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A study of the educational opportunities available for student nurse education in the outpatient department at "X" General Hospital

A STUDY OF THE EDUCATIONAL OPPORTUNITIES AVAILABLE FOR STUDENT NURSE EDUCATION IN THE OUTPATIENT DEPARTMENT AT "X" GENERAL HOSPITAL

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CHAPTER I

INTRODUCTION

The definition, "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity,"[1] adopted by the World Health Organization and widely accepted, expresses the concept of health found more often nowadays than formerly in the literature of health and health instruction. Since health is no longer considered to be the mere absence of disease, the functions of all members of the health team must take on different dimensions.

> Because of the great power of education over the welfare of mankind, the responsibility of the administration of education for the social outcome of education is tremendously important. Nursing education is a part of the whole process of education which society has made responsible for the welfare of man and society and to which society looks for the preservation of the American system of values. Nursing education carries a large responsibility for the health of the nation. The cataclysmic changes that are taking place in society are producing new and highly significant demands on all of the health services and all of education. These and other forces in present-day living constitute a distinct challenge to nursing educators. They are certain to affect nursing education and the practice of nursing, but they can be guided and their

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[1] Roy W. and Genevieve K. Bixler, Administration for Nursing Education (New York: G. P. Putnam's Sons, 1954), pp. 6-7.

> influence controlled if the leaders in nursing education are able to analyze the social and health needs correctly and plan so that nursing education is able to meet its share of these needs.[2]

Those responsible for directing programs in nursing education can no longer be satisfied with a program which is exclusively oriented to the care of the patient during his hospital illness. There is need for continued effort to establish and maintain programs which will provide the learning experiences necessary to prepare a nurse in line with needs of present-day society and capable of participating in the total health needs of the patient and members of society.

The nursing profession, aware of the need for focusing the orientation of the nurse to the broader and deeper concept of health, human relationships, and community welfare, must endeavor to seek experiential areas which will provide a social and health approach to nursing.[3] The mere fact that the hospitalized patient provides opportunity for the student to practice nursing on a comprehensive level does not negate the feasibility of exploring additional clinical areas. Continued efforts must be sustained to help students gain a clear perspective of the individual, the family, the community and relationships between health and disease. It is a generally

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[2] Ibid., pp. 5-6.

[3] Audrey Windemuth, The Nurse and the Outpatient Department (New York: The Macmillan Company, 1957), p. 73.

accepted fact that the education of students must include more than experience with the hospitalized patient if the graduate nurse is to function as a promoter of the health and welfare of society.

The outpatient department is an area within the framework of the hospital where the nurse has opportunity to integrate all that she has learned about the positive concepts of health and to apply this knowledge and understanding in a practical setting.[4] The ambulatory patient who comes to the outpatient department clinic to seek assistance with his medical problem is frequently beset with personal problems. The mere presence of the illness which prompted him to attend the clinic in the first place may well be responsible for taxing him and his family with further problems. Here is an individual who enters the portals of the hospital for a very brief period and who still maintains his identity as a functioning member of the community. Certainly an environment such as this, is one in which health and health teaching can play an important role.

Statement of Problem

Does the Outpatient Department Clinic Service located at the "X" General Hospital offer experiences which could be used in the education of student nurses?

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[4] Ibid., p. 74.

Justification of Problem

Since the outpatient department is an area of the hospital where the student has opportunity to integrate all that she has learned about the positive concepts of health and to apply this knowledge and understanding in a practical setting,[5] practice in this area would seem to be a worthwhile experience for student nurses. Sister Lennon recommends that before a teaching program is initiated in this area, a study should be made to determine the quality and quantity of material available.[6] Objectives for the students' experience in this particular area of "X" General Hospital had been formulated, but learning experiences available in the outpatient department had not been identified. The faculty of the School of Nursing recognized the need for further information in order to ascertain if the objectives were in line with available learning experiences.

Scope and Limitations

This investigation was conducted for a period of one week in the outpatient department of a 256-bed general hospital located thirty miles northwest of Boston, Massachusetts. The hospital is located in a rural, semi-industrial area. Since

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[5] Windemuth, op. cit., p. 74.

[6] Sister Mary Isadore Lennon, Teaching in the Outpatient Department, (New York: G. P. Putnam's Sons, 1954), p. 35.

several of the clinics are offered on a bi-weekly basis, the study was conducted during a week when all the clinics were scheduled. This period by nature of its length places certain limitations on the amount of information available for the study. Another factor to be considered is that this one week may or may not have been a representative or typical one. Of the eight clinics which were scheduled for this week, four attracted no patients. The observations, interpretations and conclusions were confined to the efforts of one individual, and as such express the opinion and judgments of only one individual, which in itself places a limiting factor on the study.

Preview of Methodology

The data were obtained from observations made during the individual patient's clinic visits, from individual patient's records and from conversations with personnel who were working in the area.

CHAPTER II

THEORETICAL FRAMEWORK OF THE STUDY

Review of Literature

Throughout the history of modern nursing, nurse educators have been concerned with preparing persons capable of practicing nursing in the society of their time. Many recommendations made today for the improvement of nursing education, and thought to be new, actually can be found in the early literature, perhaps worded a bit differently, but nevertheless containing the same basic concepts, namely meeting the nursing needs of the people. What has changed is our concept of nursing needs, and how to best meet these needs.[1] Miss Nightingale herself was not interested in simply keeping people alive. In Notes on Nursing, she defined nursing as helping people to live.[2] She felt that sickness could not be treated apart from the causes that bred it, and these causes were not only physical but mental and social. Frequent references to health and health instruction are found in her

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[1]Loretta Heidgerken, "Some Problems in Modern Nursing," Nursing Outlook, VII (July, 1959), pp. 394-397.

[2]Isabel Maitland Stewart, The Education of Nurses, (New York: The Macmillan Company, 1944), p. 48.

writings, and issues such as decent housing, proper sanitation, the value of health statistics, cooperation with government and other agencies, and education of the public are emphasized.[3] As history reveals, the success of the program developed by Miss Nightingale spread throughout the world, and other areas hastened to follow her lead. In 1873 the first program patterned after the Nightingale School was established in the United States, and by 1909 the number of schools of nursing had mounted to more than 1096.[4] In retrospect it must be remembered that Miss Nightingale envisioned the nursing school as an educational institution, and as such, controlled by nurse educators. However, as new programs were developed, forces at work in society tended to push the educational aim of the school into the background. As a result, programs of nursing education throughout the country did not discriminate between the aim of supplying a good nursing service for a hospital and that of developing a good educational system; in fact they were often considered identical.[5]

It is fortunate indeed that there arose from within the nursing ranks individuals who saw the need to organize the

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[3] Ibid., p. 72.

[4] United States, Office of Education, "Nurses' Training Schools," A Report of the United States Bureau of Education, II, (Washington: Government Printing Office, 1909), p. 1077.

[5] Stewart, op. cit., p. 131.

profession for more uniform standards. The year 1893 marked the beginning of a new period in nursing education. In addition to the establishment of the two professional nursing organizations (the Society of Superintendents, later named the National League of Nursing Education, and the Nurses' Associated Alumnae, later named American Nurses' Association), increased emphasis and interest was focused upon programs concerned with the education of the nurse.

There have been many individuals in the history of this young profession whose astute literary contributions, far-sightedness and vigorous leadership have assisted in focusing the attention and efforts of its members upon the raison d'etre of a school of nursing. During these formative years the efforts of leaders such as Mary E. P. Davis, Sophia Palmer, Adelaide Nutting and Isabel Hampton Robb, were directed toward raising educational standards in schools of nursing,[6] and literature of subsequent years reveals that there has been continued study in this direction. The two professional nursing organizations have had considerable influence in shaping educational thinking and practice, and upon the standards of practice in schools of nursing. Reports

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[6]Stewart, op. cit., pp. 135-186 (citing History of Nursing, III, pp. 122-131, by Adelaide M. Nutting and Lavinia L. Dock, G. P. Putnam's Sons, New York, 1907).

and publications of these organizations have been a powerful force in forming and consolidating professional opinion, and in spreading new ideas about education.[7]

A review of historical literature reveals that since its inception the profession of nursing has aimed toward meeting the needs of society, and listed among the qualifications of the graduate nurse one constantly encounters such qualities as (1) appreciation of the social and emotional aspects of illness, (2) ability to apply preventive and rehabilitative measures, and (3) ability to participate in the health teach-

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[7]National League of Nursing Education (hereafter referred to as NLNE), Essentials of A Good School of Nursing (New York: The League, 1936).

Josephine Goldmark, Report of the Committee on Nursing and Nursing Education in the United States (New York: The Macmillan Company, 1923).

Committee on the Grading of Nursing Schools, Nursing Schools Today and Tomorrow (New York: NLNE, 1934).

NLNE, Standard Curriculum for Nursing Schools (New York: The League, 1917).

NLNE, Curriculum for Schools of Nursing (New York: The League, 1927).

NLNE, A Curriculum Guide for Schools of Nursing (New York: The League, 1937).

NLNE, Nursing Schools at the Mid-Century (New York: The League, 1950).

National League of Nursing (hereafter referred to as NLN), Criteria for the Evaluation of Educational Programs in Nursing Education Leading to a Diploma (New York: The League, 1958).

ing of patient and community.[8]

Despite the fact that Florence Nightingale and other nurse educators who followed her had interpreted the functions of the nurse as both curative and preventive, stressing her role as a health teacher, little or no opportunity was provided for the student to develop these skills. Most of her experience was with hospitalized patients, in a situation where she received her education and practice on an apprentice level.

In an attempt to break away from the apprenticeship method, bring greater uniformity to programs in nursing schools, and help improve the quality and content of teaching, the Education Committee of the National League of Nursing Education in 1914 undertook to set up an optimum curriculum. This was published in 1917 under the title Standard Curriculum for Nursing Schools, and material referring to the psycho-

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[8]Florence Nightingale, Notes on Nursing, cited by Stewart, op. cit., p. 48.

NLNE, Standard Curriculum for Nursing Schools, op. cit.

NLNE, A Curriculum Guide for Schools of Nursing, op. cit.

Esther Lucille Brown, Nursing for the Future (New York: Russell Sage Foundation, 1948).

Amy Frances Brown, Curriculum Development (Philadelphia: W. B. Saunders Company, 1960), pp. 457-459.

Helen Nahm, "A Decade of Change," American Journal of Nursing, LIX (November, 1959), pp. 1588-1590.

Mary K. Mullane, "Has Nursing Changed?" Nursing Outlook, VI (June, 1958), p. 323.

E.D. Pellegrino, "The Nurse Must Know, The Nurse Must Speak," American Journal of Nursing, LX (March, 1960), pp. 360-363.

logical, social and preventive aspects although limited, indicated the newer trends in nursing.

After 1900, great advances in the field of medical science were beginning to revolutionise the entire concept of medical care and eventually brought better health care to more people than ever before in history. The social sciences were going through a period of rapid change, and older methods of charitable and philanthropic work were being reorganized. A public health movement was under way in the United States, and civic and public welfare agencies were calling for more workers. In this field the nurse was found to be a valuable worker whose contribution was genuinely acknowledged, but whose preparation was found to be lacking in certain essential elements needed for family and community work.[9]

In 1923 a survey conducted and reported by Josephine Goldmark was published under the title Nursing and Nursing Education in the United States. The major portion of this comprehensive report was devoted to a detailed analysis of conditions in hospital schools of nursing, and helped in bringing out into the open the deplorable situations which prevailed in many schools. The study pointed out that among the opportunities for student teaching in the hospital, none was richer or offered better facilities for teaching than did

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[9]Stewart, op. cit., p. 148.

the dispensary or outpatient department. A wealth of experience which was available nowhere else in the hospital was offered at the very door of the school. Mrs. Goldmark deplored the fact that most hospitals failed to use the outpatient department as a teaching field. Even when students were assigned to this area the character of their activities was often non-educative.[10]

> On the present disposition of student nurses in the dispensary, the facts assembled leave room for but one verdict: that of an educational wastefulness scarcely possible to over emphasize. The priceless opportunities offered by the dispensary are educationally lost. Student nurses leave this unique service scarcely wiser either in knowledge of disease or of social problems than they entered it. Graver, moreover, than the individual loss to the student is the ultimate loss to the public. For the modern demands made upon the nursing profession for constructive community work cannot be met by the trained nurse, however experienced in bedside nursing, who comes from her hospital experience with her mind unawakened to the medico-social problems of today; those problems which in the dispensary even more sharply than in the hospital wards confront both doctor and nurse.[11]

It is interesting to note that the 1927 revision of the Standard Curriculum for Nursing Schools, entitled

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[10] Josephine Goldmark, Report of the Committee on Nursing and Nursing Education in the United States (New York: The Macmillan Company, 1923), p. 330.

[11] Ibid., p. 347.

Curriculum for Schools of Nursing, definitely stated that elements of public health nursing be considered for all students regardless of their expected field of practice following graduation. More definite recognition was given to the care of the well child, to the health needs of the family and community and to the public health responsibilities of nurses.[12]

The reports of two studies carried out in 1927 and 1932 by the Committee on Education of the National League of Nursing Education in cooperation with the Committee on Dispensary Development in New York City revealed that although valuable resources were available for the educational experiences of nursing students, they were not being used to good advantage, mainly because of service demands and lack of teaching personnel. A program was described whereby the student's clinical experiences could be broadened and essential social and public health aspects incorporated into her program through a well-directed experience in the out-patient department.[13]

The first study of clinical resources, undertaken in 1932 by Pfefferkorn and Rottman, and reported in the publica-

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[12] Stewart, op. cit., p. 223.

[13] Stewart, op. cit. pp. 224-225.

tion Clinical Education in Nursing,[14] was followed by a similar investigation in 1934 by Johns and Pfefferkorn.[15] The results of both studies were expressed in terms of quality and quantity of prevailing disease conditions. The list of disease conditions eventuating from the latter study was revised in 1937 by the National League of Nursing Education and appeared in A Curriculum Guide for Schools of Nursing as the Master List of Disease Conditions,[16] to be used by schools of nursing as a basis for planning the clinical part of the curriculum.

Surveys resulting in statistics concerning numbers and types of disease conditions do not provide the nurse educator with a complete picture of the clinical area. One may well question the sagacity of equating clinical facilities with cold statistics. Since learning involves action, would not a study of the type and content of activities native to a specific area yield more meaningful information?

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[14]Blanche Pfefferkorn and Marion Rottman, Clinical Education in Nursing (New York: The Macmillan Company, 1942).

[15]Ethel Johns and Blanche Pfefferkorn, An Activity Analysis of Nursing (NLNE, 1932).

[16]NLNE, A Curriculum Guide for Schools of Nursing (New York: The League, 1937), pp. 566-587.

In 1939 the National League of Nursing Education made its first attempt to develop qualitative judgments of nursing schools, and developed criteria for an evaluation of this nature,[17] thus marking the beginning of accreditation on a national basis. Subsequent issues of a similar nature[18] have served as guides to schools of nursing in improving their educational programs and in recent years have undeniably helped schools to focus the activities of the curriculum upon the true purpose of a school of nursing--that of educating a nurse to meet the needs of contemporary society. Keeping in mind the broad concept of health, and the responsibilities of a school of nursing, the next step is to provide the means to accomplish these goals. Marie Andrews reported that the kind and amount of clinical resources are never more important than the use which is made of the ones available for teaching.[19] Yet the term "clinical resources" appears to have different

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[17] Bixler, op. cit., p. 372.

[18] NLNE, Manual of Accrediting Educational Programs in Nursing (New York: The League, 1949).
NLN, Criteria for the Evaluation of Educational Programs Leading to a Diploma (New York: The League, 1958).

[19] Marie Andrews, "A Study of the Clinical Resources Available on the Orthopedic Unit of the Massachusetts General Hospital for the Basic Clinical Experience of the Professional Nurse" (unpublished Master's thesis, Boston University School of Nursing, 1949).

meaning for different people. The narrow interpretation focuses on statistical summaries involving numbers of patients, disease conditions and often technical procedures. Studies by Andrews,[20] McCarthy,[21] Repetto and Haubroe,[22] Sheffield[23] and Wells[24] relative to the adequacy of clinical facilities approach the problem in this manner.

Berkley investigated the resources of a specific clinical area in an urban hospital to determine if the area offered desirable learning experiences in advanced medical-surgical nursing which could be used by senior students of a small community hospital to supplement their previous basic experience. In addition to a statistical summary, she presented the circumstances involved in the care of four patients

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[20] Ibid.

[21] Sister Maurastella McCarthy, "A Survey of the Clinical Facilities in Medical and Surgical Nursing" (unpublished Master's thesis, Boston University School of Nursing, 1947).

[22] Catherine Repetto and Barbara Haubroe, "A Proposed Plan of Teaching for Integrated Learning in a Selected Medical and a Selected Surgical Situation" (unpublished Master's thesis, Boston University School of Nursing, 1954).

[23] Gertrude J. Sheffield, "A Plan for Self-study of the Adequacy of Clinical Resources in a Basic Nursing Curriculum" (unpublished Master's thesis, Boston University School of Nursing, 1951).

[24] Dorothy Virginia Wells, "A Survey of Clinical Resources for Pediatric Nursing in 'X' General Hospital" (unpublished Master's thesis, Boston University School of Nursing, 1959).

using the case method approach, and described and subjectively evaluated the various activities centering about the care of each patient. From her own frame of reference as a medical-surgical instructor she applied her knowledge of the field to elaborate upon certain aspects which could be used in an educationally-directed plan of comprehensive care, and provide meaningful experiences for senior students. Her study showed that the area did present situations which, if used advantageously, could provide worthwhile experiences. Not only did it offer opportunity for the student to participate in the care of patients with disease conditions not previously encountered in the home school, but it also offered opportunity for her to develop skills in patient-teaching and other constituent facets of comprehensive nursing care.[25]

The study undertaken by Crocker investigated the progress of student nurses in an outpatient situation, and her problem was to ascertain whether students whose experiences were carefully selected more nearly achieved the educational objectives of the department than those who had random experiences. The students of her study were enrolled in a three-year diploma program of nursing education sponsored by

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[25] Sara Berkley, "An Investigation of the Learning Opportunities for Nursing Students at The New England Center Hospital and The Boston Dispensary (unpublished Master's thesis, Boston University School of Nursing, 1955).

general hospital affiliated with a large university medical school and situated in a metropolitan area. The focus of her study was on the four-week experience in the outpatient department which each student of the school received as a senior experience. The study was limited to two weeks during which time each student kept a record of her daily activities in the department, and at the close of the period submitted a written evaluation of her experience and was given a written test. As Crocker pointed out, the attempt to gear the test to the experience was not successful. It had a high concentration of medical-surgical nursing items which could readily be answered by a student with a good background in medical-surgical nursing exclusive of the outpatient department experience.

The findings revealed that the students whose experiences were selected met the educational aims of the department to a greater degree than did the students who had random experience. It was discovered that the outpatient experience did not add to the student's formal knowledge of disease, but there were certain disease conditions more common to the outpatient department, which could help to broaden the student's knowledge and help her to care for the total needs of these patients. The experimental students with the assistance of the investigator developed more insight into the patients' needs, and each student felt that the experience had helped her to develop her ability to establish rapport with patients.

The investigator pointed out that students should be allowed to teach only in those areas in which they have received guidance, and in which they have proved their ability and judgment.

This study was focused on the progress of designated students, and no attempt was made to examine or evaluate the learning experiences in the department. A recommendation was made that the clinics be analysed to determine which offered the greatest educational opportunities for students, and that students be given experience in those clinics only. Another recommendation was that since the outpatient department provided opportunity for the student to develop rapport with patients, she should receive experience in this department earlier in her program.[26] Archambeault,[27] Jones and Lowe[28] and Reynolds[29] reported studies which had investigated learning

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[26]Goldie Crocker, "The Study of a Selected Experience for Students of Nursing in an Outpatient Department" (unpublished Master's thesis, Boston University School of Nursing, 1956).

[27]Muriel L. Archambeault, "A Study of Some Factors Impeding the Effectiveness of Student-Patient Relationships in a Psychiatric Hospital" (unpublished Master's thesis, Boston University School of Nursing, 1956).

[28]Edith Eugenia Jones and Virginia Bridges Lowe, "A Study of the Learning Experiences in the Eight Week Period of Field Instruction in Public Health Nursing From the Point of View of the Student" (unpublished Master's thesis, Boston University School of Nursing, 1957).

[29]Olive Jordon Reynolds, "The Evaluation of the Effectiveness of a Course in Public Health Nursing Theory" (unpublished Master's thesis, Boston University School of Nursing, 1957).

experiences for students in specific clinical areas, the methods and findings of which are pertinent only to the individual institution in which the studies were conducted.

Statement of Hypothesis

The literature reveals that it is wise to examine and evaluate the learning experiences in a clinical area before assigning students there. The faculty of "X" General Hospital School of Nursing recognized the need for such a study, the results of which could assist them in best utilizing the hospital facilities for student nurse education. It was felt that the Outpatient Clinic Service could provide meaningful experiences for students, but the service had never been evaluated in terms of available learning opportunities. The hypothesis of this study is that within the framework of the Outpatient Department Clinic Service at "X" General Hospital there are learning experiences which could be used in the education of student nurses.

CHAPTER III

METHODOLOGY

Setting

The setting for this study was the outpatient department of a general hospital. The hospital is classified as a voluntary, non-profit organization and maintains a three-year diploma program in nursing which has State approval and full accreditation by the National League for Nursing.

Within the Outpatient Department at "X" General Hospital there are four services: (1) Emergency and Accident Service, (2) Employee and Student Health Service, (3) Cast Room Service and (4) Outpatient Clinic Service. The area is staffed and administered as a single unit and is under the jurisdiction of one supervisor. The professional nursing personnel of the department consist of the Supervisor, the Health Director, two general staff nurses assigned to daytime hours and one general staff nurse assigned to afternoon and evening duty. One orderly is assigned to the area during the daytime hours. The area is not staffed from 11:00 P.M. to 7:00 A.M. During the daytime period the Health Director is responsible for all activities of the Health Service. After 3:30 P.M. and on week-ends and holidays, the responsibility for this service reverts to the Outpatient Department personnel.

Students are assigned to this department for a continuous four-week period during the third year of their program. Two students are assigned to the area at a time. With the exception of four days in every four-week block when each student is assigned to afternoon duty to relieve the regular afternoon nurse on her days off, the students are assigned to day practice. The student may be assigned to week-end practice if the general staff nurse has the week-end off. There is no established pattern for this assignment, but usually each student receives one week-end assignment while in the area. While in the outpatient department, the student's educational responsibilities are confined to those associated with the student-education program of the department. She does not leave the department to attend any other classes.

The supervisor of the unit is responsible for the overall administration of the area, and her position carries both service and educational functions. She directs nursing service personnel and is also responsible for the theoretical and practical experiences of the students. The supervisor arranges the students' time schedule, their assignments within the department and writes an evaluation of each student at the end of the four-week period. Although students participate in the activities of the entire area, this study was restricted to the Outpatient Department Clinic Service.

The Outpatient Department is located on the ground floor of the Medical-Surgical Building in an inverted "L"

shaped corridor. Rooms along this corridor are used for clinic patients. Chairs and benches are set along the walls of the main corridor. The Outpatient Department Office is just inside the entrance to the department. The administration of all hospital-sponsored clinics is directed from this office, in which the departmental supervisor and secretary have desks.

The hospital social worker maintains an office in the Outpatient Department. Her salary and responsibilities are shared by the hospital and the State Cancer Association.

With the exception of the Cancer Clinic, all patients are charged a fee of $7.50 for each clinic visit. A number of patients seen at the clinic during the week of the study had previously applied for financial assistance. These patients had been referred to the Social Worker who had investigated the circumstances and contacted various community agencies. She was able to procure the necessary funds so that the patients could continue to receive treatment at the clinic. During the week of the study no new request for assistance was observed.

This study was conducted during the period of one week, a week selected at random, but one in which all eight of the clinics sponsored by the hospital were scheduled. A total of seventy-one patients attended the clinics during this week as is shown in Table 1.

TABLE 1

NUMBER OF PATIENTS ATTENDING CLINICS AT "X" GENERAL HOSPITAL DURING A SELECTED WEEK

CLINIC	DAY	TIME A.M.	ATTENDANCE
Orthopedic	Tuesday	9-12	8
Podiatry	Tuesday	10-12	0
Pediatric	Tuesday	10-12	0
Dermatology	Wednesday	8-12	42
Psychiatry	Thursday	9-12	9
Medical	Thursday	10-12	0
Surgical	Thursday	10-12	0
Cancer	Friday	10-12	12
Total			71

Orthopedic Clinic

The Orthopedic clinic was attended by one physician, a visiting consultant, whose office and practice are in a nearby metropolitan city. Three of the rooms of the Outpatient Department were used for the clinic. In order of their appearance patients were registered and assigned to rooms by the department secretary, who simultaneously placed each one's record on the door of the room to which he was assigned. The doctor went from one room to another, as designated by the

secretary. In each room was a recording machine into which the doctor dictated during or after the clinic visit of each patient. He frequently recorded the history of the patient and comments regarding his observations. He also prescribed treatments while the patient was present, stopping occasionally to clarify a point with the patient. The secretary kept the machine supplied with records, collected the used ones and later transcribed the data on the individual patient's history. Requests regarding follow-up care and referral directed to the secretary, were included in the recordings. Patients who were told to call in at a later date in regard to reporting their condition or to request further information, were instructed by the doctor to contact the secretary. Some patients were told to call the doctor's office directly. The atmosphere of the clinic was friendly and relaxed; the doctor quickly established rapport with all patients and family members, and willingly discussed problems about which the patients expressed concern. Observations for this study were made on all eight patients who attended the clinic.

Podiatry, Pediatric, Medical and Surgical Clinics

Each of these clinics was attended by one physician, a staff member of the hospital. The mechanics and activities of these clinics were not described for no patient attended any of them during the week of observation.

Dermatology Clinic

The Dermatology Clinic was attended by one physician, a visiting consultant who maintains an office and practice in a nearby metropolitan city. Three of the rooms of the Out-patient Department were used for this clinic. The department secretary registered the patients, assigned them to rooms in order of their appearance and placed their records on the doors of the rooms they entered. The doctor and the secretary went from room to room. The doctor dictated to the secretary at the close of each patient visit, usually after the patient had left the room. He included comments about the patient's history, observations made during the visit, treatment prescribed and directions for follow-up care. After the termination of the clinic the secretary transcribed the dictation and made notations on the patients' records. She also followed through on referrals as requested by the doctor. The environment of the clinic was friendly and relaxed, made more so by timely injections of humor by the doctor. Rapport with patients and family members was quickly established, and the doctor willingly discussed problems about which patients expressed concern. Observations for this study were made on the first twenty-one of the forty-two patients who attended the clinic.

Psychiatry Clinic

This clinic was attended by one staff member, a visiting consultant. Patients visited this clinic by appointment, and the majority arrived just before the stipulated time. Since the clinic visits of these patients were handled by the doctor in a private conference in a one-to-one relationship, no observations were made during the actual visits of these patients.

Cancer Clinic

This clinic was held in one of the larger rooms of the Outpatient Department, one frequently used as a classroom. In charge was the hospital social worker, who is employed on a part-time basis by the State Cancer Association. She arranged the schedule of patients to be seen at the clinic, directed correspondence relative to appointments and follow-up care, informed patients of doctors' recommendations, and was responsible for maintaining the records of the Cancer Clinic patients. She attended the clinic sessions, as did a secretary. Nine staff physicians representing such fields of practice as Medicine, Surgery, Pathology, Roentgenology, Dentistry and Medical-Surgical Specialties attended the clinic. A number of the patients seen at the clinic had been under the care of physicians who attended the clinic, and previously had been treated and/or referred by them. This clinic serves in a diagnostic and follow-up capacity. Patients are referred for

diagnosis and later return to the clinic for follow-up care and surveillance. As the patients arrived in the clinic area, they reported to the Social Worker whose office is adjacent to the Outpatient Department office, then waited on benches along the main corridor. Each in turn was called into the clinic room by the Social Worker, and asked to be seated on a stool facing the medical audience. Prior to the patient's entrance the secretary provided the doctors with the patient's history. One of the doctors then presented a summary of the medical background, previous treatments, and the reason for the present visit. During the visit the patient was questioned and examined by the doctors. At the end of the visit the patient was requested to wait outside. Active discussion about the patient's condition and preferred course of action followed. The secretary made note of recommendations and the Social Worker relayed this information to the patient. In some instances the course of action was decided upon while the patient was present. After the patient left the room, one of the doctors dictated a summary of the visit into a recording machine. The secretary later transcribed this information on the individual patient's history, and the Social Worker directed correspondence for follow-up care and referrals. Twelve patients attended this clinic during the week of the study and written observations were made on all twelve.

Procurement of Data

The investigator visited "X" General Hospital and arranged for a conference with the Director of Nursing. Permission was granted to pursue the study, and the mechanics and scope of the study were discussed. The Director of Nursing informed the Outpatient Department personnel about the study, and they expressed their willingness to cooperate. A visit to the area was made to find out about the time schedule of the various clinics and to make arrangements for collection of data. During the week of the study the investigator arrived in the department at least one-half hour before the scheduled time of each clinic, and spoke to the doctor attending the clinic, explaining the purpose of the study and her role as an observer.

No special forms were used in recording. Observations were made during the visits of patients to the Dermatology, Orthopedic and Cancer Clinics. Written commentaries were made which included on-the-spot notations about the patient, his condition and treatment, the doctor and clinic setting. Conversations were recorded as completely and as accurately as time permitted. Each clinic visit was written up as an entity. Each summary described the nature, character and content of the patient-doctor visit. Supplementary information such as age, diagnosis and spelling of name, was obtained from the patient's record. To obtain information about the Psychiatric

Clinic patients, individual patient records were investigated, and observations were made of the patients as they arrived in the clinic to register and to wait for their appointments. Voluntary comments from personnel in the department provided facts relative to clinic fees, clinic routines and characteristics of the individual clinics.

The time spent in observation was:

Orthopedic Clinic	10:30 A.M. - 11:45 A.M.
Dermatology Clinic	7:45 A.M. - 11:45 A.M.
Psychiatric Clinic	9:00 A.M. - 11:00 A.M.
Cancer Clinic	10:30 A.M. - 11:45 A.M.

A total of eight hours and thirty minutes was spent in making observations.

CHAPTER IV

FINDINGS

The findings from each of the four clinic situations studied are presented under the title heading of the clinic from which they were obtained, and includes data about the Orthopedic, Dermatology, Psychiatric and Cancer Clinics in that order.

Orthopedic Clinic

The eight patients who attended the orthopedic clinic ranged in age from one to sixty-two years as shown in Table 2. Four of the patients were over fifty-five years of age and three were under eight years. All but two of the patients were accompanied by a family member. Two women, the oldest patients, were unattended. The disease conditions of the patients appeared to fall into three main categories: those of a chronic nature requiring supportive care, those of a congenital nature requiring corrective treatment, and those associated with trauma or injury. There was a relationship between type of disease condition and age. For example the congenital conditions were found in the three youngest patients, and with one exception the conditions resulting from injury were identified with the age group in the middle. With the

TABLE 2

AGE, SEX AND COMPLAINTS OF PATIENTS VISITING THE ORTHOPEDIC CLINIC ON A SINGLE DAY

Patient	Age	Sex	Complaint or Condition
A	66	F	Rheumatoid arthritis
B	63	F	Pericapsular adhesion of shoulder joint
C	60	M	Gout, with fungus infection of foot
D	55	M	Broken back brace
E	33	F	Torn meniscus in knee
F	7½	F	Painful feet
G	1½	M	Eversion of foot
H	1	M	Clubfoot with inversion

exception of one patient who had recently been injured, all patients presented conditions which had prevailed for a number of years, or in the younger children, since birth and which required long-term treatment. For all patients the disease condition brought about changes in the usual routines of daily living, and placed varying degrees of restriction upon their physical activities and capabilities.

Patients and family members showed great interest in learning about aspects of care related to the prevailing disease condition, and also about aspects of care related to general health. Many questions were asked of the doctor, and

all who attended the clinic appeared to be in a very receptive frame of mind.

The eldest patients appeared to be quite concerned about maintaining their physical independence, and showed anxiety in regard to the degree of incapacitation which might eventuate. The parents of the children with the congenital anomalies were concerned about the length and cost of treatment, and also about the prospects of their children appearing and functioning as normal children. Considerable reassurance was given to these people.

Physical discomfort and pain associated with the illness were experienced by five of the patients. Orthopedic appliances were being used by six of the patients, four were of a supportive nature and two were for corrective treatment. The conditions which brought the patients to the clinic were not ones which would ordinarily require hospitalization.

During the clinic visit the doctor examined each patient, talking with the patient or family members as he proceeded. Manual examinations of the affected areas were carried out and also range of motion tests. In certain instances the doctor compared that day's results with the results of the test done on previous days, and when improvement was shown, expressed pleasure and complimented the patient or family for carrying out the prescribed orders.

With each of the mothers of the two young children who had congenital foot anomalies the doctor spent considerable

time. He explained to the mothers what was wrong with the children's feet and how he hoped to be able to correct the deformity. He manipulated the children's feet and explained to the mothers about the exercises he wanted done at home. The cost of the special orthopedic shoes was discussed and their use was carefully demonstrated. Both mothers showed concern about causing pain to the children when applying and using the Dennis-Browne splints. The doctor reassured both women, and told them that orthopedic appliances such as these usually bothered the parents more than they did the children. He explained that there would be no pain involved, and he had learned from experience that children adapted quite readily to their use and accepted them without too much concern. At the end of each clinic visit these mothers appeared to have a fairly good understanding of their child's problem, what the doctor proposed to do about it, as well as what would be required of them as mothers.

The female patient whose diagnosis was a pericapsular adhesion of the left shoulder joint had come to the clinic because of dissatisfaction with previous treatment from her local medical doctor. During the visit the doctor asked the patient to tell him all the details of her case. She proceeded to tell of the automobile accident when she had been thrown into the front seat of the taxicab in which she had been riding, and of the bedrest which had been prescribed by her doctor. The clinic doctor examined her shoulder and tested the degree

of mobility of the joint. He prescribed exercises requiring a pulley device, and tried to explain to her how these might be set up in her home. She appeared to be quite apprehensive about doing this, and sensing her confusion the doctor told her not to bother. He then asked her if she would be able to come to the hospital physical therapy department three times a week, and when she assented he explained to her that she could receive the proper exercises there and that the physical therapist would be able to teach her exercises she could do at home. The patient wanted to know if the pain in her shoulder would disappear and if she would regain the use of her shoulder and arm. The doctor explained that the prescribed treatment should prove beneficial, but that he wanted to keep a close watch on her. She was told to return to see him in two weeks.

Patient E lay on the bed in the clinic room supporting her right knee in a semi-flexed position as the doctor entered the room. Her husband was with her. The doctor asked the patient to tell him what her trouble was. As she started to tell him about recent years, he interrupted her and told her to start back at the very beginning of the trouble. She then began with an incident in her childhood when she was playing ball and had jumped up to catch the ball. Her right knee had let go and she fell. At that time her family doctor had called it a "trick knee". She went on to describe subsequent episodes, and how they were treated. She explained that a doctor once described the condition as "water on the knee", and that the

knee joint had become dislocated. She described how doctors, and in recent years her husband, had "put it back". She said that she had blacked out several times during the procedure. This time the knee seemed swollen and she wasn't able to move it much.

The clinic doctor examined her knee, and tested for range of motion. He then told the patient and her husband that she had a knee like a lot of football players he had treated. He mentioned that just that week he had discharged two patients whom he had operated upon, ages eighty-three and seventy-one respectively. He described in detail the condition of her knee and stated that it could be easily remedied by a surgical operation which consisted of making a button-hole incision in the side of her knee and removing a torn cartilage. Another cartilage would grow in and in a short time she should have a perfect knee. She would be in the hospital only a few days. He said that a semi-lunar (half moon-shaped) cartilage was torn, and was retracting into the knee joint. He likened the effect to a pencil between the pages of a book, preventing the closing of the book, and called it a "locked knee". He recommended that the operation be done as soon as possible to prevent further falling and possibly causing a more serious injury, and told of one woman who had waited, then had fallen and broken her hip.

Both the patient and her husband agreed to comply with the doctor's recommendation for immediate treatment. He then

proceeded to make arrangements for the hospital admission in a metropolitan hospital. He explained the procedure of that hospital, discussed hospitalization insurance and billing, and told the patient that he would see her at the hospital. Both patient and husband appeared to be very satisfied with the outcome of the clinic visit, and seemed relieved that some definite action had been taken.

Patient D had come to the clinic to have a broken back brace repaired. He was wearing one, but much preferred the other one. Both braces belonged to him. The clinic doctor had previously operated upon the patient and had performed a spinal fusion. During the discussion about the brace between the patient and the doctor, the patient's wife kept interrupting to let the doctor know that her husband had to take nitroglycerine tablets several times a day for angina pain. She appeared to be quite apprehensive and seeking advice. However the doctor said that he was just caring for the patient's back condition, but that the patient should continue to take these pills, and mentioned that another doctor was caring for his heart condition.

The patient was told that he would be called when the brace had been repaired. The clinic doctor praised the patient and remarked about his rapid recovery and early ambulation after the spinal surgery. He mentioned how the patient's progress had pleased him greatly. The patient seemed extremely pleased and further encouraged by the doctor's

remarks.

Patient F was a seven and a half year old girl who came to the clinic with her mother. The child's parents were divorced and the mother received financial assistance from the Federal Program of Aid to Dependent Children. The problem seemed to be that the mother could not find shoes which fitted the child properly, and as a result the child constantly kicked her shoes off. None of the shoes which she had bought with her limited income were satisfactory and she didn't know what to do as the agency was disturbed at her needing more money for shoes. The doctor examined the child's feet and asked the mother if the agency would pay for shoes purchased out of state, for he knew of a place across the state line where the child could be fitted less expensively and more satisfactorily. The mother said that the agency wasn't as concerned about the location of the purchase as it was about the frequency of purchases. The doctor stated that a child of this age should have shoes every six months, and that he would be glad to write further prescriptions should she run into difficulty in the future. As the prescription was being written, the mother asked if he could write it for a white shoe. The doctor looked up. The mother went on to explain that the child was making her first communion in two weeks, and she needed white shoes for the occasion. The doctor went along with this and included it in the prescription. The mother seemed quite relieved at the end of the visit, but said

she might have to return when the child needed shoes again. The doctor agreed and said he would be glad to see her and help her in any way he could when she came.

Summary of Orthopedic Clinic Activities

A.	Examinations	
	1. Manual examination of involved area	7
	2. Range of motion examinations	5
	3. X-Ray prescribed	1
B.	Surgical Procedures	
	1. Injection of medication into knee joint	1
C.	Use of Appliances	
	1. Patient fitted to orthopedic appliances	2
	2. Patient measured for orthopedic appliances	1
	3. Patient given prescription for orthopedic appliances	1
	4. Patient utilizing appliances and advised to continue their use	2
D.	Instructions for Home Care	
	1. Patient instructed to carry out special therapeutic measures at home	4
	2. Discussion of medications	3
E.	Use of Referrals and Community Resources	
	1. To Physical Therapy Department for exercises and teaching	1
	2. Agencies involved in providing care and assistance to patients:	
	Visiting Nurses' Association	1
	Crippled Children's Clinic	1
	Federal program of Aid to Dependent Children	1

Dermatology Clinic

The ages of the patients who attended the Dermatology Clinic are shown in Table 3, and presented the widest age span of any clinic group of the study. The median age of these patients was twenty-six years, with all age groups represented. Of the twenty-one patients observed, more than half were accompanied by family members. The patients afflicted with the most serious conditions were among the older age group and were among those who came alone. Patients and family members appeared eager to obtain medical and health information, and made many inquiries of the doctor who responded readily and completely. The people listened attentively and appeared to welcome his information. The relaxed and friendly environment of the clinic seemed to encourage discussion. Nine of the patients were new to the clinic, in that this represented the first visit to the clinic for treatment of the existing complaint. Complete histories of these patients were taken by the doctor. At the beginning of the clinic visits of each of the other patients, the doctor reviewed the history of that patient before proceeding with the visit.

A wide variety of dermatological conditions existed among these patients, who manifested symptoms involving all areas of the body. Some patients were experiencing early stages of the disease, while others had been burdened with the illness for some time. Conditions of both a chronic and

TABLE 3

AGE, SEX AND DIAGNOSIS OF PATIENTS VISITING A DERMATOLOGY CLINIC ON A SINGLE DAY

Patient	Age	Sex	Condition or Diagnosis
A	82	M	Seborrhea of scalp
B	62	F	Lichen sclerosis
C	53	M	Discoid lupus erythematosus with liver cirrhosis
D	52	F	Sebaceous cyst of eyelid
E	50	F	Lupus erythematosus
F	50	F	Seborrhea dermatitis
G	43	M	Trichiphyton rubrum
H	36	M	Multiple warts on forearm
I	35	F	Psoriasis
J	29	F	Exfoliative dermatoid eczema of foot
K	26	M	Psychosis vulgaris
L	25	F	Acne vulgaris or acne medicamentosa
M	23	M	Fungus infection on hands
N	18	F	Acne on ankle
O	17	F	Acne on face
P	17	F	Dermatoid acne on face
Q	7	M	Eczema on body
R	6	M	Acne on face and upper torso
S	2	F	Nodular eczema of face and legs
T	1	M	Lichen chronic circumspecta
U	8 wks	M	Eczema of fingernails

acute nature were represented. There were those which medical science possesses the knowledge to control or cure, as well as those for which the prognosis is less certain, and the treatment less well-established. There was a relationship between age and type of disease condition, evidenced by the fact that the preponderance of less serious, transitory disease conditions prevailed among the younger members, and the more serious and often chronic disease conditions were in evidence among the older patients. Ninety per cent of the patients manifested symptoms on an area of the body ordinarily exposed and easily seen. Parents of the children and patients themselves expressed concern about the change in physical appearance. In thirteen instances the doctor gave definite reassurance to patients and family members. Although the majority of patients were not significantly limited in performing their usual daily functions, the presence of the symptoms proved bothersome, irritating and often physically uncomfortable. For some patients, however, the condition did prohibit the continuance of daily chores and routines, in some instances because of physical appearance. The majority of the patients manifested classical symptoms of the disease which they had. The treatments for the conditions seen in this clinic usually do not require hospitalization. Exception to this would be in extreme or uncontrolled cases which present a different type of care, or cases where a patient already troubled by a dermatological condition enters the

hospital for treatment of another ailment.

A great deal of the time of each visit was spent in discussion between the doctor and the patient or family member. The doctor asked many questions about the condition itself and also about the effect of the treatment which he had previously prescribed, and asked for opinions in regard to which medications the patients preferred or thought had been most beneficial. Taking into consideration the patients' opinions, the doctor either changed a prescription or told the patients to continue on as before. When new medications were prescribed, the doctor gave explicit directions for their use. He described the medication to the patient, and often included the reasoning behind his choice. Precautionary measures were discussed, as well as the signs and symptoms which would warrant discontinuance of the medication, or lessening of the dose. Some of the preparations prescribed for topical use required special handling and mixing, and entailed fairly detailed instructions. In many instances several medications were prescribed for one patient.

Patient B had been brought to the clinic by her daughter. As the mother could not converse in English, the daughter did the talking. The doctor entered the clinic room where the mother and daughter were sitting and asked what had brought them to the clinic. The daughter stated that she had noticed a lesion on her mother's back, and that she had previously taken her to another doctor who had ordered X-Ray

treatment, but that had not seemed to help. The clinic doctor asked to have the woman remove her dress so that he might look at the area. The daughter helped with this. When asked if there were any lesions on other areas of the body, the answer was "No". The doctor said that he doubted this and asked to have the patient completely disrobe. He then examined the skin surrounding the rectal and vaginal areas, and found additional lesions, which confirmed his original suspicions. He then requested that the patient's family physician be called in. When he arrived, the clinic doctor brought him into the clinic room, showed him the recently discovered lesions, described the patient's condition and told him of his own recommendations for treatment in the presence of patient and daughter. Before the clinic doctor left, the daughter asked about the seriousness of the condition and of its relationship to cancer. The doctor told her that it was hard to treat, but that he would try to improve the condition. After leaving the patient's room, the clinic doctor made several comments to the observer in regard to the indiscriminate use of X-Ray treatment before diagnosis is well established.

Patient C came to the clinic unaccompanied. He had been seen before by the clinic doctor who had asked for an evaluation of his eyes by an oculist. The patient had been having difficulty with his eyesight, and also had a face rash. The doctor spoke to the patient, examined his face, and told

him that he didn't want to prescribe further until he had seen the results of the eye examination. After the patient had left, the doctor commented that he did not want to treat the patient for lupus erythematosus yet, as the patient's skin condition was similar to that seen in patients with cirrhosis of the liver. A laboratory report of a previous skin biopsy revealed that the lesion was compatible with lupus. The doctor commented on his choice of medication, but wanted to have a clearer picture of the patient's condition before starting intensive treatment.

Patient F was a fifty-year old female who came to the clinic unaccompanied. She told the clinic doctor that she had large reddened areas under her breasts, in the axillae, groins, inner aspects of her thighs, and on her scalp and behind her ears. She admitted to having had the condition for several years. The doctor made the comment that the condition was present in areas where there was fat. The patient was asked to remove her clothing so that the doctor might examine her. The patient appeared quite embarrassed, and this was noted by the doctor who told her in a very nice manner not to feel that way.

After observing the reddened areas, the doctor described the condition and his recommended course of treatment. He told the patient that the condition was caused by glands in her skin, and that he thought he would be able to help her. She appeared to be greatly relieved. This was observed from

her comments and her facial expression. The doctor ordered separate medications for the scalp and body surfaces, and went on to describe the manner and frequency with which they were to be applied. The complicated directions appeared to confuse the patient and she stated so. The doctor then repeated his directions, more slowly and stopping at intervals to ask the patient if she understood. After the second explanation the patient seemed to have a fairly good understanding of the prescribed treatment, and said she would try to carry out the orders. The patient was told to call the doctor in two weeks if she could say she was better, but she was to return to the clinic in four weeks regardless of progress.

Patient G was a furniture repair man who had come to the clinic because of a rash on his hands. The doctor examined the patient's hands and questioned him. He also examined the patient's feet, then asked him about the materials other than wood which he used in his work. The questioning revealed that the man first had an outbreak of the skin condition twenty-three years ago, but that the condition had worsened since 1946. His hands did not itch, but unless he applied a lotion, they became very dry.

The doctor talked to the patient about the choice of medication, and explained that the ultimate selection was up to the patient. The doctor stated that there was a new medication on the market, but that it was rather costly and it would have to be taken over a period of months. If the patient was

willing, the doctor said he would prescribe it. He further explained that the illness which the patient had was due to a fungus infection, and that up until recently there was no specific treatment. The patient listened and nodded his head in the affirmative, so the doctor continued to give more specific directions in regard to both oral and topical medications. The doctor recommended that the patient talk with his druggist to find out the best way to buy the pills in order to get the best price, and stated that the amount which the patient purchased would be between him and the druggist. The patient was told to call the doctor if the pills bothered him at all, and not to return to the clinic in two weeks unless there was a drastic improvement in his condition. In this case he, the doctor, would reduce the pill dosage. Otherwise the patient was to return to the clinic in four weeks.

Patient J was a twenty-nine year old male who had been coming to the clinic for treatment of foot eczema. The doctor looked at the area, then examined it more closely with a magnifying glass. He described the present condition as a highly secondary pyoderm. When asked about his progress, the patient said that the area was improving, not so itchy, but rather messy. The doctor went on to discuss home care and cautioned the patient against cutting too close to the healthy tissue when debriding the area. The patient had been referred to the skin clinic by his personal physician when the area had

become infected. He was still following the patient. The clinic doctor told the patient to call his own doctor before his next appointment which was scheduled two weeks away if the condition became worse. In the meantime the patient was told to continue the saline soaks, and the oral liquid medication. He was told to decrease the number of capsules from four to two a day, and was given a prescription for an ointment. The patient was instructed to call the clinic doctor at his office in three days unless the condition was very much better, in which case he was to return to the clinic in two weeks. The doctor told the patient that his foot was very much better, and that going through an infection such as this was often a blessing in disguise.

Patient R was a six year old male who was brought to the clinic because of a rash on his face and upper torso. His mother, who accompanied him, said he had been bothered with the condition two or three weeks. The doctor looked at the involved areas, then examined them with a magnifying glass. He questioned the mother about the history of the rash. She had previously taken the child to a local doctor who had prescribed a medication and told her to see a skin specialist if the condition did not improve. The mother said that the condition had worsened since she had seen the other doctor, that the rash had come out more, and the skin was redder and more itchy. The doctor asked the mother if she herself had had eczema as a child. She had not. He examined the child's knees, asked if

the child had been playing with a dog or a cat. He had not. Was the child taking any medication? The mother replied that she had been giving him Father John's medicine lately. The doctor stopped and thought for a few minutes, meanwhile looking at the rash. He then commented that the child had an odd-looking rash, and that he felt that it could be due to an allergy or a drug reaction. He prescribed a salve, instructed the mother about its use, and told her to call his office in three days to let him know how the condition was progressing.

Summary of Dermatology Clinic Activities

A. Examinations	
1. Visual examination of affected area with naked eye	21
2. Visual examination of affected area with magnifying glass	9
3. Laboratory examination of tissue scrapings	1
B. Surgical Procedures	
1. Use of dessicating machine to remove warts	1
C. Instructions for Home Care	
1. Patient given instructions for debridement of tissue, self-care	1
2. Patient instructed in skin hygiene (mostly in response to specific request by patient)	5+
3. Medications	
a. Discussion of medication with patient	19
b. Patients utilizing one or more types of oral medications	15
c. Patients utilizing one or more types of topical medications	12
d. Patients for whom medications had been prescribed on previous visits	
oral medications	10
topical medications	6
e. Patients for whom medications were prescribed during the observed clinic visits	
oral medications	5
topical medications	8

Psychiatric Clinic

The median age of the patients attending the Psychiatric Clinic was fifty-two, the range being from twenty-six to sixty-six years, as is shown in Table 4. The majority of the patients attended the clinic on a weekly basis. All but one of the patients were over forty-five years of age, and the majority were female. The patients waited quietly in the corridor for their appointments, most of them being accompanied by family members.

TABLE 4

AGE, SEX AND COMPLAINT OR CONDITION OF PATIENTS VISITING A SINGLE PSYCHIATRIC CLINIC ON A SINGLE DAY

Patient	Age	Sex	Complaint or Condition
A	66	F	Depression
B	64	F	Lack of memory and forgetfulness
C	64	M	Depression
D	58	F	Nervousness
E	52	M	Nervousness
F	49	F	Nervousness associated with menopause
G	47	F	Involutional melancholia
H	45	F	Neurological examination
I	26	F	Benign depression

Only one of the patients had received previous psychiatric treatment. For the remaining eight patients this illness was the initial onset of a psychiatric disturbance, and as such represented their first exposure to psychiatric assistance.

The treatments involved in the care of these patients consisted of medication, conferences and electric shock therapy. Electric shock therapy was administered in another area of the hospital and a graduate nurse from the outpatient department staff accompanied the patients to the area. Students do not observe or participate in these treatments. The treatments are usually administered in the early afternoon, following Psychiatric Clinic.

Medical, Surgical, Pediatric and Podiatry Clinics

Because the Medical, Surgical, Pediatric and Podiatry Clinics attracted no patients during the week specified for the study, no evaluation could be made of their educational worth.

Information obtained from members of the clinic staff and substantiated by census figures of the past, indicate that these clinics do not regularly attract many patients, and that the poor attendance encountered during the week of the study is a common occurrence.

Cancer Clinic

The twelve patients who attended the Cancer Clinic represented the older age group, as is seen in Table 5. Their ages ranged from forty-two to seventy years, and presented the narrowest age span of any clinic group. Of the twelve patients who were present only one was new to the clinic. This patient came to seek assistance because of a suspicious symptom. Six patients attended the clinic for a routine follow-up visit. Five, although they were regular clinic patients, had not come this time for a routine follow-up visit, but to report a symptom. The length of time the clinic patients had been kept under surveillance or treatment, ranged from three months to eighteen years.

Each patient came into the clinic room, was questioned and examined by the doctors, and was asked to wait outside in the corridor. Very few patients asked questions during the visit, but all listened attentively while the doctors were talking to them and discussing their conditions and complaints. The family members of all but one patient remained outside in the corridor. Sometimes the doctors decided upon the course of action to be taken while the patient was still in the room. In the instances when the doctors did not decide until after the patient had left the room, the social worker was the person who relayed the information and instructions to the patient and family.

TABLE 5

AGE, SEX AND COMPLAINT OR CONDITION OF PATIENTS VISITING A CANCER CLINIC ON A SINGLE DAY

Patient	Age	Sex	Reason for Visit and Condition
A	70	M	Bleeding from tracheotomy Previous laryngectomy
B	67	F	Lesion on calf of leg Previous radiation therapy to lesion on lid
C	62	F	Soreness and burning of lips, tongue and gums Previous superhyoid resection
D	62	M	Follow-up visit Previous laryngectomy
E	60	M	Follow-up visit Previous radiation therapy for brain tumor
F	59	F	Rash on tongue and gums
G	58	M	Follow-up visit Previous radical face surgery
H	55	F	Follow-up visit Previous mastectomy
I	52	F	Follow-up visit Previous hysterectomy and radiation therapy
J	50	M	Follow-up visit Previous radiation therapy to burrs on ears
K	46	F	Lesion on nose
L	42	F	Irritation of mouth and gums

The patients presented conditions affecting various areas of the body and had been, or were then, under treatment and observation for cancerous conditions involving areas of the breast, throat, brain, female reproductive organs and skin. It is perhaps significant to note that in seven of the patients, or in more than half of those represented here, the initial manifestation of the disease was characterized by a skin symptom. The cancerous condition affecting six of the patients required surgical treatment involving hospitalization and therefore can be encountered in the hospital environment, but, of course, at a different stage of development. However, six of these patients presented a condition the treatment of which did not warrant hospitalization, but one which can be treated on a clinic basis.

Of the eleven patients who had previously attended the clinic, ten had received radiation therapy and two had been treated with both surgery and radiation. Examination of three of the six patients who had come to the clinic for a routine visit proved to be negative of further cancer symptoms. These three people were among the youngest of the group and had been able to carry on their usual daily activities in the interval since treatment of the initial symptoms. They were also in the third of the group in which the greatest length of time had lapsed since the initial onset of disease symptoms. The treatment necessitated by their original symptoms did not bring about any change in their outward appearance nor markedly

limit their physical activities and capabilities. The other three patients who attended the clinic for a routine follow-up visit were found to have symptoms which warranted further investigation and possibly additional treatment. These three persons were older than the previously-mentioned three, and were in the group in which the shortest time had lapsed since the initial onset of disease symptoms. The character of the treatment necessitated by their original symptoms had resulted in drastic changes in their physical appearance and also had placed definite limitations on their physical activities and capabilities.

Of the six patients who came to the clinic to report a symptom, only one, the new patient, presented a symptom which the doctors felt was suggestive of cancer. For this patient a biopsy was prescribed. If the results of this test proved to be positive the doctors recommended radiation therapy. The doctors felt that the complaints registered by the other five patients in this group were not related to, or further complications of, the patients' previous cancerous conditions, but were caused by a medical or dental condition and, as such, could be treated by the patient's own physician or dentist. Diagnostic laboratory tests were ordered for these patients however, in order to rule out the presence of cancer.

During the visit of each patient the doctors listened attentively, appeared much interested and seriously concerned

as the patients described the symptoms which had brought them to the clinic. No less interest was shown because the doctors felt the symptoms were not related to the previous cancer condition, and the patients were encouraged to report any further unusual symptoms which might occur.

Patient A was a seventy year old man who came to the clinic because of bleeding from a tracheotomy. He had undergone surgery three years previous for treatment of cancer of the larynx. Before the patient entered the clinic room, one of the doctors reviewed the patient's history. The patient entered the clinic room with his daughter and was asked to sit on a stool facing the medical audience. The daughter stated that her father had had a cold a week before, and since that time had coughed blood and muous through the tracheotomy opening. The daughter who spoke for her father also said that he had started to attend a speech clinic in a nearby city, but had stopped because it was too much trouble. Several doctors examined the patient's neck and asked questions of the patient and daughter. The patient was then asked to leave the clinic room and wait outside in the corridor.

After the patient had left, the doctors discussed the patient's previous surgery and possible reasons for the present bleeding. One doctor mentioned that the patient had a neighbor who is a nurse, and that she frequently checks on him. Another stated that there is a question of this patient being an alco-

holic. Another doctor said that people with cancer of the larynx frequently have a history of alcoholism, and that there is a high incidence of this. The doctors came to an agreement that the present bleeding was due to an irritation caused by the cold, but that the patient was to return to the clinic if the condition persists.

Patient C was a sixty-two year old female who came to the clinic complaining of soreness and burning of her tongue, lips and gums, and of soreness in the neck region. Before the patient entered the room her history was reviewed by one of the doctors, who stated that three years ago the patient had a resection of a lip lesion and a superhyoid resection. He added that the patient was a controlled diabetic who visits her personal physician every two weeks. The patient entered the room, was seated, then questioned by the doctors as they examined her mouth and palpated her neck. The patient was then asked to leave the room and to wait outside. The doctors discussed her symptoms and stated that they felt her complaints were the result of an anemic condition. It was recommended that the patient have a blood examination, and follow-up treatment as indicated by the results.

Patient E, a sixty year old male, attended the clinic on a routine follow-up visit. The history was reviewed by one of the doctors before the patient entered the room. Four years previous, he had been treated with massive doses of radiation

for a large tumor in the region of the sella turcica. He entered the room, sat facing the audience and was questioned by the doctors. In response to the questioning he said that he was getting along well and feeling better, but that he was losing his hair and his eyesight was failing. The doctors ordered diagnostic X-ray films of the skull, and the patient was referred to an oculist. He was told to return to the clinic in three months, or sooner if he had any more trouble. After the patient had left the room, the doctors stated that some of the symptoms no doubt were due to the previous massive doses of radiation.

Patient H was a fifty-five year old female who attended clinic for a routine follow-up visit. A review of her history revealed that eight years previous she had undergone surgery for treatment of cancer of the breast. Annual check-ups in the past had proved negative. The patient came into the room, was questioned briefly, then taken to another clinic room for a physical examination. One of the cancer clinic doctors left to perform this and later reported that the results were negative. The doctors recommended that she be told to return in another year.

Patient K, a forty-six year old female came to the clinic because of a lesion on her nose. This was her first visit to the clinic. She entered the clinic room and sat facing the medical audience. Several doctors examined the

area and questioned the patient. She said that she had had the lesion since a fall about six months previous and stated that it had bled some at the time. The doctors noted a small area one and a half by two centimeters in size. After the patient left the room the doctors agreed that it probably was a basal cell lesion, and recommended that a biopsy be taken. If the results proved to be positive, radiation therapy was prescribed.

Patient L was a forty year old female who complained of an irritated mouth and gums. A review of the history before she entered the room revealed that she had first come to the clinic eleven years previous. At the time she had an epithelioma on the side of her nose. Biopsy had shown the presence of cancer, and radiation therapy had been prescribed. A year later a leukoplakia of her tongue and lips had been reported, and successfully treated. Since that time she had not been seen at the clinic. The patient entered the clinic room and sat facing the medical audience. The doctors questioned her, examined her mouth and palpated the neck region. Following her exit the doctors' discussion arrived at a consensus that the patient's present condition was probably due to ill-fitting dentures and/or an anemic condition, and recommended that she see her personal physician and her dentist. They also stated that since one purpose of the cancer clinic was to rule out the possibility of cancer, a biopsy should be taken.

Summary of Cancer Clinic Activities

A.	Examinations	
	1. Visual examination of affected area	11
	2. Manual examination for enlarged nodes	4
	3. Pelvic examination	1
	4. Biopsy of affected area prescribed	3
	5. Blood examination prescribed	1
	6. X-Ray examination prescribed	1
	7. Vaginal smear	1
B.	Therapy Prescribed	
	1. X-Ray Therapy	2
C.	Referrals	
	1. To oculist	1
	2. To medical doctor	3
	3. To dentist	2

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

The purpose of this study was to determine if the Outpatient Department Clinic Service at "X" General Hospital offered experiences which could be used in the education of student nurses.

The hospital itself is classified as a voluntary, nonprofit organization and maintains a three-year diploma program in nursing, which has State approval and full accreditation from the National League for Nursing.

A review of literature pertaining to nursing education, including that concerned with teaching in the clinical area, failed to reveal an established method for evaluating the educational worth of a clinical area. There appeared to be a need for a closer look at the activities within the clinics and in particular those centered around the care of the patients.

The investigator attended the actual clinic sessions of the patients who attended the clinics, observed what was going on, and recorded her observations.

Summary of Clinic Activities

Listed below is a summary of the activities which took place during the observed clinic visits.

A.	Examinations	
	1. Visual examination of affected area	32
	2. Visual examination of affected area with magnifying glass	9
	3. Manual examination of affected area	11
	4. Range of motion examination	5
	5. Laboratory examination of tissue scrapings	1
	6. Pelvic examination	1
	7. Biopsy of affected area prescribed	3
	8. Blood examination prescribed	1
	9. X-ray examination prescribed	2
	10. Vaginal smear taken for laboratory examination	1
B.	Surgical Procedures	
	1. Injection of medication into knee joint	1
	2. Use of dessicating machine to remove warts	1
C.	Use of Appliances	
	1. Patient fitted to orthopedic appliances	2
	2. Patient measured for orthopedic appliances	1
	3. Patient given prescription for orthopedic appliances	1
	4. Patients utilizing orthopedic appliances and advised to continue their use	2
D.	Instructions for Home Care	
	1. Patient instructed to carry out orthopedic therapeutic measures	4
	2. Patient given instruction for debridement of tissue, self-care	1
	3. Patient instructed in skin hygiene	5
E.	Special Therapy Prescribed	
	1. Physical Therapy	1
	2. X-ray Therapy	1

F.	Medications	
	1. Discussion of medication with patient	21
	2. Patients utilizing one or more types of oral medications	17
	3. Patients utilizing one or more types of topical medications	13
	4. Patients for whom medications had been prescribed on previous visits:	
	oral medications	12
	topical medications	7
	5. Patients for whom medications were prescribed during the observed clinic visits:	
	oral medications	5
	topical medications	8
G.	Use of Referrals and Community Agencies	
	1. Patient referred to oculist	1
	2. Patient referred to medical doctor	3
	3. Patient referred to dentist	2
	4. Agencies involved in providing care and assistance to patients:	
	a. State Cancer Association	12
	b. Visiting Nurses' Association	1
	c. Crippled Children's Clinic	1
	d. Federal Program of Aid to Dependent Children	1

Conclusions

The findings of this particular study substantiate the hypothesis since they indicate that the Outpatient Department Clinic Service at "X" General Hospital does offer experiences which could be used in the program of student nurse education.

The clinics which were found to offer the most meaningful educational experiences were the Orthopedic, Dermatology and Cancer Clinics. The Psychiatric Clinic was found to offer very few learning opportunities and is not worthy of consideration for use in the program of student nurse education.

Implications for Teaching Identified in the Environment of the Orthopedic, Cancer and Dermatology Clinics:

1. The patient among family members and as a functioning member of the family group.
2. The patient-doctor relationship in a setting other than the immediate hospital area.
3. The psychological, social and economical effects of a long-term or restricting illness upon the patient and his family.
4. The care of patients with orthopedic, dermatological, and cancer conditions in a setting other than the immediate hospital area.
5. The importance of and need for early diagnosis and adequate follow-up care.
6. Interviewing techniques for obtaining histories and procuring information from the patient and his family.
7. The importance of accurate history-taking, and its role in diagnosis and treatment.
8. The anxieties and fears of patients and family members, and the provision of emotional support.
9. Education of the patient and his family in regard to:
   a. Health teaching to all age groups
   b. Interpretation of doctors' orders
   c. Follow-up care in the home.

10. The diagnosis and treatment of some disease conditions not commonly seen in the hospitalized patient, or at the same stage of development.

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APPENDIX

APPENDIX

SUMMARY OF ORTHOPEDIC CLINIC VISITS

Patient A Age 62 Female Rheumatoid arthritis

Unaccompanied

Patient greeted warmly by the doctor. Doctor stated to observer, "This is my best patient." Patient beamed. Doctor helped patient on to examining table. Doctor had previously operated upon her right knee, and one which had complete immobility pre-operatively. Patient now able to walk with cane and apparently doing fine until knee started to bother her.

Doctor examined knee, bent to 120° angle, and tested for range of motion.

M.D. There appears to be fluid building up. Can notice ballotment of the patella. Sometimes stays when it gives out, causing pain.

Pt. Is it going? Won't I be able to walk? Will I have to be in a wheelchair?

M.D. We can make it better with an injection of cortisone, which will help to relieve the fluid. Will also order a knee corset to help support your knee.

Doctor explained how he had used these previously with other patients, and one in particular who had said it was the best thing that ever happened to her.

Pt. Were hers as bad as mine?

M.D. They were worse, and she was heavier. I think we can save that good one. We don't want two bad bad knees. I can inject it today. You wait here while we get it ready. I'll measure you for the knee corset also. It is made of elastic with steel side hinges.

Patient waited on table. Doctor measured knee, and injected cortisone.

Patient appeared greatly relieved.

Following clinic visit patient walked from room with assistance of cane.

Patient to return for fitting when knee corset arrives.

Patient B Age 63 Female Pericapsular adhesion in right shoulder

Unaccompanied

Patient received injury in car accident. Was sitting in back seat of taxi when car braked and she was thrown over into front seat head first. Doesn't remember if her head hit the floor, but knows her shoulder and side did. Accident happened two months previous.

Patient was taken to her sister's house which was her original destination. Local doctor called. Patient later taken home and put to bed. Has been in bed most of the time since then. Has had considerable pain in right shoulder and limited motion.

Doctor examined shoulder, and tested range of motion of arm. Noted fluid around joint.

Clinic doctor examined X-rays which had been previously ordered by the local doctor.

Doctor told patient about exercises which he wanted her to do at home. (weight lifting by use of antagonistic pulleys, three times a day for five minute periods). This did not seem too clear to her so the doctor said he would ask physical therapy department to instruct her. Asked her if she could come to the physical therapy department three times a week. She said that she could.

Doctor described his findings to patient, and instructed her to call physical therapy department for appointments.

Patient C Age 60 Male Gout, with fungus infection of foot

Accompanied by wife

Doctor examined patient's ankle.
Explained to patient why the leg was so discolored. (stretched skin)

Doctor questioned patient about his condition

M.D. Is it better?
Pt. Yes.
M.D. Much better?
Pt. Yes.
M.D. Have you been able to work around? A little? Get out in the yard?
Pt. Not too much, the weather hasn't been good, too wet and cold.

Patient C (continued)

M.D. But you could have if it hadn't been so wet and cold?
Pt. Yes.
M.D. The skin is wrinkled which shows the swelling has subsided. Wear the arch cups as much as you can. Plan to return in one month or sooner if necessary. Get a refill and continue with the pills.
Pt. What about the soaks?
M.D. No more with magnesium sulfate. Bathe with boric acid because of the fungus infection.

Patient mentioned that the pills were very expensive, costing $9.50 for a refill.

Doctor told patient to tell druggist that his doctor told him the cost of these pills had recently come down, because the supply was more plentiful. (Fulversan)

Daughter spoke up and asked if doctor would write a duplicate prescription. She thought that her sister might be able to procure the medication at work, and get it at a better price.

Doctor wrote another prescription.
Daughter You think that it really looks better?
M.D. Oh, yes, certainly.
Pt. Can I have a few beers, you know at the end of a day when I get tired, etc.? Helps me to relax.

The doctor and the patient kidded a bit here.

The doctor explained to the patient that he knew how he felt and probably would do him good, but to go slow. Asked about other forms of alcoholic beverages. Doctor told him to keep away from hard liquor, for it would only make the gout condition worse, and would do no good to treat him if he were to drink a lot and make the condition worse. "Also," he said, "it's too expensive."

Patient was told that he could return to work.

An excellent relationship between patient and doctor.

Patient D Age 55 Male Broken back brace

Accompanied by wife

Patient came to clinic because back brace is broken. Has another one, but it is not as satisfactory. Patient owns both.

Patient has some lower back pain. He cannot go without brace.

Wife kept interrupting to let doctor know that patient had to take nitroglycerine pills several times daily for angina pain. Doctor told him he was just taking care of his back condition. Explained he would have to keep taking these pills. Patient is under treatment with another doctor for his medical condition.

Patient told to wait for a call. Doctor instructed secretary to notify patient when brace had been repaired.

Patient had recently been operated upon by this doctor. Had a spinal fusion. Doctor remarked about his rapid recovery, his early ambulation. The doctor mentioned how his progress had pleased him greatly.

Patient E Age 33 Female Torn meniscus in knee joint

Accompanied by husband

Patient lying on examining table in clinic room. Complained of a painful right knee. Fell last week. Three days ago while walking, stepped on a pebble and knee let go.

Sixteen years ago local doctor called it a "trick knee."

Clinic doctor discussed history of condition with patient.

M.D. What originally was the start of it all?
Pt. I was playing ball, and jumped up to catch the ball, fell and my right knee let go.
M.D. At that time did it stay bent?
Pt. This part goes this way, and they press it together again. Doctor called it water on the knee at that time. It dislocated.
M.D. Were they able to fix it without anaesthesia?
Pt. Yes. This has happened many times since I was sixteen. My husband can put it back, but I have blacked out several times when he did it. This time I can't bend it much, and it seems swollen. Can't extend it either.

Patient E (continued)

Doctor examined knee more closely. Tested range of motion. told her she had a knee like a lot of football players and that he treated many patients for this same condition. He mentioned that just this week he had discharged two patients whom he had operated upon, ages eighty-three and seventy-one.

Said he operated on college football players during Christmas vacation. It was only a brief operation and required only two days of hospitalization. Said he had treated boys at the preparatory school where he was going later on that day for the same condition. He explained to the patient that a semi-lunar (half-moon shaped) cartilage, made of tough fibers, was torn, and was retracting into the joint. It brought about the same effect as a pencil between the pages of a book, prevented the closing of the book. He called it a "locked knee." Explained that it would be better to have the operation as soon as possible to prevent falling and causing a serious injury. He told of one woman who waited, then fell and broke her hip.

Doctor explained that the operation consisted of making a button-hole in the side of her knee and removing the torn cartilage. Another cartilage would grow, and in a short time she should have a perfect knee.

Doctor asked patient if she had hospitalization insurance. She did. Then he asked her if she could plan to go into the hospital within a day or two. She said she could.

Doctor left room to call metropolitan hospital. Returned to say that he had arranged for her to enter two days hence and have the operation the next day.

Explained to patient about the billing arrangement of that hospital, and told her he would see her at the hospital.

Both patient and husband appeared to be very satisfied with the outcome of the clinic visit, and seemed relieved that some definite action was to be taken.

Patient F Age 7½ Female Painful feet

Accompanied by mother

Mother receives financial assistance from Federal program of Aid to Dependent Children. Mother and father divorced.

Mother Her feet hurt.
M.D. They hurt?
Mother Yes. She complains all the time about her feet. She won't keep her shoes on. I can't seem to fit her.

Child was wearing a pair of loafer-style shoes.

Patient last seen at the clinic one year ago.

Mother mentioned that the people at the agency had given her to understand that the child didn't need shoes as often as she was getting them. The doctor disagreed. He asked if the agency would pay for shoes purchased in a town across the state line, where he thought she could be fitted less expensively and more satisfactorily.

The mother said she didn't think the agency was as critical about the price as it was about the frequency of purchase. The doctor stated that at her age a child should need shoes at least every six months. He wrote a prescription for a broad, strong laced oxford.

The mother asked if they could be white as the child was making her first communion in two weeks, and the child needed white shoes for that.

The doctor went along with this and directed in the prescription that the shoes be white.

The mother appeared quite relieved and said she might have to come back for another prescription when the child needed another pair.

The doctor agreed to this, and said he would be glad to see her and help her in any way that he could when she came.

Patient G Age 1½ Male Eversion of foot

Accompanied by mother

M.D. Let's look at his foot. I am going to put on Dennis-Browne splints. Keep them on him when he is lying down. Do we have X-rays of his feet?

Doctor tested range of motion of child's feet.

Mother No.

Doctor told mother to have x-rays taken that day at the hospital.

Child was fitted to shoes by the doctor. Showed mother how to adjust cross-bar. Cautioned her not to allow child to walk in them.
M.D. Will probably have to wear them for three months.

Mother was instructed to return to clinic in one month.

Child was first seen in the Outpatient Department at thirteen months of age, before he started to walk. At that time was fitted to pre-walker corrective shoes. Foot rotated outward at a 60° angle.

Local pediatrician who referred the child to clinic stated that he had noted some signs of cerebral palsy associated with a stiff knee. The clinic doctor noted that he did not detect this.

Patient H Age 1 Male Clubfoot and inversion

Accompanied by mother

Right foot shorter and very much fatter.

Examined by doctor, tested range of motion.
M.D. Take his shoe off. See if we have one to fit.

Doctor had brought several sets of open-toed, laced baby shoes which fitted on to Dennis-Browne splints.

Mother held the child while the doctor attempted to fit him to a pair of shoes, size three on the left foot, and size four on the right foot. Club foot was smaller, with a shorter heel cord.

Patient H (continued)

Mother Aren't I going to have to buy two pairs of shoes in order to fit both feet?
M.D. No. With a child you should always buy shoes a little large anyway.
Mother I have a hard time holding him and trying to put his shoes on.
M.D. What about me? (as he struggled with the child) Do we have X-rays of his feet?
Mother Yes, they were taken at neighboring hospital.
M.D. I'll have them sent over.
Now here is how I want you to fix this. Put it on when he naps and when he goes to bed at night.
Mother Won't he fuss?
M.D. No, they don't mind them as much as we think. It bothers the parents more than the children. Don't forget now, gradually force the foot outward more and more. Not so much that it hurts, though. Return in one month and bring the shoes and the braces. (Patient paid $4.00 for rental of shoes)

This child had first appeared in the clinic three months ago. Had a club foot. Local pediatrician had treated condition with plaster cast, which child had kicked off several times. Father was very unhappy about situation and brought child to this clinic. A long leg cast was applied, and kept on for ten weeks. Patient visited clinic every two weeks during this period and cast was in excellent condition. After cast was removed, mother was given instructions to manipulate foot, then return later to have Dennis-Browne splints applied.

Shortly after the child's first visit to this clinic the Visiting Nurses" Association called the clinic and said the mother had been down there for assistance. She wanted to know if the child could be referred to the Crippled Children's Clinic as the costs of this clinic were too high. It was noted in the record that the mother was worried about the bill but didn't want to change doctors. Both parents expressed confidence in the doctor and his treatment. Patient referred to social worker. Business office called the clinic and said that the child was to continue on at this clinic and that an agency would pay the bill.

SUMMARY OF DERMATOLOGY CLINIC VISITS

Patient A Age 82 Male Seborrhea of Scalp

Unaccompanied FIRST VISIT

Patient sent in by nursing home where he resides.

Patient very deaf and could not hear doctor's questions or comments.

Doctor examined scalp of patient.

Doctor requested secretary to notify nursing home of prescribed treatment.

Patient B Age 62 Female Lichen sclerosis or Leukoplakia

Accompanied by daughter FIRST VISIT

Daughter talked for patient. Patient could not converse in English.

Daughter assisted patient in undressing to expose lesion on upper back.

Daughter told doctor that patient had previously been treated by another doctor who ordered x-ray treatment. It did not help condition.

Doctor examined lesion and asked if patient had any more lesions on other areas of body. Patient said "No". Doctor requested patient to disrobe completely and stated that he doubted there were no more.

Doctor examined skin surrounding rectal and vaginal area and found additional lesions there as he had suspected. He then requested that the patient's personal doctor be called in. Patient and daughter waited in clinic room for him to appear.

When L.M.D. appeared the clinic doctor then described the condition and told of his recommendations for treatment in the presence of patient and daughter.

Daughter questioned the clinic doctor about the seriousness of condition and of its relationship to cancer. Doctor told her it was not too serious but hard to treat, and that he would try to improve the condition.

(Clinic doctor made comments to the observer in regard to indiscriminate use of x-ray treatment before diagnosis well established.)

Patient C Age 53 Male Discoid lupus erythematosus and liver cirrhosis

Unaccompanied

Patient has been having difficulty with eyesight and also has had face rash for several months.

Doctor examined patient's face.

Doctor referred patient to oculist for eye examination and said that he did not want to treat further until after that examination. Patient was told to return to clinic after eye examination.

After patient's departure, doctor commented that he did not want to treat for lupus yet as the patient's skin condition was similar to that seen in cirrhosis patients.

Laboratory report of skin biopsy revealed that lesion was compatible with lupus.

Doctor also commented on his choice of medication and wanted to have a clearer picture of patient's condition before starting intensive treatment.

Patient D Age 52 Female Sebaceous cyst of eyelid

Unaccompanied

Patient previously treated with x-ray.

M.D. Looks good.
Pt. Yes, wonderful.
M.D. Probably will need a few more treatments, but wait and see. How long has it been since you were last in to see me? Six weeks?
Pt. No, eight weeks.
M.D. Oh, that's even better. Come back in another eight weeks then.

Patient E Age 50 Female Lupus erythematosus

Unaccompanied

M.D. It's been six weeks since I last saw you?
Pt. Yes.
M.D. It's getting to look better.

Doctor examined face of patient.
Pt. Yes. My periods are difficult though. L.M.D. gave me a schedule for medications.
M.D. Well, we'll continue on with no treatment here and see you in six weeks. Continue with the B12 injections.

Patient F Age 50 Female Seborrhea dermatitis

Unaccompanied FIRST VISIT

Patient said she had large reddened areas under breasts, in axillae, groins, inner aspect of legs, scalp, behind ears, etc.
M.D. How long have you had this?
Pt. A long time.
M.D. What is a long time?
Pt. Several years.
M.D. You have it wherever there is fat.

Doctor asked patient to remove clothing. Patient was quite embarrassed and doctor told her not be be. Observer assisted patient. Doctor examined surface of entire body and prescribed medication.

Doctor explained to patient about condition and course of treatment.
M.D. Am going to give you two salves, one marked for scalp and one for body. Mix the body salve with vaseline half and half. If it wipes or washes off it's OK. If it isn't too strong, gradually increase the strength. Apply the scalp salve at night. Then shampoo the next day. Repeat this procedure three days later, then four days later, etc. In two weeks call in if you can say you're much better. Come back in four weeks regardless.

Patient G Age 43 Male Trichiphyton rubrum

Accompanied by wife FIRST VISIT

A furniture repairman

Doctor examined hands of patient. Used magnifying glass.

Pt. My nails got this way after a while. My hands are very dry.
M.D. When did you first have it?
Pt. Twenty-three years ago. Without lotion, it gets very dry.
M.D. May I see your feet and toes, please. Do you use any material in your business besides wood?
Pt. Yes, turpentine, alcohol and other chemicals.
M.D. How long? Now don't say it's been like that all your life.
Pt. A few years--at least since 1946.

Doctor examined both feet.

M.D. How do your hands bother you?
Pt. Just dry.
M.D. Do they itch?
Pt. No.
M.D. Have you ever done anything about it before?
Pt. No.
M.D. Does it bother you any more now?
Pt. No.
M.D. Listen carefully. If it had been two years ago, the treatment would be different. Now there is a tablet. You have to take it for a long time. Whether or not we use it depends upon you and if you want to. You will have to spend money and be prepared to take it for at least three months. It is not an ordinary fungus infection. Up until recently we knew what it was but there was no specific treatment. The pills shouldn't bother you. If they do, call me or your L.M.D. I will also give you a salve to use mixed 60-40 with vaseline. No need to return in two weeks unless there is a drastic improvement. If so, then I'll reduce the pills. Otherwise return in four weeks. The amount of pills you buy is between you and your druggist. Talk with him and find out the best way to buy in order to get the best price.

Patient H Age 36 Male Multiple warts on forearm

Unaccompanied

M.D. How are they?

Doctor examined area on which warts were located.
Pt. Same. How about removing them?
M.D. Any fool can burn them out. It's the question of their returning. I suppose we could burn one today and maybe more later. How long have you been on the pills?
Pt. Four weeks.

Doctor asked secretary to summon a nurse, and then requested the nurse to procure the dessicating machine, skin cleanser, aristol powder and a Band Aid. He burned off one wart and applied dressing. Patient winced several times during procedure.
M.D. Then we'll see you in two weeks. Keep up the pills.

Patient I Age 35 Female Psoriasis

Unaccompanied

Doctor examined patient's hands.
Pt. They have never cleared.
M.D. They look so much better though.
Pt. Am losing my fingernails. Some days my hands are fiery red. They don't itch, they burn.
M.D. Would you like to see an allergist?
Pt. Yes, I would. Can I show you my arm?
M.D. Yes.

Doctor observed reddened areas on arms.
Pt. I can't use a deodorant. What can I use? My whole skin feels like sandpaper.
M.D. Well, we'll see. Continue on with the medications.

Doctor gave patient the name of an allergist to contact for further assistance.

Patient J Age 29 Female Exfoliative dermatoid eczema of foot

Accompanied

Doctor examined area on inner aspect of patient's ankle. Used magnifying glass.

Described condition to patient as a highly secondary pyoderm. An infection.

M.D. How is it?
Pt. Not too bad.
M.D. Better?
Pt. Oh yes. Not so itchy, but rather messy.
M.D. When you cut the dead skin away, don't cut too close to the healthy tissue.
When do you see your local doctor again?
Pt. In two weeks.
M.D. If it gets worse, call him before that. Continue with the saline soaks. You are now taking the capsules four times a day. Well cut it to two a day. Continue with the Benadryl. I'm also going to give you an ointment to use.
Call me Friday at my office unless it is very much better. If so, postpone it until two weeks, then return here.
One point about this--your foot is much better, and going through an infection is often a blessing in disguise.

Patient K Age 26 Male Psychosis vulgaris

Unaccompanied

Patient had rash around chin and shaving area.

Doctor examined patient and asked about his condition.

M.D. How much medication are you taking?
Pt. The first week I took four capsules a day. Since Sunday two a day. It has continued to itch so I kept on two a day.
M.D. Oh that's better. I didn't give you salve, did I?
Pt. Yes, bacitracin.
M.D. Keep on using that.
Pt. I need another prescription. It's all gone.

Doctor wrote prescription and told patient to have his wife call the office in three days.

Patient L Age 25 Female Acne vulgaris or acne medicamentosa

Unaccompanied FIRST VISIT

Patient is a schoolteacher.

Papillar rash on face.

Doctor questioned patient about condition.

M.D. How long have you had this on your face?
Pt. Several months.
M.D. No previous trouble?
Pt. No.

Doctor examined patient's face.

Pt. I've been very hoarse this past week also.
M.D. I will refer you to a throat specialist. Don't get discouraged. We'll outline a program that will help you.

Doctor gave patient prescriptions and directions for use of soap, astringents and oral medications. Referred her to throat specialist.

Patient M Age 23 Male Fungus infection on hands

Unaccompanied

M.D. How is it? Before I look for myself you tell me.
Pt. A little better.
M.D. How much is a little?
Pt. It's clearing up on my fingers.
M.D. How is the day salve?
Pt. OK, but the night salve doesn't seem to--
M.D. Oh, oh, don't say that. Have you any left?
Pt. Yes.

Patient feels the night cream might be the cause of the itching. Likes the day cream much better.

Doctor told patient to continue with pills, and use day cream.

Patient to return in four weeks.

Patient N Age 18 Female Acne on ankle

Accompanied by mother

M.D. Let's look at it. How does it feel?
Pt. It never hurt.
M.D. OK, then how does it seem? (he laughed)
Pt. Better.

Doctor examined area on foot.
M.D. See the roots are turning black. It is dying. That's what gives it that color. Are you still taking the pills?
Pt. Yes, three a day.
M.D. Stop putting the medication on it. Maybe it's too strong. Call me at my office in about a week.

Patient O Age 17 Female Acne on face

Accompanied by school nurse

Doctor examined patient's face.

Questioned patient about condition since last visit.
M.D. Well, it looks better. Are you still using the cream?
Pt. Yes.
M.D. Which do you like best, the lotion or the cream?
Pt. The lotion.
M.D. Well use only that. Reduce the capsules to one a day and take them until they are gone. Then stop.

Patient P Age 17 Female Dermatoid acne on face

Accompanied by mother

Doctor questioned patient about progress and examined face.

Patient said condition was much better.

Doctor asked mother's opinion.

Mother Much better.
M.D. Did you have it last summer?
Pt. No.
M.D. What about when in the sun? Does it get worse?

Patient P (continued)

Patient said that she had been in the sun, but didn't notice if condition got worse then.

M.D. Actually that's where it got started. I'll give you something else to speed things up a bit. If it agrees, use it. If not, stop. Return in two weeks. Wash with Dial soap. Cut the pills to one a day, until a date six weeks hence, then stop them altogether.

Patient Q Age 7 Male Eczema on body

Accompanied by mother FIRST VISIT

Doctor questioned mother about condition and history.

Child has had eczema since birth.

Child is a redhead.

Doctor examined patient, using magnifying glass.

M.D. to mother I'm going to give you two salves. The thick one is for night. Apply the other one several times during the day. The condition which he has is congenital, which means that he was born with it. Does he scratch?

Mother Yes, a lot. I give him two teaspoonfuls of Benadryl twice a day as prescribed by the pediatrician. Shall I continue with it? It doesn't help his scratching at night. I also bandage his hands at night, but that's not successful.

M.D. I'm going to give you something else instead of the Benadryl. Give him one teaspoonful two or three times a day as necessary, but one dose should be at bedtime. This will clear up in a short time, and he won't have it as he grows up.

Mother What about his vaccination for school. Should he have it? Do I need special permission to omit it?

M.D. I'll give you a note to your doctor. It probably would be better to wait a while.

Patient R Age 6 Male Acne on face and upper torso

Accompanied by mother FIRST VISIT

Patient had rash on upper part of body, face and neck.

Doctor examined rash and questioned mother about history and condition.
M.D. How long has he had it?
Mother Two or three weeks. LMD said to try "X" medication. It didn't help so I came here. The other doctor said to go to a skin specialist if it didn't improve. It was very red and itchy. Looked worse, but it has come out more since I last saw him.

Doctor examined rash with magnifying glass.
M.D. to mother Did you have eczema as a child?
Mother No.
M.D. to pt. Let me see your knees.

Doctor examined knees and found them clear.
M.D. Has he been playing with a dog or a cat?
Mother No, he hasn't.
M.D. Has he been taking any medication?
Mother I have been giving him Father John's medicine lately.
M.D. It's a very odd looking rash. It could be due to an allergy or a drug reaction.
I'll give you a salve. Call me in three days and let me know how it is.
Use a little bit of the salve three or four times a day.

Patient S Age 2 Female Nodular eczema of face and legs

Accompanied by mother FIRST VISIT

Child had lesion on face and legs.

Doctor examined patient and questioned mother about history.
Mother Eight months ago she had two pimples on her cheek. They gradually got larger. The pediatrician told me it might be eczema. It didn't get any better. Another skin specialist said it was an allergy.
M.D. Did he do any tests?
Mother No, but I watched for reactions from her foods.
M.D. Did it make any difference?
Mother No, and the legs don't improve. They itch.

Patient S (continued)

M.D. Insofar as treatment is concerned there are two ways. We'll try the simple one first. After several weeks we'll see.

Doctor gave mother prescription.

Mother expressed apprehension and questioned her ability to get child to take oral medication.

Doctor discussed different ways to conceal medication in food, etc. Told her to watch and see if certain foods made condition worse. If she noticed they did, she should stop giving it to child for a while. Then later start with a small amount as a test.

Mother again expressed her concern about being able to get child to take medication and told of recent experiences. She also mentioned the interference of mother-in-law when she tried to discipline child.

The doctor gave the mother a lengthy lecture on how to get control of her own child, and the importance of firmness and showing the child who is the boss. Explained to her the danger of developing into a grave behavior problem unless she gained control of the situation.

Patient T Age 1 Male Lichen chronic circumspecta

Accompanied by parents FIRST VISIT

Doctor examined child and questioned parents about history and condition.

Noted areas on buttocks, groins, abdomen and legs.
M.D. Does he scratch?
Mother It annoys and bothers him. I didn't know what it was.
M.D. Was it scaly before you used that other stuff on it?
Mother Yes.

Doctor scraped a sample of scaly material off and put it in a test tube for laboratory examination. Explained to parents about condition.
M.D. I'll write a prescription for some ointment. Don't use it and put him in the sun. Use it when he is indoors and at night. Massage it in thoroughly four or five times a day. The rash should be gone in about two weeks. If not, call me.

Patient U Age 8 weeks Male Eczema of nailbeds

Accompanied by parents FIRST VISIT

Doctor questioned parents about history and condition.

Doctor examined patient.

Mother The pediatrician says there is a fungus infection around his fingernails. He had it in the hospital following his birth. They put gentian violet on it. His mouth is purple also, so perhaps the infection is there also.

M.D. In his mouth? Probably he put his hands in his mouth and the dye rubbed off.

Doctor told the mother he was in doubt about which would be the best treatment. If the child were a three-year-old, the treatment would be different. The preferred treatment is rather potent to use with an infant. However he would try something and see how it works.

Parents were told to check with doctor at later date. To either call him at his office or come in to clinic in two weeks.

DATA OBTAINED ABOUT PSYCHIATRIC CLINIC PATIENTS

Patient A Age 66 Female Depression

Patient has previously received electric shock therapy.

Patient hospitalized for psychotherapy.

Present treatment consists of weekly conferences and medication.

Patient B Age 64 Female Lack of memory and forgetfulness

Patient referred by local doctor.

Patient says she cannot remember which is eldest of her sons. Believes television stories are real. Cries over death of dog, and makes a great deal of minor events, but treats major subjects very lightly. Is seclusive. Has had a complete change of personality.

After six weeks of treatment has shown excellent contact.

Is a diabetic who has not adhered to her diet during this recent illness.

Present treatment consists of weekly conferences and medication.

Patient C Age 64 Male Depression

Patient has been depressed for last four months. Cannot sleep, relax. Has been unable to work.

Physical examination and laboratory studies were all negative.

Was given a series of electric shock treatments over a period of nine weeks.

Last note in record states patient no longer has feeling of rejection or dejection. Speaks clearly, readily, is communicative. Says he is feeling well, looks well, and is doing chores about house.

Present treatment consists of electric shock therapy and medication.

Patient D Age 58 Female Nervousness

Patient is a widow of three months. Cannot talk about her husband's death. Avoids thinking about him.

Gradual improvement noted since first visit to clinic six weeks ago.

Present treatment consists of conferences and medication.

Patient E Age 52 Male Nervousness

Patient says he has been nervous over a period of one year. Says it came on after he lost his job when the factory moved out of town.

Present treatment consists of electric shock treatments and medication.

Patient F Age 49 Female Nervousness associated with menopause

Patient says all difficulties came on after automobile accident. Says her past history is irrelevant, and she has always been in good health. Has had several previous hospitalizations for treatment of medical and surgical conditions.

Present treatment consists of weekly conferences and electric shock therapy.

Patient G Age 47 Female Involutional melancholia

Patient brought to hospital as an emergency. Was given a series of electric shock treatments.

Has had nervousness and insomnia. Constantly thinks one thought.

Had hysterectomy four years ago. Husband thinks this has contributed to her condition.

Present treatment consists of electric shock therapy and weekly conferences.

Patient H Age 45 Female Neurological examination

Patient referred to this clinic for neurological examination.

No further information available.

Patient I Age 26 Female Benign depression

Patient referred from the Alcoholic Clinic

Presence of domestic strife partly in relation to sex problems. Husband also called in for consultation. A long letter in record which doctor asked patient to write about herself and her problems. Patient says husband is jealous. Husband says sex life is not the same since they attended a party given by a civic organization where he noticed another man who was intensely interested in his wife.

Patient has several young children.

Patient left home on several occasions to stay with her parents.

Doctor notes improvement in condition.

Present treatment consists of weekly conferences and medication.

SUMMARY OF CANCER CLINIC VISITS

Patient A Age 70 Bleeding from tracheotomy

History of patient reviewed. Had laryngectomy three years ago for treatment of cancer of larynx.

Patient had a cold a week ago. Since that time he has coughed bloody mucus through the tracheotomy aperture.

Doctors examined patient, questioned him about condition.

Patient previously attended speech clinic in nearby city. Stopped because it was too much trouble (information from daughter).

Patient left room.
It was mentioned that there is a question of this patient being an alcoholic.
One doctor mentioned that the patient has a neighbor who is a nurse, and she frequently checks on him.
Doctors felt that the bleeding was due to an irritation from the cold.
One doctor stated that people with cancer of the larynx frequently have a history of alcoholism. There is a high incidence of this.
Patient to return if condition persists.

Patient B Age 67 Female Lesion on calf of leg

History of patient reviewed. Patient previously treated with radiation for primary cell lesion on lower lid.

One month ago patient had annual check-up and was fine.

Now complains about lesion on leg.

Doctors examined leg and questioned patient.

Patient also mentioned that she had several nosebleeds lately.

Patient left room.
Doctors felt that the lesion was caused by varices, and that her treatment should be carried out by personal physician. Felt that nosebleeds were not significant enough to warrant further investigation at this time.

Patient to return in one year.

Patient C Age 62 Female Soreness and burning of tongue, lips and gums

History of patient reviewed.

Three years ago had resection of lip lesion and superhyoid resection.

Patient is also a controlled diabetic, and visits her personal physician every two weeks.

Recently has had soreness and burning of tongue, lips and gums. Neck has been terribly sore.

Patient examined by doctors, neck region palpated, and patient questioned about illness and complaints.

Patient left room.
Clinic doctors discussed the symptoms and felt that perhaps her complaints were due to an anemic condition or a vitamin deficiency.
Recommended an examination of the blood, with follow-up treatment as indicated by the results.

Patient D Age 62 Male Follow-up visit

History of patient reviewed.

Three years ago had laryngectomy for treatment of cancer of the larynx.

Had also received massive doses of radiation therapy.

Seen and diagnosed at this clinic at that time, and referred to Cancer hospital for surgery and treatment.

Patient now complains that his eyesight is failing.

Doctors examined and questioned patient. Examination of neck revealed several enlarged lymph nodes.

Patient is due to return to Cancer hospital for check-up in two weeks.

Doctors discussed pro's and con's of radical neck resection at this time.

Decided to recommend further x-ray treatment and defer recommendation for radical neck surgery.

Patient referred to oculist.

Patient E Age 60 Male Follow-up visit

History of patient reviewed.

Four years ago treated for large tumor in region of sella turcica with massive doses of radiation.

Patient says he is getting along well but complains of failing eyesight, weakness and some loss of hair.

Patient referred to oculist.

Asked if he definitely felt better.

He said he did.

Lateral skull films ordered.

Patient to return in three months, or sooner if having any trouble.

Doctors stated that some of symptoms no doubt due to previous massive doses of x-ray.

Patient F Age 59 Female Rash on tongue and gums

History of patient reviewed.

Patient had rash on left side of face seven years ago. Was told to return if the area got larger. Has not been in since.

Now has rough areas on tongue and gums.

Doctors examined patient's mouth and questioned patient.
M.D. Have you changed your dentures lately?
Pt. No, and they are rough on the back.
M.D. How long since you noticed this roughness.
Pt. Only about three weeks.
M.D. Is it sore?
Pt. No, not really.

Patient left room
Doctors discussed condition. Felt it might be an irritation of the taste buds or an inflammatory condition of another nature. Questioned whether her diet was adequate. Recommended that a biopsy of the area be taken, and patient to see her dentist.
Patient to return in six weeks.

Patient G Age 58 Male Follow-up visit

History of patient reviewed.

Previously seen and diagnosed at this clinic for cancer of the face.

Initial symptoms were basal cell lesions.

Referred to Cancer hospital for radical face surgery. External nose removed.

Patient wears nose prosthesis which covers a large opening. Internal nose, sinuses and adjacent structures exposed to view.

Doctors examined and questioned patient. Noted a one centimeter lesion on right templar region, which they felt was suggestive of a basal cell lesion.

Patient is scheduled to return to Cancer hospital for check-up in one week.

To return to this clinic in three months.

Patient had an excellent outlook, was in very good spirits, and the doctors mentioned that he enjoyed his visits to this clinic.

Patient H Age 55 Female Follow-up visit

History of patient reviewed.

Eight years ago patient had cancer of right breast, treated by mastectomy.

Diagnosed and referred through this clinic.

No further complaints since that time.

Patient taken to another room for complete examination.

Results were negative.

Patient to return in one year.

Patient I Age 52 Female Follow-up visit

History of patient reviewed.

Patient had hysterectomy and radiation therapy fourteen years ago.

No complaints at this time. Patient feels and looks well.

Present visit is for annual check-up.

Patient taken to another room where pelvic examination performed and vaginal smears taken.

Doctors mentioned that these patients have to be followed closely. Not uncommon to experience later outbreaks of cancer following radiation therapy.

Patient to return in one year.

Patient J Age 50 Male Follow-up visit

History of patient reviewed.

Patient had not been seen in this clinic for eighteen years.

The clinic had contacted patient's wife at intervals to check on his condition.

Patient previously had burrs on ears which were successfully treated with radiation.

Patient came to clinic reluctantly this time, and only upon insistance of wofe.

Doctors noted a small lesion on nose. Patient said it was a rough spot which had always been there, and was nothing new.

Doctors did not feel it was significant to his condition.

Recommended patient to return in one year, or sooner if the lesion changed in appearance.

Patient K Age 46 Female Lesion on nose

FIRST VISIT

Patient came to clinic because of lesion on nose. Said she has had it since she fell six months ago. It bled some at the time.

Doctors examined area and questioned patient.

Noted an area 1½ x 2 centimeters in diameter. "Probably a basal cell lesion."

Recommended a biopsy. If reports are positive, patient to receive radiation therapy.

Patient to be notified.

Patient L Age 42 Female Irritation of mouth and gums

History of patient reviewed.

Eleven years ago was seen at this clinic. Had epithelioma on left side of nose. Biopsy taken at the time showed presence of cancer. Treated with radiation.

Ten years ago patient had leukoplakia of tongue and lips. Responded to treatment.

Patient now complains of irritation of mouth and gums.

Doctors examined mouth, palpated neck region, and questioned patient.

Patient left room.
Doctors felt that the condition was probably caused by an anemia or ill-fitting dentures.
Because purpose of cancer clinic is to rule out the possibility of cancer, the doctors felt that a biopsy should be taken. Patient also to be referred to personal physician for treatment of medical condition, and to dentist for remedy of dental condition.