)	To provide a new Voluntary Hospital at Beechgrove House, Drogheda	Not specified
Lady Dudley's Nursing Scheme	To provide for the establishment and maintenance of a nurse on Great Blasket Island ...	Not specified
LOCAL AUTHORITY HOSPITALS.		
Cork :		
County Home and Hospital, Cork ...	Part cost of substituting electricity for gas	Not specified
Kerry :		
District Mental Hospital, Killarney ...	Part cost of purchase of motor lorry for new farm	50% of cost
Kildare :		
County Hospital, Naas	To provide for general repairs to existing building, and equipment	Not specified
Limerick :		
County Hospital, Croom	To provide for general reconstruction, installation of frigidaire and incinerator	Not specified
District Mental Hospital, Limerick ...	To provide for the re-surfacing of roads and walks in the institution	Not specified
Longford :		
County Hospital, Longford	To provide part cost of general improvements	Not specified

The Commission's separate Reports and Recommendations regarding these applications will be found in the Appendix.