Ninety Years Ago, December 1920

Elliott Washburn, MD, in “A Wider Use of Tuberculosis Clinics and Hospitals,” described two new kinds of clinics: the occasional, traveling, or itinerant, clinic, and the consultant clinic.” Neither was connected with a dispensary or a hospital outpatient department. The occasional clinic traveled to rural areas and small communities. In New York State, Dr. Washburn noted: “We found in these small communities and in rural districts an astonishingly large amount of active tuberculosis, a very considerable proportion of which was under no supervision.” Clinic staff referred those cases to county tuberculosis hospitals. The consultant clinics grew out of the Framingham Tuberculosis Experiment, where “They induced 12,000 of the total population of 16,000 to come in for a through and complete examination...They found...that for every death from tuberculosis there were 19 living cases, 9 of which were active, and 10 were old cases which probably had never been active.” The TB Consultation clinic relied on outside tuberculosis specialists (“so that the physicians of the community have no hesitancy in sending their cases...for consultation”). Dr. Washburn noted: “The consultation and examinations are entirely free. In most cases the physician comes with the patient and Dr. Bartlett [Chief Examiner] in a great many cases, is able to point out to the physician some point in the diagnosis which the physician has overlooked.”

An Editorial, “Diphtheria in Providence,” recounts the statistics: 80 deaths in 1917, 56 in 1918, 77 in 1919, up to 61 by October 1920. The editorial stressed the efficacy of antitoxin, given on the first day of the disease. “Although there is no doubt that the chief factor in the high mortality...is due to the neglect of parents in calling a physician, not a little blame attaches to physicians.” Dr. Richardson from Providence City Hospital cited the first error: “failure to make a diagnosis.” “Although diagnosis is not always possible on the first call, suspicion is always possible and the patient should always be given the benefit of the doubt.”

Fifty Years Ago, December 1960

“Rhode Island has the Lowest Infant Mortality Rate,” Statement from the Children's Bureau, Social Security Administration, US Department of Heath, Education, and Welfare, November 2, 1960. The US infant mortality rate (under one year) was 26.0 deaths per 1000 live births in 1956, then 27.1 in 1958. (In 1915, the rate was 99.9; in 1941, 47.0.) “No state within the US matched the low infant mortality rate for Sweden – 15.8.” The rates in the US ranged from 21.3 in Rhode Island to 41.0 in Mississippi.

Roman R. Pe’er, MD, Head, Department of Surgery, Poriah Government Hospital, Israel, and Surgeon-in-Chief, Pro Tempore, Mriah Hospital, contributed “Personal Experience in Management of Hydatid Cyst, with Report of Unusual Complications.” A 37-year old immigrant from Morocco had arrived at the hospital in Israel, complaining of severe pain. After surgery, he improved, but it was not clear why. One year later, the pain recurred. “He came to us complaining bitterly about the state of Israeli medicine, stating that in his native Morocco, he would already have been dead two years ago, but here, because of us, he was neither fully dead nor fully alive.” After surgery and treatment with cortisone, the patient recovered. The conclusion: he had a foreign-body granulomata in fibrous tissue.

Alex M. Burgess, MD, Chair, Publications Committee of the RI Medical Society, announced the appointment of Seebert J. Goldowsky, MD, as editor-in-chief of the journal.

Twenty-Five Years Ago, December 1980

Wendy J. Smith, Editor, described “A New Payment Schedule.” Two Boston surgeons had developed a reimbursement schedule “based on relative difficulty of performing a procedure rather than the amount of time required.”

Ian R.H.Rockett, PhD, in “A Profile of Injury Mortality in Rhode Island, 1980-82,” reported “…trauma accounts for 38.3% of all potential productive years of life lost.” The key causes of injury deaths were traffic accidents, suicide, falls, and homicides.

Manuel E. Soria, MD, and Thomas A. Jordan, MSW, discussed “Clinical Prediction of the Violent Patient,” a discussion spurred in part by the Tarasoff ruling. “While no accurate and specific criteria for predicting violent acts exist, their incidence can be reduced.”