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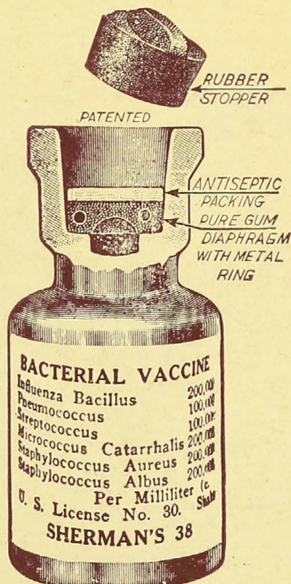

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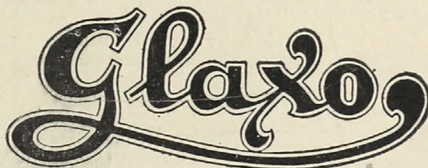

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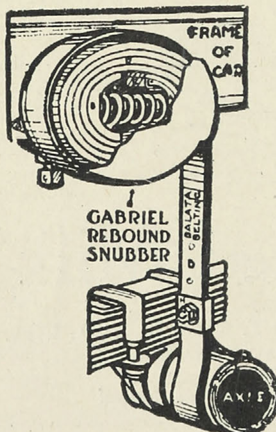

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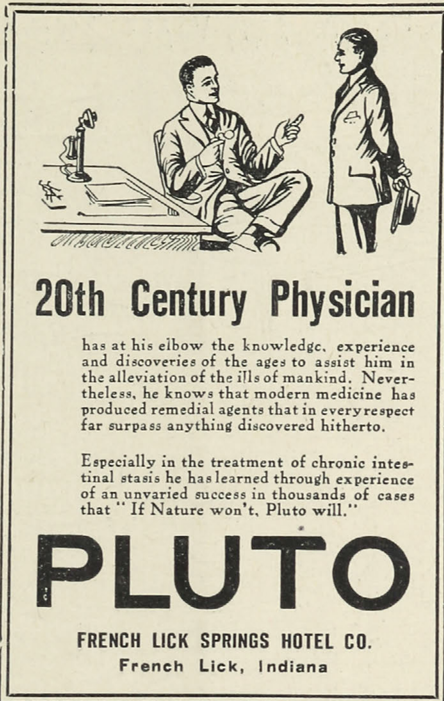

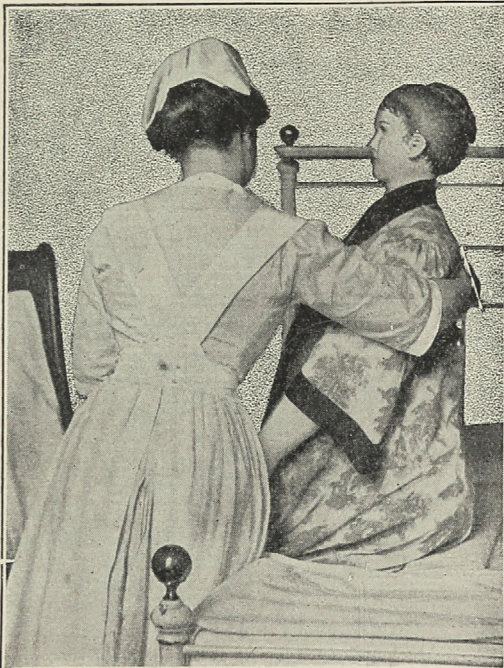

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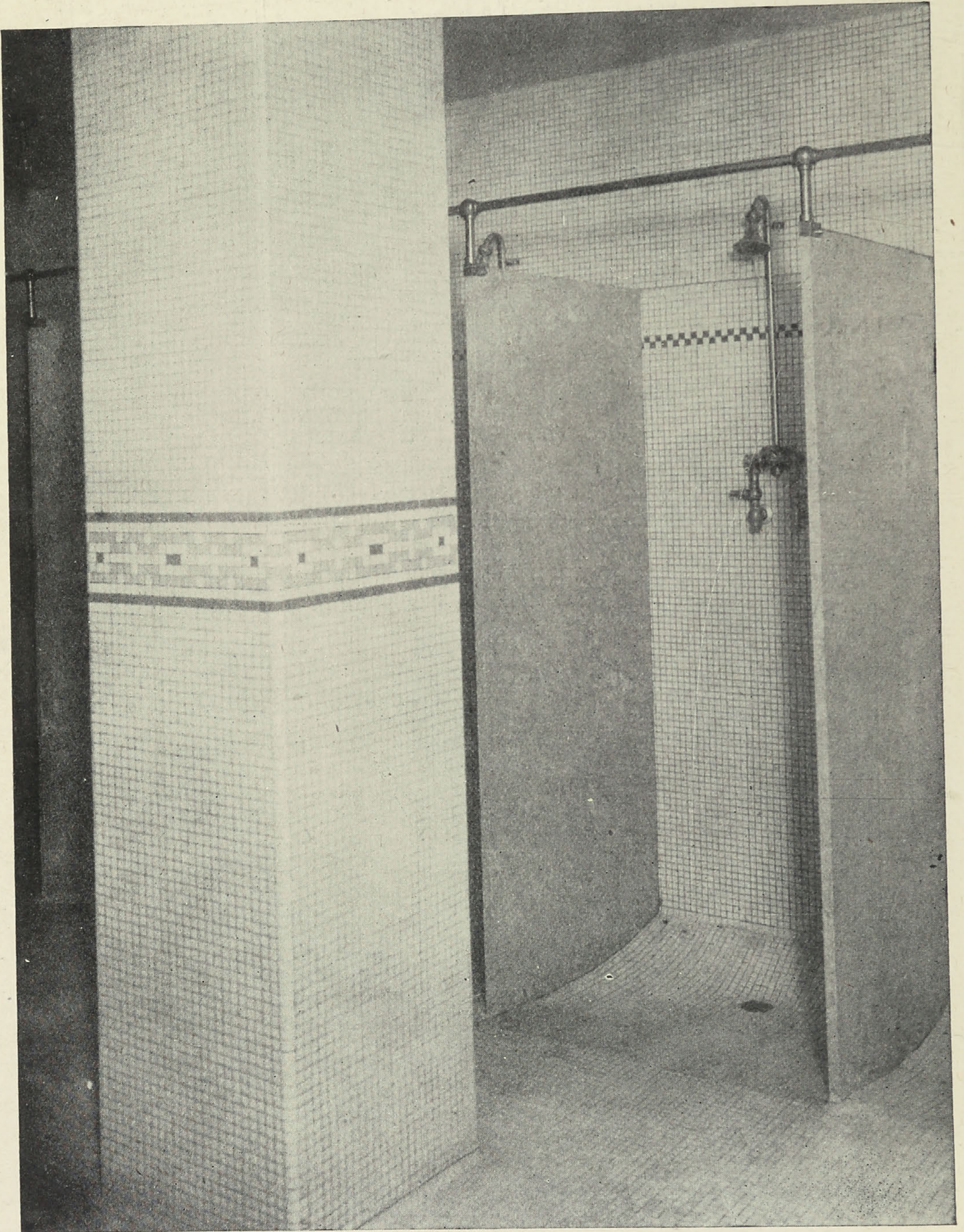

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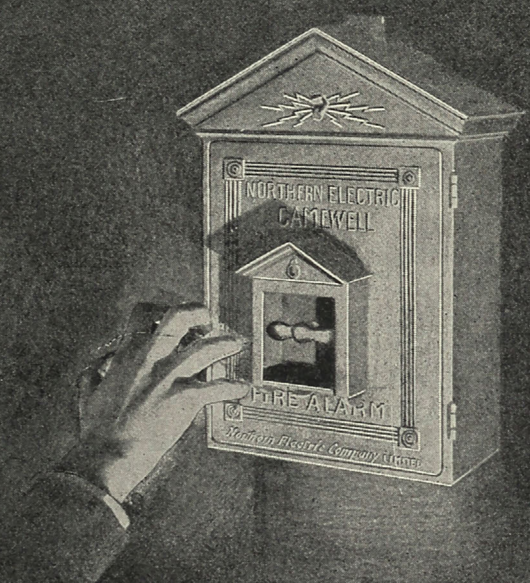

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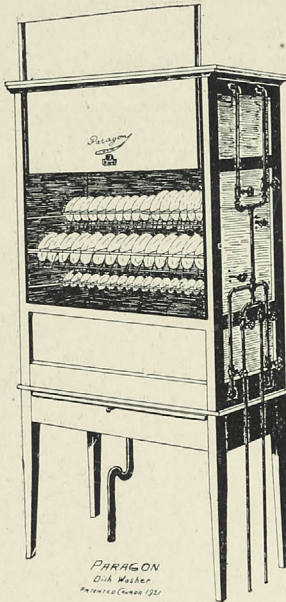

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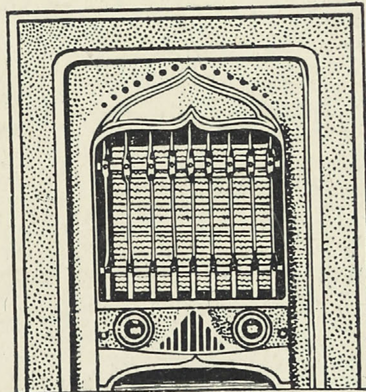

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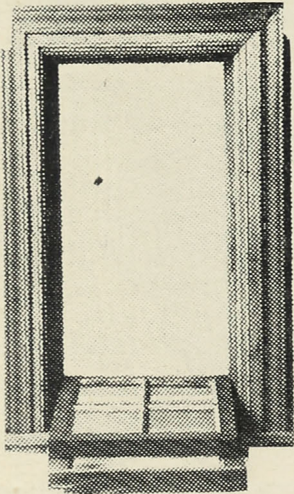

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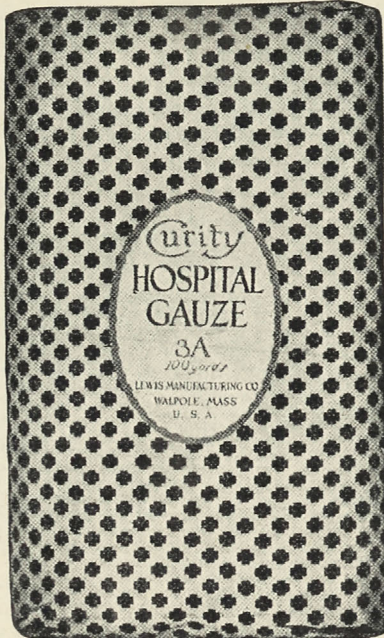

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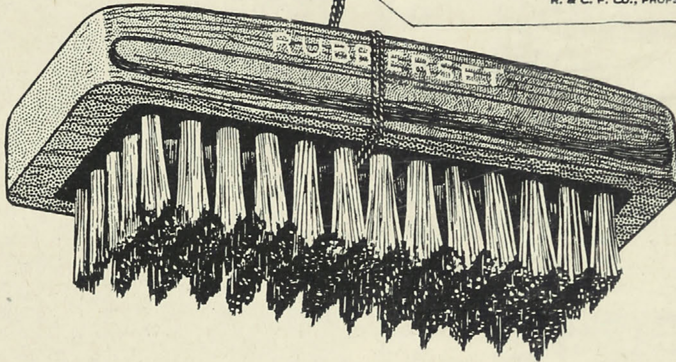

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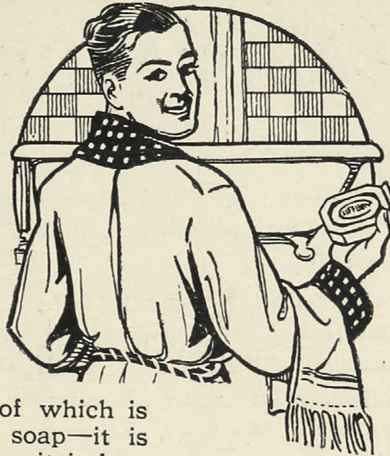

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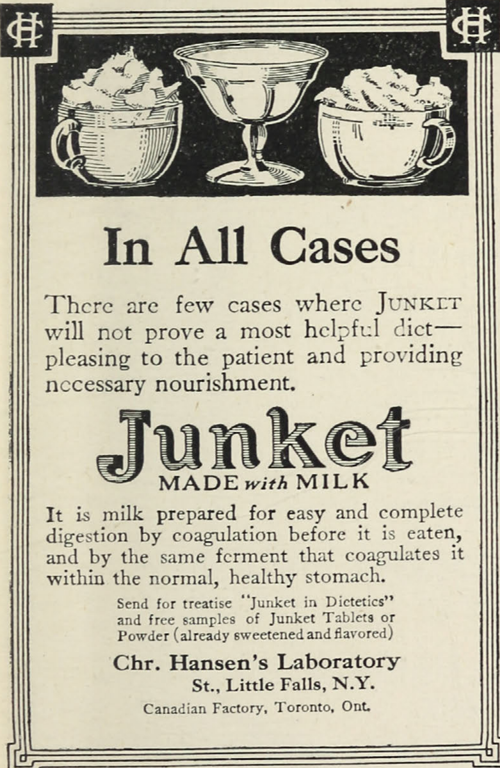

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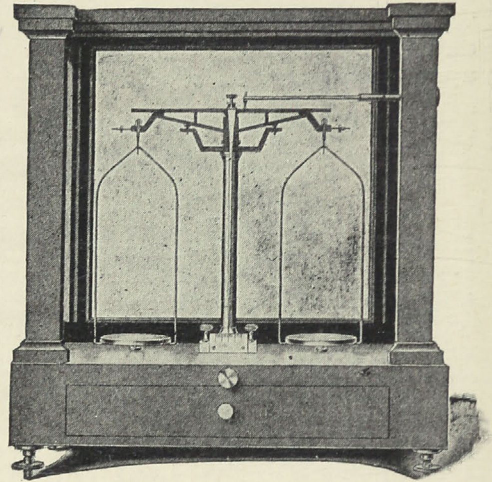

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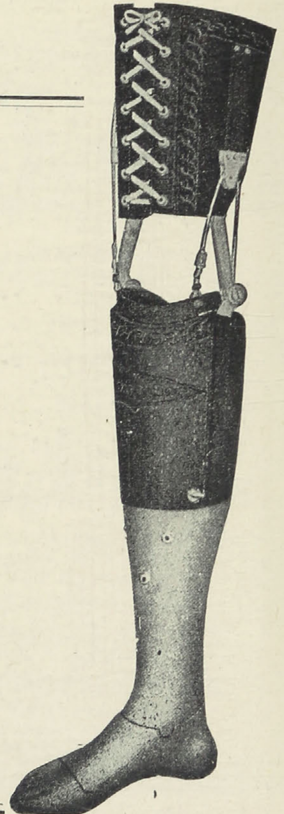

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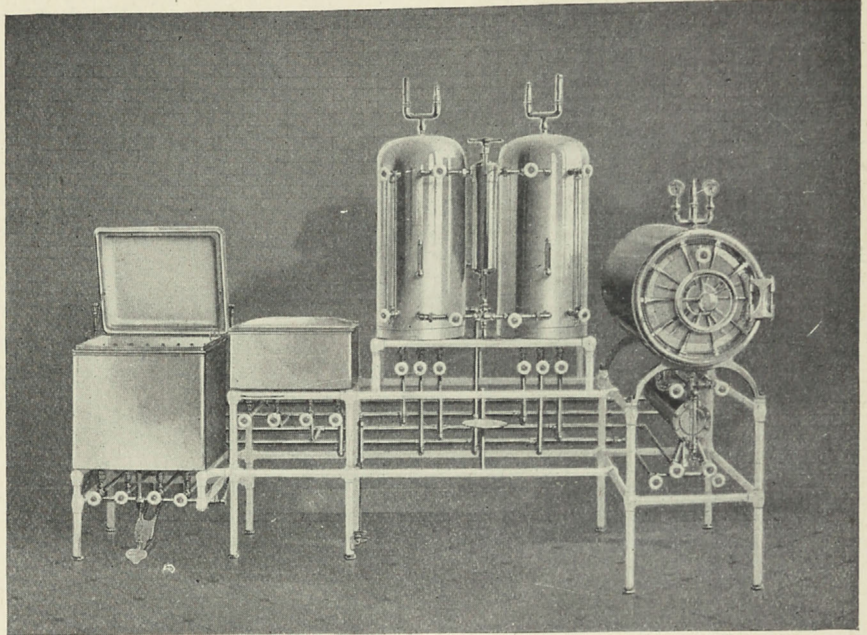

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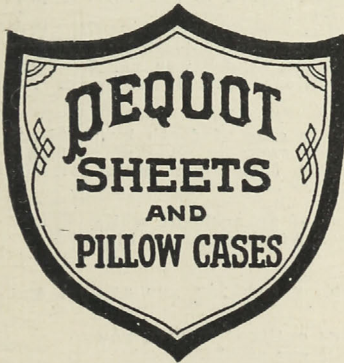

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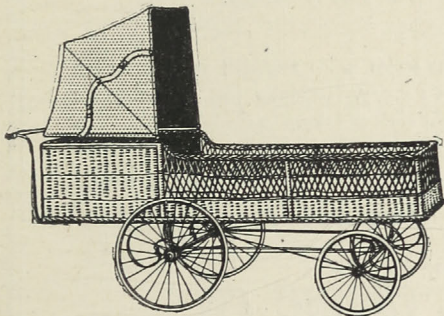

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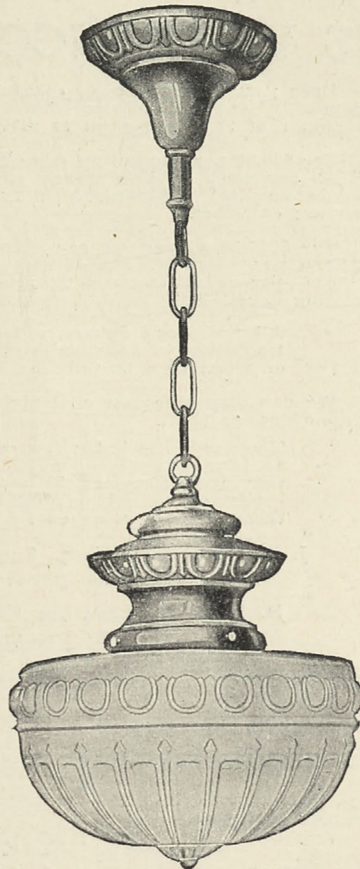

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The Hospital World

TORONTO, CANADA

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

Oct., 1921 THE HOSPITAL WORLD No. 4

THE NURSING SITUATION

Under this caption, Dr. Gilman Thompson, one of New York's most prominent doctors, makes a contribution to the *New York State Journal* of medicine. What he says comes with much weight because of his long connection with the hospital and nursing situation. Dr. Thompson is one of the few medical men who has taken a special interest in hospital construction and organization. In addition he has had an extensive private practise which has brought him in close contact with the domestic nursing problem.

He begins, like a careful clinician does, by inquiring, "What ails the nursing situation?"

The public cannot pay the rates asked ($10 per day now in New York City, the writer of this is informed). Doctors are dissatisfied because they cannot get adequate nursing. The type of women formerly attracted to nursing is dissatisfied for economic and other reasons.

In the Nightingale era the patient required relief of suffering, comfort and support; now he is a "case" for observation and diagnostic research.

The attitude of the medical profession changed and more responsibility was placed on the nurse. Then followed the training school exploitation of nurses; then the era of training school legislation to protect the trained nurse in her future work from encroachment upon the field of original humanitarian service by anyone except an "R.N."—culminating in one bill for a monopoly of the term "nurse" to those only of legalized training; "any attempt to permit the so-called 'trained attendant' to obtain the advantages of a little hospital instruction, meanwhile being firmly resisted."

Then came the war era. Although trained nurses by thousands volunteered everywhere with splendid patriotism, their numbers were far inadequate, and there was no considerable group of trained attendants to meet the emergency.

Short intensive training was widely instituted, and some conservative hospitals temporarily and more or less reluctantly opened their doors for the trained attendant type. This proved the fact long realized by the medical profession, that "a young woman of ordinary ability and moderate education can be 'trained' to make a very competent general nurse, by intensive method, most emphatically within two years." The Health Commissioner of Chicago has been giving nurse attendants a two months' intensive course, and claims to have had great success with over 4,000 pupils. Dr. Thompson thinks this may be extreme, but avers, **"I know that it can be done in three months very satisfactorily, with competent pupils and competent teachers."**

Dr. Thompson states that a few years ago when it was customary to give intensive training to 'probationers' before assigning them to definite ward duty in schools with a 3-year course, he suggested in a school

which he had helped to found, that these 3-month probationers give a public exhibition of their work; a custom subsequently widely copied, after witnessing the various bed adjustments, all sorts of bandaging, making of poultices and plasters, making records, adjusting croup kettles, giving hot pads, washing babies, etc. A medical colleague on the Visiting Staff inquired of the Superintendent of the school, "Why, Miss X., what is left for these young women to learn in the rest of their three years?"—which heartless remark was received with marked disdain!

Dr. Thompson proceeds to say that in not a few instances women trained by shorter courses have proved more satisfactory than the highly over-trained nurse who often becomes restless with simple or chronic cases, feeling, not unnaturally, that having been taught all kinds of things from electro-cardiography to voice culture, she ought to be turning her instruction to practical account.

One young woman, recently a probationer in a training school of very high standing brought her text book in anatomy. Her next lesson included a description of the splenoid bone, reproduced in a large picture. This week-old probationer was asked to learn whether there is any sodium chloride in the teeth!

The fifth era, says Thompson, is the economic period. The war took many nurses out of the country. Many of these, unsettled, have not re-entered the field. Many fields of gainful employment were opened up. The stenographer, for instance, can earn about as much as the trained nurse used to before she became a luxury for the rich only. She has shorter hours, though the eight-hour day prevails in some hospitals. She has her evenings, Sundays and holidays free and is subject to no rigid discipline during her "off" hours. She can live at home, see friends freely, go to such entertain-

ments as she likes, with whom she likes, as often as she likes, provided she does not get too sleepy to do her work accurately. The attitude of the training school, she finds, is precisely that of a young girl's boarding school, yet these women are taken only between 21 and 35. Why should she give up her freedom and spend three years studying such things as spheroid bones?

Is it any wonder, inquires Dr. Thompson, that training schools find it increasingly difficult to recruit their ranks?

Dr. Thompson claims that a nurse should be permitted to learn all she needs in a reasonably short time, and go out to earn her living. After she has become proficient in any particular procedure, it is, from her standpoint, a waste of time to go on repeating it indefinitely. The best interests of the hospital service often demands that she be kept longer at one set of tasks than she needs. It often happens she graduates without any experience in certain important methods in which her more fortunate class mate may be instructed.

It is further an undesirable feature of our training schools to turn out an A1. nurse capable of managing an operating room or a small hospital with the same recognition as one who barely manages to complete the course.

Much relief could be found by admitting a group of trained attendants to gain a moderate experience in hospital wards, thus relieving the regular hospital nurses from undue repetition of things already learned, and further by giving the "R. N." to all nurses at the end of a two years' course. Then a further certificate should be granted to those who desire to fit themselves as operating room head nurses or who attain expert knowledge of public health or industrial

nursing, nursing the insane or tuberculous, or patients undergoing special research, welfare work, etc.

And, finally, says Dr. Thompson, "In every hospital where nurses are instructed, **the curriculum should be submitted to and under the direction of the medical staff; for it is due very largely to the inertia of the medical profession that so much dissatisfaction with present methods exists.** Training school superintendents will find their task much easier if they will take a broadly comprehensive view of the entire economic situation, not alone from the city but also country practise, and prepare to meet the constantly growing demands for facilities for specialized nursing services."

HOSPITAL INTERNES

During the last decade or two interest of hospital administrators, medical staffs, attending and interne, and of medical colleges has been focussed to a considerable degree on the question of interneships. Prior to this bringing of the interne into the spotlight, there was a good deal of indifference on the parts of these various units in the career of the interne; and the interne had a sort of free and easy existence. He was not required to take histories, or do intricate laboratory work; but did do more or less indifferent physical examinations which he didn't record, made routine urinary analyses, dressed his surgical patients, wrote prescriptions for the patients of his chief and made rounds with the attending staff.

He was often chosen on account of his gentlemanly deportment.

Nowadays, it is different.

The interne is in all the large teaching hospitals putting

in a fifth or sixth year under the guidance of his chiefs. He is responsible for careful histories of patients, does routine, general physical examinations of the patient in admission and makes careful daily or bi-daily studies of the case, making proper notes of same. He does chemical examination of body fluids and assists in making examination of operating pathological specimens. He assists at operations, gives Salversans and does minor operative work on the wards and in the out-patient department, if he is found efficient and trustworthy.

Unfortunately there are too few A1 hospitals in which to train all fifth year men,—this in spite of the praiseworthy efforts of the standardization committees appointed by the Rockefeller Foundation and by the American Hospital Association.

Too many of our hospitals outside of the large centres are too poorly equipped for scientific study and their staffs are too fogeyish to do much in teaching the modern graduate in medicine with his high attainments in general scholarship, biology, physics, pathological chemistry, etc., about which many of the older attending physicians know next to nothing.

Hospitals authorities should see to it that on their staffs they have men in both surgery and medicine who have had an up-to-date training, so that the young men who come to them to do interne work shall be able to pursue their scientific work, which characterized their university course. Hospital Boards should also provide the quantity and amount of apparatus and supplies necessary to the elucidation of the diseases of the patients admitted to their hospitals and for their treatment.

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Original Contribution

THE FUTURE OF HOSPITAL AND MEDICAL PRACTISE

By John N. E. Brown, One Time Inspector of Hospitals in the Yukon

Portion of an address (illustrated with 150 views of leading world hospitals), given in Welland, Ontario; and printed in part in the Trained Nurse and Hospital Review, of New York.

To foretell the trend of social movements in these days of rapid change is difficult. Certainly no attempt should be made to do so without first viewing the present field and taking retrospect of whatever form of humane effort is under consideration.

For this reason in considering the future of hospitals and of medical practice—the care of the sick generally—a glance backward is as essential as a study of present conditions.

Prior to the Christian era there seems to have been little effort to look after the sick in institutions such as we have today.

Interest in the hospital began about the time the man travelling from Jerusalem to Jericho, fell among thieves, as recorded by Paul's physician, Luke.

He was picked up by his neighbor, after receiving the "Go-by" from the priest and the Levite; received an application of oil and wine, was taken to an inn, and an advance payment made for his care.

Thus early was manifested the hospital spirit; and here was an embryornic hospital.

The early Apostles of the Christian Church, while administering healing to mental maladies, did not forget bodily ailments. This function of the early church was one of the most important causes of its rapid growth among the Gentiles.

During the next thousand years some of the sick were ministered to by the church, and the monastery. One of the oldest hospitals in Great Britain was a monastery—St. Bartholomews—it is a type of the great British voluntary hospitals, and of a good many hospitals in America. It was founded as a monastery in the reign of King Stephen, by his Court Jester, Prince Rahere, who renounced the Court and its round of

gayety and pleasure, for a life of serious purpose and of good works.

Seeing the terrible condition of the poor citizens of London, many of them being destitute and sick, Rahere, like the Good Samaritan, took pity on his unfortunate neighbors and petitioned his old Royal Master for a grant of land in the city. A charter was granted him—which the interested visitor may still see when he visits this famous old Royal Hospital. Such was the beginning of the Monastery of St. Bartholomew, which for several hundred years was administered under the auspices of the Catholic Church.

It carried on until Henry Eight's time, dispensing alms to the poor, and giving crude care to the sick. It will be remembered that owing to certain abuses which had crept in. King Henry ordered that the monasteries of Britain should be abolished. Following this order, the citizens of London, finding that the closure of their monastery created so much hardship and distress among the poor of the city, appealed to the King to allow St. Bartholomew's to be re-established as a hospital for the destitute sick folk of the metropolis. To their request he acceded, giving a fresh charter to the appellants. This famous charter, like that granted in King Stephen's time, may also be seen in the Hospital today; and on one of the walls of the institution hangs the portrait of King Hal, done by the famous Holbein.

The hospital became a secular establishment, though retaining a religious tone up to the present, being pervaded always by the same spirit that actuated the Good Samaritan and its founder Prince Rahere.

This old hospital, as remarked, stands as a type of the magnificent voluntary hospitals of the British Isles—supported by free-will offerings from all classes and ministering to the patients brought to it, without charge. Since the war, however, these hospitals have found great difficulty in securing money enough to run them. Some of them have introduced paying wards and others are appealing to the Government for assistance; while others contemplate closing some of their wards, unless help from some quarter is forthcoming.

In addition to these voluntary hospitals Britain has Poor Law Infirmaries, in which the pauper class are treated, and which are supported from the rates (taxes). Besides these, there are cottage hospitals throughout the provincial districts which are maintained on the voluntary principle. In the large centres of population are to be found Nursing Homes,

which correspond to our purely private hospitals, and, like them, are individual enterprises conducted, in the main, for profit.

In contrast to the capricious and irregular support obtained by the voluntary system of Great Britain, the large public continental hospitals depend upon public taxation for their maintenance, being quite independent of the wealthy philanthropists.

In Paris, hospitals are supported by the city, and are governed by a Board of Charities which has also the governance of the asylums and the administration of poor relief generally.

In Vienna, the hospitals look either to the city, the province or the State for support. For a long time none of these bodies wanted to shoulder the responsibility of maintaining the hospitals. Eventually, however, by compromise the money needed to carry on has been provided from one source or another.

The Dutch hospitals are supported by city and state. Patients able to pay for care are charged.

The German hospitals are mainly supported by general taxation. A few of them, like the Virchow, receive pay from patients. The well-to-do folks in Berlin often find difficulty in getting hospital accommodation—or did, when the writer was there in 1911.

In the United States and in Canada, not many hospitals receive state aid. In Pennsylvania and some of the Canadian provinces partial support is accorded to them. The majority are supported by voluntary contributions. This statement does not apply, of course, to the maintenance of Isolation hospitals for contagious diseases (which are generally municipally supported), nor to hospitals for the insane, which are supported by the Provinces. On this continent the private hospital and private sanitarium flourish to a great or less extent.

Quite a number of American cities and a few Canadian (notably Hamilton, Ontario), have their own general hospitals, supported by the municipality wholly. In Hamilton a Commission is the governing body; the plan works well.

Sanitaria for the treatment of Tuberculosis are supported

—some purely voluntarily; others by the State; others by municipalities; and some by a joint support of two or three of these agencies.

As time goes on we shall likely see these institutions for the sick, of whatever sort, supported more and more from the general taxes. It appears more desirable and more logical to secure all the hospitals require for building and upkeep from all the people (whom they serve), than to receive only a portion of what they require from comparatively few of the people.

Through legislation enacted by the province of Saskatchewan, relative to the establishment of hospitals there, two or more communities may combine in work for carrying on such an institution. Plans are submitted to the Commissioner of Public Health, and after the whole scheme has been approved the necessary expenditures are voted upon by the people. Saskatchewan has already 39 hospitals, and 40 more are organized or in the process of organization. They do no charity work, the municipality paying for all its cases.

We shall now consider the influence of the Great War on the hospital problem and the care of the sick. All soldiers, prior to admission into the Army, were examined carefully. After acceptance if any fell ill they were examined at once and admitted (unless the ailment were trivial) to hospital where the disease was treat in its incipiency. Services or specialists in every department of medicine were available, should their services be required. Thus "Group Medicine" was exemplified.

The military hospitals were mainly of the one-storied type—if new ones were required. Not a few Hospital authorities think this type of hospital would be the best for civilian work. One sees this type in the great Virchow in Berlin. No stairs or elevators are required. The danger from fire is small; and the patient can be brought on terraces close to friendly trees and flowers, and green grass and singing birds, near to mother earth. In the past generations the construction of Hospitals has been very distinctly influenced by post-war hospitals built for civilians; and we think it will be so again.

The time is near at hand when all soldiers in the great Battle of Life will be thought as precious as our brave warriors, and like them will be periodically inspected, and if they have

any debility they will be treated for the same, as promptly and as carefully. A start has been made: baby welfare clinics have been established in many places, where well babies are kept under constant and regular supervision and the ounce of prevention administered when necessary. Schools are being inspected; pupils with bad teeth, diseased tonsils, sore throats, rashes, etc. discovered, and means employed to secure proper treatment. A good many industrial establishments are providing hospital and dispensary facilities for their workmen and women, employing doctors and nurses to give first aid, and, in some instances, to follow up the cases with complete attendance.

It is becoming apparent that the children between babyhood and school age and between the time of leaving school and entering the factory are almost as much in need of health supervision as they are during babyhood and while at school. However, a beginning has been made; yet the great bulk of the population remain uninspected physically, though suffering from many preventable and easily curable maladies—living, many of them, in deplorable homes, on improper foods, improperly prepared; not sufficiently clothed; and amid vile surroundings physically and morally.

As in the Army, why should not any citizen be examined, or, as soon as he feels ill or shows signs of disease receive attention at once, either at home, in the doctor's office, at the dispensary or in the hospital?

In a recent census made under the auspices of the Metropolitan Insurance Company in a section of Pennsylvania, the investigators found 5,399 persons sick. Of these:

5,084 were unable to work	94.2	per cent.
1,361 were in bed at home	25.2	per cent.
530 were in hospital	9.8	per cent.
3,193 were up and about	59.1	per cent.
55 attended the dispensary	1.0	per cent.
315 were able to work	5.8	per cent.

In a census taken by the same company in Pennsylvania and West Virginia, white males showed a sickness rate of 24.9 per thousand, involving a sickness disability of 23.1 per thousand.

Accidents and injurious disables	11.2	per cent.
Rheumatism	8.0	per cent.

Influenza	7.5 per cent.
Pneumonia	6.09 per cent.
Diseases of the stomach	3.15 per cent.
Nervousness	3.4 per cent.
Colds	3.1 per cent.
Bronchitis	3.0 per cent.
Measles, asthma, appendicitis, diseases of the heart, arteries, tonsilitis	51.35 per cent.

The above tables would seem to indicate that something remains to be done regarding the prevention and the treatment of disease. It is significant that less than ten per cent. of the sick (see table 1), were attended in hospitals, in spite of the fact that hospitals have become much more popular with the sick public in the last few years.

Prior to Lister's and Sir James Simpson's time, hospitals were places to be shunned on account of the prevalence of septicaemia, gangrene, and the awful torture experienced by patients who had to undergo operations without anesthesia. But with the introduction of chloroform, and ether, of antiseptics, trained nurses, departmental specialists and social service workers, the old dread of hospitals is rapidly vanishing.

That hospitals are coming more and more into favor is indicated by their rapid increase. There were hospitals in the U. S.:—

Established prior to 1851	193 or	3.9 per cent.
Established between 1851 and 1860	173 or	3.4 per cent.
Established betweeen 1861 and 1870	270 or	5.4 per cent.
Established between 1871 and 1880	371 or	7.3 per cent.
Established between 1881 and 1890	726 or	14.4 per cent.
Established between 1891 and 1900	1254 or	24.9 per cent.
Established between 1901 and 1910	2047 or	40.7 per cent.
Established between 1911 and 1920	3400 or	66.42 per cent.

In the old days hospitals were in the main boarding houses for the sick. Some are still little more than that—especially among hospitals for the insane. As time goes on the individual patients are receiving more and more care, and his disease is the subject of more intensive study by physicians who are becoming more and more skilled and conscientious. One of the largest hospitals in the world has over its entrance doorway the admonition: "In Treating the Disease do not Forget the Patient." In one of the great departmental stores of Phila-

delphia one sees placards all about bearing the inscription: "The Customer is Right."

It cannot be too much emphasized upon doctors, nurses, and employees by those in charge, that the patient must have every consideration. There is quite a tendency in some hospitals to become slack and thoughtless in respect to the rights of the patient. The malady is called institutionalism or hospitalism. Unfortunate is the hospital in which it exists.

To raise hospital ideals the American College of Surgeons for some years past has been making a survey of the entire hospital. Kindly and non-officious visits have been made to all the leading hospitals with a view to standardizing them. Grading is being done, and 377 have reached the minimum standard. 22 of these are in Canada. Hospital standardization aims to safeguard the patient against error in diagnosis, against lax or lazy medical treatment, against unnecessary surgical operations or operations by unskilled surgeons; it aims to bring to every patient, however humble, the highest service known to the profession.

The particular aspects of hospital work to which the association has given prominence are: Staff organization, the keeping of accurate records of cases, the maintenance of an efficient laboratory, the performance of autopsies, and the eschewing on the part of surgeons of the pernicious practice of the secret division of fees. Demand is made that there shall be a competent Head to each department of the hospital, who shall be responsible for the work done in such department. Frequent and regular conferences shall be held at which shall be discussed, fully and freely, all failures as well as successes. Team-work must prevail throughout the institution. Heads of Departments should be men thoroughly trained and conscientious—men who are tactful, sympathetic and able to co-operate harmoniously with colleagues and assistants, giving the latter a due proportion of the work and responsibility.

The importance of keeping records must constantly be emphasized. The history of all cases should be taken carefully, accurately and as fully as required. If it is impossible, through lack of assistance, to take them in detail, all the big points ought to be noted in the family and previous histories, in the present attack together with the leading signs and symptoms on admission. Daily progress notes should be kept. All results of laboratory findings and X-ray reports should be included, and notes made at the autopsy in case death supervenes.

Histories of cases will be of great service in time to come, not only to the particular doctor treating the case, but to other physicians having similar cases to treat.

Through the efforts of the Executive of the American Catholic Association a digest is made of all histories taken in all the hospitals belonging to that Association—some 650—to be available for all of them.

Such case histories are always available for publication in the current medical journals, and are always acceptable to these publications. The results of the clinical knowledge obtained in hospitals does not appear in book form until some years have elapsed, during which period the only outlet for this store of knowledge in the printed form is in these medical journals. These hospital history rooms contain the newest, freshest data in regard to disease in all departments of medicine.

To facilitate history-taking some hospitals have introduced dictaphones, into which the doctors may in a few moments dictate brief summaries of their rough notes. The insistence on history taking leads to more careful observation. A good history is two-thirds of the diagnosis; and a good diagnosis is the first step in the treatment.

The standard hospital must have an efficient laboratory, properly equipped and in charge of a competent officer. In the smaller hospitals the work may be done in one or two well-lit rooms, which should be provided with water, gas, electricity an acid-proof sink, with provision for the small animals needed. A good microscope, a centrifuge, autoclave, incubator, balance and microtome comprise the principal items needed along with the reagents.

If the hospital cannot afford a full-time man, one young, lately-graduated practioner may be quite readily induced to do the work, being allowed to charge patients able to pay for any work he does in connection with their cases. This man might possibly undertake the X-ray work. In some hospitals nurses do the routine urines, sputa and blood examinations; also the X-ray work. This is done in St. Catharines, Ontario. An X-ray outfit is a necessary piece of equipment for every up-to-date hospital.

The College of Surgeons stresses the importance of autopsies as essential in Standardized Hospitals. In many of the European hospitals, post mortems are performed on all

patients who die. On this continent autopsies are being obtained oftener than formerly, owing to the activity of the pathologists. Where this practise obtains its influence is reflected upon the character of the clinical work done; for it is in the dead room that the clinician's work is checked up. The reading of a brief summary of the patient's ante mortem condition and a statement of the diagnosis is a sharp stimulus to careful bedside work. The attending medical men who has done faithful, conscientious work has nothing to dread from the revelations of the autopsy; but may wait with easy poise to learn in how far he has been right; and to what extent he has failed in the anatomical diagnosis—how many lesions he has discovered, how many undetected. These findings are of great value to him and also to his students, if he be a teacher.

Even in the smaller institutions greater efforts should be made to secure post mortem examinations in as many cases as possible.

In the large urban centres the solution of the hospital problem is much further advanced than in the towns and rural communities. Hospital seers have visions of District Hospitals in every community throughout America; institutions which shall also be health centres. There will be a main building for medical, surgical and obstetrical patients, which may contain laboratory and X-ray departments, with, possibly, the culinary and laundry functions in the basement or on the top storey; a building for infectious cases, and one for the tubercular. Provision shall be made for a dispensary, which shall include a venereal clinic, a baby welfare department. The laboratory work might be done in this building in place of in the main structure, together with the post mortem work. Quarters for the personnel must not be forgotten. The laundry might occupy the basement of this building, if more convenient than the place already suggested.

This modern establishment should be in charge of a Commissioner, who should be a medical man with good business and administrative ability. There should be a surgical head and an internist, a sufficient house staff; several graduate nurses and nurse assistants, an officer in charge of the laboratory work and some efficient person to take charge of the X-Ray work. The obstetrical room in the main building should occupy a separate flat, and have a sound proof labor room and nursery. Any local doctor of good standing should be allowed

to take his patients here for care during confinement.

These local hospitals should not only form centres for healing, but for the prevention of disease, and the scientific study of disease, for the production of medical literature, and for the extension of social service to all the afflicted whether of body or mind.

The Nursing Department of these district hospitals, should undertake teaching to a greater or less extent, depending upon the capacity of the hospital and the amount of work to be done. It might well take a leaf from the work of the Detroit Nursing Association, and that of Societies doing similar work in Boston and Brattleboro, Vermont, which organizations undertake to do the nursing in homes of the middle classes or people of moderate means, who cannot afford whole time graduate nurses, and, on the other hand, do not wish to accept charitable nursing. Trained nurses are sent to do the technical nursing, and nurse assistants do the routine work, and where necessary—and this is quite often—keep the house. For example, in obstetric cases, the graduate nurse attends the mother during her crisis; the nurse assistant then goes on duty, attends the ordinary wants of the patient, and the baby, prepares meals for the rest of the family and attends to the general housework sufficiently to keep the family habilitated until the mother's recovery. The trained nurse pays daily visits for the first few days, performing any skilled work which may require doing.

Even from this cursory review of what has been done, with what is being done and what is projected, all persons interested in the growth of hospitals and the development of medical and nursing, may properly feel encouraged.

THE FINANCING OF PUBLIC HOSPITALS

M. T. MacEachern, M.D., General Superintendent, Vancouver General Hospital

Boards of trustees and hospital administrators are today facing serious problems in connection with financing public hospitals. More money is required than formerly to meet current expenses. This is due to many reasons, but to two particularly. First, it is a well-known fact that expenses of all kinds have increased enormously far out of proportion to any increase in revenue that has been secured. This increase

in expenses has taken place during the past few years, and although we are now on a falling market, little hope can be entertained of prices ever coming to a pre war state; the cost of operating hospitals, therefore, will remain higher than in the pre-war years. The second reason, and possibly the more important, is the fact that our people are demanding an increased service from these institutions, and the expense of such a service is so great that the present consolidated revenue cannot meet it. This service is not unreasonable; it is only a minimum requirement, for we recognize today that hospitals must be efficient and do their part in assisting the doctor to get as good a result as possible.

Unless they are heavily endowed public hospitals secure their support mainly from four sources. These are: patients' fees, philanthropy, municipal assistance and provincial assistance. All are agreed that hospital charges or different services to the patient are now as high as they can be made without unduly burdening the patient. From this source very little further relief can be secured; indeed in many cases today the high prices make some of the essential services for diagnosis almost prohibitive. Philanthropy has been overpowered during the war and since the declaration of peace the period of reconstruction has continued to make constant demands on it. It has been further burdened by heavy income taxes of a federal and provincial nature with the result that good old philanthropy, upon which many hospitals depended, has been forced to take a more retiring place in respect to its liberality. Municipal authorities tell us that their present consolidated revenue is exhausted and they cannot and will not give further assistance till a broadened scheme of taxation is brought in. They advise taking such matter up with the provincial government. The provincial government on being consulted present a similar answer and state that their consolidated revenue is now required in its entirety for the usual expenses of the administration of affairs in the province. What, then, about further assistance to our hospitals and health institutions? The only solution is that new revenue must be found which will provide immediate as well as permanent relief, and will put our institutions on a sound financial basis.

Granted that new revenue must be found, the question arises: how is it to be obtained? I believe that people today are ready to accept a universal basis of taxation for hospital purposes; a tax the application of which would involve in an equitable way almost every resident in the province, thus

conforming to a broadened taxation scheme in the truest sense of the word, and such a tax should be sufficient in amount to pay, either wholly or in part, the general ward service together with all that goes with it. This general ward service, to everyone paying the tax, would include board, nursing, accommodation, free use of all diagnostic facilities and all specialized treatment departments in connection with a well-regulated hospital. It might be desirable to establish a rate of $1.00 per day for a public ward, but this is a matter of opinion. The per capita allowance for each patient through such a taxation would thus be sufficient to pay for all costs of the ward, giving the patient every possible facility that would be required for competent diagnosis and efficient treatment. If the patient was still obliged to pay $1.00 per day this augmented by the per capita secured from the general taxation scheme, would certainly be a very decided improvement on the present pernicious practice of charging the patient from $2.50 to $3.00 a day. This heavy charge makes it impossible for a great number to meet their obligations in any manner whatsoever, thus depriving our hospitals of sufficient revenue and our patients of necessary services which they cannot obtain on account of financial conditions. However, whether the general ward service with all that goes with it should be free or should be charged for at $1.00 per day, is a matter of opinion; some might desire to pay some fee.

This scheme, as outlined, would in no way interfere with the right of patients to choose the doctor they would wish to attend them as well as to which hospital they would prefer to go. It has been estimated that in the Province of British Columbia that it will require a tax of about $6.00 per person between the ages of eighteen and sixty-five, to sufficiently provide a per capita allowance of at least $3.00 per patient per day. This would eliminate all uncollectable accounts and relieve the hospital of the unpleasant task now so troublesome, of collection of accounts. The great advantage, however, would be the fact that every man, woman and child, regardless of religion, colour, financial circumstances or otherwise, would have access to efficient hospital service when ill. The private ward patient would share in the advantage of such a scheme just as much as the public ward patient, for the former would have the per capita allowance credited on his private ward service, that is to say: if the per capita allowance was $3.00 per day and the private room is costing him $6.00 per day, he would have a credit coming to him of $3.00

per day, owing to the fact that he has paid his hospital tax.

The collection of such a tax could be accomplished through the present governmental machinery without any additional cost. Several ways suggest themselves, and I will mention one or two of the more important.

Firstly. For all those who are paying income tax or earning $1500 or over, an additional amount could be added to their taxation roll for the specific amount indicated as 'hospital tax," just the same as we now see an additional amount for our automobile on the present income tax roll:

Secondly. All who are not included in this manner would pay through the poll tax machinery by an additional tax known as a "hospital tax"; indeed, in this connection it would be advisable to alter the term *poll* tax to *service* tax, and we believe it would be more popular. In addition, there is also the payroll and various other means which could be used without adding additional machinery and cost for the collection of this money.

In the Province of British Columbia a careful analysis of the public hospitals has been made in respect to their financial condition. The findings show clearly that these institutions are in a serious financial condition, nearly all having heavy deficits and those that have not, frankly admitting that they are only able to avoid a deficit at the sacrifice of their patients and staff, and could not honestly lay claim to having performed their obligations efficiently, owing to lack of money. Indeed, it has come to pass that many directors of these worthy institutions find their positions so intolerable, owing to financial conditions, that soon they will have to resign as boards and ask the Government or some other authority to take over the hospitals. This is a condition which is not desirable and the British Columbia Hospital Association has taken up the question seriously with a view to a solution which will be practical and permanent. The matter has also been before representative organizations such as the Association of the Boards of Trade of the Province, the Union of British Columbia Municipalities and others, all of whom have made strong representations to the Legislative authorities. In a summary report recently issued by the British Columbia Hospital Association the following three objectives were set forth to be taken up at once:

Firstly. That some action be taken immediately to pay all already accumulated deficits which are embarrassing hospitals so much at present.

Secondly. That something should be done to prevent the accumulating of current deficits until a more permanent scheme of hospital financing be brought in.

Thirdly. That at the very shortest period of time a permanent, definite and efficient scheme of hospital financing should be established.

A recent memorial was presented to the Government of British Columbia by the British Columbia Hospital Association, which read as follows:

"Whereas the public hospitals of our Province have almost without exception come to the point where they are confronted with heavy deficits, or else are seriously handicapped in their work from lack of suitable buildings, equipment, or staff:

"And whereas this very grave condition has supervened in spite of every effort having been made to provide sufficient funds by all the usual methods:

"And whereas under these conditions it is obviously only a matter of a veiy short time before further credit will be refused the hospitals by banks and tradesmen:

"And whereas it is inconceivable that such a contingency should be permitted to occur:

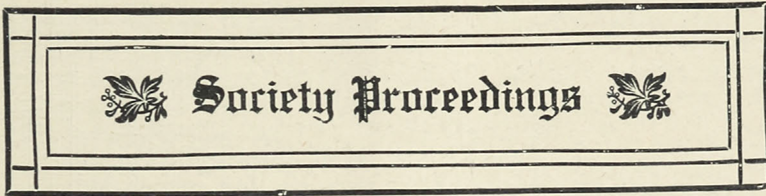
"We, the British Columbia Hospital Association, respectfully turn to your Honourable Body with the following proposals as the only reasonable solution to our problems:

Firstly. That the Provincial Government be requested to disburse forthwith the deficits of the public hospitals of British Columbia until such time as a better and more permanent financial policy for financing said hospitals is adopted.

Secondly. That the present scale of per capita grants from the Provincial Government be doubled until such time as a measure is brought in providing for a more permanent and adequate system of financing hospitals.

Thirdly. That the Government be requested to bring in a measure at the earliest opportunity to provide by a universal basis of taxation for the adequate financing of all hospitals receiving aid under the "Hospital Act."

The substance of this memorial has been taken up by various organizations and efficient follow-up work has been accomplished. No definite announcement has been made as to what the future policy shall be. However the scheme as outlined would undboutedly meet the people's approval in every way and has the advantage of not disturbing present existing organization.



THE BRITISH COLUMBIA HOSPITAL ASSOCIATION

The fourth annual convention of the British Columbia Hospital Association, recently held at Kamloops, B.C., was considered by all who attended it, the most satisfactory and successful in the history of the Association. There was a registration of almost 100 delegates, who were representative of all parts of the province.

Excellent accommodation and entertainment were provided by the board of directors of the Royal Inland Hospital, assisted by a large number of private citizens, who appeared to vie with one another in seeing that the visitors were well looked after, and given an opportunity to see and enjoy the natural advantages of the town and surrounding country.

There could certainly be no more ideal place for a convention gathering than the little town of Kamloops, which is situated centrally in the Province and at the time of the Convention, was looking its very best. Its citizens are proud of their town and its surroundings, and if the disposition of the time of the delegates had been left to their entertainers there need not have been any sessions of Convention at all. They insisted however they had come together to transact important business and resolutely stayed with the sessions.

A most enjoyable, and at the same time instructive entertainment was arranged by the local entertainers in the shape of an auto drive for all delegates to the Tranquille Sanitorium, about 9 miles from the City. It was arranged between 4 and 8 o'clock one afternoon, lunch being served the visitors by the institution.

This is the Provincial institution for the care of incipient cases of tuberculosis. Its local situation and climatic conditions are ideal. It has recently been enlarged to accommodate 200 patients. The visit was an excellent object lesson on the care of tubercular patients, and was greatly appreciated by the visitors

The Program Committee had arranged for the evening sessions to be devoted to the presentation of subjects of interest to the general public Public announcements had been made, of these sessions, and of the subjects to be presented to them with the result that there was a very fair attendance of the people beside the delegates at these more public sessions.

The leading address of the first evening session was presented by Dr. H. E. Young, Secretary of the Board of Health of the Province. His subject was "The Health Tax" and was dealt with in a most thorough manner. The doctor gave most convincing proof that, from principles of economy alone, the Government should assume responsibility for seeing that no individual of the state should be without every care and treatment necessary to make and keep him or her as far as pos sible physically fit for the ordinary duties and functions of life. The scope of effort required to bring about this greatly-to-be-desired condition of life throughout the Province, would be much broader than merely the establishment and upkeep of adequate hospital facilities. It would indeed, as far as might be possible, relieve the hospitals of a portion of the work now coming to their doors, for in its operation it would discover and remedy in incipient stages many cases which if allowed to develop unchecked, as has frequently happened in the past, would later become cases for hospital treatment, some of them eventually to gravitate into the class of incurables.

The principle laid down by Dr. Young in the paper was that of prevention rather than cure. It is to be secured by a correlation and direction of all efforts pertaining to the health of the people under a single governmental management or department. The cost of operation should be met by taxation equitably levied, a part of it raised by the State at large and part by the community served.

The paper was received with enthusiasm, having evidently struck a responsive chord in the feelings of the audience. It is without doubt a foreword of what is in the mind of those who desire to see our hospital service developed to the point where it will be available to every case requiring it.

The relation of the Workmen's Compensation Board to Hospitals was discussed at considerable length. Mr. E. S. H. Winn, the Chairman of the Board, and Dr. G. A. B. Hall, its Chief Medical Referee, being present and giving information upon the different problems presented.

Two whole sessions were devoted to nursing. The different aspects of work were presented by short papers or a

Question Drawer. Discussion was free and a good deal of useful information was elicited

The business and financial aspects came in for very much consideration. Upon one matter the delegates were a unit— some measure must be adopted that will bring the income of hospitals up to the level of what is required to enable them to provide adequate service for all our citizens and population generally. After lengthy discussion as to ways and means of bringing about the much to be desired end, it was found there was not sufficient data before the convention to enable it to unite upon a definite policy. The matter was finally referred to a standing committee of five with instructions to them to request the appointment of a similar committee from the Union of B. C. Municipalities. These two committees together with the official heads of the Provincial Board of Health and the Workmen's Compensation Board were requested to get together and formulate some course of procedure which they should recommend to the Provincial Legislative Assembly so that action might be taken by that Body at its next session to relieve the hospitals of their present financial embarrassment.

The Association by resolution also made request that the Government give special assistance where necessary to enable the various Public Hospitals to prepare proper facilities to accommodate the number of tubercular patients required of them by the Hospital Act

Reports of results of Hospital Day efforts were exceedingly satisfactory. Much interest in hospitals on the part of the public had been created. It was decided to officially adopt May 12th as Annual Hospital Day. It will be recommended that efforts on that occasion be concentrated mainly upon developing public interest in the hospitals and their work, rather than to make it a direct financial appeal

At one of the public evening sessions, a most interesting and instructive lantern-illustrated address was given by Mr. J. C. Antle, Superintendent of the Columbia Coast Mission of B.C. This organization works among the logging camps and other isolated settlements along the B. C. Coast. Their plant consists of a hospital ship and three local hospitals. It is a work strikingly similar to that carried on by Dr. Grenfell on the Labrador Coast, and has been doing a noble work in a quiet way during the past eighteen years.

The following was the questionnaire taken up during the meeting:—

Section "A"—Nursing

1. Should each nurse-in-training have a room to herself?

Ans. It is most desirable that each nurse-in-training should have a room to herself. Failing this, not more than two should occupy one room, due provision being made for proper space, air, light and sitting room accommodation, The dormitory system of four, six or more, for instance, was condemned.

2. What time should be allowed a nurse-in-training for illness?

Ans. Three weeks appeared to be the period most generally adopted.

3. What length of holidays should be given the following: (a) Official nurses on staff? (b) Graduate or head nurses in charge of wards or doing floor duty? (c) Nurses-in-training?

Ans. (a) One month. (b) One month. (c) Three weeks.

4. What should be an average salary for each of the following:—(a) Superintendent of hospital of seventy-five beds, who is a graduate nurse? (b) Graduate nurses in charge of wards or floors in any hospitals? (c) Nurses-in-training in any hospital?

Ans. (a) A minimum of $100.00 per month with room, board and laundry. (b) $75.00, $80.00 and $85.00 per month respectively for first, second and third year salaries, with room, board and laundry. (c) An allowance (not a salary) of $8.00, $10.00 and $12.00 per month respectively, for first, second and third year, with room, board, and laundry.

5. Should the superintendent of nurses be the final authority in disciplinary matters, and the consequences to be meted out?

Ans. Yes, but it is deemed advisable to always consult with the Superintendent or superior officer responsible for the hospital, and if there is no such person other than herself, she may confer with the member of the Board to whom such matters are usually referred.

6. Should our hospitals only engage and allow to nurse therein such nurses as have the R. N.?

Ans. Hospitals should only engage registered nurses, but under the present British Columbia Nurses' Registration Act it is not compulsory that every graduate nurse be registered, and therefore they cannot be prevented from nursing in hospitals if they are properly qualified.

7. Should twenty-four hour duty for special nurses be allowed in hospitals?

Ans. No.

8. Should the hospital furnish the nurse-in-training with uniforms, books, stationery and shoes, in addition to board, room and laundry?

Ans. Many hospitals furnish uniform material, text and note books, while others furnish only uniform material. It is generally agreed, however, that hospitals should supply uniform material, text and note books at least.

9. What is a reasonable proportion of patients to each nurse in a general hospital, considering both day and night separately and different types of cases, such as private, semi-private and public?

Ans. One nurse to every two and a half or three patients. A distribution as follows works very well:—*Day duty*—One nurse to every five patients in public ward; one nurse to every three patients in private ward. *Night duty*—One nurse to every ten patients in public ward; one nurse to every five patients in private ward.

10. What is the best division of duty hours for nurses in order to establish an eight-hour-day system?

Ans. Four groups as follows:—*Group No.* 1—7:00 A.M. to 7:00 P.M. with four hours off. *Group No.* 2—3:00 P.M. to 11:30 P.M. *Group No.* 3—7:00 P.M. to 7:00 A.M. with four hours off. *Group No.* 4—11:00 P.M. to 7:00 A.M.

This combination seems to work out best of all and gives an overlapping service, thus minimizing disturbance to the daily ward routine.

Section "B"—Medical

1. Why should unqualified Maternity Homes be licensed by the Government and patronized by the general public?

Ans. Unqualified Maternity Homes should not be licensed by the Government or patronized by the public. The Act of Parliament respecting this matter should specify definitely such conditions as will insure competent personnel, proper and safe accommodation, with good facilities and equipment. The present regulations in British Columbia make it far too easy to start hospitals and it is hoped that more stringent regulations will be adopted.

2. Should not the public ward be abolished in hospitals?

Ans. No, but the public ward of 6, 8 and 10 beds is more desirable than the large ones of twenty or thirty beds, which today are found in many hospitals.

3. Should not each doctor be responsible for the complete medical record of the patient and this record be left in the hospital?

Ans. Yes, he should either do it himself or see that it is done by someone else.

4. How far is the Board of Directors or Trustees responsible for the kind of work done in the hospital?

Ans. Though not legally, yet the Board of Directors or Trustees of any hospital, is morally responsible to the public to see that each and every patient treated therein receives competent care so as to bring them back to health if possible in the quickest and most comfortable manner. They must make sure that all the work carried on is efficient and that good results are being obtained. They are responsible to the public for supplying good accommodation, proper facilities and equipment and above all, a competent personnel as the staff of the hospital. Usually the Board of Directors or Trustees is spending public funds, therefore they have an obligation to fulfil, to see that such funds are spent in the best possible manner.

5. What cases, other than the so-called infectious diseases, should be isolated in general hospitals?

Ans. Typhoid Fever, Pulmonary Tuberculosis, Anterior Poliomyelitis, Epidemic Cerebro-Spinal Meningitis, Contagious skin diseases as Impetigo, etc., Erysipelas, Lethargica Encephalitis, Septicaemia, Tonsillitis,Venereal Diseases,Ophathalmia, Trachoma, suspects of all kinds, mental cases, drug addicts, alcoholics and cases which are abnoxious owing to odor, appearance, etc.

6. What is the minimum laboratory work that every hospital should be prepared to carry on?

Ans. Urinalysis; blood examinations, as white and red cell counts and haemoglobin; smears for Bacteria; examination of spinal fluid; examination of stomach contents; examination of feces; preservation of tissues for pathological investigation elsewhere. For further information regarding this question see Dr. Strong's paper delivered before The B. C. Hospital Association convention on July 7th, 1921.

7. Could a graduate nurse acquire sufficient knowledge and training anywhere in eight or ten months to fit her to carry on the laboratory, X-Ray and medical record work necessary for a hospital of less than one hundred beds?

Ans. Yes; the Vancouver General Hospital offers a course of ten months, apportioned as follows,—Medical Records 2 months, X-Ray 4 months, Laboratory 4 months. This

would give sufficient knowledge to undertake the work in a hospital of one hundred beds or less. This course, we understand, is at present limited to candidates from British Columbia.

8. How can better relations and more cooperation be established between our hospitals and the medical profession?

Ans. It should not be necessary to ask a question of this kind; however, it is unfortunate that in some instances we do not find the best cooperation between the medical profession and the hospital. The following are a few suggestions:—*Firstly*—The hospital should offer the doctor an efficient service for the treatment of his patient. *Second*—The entire hospital staff should manifest a keen interest in the patient's welfare. *Thirdly*—There should be conferences at regular intervals between the doctors and the hospital authorities. The attending doctor should be consulted in hospital matters, and indeed, the appointment of advisory committees for different phases of the work will develop a more constructive interest. *Fourthly*—A thorough understanding between the hospital authorities and the doctors, with a frank cooperative spirit.

9. How can we increase the interest of the profession and the community in hospital standardization?

Ans. Keep hospital standardization before all constantly in its actual application. Use every occasion to carry it home to both the doctors and the people in the community and apply it more strictly in the hospital. The placing of literature in their hands from time to time will help to get the interest worked up. One of the best methods is to have a standardization committee consisting of professional and lay members.

10. Should a monthly medical report be sent to the Board of Directors or trustees and, if so, what should it consist of?

Ans. Yes. Monthly report to the Board of Directors or Trustees should indicate the following:—(a) Volume of work done during the month in each department. (b) Results obtained. (c) Special consideration of,—1. Unimproved; 2. Deaths; 3. Infections or untoward results. (d) Investigation made,—1. Professional care of patients; 2. Administration problems and complaints. (e) Recommendation.

Section "C"—Business

1. Should the hospitals of British Columbia adopt May 12th as National Hospital Day always?

Ans. Yes; as a day of hospital propaganda, inasmuch as

the public needs education on hospital problems and advancement.

2. Should all hospitals publish annual reports?

Ans. Yes.

3. What should be the average charges for the following:— (a) Public wards. (b) Semi-private wards. (c) Private wards. (d) Operating room. (e) Anaesthetic?

Ans. (a) $2.00 to $2.50 per day. (b) $3.00 to $3.50 per day. (c) $4.00 to $6.00 per day. (d) $5.00 to $10.00. (e) $10.00.

4. Should the superintendent of the hospital attend the meetings of the Board of Directors or Trustees?

Ans. Yes. always.

5. Can a common basis be established for the computation of per capita in hospitals so that it may be of some comparative use?

Ans. Yes, if a proper standard of cost-accounting system be established. The basis of per capita could be as follows,—cost of all services to patient, with or without regard for such matters as depreciation, taxes, water rates, sinking fund, interest on investment or other expenditure. A common basis could be worked out in this respect. However, there must be taken into consideration the kind of service that the hospital renders to the patient, this must be more or less uniform.

6. What special econonies are British Columbia hospitals effecting today which are worth while?

Ans. Several hospitals in the province are carrying out certain economies such as—gauze reclamation, linen conservation and reclamation, food conservation, and various other economies which may be touched on in a further round table conference. Further, some of the most valuable assistance to the hospitals during the past year and which has meant a great economy to them has been:—*First*—Produce Day, which is usually set for a day in September, when all the hospitals are recipients of donations from the rural communities, especially of potatoes, fruit and other produce which can be utilized to great advantage by the institjtion. This is an annual day amongst hospitals in British Columbia and during the past year or two has met with splendid response. *Second*—Several hospitals, especially near the fruit districts, put down all their canned fruit for the year; this is carried out usually by the women in the community or the Women's Auxiliary. *Third*—The Women's Auxiliary, as organized in various hos-

pitals, have been most valuable in raising money, supplying linen, equipment and other very necessary supplies for the hospitals.

7. Should staff, other than nurses, live in or out of the hospital, and which is the most economical for the hospital?

Ans. Some hospitals find it more desirable to have all their staff, other than nurses, live out, relieving them thus of a great deal of extra equipment and trouble. However, it is generally conceded that it is more economical to keep the entire staff living in. This is impossible in many hospitals, owing to lack of accommodation.

8. What is the most desirable color scheme for walls and ceilings in a hospital?

Ans. The most desirable color scheme for walls and ceilings in a hospital appears to be a cream or buff shade or light green. In British Columbia where we have a great deal of rain, the light buff or cream walls and ceilings is the most generally used.

9. Can hospital equipment be standardized to the advantage of all our hospitals?

Ans. Yes.

10. Can the hospitals of British Columbia adopt a uniform salary schedule and also a uniform length of vacation with pay for their employees?

Ans. It might not be possible to adopt an absolutely uniform schedule, but one more or less uniform could be arranged with a degree of variation for certain conditions. Such a schedule would serve as valuable information to all our hospitals and would be a working basis for each of them.

Following are the names of officers and Executive Committee of the Association for the ensuing year:—

Officers

Honorary President.—Hon. J. D. MacLean, Victoria.

President.—Dr. H. C. Wrinch, Hazelton.

1st Vice President.—Geo. McGregor, Victoria.

2nd Vice President.—R. A. Bethune, Kamloops.

Secretary—Dr. M. T. MacEachern, Vancouver General Hospital, Vancouver.

Treasurer—Mrs. M. F. Johnson, R.N., 786 Bute Street, Vancouver.

Executive Committee.—Miss E. I. Johns, R. N., Vancouver; Rev. Father O'Boyle, Vancouver; Miss J. F. McKenzie, R.N., Victoria; E. S. Withers, New Westminster; Miss M. P. MacMillan, R.N., Kamloops; Miss L. S. Gray, R.N., Chilliwack; Charles Graham, Cumberland; D. G. Stewart, Prince Rupert; W. E. Wilks, M.D., Nanaimo; G. R. Binger, Kelowna.

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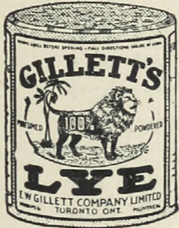

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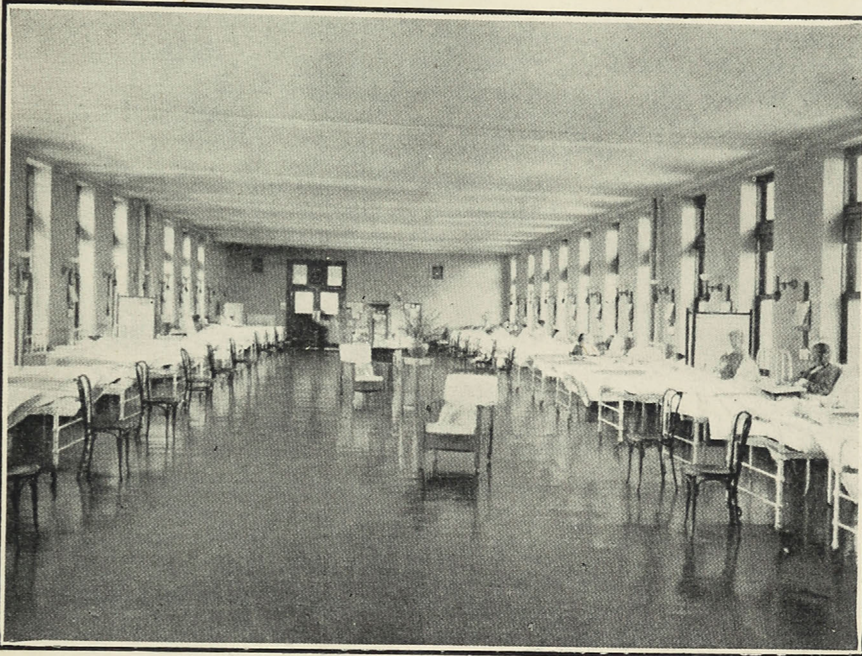

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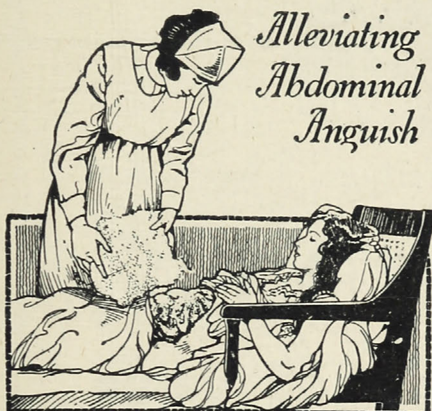

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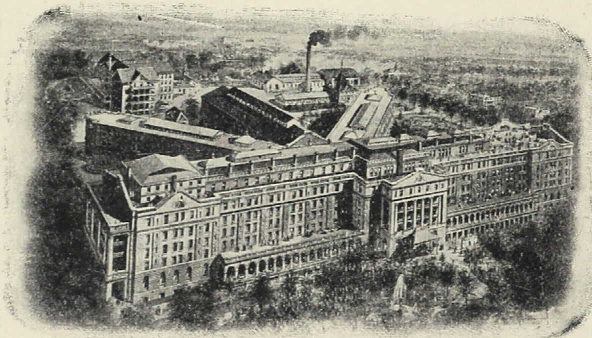

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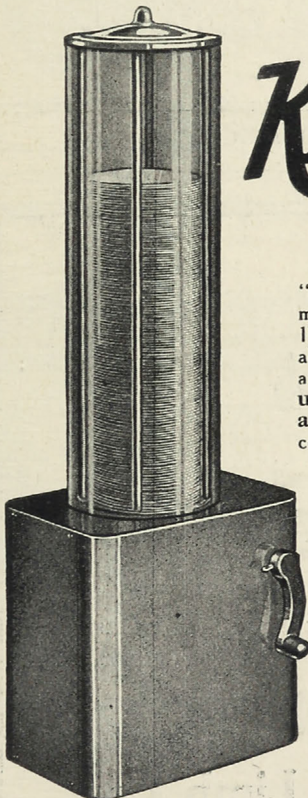

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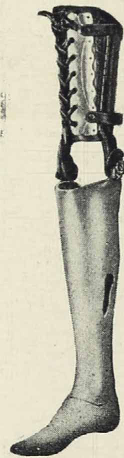

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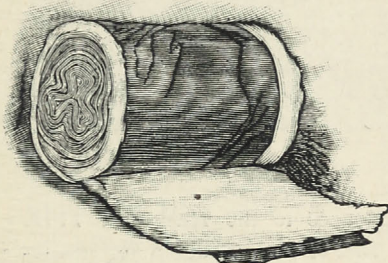

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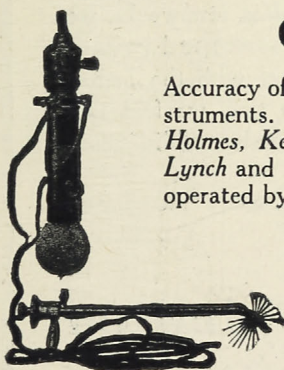

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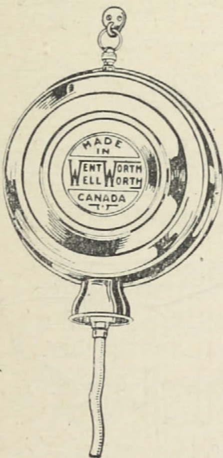

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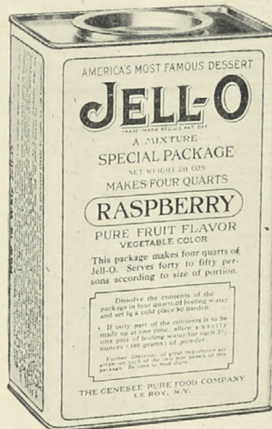

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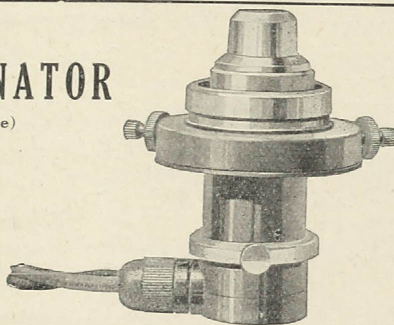

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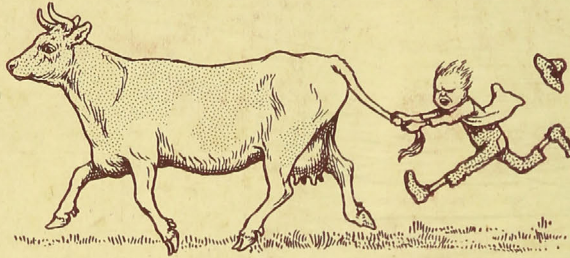

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