Dr. Collins: Doesn't the law demand that we shall take in everybody?—Yes.

And the natural sequence of events would be the rapid filling-up of the Hospital?—It would depend entirely on the attitude of the resident staff.

If a patient came to the Hospital with a recommendation from a medical man whose experience would be riper than the junior resident's, would you approve of the junior saying yea or nay?—The resident staff—I don't care if it is the junior or the senior.

Then, if a patient came without a certificate, the junior was assisting at an operation, and the senior was at a Board meeting, what is the porter to do? Leave the patient outside?—A certain hour in the morning should be fixed for the admission of patients, and admission refused in the afternoon, excepting in emergency cases.

Dr. Collins also pointed out a difficulty which he had experienced. He was operating, and the junior (the only other officer on duty) was assisting him, when a patient without a certificate was brought to the door. The operation could not be left, and the porter could not bring the case in, as he did not know what disease it might be. That Dr. Collins said, had occurred more than once.

Dr. Lewis: If the certificate is necessary you should encourage it.

Mr. Beetham: But not turn away patients without a certificate.

Dr. Collins: When you were on the staff did you hear of complaints of persons being left three or four hours without being attended to?—Yes, I heard, but not specific complaints.

Dr. Collins: Would you recommend a casualty officer being appointed to be on duty to treat only injured persons?—I don't think it is necessary.

Do you recommend the appointment of another resident?—Making three residents and a Superintendent, no.

Mr. Beetham: The duty of one to admit those who haven't got certificates from medical men?

Dr. Collins: Do you know the Melbourne Hospital, with 320 beds, has eight residents, and Auckland, with 200, has only two?—You can't compare Melbourne with Auckland. One is a teaching school, and is in no way similar.

Dr. Collins: Do you think it is fair to make the Senior Medical Officer responsible for fractures and dislocations?—No, it is quite a wrong system.

Isn't the Senior Officer much more liable to actions for damages than an honorary surgeon?—I understand that you are not liable for damages for failures at the Hospital. I say that because in Dr. Floyd Collins's time he was proceeded against twice, and only verdicts were given against him.

Before I was appointed who had charge of fractures and dislocations?—The honorary staff.

Dr. Collins: Isn't it customary in every hospital for juniors to put up fractures?—As a rule they do in simple fractures. In some cases the patients are treated with first aid till the arrival of the honorary surgeon.

A number of questions as to how fractures are dealt with, and when the bandages and splints are taken off, followed, causing Mr. Beetham to remark, "If we go on in this manner we shall soon become duly qualified medical practitioners. We don't want to be medically educated."

Dr. Collins: You think I have had too much responsibility placed on me in regard to fractures?—I do.

Dr. Collins: I agree with you.

At this stage the Commission adjourned.

When the Commission resumed on Monday, the 24th October, *Dr. Lewis*, whose cross-examination had been concluded when the Court adjourned on Friday last, was re-examined by Mr. McVeagh, as follows:—

Mr. McVeagh: Do you approve of consumptive and cancer cases using the same lavatory in common with other patients in the same ward?—No; I don't think that is at all advisable. It is against all modern ideas of the treatment of such cases that such a state of things should be permitted.

Dr. Lewis stated further that it would be detrimental to the typhoid-fever cases to put a delirium-tremens case in the same ward. He did not foresee any difficulty in a proper system of administration in the way of the resident members of the staff deciding what cases were suitable for admission. It was the duty of the resident staff to be a board of admittance. He did not think it would often occur that the Senior Medical Officer and the resident staff would be so occupied that they could not spare a few minutes to inspect a case that was brought to the door. Or, as an alternative, the patient could be taken to the out-patients' ward and made comfortable there until one of the resident staff was available. The Matron or one of the senior nurses could see the case and report to the Senior Officer the condition of the patient seeking admission.

Mr. McVeagh: What is your opinion in regard to the Senior Medical Officer having the same status as members of the honorary staff—attending all meetings of that body, and voting on all questions?—So long as such a system exists there cannot be a satisfactory state of things at the Hospital. I cannot see that the honorary staff should be subservient to a paid official of the Board.

Mr. McVeagh: Why did you resign from the honorary staff?—I was not satisfied with my position at the Hospital. I did not feel that I was happy and comfortable, and I could not take the interest in my work as I would like to have done.