



PRESENT STATUS AND PROBLEMS OF OUT-PATIENT WORK.

BY MICHAEL M. DAVIS, JR., Ph.D.,
Director of the Boston Dispensary.

Report of Committee on Out-Patient Service, American Hospital Association.

The dispensaries and out-patient departments of the hospitals of the United States are growing yearly in importance as a part of medical service to the public. The Federal Census of 1910 reports the existence of 574 dispensaries and out-patient departments treating 2,349,000 patients during the year. Only six years previously, when in 1904 a special report of benevolent institutions was issued by the Census Office, there were but 156 of these institutions, and the number of patients was only 1,611,000. Thus in six years the number of dispensaries and out-patient departments increased near four-fold. The number of patients increased of course much less rapidly, as the newer institutions are largely for tuberculosis, and are small in size; yet, even so, the increase in patients treated is over 50%.

STATISTICS OF OUT-PATIENT WORK.

As a matter of statistics the figures reported by the Census Bureau for 1910 are undoubtedly too small. There has been considerable confusion; in the reports made to the Census Bureau, between the number of patients treated and the visits paid by these patients and also—surprising as it may seem—between out-patients and bed-patients. The officials of the Census Bureau tell me in correspondence that they have done their best to get the hospitals to report bed-patients as bed-patients and out-patients as out-patients, and not to swell the number of hospital cases by putting out-patients within that total. In the present state of out-patient statistics, it is perhaps beyond sane expectation to think that when a hospital does not accurately distinguish in its report between bed-patients and out-

patients, it will give attention to such a relatively subtle matter as to discriminate between patients treated in the dispensary and visits paid by these patients. But the millennium will come sometime!

Meanwhile, a comparison made with reports of local authorities in certain states and the Census figures show the Census figures to be below the truth. In Massachusetts the State Board of Charity receives reports from all hospitals and dispensaries and the same practice exists in New York. The Massachusetts report indicates that the Census figures for patients treated is about 20% too low; and the New York figures are 15% too low. It is probable that 2,750,000 to 3,000,000 individual out-patients were treated during 1910 and surely 3,000,000 are annually treated in this country at the present day.

The printed report of the Census Office, giving the 1910 figures, has not yet appeared, and I am indebted to the officials of the Census Bureau for the advance summary which they have kindly furnished me and for helpful correspondence concerning the method by which the statistics were gathered.

Out-patient work is not evenly distributed over the country. In 1910, just two-thirds of all the dispensaries and out-patient departments were in New York, New Jersey, Pennsylvania or in the six New England states; 60% were in New York and Pennsylvania alone. In the six years between 1904 and 1910 the number in New York trebled; in Massachusetts, doubled; in Maryland, doubled; in Illinois, a little more than doubled; in Ohio nearly trebled; in Missouri more than trebled; in the District of Columbia more than quadrupled; and in Pennsylvania the number of dispensaries increased twelve times. This remarkable growth in the number of institutions is in a considerable degree accounted for by the use of the dispensary in the national anti-tuberculosis campaign. Nearly all of the increase in Pennsylvania and fully half of the increase in the United States as a whole is due to this factor. The establishment of dispensaries has thus far been chiefly in the large cities, but there are indications that this will not remain the case. Tuberculosis dispensaries are established in every county in Pennsyl-

vania; and, under a new law, are to be established over all the state of Massachusetts. With the exception of these tuberculosis dispensaries, the typical out-patient work of course is to be found in the larger cities.

This increase in dispensary work places before the medical profession and hospital authorities certain serious problems, of which competition with private practice is one. These problems must be faced and solved; but the ultimate test on which the general public, which supports all the institutions, will base its contributions or its tax levies, will be the service of these institutions to public health. We must not reach decision upon any of the important problems of dispensary service with any narrower vision of it than as a part of the public health movement.

LACK OF ATTENTION TO OUT-PATIENT DEPARTMENT.

In view of the remarkable development of out-patient service, it is all the more noteworthy that most hospitals which conduct out-patient departments have paid so little attention to them. The dispensary might be described as the dark horse of the medical institution kept hidden under a blanket!

Fifty-six annual reports of well-known hospitals have been examined to see what they said about their out-patient work.* The out-patient departments of these 56 hospitals had under treatment last year over a million persons; yet three-quarters of the annual reports made absolutely no mention of the fact that the hospital has an out-patient department, except such indication as is to be found in a brief statistical table of patients and visits.

*A postal was sent to about 250 hospitals, selected as among the leading ones in the country from the membership list of the American Hospital Association. Some were taken from every state in the Union. The postal card asked that an annual report be sent. In return 93 reports were received. Thirty-four of the 93 hospitals which sent reports had no out-patient department. Of the remaining number (59) 56 annual reports were received in time for tabulation.

All of the hospitals that did not send reports received a second postal card, so that 37% of responses represented the results of two requests.

Reports were also secured from a number of dispensaries not connected with hospitals, these not being included in the above figures.

A very well-known hospital in one of our largest cities issues a handsome report of 160 pages. The medical wards, the surgical, orthopedic, maternity, gynaecological, eye, children's, and neurological wards have each an "Auxiliary Committee," and each Auxiliary Committee presents a report of its special work, needs and financial supporters. Altogether these wards treated over 4,500 patients last year. The out-patient department of this hospital treated just about three times as many; but the out-patient department has no Auxiliary Committee; it has no special report; and, except for the statistical tables, one would only know that the hospital had an out-patient department from two sentences in the report of the President of the Board of Trustees to the effect that the dispensary service has been improved, that Social Service has been established, and that the patients in the dispensary have been supplied with individual drinking cups!

The report of this Board of Trustees is exceptional in one respect, namely, that the dispensary is mentioned at all. Only eight hospitals out of the 56 had any special report for the out-patient department in their annual report; and in three of these eight cases the "report" was merely a formal presentation of figures. There were also four hospitals which gave a little space to discussing the problems of the out-patient department, but did not dignify it by giving any special page or heading. Thus only 15% (nine out of 56) *said* anything about their out-patient department. Can it be true that an out-patient department may treat 1,000 or 20,000 human beings in a year and not have any problems or any needs?

Without entering further into the details gathered from these annual reports,* enough has been said to

*As to out-patient statistics, all the hospitals except one mention the number of patients treated, and all except two give also the number of visits paid by these patients. Nearly one-third (17 out of 55) of these hospitals, however, give only the total number of patients and visits, and do not divide them according to the different clinical departments. If one examines a number of hospital reports, one is also forced to note with pain that 73% of them (42 out of 56) have no index or table of contents, so that it is necessary to hunt through a report of from 40 to 150 pages to find anything in it that one is looking for, such as out-patient statistics.

show the small number of the crumbs which the average hospital management throws to this poor relation at the hospital table, How can hospitals expect to get funds to improve out-patient work so long as they hide its light under a bushel?†

PRESENT FACTS OF OUT-PATIENT WORK.

For this Committee Report, facts have been gathered, through correspondence, concerning the present methods of organization and work of out-patient departments and dispensaries. Information is available from 76 institutions, of which 49 are hospitals and 27 dispensaries not connected with hospitals. While the number of hospitals is small, most of the large representative institutions having out-patient departments are included.

The facts appear tabulated as Appendix II. The more important items are* :—

All the hospital reports give the list of their medical staff, usually, though not invariably, classified under clinical departments. The diseases treated in the out-patient clinic were presented in a surprisingly large number of cases, considering the relatively small value of the information thus conveyed. Twenty-three out of 56 hospitals published a more or less extensive list of diseases treated, usually with the number of cases of each disease.

The reports of finances are of great negative interest. Thus out of 56 hospital reports:

7 gave no financial statement of any kind;

33 presented a financial statement, but not classified in such a way that the expenses of the out-patient department were either given or ascertainable;

16 presented a financial statement so itemized that the expenses of the out-patient department were separated.

†A suggested outline of what the annual report of a hospital should present concerning its out-patient department is printed as Appendix I.

*A printed blank was sent, with a return envelope, to the 250 hospitals previously mentioned and to 34 dispensaries not connected with hospitals. Eighty-eight of these blanks were returned, and 76 were capable of tabulation. While this number represents a little less than a third of the out-patient departments and dispensaries in this country, excluding tuberculosis dispensaries, it does include almost all the larger and more representative institutions. Of course it must be remembered that a large proportion of the 250 hospitals that were communicated with had no out-patient departments.

1. *Organization.*—Seventy per cent. (31 out of 49) of the hospitals had no person in executive charge of the out-patient department. Of the 14 hospitals reporting a “permanent superintendent of out-patient work,” this official is evidently, in many cases, only a head nurse, and in others is an assistant superintendent of the hospital, who serves in the out-patient only for a fixed term. The out-patient department is, of course, under the authority of the superintendent of the hospital, but he obviously cannot undertake its actual supervision. Three well-known hospital superintendents have estimated the portion of their time which they charge financially to the out-patient department, presumably representing the amount of time directly given to out-patient supervision. These estimates were, respectively, 10%, 2% and 0%.

The typical arrangement, however, is for the out-patient department either to have in charge somebody who is interested in it, as a policeman is in his beat, to see that nothing goes wrong during his short period of incumbency; to have a head nurse or registrar, who does the best that a nurse or a clerk can do without authority or training to do more; or, finally, to have the dispensary run by its several departments, according to the method in which the ancient kings of Ireland are said to have conducted their affairs.

A very few institutions have recently placed a qualified person in responsible charge of the out-patient, with permanent tenure. How can an organization having a large working staff and dealing with thousands of persons, be efficient or progressive without an executive head, with real responsibility?

Of the 27 dispensaries not connected with hospitals, two-thirds (18 out of 27) say they have a “permanent Superintendent.” In most cases, however, this person is only a registrar or admitting clerk, and the dispensary really has as many executive heads as it has clinical departments.

2. *Payment of the Medical Staff.*—Six out of 49 hospitals pay all of their out-patient staff; three more pay some of them. All but two of these are out-patient departments of large general hospitals. A salaried staff is naturally much more frequent among the dispensaries unconnected with hospitals, only half of

which do not pay at least some of their medical men. Further facts indicate that while an apparently growing number of hospital and dispensary men desire a paid out-patient staff (if they had money to pay them!) there is a very considerable number (nearly half of the hospitals) who say that they do not believe in paying salaries to out-patient men.

3. *Social Service Department.*—Such departments are reported from 59% of the institutions, and are favored by 94%.

4. *Records.*—Seventy-two per cent. state that they make some record every time a patient visits the clinics; but only 60% have a list of the names and addresses of their patients.

5. *Technique of clinical work.*—Is it part of the routine, in medical clinics, to make laboratory tests of urine and blood for each patient, and to make a record of weight? In round numbers, 40% of the clinics report that they do this in some cases; 20% that they do so in all cases; and 40% that this work is not done at all. The proportions vary slightly between the tests of urine, blood and weight; urine being tested most frequently, weight next most frequently, and blood least frequently of the three. These figures refer in nearly all instances to the medical clinics only.

“Are physical examinations made, and recorded as a matter of routine, on the clinical record of each patient?” Forty-seven out of 76 institutions report that this is done in all cases,* 15 say it is done in some cases that seem specially to call for it; 12 admit that it is not done at all.

6. *Dispensary Abuse.*—So much material has been collected on this topic that it will be published as a separate paper. The subject has been discussed with more length and more heat than any other in this field. One little group of facts must be included here. Thirty-six institutions—mostly very representative ones—have reported the number or percentage of applicants who were excluded from admission, in a given period, because they were “not proper subjects”; i.e., were thought able to pay a private physician. These

*While not always so specified in the returns, this undoubtedly refers in nearly all cases to the medical clinics only.

36 institutions treated approximately 520,000 out-patients last year:—

3 of the 36 excluded between 5% and 20% of the applicants.

5 of the 36 excluded between 2% and 5%.

7 " " " " 2% and $\frac{1}{2}$ of 1%.

21 " " " less than $\frac{1}{2}$ of 1%.

In other words, four-fifths of these 36 institutions excluded less than 2% of the applicants, and more than half refused a merely negligible number.

May not this conclusion be drawn? *The protection of the institutions and the medical profession from abuse by the small per cent. of improper subjects for out-patient treatment, is a necessary task; but the provision of efficient treatment for the 90% or 99% of patients who are admitted is a first essential.* Local conditions vary, and in some cities and some institutions this problem is larger than in others; yet, in general, what the out-patient service needs is a constructive program.

This further may be said, that the lack of agreement not only as to what can be done, but also as to what should be done, is nowhere more apparent in out-patient work than in dealing with this bugbear of "abuse."

7. *Cost and cost accounting.*—Schedules have been collected from six well-known institutions, showing how the superintendent estimated the cost of the out-patient service and of its various divisions. To present the details of these schedules, would suggest unfair comparisons. The following points may be made:

(1) The typical hospital does not maintain a considered segregation of the expenses of its out-patient department. Forty out of the 56 hospital annual reports (71%) previously referred to did not give the dispensary cost items separable from the hospital items.

(1) A relatively small number of hospitals do make a careful segregation of out-patient expenses; but each has its individual system, so that the expenses cannot be safely compared in detail.

(3) The *average cost per visit* of an out-patient is the best unit of expense, so far as a unit is desirable.

(4) Costs per visit vary widely, even among the institutions of high medical standing. The following table presents certain figures on this point:—

COMPARISON OF AVERAGE COST PER VISIT AT SIX OUT-PATIENT DEPARTMENTS.

Hospital or Dispensary	Visits last year	Expen't's last year	Aver'ge cost per visit (in cents)	Remarks.
A.....	51,000	\$26,600	52c.	A dispensary not connected with a hospital.
B.....	69,600	23,500	33.8c.	An O.P.D. of a large general hospital.
C.....	115,000	55,000	47.8c.	A dispensary with a small hospital
D.....	132,000	24,000	18c.	Same remark as for B.
E.....	136,000	78,200	57c.	" " " "
F.....	236,000	43,700	18.5c.	" " " "

Thus of these six institutions giving the detailed schedules referred to, three spend approximately the same amount on out-patient service—\$25,000 a year. But the visits paid by patients to these three are, respectively, 51,000, 69,000 and 132,000; and the average cost per visit, therefore, respectively, 52 cents, 33 cents and 18 cents. Institutions D and E have approximately the same number of visits—a little over 130,000—paid by patients during the year; but one of these two institutions is spending \$24,000 in the year in its out-patient, and the other \$78,000, the average cost per visit being, therefore, 18 cents and 57 cents.

(5) Differences in average cost per out-patient visit are due partly to differences in organization, character of equipment, extent of medical teaching, etc.; partly to actual differences in standards of efficiency; and, finally, are partly factitious, owing to different methods of accounting.

(6) Although for these reasons comparisons of average cost per visit must be made with great caution when different institutions are compared, this cost unit is of the utmost value to every dispensary and out-patient department in the annual study of the progress of its own work. The greatest value of keeping good dispensary accounts is in self-criticism rather than in comparison.

(7) What shall we do about this matter of cost? If accurate and uniform cost figures for hospitals are still

difficult to get, must not accurate and uniform out-patient figures be inconceivable? The inconceivable, however, happens when it becomes necessary. With the rapid growth of out-patient work, and its assumption by municipal and state authorities, segregated dispensary accounting is a near necessity.

To draw up a form in which dispensary accounts should be classified, appears to be one of the most important and desirable pieces of work in this field. Such an assistance in accounting is needed, not only by out-patient departments of hospitals, but by the rapidly increasing number of dispensaries unconnected with hospitals. Such a form should not be complicated; but its preparation needs much care, and should be undertaken by a committee, as I shall suggest later.

PRESENT QUESTIONS AND PROBLEMS.

I take this occasion to speak of some needs of out-patient work which specially merit discussion because they are now, as it were, on the firing-line.

1. Should not every out-patient department or dispensary of any size, have a permanent Superintendent in responsible charge?

2. *More continuous and closely organized medical service.* The question of the payment of a physician for out-patient work arises here. On this point differences of opinion undoubtedly exist. A majority of those answering the question in the schedule believe that payment of physicians is desirable. The very respectable minority who gave a negative opinion may, it is true, have been partly impelled to do so by the belief that it is foolish to say you believe in paid doctors when you have no hope of getting money to pay them.

It is undoubtedly true that the increase in the amount of out-patient work which has come so rapidly, and the demand for higher standards of work which is certain to come—both contribute to increase the difficulty of securing enough good medical service without payment. The pressure falls first and most severely on the dispensaries not connected with important hospitals, but having teaching. Large hospitals, well known in their communities, and associated with medical schools, are likely to feel the pressure less or later.

There can be little doubt that a steady movement in the direction of paid services will take place. There can also be no doubt that the money to provide for paid services cannot be secured until the public is more fully and intelligently informed about the needs and the importance of out-patient work.

3. *Social Service Departments* must be largely developed and organized closely in conjunction with the nursing service in the clinics and in the patients' homes.

4. *Admission systems* must be planned not only to keep the so-called "unworthy" out, but to reveal otherwise undiscovered needs of the so-called "worthy" who are admitted. A properly trained person at an admission desk is in a strategic position to benefit every phase of the dispensary's work. The use of a member or members of the Social Service Department in this position is, and should be, increasing.

5. *Should patients be charged any fees?* A speaker at last year's session of this Association answered this question in the negative. The reason was apparently in part from the belief that if a dispensary is a charity, it should not dispense charity at a price, but charity *straight*. Another argument purports to show that nominal fees cheapen medical service. A committee of the New York County Medical Society, in a recent report, suggested a further objection to the fee system; namely, that because the medicine and supplies used were thus paid for, the "burden of the charity of the dispensary" was "left exclusively on the medical profession," and that "charitable institutions should dispense charity to the extent of their ability and no more; that they should not make money for the purpose of extending their work . . . We believe the dispensary should be maintained for the benefit of the poor only." The impulse toward this trend of thought may possibly have been a feeling that dispensary work has gone too far in New York, and that anything that can be done to limit it, such as cutting down the resources of the dispensaries by limiting fees, will be a good thing.

Does "poor" mean destitute? Is not poverty a relative term? Are out-patient departments medical soup-kitchens? Is the test of fitness for dispensary treatment the inability to pay ten cents, or the inability to pay for

the medical care needed to maintain health and working efficiency?

Small fees paid by the patient at each visit, and for medicines, etc., are, if rightly managed, a boon to an out-patient department. They bring not only some money, but distinctive administrative advantages. They promote better records, tighten lines of responsibility, and necessitate some one in charge of the admission system who has sufficient authority to decide who shall be admitted without fees. If no persons are let in who have too much money, and no persons are turned away who have no money, may we not satisfy both those who are anxious to prevent abuse and those who burn to do straight charity?

6. *Efficiency tests.*—Business experts have come to the belief that when a man spends a thousand dollars for getting certain results, but does not spend one dollar for testing what those results are, he has wasted some of that thousand dollars. The out-patient departments and hospitals of this country are spending millions of dollars yearly in treating patients. How much are they spending in testing results of treatment? Are efficiency tests practicable in such a complex and personal thing as the medical treatment of out-patients? With the understanding that all tests have to be applied with a common-sense view of their limitations, I think they are of value; in fact, are a necessity. Three practicable efficiency tests will be mentioned.

(1) *Number of visits per patient.* If you find that 35% of cases of acute gonorrhoea pay only one visit to your men's genito-urinary clinic, and if 60% pay not more than two visits, will you consider the treatment in that clinic efficient? If in a certain medical service the average number of visits per patient is $1\frac{1}{2}$ and if during another service it is 3 plus, by which service would you rather be treated?

The number of visits paid by a patient is a figure easily ascertained, wherever elementary records are kept. When the patients or their records are taken in groups in which all have the same diagnosis or similar diagnoses, we can arrive at valuable conclusions. Comparisons between clinics in different institutions or even different services in the same clinic, must always be made with caution, but with reason-

able safeguards in interpretation, the *number of visits per patient, classified by diagnosis*, will be found a highly useful efficiency index. The amount of waste work that is found to be spent on patients who pay only one or two visits, when effective treatment clearly calls for several visits, usually stirs up the medical and lay authorities of an institution as much as anything can.

(2) *Medical results analysed on consecutive cases.* When records are carefully kept a clinical physician can take a number of patients with a given diagnosis and classify the results achieved as "cured," "materially improved," "pending" or "lost" because of failure to return. It is essential to take cases in consecutive order so as not to exercise selection. This test goes deeper than the preceding, but takes much more time and is too dependent upon full and accurate records to be generally available in out-patient clinics at present.

(3) *Medical-Social Surveys of Clinical Work.* A hundred or more cases may be taken (consecutively or at random) from a particular clinic, or from an institution as a whole. Then, a certain period after the diagnosis has been made in the out-patient clinic, a visit may be paid by a properly trained nurse or social worker to the home, and a report made to the physician of the patient's condition, or the patient may be brought back and again examined. In either case this method makes it possible to study the work which was actually accomplished by the dispensary for a group of patients, the number who made one visit and never came back, the probable reason for the failure to return; at the other extreme the number who were cured or substantially benefited. Finally we shall get a glimpse of the home conditions of poverty, ignorance, unemployment or neglect, which very often militate against successful treatment by the physician, and which without the assistance of a social worker, cannot be overcome.

Such surveys have been conducted in at least two institutions and have proved to be of great benefit. This value is not merely in criticism; for such surveys give positive suggestions as to how existing resources may be used to improve treatment. They also serve to provide facts upon which appeals can be made for funds for more resources.

7. Civic Problems.

(a) *Licensing of Dispensaries by State law.* New York and Colorado are the only states which have done this, but with the growth of both reputable and disreputable dispensaries, such legal regulation is certain to extend elsewhere.

(b) *Regulation or supervision of dispensaries* by the municipal Board of Health has appeared to some extent, and is also likely to increase.

(c) *Co-operative arrangements* among the out-patient departments and dispensaries of a city. The Associated Out-Patient Clinics of New York City have made a notable beginning in this direction. Such associations must ultimately be brought about in all large cities, both for the purpose of mutual protection of reputable dispensaries against abuse and for the positive aim of mutual assistance in establishing and maintaining high standards.

(d) *Municipal support or control of dispensary work.* This subject received some attention in the Out-Patient Committee Report last year, but I am unable to agree entirely with the conclusion therein reached. The pressure for funds and the probability that the need of paying physicians for out-patient service will increase, have caused many persons to think seriously that the only solution of the financial question is the assumption of dispensary work by city authorities. The activities of government are widening rapidly in many directions, as we all know, but it seems to me that, in the few localities with which I am familiar, it is premature to present a program of city ownership and control of dispensary work.

At least, I am confident that the development of standards of dispensary work is a prior necessity. Methods of out-patient service are not yet sufficiently worked out, agreed upon and standardized, to expect that many municipalities can fairly be asked to take over all local out-patient departments and dispensaries and deal justly by them. Those of us who are now concerned with administering out-patient work, have the present responsibility of working out standards, before we are justified in coming forward with a general program for municipal dispensaries on a large scale.

A COMMITTEE ON METHODS OF OUT-PATIENT SERVICE.

Much has been said in this paper upon the need of standards, and with a few more words on it I shall conclude. It has seemed to me that the American Hospital Association bears a special responsibility in this matter. The American Medical Association has a committee on "Dispensary Abuse," but there is nowhere a committee to do constructive work on the dispensary problem. The American Medical Association stands primarily for the interests of the medical profession. The Hospital Association, on the other hand, is in the peculiarly fortunate position of representing the joint interests of the medical profession and the lay public, through which the financial support of medical institutions chiefly comes. Standards and methods used in out-patient institutions are a matter of interest to the general public because they vitally concern public health. It would seem fitting and practical if the American Hospital Association should think it proper to have a Committee, say, of five members, appointed as a Committee on Methods of Out-patient Service. A committee of one, which has been appointed during the last two years, is capable of presenting a report such as that which you are enduring, but a committee of one cannot be representative.

What is needed now is a carefully-worked-out, concrete statement of at least minimum requisites for efficient service in an out-patient department or dispensary. There is nothing of this kind now available. I therefore urge that such a committee be appointed to present a report at the next meeting of this Association.

Perhaps it will be said that the superintendents of hospitals and dispensaries know very well today what is needed to improve out-patient work—money. Money is a most convenient necessity, I admit; but money must be secured by persuading somebody to give it—either municipal or state legislatures or private individuals endowed with philanthropic instincts *and* means. It is not easy to get money for something which the public does not know much about, and which is not given much apparent consideration by those who are supposed to have expert knowledge of it. In just such a condition

are the out-patient department and the dispensary today.

Two things are required before adequate support for dispensary work can be expected: *facts and a program*. Facts we must have, showing what the results of dispensary work can be, what the results under existing conditions are, and what is needed to make the results better. Outlines, drawn up by recognized authority, suggesting the requisites for efficient results, will be the greatest possible leverage in the hands of those who wish funds from public or private sources to place dispensary work on a higher plane. Facts and standards are the pre-requisites to a program of improvement. Public authorities and private givers like to know what is going to be returned for their money, and to have a definite program presented, before they are willing to do what the boys call "shell out."

If we read many signs of the times aright, the utilization of out-patient clinics for the treatment of sickness and the prevention of disease is going to increase rapidly. The out-patient department or dispensary is already playing a great and growing part in the anti-tuberculosis campaign; the campaign against the hook-worm has employed it on a large scale; the dispensary method has been adopted in the fight against infant mortality, and every summer now sees an increase in this field. Out-patient service is thrown more and more into the foreground by such influences as the rising cost of living; the increase in the cost of medical service; the recognized difficulty of providing competent specialists at prices within the reach of even the middle classes; and, perhaps more than all, the growing public demand for better care of the health of children. Workmen's Compensation laws, already established in many states, and other forms of social insurance which are in the field of political discussion—are bringing to this country, as they have brought to Germany, England, and other nations abroad, serious questions involving radical changes in the character of medical service to the mass of the people. These problems must be attacked from a broad standpoint which considers both the interests of the medical profession and those of the general public together.

The establishment of higher standards of out-patient service; the elaboration of a technique by which the treatment of out-patients can be made thoroughly efficient—are the immediate problems which we are facing. The solution of these problems of efficiency is a pre-requisite to the larger utilization of the dispensary as a constructive and permanent agent of promoting public health.

APPENDIX I.

Suggestions of material which the Annual Report of a Hospital should contain, concerning its Out-Patient Department.

1. *Arrangement.*—The opening portion of the Annual Report should give an idea of *all* the divisions of the hospital, and should put them in some perspective. Every report should have a table of contents.

2. *A Special Report for the Out-Patient Department.*—Every hospital in which the number of out-patients equals or exceeds the number of ward patients should give a special section of its report to the out-patient department, as a division of the hospital work. Such a report might be a section of the trustees' or superintendent's report, or it might be a report of a special committee on the out-patient department. Such a special report ought to contain:—

An idea of the general organization of the dispensary and of its medical service. It is probably well to print detailed statistics of the dispensary in the statistical section of the report, and only the general figures here.

Changes during the past year which have taken place in relation to such matters, as building, equipment, medical staff, executive staff, clinical methods, social service, etc.

Something about the problems of the work. The public really ought to be given the impression that the authorities of the hospital are *thinking* a little about the dispensary as well as running off clinics.

3. *Out-Patient Statistics.* The Report should state, for the period covered by it, (1) the number of patients, classified by clinical departments; (2) The number of visits made by these patients, classified by departments; (3) The average number of visits per patient for each department.

Statistics of special work—X-Ray, social service department, etc., should be given.*

4. *Finances.*—The cost of the out-patient department should be included in the Treasurer's Report, itemized so far as practicable. and the income from fees paid by patients, if any,

5. *Regulations Concerning Admission and Treatment.*—The rules governing admission of out-patients, the days and hours on which clinics are open, the class of patients taken, and the fees charged, if any, should be stated succinctly in every Report. Ninety per cent. of the 56 reports give no such information.

* The list of diseases treated is not included among the foregoing "requisites." The value of such a list, if carefully classified, is not questioned; but the amount of labor in preparing it is relatively so great that, if a choice is to be made between presenting it and the facts above mentioned, it seems that the facts above mentioned ought to come first.

APPENDIX II.

Organization and Methods of Out-Patient Work in 76 Institutions.

	19 Large Hospitals 18 Small Hospitals 12 Special Hospit's 12 Large Dispen'r's 15 Small Dispen'r's				Totals										
	Yes	No	Partly Yes	No	Partly Yes	No	Partly ans.	Not							
Paid doctors	4	12	3	1	17	..	1	10	3	10	2	14	52	8	2
Believe in or favor paid doctors	9	3	3	6	9	..	3	5	2	10	..	35	24	3	14
A permanent Supt. A Social Service	8	11	..	3	15	..	3	8	2	10	..	32	42	1	0
D Department	12	2	..	8	5	..	7	5	4	8	..	41	25	0	0
Favor Social Service Dept.	19	..	..	16	1	..	12	..	..	12	..	71	3	0	2
Rec'ds kept on cards	13	0	6	11	5	2	9	1	5	4	3	46	14	16	0
Patients' visits recorded	12	2	5	14	3	1	11	0	2	7	3	55	10	11	0
Index of patients kept	12	6	1	8	9	..	10	1	6	7	..	44	29	2	1
Physical exam. recorded in all cases	13	1	..	8	4	..	4	..	7	4	?	47	12	1	1
"In some cases"	5	..	..	5	..	..	1	..	..	..	..	15	..	..	..
Test of Urine a clinical routine..	2	6	11	3	8	7	5	1	4	3?	4	17	26	32	1
Test of Blood a clinical routine..	1	7	11	2	10	6	2	2	4?	5	3	10	31	34	1
Weighing Patient a clinical routine..	1	7	11	3	9	6	5	1	4	5	3	10	30	30	0

(b) Form* for classifying Medical Results correlated with number of visits paid.
EFFICIENCY TEST IN **DEPARTMENT**
 for months of **191**
 Diagnoses Tabulated

Visits per Patient	MEDICAL RESULTS						Total Number of Cases	Percent
	Continued Treatment, discharged cured	Continued treatment, ceased or was discharged improved	Ditto, not improved.	Treatment pursued & now continuing.	Case transferred to care of another Medical or Social Agency	Result unsatisfactory: patient failed to return for treatment. "Lost Cases"			Medical Outcome Unknown.
One								
Two								
Three								
Four								
Five								
Six to Eight								
Nine to Twelve								
Over Twelve								
Totals								
Percentages								

*Printed copies of these forms may be obtained by addressing the author at 25 Bennet Street, Boston, Mass.

DISCUSSION.

PRESIDENT: This paper of Mr. Davis' is a very interesting and instructive paper. Perhaps the President will be excused if he makes one or two remarks. As to municipal control of dispensaries, would it not be well to wait until municipalities do well what they have undertaken now before they take up this work. As for dispensary abuse, of which we have heard so much, the older I grow and the more years that I have to do with out-patient departments of hospitals, the less sympathy I have with this talk of dispensary abuse, and the more sympathy I have with the patient who is turned away and sent into the hands of some physician, or some medical institute where he will not get the care that he needs. I have less and less patience with this talk of dispensary abuse. Mr. Davis has made a recommendation that a Committee on Out-Patient Departments be appointed for the ensuing year. The by-laws call for a committee of one. I take it that there will be no objection to the incoming President adding to this committee. It certainly is a most important subject and one which, as Mr. Davis has said, has been so far neglected in most parts of the country. There are a few hospitals in the country that have done out-patient work as they should do it and they have plenty of room for improvement. Is there any further discussion on this paper?

DR. FOWLER: I beg the pardon of the meeting for appearing so often, but I am an enthusiast along hospital lines, and the remarks made by the distinguished essayist and the President have caused me to attempt to say something in response. As you know I am superintendent of the City Hospital of Louisville, Kentucky, and we treat on an average 125 people a day in our out-patient department and expend something like \$15,000 per annum, and we think we do it well. We keep specific records, and four hours in the morning we put a staff officer in there, not an interne, and four hours in the afternoon, and the other four hours are taken care of by the internes, by the house staff; so we do not lose an hour in the day in treating those poor people that come from all over the city, some of them walking five or six miles, and we also honor every prescription marked "Charity" by any physician in the city, and in addition to that we furnish every nurse, all the district nurses, all the King's Daughters nurses, all the Jewish charity nurses, in fact, all those institutions, with anything that they demand, their daily supplies in visiting the poor over the city, and I believe that the city is the only one to get back to a movement of that kind. My experience has been with the other organizations that that is why they came to us, that they could not raise the money, but my city has been extremely liberal and have authorized me as Superintendent never to stop at any expense. I have spent as much as \$11¢ buying serum for one child. That is the remark that I desire to make.

PRESIDENT: It is refreshing to hear of a city which is so well conducted. Are there any further remarks on Mr. Davis' paper? If not we will go to the next paper.

