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The Massachusetts Medical Society.

MEETING OF THE SECTION OF HOS- PITAL ADMINISTRATION, JUNE 12, 1917.

THE CHAIRMAN, DR. HOMER GAGE, Worcester: This is the first year of the Section of Hospital Administration, and its existence is due largely to the work of Dr. E. A. Codman in the meetings of the Clinical Surgical Society, which has brought to our minds, perhaps more forcibly than ever before, the necessity of doing something to find out whether our hospitals are really doing the work they are intended to do, that we think they are doing.

We have taken it for granted for a long time that hospital work is being done just as we think it ought to be done, but we have never undertaken any real method of standardizing hospitals, or the work in the hospitals, or of following up the results of hospital treatment to find out whether the hospital treatment was accomplishing what it was intended to accomplish. Of course it is money thrown away if a patient comes to a hospital for medical or surgical treatment and pretty soon after leaving the hospital has to return for more or further treatment, and if that is being repeated it simply means we are wasting our hospital endowment; and with the enormous increase in the number of hospitals it becomes apparent that some work must be done to find out exactly how we stand, and what our results are. We must have some means of determining the char-

acter and success of the work which we are doing, and it is the outgrowth of that feeling that led to the establishment of this Section.

THE FOLLOW-UP SYSTEM.

BY CHANNING C. SIMMONS, M.D., BOSTON.

THE end-result and follow-up systems in use at certain of the hospitals at the present time is a comparatively new development and is a distinct step in progress in the keeping of hospital records. Certain of the larger hospitals have adopted the determination of the end results of their cases as a routine part of the record work, and it is done automatically, while many others in good standing have as yet made no provision for it. The end-result work, to determine the results of treatment of cases treated at the institution, is distinct from the follow-up work in use in out-patient clinics, notably in the children's and orthopedic departments, and it is of the former only that I shall speak. I have been interested in the work since it was first started at the Massachusetts General Hospital. I do not refer to groups of cases worked up by individual men, but of the work as part of the record system of a hospital under the charge of the librarian or custodian of the records.

To determine the result of treatment of a surgical case and post this result in the record is, without question, of distinct advantage to the hospital, the science of surgery, the surgeon who performed the operation,—showing him his successes and his mistakes,—and, above all, to

the patient. It completes the record of a case, and soon shows which operation, if there is a choice of two for a given condition, is the better, and whether one is better in one man's hands and a second in another's. It also allows the comparison of statistics of different men. I believe the personal equation comes in in surgery as much as in any other profession, and, although I believe in the efficiency propaganda, I think it can be overdone to the detriment of the patient; and when all is said, it is his condition we are trying to improve.

Mrs. Myers, the librarian of the Massachusetts General Hospital, made a trip last fall, visiting many of the larger hospitals in the country and studying their record systems, and I have been surprised in reading her report to learn how many of the larger hospitals in the country have no provision to determine the end results of the cases treated. I give below a list of nine hospitals, five of which are in Boston, that have some form of follow-up system, and the methods they employ. The end-result work is limited almost exclusively to the surgical cases, but I see no reason why it should not be extended to include some of the medical cases as well.

Massachusetts General Hospital. Letters are sent all surgical patients one year from the date of discharge, asking them to report at the hospital for examination, or write stating their present condition. If they report, they are examined in the accident room by the house surgeon. If there is no reply to the letter, nothing further is done, but if the letter is returned "unclaimed" a second is sent to a friend. In one year, as far as can be determined, about 75% of the cases were heard from, but in all probability in not over 60% was the information obtained by the hospital routine (2739 cases). The system is fair but far from perfect.

Peter Bent Brigham Hospital. A system similar to that at the Massachusetts General Hospital, and about as effective.

Collis P. Huntington Hospital. The end-result and follow-up work is in charge of a social worker, who does practically nothing else. For the three-year period, 1912-1914, 603 cases (95.6%) were followed. At present there are about 500 new cases a year.

Boston Dispensary. A very good follow-up system in charge of social workers. As this institution is practically only an out-patient clinic, there is little end-result work done (Howard¹).

Carney Hospital. There is no provision for end-result as a part of the hospital routine. There is, however, a paid social worker following up the surgical cases, under the direction of Drs. Bottomley and MacAusland. She is developing an end-result system.

Presbyterian Hospital, New York. This hospital has, as far as I can determine, the best

perfected end-result and follow-up system of any in the country. Carscaden² has described the system at length and says that for one year the results on 91.6% of the cases were determined (2278 cases). It is under the charge of a social worker.

New York Hospital. There is no end-result system maintained by the hospital. Dr. Gibson³ has a system in force on his, the first surgical service, and Dr. Bancroft⁴ a similar one on the second surgical service. Both of these systems are admirable and are in charge of social workers, but, as I understand it, are financed by the men themselves.

Michael Reese Hospital, Chicago. Letters are sent to all patients one year from the date of discharge, asking them to report for examination. The system is fair, but can be improved.

Mayo Clinic, Rochester, Minn. No regular system. If a surgeon wishes to follow up a group of cases, he is given the proper facilities, and the letter sent is passed on by a clinician, a surgeon, and a pathologist, to make sure all necessary questions are asked.

The above list is not intended as a full one of all the hospitals that have a follow-up system, but only to give a general idea of the methods employed.

The difficulties of the work vary as to the type of patients treated. In hospitals drawing patients from thickly settled districts, as the East Side of New York, it is fairly easy to trace cases and to get them to report for examination as, although they move often, they never move far from their original address. At the Massachusetts General Hospital, on the other hand, the patients come from all over the New England states, and it is difficult to get them to report, but as they are more intelligent than a foreign population and rarely move, they will usually answer a letter. Their friends are also easier to locate.

I believe that if the work is done properly and conscientiously, 90% of a group of surgical cases can be traced at the end of from three to five years. I personally have tried to determine the results in four groups of cases in the last ten years, and have been able to trace over 90% in each instance. These were as follows:

Cancer of the breast, 416 cases, 3 to 13 years after operation, 90.8% traced.

Cancer of the tongue, 112 cases, 3 to 8 years after operation, 93.7% traced.

Inguinal hernia, 162 cases, one year after operation, 93.8% traced.

Umbilical hernia, 70 cases, one to five years after operation, 91.5% traced.

These personal figures for cases at the Massachusetts General Hospital compare closely with those given for the Presbyterian and New York Hospitals, where the system is under the charge of a paid social worker and done automatically. It also shows that the class of patients makes very little difference.

At the Collis P. Huntington Hospital we have a social worker who does practically nothing else. She has developed a system of her own which, however, is applicable best to a small hospital of this type, averaging now about 500 patients a year. As this is a hospital for the treatment of malignant disease, no record is considered complete until the patient is dead from malignant or other disease. The figures for the three-year period, 1912-1914 (603 cases) are as follows:

Reported on account of letter sent	81	} 576 cases (95.4%)
Reported by letter	82	
Found to be dead	381	
Under regular observation	32	
Letters unanswered	16	} 27 cases
Letters returned unclaimed	11	

In establishing an end-result system there are certain points it is necessary to bear in mind in order that it should give the best results. In the first place, it is necessary to have the interest and active support of the visiting staff, not their passive acquiescence only. The staff must assist in the work and do all in their power to further it. If they do not like the methods the social worker or whoever else is in charge of the work employs, they should say so and do their best to correct errors, not grumble and find fault with the whole system. I think there is no question now that social service and allied work, properly supervised and administered, has come to be a recognized part of all well-organized hospitals. They must, however, work with and under the staff, not as two separate organizations under the same roof.

It is important the patient be told before his discharge that he will receive a letter asking him to report at a given time. It should be impressed on him that this is for his good, and that the doctors take an interest in him. Unless this is done many will pay no attention to letters, as they think the hospital is dunning them for an unpaid bill.

Time to Report. The ideal method is to have each case judged by itself, and told to report at a time deemed proper for that case. Three months is a good unit of time for most cases. Many will be well at the end of that time, and it will not be necessary to see them again. On the other hand, cases of carcinoma should be kept under observation for several years, and should report regularly every three to six months.

Examination. All cases, if possible, should be seen by the surgeon operating upon them, as he knows the case better than anyone else, and can see the results of his work, good or bad. If he cannot see them, someone having good judgment, in authority, and interested, should be delegated to the work—not a house officer.

It is of assistance to have the record, or a good abstract, in the examining room at the

time the patient reports, as it is impossible to carry all the data in regard to a given case in one's head. After examination I believe all notes should be made in the record itself and signed. If more convenient for handling, the notes may also be made on a separate card similar to that advocated by Dr. Codman.^{5, 6}

Suggestion for Establishing an End-Result System.—I believe all hospitals should have end-result reports on all cases, but the actual details of the system must depend, to some extent, on local conditions. I shall refer those interested to the articles already cited, rather than go into the details of a system. The hospitals that have adopted this work all have very much the same routine, although that at the Presbyterian, in New York, is probably the most perfected.

There are certain general suggestions which, if carried out, will make the work easier. The admission card of every patient should have the address of two friends, one of whom has a permanent address, as well as of the patient. If the patient is a woman, her Christian name, as well as that of her husband, should be obtained. It is also well to note the address of the physician or person recommending the case. Care should be taken to spell foreign names correctly.

The work should be under the control of the librarian or custodian of the records. It should be automatic and in charge of a full-time social worker, or similar trained person, and not left to a stenographer or ordinary clerk. It should take the full time of one person and part time of a second to do the work of a hospital having a discharge list of from 3000 to 4000 a year, but one of these only need be trained.

The worker should see each patient at the time of his discharge, and give him a card asking him to report at a given date, or explain to him, he will receive a letter about that date. At the time the patient is to report she should have the record in the examining room, and should also notify the surgeon. With a visible index file, the worker can easily keep track of the cases. If possible, the patients should be given the opportunity to report on an evening or Sunday, as to many, reporting in the daytime means giving up a half day's work. At the Massachusetts General Hospital the patients receive a letter asking them to report one year from the date of discharge, and this year I have notified patients I operated upon a year ago I would see them personally if they reported Sunday morning. From 5 to 12 report each week. If they report week days they are seen by the house officer in charge of the accident room. At the New York and Presbyterian Hospitals the staff meet once a week, see the cases operated on previously who are reporting, and discuss the work of the service. This is an ideal proceeding, but almost impossible of attainment.

If patients do not report, and do not reply to letters in a reasonable time, the worker should

try the various methods used to trace cases. In 1912 I published a short paper⁷ giving the methods I had found useful in tracing a given case. These suggestions are applicable, particularly to Massachusetts hospitals.

1. If there is no reply to letters sent, the worker should call at the patient's residence, and if he has moved make inquiries of the neighbors, laying stress on the fact that she is not a bill collector, but wishes to ascertain his health.

2. Write to the friends and physician.

3. Look up the patient or friends in the telephone book or in the local directory of the town in which they live, following them through year after year, till the change in address is found. (Directories of all towns in the state are in the office of the State Board of Charities in the State House.)

4. In cases of malignant disease, go through the files of deaths in the bureau of vital statistics at the State House, to rule out patients dead. (If you give the clerk a list of the correct names of the patients with the age and address and the probable date and cause of death, she will usually do this for you.)

5. If the patient comes from a small town, write to the postmaster or town clerk. They can usually give you some information.

6. Write to the state boards of health at the capitals of the New England states, inquiring if the patient died in that state.

7. The police will sometimes give you information if you tell them why you want it.

8. If you believe a patient with cancer to be living, but can get no reply to a letter, send him a registered letter. You will get his signature any way.

9. The Confidential Exchange of the Associated Charities has a record of many of the poorer cases.

10. Make all letters polite and personal. You are much more apt to get answers than if a "Neostyle" letter is sent.

There are many other methods of tracing cases that suggest themselves as one does this work.

I hope in the near future to see more of the leading hospitals adopt some form of end-result records and also to see the work done on the medical as well as the surgical cases, to which it is limited at present.

REFERENCES.

- ¹ Howard, A. A.: *Jour. Am. Med. Assoc.*, 1915, Vol. lxxv, p. 1962.
- ² Carscaden: *Jour. Am. Med. Assoc.*, 1916, Vol. lxxvi, p. 802.
- ³ Gibson: *Annals of Surgery*, September, 1916.
- ⁴ Bancroft: *Johns Hopkins Hosp. Bull.*, 1916, Vol. xxvii, p. 201.
- ⁵ Codman: *Surg., Gyn. and Obst.*, January, 1914.
- ⁶ Codman: Report of the second two years of the Codman Hospital.
- ⁷ Simmons: *BOSTON MEDICAL AND SURGICAL JOURNAL*, 1912, Vol. clxvii, p. 54.

DISCUSSION.

THE CHAIRMAN: This is an important paper of Dr. Simmons, and very suggestive. There is one other means of looking up patients that has come to my notice lately, and it is in connection with what is really one of the most important works,

medically, undertaken for a good many years. It is being undertaken at the Mayo Clinic, at the suggestion and practically by the request of the Medical Directors' Life Insurance Association, to try to get at what are the real results of operations. Dr. Charles Mayo read a paper before that Association in New York in October of last year on the relation of gall-bladder surgery to life insurance that was a little disappointing, and the disappointment was expressed simply because it did not give figures; it gave impressions only. It gave figures of the immediate successes or failures, but that was all.

As a result of that discussion, Dr. Mayo stated that they would be very glad indeed to extend the facilities of their records to the Medical Directors' Association, to determine according to actuarial methods exactly what the results were and to translate these into insurance language. That invitation was accepted, and the actuary of the New York Life Insurance Company went out there and they started an investigation on three lines: on the line of gall-bladder operations, on operations on gastric and duodenal ulcers, and on thyroids. Such knowledge is of such great importance to the insurance companies that they have said if, after these records are gone over carefully and everybody found out who can be found out by personal solicitation or by writing to friends, the list of those who cannot be found out be given to them, that the matter will be treated confidentially and the patients will be carefully looked up by their inspection systems. They believe that then they can get as good results as Dr. Simmons says he is getting when he puts his personal attention on the matter.

To my mind, the results of these investigations ought to be of immense importance. We have got a start in this work of Mayo's under very favorable conditions. It is more than the follow-up system; it is pretty nearly the end result of each case, and is going to show the mortality statistics in these cases—not necessarily the mortality due to the particular condition for which they entered the hospital, but its relation to their natural expectation of life; and all of these things are most interesting.

One other thing, about having these cases report on Sunday. At the Presbyterian Hospital the three surgeons at the head of the surgical division alternate in attendance on Sundays—first one is on duty and then the next, and so on. I endorse this plan. Someone of the visiting surgeons is there every Sunday morning, and the patients are requested to report at that time. This is of special importance in a large metropolitan hospital, where many of the cases cannot come at any other time.

Dr. Simmons' paper is open for discussion or suggestions.

DR. P. E. TRUESDALE, Fall River: I would like to ask what the Massachusetts General Hospital will do, for instance, when its new private ward is established? Will the blanks or inquiries be sent to the doctors or directly to the patients?

DR. SIMMONS, Boston: I personally could not answer that. I should suppose it would be regarded as a private hospital.

DR. J. B. HOWLAND, Boston: I should assume that these were private patients, and the doctors will do as they please with them.