OUT PATIENT CLINICS

XII.

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BIBLIOGRAPHY

"Hospital Organization and Management,"
by Malcon T. Mac Eachern

"Report of the Out-Patient Committee of the American Hospital Association," bulletin no. 67, 1926

"The Final Report of the Committee on the Costs of Medical Care," adopted, October 31, 1932

"Clinics, Hospitals and Health Centers,"
by Michael M. Davis, Ph. D.

"Hospital Organization and Management,"
by Capt. J. E. Stone of St. Thomas Hospital, London

"Dispensaries, Their Management and Development,"
by Michael M. Davis and Andrew R. Warner

"Methods and Problems of Medical Education,"
series nos. 5, 18, 20

"American Journal of Nursing,"
issues: March, 1923
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March, 1929

OUT-PATIENT CLINICS

The out-patient clinic is one of the newest developments in hospital history. Its main function is the same as that of the in-patient service, care of the sick. Yet it differs because it cares for the ambulatory patients. The same degree of care must be exercised for both. The clinic is moving along in the same direction as the hospital, though not so generally nor so far.

The early purpose of the out-patient department was to provide medicines to the destitute sick, hence the name "dispensary."

In 1696, the first dispensary in London was founded by charitably minded physicians to give medicines to the sick poor to whom they were willing to give medical services without charge. Early dispensaries of this country were established in larger eastern cities as Philadelphia, New York, and Boston for the same purpose.

London overcame the plague in 1665. Following it was poverty, resulting in sickness and misery. In 1687, it was voted that all memberes of the College of Physicians, their professional organization, should give their services free of charge to the poor. However, no means was found of providing the medicines which the physicians wished to prescribe. The London pharmacists, a guild called the Apothecaries' Hall, would not lower their prices, even when the College of Physicians requested it on behalf of the poor. Fifty-three leading c

spirits signed an agreement in December, 1696, to pay ten pounds apiece to to Dr. Thomas Burwell, one of their number, which sum was to be used for medicines for the poor. The first Dispensary in the English-speaking world was opened in the College of Physicians.

In the first five years it is recorded that twenty thousand prescriptions were given out. The physicians, however, complained that the dole of medicines was more highly regarded than the physicians services. The attitude of the London public seemed to be that medicines and medical service were a dole for the needy.

Diseases were not treated for the cause but for the symptoms. The spirit of service characteristic of the medical profession arose and continued through the whole history of the dispensary movement from the early beginning.

Dr. Wylie stated,"The dispensaries, as they are now managed, without any certain knowledge as to the need of the help they give, are nothing less than a promiscuous charity exactly similar to the notorious soup kitchens, medicine being substituted for soup.....The self-respect of an individual is injured the moment he accepts alms, and the habit of taking alms invariably tends to a complete loss of self-respect and consequent degradation. It matters but little whether alms be medicine or food, the principle remains the same."

The later history of the first London Despensary is obscure. Not until the latter part of the eighteenth century are dispensaries again noticeable in London. In 1770 the so

called "General Dispensary" was started and four years later, the "Westminster Dispensary;" in 1779 the "London Dispensary," in 1780 the "Flushing Dispensary," and in 1782 the "Eastern Dispensary." These institutions were supported mainly by private subscriptions, usually of one guinea. Patients were only accepted when recommended by subscribers and it is said they were required, when discharged from the care of the Dispensary, to return thanks to the subscriber by letter. Dr. Lettson, one of the first physicians of the London Dispensary, said in 1801, referring to the five London Dispensaries, "Fifty thousand poor persons are relieved annually, one third of whom are attended at their own dwellings, a mode of relief which keeps the branches of the family from being separated," The expense was trivial.

Dispensaries do not appear to have been established in America until after the Revolution, but soon after , each of the three chief cities in the United States had followed the example of London and established a Dispensary.

The first was started in Philadelphia, 1786. It still stands on Independence Square occupying the same building which was erected in 1801 and which with slight modifications serves for thirty thousand odd patients who pass through it annually. In New York city, 1790, was established the New York Dispensary and unlike its Quaker brother was passed from one building to another, enlarging as it moved. The Boston Dispensary was established in 1796, where Thompson's Spa now stands.

The London system was maintained in the three earliest

American Dispensaries. Persons afflicted with venereal diseases and alcoholism were not treated by the Dispensary.

The early Boston Dispensary consisted merely of a drug store, with a physician who was to be in attendance daily except Sundays. Ambulatory cases might see him there at eleven o'clock. Patients too sick to visit him were to be treated in the home.

In New York additional Dispensaries were founded early in the nineteenth century. The London and New York Dispensaries had already established clinics on the modern principle by which the physician treated ambulatory cases at a given time and place, not in informal conferences at the apothecary shop. Thus the system of recommending patients by subscribers fell into disuse and was finally abandoned. Clinics as we know them today were developed. The Boston Dispensary started these clinics in 1856.

Much more recently we see the charitable motive and the teaching motive balanced in the utterance of Sir William Osler, in his address at the opening of the Cardiff Hospital in 1908. He said that just relief of the poor is too narrow a function. It also takes in the phase of training of younger members of the medical profession. Some of the most brilliant reputations in the country have been built up upon the solid foundation of notes taken in out-patient departments. Let the medical students see the patients in their native state before the nurse has scoured and cleansed them in the ward.

The teaching motive has been one of the most important stimuli to the development of such great historic out-patient departments as those of the Johns Hopkins Hospital and the Massachusettes General Hospital.

The out-patient service and the hospital have developed similarly in three ways: first, in the change of emphasis from the charity to the medical sevice; second, in the broadening range, including other social classes than the destitute; third,, in the institution of payment by the patients.

Patients use to leave the dispensary with the average of two or more perscriptions. Today perscriptions have been reduced to one fifth of that of fourty years ago. Medical service and not medicine is delivered to the patient in the modern clinic. This change is due to the improvemtnts in medical practice.

In a clinic of good standing a patient is no longer merely looked at; in general medicine and in pediatrics, for example, they receive a careful physical examination, The weight, pulse, and temperature are taken, and often blood pressure. Laboratory tests are made.

The study of insanity and of mental defects has led to the foundation of national and local committees on Mental Hygiene. It is now understood that it is desireable to get hold of mental diseases in their early early stages and that there is economy in providing after-care for the discharged patients of insane hospitals. Hence a growing number of psychiatric clinics have been founded. Of these the most promin-

ent are institutions like Phipps Clinic in Baltimore and the Boston Psychopathic hospital, but in New York and Massachusettes out-patient clinics for mental diseases have been begun in connection with the insane hospitals. Massachusettes has moved along the farthest, establishing a chain of clinics all over the Commonwealth. The time is approaching when no system of hospitals for the insane will be considered adequate unless it is supplemented by a set of local out-patient clinics for preventative and follow-up work.

Industrial clinics exist because it is believed by employer or the trade union that economic benefit can be secured through institutional medical practice to a degree not likely to be achieved through individual private practice.

Obviously, when any type of medical service proves more effective when rendered in a clinic, at the same cost as private practice, or proves about as effective at less cost, it will be sought by all who can gain access to it, whatever their economic class. This tendency explains why certain expensive forms of specialized medical work, as refraction, hay-fever, inoculations, gastro-intestinal diagnosis, draw many persons to clinics who could and would pay a general practitioner if he did this work. It also explains why well-to-do persons patronize the Mayo Clinic, the Cleveland Clinic, the Henry Ford Clinic, and diagnostic clinics at well -known hospitals, believing they thus get better service, whatever they pay for it.

The opposition to fees is due partly to the laymen

who cling to philanthropic ideas of past generations, and partly to physicians who feel that payment of fees in clinics tends to draw certain patients away from the doctor's private office. There is a steady tendency to charge fees. A generation ago, ten cents was the usual fee and was often charged only that amount at the first visit. Now twenty-five cents is usual and fifty cents or more per visit are not uncommon.

The pay clinics were originally for the very poor. Increasingly, they have come to serve persons who cannot meet the usual expense of private medical care. In the Eastern cities, particularly, a large number of clinics have begun, since the war, to charge fees, usually of nominal amounts, or enough to cover the cost of care, but physicians are expected to give free service. The physicians are compensated for their services on a salary or fee basis.. This is especially true in dental clinics. It is interesting to know that hospitals direct more dental clinics than any other single agency. The clinics must be well organized in order not to provide hurried and impersonal service.

Recently, medical staffs have arranged to utilize hospitals for their private office practice by referring cases for x-ray ar laboratory service, by using rooms for consultations or conferences with other hospital staff members on private cases, or by actual rental of space in hospital buildings. Data accumulated by the Council on Medical Education and Hospitals indicated that in 1931 nearly one thousand hospitals

were used to some degree by four thousand five hundred physicians who maintained offices or office hours for private ambulatory patients in the institutions..

This has proved advantageous in some respects for it conserved the physicians time in treatment of private cases, and it saved the patients in some instances. The hospitals are in favor of it for it increases the amount of service rendered by their equipment, and thus lowers the unit-costs of certain hospital functions and increases the revenue.

However, certain difficulties arise. Previously established commercial agencies providing x-ray or laboratory service do not like the competition. Some institutions may extend privileged on an uneven or undesirable basis among members of the of the staff.

Pay clinics are sponsored and financially aided by the public through voluntary or tax funds. They are dependent upon the people for their maintanence. They should delegate control and management of the professional aspects of the service to the physicians and dentists concerned. They are linked closely with appoved hospitals and, hence, use the hospitals facilities. Also, pay clinics provide home service and public health nursing care. As funds permit, the smaller clinics should provide dentistry, medical social service, and the provisions of drugs, eyeglasses, and other appliances.

The arrangement and equipment of the health clinic are the same as those of the general medical clinic, the

service differing chiefly in its procedure and in the time arrangements, as well as in the content of the work itself. The health examination involves so much time and special detail that it cannot usually be conbined with the work of a general medical clinic treating the sick. It must be held at special times. Another reason for this separation is that few doctors, among the many who are ready to serve the sick in clinics, find health guidance sufficiently interesting to be willing to undertake it. Since health examinations are not emergency work, it is well to put the service on an appointment basis. It is most essential to select physicians who are vitally interested in this type of service. Assistant physicians in a clinic under the direction of a suitable chief need tactful supervision and careful training.

A concrete illustration of one method of conducting a health service for adults, tested by three years experience, is at Cornell Clinic. As it is a subdivision of general medicine, good suprvision and co-ordination with the specialties is assured. The health examinees come by appointment at an hour when the General Medical Clinic is not in session. Following is the routine:

Like all medical work, the service includes the history, the examination, and the treatment. The history-taking is facilitated by a questionnaire filled in by the health client,

before examination. This serves as a basis for discussion with the doctor, and has been found advantageous in preventing omissions in any field of the examinee's life. The technique of the examination differs in no way from good medical technique in practice.

At Cornell, a nurse is available to take temperature, pulse, weight and height, test vision, hearing and hemoglobin. The urine is tested for sugar, albumen, and specific gravity by the technician assigned to the medical clinic. These tests take about ten minutes and are made before the doctor sees the examinee. Treatment includes reference to a private doctor or to a clinic for the correction of defects or attention to an acute condition. It also involves written instructions as to modifications in habits and activities. This is necessarily emphasized by suggestions that make the plan seem worth while. The social worker goes over the plan with the client, making individual adaptations needed to assure the practicability of the suggested regime. An appointment is made for a return visit within a month, unless the examinee is transferred for indicated medical treatment.

Regarding exercise, in city communities, gymnasium classes for recreative or corrective work are springing up in great variety as to both price and quality. Until recently, exercise has been little used in curative work, except in orthopedic clinics, or hospitals. With the establishment of cardiac clinics, the need for directed exercise became evident

and in several out-patient departments exercise classes have been made part of the service. These classes have been on a group or class basis as at St. Luke's Hospital, New York, or on a purely individual basis as are most clinic procedures. So far as is known, all such services have been for children.

The out-patient department of the "Royal Victoria Hospital," Montreal, has a three-fold purpose. First, it is for the investigation of cases and the treatment of out-patients, both those who do not require admission and those who have been discharged but still need supervision. Second, it provides material for examination, actual work, and instruction for medical students of McGill University. And, third, the Social Service Department is situated here and taked care of a large part of the philanthropic work as well as a tremendous amount of public health education.

The department was planned for adequate space for clinical work and treatments, awell organized and well located social service, and space for instruction with no overlapping. It is a self contained unit with a separate enterance from the main part of the hospital. The rooms are grouped according to the different services. On the first floor are the waiting rooms, offices, the Social Service Department, and the Geneto-Urinary Department. On the second floor are the departments of Medicine, Pediatrics, Dermatology, Psychology, and Neurology. On the third floor, the Gynocology, Surgery,

and Thyroid Clinics are located. And on the fourth floor, the three clinics of Orthopedics, Otolaryngology, and Ophthalmology. The building also contains a chapel with a seating capacity of one hundred. Regular morning service and communion for the the nursing staff are held here, and, occasionally, a private funeral of a patient from the hospital. There is a morgue, and there is a medical theater, also with seats for one hundred, where examinations and lectures may be held without being disturbed.

The Medical Clinic is divided into two parts, for male and for female. Two doctors in each room are able to work together or independently examine and advise the patient. The Laboratory is equipped for urinalysis, for all forms of gastric analysis, and for microscopic examination. However, the pathological specimens go to the Department of Pathology. The Cardiac Examination Room is connected with the Medical Clinic. Wires have been run through to the medical wards so that electrocardiograms can be made here for ward patients as well as out-patients. Here they do pulse tracings and tests for vital capacity.

In the Asthmatic Clinic sputum examinations and specific innoculations are given to the chronics. The hay-fever cases are subjected to pollen tests and innoculated in increasing doses until desensitized.

In the Pediatrics Department, the work is chiefly correcting diets and recommending perscriptions, largly cod-liver oil compositions. For more serious ailments, the child

is sent to the hospital or to other clinics.

Patients are recommended to the Psychiatric Clinic by institutions, doctors, private individuals, and other clinics. There is a well rounded and complete system of analyzing the patient. The analyses are done with memory tests, noting the appearance, the behavior, the thought processes, the motor status, etc. A personal history is taken. The Binet-Simon record tests, cards, puzzles and weights are used. The Patient is never allowed to see his card or case history, for he must never suspect psychosis. No treatment is given here, but analyses are made and the findings are reported.

The in- and out-patient departments of the University of Michigan Hospital are closely connected. An effort is made to correlate the two units. The head of each professional department is in chare of the examination and treatment of the patients in both departments of his service. In the larger departments, the staff is usually devided between the out-patient clinic and the in-patient wards. The rotation within the staff gives a varied experience with both types of work.

All patients are first seen in the out-patient clinic. Approximately thirty thousand individuals are treated yearly. It is found to be less expensive and more rapid, having this method. When a patient does not require very active hospital care, but must be kept in the institution,

he is admitted to the Convalescent Hospital and treatment is continued in the out-patient clinic. No definite rule is made as to the type of patient treated in the in- or out-patient department. It is descretionary with the chief of the service, but in every case a very active service is maintained among the strictly in-patients.

The organization of the medical staffs of the individual services follows very closely academic rank. The chief of each individual service is the professor of the department in the Medical School. His immediate assistants are the associate and assistant professors, aided by the instructors and and interns. The responsibility of the staff of each service is divided between the treatment of patients and the instruction of students.

At the University of Michigan Hospital, Ann Arbor, Michigan, all the students spend a certain amount of time in the various departments of the out-patient clinic. In the Department of Dental Surgery, the students are not assigned to this department for a regular course, but are encouraged to spend as much time as possible there acquainting themselves with its relation to general medicine and surgery. During their senior year, the medical students take full charge of an out-patient case.

All student examinations are supervised and, to a great extent, each case is discussed by an instructor with the

student. Some of the student's records are incorporated as part of the permanent record of a patient. These are in most cases out-patient records. Laboratory work is usually done for experience by the student and the results are verified for a check by the intern.

Believe it or not, there is even an out-patient department in a modern mission hospital at Soochow, China. It is located on the eastern edge of the ancient Woo City, now known as Soochow. The city is in the center of the fertile and densely populated, lower Yangtse Valley, and for two thousand years has been the leading city in that section of China. Neither drought nor flood is ever severe enough to make crops a complete failure as they may be elsewhere in China. Since the entire lower Yangtse Valley is slightly above sea level, it is more advantageous to build water-ways than paved roads. No small village exists that cannot be reached by a canal boat, just as in the United States all farms can be reached by roads. It is a large percentage of this wealthy area that the Soochow Hospital attempts to serve.

It is a modern institution where high grade medical and surgical work can be carried on. It required $250,000 of local currencey to build and equip the plant. The out-patient clinic is separate from the main hospital. Its architecture is that of the Peking palaces. The walls are of large polished gray brick. Its rooms are arranged similarly to those in an American clinic, and is an efficient, well organized

unit. There are five departments: Surgery, including eye, ear, nose, and throat, Pathology, General Medicine, Gynocology, and Obstetrics.

In1921, the Cornell University Medical College reorganized its long established teaching clinic as a pay clinic, and aimed to provide self-supporting individuals of moderate means with a high grade of medical service.

By 1922, a large public response to the opportunity offered, and assured the future of the pay clinic. It was the desire of both college authorities and the Committee on Dispensary Development that every possible use be made of the facilities of the clinic for educational purposes, for medical students, men and women in dispensary administration, and in those phases of nursing and social work in which an out-patient clinic provides instructive material. It was believed that the educational use of the clinic would improve service as well as meet an active demand for personnel trained along these lines.

A study and report of the deucational facilities was made under direction of Michael M. Davis, Jr., Executive Secretary of the Committee, and with aid of Lillian Clayton, M.A., Nutting, and Annie W. Goodrich. Certain facts and principles appeared of general interest to nursing educators.

Out-patient departments have been little used for training of nurses. It called to the attention of the nursing profession, and particularly to nursing educators, those portions of study which bear upon the importance of the out-patient depart-

ment as a field for nursing education.

An out-patient clinic is organized primarily for clientele service to humanity while education joined with scientific research should have a potent influence of high intellectual worth upon the clinic personnel.

Practice of medicine and social work are so closely related as to fuse into a whole, thus accomplishing the full measure of its usefulness. It is a link of the entire public health movement. The oportunities of the student and graduate in such an organization are:

1. Technical experience.
2. Nursing knowledge derived from the various clinic specialties.
3. The study of the social aspects of nursing education.

Most of the technical training is from the student's hospital period. In the clinic she receives her experience in dispensary methods in the skin, x-ray therapy, nose and throat, eye and ear clinics. There might be diagnostic practices and treatments with which the nurse might not be very familiar. Certain phases of the work of general medical and surgical clinics which are seldom seen in the institutions as they do not require hospital care_____such as digestive disorders, glandular and nervous disturbances, common colds, many chronic and minor surgical conditions, as well as certain postural defects, etc. Also, there is the supervision to convalescent orthopedic patients after discharge from the hostpital.

The nurse should gain in understanding and knowledge of

disease and injury, sickness prevention, and public health promotion which should enable her to see the patients in relation to environmental conditions in a way that is seldon afforded in the hospital. The atmosphere of the clinic is inherently more conducive to the health idea than is that of the hospital where emphasis is mainly curative.

The very nature of the out-patient department should imbue the student nurse with a sound point of view toward the whole health movement, including its social background. By studying under competent direction the problems which patients present, the nurse should become more fully aware of the causes and of the social and economic significance of disease. She should gain true perspective of the importance of health in the social fabric. She should get a more vivid and real picture of the patient as a person, in the dispensary. She sees him in his own clothes, with his friends, and with some of his social environment still clinging to him.

There should be a field for the graduate nurse who desires to specialize in nursing administration, in executive management, and in supervision of nursing in clinics. The clinical experience would be invaluable for the nurse who had not had the opportunity to study social phases of public health. The graduate nurse might be more fully prepared by this training in the clinic for school, industrial, child welfare, and other branches of public health nursing. She would gain knowledge of the principles underlying treatment of minor diseases. By

affiliations this experience might be used to supplement the education of under-graduate nurses who are in hospitals where there is no dispensary service.

Such a program in connection with training schools would require considerable modification of the usual curriculum of the under-graduate nurse; the effectiveness would depend not only on the enterest and intellectual grasp of the educational directors and instructors, but even more upon the spirit and cooperation of the whole clinic force, the medical service, the administrative service, the nursing and social service. Close correlation must necessarily be maintained with the educative work for the nurse in the out-patient department.

So little has been done in practical use that it must be regarded as a field of experimentation. It is a field in which experiment is greatly needed.

Superintendents, educational directors and instructors of training schools are urged to consider this phase of nursing education and to take such immediate steps as to be practicable to utilize more fully the vast educational possibilities of the out-patient department in connection with the existing systems of graduate and under-graduate training.

Fifty years ago, the North End Diet Kitchen in Boston was establishes as a charitable institution to provide diets at a nominal cost. They were authorized by doctors and nurses and certain releief agencies. In 1923, it became a part of

the out-patient clinic of the Massachusettes General, maintaining its original title. The kitchen is open on clinic days for ambulatory patients in the morning and for discharged patients in the afternoon. Special clinics for diabetics are held two mornings a week and an epileptic clinic is held on one morning. Others receiving dietary treatment include cases of gastric, nephritic, obesity, asthma, pernicious anemia, and cardiac trouble. It is in co-operation with and under the supervision of the medical department of the hospital. Dietary treatment in charge of a trained and an assistant dietician, a student dietician, and a student nurse.

The doctor refers the patient to the diet kitchen where actual food is used for demonstrations. The patients are showed how to measure and prepare their food.

The student nurse receives three weeks of observation and learns how to arrange the diets in menu form and demonstrate and prepare food.

The out-patient department is one of the richest teaching fields for the student nurse. Hundreds of patients come who have early-stage conditions rarely found in hospitals make it important to carry on her health program and to realize the sociological conditions which are contributing factors to these maladies.

To insure educational work in the clinic, it is necessary to have an active service in all out-patient departments;

to have adequate supervision, more than finding out what she can for herself. The supervisor should be a graduate with executive and teaching ability. She should be responsible for the nursing administration of the clinic. It is necessary for her to have a sound professional background with instruction, experience in public health , experience in out-patient work, and supervision, and also a psychological and socialogical point of view. Her assistants should also be trained in out-patient work and public health and be permanent on the staff and responsible for administration of the clinic and most of the teaching. The student should have administrative work as well as the studying of cases. It is necessary to have an interested and co-operative clinical staff. This may be attained by assuring the staff of uniformity and continuity of service. They can demonstrate the unusual. An adequately staffed social service department is needed to carry out or follow through cases. The student can derive great benefit by working out problems with the social worker. This must be a well planned physical plant with class room space, convenient laboratory facilities and offices for the teaching staff with good reference books. The student is relieved as much as possible from non-nursing procedures by employment of an adequate supplementary staff so that she will have more time for education.

The hospital alone cannot offer the picture of patients as human beings and members of society. The student learns

to appreciate the home and the limitations. Her social sense is awakened and she can better give sympathy and understanding.. She familiarizes herself with various health and social organizations which are all so closely related. She will know the field and how to obtain aid.

The curriculum is debatable. The junior year is too early to enable the student to become familiar with or cognizant of social aspects of patients. The students haven't judgment, experience or knowledge to do health teaching and need more supervision. Other possibilities are to correlate ward work and out-patient work in each department, or to make it a post-graduate course.

The principles of schools of nursing and others interested in improvement in nursing service in out-patient de departments and in better instruction of student nurses, through utilization of clinical material and better correlation of subjects taught have been waiting for the findings of the Committee of the National League of Nursing Education in charge of the Study of the Nurse and Nursing Service in the Out-patient Department.

The purpose of the study was to determine "What contribution the nurse makes to the out-patient departmnet, and what contribution the out-patient department can make to the education of the nurse.

The methods used are as follows:

1. A study of the individual clinics in six different out-patient

departments.

2. An analysis of the work sheets kept by student nurses to obtain a record of the out-patient assignments and approximate time spent on each.

3. Observation of student nurses at work during the entire out-patient service and conferences with individual students.

4. A study of the general organization and operation of the out-patient services.

5. A study of the curricula of schools of nursing and reports which point out possibilities and advantages of incorporating out-patient work in the programs of the student nurse.

The proportion of time of student nurses is utilized approximately as follows

Assisting in clinics.....40%-58.1%

Preparing for clinics and clearing away.....15.5%-33.5%

Preparing supplies.....4.9%-16%

Home visits.....1.2%-23.7%

Miscellaneous.....1.1%-6.5%

The students nurses' duties seem to be chiefly assisting patients to adjust to clinic situations, helping with physical examinations, treatments and minor surgery, obtaining temperature, pulse, and respiration, weights, and urine specimens.

In some clinics she has to depend upon herself, her own observations, and the chance word of a doctor, to obtain her education, but in others regular instruction is carried on. It is believed that much can be done to render the timethe nurse

spends in the clinics more effective both in respect to her own education and to the service she gives there. Successful team work is the only basis upon which most work will succeed, so nurse directors are admonished to stimulate better co-operation between the nursing service and other services of the out-patient department. There should be opportunity for intelligent comprehension of the clinics and services, which are so definitely a part of organized community health service. She should be assisted to understand the scope of these programs so that, as a graduate nurse, she may assume her proper responsibilities in the community.

The Committee believes that student assignment to out-patient service should have a definite relation to the educational plan as a whole and recommends that very early in her course the student be given an orientation in the community aspects of disease. This should include observation in out-patient clinics and homes, and excursions to community organizations. The out-patient training may be taken as part of each service, lasting for two or three weeks for each, or it may be taken all at once to cover all the services during that one period.

Finally, the Committee recommends the seeking of interest and co-operation of physicians, of training for students and for graduate supervisors. It is suggested that an attempt be made to develop the clinic as a practice field for public health courses.

The most up-to-date departments in America are buildings of several stories in height, attached to, but separate

from, the main hospital buildings. The usual arrangement is a large waiting-hall on the first floor, connected with smaller halls on the upper floors for each department by the usual elevators. The elevator plays an important part in modern American life, and, in hospital, as in other buildings, the staircase is relagated to inferior position, and used mainly for fire escapes and floor-to-floor services. The elevators are near to the main enterance-hall, which is generally made as attractive as possible architecturally, and as far as possible follows the lines of a hotel. The idea is also carried out in the waiting room, which is unvariable comfortably furnished in the style of a hotel lounge, and in the private room adjoining the superinteneant's office, where financial matters may be discussed without disturbance.

The duties of an out-patient department are to furnish immediate service to the ambulatory sick while in the early stages of disease when treatment provides the best results, and thereby reduce the cost of hospital care for this large group of the community; to select those cases which require hospital care and arrange for their admission. It must bridge the gap between the out-patient department and the ward by transmitting with the patient the medical records, laboratory reports, and social service records, the latter including the social diagnosis and eligibility determination, thereby furnishing to the hospital staff a picture of the patient's living conditions and social background. The clinic must relieve the hospital promptly of the patient who no longer requires ward care by arranging

for the return to his home and for the continuation of treatment in the out-patient department. It is obliged to provide adequate follow-up care of the discharged ward patient to see that living conditions are kept at a proper standard. In this manner the health of the cured patient is maintained. It is the departments duty to prevent disease through special clinics, and to serve as the clearing house of the hospital for the dissemination of knowledge relating to the health and welfare of the community.

Celerity and accuracy in dealing with such a large number of miscellaneous cases is absolutely essential. In some hospitals, out-patient and casualty departments form one unit, both as to position and as to the work carried out, while at others they are quite separate and distinct in their methods of working. In some instances there seems to be a tendency to merge casualty and out-patient departments.

It is said that the ease with which a person can get medical relief has a pauperizing effect on him. It is doubtful if this is the case as the treatment given at the voluntary hospitals has had the effect of keeping a large number of persons in time of sickness off the parish and thus saved them from pauperism. Unsuitable cases are sent to the Poor-Law infirmaries, but this is only done when it is felt that the treatment afforded by the hospital will not have the effect of curing the person.

The Local Government Committee presided over by Sir Donald Maclean in its report of December, 1917, recommend-

ed the abolition of Boards of Guardians. On the second reading of the bill first introduced for the setting up of the Ministry of Health, it was said that "The Government accept the recommendations of the committee that all services relating to the care and treatment of the sick and infirm should not be administered as part of the Poor Law, but should be made a part of the general health service of the country."

The case for the abolition of the guardian rests, so far as their health functions are concerned, not on any suggestion that these functions are inefficiently performed; this is so far from being the case that many of the Poor Law infirmaries with their staffs and equipment would be a real acquisition of the community as a whole. But the existance of a separate and costly administration for dealing with the health of one section of the community is unsound in principle. Further, it is of the essence of any sound scheme for the co-ordination of health services that the general responsibilities for the prevention and for the cure of disease should be vested in an authority, so that all measured directed to either or both of these objects should be properly related and directed.

Remedial suggestions have been made for the removal of abuses and shortcomings of out-patient clinics. Some have advised the total abolition of such departments and of the whole of the existing out-patient system, so as to confine the hospitals solely to the treatment of the in-patients. In Scotland the majority of the hospitals have no out-patient

departments, the students acquiring a portion of their training in the dispensaries, but it is doubtful if this is a conveneient arrangement except in a partial degree. It is admitted, however, that hospitals ought to provide for cases of real urgency and for cases recommended by medical men for hospital advice and treatment. It is thought that these cases would provide suficient material for the instruction of students and the residue of patients who could not pay for private attendance should be relieved at the provident dispensaries or by the Poor-Law infirmaries.

In Scotland much of the ordinary out-patient work is done by dispensaries which are run by various philanthropic societies connected with the medical missions. These dispensaries provide medicine, and out-patients who attend the hospitals are generally sent there by the dispensaries or by general practitioners, for a consultative opinion. At one hospital, for instance, no medicine is given to out-patients; they are given advice and perhaps a perscription, and this they get made up for themselves outside or take to a dispensary.

On the other hand, there are those connected with hospitals having schools attached to them who would strongly object to the abolition of these departments. They regard them with the utmost importance because of the training they afford the students. In such departments students see the beginning of disease, a most valuable portion of their training, and the closing down of these departments would be a calamity to the

public and disasterous to the art of medicine.

Naturally with so many opinions being expressed, proposals for reform have also been made, such reform being distinct from total abolition, the main objects in view being to restrict admissions to those who are proper objects of charity and to prevent overcrowding.

Except in those hospitals which have adopted special measures the only checks upon an applicant who is not palpably as an unsuitable case for free treatment, are the limited time during which the doors of admission are opened, and the delay and discomfort which he may suffer in the waiting room before his turn comes for treatment.

Limitation by numbers, i.e., taking no more than a certain fixed number of new cases each day, is the most effectual check yet devised. Urgent cases are of course treated irrespective of this limit.

There is an increasing weight of opinion in favor of the out-patient departments of hospitals being used for consultative purposes and a number of such departments are so used at the present time, the passport for admission being generally a letter from a doctor.

The want of sufficient accomodations for out-patients is an inconvenience which under existing circumstances is very much felt at many hospitals, both in London and the Provinces.

Hospital letters were once quite popular. Subscribers and donors to the funds were entitled to receive so many letters of recommendation, the number varying according to

the amount given, and whether it was a donation or a subscription. At one large hospital in London contributors were entitled to receive three letters of recommendation, which were available for twelve months, for each guinea susbscribed.

These letters afforded certain privileged to the persons obtaining them from donors and subscribers. These privileges included attendance at an out-patient department with free medicine or admission to beds, if necessary, but the hospital authorities generally reserved to themselves certain rights, and subscribers and others were urged to assist in avoiding any abuse of the privileges by withholding letters from persons who were not suitable cases for gratuitous relief.

Generally speaking, the practice of hospitals where such letters were in use appeared to be to give a slight preference to applicants bringing letters over those (and they were the vast majority) who came without them. An out-patient letter would sometimes open the way direct to the out-patient department, where as a person not so provided must first pass through the casualty or receiving room and take his or her chance of being passed on or treated summarily there. But any person whose illness was sufficiently serious appeared to be considered equally in either case a proper subject for treatment. So in regard to admission to wards, the only privilege attaching to a letter seemed to be that, where two cases were of equal gravity the preference would be given to

the recommended case; but it was evident that disease or the condition of the patient, and not the recommendation of the subscriber, was the real passport of admission and treatment; the selection of the applicants to be taken in rested practically with the officer whose duty it was to admit to th hospital.

The practice is now being recognized as a bad one. Such methods of admission invariably lead to petty patronage; they assume the vanity of the smallest subscriber and play up to it. Nothing can justify them unless it is the existence of people who would not subscribe for the maintenance of heaven without an annual report and the right to recommend four souls for immediate admission. It is at best a device for obtaining funds. Abolition is desired, but no method for funds had been devised.

The use of letters by subscribers for the treatment of their domestic servants might be said to be a missuse of hospital accomodation. Although, the funds of the hospital might derive benefit from the practice.

Here, I will list some objections to out-patient departments:

1. The long period of waiting.

2; The number of persons who attend for treatment is so great that they cannot by properly examined, and that in consequence;

a. patients are often wrongly treated.

b. treatment by too junior officers.

3. The hospitals encourage a large number to come in order to raise funds by showing a large number of cases treated.

4. The limited treatment has a bad effect upon students.

5. The evils of overcrowding and hurry are aggravated by the treatment of trivial cases which ought never to come to the hospital.

6. No sufficient discrimination is used in the reception of out-patients and in consequence;

a. persons are treated free who should pay.

b. poor are pauperized and rendered unprovident.

c. provident dispensaries are stifled.

d. the general practitioner is both deprived of his patients, and driven to reduce his fees.

However, the practitioner does receive some benefit. It affords him a ready means of obtaining a consultive opinion in difficult cases, and enables him to send to a hospital a patient who cannot pay his fees.

Organizations especially formed to advance the technique and standards of dispensary service have recently appeared. First, in the field was the Associated Out-Patient Clinics of New York, established in 1912, largely through the interest and initiative of Dr. Goldwater. It is a co-operative association of dispensaries and out-patient departments, its stated purpose being;

1. To co-ordinate the work of the institutions in New York City.

2. To establish clinical standards.

3. To promote economy and efficiency in the management of dispensaries.

The Association has published a number of valuable

studies and standards.

Second in order, was the Committee on Dispensary Work of the Americal Hospital Association, organized after the annual convention of that body in September, 1913. This Committee has undertaken:

1. Studies of the growth in number and extent of Dispensaries in the United States.
2. Study of special problems and of different types of Dispensaries.
3. Certain elementary standards of organization and management have been formulated, and promulgated through the publications of the American Hospital Association.
4. Through an annual questionnaire, new features in dispensary work have been collected and published in the Committee's Annual Report.

Behind the growth of Dispensaries in this country, are four main impelling forces, arranged in the order of their development: (1) the charity motive (2) the medical motive (3) the public health motive, and (4) the economic motive.

What are the fundamental principles of the organization and management of a Dispensary, and of its relationship to the community? What group or "social class" of patients do Dispensaries serve? What classes should they serve? How shall the functions of the physician, the nurse, the social worker, and the administrative officer, be inter-related so as to make an efficient institution?

Some of these questions lead us from general principles into the practical technique of arrangement of rooms, medical and

surgical equipment, records, follow-up systems, statistics, and finance. The small Dispensary, as well as the large ones, must have attention and special needs of different types of Dispensaries must be described. Last, but far from least, arise the broad public problems which Dispensary work is now placing before the medical profession and the public. What part are out-patient clinics to play in providing medical service to the people in the future? What is to be their place in public health work, in social service, in industry? Convlicting tendencies appear in this field, between the fine tradition of the family physician and the growing dominance of the specialists, between the desire for individual relationship, between patient and doctor and the increasing efficiency of institutional medicine, between uncertain support from private funds and support by taxation with political representation upon the managing board; between enlarging social service and arising objection to "charity." Among such alternatives what furure shall come forth?