Professional staffs of hospitals are not paid by money, but by opportunity to make reputations with which to trade. Hence there is a temptation to experiment and practice technique.

The object of a doctor who wishes to make a large income is not to do his work better, but to do his work among richer persons.

Old-fashioned medical ethics require doctors to give their services to all cases who come to them and discountenance the refusal of treatment to those who cannot pay a certain price.

Two-thirds of the public do not pay their physicians adequately for their time; the other third has to pay, but has no means of knowing whether it gets better service.

Custom pardons the doctor for failure to cure.

The medical student is taught by *precept* in the medical school that he should seek consultation, if he cannot make a diagnosis or if he doubts his ability to give skilled treatment; but in the hospital he is taught by *example* that seniority, the number of the ward, and the calendar justify his understanding diagnosis or treatment which he knows some colleague can do better.

Medical ethics considers that a doctor has a right to his patients no matter what his diseases, but common sense would say that a doctor has no right to his patient unless he knows what the disease is, and how to cure it.

A member of a hospital staff who uses his position merely to increase his private practice without making a return in teaching, clinical research, executive or other work for the general good is not considered more commercial and less honest than a man who runs a private hospital and accepts only cases he can cure or relieve.

Up to the present time the public have regarded hospitals as places for the treatment of the sick, but not necessarily for their *successful* treatment. It is as if factories were simply places to make things of every variety, and not necessarily good things at that.

### *Customs of the Hospitals*

Hospitals make little effort to ascertain the quality or amount of their product.

The professional staffs are sometimes appointed through nepotism, influence, social position and politics, and promotions are usually made by seniority.

The public is willing to pay large differences in fees for the supposed difference between one surgeon or physician and another, but at the hospital this difference is said not to be demonstrable.

The personal equation enters so largely in the treatment of a patient that standard treatments may be difficult to establish.

Hospitals should limit their practice to those cases they can diagnose and relieve instead of accepting all kinds of cases, so as to give practice to their staffs. A hospital should increase the variety of its cases by adding to its staff men competent to treat *successfully* each new variety.

What is given away should be standardized as good enough to be sold.

The trustees of hospitals should remember that their funds were bequeathed for the benefit of the sick poor without the generation being specified. Nepotism, pretense and hypocrisy in this generation create more harm by example in the next generation than the prestige of the hospital does good in this generation.

Our charitable hospitals have become competitive businesses and are (unconscious, not always unconscientious,) wolves in sheep's clothing. To put the hospitals back into charity and out of competitive business we need private hospitals which aim to accept only cases which they can relieve or cure.

The last place for success through humbug is an institution supported by endowment. It can afford *truth at any price.*

There are many institutions that have accepted the general principals of the End Result System, but as far as I know the Presbyterian Hospital in New York has advanced farthest in the perfection of details, and the University of Pennsylvania Hospital in Philadelphia, and the Massachusetts General Hospital of Boston are not far behind. The Mayo Clinic has always in the past practically lived up to the End Result Idea without actually formulating it.

### A Brief Explanation of the End Result System

For every patient who enters the hospital a permanent "End Result Card" (5 by 8 in.) is kept.

On this card are entered laconically

The symptoms for which relief is sought.

The diagnosis on which treatment is based.

The outline of the treatment given whether operative or medicinal.

The complications of convalescence or in consequence of the treatment.

The final diagnosis at discharge from the hospital.

The name of the physician or surgeon who orders or gives the treatment.

Reference to the volume and page of the detailed record.

The address of the patient, of his physician and of a friend.

A year later the patient is "followed up," and a note of the success or lack of success of the treatment is made on the back of the card.



Thus these cards form an authoritative record by which the Efficiency Committee or other authorized persons may analyze the Products of the Hospital to determine methods whereby the Efficiency may be increased.

It is manifest that constant errors in diagnosis and failures in treatment will be made; but if these are recorded, intelligent effort can be made to diminish their number.

Such *consecutive* diagnostic and therapeutic comparisons will be the beginning of true clinical science and will ensure the *patient* the thing which he desires —*therapeutic efficiency.*

Who is to insist that this is done in a given hospital?

### *The Efficiency Committee*

The function of the Efficiency Committee should be suggestive—*not executive.*

Its essential duty would be to take an inventory of the products of the hospital—that is to critically scrutinize the End Result cards. By this means the waste products would be detected and brought to the attention of the proper departments so that improvement may be made.

This analysis of the End Results might be done in detail by the Committee or be referred by it to the heads of the departments, subject to its review in detail.

The publication of the annual morbidity report should be in its hands and it should be expected to compare the results of the hospital with those of other hospitals to make sure that its standard is high.

As to the responsibility for efficiency, this Committee should stand in the same relation to the Trustees as does their expert accountant.

The Committee would also prove useful at times when promotions of members of the Staff are considered, for though there are many other reasons to be thought of when promotion is made, the demonstration of a high degree of efficiency in the actual treatment of patients should be a *sine qua non.*

The members of the Committee should be elected by the different bodies which they represent, at least one member each from Trustees, Staff and Administration. In number they would vary with the size and number of the separate services in the hospital. The presence of a Trustee on this Committee is essential.

There is nothing very terrible or very expensive about these suggestions—they are merely novel. They were made by the Committee on the Standardization of Hospitals of the Clinical Congress of Surgeons.

They were particularly designed to be so simple as to fit into any hospital organization large or small.

You could start these plans in your hospital now, and no matter how much you improved on them later —the same basic plan would be there. Is the expense worth while?

In the disbursement of Charitable Funds, saving money means increasing the quantity or value of the product for which the funds are spent. Can you afford to go on spending money without knowing what your product is?

If the Trustees of hospitals cannot assure their patients of efficient medical and surgical service, how can the plain citizen select a doctor or a surgeon?

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* *Report of Committee on Standardization of Hospitals. Surgery, Gynecology and Obstetrics, January,* 1914.

** *The Product of a Hospital. Surgery, Gynecology and Obstetrics, April,* 1914.

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Dr. Judson Daland[1]: I came here tonight to learn, and fear that I can give but little in return. All that has been said by my predecessors is absolutely true. Efficient management as observed in most medical colleges, hospitals, dispensaries, and in private practice is in the dark ages.

Dr. Codman has very properly drawn attention to the importance of knowing the end results in the treatment of diseases. To secure a complete knowledge of end results necessitates a comprehensive system of note taking and recording, so that not only may proper deductions be made from a single case, but also a large number of similar cases may be analyzed by the use of statistics and thus made valuable. If the records of most hospitals are examined from this standpoint they will be found to be practically useless, and it is therefore impossible to properly utilize the enormous amount of work done in various hospitals in different parts of the United States in order to determine the end results of treatment.

A system agreed upon and utilized by a large number of hospitals would facilitate a study of this nature upon a scale so large as to definitely establish important principals regarding the value of the present day methods of diagnosis and treatment of diseases. For many years the medical profession believed that gastric ulcer was more common than duodenal ulcer. A statement study demonstrated that duodenal ulcer was more common than gastric ulcer. The single example illustrates how misconceptions may be rectified, and in other domains of medicine the application of the fundamental principle controlling efficient management will unquestionably be of *vital* importance to suffering humanity. I therefore urgently request the co-operation of the members of this Society to this end.

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