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THE HOSPITAL WORLD

Vol. XVIII Toronto, September, 1920 No. 3

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The Prevention of Fires in Hospitals

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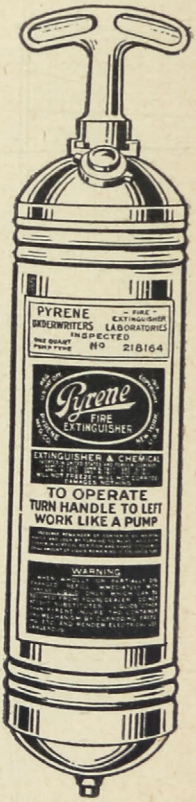

The Pyrene Manufacturing Co. of Canada, Limited

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ELECTION TO THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.

170 University Avenue.
Toronto, August 23rd, 1920.

To the Members of the College,

Gentlemen:—I beg to advise you, in accordance with the Ontario Medical Act, and amendments thereto, and the By-laws of the College—

That the Quadrennial Election, to select Representatives for the Council of the College, will be held this year, date of said election being Tuesday, October 19th, 1920;

That the time for receiving Nominations of Representatives will close at the hour of two o'clock p.m., on Saturday, October 2nd, 1920;

And that the Nomination Papers of the Candidates must be in the hands of the Returning Officer for each Division at that time.

By order,
H. WILBERFORCE AIKINS,
Registrar-Treasurer Coll. Phys. and Surgs., Ont.

The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire

Vol. XVIII. TORONTO, SEPTEMBER, 1920 No. 3

Editorials

HOSPITAL ECONOMY

IT is good hospital economy to have plenty of hospital grounds, beautifully landscaped; abundance of sunlight, and oceans of the purest air, with the greatest amount of quietude of environment. It is good economy to have plenty of room for patients, and plenty of room in which to work; to have kitchens and laundries, and utility rooms, ample, airy and sunny.

Wards, with their many accessory rooms (serving pantries, sink-rooms, bathrooms, linen closets, appliance rooms, small laboratories, and toilets), ought to be so arranged as to be convenient for nurses, doctors and workers generally—thus economizing energy by saving steps.

A thousand and one devices make for economy in hospital management and ward administration, e.g., plenty of telephone and signal accommodation; lots of dishes, utensils (preferably aluminum), and

instruments, elevators and dumb waiters, properly placed and constructed; convenient arrangement of kitchen furniture and devices, of service room fixtures, and laboratory furnishings; durable material in floors and in walls; high quality of paint and finish; large window panes, glass door-knobs—all are examples of good, economical features in construction.

Then, of course, there comes in the care of things. Some one ought to be responsible for seeing that nothing, if possible, is lost or stolen; that everything, when not in use, is kept in a proper place; that broken or missing articles are immediately replaced; that workers are taught how to use delicate instruments of precision. Careful inventories should be frequently and regularly made. Torn clothing or linen should be mended at once. Rubber goods need especial care. Economy in the use of food can be governed by seeing that so much per day per patient is allowed—as is fair and necessary—and no more. This can be ascertained by a proper accounting system. Again, much economy can be practised by inspecting waste and discarded articles.

In these days, when prices are so high, the strictest economy ought to be observed in every way.

A NEW PLAN

EMPLOYEES in all kinds of industrial organizations are receiving much more consideration than they did a decade or so ago; witness the social service

departments, welfare bureaus, educational departments now associated with most of the big industrial plants.

And this is as it should be.

Hours have been shortened, vacations lengthened, wages during illness have been paid, wage-earners' homes have been visited with a view to rendering assistance needed, and laborers treated a little more like human beings than formerly.

Hospitals have not been in the van in this movement—rather lagged behind. It is high time hospitals in general began to consider this problem.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

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Society Proceedings

HOSPITAL STANDARDIZATION

(Continuation from August issue of report of meeting held at Calgary, Alta., April, 1920.)

Meeting called to order by the Chairman.

The Chairman read a lengthy telegram from Dr. Hunter, of Manitoba, relative to rural hospitals and standardization. Dr. Hunter feared that hospital standardization would not help the small rural hospital—which is so essential in the community, and suggested considering them in a class by themselves. However, it was pointed out by the Chairman that hospital standardization would help the small rural hospital, as would likely be shown this afternoon before the session was over.

It will be seen that the morning session was merely "preliminary," with reports from various provinces upon various points. There was a little discussion, particularly upon the question of the splitting of fees amongst physicians and surgeons. This practice is strongly prohibited under the standardization scheme introduced by the American College of Surgeons, having for its objects the elimination of incompetent surgery and for the qualified surgeon who performs the major surgical work to receive the fee to which he is entitled. The Chairman of the Galt Hospital Board raised the question as to whether a man who had been a qualified surgeon and was incapacitated by his work, say had lost an arm, was not entitled to some portion of fees from the practice which he could introduce, but he was informed that, although this would be an unfortunate case, such a man was "down and out," and being no longer able to perform the work, was not entitled to receive pay for it.

The afternoon session was confined to the study of hospital standardization. A copy of the minimum standard suggested

was presented to each present. Before proceeding to discuss this clause by clause, Dr. R. E. McKechnie, F.A.C.S., of Vancouver, who is also President of the Canadian Medical Association and Chancellor of the University of British Columbia, will give us an address on hospital standardization.

Dr. R. E. McKechnie said:

"We know very well that a number of hospitals are no better than boarding houses. Their facilities are poor and everything is done in a slipshod way, and until a few years ago the only hospitals that attempted to be modern were those connected with medical colleges. The American College of Surgeons, in 1913, decided to commence a great work in trying to improve hospitals. The first thing which they did was to make a survey of the hospitals of Canada and the United States, taking particularly those of one hundred beds and over. It was hoped that a similar work could be carried on as was accomplished in connection with the medical colleges some years ago when they went under review by the Carnegie Foundation Society in both countries, and a survey was made which revealed many colleges that were not even reaching a reasonable standard. These were either improved or ceased to exist, and the same fate now hangs over some of our institutions. Everything tends towards the public paying for the upkeep of hospitals, and they will want to know that their money is well spent, and I do not think any intelligent community will object to pay for good work. Public opinion, indeed, will demand sooner or later that our institutions produce the highest standard of efficiency, and I am glad that we are analyzing our conditions to see if we are living up to this required standard.

"This great movement is now being carried on by the American College of Surgeons, a group of men from Canada and the United States, banded together to promote the highest ideals and ethics in the practice of their profession. They have realized that the hospitals are the work-shops or laboratories for the profession and in many cases are not producing the results that their ideals or standards demand. Like good fellows

they have also helped to finance the movement. Two surveys have been completed—the first in 1917, bringing a great deal of information and data from which a practical standard has been evolved. In the first survey 671 hospitals having one hundred beds or more were examined, and there were only 89 of those which could measure up to the minimum standard requirement. Under the stimulus of criticism from the profession and the public, there was brought to bear pressure on these hospitals, and at the end of the second inspection or survey, in place of 89 who qualified or measured up to the minimum standard, 198 had done so. Finally, at the end of the third survey, which will be this year, it is hoped that 400 at least will have reached it.

"What are hospitals for? Are they places for doctors to send patients in for the convenience of the doctors? Are they for the convenience of the patient or the convenience of the general public? Are the patients merely incidental? The answer may be summed up in a few words, and in a thought we must always keep before us: 'The patient is the unit of consideration at all times, and the success or efficiency of your hospital will be measured in the quality of service rendered and the product which is the end result in your patient.' The public need enlightenment along these lines so as to demand such proper conditions as are safe and good for the patient and we are coming to that stage when the public have to take more interest in the hospitals and patients, as they are usually paying the bills and it is a practical work for them to do. Naturally they will want to know if they are getting full value for the money they are spending. Many a hospital is being run in such a way that I do not blame the public if they grudge the money that is being spent on it. No intelligent community will refuse to support the hospital which is doing good work. A large number of hospitals have been doing first-class work, meeting their full responsibility in respect to looking after the sufferers, and these institutions are going to secure public support. Our educational propaganda will do great work in helping such a condition, and it is just as essential that the hospitals, the various members of the staff and the patients themselves, use prop-

aganda on the public to educate them up in their duty towards the hospitals, and it is just as important that the public should bring this influence to bear on the hospital authorities and the doctors attending the various hospitals and make them do their work properly.

"We hear to-day a great deal about 'group medicine,' and I am a firm believer in it. This group I refer to would include all the doctors in the community attending the various hospitals. My interpretation is that of having the fullest facilities at the disposal of every doctor in the community where he can do full justice to the patients he is looking after. At one time there was a real necessity for small groups of men, but that group was the smallest and most selfish aspect. What we want is a scheme whereby every medical man in the profession has just as much benefit from expert opinion and advice as any member in that group would have. This can be accomplished in a hospital properly equipped with all the necessary diagnostic and treatment facilities, such as X-Ray, laboratories of all kinds, etc., all of which are necessary in a well regulated hospital. The doctors can send their patients in and take advantage of these facilities, and thus the physician or surgeon can work up his cases to the maximum and do full justice to them. Thus the humblest member of our profession—the young man just from college—can have full benefit. That is what standardization of hospitals will lead you to. It will lead you to group medicine centered around well-equipped hospitals all over the country where the whole community is going to be benefited by service spreading out from the centre to all the medical men round about. To-day there is no room for private clinics in British Columbia. Every man in the City of Vancouver has the advantage of the magnificent equipment of the General Hospital, and through such arrangement the general standard and calibre of our medical profession is raised.

"Coming now to the question of the practice of the division of fees or fee-splitting, I may say that I do not think there is much being done in our provinces. Our profession is above this, I hope. Our friend from Lethbridge raised a question this

morning which I hardly think was sufficiently answered—when he quoted the case of an eminent one-armed surgeon called in to the operation to stand by. That eminent one-armed man was entitled in the instance related to a fee exactly commensurate with the value of the service he rendered, and he was quite entitled to receive a fee for that. He was not entitled to any recompense for having lost his arm or having been deprived from earning a larger fee at this particular operation by not being able to do it. He is entitled to a just recompense for his remaining powers. Supposing an eminent violinist lost one arm and he toured the country with another violinist, giving him advice all through the concert—how much should that consulting violinist get for this work? The real work is being done by the violinist who is doing the playing. There is no consultant who can stand at a surgeon's elbow and direct him and make him do a good operation if he is a poor operator. You cannot thus stop a man from cutting a nerve or doing some irreparable damage even if you are standing at his elbow. Fee-splitting was carried on in the east with Chicago as a centre at one time to such an extent that dishonor was brought upon the medical profession. Doctors from outside districts would visit as many Chicago doctors as they could, to see which one would give them the biggest commission, and as a result of this the patient would go to the lowest bidder, who is usually an incompetent surgeon or a young fellow out of college. I have gone through the various stages in regard to this fee-splitting business and find it opens the opportunity to abuse, thus making only one remedy for it, and that is, complete abolition of it. You may say that the man who has had the previous care of the patient has perhaps worked the case up, has the right to a share in the fee which the surgeon wins with his operation, but he has not. Each man has an absolute right to the money he has earned, and no more, and this man has a particular right to put in his own bill for his services in working the case up, but should not claim any of the operator's fee. There is a tendency towards charging excessive fees, especially by the younger practitioners, but I believe in a surgeon charging a reasonable fee

commensurate with the seriousness and difficulty of the operation, and also commensurate with the ability of the patient to pay. We must prevent immature surgeons from rushing into surgery and charging fabulous sums, doing great harm to our profession. If the general practitioner had the courage to demand what he earns, so many men would not go into surgery. Finally, let us regard fee-splitting as entirely banished from our institutions, and that means that any surgeon doing work shall be paid for the work he does, and any patient paying any such bill will know for what reason he is doing so; or, in short, every man is entitled to his just fee and the collection thereof.

"In conclusion, I trust that this Conference will formulate a definite policy along the lines required and see that such a policy is duly executed to the fullest extent in all our institutions of this wonderful Western Canada of ours."

In reply to questions, the speaker stated with regard to the payment of the assistant surgeon he may have brought in the case, under the American College of Surgeons' ruling each man collects his own fee and each man runs his own chance.

In hospitals where no pathological expert exists, specimens could be sent to the central or divisional laboratory in the Province of Alberta; for instance, specimens may be sent to the University at Edmonton, and Dr. Rankin has promised to do pathological work there free of charge.

The Chairman now threw the meeting open for discussion, and several persons raised certain questions and spoke briefly.

Mayor W. D. L. Hardie, of Lethbridge, and President of the Galt Hospital Board, was very much interested in the paper which had been read, particularly that in regard to division of fees, since there seemed to be such a number of interpretations of this practice. Explanations were given by Dr. R. E. McKechnie and others, and this matter made very clear to all. Drs. Stephens, Gibson, and others also took part in the discussion.

The Chairman remarked that he felt that the splendid papers and discussion that followed should not be allowed to be passed on unheeded, and that it would be wise to have a Re-

solution Committee formed to make note of any resolutions which arose from time to time and formulate them into a constructive policy. In accordance with that he appointed the following:—

Dr. M. T. MacEachern, British Columbia
Dr. L. S. Mackid and Alderman McTaggart, Alberta
Dr. G. R. Peterson, Saskatchewan
Dr. George Stephens, Manitoba

to act as a Resolution Committee and report later to the meeting.

The Secretary now read the minimum standard requirement as laid down by the American College of Surgeons, and recommended for adoption throughout Canada and the United States. Clause by clause was dealt with and discussed and finally moved and adopted.

Clause 1. That physicians and surgeons privileged to practise in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed," nor need it affect the various existing types of staff organization. The word "staff" is here defined as the group of doctors who practise in the hospital, inclusive of all groups such as the "regular staff," "the visiting staff" and the "associate staff."

It was regularly moved and seconded that this clause be adopted as read.

Clause 2. That membership upon the staff be restricted to physicians and surgeons who are: (a) competent in their respective fields; and (b) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees under any guise whatever be prohibited.

Considerable discussion took place on this as to who was to judge whether the person is competent or not in their respective fields, and as to how it would work in the case of appointment of a new man to the hospital staff. It was finally agreed that everything in this connection was up to the Board of Trustees, and the following suggestions were made as to the best methods to be followed by the Board:—

Firstly—That there should be held regularly each month meetings at which the medical work would be reviewed by the Staff, and such information prepared as was necessary for the Board of Trustees.

Secondly—That a system of Case Records be carefully kept so that all the work and the results of any doctor in the Hospital can be readily known and membership in the Hospital Staff based upon this.

Thirdly—That the Board finally, has to take the responsibility, and the best source for obtaining the evidence is probably the Advisory Medical Committee of the Hospital.

Clause 2 was adopted.

Clause 3. That the staff initiate and, with the approval of the governing board of the Hospital, adopt rules, regulations and policies governing the professional work of the Hospital; that these rules, regulations and policies specifically provide:

(a) That staff meetings be held at least one each month. (In large hospitals the departments may choose to meet separately.)

(b) That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analyses.

In connection with this clause it was impressed that the staff as defined above has no executive powers, and any rules they make or suggest must be submitted to the Board, this body being the final authority. The Board of Directors have the responsibility of judging who is competent and incompetent, but such information can be obtained from a Medical Advisory Staff. It was stated that the most satisfactory method appeared to be the one recognized medical head in the hospital subject to the Board, and the need of co-operation between the hospital staff of physicians and the Board of Management was greatly emphasized.

Clause 3 was adopted as read.

Clause 4. That accurate and complete case records be writ-

ten for all patients and filed in an accessible manner in the Hospital, a complete case record being one, except in an emergency, which includes the personal history; the physical examination, with clinical, pathological and X-Ray findings when indicated; the working diagnosis; the treatment, medical and surgical; the medical progress; the condition on discharge with final diagnosis; and, in case of death, the autopsy findings when available.

It was pointed out the growing necessity for keeping full and careful medical records of cases admitted. The Vancouver General Hospital has evidently a very elaborate and ideal system of keeping records of patients. In hospitals where there are internes they could be responsible for these records, but in the smaller hospitals the Boards are obligated to the extent of providing additional clerks, including those who are capable of taking dictation from doctors, as to findings in operations, etc. In the Vancouver General Hospital such clerks are employed in the operating room and in the record office, and it was estimated that the cost was two cents per day per patient in that institution for records alone. Such records are, of course, strictly confidential and no outsider can have access to them without the written sanction of either the patient concerned or the doctor.

Clause 4 was adopted as read.

Clause 5 was adopted as read.

Clause 5. That clinical laboratory facilities be available for the study, diagnoses and treatment of patients; these facilities to include at least chemical, bacteriological, serological, histological, radiographic and fluoroscopic service in charge of trained technicians.

General discussion then followed, and from consideration of the various clauses it was found that there were very few hospitals that could not comply with such a standard. All hospitals, for instance, should have records. Dr. Seymour, Chairman, contended that every hospital should have an X-Ray and laboratory to do the routine work at least, otherwise they were not hospitals but mere rooming houses. The more difficult

laboratory work, as pathology, could be sent to the district or divisional laboratories, especially in the Provinces of Manitoba, Saskatchewan, Alberta and British Columbia, where they have provincial or university laboratories to look after this work. The entire consensus of opinion at the conclusion of the discussion was that the minimum standard was very practical and should be accepted by all hospitals. The Chairman even considered that such hospitals as those carrying the minimum capacity of twelve beds in his province, should comply with all the conditions laid down, but Dr. MacEachern explained that it was not the intention to deal with the hospitals of less than fifty beds at present with regard to the minimum standard, but if it could be accomplished in any such institution, that it was a more ideal condition.

A motion was then moved, seconded and carried, that the minimum standard as a whole be adopted.

The afternoon session came to a close with two resolutions, as follows:—

Resolution No. 1 was presented by Dr. George Stephens, of Winnipeg, and seconded by Dr. A. E. Archer, of Lamont.

RESOLVED THAT this Conference of Western Hospitals of the Provinces of Manitoba, Saskatchewan, Alberta and British Columbia, now in session in the City of Calgary, this 26th day of April, 1920, approve of the Minimum Standard as laid down by the American College of Surgeons, and recommend that it be adopted by the Hospitals and the Hospital Associations of the four Western Provinces.

The resolution was carried unanimously.

Resolution No. 2 was moved by Dr. M. T. MacEachern, of Vancouver, and seconded by Dr. George Stephens, of Winnipeg.

RESOLVED THAT the Conference of Western Hospitals of the Provinces of Manitoba, Saskatchewan, Alberta and British Columbia, now is session in the City of Calgary, this 26th day of April, 1920, do hereby express our sincerest regret at the untimely death of Hon. A. G. MacKay, Minister of Public Health and Municipalities of the Province of Alberta. We

realize that not only the Province of Alberta but the whole of Canada has suffered a great loss; and

BE IT FURTHER RESOLVED THAT a copy of this Resolution be sent to the Premier of Alberta.

The resolution was carried in silence.

The Conference then adjourned till 8.00 p.m.

EVENING SESSION, 8 P.M.

The Chairman called the meeting to order and announced that Miss De Sachet, Supervisor of Records in the Holy Cross Hospital, Calgary, consented to give a paper on the record system in the Holy Cross Hospital.

In this paper Miss De Sachet set forth very clearly the method employed in the Holy Cross Hospital of Calgary. As previously pointed out, this hospital has adopted a system of record-keeping which is very complete without being too elaborate. The nurse in charge of the records attends to this matter exclusively. The records consist of the following:—

1. A summary card, giving full particulars of the patient, disease, etc.
2. A certificate, signed by the patient relieving the Hospital from responsibility but at the same time assuring the patient that the Hospital authorities will do everything in their power to render efficient service.
3. The Case Record.
4. The progress notes.
5. Operation record.

As the reader of the paper pointed out, those in authority in a well-organized institution cannot fail to recognize the value of a good system of record-keeping for the protection of the patient as well as the hospital. The method devised in the Holy Cross Hospital enables the record-keeping to be done by one person, and this, it was stated, could be taken care of in any hospital accommodating from one hundred and fifty to two hundred patients daily. At the Holy Cross Hospital on ad-

mission each patient is given a number, which number, by a clever combination of letters and numerals, denotes the date of admission, and this number is the patient's distinction on all of the records kept. Within forty-eight hours the doctor in charge of the case is required to fill in the personal and family history of the patient, and in seven days he has to give the final diagnosis. On discharge the final diagnosis is given with complications, etc., and the condition of the patient on discharge. On the completion of all the papers relative to the case, they are filed in a systematic cross index which gives all the information desired about the patient for future reference. This system gives accessible information on:—

First—The work of different attending doctors during the month.

Second—The different diseases with results.

Third—The different operations with results.

Fourth—Complications.

Fifth—Infections.

Sixth—Deaths and causes.

Seventh—Summary of work.

The system certainly appealed as being suitable for hospitals and the real secret of it would appear to be a competent person who watches closely this phase of hospital life and sees that all information is obtained from the physician and duly recorded.

Records must be produced on all cases before operation, unless in emergency, and these must be written up within forty-eight hours. Daily rounds are made by Miss De Sachet to see that all the records are attended to, and being a nurse she checks over the nurses' clinical charts and notes. The attending doctors at the hospital write all the histories, and there is a monthly review of the work with the staff, at which meeting a summary of the work and results is produced.

Considerable discussion followed this paper, and Miss De Sachet was highly complimented by several of the speakers.

The Chairman now called on Dr. M. T. McEachern, of Van-

couver, to give an address on "The Practical Application of Hospital Standardization in an 'Open' Hospital." All points in this address were clearly illustrated by a large series of slides. The address was as follows:—

"You may readily agree with me when I tell you there are many difficulties to overcome in an 'open' hospital, particularly in connection with our standardization programme, but these difficulties are surmountable whether the hospital is 'open' or 'closed.' All hospitals have similar functions to perform, namely: Curative, preventive, scientific, educational, teaching and training. We must always keep these functions in mind when administrating our institutions. To-day in the hospital which I represent we find many difficulties to overcome, owing to natural circumstances or prevailing conditions, namely:—

1. Magnitude of the Institution.
2. Wide range of clinical material.
3. Rapid growth of the Hospital.
4. The increased cost.

"So many of our hospitals to-day are financially embarrassed, and indeed you can get money for everything else readily but for the sick and for hospitals. People of this great country of ours must be educated up to the fact that the hospital is the greatest economic asset in the community, apart from it being a sacred service to humanity. Let the day soon come when commercialism, materialism, indifference, apathy and everything else detrimental to our splendid institutions, is replaced in the minds of our people with the consciousness of the sacred duty and privilege to help these institutions financially so as to do the very best by those whom they are treating. If our institutions paid a dividend in 'cold cash' instead of a dividend in health restored human beings, how much more popular they would be. During the greatest world war ever seen, our war hospitals everywhere were to the last detail efficient. That was fine and the service was wonderful—but why not in peace time?

"Our hospitals to-day must become efficient. They should

give the patients all the facilities necessary for a good diagnosis, for competent care and treatment throughout. They should restore the patient to health as quickly as possible. They should restore the working man to earning capacity in as short a time as it can be accomplished. To do this the motto must be *One hundred per cent. efficiency care for our patients.* How many hospitals can measure up to this?

"Our institutions must have internal organization, especially if they are any size. This has to do chiefly with the paid staff, which should be organized on a clear and comprehensive basis with proper division of authority and responsibility, guarding against overlapping or omission and securing the best co-operation between departments. I believe in having one head only to the hospital, and the work divided into three natural phases: Medical, Nursing, Business, each having competent executive heads, and these three divided further into departments, as the case may be; each department finally having a competent head or supervisor who in turn is responsible for their executive head and through them to the chief executive officer, who stands between the internal organization and the higher governing Boards. This means efficiency and the proper division of authority. Added to this I would recommend meetings of heads of departments once or twice a month to discuss the various interrelations of departments and matters pertaining to the good of the hospital.

"The attending staff of the hospital should be selected by the Board of Directors or Trustees on a sound basis. In our case the Medical Association of Vancouver sends up several nominations and from these the Board of Directors selects a staff. It does not always follow that the one who heads the list gets the position. There are two very important qualifications, which are as follows:—

(a) The senior staff must either be specialists in the department to which they are appointed, or that branch of medicine must be the predominant part of their practice;

(b) That both senior and associate members of the staff must have some qualification which marks efficiency in that department, either:

1. An additional academic degree in that branch, or

2. A record of efficient work checked up by records of cases with diagnosis and end results, made at the instance of Directors from their work in the hospital.

"Formerly the Boards of Trustees selected with little or no information, but now all this is carefully compiled and each man's record more or less accurately ascertained. The staff embraces all the services, including Medical, Surgical, Obstetrical, Gynecological, Eye, Ear, Nose and Throat, Genito-Urinary, Pediatrics, Chest Diseases, Dermatology, Orthopedics, Neurology, Metabolism, Anesthetics, X-Ray, Laboratories, Physiotherapy, etc. They hold position for five years. They are divided into senior and associate, and make their own mutual arrangements about carrying on the work, usually taking a month's service at a time. The working of the staff is divided into two branches:—

First—Administrative.

Second—Clinical.

"In the administrative phase the staff is divided into several working committees, one for each of the various departments which bring in reports monthly pertaining to the betterment and efficiency of that department.

"Clinically, the staff discusses and reviews the work of the hospital and sometimes a great deal is done in small working committees specially appointed. The most of this is carried out through our Medical Records Department and through a regularly organized medical investigation system. The staff of the hospital must be at all times alert to everything that tends to the betterment of the institution and the elimination of all things that do not tend to the best working for all concerned.

"The hospital must have laboratories and facilities with which to make a diagnosis, and these laboratories consisting of such as can do the usual tests, including Bacteriology, Pathology, Serology, etc. It may not be possible to do this in all our institutions, but every institution must be equipped to do the necessary routine work, and have an X-Ray. For the more complicated work, as Pathology, provision can be made in the dis-

trict, provincial or university laboratories to carry this on. Any facilities, therefore, that are helpful in making a more accurate scientific diagnosis must be provided, either in the institution or be available somewhere else. The laboratory systems everywhere are now being brought to such a state of perfection that there is no reason why every institution should not have a proper service.

"Possibly the greatest difficulty in all our hospitals to-day is the getting of good records. There are just a few points I want to make about this subject:—

First—Medical Case Records on every patient in every institution that goes by the name of "hospital" are absolutely necessary.

"You would not expect to run any business or commercial concern without records. How much more, therefore, is it necessary to have these in institutions dealing with life and death every minute in the day.

Second—Medical Case Records are possible in every hospital, inasmuch as these records can and should be compiled by any doctor.

"There was an idea that medical students were the only ones who could and should write up medical case records. That day has gone and now the practitioner in every institution must feel his obligation to make out proper records for his patients, which records shall be the property of the hospital. In our institution we demand records, and fortunately, have a number of internes who write all the public and semi-public Case Records. In the private and semi-private cases this is not always possible, but we ask the doctors attending to do so, giving them three choices.

1. Write it themselves.
2. Dictate it to a stenographer, which we supply; or
3. Leave an order for an interne to write it.

"We demand a written report in the Operating Room of all our operations, "What was done" and "What was found." This is further checked up by the Laboratory and their report put on the same page, on the opposite side. All diagnosis should

be posted before operation. All cases should be written up before the operation starts, excepting in cases of emergency.

Third—Medical Case Records are private and should only be produced to the doctor in charge of the case, the patient himself or herself, or on an order of either one or a court.

"This being laid down as a rule, will help to get many records from patients if it was felt by them that there might be some danger of the report not having the necessary privacy.

"The Hospital must, if possible, meet the attending doctors part way in the getting of good records. It may be that they will have to add a Medical Clerk stenographer, but at any rate, they can afford convenient forms and keep them in a convenient place. We recommend a semi-stereotyped and semi-diagramatic form, similar to this, that I am showing you on the screen.

Fourth—All Medical Case Records should be very carefully scrutinized and summaries produced at the end of each month showing the actual results of the work, much the same as this form I am passing around, which shows the results obtained during the month and checks up incompetent work, infections, etc. Boards of Directors or Trustees should demand that in each and every case proper records be compiled, for after all Boards of Directors or Trustees are responsible for the institutions and for the money spent therein; therefore it is only their duty and privilege to make sure that this money is well spent and the patients getting good and efficient care.

"In connection with Medical Case Records, I could mention a great many practical uses of same. Let us look into a few.

Firstly—In checking up the work of the Institution as to whether it is good or bad.

Secondly—In the assistance which it gives when working out a case which has been in previously or, as we call them, in the "return" cases, where the subsequent history has a good deal of bearing on the past. To illustrate this: A patient entered a far Eastern hospital some time ago with some obscure abdominal condition. This condition baffled her surgeon, as she had had a former operation, but unfortunately did not know much about it. A wire transmitted to Vancouver to our Medical

Records Department revealed her past history, and this information was secured in less than fifteen minutes. The whole transaction transpired over the wire in very short order and the information thus received at the other end was of great value in diagnosing the case. If that patient had come into this Institution her past history would have been available for her present illness.

Thirdly—These Medical Case Records are invaluable for scientific purposes and the advancement of medical knowledge. We all know that all medical knowledge, data and scientific advances have been based on actual cases, and these histories are only obtainable through a good record.

Fourthly—The value of Medical Case Records from a Medico-legal aspect. There is not an hospital on the face of the earth that I know of that will not, some day, be threatened with or face a lawsuit against them. How comforting to turn up to an actual Medical Case Record, which is recognized in the court, and find on this Record all the true data of the case. Any money spent on such a Record system will be amply repaid even from this point alone.

Fifthly—Through a properly regulated and organized Record system reports of the work of the various attending doctors can be readily secured, which will not only tell the quality but also the quantity of surgical work being done in the Institution. On this report the Board can base their opinion when selecting members to fill vacancies on their Staff.

Sixthly—The Medical Case Record is of great value to all Public Health officials in ascertaining many points which will guide them in their combat against conditions which are detrimental to health. The seasonal incidence of disease and comparative statistical data is always readily available from the local hospital when such is required.

Seventhly—Staff review of clinical work of the Hospital. Through the Medical Records Department, good clerks and records, review data can be secured on any disease. For instance, —during the month of May in our hospital, we will consider the question of Appendicitis, especially from the surgical side.

Last month we considered the question of influenza, and the month previous we reviewed all the Hernias of the previous year, showing cases which had complications and with an explanation why. This review of the work of the hospital by the medical staff is of great value, not only to the hospital, but to the men themselves.

"We must not, therefore, look upon Medical Case Records as either being impossible or being a luxury. They are as essential for the institution as the food we eat is for the body. A great deal more could be said about these Records but time does not permit and the lantern slides will demonstrate to you the system complete as being used in the Vancouver General Hospital.

"In conclusion, let me say that hospital work has now become an intensive specialty and you can quite see the importance of it being such. After all the hospital is nothing more than the work laboratory of the doctor and the nurse, the patient is the product. We judge our success or failings on the product. We know what we require to have a good product and therefore it should behoove us all to live up to it as conscientiously as we can."

Considerable discussion followed and questions asked pertaining to the system outlined.

Meeting adjourned at 10.30 p.m.

TUESDAY, APRIL 27TH, 1920—10.30 A.M.

Meeting called to order by the Chairman.

The Chairman tendered an invitation from the Calgary Medical Society for luncheon at the Palliser Hotel at 12.30 to all the delegates present. This invitation was presented through Dr. McGill, President of the Calgary Medical Society.

Dr. M. T. MacEachern read several resolutions which were referred to the Resolution Committee to report on during the afternoon session.

Dr. R. E. McKechnie arose at this point to use the privilege of asking that the Secretary request the morning paper to correct a statement regarding his remarks about fee-splitting. The paper

suggesting he was in favor of certain forms of "fee-splitting" but he wanted it distinctly understood that he was opposed to "fee-splitting" in any form whatsoever.

The Chairman now announced that the question of Hospital Financing was open for discussion by the meeting, and Dr. M. T. MacEachern, being asked to lead, suggested that we confine our remarks particularly to charges and costs made by the different hospitals in the West. Several hospitals therefore reported and it was found that the average prices per day pertained.

Charges.

Private wards ranged from $3.50 to $8.00 per day, and the average seemed to be $4.50 to $5 per day.

Semi-private wards ranged from $2.00 to $3.50 per day, the average being $3.00 per day.

Public wards ranged from $1.50 to $3.00 per day, and the average was $2.00 per day.

Per Capita or Per Diem Cost.

At the outset it was explained that the per capita per diem cost was a very relative term and really to get at an accurate basis a knowledge of the service rendered was necessary before a comparison could be made. However, it was found that in the Western hospitals the per capitas ranged between $2.78 and $4.50 per patient per day, and that the average per capita under the present conditions was $3.50 per day.

Municipal and Government Aid.

In considering the financial support received from the various municipalities and Governments in the four Provinces, it was found that there was a great variance in arrangements, and no average could be ascertained.

Purchasing of Supplies.

Interesting discussion followed re purchasing supplies by tender and in the open market. The question of a Purchasing

Agent and Bureau for the Four Western Provinces aroused great interest. Dr. Mackid, of Calgary, pointed out several advantages showing where:

First—Large sums of money could be saved by such an arrangement, and

Second—That more standard and efficient articles could be secured.

This bureau at all times would serve as a source of information to all the hospitals. Dr. Seymour outlined the Bureau now in the Province of Saskatchewan, which is used by the hospitals there, and suggested a similar arrangement should be made for the four provinces. A resolution favoring the adoption of this idea was submitted to the conference by Dr. Archer, of Lamont, at the afternoon session.

The Chairman now called on Dr. O. R. Avison, of Seoul, Korea, who gave a very interesting discourse on Medical work in Korea. He reviewed his early medical experiences and the evolution of medical science in this country. Dr. Avison, who, twenty-seven years ago, left Toronto for Korea to look after medical science amongst the Koreans, told the delegates of his early struggles and disappointments, with the ultimate success which he obtained. He intended to start constructive work instead of practice and to his dismay discovered that the Koreans possessed no medical or scientific language. His first great work was the translation of Gray's Anatomy into Korean, and fifteen years later had the satisfaction of seeing seven Koreans graduate in Medicine, whom he instructed. At the present time, directly as the result of his work in medicine amongst them, one hundred Koreans are successfully practising medicine in Manchuria, Siberia, China and Korea, while thirty small hospitals are in operation. Dr. Avison is in Canada endeavoring to interest a number of doctors and nurses to go to Korea to man the hospitals.

Dr. M. T. MacEachern suggested that we now discuss the nursing problems in our hospitals, in view of the fact that Miss Edy of the Calgary General Hospital was present, and fearing that she might not be here at the afternoon session. Dr. Mac-

Eachern made further remarks on the question, bringing up the problems of the present day. He said: "The greatest difficulty we have to deal with to-day is the shortage of applicants for our Training Schools. I believe that this shortage is not altogether an actual shortage, but a relative one. The scope of service of the undergraduate and the graduate together with the exacting demands of the institutions and the medical profession have greatly increased the work of the nurse, and as a result we need a larger number than we had formerly. Again, the public of to-day demand a service which is out of all proportion to that of former days; in fact the service demanded by the public has almost increased in a parallel way with the high cost of living. However, there are several reasons why there may be an actual or apparent shortage of applicants:

Firstly—The scope of work for the undergraduate in any hospital and for the graduate in the hospital and outside the hospital, has gradually broadened in the last few years, together with the demand put upon them in their service. Hospitals to-day are fast developing special departments and using nurses. For instance—there are a large number used as technicians, as admitting officers, Social Service, etc. In a large number of hospitals to-day nurses are even giving anesthetics. Indeed, the last few years have brought a tremendous expansion in all fields, whether it be nursing, school nursing, infant welfare, tuberculosis, mental hygiene, industrial nursing, etc. Now I hear they are putting nurses on the Trans-Atlantic and Pacific steamers; consequently the demand has been a little more than the supply.

Secondly—There is too much of a tendency to commercialize this profession instead of keeping it more in line with the idealism of the Florence Nightingale spirit.

Thirdly—There is an outside influence at work to lower the standing of qualifications and of efficiency; indeed I am quite correct in saying that some of our medical profession consider that any old woman is good enough to nurse to-day, and fail to realize that the nurse is their ever-constant "third eye" on the patient during the whole twenty-four hours, whereas their observations are more or less casual.

Fourthly—The nurse-in-training has been more or less exploited by our hospitals for the menial work, which could be done by maids or others, and thus allow the nurse to devote herself to the real nursing care of the patient.

Fifthly—The hours are too long, as we are unable yet to give them all an eight-hour day.

Sixthly—The lives of nurses-in-training should be made more attractive and the course of instruction which is given.

Finally, the Training School must not be regarded as a convenience or side issue of the institution, but one of the high ideals of the institution. I would recommend the putting on of an educational campaign to enlist more applicants for our Training schools. We lose a large number of good applicants who are graduates from high school but are too young to commence training. Where possible, we should link our Training schools up to the higher educational institutions in each province, or I mean the University. In British Columbia we have recognized this latter point and in our University have a Department of Nursing where the girl who completes her high school and passes her matriculation, secures two years' academic education in the University, and this, combined with the two years actual nursing service in the hospital, with a fifth year for specialization in Public Health Administration and Teaching, gives her the University degree and qualifies her for more or less of a leader in her profession in one or other of these lines, as well as a good, sound, practical nurse. In this way we fill a great need in our Province without having to import from other countries."

Miss Edy, Superintendent of Nurses of the Calgary General Hospital Training School, read a paper on the nursing shortage throughout Canada, and attributed it, among other things, to the lure of the American hospitals to Canadian girls. The American hospitals, it was shown, offered a number of extra inducements for Canadian girls, stating that wherever possible a preference was shown them. The large departmental stores, industrial houses in Canada, and other inducements, had attributed towards depleting the nursing fields, owing to the better working hours offered and the improved working conditions. She concurred heartily in the remarks of the previous speaker,

and felt that there were a number of ways of getting at this question.

Discussion arose from many present, chiefly centering around the question as to whether a nursing probationer labor for love or for pay. It was shown that probationers were paid, in the majority of Western hospitals, $8.00, $10.00 and $12.00 monthly, though some hospitals, such as the Royal Alexandra in Edmonton, paid as high as $25.00 per month. There seemed to be a wide divergence among the amounts paid to nurses-in-training, and it was stated by some speakers that in several large hospitals in the East no remuneration was given, and indeed, in one hospital, a charge was made for the privilege of being allowed to train. There were many adherences to the old-time principle—that probationers should still continue to offer their services with little or no consideration as to monetary remuneration. Dr. M. T. MacEachern, of Vancouver, and Dr. L. S. Mackid, of Calgary, were both strongly of one mind—that the attractiveness of increased salaries for nurses-in-training would have a tendency to make this profession more materialistic disrupting discipline and efficiency, and that young women who volunteer to follow this calling should do so from a higher motive than that of the amount of remuneration to be received. Dr. R. O. Rothwell, of Regina, spoke strongly against this contention, and was in favor of paying probationers a living wage considering the high cost of living now-a-days. In this he had the support of a number of prominent Western hospital authorities. Mayor Hardie, of Lethbridge, and Chairman of the Galt Hospital Board, who had taken an active interest in the proceedings throughout, was of the opinion that the present scale paid probationers was entirely inadequate. He said in part: "The spirit of idealism is rapidly passing out, to the betterment of the country, and a more materialistic age has taken its place." He was of the firm opinion that there should be an increase in the monthly allowance given nurses-in-training. Alderman McTaggart, of the City of Calgary, expressed his views stating that the securing of better type of girls to enter the training service in hospitals would soon be accomplished by paying what he characterized as a "decent salary." He stated that a Nurses'

Home was necessary for Calgary, and asked the opinion of the delegates as to the advisability of allowing the nurses to reside at home as the eight-hour law was in effect. The answer to this question was that it would disrupt the discipline very quickly, as had been proven in previous instances.

It was desirous on the part of delegates to arrive at some uniform standard scale of pay for nurses-in-training, but it was readily seen that there was such a diversity of opinion, which was very strong on both sides, that it would be impossible to bring in a resolution to cover this point, and the discussion thereon terminated till the afternoon session.

Dr. G. E. Stanley, M.L.A., was of the opinion that the election of Hospital Boards by the people was the sanest way. He emphasized the need of a universal interest in hospital work and advised against the narrowing down of the personnel of any Hospital Board. Municipal hospitals fill a long felt need but municipal management was not always the best form.

Dr. McGill, President of the Medical Society of Calgary, announced the luncheon to be given in the ballroom of the Palliser Hotel in honor of the delegates by the Calgary Medical Society.

Meeting Adjourned.

Luncheon with the Calgary Medical Society in the ballroom of the Palliser Hotel. Dr. M. M. Seymour, Chairman of the Conference, at the close of the luncheon extended to the members of the Calgary Medical Society a very hearty vote of thanks for their kindness and consideration to the delegates at this particular time.

AFTERNOON SESSION, 2.30 P.M.

Meeting called to order by the Chairman.

The Chairman called on Dr. M. T. MacEachern, of Vancouver, to present the resolutions on behalf of the Resolution Committee. These resolutions were as follows:—

RESOLVED, THAT this Conference of Hospitals of the Provinces of Manitoba, Saskatchewan, Alberta and British

Columbia, now assembled in Calgary, this 26th and 27th days of April, 1920, recommend:

Resolution No. 1:

(a) That a Western Hospital Association, comprising the above mentioned four provinces be formed, and that the Association be known as "The Western Canada Hospital Association."

(b) That this Association have for its objects:

1. To promote the work of Hospital Standardization according to the requirements laid down.

2. To stimulate hospitals generally, for greater efficiency.

3. To stimulate more co-operation and team-work amongst our Associations and Hospitals.

4. To act as a Clearing House for all the problems of our Associations.

(c) That the officers of the Associations be:

An Honorary President from each Province.

One President.

A Vice-President from each Province.

A Secretary-Treasurer.

An Executive Committee of twelve members, consisting of one lay member from Boards of Directors or Trustees, one hospital superintendent, and one member of the American College of Surgeons, from each Province.

(d) That membership in the Association be limited to membership in the Provincial Association.

(e) That the Association meet annually in each Province in turn and at the same time as the Provincial Association of that Province.

(f) That the expenses of such an Association be financed through each of the Provincial Associations.

Resolution No. 2:

That the National Hospital Association of Canada be revived and, if possible, hold a meeting this year about the time

the International Hospital Association meets in Montreal; and further, that in the reorganization provincial representation be given on the Executive.

Resolution No. 3:

That the dates of holding Provincial Hospital Association conventions be better correlated, so that members of the different Associations may attend more than one convention if they so desire.

Resolution No. 4:

That we heartily approve of Hospital Associations in each Province, and further recommend that they should be affiliated with the National Hospital Association of Canada.

Resolution No. 5:

That some means be devised to bring the question of Hospital Standardization before the Canadian Medical Association convention in Vancouver in June.

Resolution No. 6:

(Presented and moved by Dr. Archer, of Lamont, and seconded by Dr. Mackid, of Calgary.)

WHEREAS the individual Hospital Boards, particularly in smaller hospitals, are frequently unable, through lack of complete information, to buy certain hospital supplies economically and to procure the most efficient equipment for their needs;

BE IT RESOLVED, THAT this Conference strongly endorse the establishing of a Western Hospital Association Bureau of Information as soon as may be possible.

The duty of the Bureau should be to make available to all hospitals desiring it, information collected from all possible sources re:

(a) The purchasing of standard hospital supplies;

(b) Standard and efficient types of hospital equipment such as sterilizers, operating room furnishings, X-Ray Laboratory equipment, kitchen and laundry equipment, especially such type as would be valuable for small institutions;

(c) To act as a general Clearing House for information of value to the members of the Association.

These resolutions were all explained to the delegates and after due discussion of each with a mover and seconder, each one was adopted. All these resolutions were therefore accepted.

Moved by Dr. M. T. MacEachern, Vancouver;

Seconded by Dr. G. Stephens, Winnipeg:

THAT this meeting appoint a President and Secretary-Treasurer, and the rest of the officers to be appointed through the Provincial Hospital Associations. Carried.

Moved by Dr. G. Stephens, Winnipeg;

Seconded by Dr. M. T. MacEachern, Vancouver:

That Dr. M. M. Seymour, of Regina, Commissioner of Public Health of the Province of Saskatchewan, be appointed as President, and Dr. J. W. Warren, Acting Superintendent of the Calgary General Hospital, be appointed as Secretary-Treasurer. Carried.

Moved by Dr. M. T. MacEachern, of Vancouver;

Seconded by Dr. L. S. Mackid, of Calgary:

THAT the next Conference meet in Regina in 1921, at the time the Provincial Hospital Association meets there. Carried.

It was further recommended by the Conference that a report of this meeting be brought to each Provincial Hospital Association and that such Association should be requested to appoint the following members to the Western Canada Hospital Association:—

An Honorary President.

A Vice-President.

An Executive Committee of three members—one lay member from Boards of Directors or Trustees, one Hospital Superintendent and one member of the American College of Surgeons.

It was further recommended that each Province should give $25.00 towards expenses of the Western Conference this year for the purpose of covering the cost of a printed report.

The meeting closed by the moving of several votes of thanks and Dr. R. E. McKechnie, of Vancouver, moved a vote of thanks to the Mayor and Aldermen of the City of Calgary, for their exceeding kindness and courtesy during the Conference. This was seconded and unanimously carried.

A very enthusiastic vote of thanks was tendered to Dr. M. T. MacEachern, Vancouver, who was responsible for calling the Conference together. Dr. Mackid, of Calgary, Dr. Seymour, Chairman, and several others spoke to this motion and strongly emphasized the great benefit and good which would arise out of this meeting.

A hearty vote of thanks was passed to the Press of the City of Calgary for reporting the meetings so splendidly, and finally a vote of appreciation was tendered the Chairman and Secretary of the Conference.

Items

PICKERING COLLEGE TO BECOME A COUNTY HOSPITAL

A DEPUTATION, headed by the Mayor of Newmarket, appeared before the York County Council on June 3rd, to urge the purchase of Pickering College for a County Hospital. It was pointed out by the various speakers that the old Quaker school had been used by the Government during the war as a hospital, under the D. S. C. R., and that the Government was willing to dispose of the equipment for a reasonable sum. The Society of Friends and the executors of the estate of the late Elias Rogers, who are owners of the college, have given the county to understand that if it is considered that the use of the building will be of greater benefit to the county as a hospital, rather than a school, they are willing to sell. It was stated that the purchase price would be in the neighborhood of $100,000. The deputation asked also for a grant of $50,000, as an endowment fund, and expect to raise an additional $50,000 by voluntary subscription.

PROVINCIAL APPOINTMENTS

ONE or two staff changes have taken place in Provincial institutions. Dr. Peter McNaughton, formerly Assistant Superintendent at Hamilton, has been appointed head of the Coburg Hospital, which has reverted from the D.S.C.R. to the Provincial Secretary's Department. Dr. W. K. Ross, who was assistant and for a period acting Superintendent at the Kingston Hospital, has been transferred to Brockville in place of Dr. J. C. Mitchell, deceased.

MRS. F. F. DALLEY, of Hamilton, has given $10,000 to the City Hospital for research work. The fund will be administered by trustees.

NURSES GRADUATED AT BELLEVILLE HOSPITAL

At the Belleville General Hospital on July 8th, eight nurses who had finished their courses received their diplomas: Misses Rachael Finnie, of Peterboro'; Edna Howard, Mallorytown; Jean Cunningham, Peterboro'; May Henry, Peterboro'; Sepha Clarke, Trenton; Evelyn Cunningham, Hamilton; Zeda Pue. Baillieboro', and Edna Huston, Peterboro'. Judge Wills presided.

Dr. W. J. Gibson, on behalf of the Medical and Hospital Board, presented the diplomas and delivered an address on "Ideals." He urged the graduates to maintain their esprit de corps. He said that with the present fair fee which nurses are obtaining they should give increased service.

Mrs. W. C. Mikel, President of the Women's Christian Association, which conducts the hospital, presented nurses' pins to the graduates. Prizes were awarded as follows: Gold medal for highest marks, Miss May Henry; in anatomy, Miss May Henry; in general proficiency, Miss May Finnie.

After the graduation the guests inspected the new maternity building, and were later entertained at a reception on the hospital lawn.

BONDS FOR NURSES' HOME

Tenders for a $100,000 issue of the municipality of St. John. N.B., for the purpose of meeting the cost of the Nurses' Home in connection with the General Public Hospital, closed on June 21st.

SANATORIUM FOR OTTAWA

Mr. and Mrs. E. C. Whitney, of Ottawa, have given $100,000 in Victory Bonds to the Corporation to be used for the construction of a tuberculosis sanatorium in connection with the City of Ottawa Sanatorium.

Book Review

THE TREATMENT OF SYPHILIS

A VERY valuable and interesting work has just been published by The Macmillan Co., New York. It is entitled *"The Treatment of Syphilis,"* and is from the pen of H. SHERIDAN BAKETEL, A.M., M.D. The volume covers very thoroughly and convincingly the field of intravenous and intramuscular medication, and the administration of arsphenamine or neoarsphenamine. It gives in minutiæ, step by step, the proper methods for the actual introduction of arsenical products into the system.

Speaking of the after treatment in cases where intramuscular injections have been given, the author says:

"In England and on the Continent it is the habit, after giving an intramuscular injection, to cover the surrounding parts with sterilized absorbent cotton fixed with elastic collodion. The patients were instructed to rest in bed for twenty-four hours and according to various reports, the majority of them complained only of stiffness in the hip and thigh and occasionally of pain in the lower extremity.

"Some physicians also utilize a clay dressing, like antiphlogistine, in place of cotton. It is their custom to cover the entire gluteal surface with a thick layer of properly heated antiphlogistine and to cover this with gauze, and over that absorbent cotton. This application seems to work well following the intramuscular injection and not only aids in the prevention of pain and to a considerable extent prevents any abscess formation, but enables the patient to attend to his ordinary affairs."

Dr. Baketel is Professor of Preventive Medicine and Hygiene and Lecturer on Genito-Urinary Diseases and Syphilis in the Long Island College Hospital, Brooklyn, N.Y.; Attending Syphilologist and Chief of Clinics at Volunteer Hospital, New York; Genito-Urinary Surgeon to the House of Relief of the New York Hospital; Lt.-Col. Medical Reserve Corps, U. S. Army, etc., etc.

COMMERCIAL DEPARTMENT

The Making of Kellogg's Krumbled Bran

You are familiar with the advantages of Bran as a remedial agent in preventing and overcoming constipation through the diet. Its value, you will agree, is being recognized more and more by physicians and dietitians.

The manufacture of Kellogg's Krumbled Bran, while quite simple is only made possible by a new shredding mill recently perfected by this company. In the process of manufacture only the highest quality selected wheat bran is used. The bran is thoroughly cleaned, removing all flour and foreign material, sterilized and mixed with the famous Kellogg flavor. It is cooked for a short time in large rotary steam cookers under high steam pressure, then dried in rotary drum driers until it is quite dry. The flavored, cooked and dried bran is now ready for shredding. This is done by means of two grooved rolls, one roll being pressed against the other and the bran passed through between. The pressure is so great that it unites the bran flakes, cutting them off in the form of long shreds. These shreds are then baked in huge flight ovens travelling back and forth, dropping one flight to another until they pass through the oven, a distance of about six hundred feet, which requires approximately thirty minutes to do this cooking or toasting. The toasting is done by means of gas burners.

There are four of these huge ovens in our Bran Department. We manufacture all the gas for the ovens, and it requires over four hundred thousand cubic feet per day for each oven.

The chemical analysis of Krumbled Bran is as follows: Moisture, 2.5; protein, 15.4; fat, 2.2; crude fibre, 9.9; ash, 8.4; carbohydrates, 60.4.

Sheffield Lunch

"Where varied choice tempts tired appetite
Where Quality's a motto ever kept bright."

Sheffield Lunch, Limited, corner Yonge and Adelaide Sts.

Lister's Diabetic Flour

Physicians who have studied diabetes most thoroughly are convinced that the successful management of this disease resolves itself primarily into the choice of a suitable dietary. They are relying less and less upon drugs because their use has met with but transitory success.

Consisting of specially prepared alimentary caseins, Listers Flour is free from carbohydrates because, for very natural reasons, it could not be otherwise. It is the ideal bread substitute. It satisfies diabetic bread hunger, and it renders possible the control of the patient's intake of carbohydrates with reasonable accuracy.

In establishing a diet of Listers Flour it is known for a certainty that so far as this portion of the regimen is concerned, the carbohydrate intake is nil. This has a two-fold bearing; it removes the element of doubt, and it simplifies the work of the physician in estimating the patient's carbohydrate tolerance, for by suppressing the starches and sugars temporarily and then checking up the results following their gradual resumption, he can determine the point beyond which the patient should not go in his consumption of these elements. The indicated proportion of carbohydrates may thereupon be prescribed in the forms most desirable, while Listers Flour products make up the deficiency. Listers Flour can be obtained from W. Lloyd Wood, Toronto, Canadian Agent.

Solving Life's Problems

"If I were King," said W. E. Henley, "my pipe should be Premier," and certainly it is a weighty tribute to the virtues of tobacco that so many great men invoke its aid at critical times. Marshal Foch says that he won the war by smoking his pipe. Tobacco enabled him to keep calm and concentrate all his strength upon his job. "Solve your problems with a smoke" is practical advice which has proved its efficacy.

Standard Floor Dressing

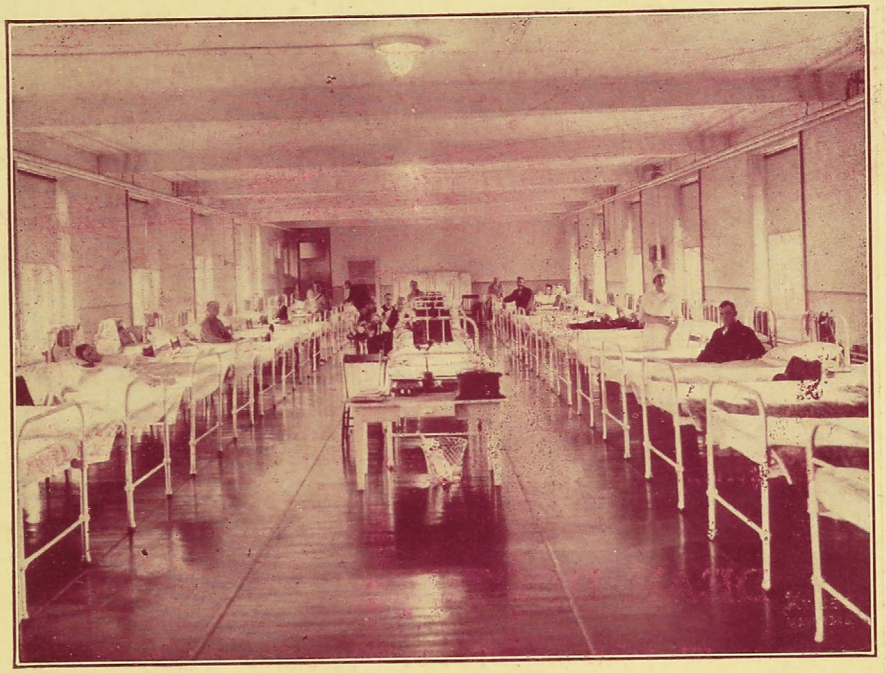
It has, for a decade or more, been an accepted fact that the greatest menace to successful surgery in a hospital is dust. Antiseptic surgery cannot be carried on if the air is infected with dust in any form, so that it behooves an institution to prevent the atmosphere, in its surgical wing at least, from being contaminated. The most successful antidote to such a condition is the use of a proper floor dressing. Such a preparation is known as Imperial Standard Floor Dressing and by its use dust becomes a thing of the past. Not only that, but it acts as a preservative of the surface of wood, linoleum and oilcloth. One treatment lasts for three or four months, a gallon covering from 500 to 700 square feet of flour surface. Mr. Hospital Superintendent, *nuf sed.*

Ingram and Bell's Enlarged Quarters

Owing to the phenomenal increase in their business, Messrs. Ingram and Bell, McCaul Street, Toronto, have been forced to add two additional stories to their warehouse. It must be most gratifying to them that this is necessary, as it is but a few short years since they built on their present site. Both of the principals in the firm have, owing to their personality and business ability, made many friends in the medical profession throughout the Dominion and none grudge them the success they are meeting with. The Hospital World joins in wishing them continued prosperity.

McCrimmon's Fluid

This is a preparation of remarkable potency and is meeting with the endorsement of many physicians. In the treatment of Poison Ivy, it is most efficacious. As a spray in cases of Pharyngitis, as a wash in indolent ulcers, it gives rapid relief. When used in the operating room and hospital ward, it will be found second to none as a germicide and antiseptic.



Clean, Restful Colors and Durable Finishes

were demanded for the Prince of Wales Hospital, pictured above and were secured through the use of the Canada Paint Products supplied for the work.

On the walls and ceilings SANITONE was used. A durable pure oil paint, with a softly, pleasing finish, SANITONE is waterproof, and may be washed when necessary, without injury to the surface.

For the beds, furniture and woodwork, ALBA GLOSS ENAMEL was selected because of its pure white, porcelain-like finish and great durability.

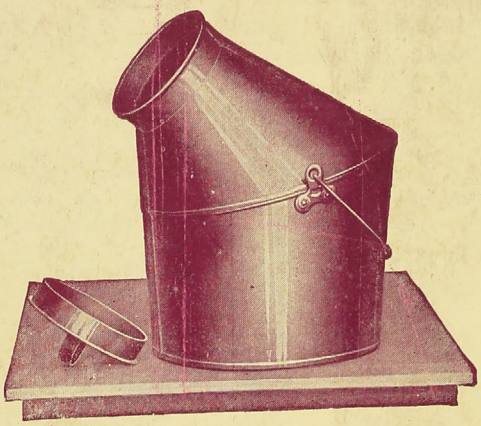
A durable, high-grade varnish that would stand severe usage was essential for the floors. Therefore, SUN VARNISH was selected. Its glass-like finish—waterproof and heel-proof—makes it the ideal floor finish for hospital interiors.

We welcome enquiries and would be glad to furnish full particulars, prices, etc., regarding Canada Paint Products.

The Canada Paint Co. Limited

Makers of the Famous Elephant Brand White Lead

Montreal Toronto Winnipeg Calgary Halifax Vancouver



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