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THE IDEAL CLINIC IN LARYNGOLOGY.

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The treatment of diseases of the nose and throat is carried on to a greater extent in an out-door clinic, without the aid of hospital facilities, than any other clinical division of our profession, with the single exception of dermatology. At the same time the clinic in laryngology, without exception, requires more elaborate equipment and more careful organization for its successful and satisfactory operation than that of any other specialty. A short study of the difficulties met in the running of such a clinic may therefore be of interest to those who are trying to overcome them.

Equipment.—The proper “housing” of the clinic with regard to economy of space and ease of operation first demands our attention. While this will of course depend largely upon the routine to be followed and the space at our command, the most practicable division is to provide three rooms, if possible, with an additional small dark room for transillumination.

The first room is used for taking the history and making the primary examination of new cases. In order that the examination may be thorough, it is essential that it should be conducted systematically and amid as little confusion as possible. This is best accomplished by this part of the work being done by one physician and a nurse. The room may be comparatively small, containing sink, sterilizer, table and light for physician, and desk for nurse, at a convenient distance for her to take down dictation of conditions found. With a little care the position of the desk can be so arranged as to allow the nurse to take the personal history of the patient previous to the examination without changing her position.

The second room should be entirely for the treatment of old cases. Each member of the staff should have his own table or booth, the sink, sterilizer, instrument cabinet and writing desk may be conveniently used in common.

The third room should be an operating room, where a general anesthetic may be given when desired. The nearer this room approaches the ideal hospital operating room in equipment the better. In addition it should be provided with an operating chair, properly screened from the rest of the room, where the longer operations under local anesthesia may be performed. Whenever the operative cases are numerous, adjoining narcosis and recovery rooms are of great convenience in handling the cases.

The dark room contains a transillumination apparatus. It may be of small size, and should open off of the room for the examination of new cases (if impossible to have it connect with both rooms).

The selection of instruments and furniture for the clinic is too large a subject to enter into in a paper of this length. Let me suggest, however, that the instruments should be supplied by the clinic. The practice of requiring each member of the staff to bring and use his own instruments, as followed in some institutions, never works well. It often happens that an assistant does not own the best instrument for the purpose, or if he does it is not on hand when wanted. It is much better to have at the clinic a complete outfit of useful instruments, carefully selected by the physician in charge. This adds materially to the expense, of course, especially to the running expenses, when the cost of repairs and new instruments is counted in, but the results are well worth the outlay. The advantages of a card system of records are so well recognized that they need but to be mentioned.

Staff.—The staff should consist of an attending physician with as many assistants as necessary, a clinic nurse, and if the operating room is to be used during clinic hours, a second nurse to assist at operations is necessary.

Routine.—A carefully arranged routine should be established and strictly followed. This not only increases the interest of the staff, but also adds greatly to the efficiency of the clinic, doing away with confusion and neglect. The routine must be arranged to suit individual clinics, but that of which

the following is an outline has proved in the main satisfactory.

The nurse having previously taken the personal history of the new cases (before the clinic hours, if possible), calls a new case into the first room for the primary examination. It is best that this examination be made by the physician in charge. This may seem to impose an irksome routine on the attending physician, but in skilled hands the examination of the majority of cases is quickly made, and in no other way can he keep in touch with all the cases, and regulate the treatment. The result of the examination is dictated to the nurse who records it on the patient's record card, together with suggestions for operation or treatment. The case is then assigned by the attending physician to one of his assistants, the name of the assistant being stamped on the record card and also on the patient's identification card. On returning to the clinic the patient is called into the second room by the assistant to whom he was assigned, and the recommendations for treatment previously noted on his card by the attending physician are carried out. If for any reason the attending physician wishes to see the patient a second time, he need not assign him to an assistant at his first visit, in which case the patient returns to the attending physician at each subsequent visit, together with the new cases, until assigned. If an assistant wishes further advice about a patient he may at any time bring him in to the attending physician for consultation, and should always return the case for re-examination before final discharge. To regulate the use of the operating room, operations done under a general anesthetic should be done by appointment, and cards given to the patient showing the time, etc.

The above outline may at first sight seem to indicate a rather cumbersome and inflexible system. A little study, however, will show the opposite to be true. In the absence of the attending physician the first assistant assumes his duties, examining and assigning the new cases. A case of uncertain diagnosis he may leave unassigned, and it is seen by the attending physician at his next visit. Or the physician in charge may at any time turn over his work to an assistant, and be free to operate or otherwise employ his time, knowing that the routine will go on uninterruptedly, and that

interesting or difficult cases will return to him at a subsequent visit. This system also allows one assistant to follow a case through its whole course of treatment, as is necessary both for the interest and instruction of the physician and the benefit of the patient.

With the facilities and system described all the operations and treatment necessary in laryngology, with the exception of radical operations on the sinuses, may be carried out. There will be a "hundred and one" details and problems which must be worked out by the individual clinic. Some must provide for students, undergraduate or postgraduate. There are record cards, appointment cards, blanks, etc., the printing of which should be carefully considered. And practically all institutions are hampered in doing all that they wish to do, as well as they would like, by lack of funds. None of us will attain perfection, but this paper is a plea that more thought and care should be given to the management of the clinical work of our specialty—at least the thought and care which the general surgeon gives to his hospital wards and operating room.

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