DAMAGE TO BOOKS

Readers are reminded that under the provisions of the Canadian Criminal Code any wilful damage to property constitutes a criminal offence for which severe penalties can be inflicted.

Minor damages render the offender liable to a fine of $20.00, and he is also bound to compensate the owner up to a limit of $20.00. Refusal to pay these sums is punished with imprisonment up to two months. (Sections 539-540).

More serious damage can be visited with a term of imprisonment up to two years. (Section 510-E).

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ORIGINAL CONTRIBUTIONS

The Hospital World

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Good Care to the Patient.

In reply to a query from "The Hospital Review" to one of the Editors of this journal, "What Constitutes Good Care to the Patient," he replied as follows:—

Good care for a patient means kind, skilful attention by every individual in the hospital employ, who has to do with the patient and his friends. We include friends, because discourtesy to friends or relatives may react unfavorably upon the patient.

The ambulance porters can create an initial good impression by their gentleness in manner, their voice and general behavior in transferring the patient to the hospital.

The receiving officers, clerks, doctors, nurses and orderlies can express the spirit of the hospital by their attitude and method of handling the incoming guest. If the whole hospital personnel with whom the patient has had contact have done their work properly by the time the patient has been bathed and made comfortable in other ways, he has acquired confidence in the hospital. This state of

mind is necessary if the treatment given is to have the best results.

The interne who takes the patient's history has an important role to fill. He usually gives the preliminary orders, as to diet, medicine and general management. If his manner is pleasant and he demonstrates skill in his examination, added confidence is instilled into the patient's mind.

The neglect of prompt measures of relief for the patient's ailment leads to distrust, opposition and dissatisfaction. The patient's co-operation ought to be gained by early diagnosis and early measures of relief.

The judicious practitioner will try to relieve the patient's anxiety as much as possible, advising him to the proper extent of the nature of his disease and of the measures to be used for his relief.

Good care can be given despite the lack of very elaborate equipment or perfect environment. The spirit of the personnel counts for more than these. Good care, of course, includes clean rooms, clean clothing and bedding, good food daintily served, quiet and absence of fuss. These plus careful nursing and medical skill fill the bill.

In conclusion, good care includes suitable reading, amusements and occupations for the patient.

Finally, the presentation of the account to the proper friend at the proper time is an item that careful administrators give attention to.

Color in Hospitals.

William O. Ludlow writing in the "Modern Hospital," says that we should cover our hospital walls with color, selecting those that give warmth and quiet. In the lobby use sunlight tones, if it is not well-lighted, and duller shades if there is plenty of sunshine. Place in the reception room an Oriental rug, substantial wicker chairs, upholstered with quaint chintzes or cretonnes, with window hangings to match and walls painted to tone in. For wards, halls and operating room, the writer recommends a light, warm, gray tone—buff.

In selecting the color regard must be had to (1) Conserving the light in the room by reflection, for sunlight and electric light are both valuable. (2) The color must be one not too easily soiled. (3) It must not produce eye-strain. (4) It must be agreeable and cheerful to the patient.

Taking buff as a base color, Mr. Ludlow would vary it according to the type of room and orientation. In the wards or private rooms on the north he would mix a little yellow to simulate the sun's glow. In the east and west rooms—buff straight. In the south he would add a little gray and green—making a cooler color. A French gray is very pleasing for southern rooms, particularly if enlivened by window hangings, rugs or furniture showing touches of pink.

Hallways are best painted with sunlight colors —also kitchens, laundries and rooms that do not get abundant sunlight.

In operating rooms a soft olive green five feet wainscot with light colored walls and ceilings has given good satisfaction. A dull French gray tile for the wainscot and a lighter gray above is also good.

Suitable stencil decoration pays, as the eye wearies with too much plain, unbroken surface— some fanciful leaf bands, punctuated by bright berries, or birds and flowers; or, in a children's ward, with quaint animal forms or brownies.

Iron beds painted with light blue, green, buff, and brown are common now. Bureaux, tables and chairs of oak, birch or maple are advisable. Dainty washable hangings at the windows give a home-like atmosphere.

All these things have a therapeutic value in consoling and cheering the mind of the patient, leading it away from its own ennui and burdens.

OBSTETRICS

Dr. J. O. Arnold, of Philadelphia, contributes a fine article in the New York Medical Journal. Among many valuable points he says: "I practically swear every woman patient to follow my instruction absolutely or to discontinue my services. I point out the real dangers from bad eating. The entire food allowance I divide into five equal parts—one to be taken every 3 hours until all are consumed. A liberal variety of nutritious and digestible food is allowed; milk and water only to drink. Five times daily she is given one-half a teaspoonful of bicarbonate of soda or other alkali, such as milk of magnesia—to be increased or decreased according to its effects on the reaction of the urine and her general condition.

Dr. Arnold stresses the importance of diagnosing occipito-posterior positions, and doing trimanual rotation. He also advises the little steritizable metallic cone for frequent stethoscopic examination for betal heart sounds. Gloves he advocates; and likewise rectal examinations only. For asphyxia neonatorum (except pallida) he uses an aspirator, instead of the old custom of slapping, swinging and reflex stimulation. He finds pituitrin valuable in the third stage—a helpful and blood saving procedure; and also for the induction of labor. Dr. Arnold says the efforts everywhere being made to reduce the time and amount of suffering, and to conserve the

maternal energies in labor constitute the most far-reaching and beneficent move in the obstetrical world to-day. So he commends the work of Porter, of Buffalo, who does podalic versim; and of DeLee, who does a prophylactic forceps delivery. Dr. Arnold summarizes his own practise thus:

1. By the use of morphine and scopolamine in sufficient quantity to lessen the severity and usually the length of the first stage.

2. By terminating labor artificially as soon as the first stage is completed by the natural forces; or as soon as it is evident that the natural forces have failed to complete it,—done by giving an anesthetic, applying forceps, bringing down the head (if it is not already on the pelvic floor), doing a good, free, perineotomy, (preferably, lateral oblique), and at once delivering the child.

3. The moment the head is born, an ampoule of pituitrin is given intramuscularly. By the time the child is ready to be handed over to the nurse, the uterus is ready to expel the placenta, either with or without assistance. This is followed immediately by an intramuscular dose of ergot and a hypodermic injection of morphine and atropine.

4. The perineotomy wound is now closed by three or four rows of buried satures, the last of which is a subentaneous silk-worm gut. Great care and skill are required for the proper closing of this wound, is well for its making, but the gratifying re-

sults will amply repay for the time and care thus given. The method of giving the pituitrin and ergot shortens the third stage, saves blood, and, with the morphine, makes little more anesthetic necessary for the wound closure.

Delivery thus accomplished robs labor of its chief terrors, and leaves the patient unafraid of a future frequency.

STORAGE

Hospitals do well to have ample room for storage of foods. This enables the foresighted administrator to buy in quantity when the market is low.

Roots should be bought in the fall when ripe and ready to dig. They should be put away dry in a compartment or compartments with a dirt floor covered with slats. The walls and ceiling should be hollow. There should be windows, usually kept darkened. A ventilator should be put in of sufficient cubical area running from the out-of-doors near the ceiling to within a foot of the floor and provided near the bottom with a damper. This damper should be opened and closed when necessary by some reliable person who will be guided by temperature outside and inside, as indicated by good thermometers. Potatoes, artichokes, carrots and other vegetables may wilt if not inspected frequently. If

this is noted, a barrel of water may be placed in the compartment.

On the other hand too much moisture in the air will cause mildew. A temperature around 35° F., to 40° F will answer fairly well; and the rooms should be kept dark to prevent sprouting. Canned goods do better in a cool dry place. They will stand considerable heat, but deteriorate if they have much of it.

Eggs should be stored in April and May in cold storage, where possible. If that cannot be secured they may be put away in water glass. Where possible secure sterile eggs. Those stored after June should be used first, as they do not keep as well as those packed earlier. Cereals should be kept in a dry place, frequently inspected, and kept in containers which are rat and vermin proof.

Butter and milk should be kept in cold storage. It is advantageous to have a central cold storage which need not be opened too frequently, and refrigerators for daily supplies. In the larger cold storage rooms a double ante-room is an economy, the one nearest the stores, being itself somewhat refrigerated.

All articles for storage should be carefully selected, injured and imperfect specimens being rejected.

CANCER WEEK

All doctors are interested in the further onslaught on their exchequer by the work of the cancer control workers. The Society for Cancer Prevention is doing good initial work. Cancer week—Oct. 30th to Nov. 5th—was specially observed throughout the Dominion. The object of this society is to bring cases of cancer early to the notice of a qualified physician for proper advice, and to prevent them falling into the hands of charlatans. Some 90 prominent doctors are on the directorate. The chief Canadian Director is Dr. Armstrong, of Montreal. Drs. C. J. Hastings and B. P. Watson are directors for Toronto. The Toronto Academy of Medicine had an evening during cancer week devoted to the subject, when Dr. Primrose, Dr. Gaylord, and Dr. Schreiner discussed the question from various standpoints.

The society for the prevention of cancer was established in 1913, and has carried on a propaganda of considerable value. As a result of its efforts in part the death rate from this disease may be said to be stabilized. For every community of 5,000 people a chairman has been appointed in each state of the Union. The desire is to have the same for each Canadian Province. Lecturers on the subject deliver addresses before societies and literature is being distributed. One leaflet is entitled "Vital Facts About Cancer." Appropriate lantern slides and

films are shown between acts at the movies, and these will have a marked educative value. The various health officers in the United States and Canada are taking practical steps to aid the movement. Dr. Hastings, of Toronto, issued a bulletin on cancer during cancer week. Cancer specialists are addressing medical bodies and editors of journals and newspapers are giving publicity to what is being done. The Cancer Society is sending out stacks of literature on the subject. Arrangements are being made with nurse training schools and nursing organizations to take up the matter; also insurance companies; professional groups of welfare and social service workers; manufacturers' associations, church clubs and fraternal societies. Demonstrations are given in certain localities.

Twenty-five years ago concer was looked upon as a fatal malady. Not so now. We know of spontaneous recoveries in human beings. The researches of Gaylord and his assistants resulted in the discovery of about a dozen well authenticated cases of spontaneous cure. These occasional spontaneous recoveries, pointed the way to the four of five foundations of cancer research in the United States. Study of the problem thus far indicates that **Cancer is not one disease.** The idea that it was a single process has held back research for many years. Several types in the lower animals have been discovered. Neoplasms can be produced with different kinds of agents. The successive applica-

tion of tar to the bare skin of mice has produced cutaneous horns, at the base of a small percentage of which epitheliomata have developed. Under certain conditions metastases have been produced. Another group of tumors are the work of parasites—e.g., the worms that attack the bare feet of laborers in Egypt. These enter the system and deposit eggs in the bladder wall with the formation of granulation tissue metamorphosing into sarcomata and carcinomata—true neoplasms. Cancer also occurs among workers in anyline dyes—caused, probably, by chemicals. Then there are types of cancer of the stomach and oesophagus of rats caused by nematode worms. These lead one-half of their lives in cockroaches. In sarcomata in chickens a filterable virus has been isolated and filtered from the tumors—thus exemplifying how an infectious agent can cause neoplasms and death of the animal infected. Thus it cannot longer be said that cancer is caused by an organism."

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AN ADDRESS

BY THE ARCHBISHOP OF CANTERBURY, DELIVERED AT THE ANNUAL SERVICE OF THE INCORPORATED ASSOCIATION OF HOSPITAL OFFICERS.

I wish to take as a text or motto some words which seem to me peculiarly appropriate to gatherings such as this. It is "Christ: from Whom the whole body fitly joined together and compacted by that which every joint supplieth . . . maketh increase of the body unto the building up of itself in love." A vigorous and most capable man—perhaps one of the most notable and vivid personalities in a sordid world—was writing towards the end of his life from a prison in Rome. He was giving a new message to the peoples, or some of them, in the great cities of the world. It was a message about a new beginning—a fresh start for human life; a new proclamation of an universal sort. The letter, the Epistle to the Ephesians, was a circular letter: it was written for others besides the men and women of Ephesus. The message was given at a great crisis—the greatest perhaps till now in the world's history—the hour when the dominant world forces, the culture of Greece, the law and orderliness of Rome, were on the wane, and a new light was flashing across the world from Jerusalem to Antioch, from Antioch to Venice, from Venice to Imperial Rome. The note of the new message was UNITY IN SERVICE. The message which was told in that crisis of human history is again told at this time, certainly the greatest crisis since then, and the people generally should realize it and use their opportunities as many were trying to do.

The gist of that message was that God wished those people who were in earnest to be welded into a society—a body which would be responsible for the welfare of the world; and Christ, in His message given forth by St. Paul, showed us how it was to be done. That message says that we are a part of a society of men, a living pulsing thing: we are fashioning it, or can fashion it, into a stronger force. That society is an organism comprising all varie-

ties of material which go to make up the body corporate. It has one link or bond, one cement which unites it, one Personal example, its living Parent. The sense of His Person is more readily and more constantly felt and expressed by some persons than by others, but if this earnestness, self-sacrifice, and devotion is traced to its very source, remembering the environment in which workers are placed to-day and the beginnings of that environment, its most vital centre will be found to be in the life and human environment of Christ, from whom the whole world, fitly joined together, and compacted by that which every joint supplieth, maketh increase of the body unto the building up of itself in love. That was the message of the scarred, travel-worn, eager old man nearly nineteen hundred years ago. It came flashing into those busy, crowded, slave-cursed cities of the Mediterranean—the cities of the Roman Empire.

That seems far away from us gathered in London under conditions so different, gathered apart in our human work and activity. But it is not apart, it is close. The principle which that far-seeing message laid down still holds good. There is a corporate loyalty now to that example which St. Paul gave, a fellowship, a devotion to service on the lines he set down. There is a coherence on that basis, a coherence even of those men and women who do not regard themselves as being specially religious, either in origin or character. They are not apart, but a part. That is the root of the counsel. The society comprises all sorts of people; in some lands it may have a national character.

I remember reading a lecture delivered at the Royal College of Surgeons by Sir James Paget sixty or seventy years ago. Its theme was the place of an active, recuperative, repairing agency which exists in every human body, and the power of that agency to make good all sorts of injuries, even those which were rare and not to be expected. It has often seemed to me that the picture—of which I am not capable of estimating the value in its technical sense—drawn by a master hand, of something resident in the human body, corresponded very much to the place of our hospitals in the body of the community as a whole. Paget

called it the gospel of repair and recuperation, something which was of use in our necessities and in our troubles.

We have passed through a war far and away unparalleled in its horrors in the story of the human race. I suppose it is true to say that never was there at one time so vast a number of maimed and hurt people as there is to-day. Certainly there has never been so vast arrangements for their relief. That is an object lesson patent to us everywhere. Hundreds of thousands of men will live the rest of their lives with the thought upon them of what these years of suffering and of the treatment of their suffering has meant for them. It is a new experience in the life of our citizens which they never thought to go through. With that experience we are going to make a new start in the national and international life. And with those memories and thoughts upon us we are going to make use of them for good; become more active, more coherent, more hopeful and expectant in our common life "compacted by that which every joint supplieth." Especially does this apply to such work as that which unites us here to-day. I dare not say for a moment that there is only one way in which a united, compact action can be taken, but I do believe it to be true that all wise effort of this sort can be traced back to one great source. Speaking generally, the workers of the land are loyal to the principles which Christ taught in His life and in His death, the principle of service to the weak, service to the needy. St. John, years after the death of Christ, looking back on the past, said, "Whoso hath this world's goods and seeth his brother have need" (of any of the bodily, mental, or spiritual requirements) "and shutteth up his compassion from him, how dwelleth the love of God in him?"

With these thoughts let us see that the recuperative force which, in our hospitals, lay at the centre, remain as effective, as strong, as potent for body, mind, and soul as we can make it. For that purpose we are compacted into one body: each set of people bears its part, "making increase of the body," making the whole structure stronger, "by the building up of itself in

love." This love will tell in outward acts; let us resolve to make as efficient as we can that great recuperative force, the gospel of re-education and amelioration, and see that it is exemplified in our outward life in the hospital system. So we can go forth to-day with those memories upon us, to work freely, ever bearing in mind the words "freely ye have received, freely give."

STATE OR MUNICIPAL CONTROL OF HOSPITALS VS. VOLUNTARYISM

MR. H. F. SHRIMPTON.

The startling announcement recently made by the *Daily Express* on the subject of "A Ministry of Public Health" gave some broad details of a scheme which would throw the whole medical system of the country in the melting pot, and the taking over by the State of the established voluntary and poor-law hospitals. The scheme aimed at "nothing less than the nationalization of the medical profession, involving free medical attendance for all without any element of charity."

Though the positive statement so circulated was, in an official sense, premature and unauthorized, it is not to be dismissed merely as unfounded. The War Cabinet are understood to have sanctioned not only the principles, but the details, of a scheme. The preparation of that scheme was one of Lord Rhondda's chief activities during his six months' tenure of the Presidency of the Local Government Board, and he was loth to leave this position until he had seen his plan adopted. It was, however, taken up by Mr. Hayes Fisher, his successor, and its approval by the Cabinet would have secured its prompt adoption but for the conflicting and varied interests involved, which have, for the time being, held up the whole idea.

At the outset it must be stated that the subject is not new; in the middle of the last century a "General Board of Health"

was in active operation as one of the Government departments. Aften ten years of service (1848-1858) this Board was abolished owing to difficulties which then arose, and the functions it exercised were distributed. The idea of recombining the administration of public health work, and collecting it under one department, was in 1883, revived, and was undertaken by the Sanitary Institute.

For three years (from 1890-1892) a Commission of the House of Lords sat to enquire into questions of hospital relief and medical education in London. That Commission made a very valuable report and certain recommendations, the main one being that a Board should be officially established which would bring together all the various agencies for the treatment of the sick-poor.

The achievements of the voluntary hospitals during the past two centuries is a glorious page of history, but changing conditions seem to call for readjustment of present methods, and by the suggested "Ministry of Public Health" the stability and efficiency of hospital support which at present prevails will be put to the test. Many problems have to be faced, and I take it the object of the debate to-night is to find out what present problems it will solve, what new problems it will create, and to ascertain if the time be ripe for the adoption of a scheme which is so far-reaching and of such a revolutionary character.

One of the most important questions which has engaged the attention of hospital managers for many years past has been "Hospital Abuse and its Cure," and this is undoubtedly one of the problems which would be solved.

The sick man whose illness cannot be successfully treated at home has but two alternatives—the public hospital or a private nursing home. With the two extremes of society there is no difficulty: the rich man has a choice of nursing homes and the poor man has the hospital; but the middle-class man is driven to the hospital through force of circumstances in the absence of provision appropriate to his measure of ability to pay, as, should he choose the private nursing home, he would be crippled financially by the

strain upon his limited resources. The reorganization of medical relief on such a plan as has been indicated would conserve the interests of all, and yet preserve personal independence and self-respect.

There is, of course, the ethical question of the independence of the individual as regards the State, but State aid does not—or should not—imply impoverishment. The assumption that degradation of character is going on owing to State aid is a pre-supposition that it is well to examine. In the matter of education State control brought about a better condition and yet maintained independence.

The medical staffs, too, would feel that they were neither bestowing their generosity on the undeserving, nor indirectly contributing to the impoverishment of their professional colleagues in general practice.

The nationalization of hospitals would open up facilities for communication, enabling doctors in the country to send cases to the hospitals which originally they had been compelled to treat themselves. In this way the hospitals would become centres, open to rich and poor alike, for the exercise of the greatest medical skill that a great city can command.

"Free medical attendance for all without any element of charity" would not mean the reducing of voluntary hospital work to the present level of the poor law infirmary, with admission by a relieving officer through the workhouse.

Hospitals would be the embodiment of the highest attributes; their educational functions would remain unimpaired, and the medical profession would be able to regard them as valued allies in special cases instead of looking upon them as competitors.

This opens up another problem—the question of payment for professional services. Looking at the question from a broad point of view, it seems obvious that every professional man should be paid adequately for his services either in a hospital or elsewhere.

A great deal is possible by co-operation, and the consolidation of the public health administration of the country which would be brought about by this change would mean that there would be no overlapping. The evils and the waste of the overlapping and duplication of the poor law and the public health medical services, of the general hospitals and the special hospitals, are so gross that it is inevitable that they must sooner or later be merged.

The competition of hospitals for funds, which is a terrible responsibility to those who are managing the hospitals, would be abolished, as also would competition in other directions, and this would create a better condition inasmuch as all would be working together for one common good.

Not the least important achievement of the scheme would be uniformity of practice in all hospitals and a uniform system of medical relief for all.

Free and easy methods as to admissions, attendance, buying, catering and control would not be possible under State inspection.

Hospitals under the State would mean a sufficient provision of beds to meet the needs of the community. The question of the large waiting lists has become so pressing that Parliament has been asked to institute a Committee of Enquiry into the working of the hospital system of the country on the ground that the care of civilians in sickness or accident can no longer be left to voluntary institutions which, even before the war, were unable to cope with the demands made upon them.

In this connection it must be emphasized that hospitals in the past have met the demands for increased accommodation by waves of philanthropy, but the fitful and uncertain character of voluntary giving is too largely dependent upon emotion and varying interest to be an entirely reliable source of income. It seems unfair, too, that one class alone should maintain an institution in which all have a vital interest.

With the great changes which legislative enactments have brought about in the medical examination of school children,

State insurance, the Tuberculosis Act, and the Venereal Diseases Act, together with the great increase in population, there is reason to believe that the voluntary system will fail to meet with anything like adequacy the approaching demand for increased hospital accommodation.

In a paper by Dr. Hume, read at a conference at Newcastle in 1914, he states that "unsurpassed as our hospitals are as clinical schools, they are lagging far behind those of other countries in the means of scientific training. The chief reason for this is want of funds, and it is a question how far this want is likely to be remedied so long as the resources of the hospital are derived from an exclusive reliance upon voluntary support.

In the analysis of the change of conditions which call for a readjustment of present methods, it will be well to ascertain if the time be ripe for this drastic measure. The most significant change which has in the last few years shown itself is the growing reluctance of the voluntary subscriber to give to hospitals, and undoubtedly he has become influenced by the alteration of position and attitude on the part of the recipients of hospital benefits, and he has become distrustful of the future of the trend of recent legislation. Hospitals, too, are showing a change in character. Paying wards are not uncommon and grants for treatment given are accepted. They are not therefore dependent exclusively upon voluntary support. There is also a change in the attitude of the patient—the claimant for treatment is more exacting and more desirous for free treatment. Mr. E. W. Morris, the house governor of the London Hospital, well describes this change. He says "There is a change in character and a change in social state.

"As to the poor patient's change in character, he by no means looks upon himself as a 'miserable object.' He is probably a member of some trade union. He joins associations to resist the power of the rich. He is perhaps a Socialist. He has his own member of Parliament. He does not accept favors; he claims rights. His tendency is to claim free healing as he claims free education for his children, and free food and old age pensions.

"As to the change in social status. The sick-poor of our modern hospitals is often a person who is not poor except to meet sickness; he cannot possibly afford the heavy expenses of modern methods of healing, whether medical or surgical, so he has gradually drifted to the hospitals, where such skilled attention could be had for the asking. He came at first with some diffidence, but this is now getting somewhat threadbare; he accepts the state of things as he finds it. The necessity for laying by for sickness or of insuring against sickness becomes less and less; he takes the free relief in sickness into consideration when making up his annual budget . . . . He does not take his blessings as a right; he has simply grown used to the existing state of things and accepts them without question."

The findings of the Poor Law Commission in its report show that the poor law, on its side, has been obliged to provide for the sick on a scale continually advancing with the standard care for the sick. There is a change then at the poor law infirmary; we all recognize there is a change at the hospitals. The advance made is evident and remarkable; administration has progressed with the advance of medical science. This surely implies the necessity of reorganization both on the part of the hospitals, the poor law infirmaries, and the profession generally.

The State has a duty to perform to its citizens, and the foremost duty must surely be in the direction of maintaining healthy citizens. A great deal of disease being preventable, it would be the business of a ministry of health to see that people were maintained in a state of health rather than to cure a diseased community. The State demands that we shall be provided with an education, it controls the quality of our food; is it not fair therefore to expect that it should provide the means of access to health?

THE HOSPITALS OF COLOGNE

A PAPER READ BEFORE THE INCORPORATED ASSOCIATION OF HOSPITAL OFFICERS BY MR. E. S. DARMODY.

It is always supposed in a general way that the hospitals of Germany are supported out of the rates and taxes and the hospitals of Great Britain by voluntary contributions. This supposition, however, requires modification. In England, for example, only a minority of beds are housed in privately-maintained hospitals, although incomparably the more important fraction. In Germany, on the other hand, contrary to general belief, the philanthropic hospital is by no means unknown. In Cologne the proportion of private beds is at its highest. In the year 1907 there were in the whole town 4,152 hospital beds for civilians. Out of these, 2,384, or 58 per cent., were municipal and 1,768, or 42 per cent., charitable. The public beds were contained in six hospitals, four of which were general, one ophthalmic and one children's. The last, although administered by the municipality, is the gift of private generosity. The private beds were distributed among fourteen hospitals. Of these twelve are maintained by various Roman Catholic orders, and one each by the Protestant and the Jewish congregations respectively. All these admit patients irrespective of creed.

Figures for the year 1907 are given, since in that year the municipality published, on the occasion of a visit from the doctors and scientists of Germany to Cologne, a volume containing descriptions of the principal institutions of the town.

But though England and Germany are alike in possessing both public and private hospitals, yet there are differences between the former and the latter in either country that are interesting to note. England is the home of the enthusiastic amateur, Germany of the trained professional.

First, to take the public hospitals. The difference between city government in the two countries is so great that a short sketch of German municipal organization must be attempted. Let us suppose a town council consists of 100 members. Each political party con-

testing the election prepares a list of 100 candidates, placing them in order of its own preference. The voters have one vote apiece, which they give not for individual but for one of the several lists. The votes are counted. Say one party secures 60 per cent. of the votes, the first sixty of its candidates are elected, another party 25 per cent., twenty-five of its list obtain seats, and so on.

The town council has the power to appoint its chief magistrate, the *burgermeister*. This dignitary is not one of the elected members of the council, as is nearly always the case in England. He is a trained civil servant, and is paid a good salary by the town. He is both the servant and the master of his employers. Once appointed he becomes a sort of mayor and town clerk rolled into one. He presides at meetings of the council and votes, and he is also the chief executive officer. His appointment is for twelve years and he can be reappointed or not as the council please. On the other hand, he may, before the expiry of his period, apply for appointment perhaps of a larger town, or he may be selected by the central government to be *oberpresident* of a province or even a cabinet minister. The *burgermeister* appoints the heads of his departments, officials who correspond to the borough surveyor, treasurer, education officer, or medical officer of health. Each of these assessors has a seat and vote, although they are salaried officials of the body of whom they are servants, and each one is chairman of the committee of the council which deals with his department. The official under whom the town hospitals are placed is sometimes a lawyer and sometimes a medical man. The hospitals committee, or *deputation* as it is called, is composed partly of members of the council and partly of citizens of the town, not members of council, known to be experts or interested in the subject, nominated by the *burgermeister*. When this joint committee meets the medical director and the lay director of each of the town hospitals attend. They are allowed to speak but not to vote.

For each hospital there is a sub-committee (*curatorium*) but this consists of four persons only. One medical and one lay member from the deputation with the medical and lay directors of the hospital. Both the *deputation* and the *curatorium* only

meet when required. They have no periodical sittings. The actual day-to-day administration is carried on by the medical director (*leitender artz*) and the lay director (*verwalter*). The medical director corresponds to our senior physician or senior surgeon as the case may be, but he is responsible for a vast amount of administrative work in addition. There is no medical committee. The medical director may consult his colleagues informally, and usually does so, but he is by no means bound to follow their advice. The *verwalter*, or lay director, is the equivalent of our secretary, superintendent or house governor, and performs almost identical duties save that in the case of town hospitals he is relieved of the duty of money raising. He more often resides in hospital in Germany than in Great Britain. He is usually a man who has passed his whole working life in hospital service. Of late years there has been an agitation among the doctors' union that the post should be filled by some one with medical qualifications. Some large hospitals possess a medical *verwalter* who then resembles the medical superintendents of the Scottish hospitals. I was informed, however, that the municipal authorities do not look with favor on this arrangement, but prefer for the post a man with purely administrative or business training.

The charitable hospitals are organized on exactly similar lines as the municipal hospitals except that the place of the town council is taken by a committee of management, and the task of raising money falls upon the lay authorities. The committee, however, appears to play a very much less important part in the affairs of a German than an English voluntary hospital, and the business of money-raising is immensely lightened by the insurance system and the universal practice of taking paying patients. Only sufficient funds are needed to provide the difference between the total expenditure and the payments made on behalf of insured persons, and the fees of those who prefer treatment in a hospital rather than in a nursing-home.

A question which naturally occurs perhaps at this point is: What are the relationships between the voluntary and the municipal hospitals? So far as I, a stranger, could observe, the two systems

seemed to live alongside one another quite harmoniously. The municipal authorities were evidently grateful for their services and in no way jealous or anxious to encroach upon them. The officials of the voluntary hospitals look up to the town hospitals as being magnificent examples of their kind, as, indeed, they are, although they privately hold, I believe, the opinion that voluntary hospitals can be run as efficiently and more economically on account of the absence of bureaucratism. As regards the cost of maintenance and administration of private institutions, I find it almost impossible to get any figures. The income and expenditure of the town hospitals is given with satisfactory fulness, but in the case of the voluntary hospitals, with the exception of a few figures on the cost of building, no information is given as to finance. Whereas in Great Britain the publication of full and clear accounts is, so to speak, the corner-stone of the voluntary system, in Germany neither hospital nor public seem to expect a financial statement. Contrariwise, inspection by a Government official, which is regarded as such a bugbear by English voluntary hospitals, is accepted by the German charitable institutions as the most natural thing in the world, while the public look on it as a reasonable safeguard of their interests.

The inspecting officer is an official of the province, an area of local government higher than that of the city, next below, in fact to the Central Government. This official inspects both municipal and voluntary hospitals alike, and I was told his inspection was exceedingly thorough. In addition to the responsibility of inspection, the province provides lunatic asylums and sanatoria for tuberculous and nervous cases. The town hospitals restrict themselves to the treatment of acute disease.

I had intended to confine this paper more or less to the administrative side of hospital work, but it is impossible to close without saying a word about the nursing.

The outline of administration that I have given may perhaps suggest a bureaucratic system even in the philanthropic hospitals, in which much power is intrusted to individuals and to officials, in which a danger might lurk that convenience of administration

might be put prior to the claims of the patients. The guarantee against this is, I think, at any rate in the mind of the public, the fact that the nursing is in the hands of religious sisterhoods. Each Roman Catholic Hospital is nursed by members of the order which founds and maintains it, and one order supplies sisters for all the municipal hospitals. The Protestant hospital is nursed by deaconesses, and the Jewish hospital has an institute for training nurses of its own persuasion. The course of training in German lasts only one year, and at the end of that they are usually capable of passing the State examination. Naturally their learning does not cease after their examination. A devoted and enthusiastic woman can continue to learn for the rest of her career. But, even making allowances for this consideration, I do not think I shall be guilty of national prejudice when I state my belief that the standard of English nursing is superior to that of Germany. In fact, the small number of nurses in the German hospitals puts nursing, according to British notions, out of the question. For the 4,152 beds of Cologne there are only 882 nurses, which works out at 0.21 nurse per bed. Nevertheless, the fact that these women or men have adopted their profession out of the highest religious motives inspires confidence in the public. It supplies that spirit that otherwise might be wanting which supporters of the voluntary hospital believe animates their system.

In this brief description stress has been laid on the points of difference, but naturally in organizations which have the same object in view, the healing of the sick, the points of resemblance are very much more numerous. A hospital officer of either nationality would very speedily find himself at home in the work of the hospital of what to him was the foreign country.

DO OUR HOSPITALS COST TOO MUCH MONEY?

"My cases never did better than in the old hospital plastered with mud," said Lientenant-Colonel Henry Smith, celebrated surgeon and eye specialist, when he addressed the Toronto Academy of Medicine at the University of Toronto recently. Dr. Smith

explained how he had conducted a hospital in India on $4,000 a year with 600 surgical beds filled four months in the year. In the interests of economy he had dispensed with the cook-house, which he had found a fruitful source of graft. Bedding, hospital uniforms and highly medicated dressings had been discarded next, for the bedding and clothing brought by the patients and for raw cotton bought at two cents a pound. Dr. Smith's address was of a technical nature throughout, dealing with many remarkable surgical cases handled by him during his long and highly successful career in India, but in conclusion he said, "the point I wish to press is that the increase in ritual in hospitals does not imply increase in efficiency in the treatment of disease."

Corroboration of this point of view comes in a chapter devoted to "Primitive Surgery," in a book "Among the Hill Tribes of Algeria," recently published by M. W. Hilton-Simpson of London, England. The operation of trepanning, a delicate bit of brain surgery, is often successfully performed by the surgeons in this region who have nothing but the most primitive tools, who know nothing of antiseptic surgery, and pay no attention to even the most elementary rules of cleanliness.

Mr. Hilton-Simpson says:

"Let the reader imagine the interior of an ordinary dark and dirty stone hut.

"In a corner of it, upon a heap of mats, rugs or old sacks, lies the patient, surrounded by friends who have come in to help the surgeon, awaiting in his own home the arrival of the practitioner who has been summoned from some neighboring village to attend him, for by no means every hamlet can boast of a doctor among its inhabitants. A fire glows upon the hearth tended by some of the women of the family, others of whom are busy tearing up strips of cotton dress material to serve as bandages, preparing bowls of water or, if they be skilled in the requirements of a Shawia sick room, melting the butter and honey which the doctor will almost certainly require for his dressings.

"Presently the great man arrives accompanied by one or more of his pupils.

"A preliminary examination having shown him that an immediate operation should be performed, the doctor produces from a leathern wallet provided with several pockets, which he is wearing slung over his shoulder, beneath his cloak, the few simple instruments he will require and selects the one with which he will commence his task. The European spectator will note when the surgeon commence to use his drill that not only does he seem to disregard even the most elementary principles of surgical cleanliness as understood in Europe, but that he does not even attempt to wash his instruments before use.

"I have frequently questioned Shawia doctors upon this point, and have always received the reply that they clean their instruments after use only, and then merely by washing them in any water, cold or hot, which may be available.

"An operation having been completed, a dressing of honey, butter, and certain powdered herbs is applied to the part, which is then covered with a pad of sheep's wool held in place by dirty strips of the dress material provided by the patient's household."

This sort of surgical operation is not "good enough" you say? Admitted. But in coming away from these primitive methods of healing, have we not come too far and at too great a price?

Last year, if the taxpayer in Toronto had met his bills for hospitals through a direct tax, he would have had to pay not much less than $2,5000,000 for these public utilities, of which nearly $1,5000 000 would have gone to the upkeep of the General Hospital alone, as the total operating costs of that institution for inside and outside services in the year 1920 amounted to $941,761 00. The cost per patient per day in Toronto General Hospital is $3.41, a figure rather higher than that of many other hospitals in Ontario, but justified by the claim of its managers that "it gives a better service." That it gives a great service cannot be disputed, when it is known that over 6,000 out-patients per month pass through its clinics, that last year there were 70,000 preventive treatments administered, and that the cost of the public wards alone

was $229,000 more than the amount provided by the municipal or provincial governments, a deficit which is made up in part through the profits from private wards and from the proceeds of paid subscriptions to the hospital.

But in 1920 the total excess of costs over revenues was $225,313.66. Revenues for this as well as most general hospitals in Ontario are derived from city, provincial and federal grants, from private subscriptions, from the fees of paying patients, from income from any property held, and from special grants, such as the $146,000 paid by the Dominion government to the Toronto General Hospital in 1920, or from other governing bodies which are approached when the apparently inevitable deficit appears.

In a word, hospital expenses, whether in the General or other public hospitals, come in the long run, and in very large measure, from the pockets of the taxpayer, a statement equally true whether the tax is known as a tax, is called a subscription, a tag day fee, or a hospital collection in the churches.

The total expenditure in Ontario on hospitals in 1919 was $6,346,707.59. Last year this sum presumably was increased, but the figures are not available.

How much of such expenditures go into unnecessary "ritual" such as that referred to by Lieut.-Col. Henry Smith.

In the year 1919, in one of the largest hospitals in Ontario, medical and surgical appliances, bandages, etc., cost, according to government report, $36,682.83, surgical instruments $7,971.73; bedding, napery and general house furnishings, with patients' clothing, $37,964.45; laundry supplies, brooms, mops, brushes, soap and other cleaning materials, $11,168.31; nurses' uniforms, $1,059.75; while salaries and wages totalled $283,316.02.

No one would suggest for a moment that all of these expenditures or a very great proportion were for unproductive ritual. But is not modern healing as conducted in general hospitals too expensive to the taxpayer, too high-priced for the paying patient, and of too "charitable" a character for the public patient considering that so high a percentage of the cost of upkeep of hospitals is a direct tax on the general public?

TORONTO HOSPITAL FOR INCURABLES

The forty-seventh annual meeting of the Toronto Hospital for Incurables was held on October 24th, at 130 Dunn Avenue, and was marked by encouraging reports, by interesting reminiscences and by a cheerful looking forward to the future.

The presence of his Honor, the Lieut.-Governor had been anticipated with a great deal of pleasure, but Colonel Fraser read a letter from him expressing regret at his inability to attend the meeting owing to the illness of Mrs. Cockshutt.

In his Chairman's address Mr. Ambrose Kent referred to the day of small things, when the Home for Incurables in Bathurst Street contained six beds. Later the Dunn Avenue property was bought, and the building there accommodated at first only 30 beds. Today there is room for 250 patients. Twenty years ago it cost $20,000 for maintenance, whereas this year the price of maintenance was $169,541. Within the last few years, Mr. Kent said, there had been many bequests, and the interest on these legacies amounted this year to $6,662, this sum being applied to the maintenance account. The devotion of the board was also referred to by the Chairman, who stated that in 20 years a quorum had never been lacking at the monthly Executive meetings.

Dr. Edmund E. King, in presenting the report of the Medical Board, told of 224 patients at present in hospital, 90 of whom are bed patients. He paid a tribute to the efficiency of the nurses, and spoke of the trouble caused by well-meaning people sending boxes to the patients containing eatables that are unsuitable to their diet.

The Superintendent, Miss Cook, in her report, told of the many kindnesses shown the patients by friends of the institution, and referred to the pleasure the afflicted ones derive from various kinds of handwork. At the National Exhibition the patients carried off two special prizes, five firsts, one second, one third and one fourth.

The report of the Secretary-Treasurer, Miss Groat, revealed a deficit of $6,903.83, as compared with one at the beginning of the institution's year of $21,589.65. Expenses amounted to $154,-

872.84, as compared with $142,003.10 in 1920. During the year 98 patients were admitted, 55 men and 43 women; 24 were discharged and there were 67 deaths.

The Hon. W. A. Charlton moved the adoption of reports, and Judge Mott seconded the motion, after which Rev. Dr. G. H. Williams gave a brief closing address.

Among those present was the oldest member of the Board of Management, Mrs. Grant Macdonald, who wore a beautiful corsage bouquet of roses and violets, presented to her by the oldest patient in the hospital.

HOSPITALS IN RUSSIA

Mr. Charles Richard Crane, an old Russian traveller who recently visited Russia states that it took him three months to go from Pekin to Prague. In an interview in the *Observer*, he says:

"During my three months' journey I was on all kinds of trains, sometimes on freight trains, at others on hospital trains, but never on fast passenger trains. The fast passenger trains are only for officials. Private people are prevented from travelling. I saw no materials being transported except military material.

"Round the railway stations there were always crowds of refugees. Whenever a train came in, especially if it were a freight train, there would be a great struggle to get on it, some going east and some going west, all wanting to go somewhere else, on the theory that any place must be better than the one they were in.

"There is no surplus of supplies anywhere, and nothing is produced for export to any distance. Industry has stopped almost entirely. Only a few plants here and there are running in a half-hearted kind of way. There is a great shortage of material, and in the basin of the Don there is not a pound of coal, and not a single man at work. One of the worst places this winter will be

Petrograd. It is a neglected town, not in an agricultural district, and it is very short of food and of wood.

"Nowhere is there any medicine. I saw one of the oldest physicians in Moscow, and he told me that until about two years ago he used to write prescriptions, just as the Bolsheviks issue tickets for food, it being up to the patient to find his medicine. But at last he got tired of the insincerity of this practice, and he does not know whether he will ever be able to write a prescription again. The only medicine I saw in all Russia was in Siberia, and that was old Red Cross stock, and was fast being used up.

"Hospitals are no longer anything but mere buildings. There is nothing in them—no soap, or medicine, or linen, or bedding, or anything else. For twelve days I travelled on a hospital train with soldiers from the Mongolian front, and following them into hospitals and saw the kind of attention they received. The poor people in the hospital did the best they could for them, but there was nothing of any kind for their use, except the merest fragments of things. The Red Army is now very full of scurvy, and I was told that there is a very great deal of tuberculosis.

"The whole situation, in fact, is getting worse and worse. Every day transport becomes more uncertain, and every day part of the rolling stock disappears. The problem of distributing supplies is going to be extremely serious. I think the only possible channels of relief are Petrograd and the Black Sea ports which are nearest to the famine area."

IS TORONTO'S PUBLIC HOSPITAL ACCOMMODATION SUFFICIENT FOR TORONTO'S NEEDS?

Hospital Accommodation Statistics of Other Cities

afford no sure standard to apply to Toronto conditions, but they may throw some light on Toronto's hospital problem. Smaller cities, as they are not so apt to have private hospitals, should naturally show a greater number of beds in public hospitals than

larger cities. Communities which are largely residential or commercial should not be expected to have as great public hospital capacity as should industrial communities. Some cities have more highly developed departments of Public Health than others, and might naturally be expected to require fewer public hospital beds. Some cities provide greater service in out-patient department than others, and might be expected, therefore, to require less in-patient accommodation.

NUMBER OF BEDS PER 1000 POPULATION (FOR THE YEAR 1919) IN SOME CANADIAN AND AMERICAN CITIES

Toronto	4.6	Detroit	4.2
Brantford	5.2	Cleveland	4.9
Victoria	6.3	Philadelphia	5.
Hamilton	7.3	New York	5.4
Ottawa	9.1	Buffalo	6.
Guelph	9.9	Chicago	6.
Chatham	11.6	Pittsburg	7.2
Vancouver	13.8	Cincinnati	7.5
London	14.8	Boston	8.3
Port Arthur	16.7		
Brockville	17.2		
Kingston	19.4		

Figures for American cities taken from Bulletin of Detroit Bureau of Governmental Research.

WHETHER A COMMUNITY'S HOSPITAL ACCOMMODATION CONFORMS TO THE COMMUNITY'S HOSPITAL NEEDS

is, however, not only a matter of quantity but of the adaptation of the plant to the various needs. With this in mind, the Bureau attempted to make an analysis of the Hospital Census of six public General Hospitals in Toronto, on a certain selected day in 1921. It was possible, however, to get sufficient complete data from two only. The hospital population on the day chosen, in the two hospitals, was almost at the peak.

Of the total number of beds in these two General Hospitals. 87.3 *per cent.* (x) *were occupied, but of those occupied* 15.9 *per cent.* * *were occupied by Cronic cases and* 14.1 *per cent.* * *were occupied by Convalescent cases.*

That is, only 70 *per cent. of the occupied beds, were occupied by acute cases, which are the only cases which should be found in a General Hospital.*

can be cared for much more effectively and economically in hospitals built, equipped and staffed for the purpose of treating chronic and convalescent patients.

The capital costs and per diem operating costs of such hospitals are much less than for a hospital treating acute cases. Moreover, the presence of chronic and convalescent cases in a general hospital detracts from the efficiency of the treatment of acute cases. There is, of course, some accommodation for chronic cases in Toronto, but that it is quite insufficient is well known to all Public Hospitals which, in the interests of humanity, are compelled to accept many chronic cases for whom there is no room elsewhere.

The treatment of chronic cases in expensive hospitals for acute cases, is a serious financial drain on the community, as the per diem for the former should naturally be much less than for the latter.

There are almost no facilities for the care of convalescent cases outside of General Hospitals, except an extremely small number of beds in private hospitals. Frequently convalescent patients cannot be sent home and, as there is no other proper place to send them, they must be kept in a general hospital, at a rate based on General Hospital costs, although recovery would usually be much more rapid in a properly equipped convalescent hospital. As is always the case, the community pays the bill for inadequate community planning.

Do We Need More Public General Hospitals?

If all the public hospitals at all periods of the year, have a percentage of chronic and convalescent patients approaching that of the two hospitals studied, on the day chosen, it would seem certain that there is at present, and will be for some time in the future, ample general hospital accommodation.

The proper policy would seem to be not to build sufficient general hospitals to hold all acute, chronic and convalescent cases,

but to reserve the general hospitals for acute cases—thus leaving a large margin for expansion within the present plant—to provide facilities for convalescent treatment in a specialized hospital and to secure additional facilities for chronic cases. This would be much less expensive both in capital and current costs. (*Bureau of Municipal Research.*)

(x) Owing to the fact that not all beds in hospitals can be used for all types of sickness a certain number of beds will normally always be vacant in spite of any measures which may be taken. Any plans for adequate hospitalization must, therefore, take into account a fair allowance for this margin of vacant, but not available, beds.

* (These percentages are much larger, if beds in public wards only are considered).

WASTE IN THE KITCHEN

BRITISH housewives' cooking methods were trenchantly criticised by Dr. Drinkwater in an address to the members of the Edinburgh Rotary Club. There was at present, he said, a good deal of talk about waste, but it always struck him that there was a great amount of waste connected with the kitchen range, not only in the unnecessary piling on of coals, but in the unscientific cooking of food. British cooking methods were the most unscientific in the whole of Europe. To a great extent he blamed the cookery books. We had not, in this country, scientific cookery books. The old classification of food into flesh formers, heat producers, and bone formers had now to go. Modern research had shown there was no such thing as a heat producer or a flesh former or a bone former—all foods came under all three headings. Chemical analysis of food was of no use. It told you the composition of the food; but you had to know also whether or not it could be assimilated by the body. The egg was a valuable food. In the ordinary way an egg was boiled for three and a half minutes. What was the result? The white was hard and the yolk was soft. The white was coagulated and insoluble and therefore could not be assimilated. They had the same thing in meat, which to all intents and purposes was the white por-

tion of an egg. Let them apply science to the cooking of an egg. Take it and put it into a pint of boiling water. The water was not to be allowed to remain on the fire, but removed at once and covered up with a cosy. In a quarter of an hour or twenty minutes the egg would be properly cooked. It had never, during the process, been heated to the boiling point of water, and the result was that the white was not coagulated and could be quite easily assimilated. In the same way meat got heated up under the ordinary process until the outside got hard. The albumen of the roast was coagulated, and had a brown appearance. Meat should not be brown. It should have the albumen in its proper condition. They could not do that if they roasted the meat at a temperature above 200 degrees. If they cooked the joint so that the red juices exuded the whole nitrogenous matter would be absorbed into the body. They would find that a joint went very much further cooked at the lower temperature.

They had heard a good deal in the last few years about the hay box. It was the outcome of the Norwegian cooking pot. He examined for many years for the Government diploma in cookery, and some years ago someone in Edinburgh was interested in supplying food to Volunteer camps in a proper way. Several experiments were tried. One morning they put into this Norwegian pot at eight o'clock a chicken, some bacon, and vegetables. At four o'clock they opened the box. The fowl was splendidly cooked, the bacon was well cooked, though the vegetables were not. Vegetables required a higher temperature. This experiment proved that they could cook food without a high temperature and without fire. It was a well-known fact that a man never could get a grilled chop or steak at home such as he could get at a restaurant. In the ordinary range you had the hot air passing over the piece of meat and drying it up. In the grill in a restaurant it was cooked on a slope, and any air that passed went under and not over the meat. The modern system of baking was superior to that of roasting. Speaking of the cooking of potatoes, Dr. Drinkwater explained that the ordinary maid peeled away the valuable part—the potash salts which were between the outer skin and the potato itself. Potatoes ought to be cooked in their skin, and the skin should be removed

at the table. They would find this was always done in Ireland; perhaps it was not the best country to refer to at the moment, but the Irish knew how to cook a potato. Where potatoes cannot be cooked in their skins they should be steamed. The ordinary cook would say that stewing meant boiling for a long time. The best cooks for stews were the Italians. They stewed food in an outer and inner vessel, like the carpenter's glue-pot. Stewing was cooking meat in its own juices. By a long-continued boiling you got a ragged mass, which was of very little use as food.

The French peasant woman, with a small earthenware vessel, a handful of charcoal, and a stove that bore no relation whatever to our kitchen ranges, could cook a small piece of meat and vegetables, and could pursue her outside work, sure that there would be good and savoury meal for her husband and children at the proper time. The peasants of France could in this way make a meal which no cook in this country could produce with her elaborate kitchen range. There was a French saying that cooking was an art, but that to roast required genius. He asked the Rotarians to impress some of these points on the ladies of their households. If they could only get the working-class wives to take an interest in this matter they would solve to a great extent, he believed, the drink question. Our temperance reformers did not recognise that bad cooking was one of the greatest causes of intemperance in this country. If they had ever been in the position of travelling in the wilds and being without good cooking they would know the craving for alcohol at the end of the day.

Mr. Hunter presided at the address, which was listened to with great attention, and a vote of thanks was moved to Dr. Drinkwater by Mr. Bell, who suggested that the members should send their wives and children to the church on Sundays, and give a demonstration in the home of the scientific methods of cooking.

HOSPITAL ADDITION

The tender of the Russell Construction Company of $142,263 for the construction of an addition to St. Joseph's Hospital, Peterboro, has been accepted, and work has already begun this week. The new building will unite the latest features in hospital construction and practically double the accommodation of the institution.

FURTHER BENEFACTION TO COBOURG HOSPITAL

Mr. W. F. McCook, President of the Pittsburgh Steel Co., a summer resident at Cobourg, has made a further benefaction to Cobourg Hospital, this time an electric sterilizing plant, valued at two thousand dollars. This plant is one of the best of its kind in Canada. Mr. McCook liberally subscribed a short time ago to the elevator fund of the Hospital, and presented the Institution with a new ambulance.

SOCIAL SERVICE AT TORONTO UNIVERSITY

The students of the social department of the University of Toronto are less students than they are social explorers.

Students of the sciences, arts and medicine are students indeed. The laws which put up the pyramids of Egypt serve to put up railway bridges. What Roman poets wrote is the same yesterday, to-day, and to-morrow.

But despite Plato and all the prophets and philosophers who have passed on the torch from hand to hand through the ages, there is still poverty, misery, inequality, and unrest in the world.

Into this vast, grim problem go the students of the social service classes of the university, not with their heads, but with their hands; not with their hearts, but with their heads.

And with the exception of nine men the students are all women.

The social service course is so new that the popular conception of it in the minds of the great majority of citizens is a nice, namby-pamby series of lectures to young ladies with nothing much to do on how to dispense charity and benevolence, how to conduct oneself at a mothers' sewing meeting, how gracefully to scatter alms.

Perhaps the greatest function of the social service course is that it takes educated young women out of all sections of the community, the daughters of millionaires, some of them, and confronts them with the actual social conditions of the city. Not as these young ladies would eventually see them, as public-spirited matrons on the boards of various charitable organizations, from the outside in; but as workers, from the inside in.

Less than half the work of the social service course is theory and lectures. The bulk of the work is "field work," actually dealing with the problems of unemployment, disease, need, delinquency and the thousand other afflictions of the underprivileged part of the community. And to get this practical "field work" the students of social service are apprenticed to the various social service institutions of the city, without whose aid the course would be valueless.

In the social service course at present are about sixty women and nine men. The majority of them are aiming at a career of social service either in institutions or in connection with schools, industry, or the nursing and public health profession.

The course runs two years. Sixty graduates of it are already scattered in cities all over Canada. And 150 nurses are taking a special course in it. Amongst this year's students is a young woman from South Africa, sent here for training by the government of that dominion.

Lectures are given in economics, certain medical subjects, the theory of case work, and similar subjects. But early in the course the students are allocated to the various organizations doing practical work in the city, such as the Neighborhood Workers' Association, the University Settlement, St. Christopher House, Central

Neighborhood House, the Catholic Charities, the Big Sisters' Association, etc.

As an apprentice, the student progresses, carefully supervised, through a period of months in record reading, friendly visiting, simple tasks, record writing, and then her first big job—a "first interview," followed by a written diagnosis of the need in the case and a worked out plan.

This latter sounds simple. But it is a labor involving wide and thorough investigation of former neighborhoods, of present associations, the history of the family or individual from start to finish. And the working out of a plan means a very technical job of psychological analysis. For the application of a plan for the attack of a problem usually means the re-educating and the changing of the entire mental attitude of the client.

These students actually render social service in the studying of it. There are no dalliers. The work is homely and hard. Some of these real life problems these girls have to enter into would daunt many a man.

The students visit as many institutions as possible, such as clinics, hospitals, courts, institutional homes, and so forth, until they are fully acquainted with the social resources of the city and the means of dealing with delinquents, defectives, deficients of all sorts.

They do not play around the edge. They are sent by the organization to which they are apprenticed to do the work of investigators. They visit homes stricken by the death of the bread-winner—that blackest, sheerest problem—homes wrecked by disease, unemployment, desertion, delinquence, misfortune in every guise. These college-trained girls deal with life in the raw. For instance, they lunch in police stations when visiting city health nurses. They sit up in a wild night with a dumb, bereaved woman and discuss the absolutely blank future of a little family. They meet men gone wrong, girls gone wrong, they see what unemployment really means, they see what strikes, lock-outs, cuts in wages, all such things mean.

The women are loosed in the world! They have smashed booze. They have jammed mothers' pensions through and certain criminal laws.

Now, as college women, they are investigating the ins and outs of social and industrial unrest, unbalance.

Old Mister Tight-wad Tory, old Mr. Stand Pat, rich reactionary, poor, half-baked, wife-beater, deserter, all ye males rich and poor who trust in the power of the big stick: look out!

The women are getting wise and getting together!

ABSTRACTS

*The Factory Nurse and Industrial Supervision. *W. Pryll.* Zentralbl. f. Gewerbehyg., June, 1920, 8, No. 6, 107—109.—The latest report of the Prussian Industrial Council recognizes fully the value of the work of the industrial nurse, but leaves open the question whether industrial nursing is to be a permanent institution, or is only a war measure—to disappear now that the chief motive for its introduction, the presence of a great number of women in industry, is no longer existent. The writer of the article holds the view that this work ought not only to be maintained, but to be extended and gradually brought under legal provision and given state backing. For Germany's work of reconstruction, sound men are needed and the need and the opportunity for prophylactic sanitation are greater than before the war.

The place of the factory nurse is in the shop. Here her work is a broad and complex one. It includes the sanitary protection of the workers and attention to social problems that arise in the factory. The nurse must take part in the work of overcoming specific dangers to health, and in the periodic medical inspection and the like that must be carried on. Tuberculosis and syphilis and other sources of contagion must be kept under control. The importance of the work of the industrial nurse creates a problem of selection of personnel for the work. Industrial nursing is rather an art than a science, and much depends upon the qualities of the nurse. Also she must be free from too much dependence upon employer or worker for the security of her position, and this is one of the reasons why the work needs state backing. The form

*Journal of Industrial Hygiene

which this state control or aid shall take is a matter for later consideration, but in some way industrial nursing must become a part of the whole system of industrial supervision.

PUTTING THE EX-CONSUMPTIVE BACK ON THE JOB. Bull. N. Y. Tuberculosis Assn., Inc., Oct., 1920, 1, No. 7, 1—4.—"The all too frequent recurrence of tuberculosis, among those whose disease has been apparently arrested by sanatorium or other treatment, has long been a problem calling for solution. The commonest cause of such relapses has been the return from ideal sanatorium life to the same unfavorable working and living conditions under which the disease first started. The sudden change from absolute rest to a full day's work—without a hardening process—is almost equally dangerous. The situation must be met by the gradual utilization of occupation therapy and vocational training, at the sanatorium in the country, followed, in town, by industrial rehabilitation at a sanitary workshop and by improvement of home conditions.

"The Federal Board for Vocational Education, having a large number of ex-service men suffering and recovering from tuberculosis, and recognizing the above facts, proposed to the National Tuberculosis Association and the New York Tuberculosis Association that a workshop for such industrial rehabilitation be established in New York City.

MODEL WORKSHOP IN LONG ISLAND CITY

"The New York Tuberculosis Association, after preliminary investigation of suitable trades and the best location, opened, on June 15, 1920, a model workshop in Long Island City for the training, under ideal sanitary conditions, of arrested cases of tuberculosis. It is incorporated under the name of the Reco Manufacturing Company, and is under the direction of an active committee of public spirited business men, headed by Mr. Fred M. Stein, who established some years ago the Altro Shop, the first successful workshop of this kind for the needlework trades.

"The shop has now been running five months. It is situated in the newly developed manufacturing section of Long Island City, in the Borough of Queens. The building is new, has light and air on all sides, is up to date in every respect, and is within five minutes' walk of the subway from Manhattan. The plant is on the third, and highest floor of the building. The workrooms have large windows on all sides, and there is a maximum of air and sunlight for its occupants. The shop is equipped with hygienic and sanitary fixtures.

Admission Requirements

"At present only men with arrested or quiescent tuberculosis and negative sputum are received by the Reco Manufacturing Company. The men now under training are largely ex-service men, but civilians who are suitable patients and anxious to take up any of these trades will be accepted if they are prepared to spend the full period of apprenticeship. They should apply or be referred to the Manhattan Office, at 10 East 39th Street, at 9 a.m., daily, except Sunday. Properly qualified visitors are always welcome and arrangements for such visits will be made on request.

Medical and Social Supervision

"All applicants are subjected to a thorough medical examination before admission. Close and exhaustive histories of each patient are taken and the effects of the work carefully noted; but, it is a workshop and not a sanatorium, rest-camp or health school. Care is taken that the medical and social work, while thorough, is not obtrusive. All examinations are made in Manhattan at the offices of the New York Tuberculosis Association. After a man is admitted to the shop and has started training, he is re-examined at the end of the first week and later once a month to determine the effects of the work. If his condition is at all questionable he returns oftener. In case of a relapse men are returned to the sanatoria or hospitals for proper care. Only one such case has occurred so far. Close supervision is kept of all men under training by means of these periodic examinations, and also by the trained nurse, who is at the shop several hours daily and takes temperature and weight of each man weekly.

"The amount of work that each man is first allowed to do, as well as any increase of it, are specifically prescribed by the medical officer. A first aid kit is kept at hand; the nurse's room has a couch and emergency facilities in case of need.

"It is intended that the shop be like any other well-conducted factory, with the added fundamentals of teaching non-injurious, well paying trades, by part or full time training under strict medical supervision, and under the best obtainable hygienic surroundings. A cafeteria lunchroom has been installed and nourishing meals are served at cost. A rest room will be provided on the roof, protected and furnished with reclining chairs, tables and reading matter. The men are encouraged to rest after their lunch and work periods.

"The home conditions of the men receive equal attention. Much of the good work may be undone at the home, where bad conditions beyond the patient's capacity to remedy may be present. A trained social worker investigates and visits regularly the home of each man. The benefit of her experience and advice is freely given; the best use of the rooms and resources available are pointed out. Family cares and worries are cheerfully shared; children in need of building-up are cared for; the advice of the physician is emphasized and followed up.

Trades Taught

"The trades selected to be taught at the shop are watch repairing, jewelry manufacturing and cabinet making; these were chosen only after careful investigation. They are deemed most desirable because not injurious to the lungs nor especially fatiguing. Workmen in these trades are very well paid and there is a great demand for men skilled in these particular occupations. The instruction is carried out by experienced men who are experts in their respective trades. According to conservative experience, the present wages men may earn in these trade are from forty to seventy-five dollars a week.

"When the students in the shop have gained enough skill to do marketable work they are paid wages on a piece-work basis. The skill that some of the men have developed has been surprising; without any previous mechanical experience, some have become proficient enough to make saleable articles within two and a half months on only part time training.

Ideals in View

"It is the intention to make the city model workshop the last step in the training and treatment of the tuberculosis. Schools for pre-vocational training on certain sanatoria (Loomis, Otisville and Galord Farm) are conducted by the New York Tuberculosis Association, where preliminary instruction is given to the sanatorium patient and he is prepared for transfer to the workshop as soon as his physical condition warrants. In this way the harmful gap of uncertainty following discharge is bridged. A record of his work at the sanatorium is kept and forwarded to the workshop. This pre-vocational training decreases the amount of time a patient will have to stay in the sanatorium, through the curative effect that it will have on his disease, provided he is interested in the trade. It also shortens his time at the shop because he enters with the special tools required, and is therefore ready for advanced instruction and will begin receiving wages all the sooner.

"It is the aim to gradually increase the working hours of the man with arrested tuberculosis until he can do a full day's work; to teach him a well-paid trade, keeping him all the while under medical observation until his ability and physical condition warrant discharge; finally to find him a suitable position. Thus trained, hardened and re-established in life, his chances of again falling a victim to tuberculosis will be minimized, and he can take his place in the community as a healthy, self-respecting self-supporting citizen."

TUBERCULOSIS IN HOSPITALS

Dr. R. W. Bruce Smith, became firmly convinced before his lamented decease that general hospitals ought to accept tubercular cases. In fact, through his recommendation, the provincial made their per capital grant to hospitals contingent on their accepting patients with pulmonary tuberculosis. This was a hardship to hospitals with no special word for such cases. The other patients share the general public's fear of the disease, the nurses, many of them were also frightened and a few of the ordinary doctors. The reception of these pulmonary cases meant additional to the hospital expense in caring for them.

However, with the training doctors and nurses get now in medical asepsis these cases are not the menace they formerly were to other patients, to doctors, nurses and attendants.

Surgeon-General Cumming of the United States Public Health Department recommends that every general hospital should admit tuberculosis patients and provide separate wards for them. He maintains that this provision would ensure earlier diagnosis, would make possible the training of internes, would popularize treatment in the home climate, would provide convenient facilities for the observation and prompt treatment of patients, and would develop a sharpened perception and higher degree of skill by which the family doctor would make earlier diagnosis, and even forestall the development of clinical tuberculosis in the adult before a definite diagnosis is possible.

The Modern Hospital editorially says that the question should be kept before the public, the medical profession, and those responsible for hospital administration until it is properly disposed of. The contribution of hospitals to the public service would thus be greatly enhanced, the tuberculosis clinics would be strengthened, the public mind would be swept free of harmful misconceptions and hospital internes, into whose hands the whole public health movement of the future eventually must be committed, would not enter into practice, as they often do to-day, lacking the power to make an accurate diagnosis and a reasonably correct prognosis in cases of pulmonary tuberculosis.

ELGIN MEMORIAL HOSPITAL BY-LAW CARRIES

The by-law submitted to the property owners on November 14th for the issuing of $100,000 in 30-year debentures to be used in the erection of the Elgin Memorial Hospital was passed by a majority of 450 votes, approximately two for the project, to every one against it. The vote was a light one. The hospital has been estimated to cost $165,000. The Elgin County Council will be asked to make a liberal grant, while the remainder will be raised by private subscriptions. The hospital is to provide accommodation for 65 beds, while the present Amasa Wood Hospital, with 60, will be used as an annex. The plans include a large Memorial Hall, where the names and deeds of the soldiers who fell overseas will be preservd.

Text-Book of Materia Medica for Nurses, compiled by LAVINIA L. DOCK, Graduate of Bellevue Training School for Nurses. Seventh edition, revised. Revised in accordance with the Ninth Decennial Revision of the U. S. Pharmacopoeia. G. P. Putnam's Sons, 2 West 45th St., New York. (The Knickerbocker Press) 1921. Price $2.25.

This book describes the metric system, gives a list of poisons and the treatment of poisoning, discusses emetics, the hypodermic administration of drugs, electro-therepeuties and radiology. Remedies are classified according to their effects on the various systems: circulatory, respiratory, digestive, nervous, integumentary, urinary and generative. Then comes a discussion of drugs having a general systemic effect in blood and tissue, antiseptics, disinfectants and mineral waters.

The Blood Supply to the Heart in its Anatomical and Clinical Aspects by LOUIS GROSS, M.D., C.M., Fellow in Pathology, McGill University, and research Associate, Royal Victoria Hospital, Montreal. With an introduction by HORST OERTEL, Strathcona Professor of Pathology, McGill University, Montreal. With 29 full page plates and 6 text illustrations. Paul B. Hoeber, 69 East 59th Street, New York. Price $5.00.

This is a notable contribution to the technical and scientific reputation of McGill University upon the occasion of the recent Centenery celebration there. It displays enthusiasm for useful research in a very marked degree, and brings fully up-to-date for those carrying on similar work, the enormous mass of work already done, and sets forth in comparison form conclusions that have stood the test of time and further investigation. Most of the problems investigated are of distinct clinical interest, apart from their anatomical and physiological importance. The illustrations are capital, and the book-making excellent.

The Hospital World

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Hospital Income

As time goes on we are becoming more democratic. The Big War and its sequelae gave Kings and Aristocrats a bad jolt.

The plutocrats come next. Some of them, with philanthropic hearts, have always been friends to hospitals—and have been famous through having founded hospitals or given largely to hospital support. But democracy is now claiming so much income tax from the rich and such large succession duties that those of them who might support hospitals generously are drawing in their horns. As a result trustee boards are appealing more and more to municipalities and governments for support. In many European countries the Hospitals have been taken over by the state or municipality. In some of the newer states, provinces and territories, the Governments themselves have taken the initiative founding hospitals, depending on the municipalities in which the hospitals are located to help out. This, of course, does not close up the fount of private

benevolence, though it tends to. For in all places we see hospitals supported entirely by taxation the recipients of certain largesse from the wealthy.

We are now passing through a transition stage. Many of our hospitals are operated by Trustee Boards, the major influence in which represents private benefaction, but the trend of the times is toward public ownership.

The service rendered in many publicly supported hospitals has not been as good as that in those in which private philanthropy has the upper hand; but it is improving all the time. The Boston City in the United States and the Hamilton Hospital in Canada stand out as examples of how well publicly owned hospitals can be administered.

A Raw Deal

In a recent number we proposed that members of hospital staffs should be paid. This is done in a degree in an occasional hospital. The Toronto University Hospital—The Toronto General—has a clinical staff—some of them on salary, some not: the chiefs, full time men—being paid—their assistants not. The latter received a small honorarium—some

$250 per year—until lately when this was cut off. One of our contemporaries criticises this action of the university authorities. We believe the criticism is just. Along with the announcement of this cut was the statement that the Rockefeller Foundation had given a large donation to the university to assist medical education. These two statements in the one communication gave a rather unpleasant flavor to the recipients of the letter. Surely such an action was picayune. These men, to some of whom the small stipend meant something, must have felt hurt at this petty action. One member of the staff—doubtless voicing the opinion of others—complains that there has been created an unfavorable atmosphere. "We never know," said he, "when our heads are going to be chopped off." Several men's services were dispensed with—no adequate reason being given for this summary treatment. Several good men on the staff in pre-war days returned to find themselves supplanted. Their wailing doen't enhance the reputation of the university and hospital authorities.

The cure of all this lies in the hands of the medical men themselves. Those who have been unfairly dealt with should have some means of redress. The profession should frown down on such tyranny and

high-handed dealing. No clique should be allowed to dominate appointments and salaries. These men who are indentured should protest—should make known their feeling of chagrin and abasement. They should go further: resign. The capitalizing of the charitable, meek and subservient spirit of the profession has about reached its limit. The permission to do work on a hospital and university teaching staff for the prestige, honor and glory of the thing has gone far enough. We hope our representative medical academies and associations will take this matter up and express their opinion about it. The laborer is worthy of his hire. The man who works is entitled to a quid pro quo in coin of the realm. The men who have come into money through inheritance or fortunate marriages should not usurp these payless jobs. They may be able to give of their time and services without remuneration; but there are other just as competent and efficient men who cannot.

The dole, instead of being cut off, should have been increased ten-fold.

Fee Splitting

Members of hospital staffs are beginning to be asked to sign solemn declarations that they will not

indulge in secret division of fees. This laudable action on the part of hospital authorities has resulted mainly through the propaganda of the College of American Surgeons in co-operation with a committee of the American Hospital Association.

Just how prevalent fee-splitting was is difficult to say. The fee-splitters are a silent folk, so who split fees and who didn't has been largely a matter of surmise. We dare say some of those, ardent in the abolition of the nefarious custom may have been sinners themselves, who desired to repent, or dwellers in the wilderness of temptation; perhaps their medical confreres who were wont to turn over the wealthy patients for operation expressed their avidity for a portion of the swag in looks and tones hard to ignore.

The open and above-board way is always the best. The patient should know to whom his money goes and for what service. There need nothing be lost. The physician who has made the necessary preliminary work in diagnosis and preliminary treatment, who assists at the operation as anesthetist or assistant to the surgeon and who takes over all or a portion of the aftercare ought to receive his guerdon. There is no occasion for secrecy. Let the facts of

the case be pointed out to the patient or his friends who pay the shot and there should be no demur at the amount paid the family physician or at that charged by the surgeon.

We hope there are no surgeons too proud to sign or who, conscious of their probity in regard to the matter, feel it is infra dignitate for them to sign.

Let All Sign.

Hospital Progress

The first number of "Hospital Progress" we have received—Vol. II, No. 12—is replete with good articles. It is published at 221 Grand Avenue, Milwaukee, Wisconsin, and is the official magazine of the Catholic Hospital Association of United States and Canada.

The December number has a special article on the St. Vincent Charity Hospital of Cleveland. It contains also a report of the conferences of the Catholic Hospital Association at a recent meeting in St. Paul.

The Catholic Hospitals of this continent are doing a magnificent work. The Sisters have caught the spirit of progress and efficiency which has been per-

meating the hospitals of other denominations and of those supported by municipalities, states and private philanthropists.

In our observation the hospitals of this church were rather in the rear of many of the other sort, as regards house service, dietary and general efficiency. They were always noted for their kind and sympathetic treatment of their patients, but their lack of money often forced them to more economy than was good for the service. But the Catholic hospitals are now coming to the van. Dietaries are improved, laboratories are being established, records are being kept, the nursing schools are being better managed and great advancement is taking place along all lines.

One of the leading spirits in this betterment is the Rev. Father C. B. Moulinier, who visited Canada a year ago and spoke in numerous places so effectively on hospital standardization.

And now comes the organ of the Catholic Hospitals, which we welcome to the hospital publishing field. It will do much to stimulate interest in hospitals, Catholic and non-Catholic.

Non-Specific Protein Therapy

Over in Ann Arbor, Cowie and his associates have been trying out the treatment of rheumatism, chorea, scarlet fever and other conditions with injections of dead typhoid bacilli. Cowie points out that arthritis is one of those infectious processes which instead of tending to cure tend to chronicity and bodily morphological abnormalities. Could we successfully attack arthritis in its potential state we might hope to cause its comparative disappearance from the community. We are already seeing the effects of removing infectious foci. Cowie asks: How can we, on a large scale for the masses, acquire immunity against infectious processes in and about joints?

Before using foreign protein therapy we should have knowledge of its mode of action, and its real limits of safety.

It is common knowledge that most remarkable effects follow intravenous injection of foreign protein in some cases of arthritis. It is also true that cases apparently of a similar character do not improve. While the miracles wrought are as great as those performed by 606, they differ in that we cannot produce them with any degree of positiveness.

Until we know how and at what times and places the foreign protein produces its effects, we will be as ignorant of the proper method of using it in infections as were the earlier physicians in the use of quinine until the plasmodium was discovered and its life cycle known.

Cowie holds that in quite a percentage of cases of typhoid the disease can be aborted or its course shortened by the use of foreign protein therapy.

"In a series of cases," he says, "I am quite sure of the final results—suppurative foci, furunculosis, gonorrhoeal vaginitis, suppurative mastoiditis may be definitely influenced by protein therapy, when other treatment has failed." He says the most striking effects are noted in pathological conditions in the eye—iritis, panophthalmitis, uveitis, pneumococus corneal ulcers, hypopyon ulcer, granulomatous hematoma due to hemolytic streptococci. In 13 cases of chorea of from three weeks to seven years standing, improvement followed in 12, and cure in 61% of them. In muscular and joint rheumatic attacks without structural change, definite help was afforded; also cases of Still's disease. The subacute or mild chronic cases were very satisfactorily managed by this method. Surgical foci were searched for and removed wherever found.

In Pemberton's series of 256 cases of arthritis 26.-75 per cent. showed no foci. In such cases foreign therapy should be tried. Those parts of the body affected to which there is a free blood supply are the most likely to be benefitted by foreign protein therapy. Comie employs seldom under 500,000,000 of killed typhoid bacilli, and often gives a billion of them even to children. He has never had any untoward results, though patients complain of feeling ill following the injection. Some have attributed the effects to the hyperthermia produced. In acute cardiac conditions and hyperthyroidism non-specific foreign protein therapy is contra indicated.

Pulmonary Hemorrhage

Schwatt, writing in the New York Medical Journal on hemorrhage in pulmonary tuberculosis, holds that bleeding is rarely immediately fatal; that the great majority of hemorrhages are self-limited through the inherent tendency of the organism to effect a spontaneous control by changes in blood pressure, by increase in the coagulability of the blood, by contraction of vessels and by thrombus formation. The undisturbed forces of nature are more effective and less harmful in controlling the bleed-

ing than any drug therapy. The immobilization treatment and the use of morphine do a great deal more harm than good, and are the causes of complications more dangerous than an untreated hemorrhage. There is no drug or other treatment except artificial pneumothorax that can be said to stop a hemorrhage. The principal function of the physician is to reassure the patient, to allay mental excitement, to lesson excessive cough, to place the patient in a comfortable position at reasonable bodily rest and to avoid meddlesome therapy. Fluids should not be given as nourishment during active bleeding; rather lukewarm soft and semi-solid foods —milk in small quantities, cereals, soft boiled egg, jellies and gelatin. No effort should be made to move the bowels for a few days after the active bleeding has ceased. Then only mild laxatives.

Booze

Men of greater or less importance from the Old Land speed across the Atlantic in 5 days, rush through a portion of Canada and the United States; are treated to the stored up booze in the cellars of their hosts, are told that the stuff is plentiful and freely circulated, that there is more drinking than

ever, that the quality drunk by stealth by the rank and file is poisonous, etc., etc., and our visitors cable to the newspapers at Home that Prohibition is a failure in the United States and Canada.

The sober folk who live here know that no open bars flourish to tempt the boys, that crime and insanity are wonderfully lessened since the bars were closed, that many, many homes have been rehabilitated since the head of the house, who used to spend all his earnings at the bar, has stopped drinking perforce.

This good and true news hasn't percolated through to the Old Land yet, where Booze is still regnant. Pity.

Nova Scotia Survey

A survey was made by Dr. C. K. Clarke and his associates of Nova Scotia. As to the insane they recommend the abolition of the county system of care, and the establishment of two provincial hospital centres provided with farm colony facilities; the establishment of a commission to control affairs of provincial hospitals; the establishment of two small

psycopathic hospitals, the immediate need being one in Halifax and contiguous to the general hospital.

They recommend an increase in the nursing staff of the Nova Scotia hospital for insane, the addition of a social worker, a pathologist, a part-time dentist, improvement in the hydro-therapy apparatus and a fuller development of occupational therapy.

As to gaols, they recommend psychiatric examintion of prisoners, the establishment of juvenile courts, and that juvenile offenders be not confined with adult prisoners. They also recommend the establishing of an industrial farm for minors and a gaol farm .

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PAINTING THE HOSPITAL

GEORGE B. HECKEL, PHILADELPHIA

Again the editor has handed me an olla podrida for digestion at one meal. He asks me to prescribe "the treatment of special surfaces in hospitals", which class of surfaces he indicates as "such things as the clothes chutes, radiators and piping, iron and steel work, hardwood floors, cement floors, floors in operating rooms and laboratories, etc." In this section I think he has left very few items which can be considered as "et cetera".

His list being practically complete, let us follow the advice given by the King of Hearts to the White Rabbit in Lewis Carrol's exquisite little book, "begin at the beginning and go on till you come to the end; then stop".

CLOTHES CHUTES

The chief desiderata here are cleanliness and cleansibleness (that word, invented by myself, I regard as a worthy competitor to "Roentgenology" and "exsanguinate", which latter I have recently encountered as a synonym of "bleed"), and smoothness. All of these desiderata are supplied by white enamel. Soilure stands out upon it like dementia on a cubist picture it is easy to cleanse; and, its vehicle being varnish, presents the smoothest surface attainable with paint or varnish. Not fewer than four coats are desirable. As a second choice, though I have never seen it used for this purpose, I should think that "mill-white" would also meet the requirements. These suggestions are made in lieu of the plastic coatings simulating white tiling, which are, of course, preferable.

RADIATORS AND PIPING

Who first conceived the notion that these, being made of metal, should be painted to simulate another metal, I do not know, but I do know that this happy thought has caused the ungraceful, if necessary, radiators in the land, to stand forth conspicuous as fraudulent gold, bronze or aluminum creations that harmonize with nothing and interfere seriously with their only proper function.

The proper color for piping and radiators is the color of the wall against which they stand. It is enough to be compelled to hear them, as we sometimes must, without having to see them at every turn. The old dictum that "children should be seen and not heard" is seriously questioned to-day; but of radiators we can assert confidently that they should be neither seen nor heard. When they have given us the highest heating efficiency of which they are capable they have performed their full duty.

But in a metallic coating they do not give us full efficiency by twenty per cent or more. The Engineering Department of the University of Michigan and later the Institute of Industrial Research at Washington, settled this question for us some years since. Here are the conclusions of the former, confirmed by the latter:

"The painting of radiators may materially affect the transmission of heat. A series of experiments were conducted about two years ago to determine the effect of painting. Two cast iron rectangles were used; one was painted and the other left unpainted so that the painted radiator was always compared with the same unpainted radiator. The results of these tests were very interesting. The radiators were first tested both unpainted and the condensation in the two was practically alike. One radiator was then painted with two coats of copper bronze and it was found that the heat transmission was reduced 24 per cent. from the original cast iron. Two coats of terra cotta enamel were then placed over the four previous coats and the heat transmission was three per cent. better than the original cast iron unpainted. This was repeated for fourteen coats, the last two coats being aluminum bronze. The transmission then showed a reduction of 27 per cent. and additional tests were conducted with various enamels, Japan, lead paint, and zinc paint."

"In general aluminum, copper and metal pigments in the bronzes reduce the heat transmission. This is probably largely due to the composition of the bronze and partly to the vehicle which contains this pigment. Enamel, lead paints and zinc paints almost all show no loss in heat transmissions. The experiments show that the effect is largely surface effect and not conduction effect. The results show that the loss of heat from radiators depends largely

upon the surface effect and to a very small extent upon the conduction of heat through the metals."

My own home is warmed through a series of piping and radiators that always remind me of the complicated steam piping of a battleship, but they do not imperiously hit one in the eye. They are all painted with the same flat paint, in the same tints as the walls behind them. One can see them without searching, but they do not assert themselves; and this, treatment has proved, in every way, satisfactory.

Iron and Steel Work

"The prime object of painting ferrous metal surfaces is to prevent rust. Iron is largely made from ore which is essentially rust (haematite) and displays a marked propensity to revert, if given half a chance. It is but a slight hyperbole to say that it loves oxygen—hates its gray metallic garb and longs for the bright colors of its oxides, and one of the principal tasks of the owner of iron structures is to foil this propensity.

There are two general principles of procedure by which this may be accomplished. Both oxygen and moisture are necessary to the process of rusting, therefore, if either air or moisture be absolutely excluded, iron cannot rust. Both will penetrate an ordinary oil paint film and even an impervious film may sooner or later, crack; so that this method, though common, leaves something to be desired.

The second method depends on the fact that certain chemical substances seem to have the power of annulling the hunger of iron for oxygen, rendering it passive and inhibiting corrosion, as the technologists neatly and lucidly express it. Chromic Acid is one of the most powerful of these so-called inhibitors; red lead, zinc oxide, sublimed blue lead and other basic pigments sharing the same power to considerable extent. Chromic acid, by the way, is a component of several familiar pigments—basic lead chromate, chrome yellow, zinc chrome, for example—which exhibit this property to a high degree.

Obviously, since it is only by actual contact, that pigments can act, we have only the first or primary coat to consider. While

the principle is not admitted by all technologists, much experience has proved that the best priming coat for a steel surface is basic lead chromate (scarlet chrome) and that priming coats containing zinc chrome are highly efficient. Red lead, also, has very many advocates and long experience has demonstrated its efficiency; while many manufacturers use zinc oxide in the pigment combination for the same purpose.

The priming coat of the New Jersey Zinc Company for steel or iron is as follows:

"All loose mill scale and all rust shall be thoroughly removed before painting by the use of hammers, scrapers and wire brushes, and all grease shall be carefully washed off with benzine. Three coats of paint shall be applied.

The pigments for the priming paint shall consist of 85 per cent. iron oxide and 15 per cent. pure Zinc Oxide. This paint may be purchased either in paste or ready mixed form with the Zinc Oxide incorporated in the process of manufacture. The iron oxide used shall contain no free sulphur, water soluble sulphates, acids or alkali, and shall contain not less than 80 per cent. of pure unhydrated ferric oxide, without addition of any compounds of calcium, barium, aluminum or magnesium.

"The oil contained shall be pure raw linseed oil in accordance with the specifications of the American Society for Testing Materials and the vehicle shall have an acid number not exceeding four. The only constituents allowable besides those named shall be turpentine or benzine and liquid dryer, which shall be free from resin or gum resins and rosin compouns—in other words the dryer shall be pure oil dryer, reduced, if desired, with turpentine or benzine or both.

"The second and third coats shall be any approved linseed oil paint of the desired color; though it is specified that where white or a tint requiring the use of white is necessary, the white paint used shall conform in all respects to the specifications governing similar paint on woodwork."

It has the advantage of being cheaper than any of the rest, and has proved very efficient.

With a proper priming coat next to the steel any good oil paint of any desired color will be found satisfactory for the subsequent two coats.

Just here I think a word about iron fire-escapes may be in place. Like the revolver in Texas, they may never be needed, but when needed the need is imperative. They rust like any other steel structure and should be carefully and conscientiously guarded so that they may not fail in an emergency.

Hardwood Floors

Long since I wrote, in an advertisement, "Floors are made to be walked on, not to be looked at." A floor in a hospital is walked on by many feet. It is also the depository of such dust as finds its way into the guarded precincts, and dust is the aeroplane of the microbe. Therefore, floors in a hospital should be resistant to abrasion and cleansible without injury.

The proper coating for a hardwood floor is floor varnish, the best obtainable. Not fewer than three coats should be applied at the beginning; preceded, if it be of an "open grain" wood (oak, chestnut, ash) by a floor filler, properly applied. If the wood be very light in color (white maple, for example), and retention of this color be considered important, a very thin coat of white shellac may be applied before varnishing. The proper consistency is obtained by diluting ordinary white shellac varnish with an equal volume of "special denatured" alcohol. Shellac itself, as a floor coating, while convenient and pleasing in appearance, is too brittle and too easily defaced by wear or by water, to provide a satisfactory floor finish. Used, however, as suggested, it prevents the oil-varnish from soaking into and darkening the wood.

As soon as the varnish on a floor shows signs of wear, one fresh coat should be applied. A booklet on the treatment and care of hardwood floors, published for the National Varnish Manufacturers' Association, is available free to anyone interested in the subject.

Cement Floors

There are three common objections to cement floors, one of which is susceptible to removal by proper painting: the surface wears off and creates dust, they are cold, they are hard and con-

sequently tiring to the feet. It is said that in New York City, servant girls refuse to work in an apartment kitchen with a cement floor unless the floor is covered with linoleum or carpet. These latter defects, however, are inherent in the material, which is obviously admirable on many account

The only difficulty in the way to successful painting of a cement or concrete surface is due to the "free lime" in the surface, which reacts with oil acids of the paint vehicle to produce "lime soap"—calcium linoleate, etc.—with the result that the coating does not adhere. Time reduces this tendency, so that a weathered cement surface can be painted successfully without preparatory treatment. The safer plan is, nevertheless, to apply a solution of zinc sulphate, six or eight ounces dissolved in a gallon of water. The lime reacts with the sulphuric acid radicle of the zinc sulphate forming calcium sulphate (gypsum), leaving the zinc in the form of zinc hydroxide. These are both inert to the oil acids, and any good floor paint will be satisfactory on a cement floor so treated, after thoroughly dry. It is advisable to add about one pint of good floor varnish to the paint selected, to apply three coats, and to finish with a final coat of the same varnish.

Floors in Operating Rooms and Laboratories

In the previous article on paints for operating rooms the proper colors for floors have been discussed. For the rest, the preceding paragraphs on cement floors apply, if we omit the suggested preliminary treatment. Wood floors in operating rooms, however, should be carefully levelled and "filled" before painting, so that there may be no crevices for the lodging and harboring of microbes.

The laboratory floor, if of cement, may properly be treated in the same way as recommended for cement floors in general. If of wood, the chief object is to render it water, alkali, and acid proof. This is not completely possible with ordinary paints or varnishes but we can approximate perfection with a floor varnish of the highest quality. The wood floor should first be properly "filled," then given four coats of the varnish. If paint is preferred

there should be three coats of floor paint to which about one pint of floor varnish per gallon has been added, topped with a finishing coat of the clear varnish.

Bakelite has been used with some success as a floor coating for laboratories. It is perfectly resistant to chemicals, but in the one case where I have seen it used it cracked rather badly.

When all is said and done, however, probably the best flooring for a laboratory is the plastic white cement to which I have several times alluded; but woe to the beaker or test tube that falls either on this or on a cement floor. The floor of my own little laboratory is of the latter and no item of glassware has ever emerged scatheless from contact with it. An elastic cement would be ideal!

THE HOSPITAL DIETITIAN

By G. Helen Rawson, Dean of the Home Science Faculty, Otago University.

"I am confident that one of the earliest developments in our hospitals generally will be the establishment of nitritional clinics, and that vastly more attention will be given to the dietetic department of these institutions. . . . For my part, I feel that the dietary of a hospital is of almost more importance than the pharmacy."—Dr. Edwin Locke (Boston.)

"I think that at the present time the most important thing is to get trained dietitians into our hospitals. . . . It is never going to be possible satisfactorily to treat certain kinds of diseases like diabetes and other metabolic conditions without the help of hospital dietitians."—Dr. George Blumer, Dean of the Medical Faculty, Yale University.

It is true of the hospital as of any other large business enterprise that success depends upon the harmonious co-operation of efficient individuals, each with a keen sense of the importance of his task, and yet with a sympathy and reverence for the tasks different from his own, and executed by people with very different training and different skill. Disaster may overtake such an

enterprise if there is lack of efficiency in even one of the units; it may also come if all units are efficient but are incapable of team-work.

In hospital circles at the present time there is a feeling, more pronounced in some quarters than in others, that maximum efficiency has not yet been attained. It is admitted that medical and surgical skill have reached a high-water mark of efficiency, while the nursing profession is one that attracts a large proportion of unselfish and devoted women, who without doubt do their share of skilful service, and who willingly co-operate with the doctors. The doctors and the nurses form the strong links in the chain, and if they alone were concerned no doubt the hospitals would be eminently satisfactory. But a patient cannot recover or feel at one with his surroundings if he has nothing but physic and good nursing. There is an army behind the scenes which prepares his food, washes his clothes, and executes all of the thousand tasks which bring comfort and happiness of skillfully executed, and equally surely raise grumbles and disharmony if indifferently or badly performed. And here is the weak link in the chain of many a hospital; its medical and nursing staff have kept abreast of the time, but the food-preparation and other household activities have been controlled by officials with no special training. Some, with a native genius, have been wonderfully successful; but it is no exaggeration to say that in the majority of hospitals where lack of harmony prevails among the patients the root cause lies in the preparation and service of the food and in the general housekeeping.

Having discovered the malady, we must now consider the remedy—and it is a drastic one. We must change our point of view entirely towards institutional housekeeping. We must no longer think that an ill-trained, poorly paid person is adequate for this vital part of the hospital administration. We need a person trained in the principles of management, with a sound knowledge of dietetics, and with sufficient skill in household arts to be capable of training subordinates in right methods. Such skill is as valuable in its own way as nursing and surgical efficiency are in theirs, and therefore the status of such an official must un-

doubtedly be similar to that of the surgeon and the matron if the right sort of individual is to be attracted to this new profession of institutional housekeep.

To many who read American publications this revolution in the housekeeping of hospitals will not come as a sudden and unexpected recommendation. Every first-rate hospital in America has at least one "dietitian"—generally a woman—whose functions range from purely institutional housekeeping to the training of the nurses in dietetics and the preparation of special dietaries in the so-called diet-kitchen—a kitchen reserved for the training of the nurses and for the preparation of special foods. It requires no small amount of talent to be a successful dietitian; without the natural gifts of good health, tact, and administrative ability it is useless to enter this profession; only extensive education and experience can bring the requisite knowledge of nutrition and household arts which are essential in this field of service. A dietitian must always be alert; she must control food-supplies, methods of preparation of food, and the distribution of food to the wards; she should reduce to a minimum the alarming waste of foods which undoubtedly takes place at the present time in the majority of hospitals. In a small hospital she may supervise the laundry and the cleaning, and she may instruct the nurses, and prepare the special diets; while a large hospital may need several specialists to share these various duties.

It may be feared that the introduction of such highly paid officials would be impossible at the present time when strict economy and even retrenchment are imperative; but, as in all efficient business enterprises, it pays in the long-run to give a high salary and get skilled service. The experience in many American hospital supports this statement; it is universally found that the efficient dietitian can by wise choise of food materials, and by eliminating waste, not only ensure satisfactory food service, but do this at no greater cost to the institution than was involved when cheaper service was employed.

The time is ripe in New Zealand for the introduction of dietitians into the hospitals. The Hospitals Commission which recently inquired into the organization of our hospitals recommended that

dietitians should be trained and established in the hospitals, and the means for such training will shortly be available in the home-science department of the Otago University. It is also necessary that, before taking full responsibility, an intending dietitian should spend three to six months in a hospital as a pupil dietitian under an expert; it is only in this way she can learn the working-conditions of the institution. Trained thus, with university status, the dietitian will naturally take her stand as a professional woman, and it will be possible for the first time to have the harmonious co-operation between the doctor, the nurse, and the institutional housekeeper and dietitian which will bring harmony and efficiency.

WORK OF MISSION HOSPITALS REVOLUTIONIZES CHINA'S IDEAS ABOUT MEDICINE AND SERVICE

Under the title of "The Message of the Mission Hospital," Dr. Harold Balme, President of the Shantung Christian University, in a recent issue of "Medical Missions" has some interesting things to tell of the work of medical missions in China and the contribution they are making to the spread of Christianity.

"We are apt sometimes to forget," he writes, "that where Christ is not known and His teaching not practiced sickness and pain are always associated with fear and despair. How easily one can see that in China today!

"I cannot help thinking of the sick-bed of a little Chinese child —the expression of fear and apprehension on the part of the mother; the anxiety of the child herself; the weird exorcisms of the priest. I think of that same child brought for the first time to the mission hospital, and of the renewed fears of the mother in view of the appalling practices which she has heard ascribed to the foreign doctor. But it is perfect love—such love as the mission hospital tries to represent—that casts out all such fear.

"I shall never forget that little girl who was brought in such a fashion to the first hospital in which I ever worked in China. She

had been run over by a heavy vehicle; her jaw was broken and her face lacerated. She was brought to the hospital in an old-fashioned country cart, and, as I turned back the curtains which covered up the windows of the cart, that poor little girl's look of terror and shriek of fear made an impression on me that time will never efface. For days I did not dare to go near the child. I operated on her without her ever seeing me. But gradually the old fears left her and a new confidence began to dawn, and I know of few things in China that have touched me so much as to watch the gradual growth of that little child's faith.

"But the message of the medical mission does not stop there. Christ did not only come that we might have peace and confidence. He came that we might have life, and life more abundantly. And if the medical mission has a message for the world today it is emphatically a message of life—of radiant, abundant life.

"It is full and abundant life that the hospital seeks to express, and that means the clear presentation of the teaching of Jesus Christ on the one hand, and the use of the best possible means for the restoration of health and strength on the other. Let us not make the mistake of supposing that there is some antipathy between the medical and the evangelistic sides of our mission hospital work. Both are alike needed, and needed at the highest possible standard if they are truly to represent that great gift of abundant life which Jesus Christ came to bestow. We can truly say that a great message of the medical mission is 'by love serve one another.'

"In the early days in China it was almost impossible to reach such a stage as that. There was no dynamic which urged the Chinese into such self-sacrificing service. And the first mission hospitals had a large enough task before them in their efforts to dispel the fears of their patients. In those days they had to take in the whole family in many cases before they could get the sick man's consent to enter a hospital. The first operation in Canton was only performed because the patient was given $50 to submit to it. And even in my own early days—only 15 years ago—I remember how carefully we had to select our operation cases.

"But what a wonderful change has taken place! Today, if you will visit the hospital in Tsinanfu, you will probably find from 15

to 20 little children in our wards, who have been left there with every confidence by their parents. If one of them happens to die, there is never the slightest suspicion that death has been caused by ill-treatment on our part. We enjoy the fullest confidence in all our hospitals in China today.

"In those early days it was all we could do to secure such confidence, and there was little or no response to the message of service. I have seen men lying in the blazing sun, untended, during an epidemic. This was not because the people there were barbarous; it was simply that they had no sense of responsibility, no motive compelling them to such service.

Then, as the result of the great missionary giants of the past, and of a hundred years of prayer, we began to see the change. A new sentiment began to manifest itself in China, in the direction of service for others, and of self-sacrifice. Men began to realize that China was not going to be saved nor to be set free from all her suffering by British or American workers, but by the Chinese themselves. And what has been the result? Today we have in China some of the most up-to-date medical schools to be found anywhere in the Far East.

"China has begun to realize that modern medicine is a priceless boon which she must have. And to us who are humble followers of Jesus Christ has been given this wonderful privilege of taking to her this new message of service, and of giving her the very best that we possess, in our efforts to train men and women who will not only be thoroughly efficient doctors, but who also will have caught a new and inspiring image of Jesus Christ in their own lives.

"As one looks at China today, with all her tremendous need, one thanks God for the men and women who are catching this new vision of service, and are helping to spread the only message that can save this troubled, suffering world."

SHRINERS BUILD HOSPITALS FOR CRIPPLED CHILDREN

A chain of hospitals for crippled children throughout Canada and the United States is projected by Rameses Temple, Mystic Shriners.

These institutions will be located in the most advisable centres, and will not conflict with similar existing institutions. They will be under the direction of the best orthopedic surgeons available. Their doors will be open to all children under the age of fifteen, regardless of race or creed. When a local hospital can handle a case more advantageously than the nearest Shrine hospital a certain amount will be allowed by the latter for treatment.

This project will involve an expenditure running into millions of dollars. It is the outcome of three years' contemplation and investigation by several subsidiary councils appointed by the Imperial Council, which definitely gave its sanction at Des Moines in June, 1921.

Contracts have already been let for the building of five hospitals—at St. Louis, the parent hospital; San Francisco, Cal.; St. Paul, Minn.; Shreveport, La., and Montreal. Others will be added as conditions warrant and funds avail.

The Montreal hospital, first of the series in Canada, will be commenced at once. It will cost $250,000.

To Freeland Kendrick, Past Potentate, of Philadelphia, belongs the credit for originating the enterprise. He made the first subscription—$10,000. Funds now on hand total $2,000,000. A current annual revenue of more than $1,000,000 will be raised by the Shrine for overhead and operating expenses. Subscriptions will be accepted, but not solicited. A member of the board will be given supervision of the hospital nearest his residence.

"Let us all rejoice in the happiness that is in store for the helpless children," says the Rameses Shrine in its announcement of the enterprise.

HOSPITALS IN EDMONTON

The new wing of the Royal Alexandra Hospital, which exclusive of equipment will cost approximately $275,000 is now nearing completion and will be opened about January, 1922.

The hospital will then have accommodation for 250 patients, and will have all modern facilities for giving the best service possible, surgical, medical, and maternity. It is anticipated that the Hospital Board will shortly appoint a Medical Superintendent for which position applications are now being requested. Since the resignation of Dr. Fyshe last December, the position has been vacant but the near completion of the new wing and the increased accommodation for patients thereby secured, has made the appointment of such an official very advisable. A training school for nurses of whom there are about 45 is maintained. This hospital has been built and is financed entirely as a city hospital.

The recently completed extension to the General Hospital, which includes nursing home for the nurses, rooms for X-ray equipment, laboratory and maternity wards is a splendid addition of four stories and would be a credit to any hospital. It has been erected at a cost of over $100,000 and increases the available accommodation to 175 beds. The facilities provided for the treatment of all classes of patients, surgical, medical and maternity are excellent. This hospital is conducted under the management of the Grey Nuns and was the first hospital enterprize established in Edmonton, the nucleus of the present hospital having been built in 1895. A training school for nurses is also carried on, there being about 60 nurses in training.

The Strathcona Hospital, near the University of Alberta, a well equipped and fully modern institution erected as a city hospital at a cost of $300,000 has for some time been placed at the disposal of the S. C. R., for the care and treatment of sick and disabled soldiers. There are at the present time about 150 patients being treated there, and it is likely that it will be required for this purpose for some time to come.

The Misericordia Hospital conducted by the Sisters of Misericordia is a modern building with complete equipment for the comfort and convenience of patients. Only the southern part of the hospital, as designed, has as yet been erected. The capacity of this wing is 75 patients. Nurses to the number of 18 are taking the course of training provided at this hospital.

The Isolation Hospital, which including the detached building for smallpox, has a bed capacity for 90 patients, is the only hospital in Edmonton which does not attain to modern standards as regards the building and accommodation. For some years the need of a new hospital has been acutely felt and it is anticipated that something will be done in the near future to provide a new and complete hospital for infectious disease.

The total bed capacity for Edmonton Hospitals, including the Isolation Hospital at the end of 1921 will be approximately 750 beds.

Society Proceedings

THE WESTERN CANADA HOSPITAL ASSOCIATION

First Annual Convention, Regina, Sask.

Tuesday and Wednesday, November 1st and 2nd, 1921.

The first annual convention of the Western Canada Hospital Association was opened in the City Hall, Regina, Saskatchewan. There was an exceptionally good attendance of delegates from the provinces of British Columbia. Alberta, Saskatchewan and Manitoba, as well as several visitors from the Eastern provinces.

The president, Dr. M. M. Seymour, Commissioner of the Public Health for the Province of Saskatchewan was in the chair. Opening the convention, Dr. Seymour briefly reviewed the purposes for which the association was formed a year ago at Calgary and the manner in which it came into existence. At the close of the short business session the president called upon Dr. George F. Stephens, Superintendent of the Winnipeg General Hospital, who spoke on "The Hospital's Responsibility to the Community." Dr. Stephens said that the three primary responsibilities of a hospital are, 1st, the care of the sick; 2nd, education and 3rd, the prevention of diseases and the promotion of health. In the care of the sick many conditions enter. The hospital exists for the patient. The patient should get the best of care that the hospital can give him. On the matter of education, every hospital has a very definite responsibility to educate those within its walls. The hospital should anticipate the needs of the community and lead rather than be driven. The third function of the hospital and one that is attracting more and more attention throughout the continent, is the public health aspect and the prevention of disease. The hospital must reach out beyond its own walls to assist in every possible way the existing public health agencies. The hospital must assist

in educating the community along public health lines and preventive medicine. There are many lessons to be learned from our friends of the East and South, yet our conditions are not the same and we must work out our own problems.

At noon, the delegates were the guests of the City of Regina at a luncheon in the Kitchener Hotel where they were wormly welcomed on behalf of the city by Mayor James Grassick and on behalf of the Province of Saskatchewan by Premier W. M. Martin. The Hon. W. M. Martin told the delegates that there is a larger amount of hospital accommodation in proportion to the population in Saskatchewan than in any other province in Canada. There is, he said, one hospital cot for every 400 of population in the province and eleven of the thirty-nine hospitals in Saskatchewan are operated on the Union Hospital system.

At the afternoon session Dr. MacEachern read a paper by Dr. H. C. Wrinch, President of the British Columbia Hospital Association who was unable to be present at the convention. Dr. Wrinch's paper dealt with the "Hospital Situation in British Columbia." "In our larger centres, we have hospitals and equipment of as modern and complete a character as would grace the largest and oldest cities on the continent. In the smaller towns there are also some, less elaborate but nevertheless well equipped and staffed hospitals of from 50 to 100 beds. Outside Mental Hospitals or Sanatoria, British Columbia has no "Government" hospitals so called. The local government meets its obligation to assist the indigent sick of the province by making a grant. The amount of this grant was fixed by statute about 16 years ago. Under then existing conditions the grant was liberal, the allowance now is absolutely insufficient. Following the request of the British Columbia Hospital Association an official inspection of hospitals has been inaugurated by the government."

"Certain features of Military Hospital Administration which may be applied with advantage to Civil Institutions" was the subject dealt with by Lt-Col. H. E. Munroe, O.B.E., M.D., F.A.C.S., "The chief value to civil institutions of the features of military hospital administration lies in: organization, records and treatment. With regard to organization, perhaps the most important feature which

has been, more than any other cause responsible for the marked efficiency in military hospitals, is the centralization of control. Every civil institution should have, as a superior officer, a medical superintendent who would exert a cohesive influence throughout the whole institution. With regards to records, there is one form used by the military authorities that is most complete and could with advantage be used in civil institutions:—the case sheet and medical history sheet. This form contains every item of importance from a medical standpoint from the time the soldier meets with illness or injury until the date of his discharge. So far as treatment is concerned there is no better example of the value of group medicine than that carried out in the military institutions.

Dr. M. R. Bow, Superintendent of Regina General Hospital, gave a very interesting address on "Co-ordination of Hospital Services" pointing out that "System" is replacing "Chance" in every line of work and the need of correlating the service was a prime essential which the hospital executive must ever keep in mind.

After discussion on Dr. Bow's address which was led by Dr. MacKathern, the delegates travelled by special street-cars to Government House where they were received by His Honour the Lieutenant-Governor and Miss Newlands.

The evening session took the form of a public meeting which was held in the Auditorium of the City Hall. The President, Dr. Seymour was in the chair and was supported on the platform by Dr. R. T. MacEachern, Vancouver, Dr. A. K. Haywood, Montreal, The Rev. Father T. J. MacMahon, S. J., Chairman of the Catholic Hospital Association and Alderman J. K. McInnis, Chairman of the Board of Governors of the Regina General Hospital. Dr. MacEachern took the chair while Dr. Seymour delivered his presidential address.

Before beginning his address Dr. Seymour called the attention of the gathering to the fact that this week had been named "Cancer Week" and proceeded to give the public present a great deal of information about cancer which the American Society for the control of cancer thought should be generally known. In the course of his address Dr. Seymour pointed out that in Canada the first

hospital, established in 1639 was the Hotel Dieu at Quebec. The Hotel Dieu in Montreal was founded in 1644. The first hospital in the United States was erected in Manhattan Island in 1663, so that Canada had two hospitals built before the first hospital was erected in the United States. The president then went on to talk of Western Canada hospital problems and explained the objects of the Association, 1st, to promote the work of hospital standardization according to the requirements laid down, 2nd, To stimulate hospitals generally to greater efficiency, 3rd, To stimulate co-operation and teamwork among hospital associations and hospitals, 4th, To act as a clearing house for all the problems of the hospital associations in the west of Canada. The motto of the Western Canada Hospital Association, he was, was "One hundred per cent. efficiency care for our patients."

Dr. MacEachern followed with an able address on hospital standardization and its effect on service to the patient. "It is the mission of the hospital to serve the public," he said, "and to fulfil this mission standardization is essential." The public were now demanding, more and more, the standardization of their hospitals and governments in the various places were helping along the movement by curtailing the financial assistance given to hospitals which were not aiming to reach the highest possible standard. "Financing Hospitals" was the subject of the address which followed by Dr. Haywood, Superintendent of the Montreal General Hospital. Dr. Haywood told of his experiences in financing in the East. His talk proved to be entertaining by the manner it was received by the audience.

The second day of the convention was opened with a typical hospital staff meeting arranged by the Regina Medical Association. This was an actual meeting of the medical staff of the Regina General Hospital and was intended to show the delegates how the hospital staff meetings are conducted. Dr. D. S. Johnstone occupied the chair. Dr. J. G. A. Scroggy, Kerrebert, Sask., followed with a paper on the administration of the small hospital which gave rise to some discussion led by Mr. W. F. Kerr, Commissioner, Sask. Red Cross Society. A group photograph was taken of the delegates who then went on an automobile tour of the city, visiting

the hospitals, legislative building and the Royal Canadian Mounted Police barracks. At noon a luncheon and welcome was given at which the delegates were the guests of the Regina Medical Association. The luncheon was presided over by Dr. H. H. Mitchell.

At the afternoon session Dr. W. A. Dakin, late Superintendent of the General Hospital at Regina read a paper on "The Hospitals and the Press," in which he urged for the benefit of all, co-operation between the hospitals and the press. Dr. R. G. Ferguson, Superintendent, Saskatchewan Sanatorium, Fort Qu'Appelle, followed with an address on the "Morale of the Hospital Staff." The thanks of the convention to Dr. Seymour, retiring president, were voiced by Dr. MacEachern and heartily endorsed by the members of the convention. In the evening the Government of Saskatchewan held a reception for the delegates at the Legislative Building. It was decided that the next convention be held in Winnipeg, Man. Dr. Geo. S. Stephens was appointed president of the Association for the coming year and Dr. L. A. C. Panton of North Battleford was appointed secretary.

The following resolutions were passed at the convention:

"Resolved that the Western Canada Hospital Association recognizes the need of psychopathic wards in general hospitals for the more scientific observation and investigation of mental and borderline cases and that the attention of the provincial governments be called to the need of such provision and request for financial assistance for same."

"Whereas cancer is found to be materially on the increase and

Whereas it is generally believed that Radium is beneficial in the treatment of many cases,

Be it resolved:

That the provincial governments be asked to supply to the largest hospital centre in each province an adequate supply of Radium for the treatment of all cases."

Perhaps the most outstanding feature of the convention, and one that has hardly been touched upon in the above review was the fund of information contributed to the meetings by Dr. A. K. Hay-

wood, Superintendent of Montreal General Hospital. Dr. Haywood came specially from Montreal to Regina at the request of the President and Convention Committee. He addressed the convention at the public meeting on the first evening, at the luncheon given by the Regina Medical Association and on various occasions during the discussions following the reading of papers.

There was a general feeling that it was impossible to have too much of Dr. Haywood during his two days stay in the city. His breezy talks on hospital management reflected in every sentence the efficiency and discipline with which the Montreal General Hospital is operated and his presence at the convention was an inspiration to all the delegates.

THE SASKATCHEWAN HOSPITAL ASSOCIATION THIRD ANNUAL CONVENTION

Regina, Sask.

Thursday and Friday, November 3rd and 4th, 1921.

The Saskatchewan Hospital Association's third annual convention was opened in the City Hall, Regina, Sask., on the morning of Thursday, November 3rd, with an attendance of over one hundred delegates. All of the thirty-nine hospitals in the province were represented. Many of the delegates from British Columbia, Alberta and Manitoba who went to Regina for the convention of the Western Canada Hospital Association, which was concluded on the previous day, remained over and were present at the sessions of the Saskatchewan Association.

Mr. J. O. Hettle of Saskatoon, president of the Association, occupied the chair during the first morning session. During the convention many timely topics were discussed and several addresses were given and papers read by eminent representatives in the different fields of hospital work.

Moose Jaw was decided upon as the meeting place for the next annual convention and the following officers were elected for the coming year: Hon. President, Premier W. M. Martin; President,

Joseph Needham, Unity, Sask.; 1st Vice-President, G. E. Patterson, Regina; 2nd Vice-President, W. F. McBean, Moose Jaw; 3rd Vice-President, Miss E. B. Renton, Moose Jaw; Secretary-Treasurer, T. T. Murray, Saskatoon.

At noon on the first day of the convention the delegates were the guests of the Board of Governors of the Regina General Hospital at a luncheon in the hospital where they were given an enthusiastic welcome and afterwards taken on a tour of inspection of the two city hospitals.

At the close of the convention votes of thanks were extended to the retiring president, Mr. J. O. Hettle, and the retiring secretary, Mr. G. E. Patterson and afterwards there was a reception of the delegates given by the sisters at the Grey Nun's Hospital.

Miss M. E. Turner, of the City Hospital, Saskatoon, read a paper on "Nursing Problems," which aroused a good deal of discussion. Miss Turner said that we all have a very clear idea of the nurses's duties to the hospital, but the duties of the hospital to the nurses have not been so clearly defined and in some cases had not even been considered. It is essential that the nurse be given a home life. Provision should be made for the nurse's amusements and recreation. Student nurses should have separate rooms. Each should have the opportunity of being alone if she so wished. There should also be provided a study room. All training schools should demand from pupil nurses a standard of education. It should be compulsory that each pupil be supplied with the necessary text books required by the standard curriculum. All hospitals of fifty beds and over should have an instructress of nurses. One of the problems of the smaller schools is to provide sufficient training in special branches of work. These schools may affiliate with another school to supply the deficiencies and usually with good results. Nurses wishing to take post graduate work have usually been going to the United States for this work and I feel that all our training schools of over 300 beds and having an instructress of nurses, both in theory and practice should offer a post graduate course. The introduction of a practical, sensible course on dietetics into training schools has meant a very decided improvement in the whole dietetic department of many institutions. One of the weakest points in the

whole machinery of many hospitals has been and still is the dietetic department."

Discussion on Miss Turner's paper was led by Miss E. B. Renton of Moose Jaw General Hospital. She emphasized the importance of keeping pupil nurses happy. A helpful interest should be taken in the pupil. She should be encouraged in loyalty and the spirit of unity as well as discipline.

Dr. O. E. Rothwell, Regina, agreed with Miss Turner that one of the problems of the smaller hospitals was the arranging of post graduate courses for the nurses. There were certain features which could not be got in the smaller places.

Dr. M. T. MacEachern of Vancouver gave an address on "Hospital Administration and its Problems." In dealing with this subject, Dr. MacEachern said that the first need in all hospitals is organization. For the economical management of a hospital reclamation should be peristently practiced. If you cannot mend a thing you should cut it down for other purposes. Much money, he said, could be reclaimed on linen alone. Good economy, he believed, was to give your patients lots of food and good food. In the hospital's relations with the public those in charge of hospital administration should see that the community is given good intelligent publicity. The public, generally speaking, has some rather ignorant and erroneous ideas about hospitals. Good publicity would help to dispel these ideas. In the nursing department, the nurse should obey the doctor's orders implicitly. The doctor may order; but if the nurse does not carry out the doctor's orders, nothing is accomplished. The nurse should be trained to make accurate observations and record them on the chart. The nurse's eye is constant, the doctor's only casual. The doctor has to depend a great deal on what the nurse reports.

The afternoon session of the first day was presided over by Mr. Joseph Needham, of Unity, Sask. He called on Mr. T. T. Murray, of Saskatoon, who gave a very delightful talk on his visit to the convention of the American Hospital Association at West Baden.

"Organization of a Union Hospital District," was the subject of a paper delivered by Mr. A. C. Sarvis, of Moosomin, Sask. Mr.

Sarvis went into all the details of how union hospitals were established under the existing laws of the province, relating some of the difficulties which will yet have to be overcome. Dr. M. W. Seymour, Commissioner of Public Health, for the Province of Saskatchewan suggested that a committee be appointed to draw up a resolution dealing with the defects of the present act for presentation to the Provincial Government. He said he could assure the convention of the serious attention of the legislature to this matter. Messrs. Needham and J. W. Heartwell and Dr. Seymour were appointed to draft such a resolution.

Mr. J. W. Heartwell, of Rosetown, Sask., then read a paper on the "Operation of Union Hospitals," dealing with the manner in which these hospitals were being conducted after being established under the Union Hospitals Act of Saskatchewan.

The morning session of the second day of the convention, was presided over by Alderman J. K. McInnis, President, Board of Governors of the Regina General Hospital. The first speaker was Mr. O. J. Godfrey, C.A., of Indian Head, Sask., who went briefly into the question of "Hospital Accounting." Mr. Godfrey pointed out that the forms of report which at the present time the smaller hospitals have to send to the government are absolutely valueless. They present a cash statement only and any business man will tell you that cash statements are not only useless but are also misleading.

The afternoon session of the second day was presided over by the president, Mr. Hettle, who called upon Mr. A. Wilson, of Prince Albert who addressed the convention on "Municipal Hospital Finance." Mr. Wilson said that hospital finances should be in just as good shape as those of any other kind of business institution. If the balance sheet shows a deficit at the end of the accounting period there is something wrong in the management of the hospital.

The chairman asked the secretary to read a paper on the same subject by Mr. Howard Jones, Secretary Treasurer of Lloydminster and District Municipal Hospital. Mr. Jones, unfortunately was unable to remain to address the convention himself. He dealt principally with the difficulties experienced in his district on account of the fact that the hospital at Lloydminster is jointly

owned by municipalities in the two provinces of Saskatchewan and Alberta. Under present legislation, Mr. Jones pointed out, both in Saskatchewan and Alberta every patient must be treated as an indigent, because indigency or inability to pay, in most cases has to be proved and is not frequently known upon admittance. To be certain of fixing the responsibility, it is necessary to notify the municipality in every case. This procedure was very costly, especially in a hospital such as theirs where they handle six or seven hundred patients in a year.

"The Construction of a Modern Hospital" was the subject of a paper by Mr. R. M. Thompson, of Saskatoon. He outlined the way in which he considered the different departments of a hospital ought to be planned. He emphasized the necessity for fire-proof construction, pointing out that this could be obtained in many cases at a cost equal to, if not less than, that of erecting a non-fireproof building and the insurance was lessened so materially as to make up for any increase in the initial cost.

HOSPITAL SUPERINTENDENT PASSES AWAY AT CHATHAM

Miss Ethel Anne Wood, Superintendent of the Public General Hospital of Chatham died on December 9th. Two weeks before she underwent operations on her eye, nose and throat. Miss Wood was graduated from the Owen Sound Hospital, afterward taking a post-graduate course at Bellevue Hospital, New York, and previous to coming to Chatham had been Superintendent at Cobourg, Owen Sound and Picton hospitals.

ST. BONIFACE HOSPITAL

St. Boniface Hospital at St. Boniface, Manitoba, conducted by the Grey Nuns, Sisters of Charity, observed on August 24th, the Fiftieth Anniversary of its founding. The hospital, the Sisters in charge and the staff were the recipients of congratulations from the entire community. The hospital which had been entirely renovated for the occasion was beautifully decorated with flowers, garlands and lights. The hospital grounds were brightly illuminated in the evening and decorated with bunting.

The program of the day began with Pontifical High Mass sung by Father S. Caron, assisted by members of the clergy from the archdiocese. Among the distinguished visitors at the Mass were Mother Dionne and Mother Assistant of the Order of Grey Nuns and Sister Lamoureux, who was Sister Superior of the hospital from 1902 to 1909. Among the notable secular visitors who crowded the chapel was Lady Dubuc who was present at the dedication of the first bed of the hospital and also of the first building.

The sermon of the occasion was preached in French and English by His Grace, Archbishop Beliveau of Montreal. His Grace likened the Order of Grey Nuns, Sisters of Charity, to the good samaritan who took up the wounded man and gave him help until he recovered. He outlined the work of the Grey Nuns in Western Canada where they are particularly active, saying that in cases of sickness and destitution, they are never wanting where relief can be afforded.

Between the hours of three and four o-clock in the afternoon, the lady patronesses of the hospital and the wives of the attending physicians were tendered a reception by the Sisters and the members of the nursing staff. Sister Superior, St. Jean del'Eucharistie, received the guests.

Following the ladies' reception, the graduate nurses who have been trained in the hospital and who are now scattered over the Province of Manitoba, were received by the Sister Superior, the visiting members of the Order, and the Sisters resident in the hospital. Nearly 150 nurses were present.

At 7 o'clock in the evening a dinner was tendered to the doctors, the visiting clergy, the local city officials and the male benefactors of the hospital. His Grace, Archbishop Beliveau, His Honor Mayor Sullivan and Dr. J. P. Howden, who presided, were among the guests. Among the speakers were Honorable G. Malcolm, Dr. James McKenty, Dr. L. D. Collin, and Dr. George F. Stephens, Superintendent of the Winnipeg General Hospital.

On August 25th a reception was held for the Sisters of all the religious communities in the Winnipeg province. The visiting Sisters were entertained at dinner and at an evening reception. The celebration of the hospital jubilee closed on August 30th with a Pontifical Requiem Mass for the patients who have died in the hospital since its foundation.

Discusses Standardization

Among the several addresses at the dinner, two papers attracted especial attention. The first of these was read by Dr. James McKenty on Hospital Standardization. Dr. McKenty said in part:

"Hospital Standardization is in the nature of a reform of certain abuses in the practice of surgery.

"The eminent men in the profession have long been aware that many unnecessary operations were being performed by men of mercenary motives, that also many operations were being imperfectly performed by men without training in surgery. The evidence of this was found in the number of patients coming to the large hospitals in the great centers of population in Canada and the United States of America, who were found to have had unnecessary or unskillful surgical operations performed upon them.

"In order to remedy this abuse the American College of Surgeons was organized, the intention being that it should fill the place upon this continent that the Royal College of Surgeons fills in Great Britain and Ireland, that is, by granting to adequately trained men the Fellowship of degree, the possession of which is accepted by hospitals in the British Isles as evidence that the holder is competent to undertake major surgical operations, and without

which no doctor is given an appointment upon the surgical staff of any hospital. That very little surgery is done and no hospital position in surgery is held by any, excepting men possessing the F.R.C.S. degree. Here upon this continent it has been customary for most of the general practitioners to do also major surgery with the result that much bad surgery has been done upon this continent.

"But the custom which permitted untrained men to attempt major surgery was not the only cause of much inefficient work. Another factor was the inadequate equipment of a a large number of hospitals upon this continent, hence the co-operation of hospitals in the reform movement became necessary. After three years of investigation and study of the situation, a minimum standard regarding equipment and trained personnel was formulated for hospitals of 100 beds or over. Hospital Boards, everywhere, recognizing that they shared in the responsibility for the character of the service rendered patients in their institutions, heartily co-operated in the program outlined by the A. C. S. Already much improvement had resulted.

"You will be glad to know that the first inspection of Canadian hospitals made in 1920 finds St. Boniface one of the three hospitals in this Province that is worthy of a place on the "Approved list," and I am sure it will always, so long as it remains in the control of the Grey Nuns, continue to occupy the position of first rank."

The Service of St. Boniface

The services of the hospital and of the Sisters were described graphically by Dr. D. Collin, who said in part:

"A great conqueror, Cyrus, I believe, passing through a plain of Asia, noticed one day a tree of astonishing vigor and beauty. Its powerful roots, sunk deep in the soil were nourishing a soaring and straight body crowned by branches symmetrically disposed and covered with thick foliage. This tree, owing to its imposing height, its luxurious vitality and its majestic appearance, was so strikingly admirable that the Monarch, as an expression of his feelings, had it decorated with a band of gold.

"This deed of the conqueror conveys clearly the impression which extraordinary greatness, beauty and kindness bring to the human mind; and in the bestowal of palms and crowns does spontaneous admiration then manifest itself.

"Fifty years have elapsed since the day when the Reverend Grey Nuns opened the small shelter containing but four beds. To-day, they administer a lofty institution of 428 feet in length with a capacity of 500 beds, which represents the extraordinary growth of 1 to 125. The present hospital is in Canada, one of the most important ones. Its equipment is one of the most modern and complete. I shall not dwell on the historical phases of the progressive developments of the institution, this being well brought out by the artistic program-souvenir of its golden jubilee.

"In days of old, Cyrus was admiring the gigantic tree. To-day, in glancing over the rapid development of St. Boniface Hospital, we also are struck with admiration and willingly bestow the crown of merit to the Community which has in relatively such a short time, accomplished this wonderful masterpiece. Yes! we admire the vast proportions of the structure, its practical and efficient equipment, its intelligent and devoted administration; but what we find most remarkable of all, is that this institution, this refuge of human sufferings, could not have come into existence and develop as it did, but for the countless sacrifices in time, resources, tedious work, health and even lives of the valiant daughters of the Venerable Mother d'Youville.

"St. Boniface Hospital is not a financial institution; it is a charitable institution, in a high degree humanitary, because it is essentially Christian. In this is the secret of its success and the sympathetic appreciation extended to it by the public as well as the patients and the physicians who are good judges of devotedness, intelligence and results. As the proof of this, we might be allowed to state that the patients who have made a stage here and received treatment, lose the instinctive horror for hospitals and willingly come back when necessary. And besides, St. Boniface Hospital, according to statistics, is one of the hospitals where the rate of mortality is the lowest.

"Half a century is relatively a short period in the life of an institution destined to become several times secular. And if already more than 124,000 persons of all nationalities and creeds have sought here health or at least relief from their sufferings, thousands of others shall come yet and thus give to the Sisters of Charity and those who second them, the occasion of devoting themselves generously to the saving of lives and the assuaging of afflictions.

"In considering the beneficent mission filled during these fifty years by St. Boniface Hospital, one cannot but heartily wish that it keep on growing and prospering more and more as the great tree firmly rooted in the soil of our fertile plains.

"We believe it to be our duty to respectfully and gratefully bow to the workers of the first hour; Sisters, physicians and nurses, who have laid as we might say the foundations of the enviable reputation enjoyed by the hospital.

"In the name of the medical profession, we thank the administration for its orderliness and progress. It has not counted sacrifices in order to assist the doctors in their respective branches, and its efficient co-operation in continually improving conditions immensely facilitates the tasks of the doctors, while increasing the chances of success and minimizing the risks.

"We also owe eulogy to the nursing body, which is perfectly trained and disciplined by the Sisters. The nurses are a great and indispensable help to the medical body, who know that they can rest at ease and rely implicitly on their ability and devotedness. As we all know that a large share of the work and self-sacrifice is that of the Nursing Sisters, far be it from us to forget them. We would like very much indeed to mention a few names; but out of respect for the feelings of our modest Sister-nurses, we shall not do so inasmuch as their zeal and merit are so well known that it needs not be proclaimed here; their merit speaks for itself and is proclaimed by all those who have seen them at work.

"If the institution deserves rightly the eulogy and gratefulness of all, this eulogy and this gratefulness are rightly due to its operative soul: the Order of the Reverend Grey Nuns. The good ac-

complished here is the most convincing evidence of the usefulness of religious communities and more particularly of theirs. In devoting themselves to the care of patients, they fulfill a mission of extreme utility to our country. Indeed, the part of a soldier fighting for his country is very great; but how much more sublime is the vocation of a sister-nurse, sacrificing her youth, her future and her life for the care of the sick. Therefore, it is only a duty of strict justice to proclaim highly all that our country owes to the Reverend Grey Nuns and wish them, besides the reward that they expect from Him, Who said: "That he who giveth a glass of water in His name shall not be without reward," every success in their work and long life for their community.

"To sum up all I would wish to express, I conclude by saying: Prosperity and long life to St. Boniface Hospital, honor and gratefulness to the devoted Grey Nuns."

THE HISTORY OF ST. BONIFACE HOSPITAL.

St. Boniface Hospital dates back to 1871. The Grey Nuns had been active in the frontier settlement of St. Boniface as far back as 1844, when their mission undertook the education of the children of the scattered pioneers of the community. Their Work, however, soon was extended to nursing sick and invalids and taking care of orphans. The hospital of St. Boniface was establised on August 5, 1871, in a small wooden building which afforded space for four hospital beds. In 1877 the Sisters acquired a house which increased the capacity to ten beds. This building was enlarged in 1886, again in 1893 and in 1899. A separate institution, St. Roch's Hospital, was established in 1899 in proximity to the main hospital as a special institution for contagious diseases.

In 1905 the south wing of the present building was erected and with it the total bed capacity of the hospital was increased to 350 beds. In 1914 the central portion of the old hospital was torn down and a new six story structure of fireproof construction was erected. The building was completed in 1916 and occupied on June 22nd of that year.

The hospital now is located in a building 428 feet long, fully equipped with laboratories, operating rooms, and private and public words. The bed capacity is 500. During the war and even at the present time the hospital is treating veterans of the European war. Up to December 31, 1920, a total of 30,029 soldiers had been treated.

Book Reviews

General Pathology—An introduction to the study of medicine, being a discussion of the development and nature of processes of disease, by HORST OERTEL, Strathcona Professor of Pathology and Director of the Pathological Museum and Laboratories of McGill University, and of the Royal Victoria Hospital, Montreal, Canada. New York: Paul B. Hoeber. 1921. Price $5.00.

The production of a successful work upon a scientific subject demands of the author a profound knowledge of his subject. The mental capacity to visualize it from the position of those less well informed and the clarity of thought to present in clear and concise language, what he and other workers in the same field have learned from carefully recorded observation and research. The present work on general pathology by Ortel possesses in a large measure the above points of merit and it is not undue praise to bespeak for it a wide circle of friends.

The author has very clearly developed the thought that in the study of disease, existing conditions must be approached within the frame of Modern Biology; and that we must interpret our observations in the light of expressions of Physico-Chemical Laws. That the historic development shows how one step of thought influences the next and thereby enables us to arrive at a proper valuation of current ideas; that the vizualization of possible pathological occurrences (approached from their anatomic histological development leads to a clearer understanding of disease.

The author has achieved a distinct advance in the presentation of the subject of general Pathology, and in all fairness we must say that he has given the medical profession, a work worthy of rank with those of some of his notable predecessors in the same field of scientific research.

Food Products—Their Source, Chemistry and use by E. H. S. Bailey, Ph. D., Professor of Chemistry and Director Chemical Laboratories, University of Kansas. Second revised edition, with 92 illustrations. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. Price $2.50 net.

This is a most interesting and useful little volume giving an account of the source, composition and use of nearly all foods. To quote the preface "The general principles of food production, manufacture and preparation are discussed in such a way that the reader may have a practical knowledge as to what constitutes a good food and where it may be obtained."

It is written to serve as a text book for students of food in universities and high schools, but it will be found a most useful addition to the library of the internist. It is not a book on dietetics, but it contains much useful information about the source and manufacture of foods that are not found in works on diet.

The Hospital World

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Hospitals 80 Per Cent. Clean

A statement made by Dr. T. G. Cobb of the U. S. Public Health service to the effect that a certain N. Y. hospital was "eighty per cent. clean", gave a recent issue of Life an amusing page of burlesque illustrations;—a small boy "80 per cent. clean behind the ears",—eggs "80 per cent. strictly fresh",—a fair damsel accused "80 per cent. innocent".

But since the statement of the aggrieved Public Health official was evidently made in all sincerity, it moves us to inquire just what is the unit of perfect cleanliness; what condition should exist in a 100 per cent. clean hospital, and how low a percentage of cleanliness may be considered a 'pass' ranking.

Is a 100 per cent. clean hospital possible, or is it a matter of standardization, and who sets the standard? To-day's standard of cleanliness is far in advance of that of three, two, or even one decade ago. The revelation by science of the inquitious 'germ' and its processes has at least, like the proverbial new broom, swept clean much of the accumulating dirt to which hospitals are especially prone.

Again, in how far is cleanliness a relative term? Should the same standard of cleanliness be demanded from the big New York hospital and the humble **Hotel Dieu** in Red Gap, Arizona? Presumably, in New York, if anywhere the 100 per cent. should be expected; yet the investigators were "horrified at the filthy condition prevailing. Dirt and litter were everywhere".

Now if this were truly reported and still pronounced "80 per cent. clean" by the defending U. S. official, how about 50 or 40 per cent., and what percentage would a hospital cease to be an hospital and become a pig-stye. With apologies to that animal.

Undoubtedly there are degrees of cleanliness. The small boy standard is not that of the adult; the Hottentot not that of the fastidious Anglo-Saxon; the slum-bred dweller not that of the Hillcrest citizen. It does not necessarily mean the extravagant sterility of marble floors, plate glass and nickle furnishings, since a recent eminent visiting surgeon asserted that as great operating success had been achieved under humblest hospital conditions in the Orient, as in the costly hospitals of our Western cities.

Yet cleanliness should be cleanliness absolute in every hospital, as far as science within and environ-

ment without can command. The 100 per cent. may be, must be a constantly changing ideal, as medical science advances; but it must be striven for to the utmost.

Hospital Progress

The Modern Hospital in its January number reviews the work of hospitals in a general way during 1921. Dr. Billings opens by drawing attention to the two important objectives decided upon in Montreal in October, 1920: (1) To promote co-ordination of all hospital agencies engaged in hospital betterment and to encourage co-operation . . . to the end that efficiency, economy and avoidance of duplication of work may be secured; and (2) to establish a hospital library and service bureau at Chicago. The hospital conference held in Chicago in March, 1921, adopted standardization, endorsed the standards of the College of Surgeons, decided to negotiate for the transfer of field work of the College to the Hospital Conference, if so desired by the former; decided to formulate standards applicable to follow-up work, statistical reports of clinical work, accounting, nursing and the like; decided on (a) the training of executives, (this in co-operation with the work of the Rockefeller Foundation); (b) on the development of higher medical standards and more efficient community service by post-graduate

teaching, by supporting the further development of intern standards of the America Medical Association, promoting the fifth or intern year as prerequisite for independent practise; (c) to encourage teaching of graduates at hospital centres; and (d) to promote plans for the establishment of closer relations between practitioners and well-equipped dragnostic centers at hospitals and dispensaries.

The Conference, beside meeting in March in Chicago, met at West Baden during the week of the American Hospital Association meeting. At both these meetings papers were read and discussions given bearing on the above program. During the year the Hospital Library and Service Bureau had a phenomenal development and did good service to the public—far beyond the expectation of its founders.

The Catholic Hospital Association

Dr. B. F. McGrath, secretary of this Association, reports that among its achievements in 1921 were (1) an increase in membership; (2) the organization of several state and district conferences; a successful summer school for technicians at Loyala Medical School; the holding of a conference at St. Paul in June at which a "questionnaire box" and a model staff meeting were specially featured; the ad-

dition of new departments to its official publication, and the formulating of its own standard on a high scale.

Progress in Canada

Dr. M. T. MacEachern, of Vancouver, B.C., recently called attention to the work of the Provincial Associations—British Columbia, Alberta, Saskatchewan, Manitoba; also to the Western Canada Hospital Conference, and the Western Canada Catholic Hospital Association.

In the medical department of hospitals, Dr. T. R. Ponton had made a survey of every general hospital of fifty beds and over. All hospitals were willing to accept the minimum standard At the end of the survey it was found that 62.7 per cent. of the hospitals of 100 beds and over had reached this standard.

Great progress had been made in laboratory services and in the department of dietetics. Much advance had been made in treatment, particularly along the lines of physiotherapy and radiology. The eight-hour system for nurses had been generally adopted. The larger training schools had been taking advantage of certain courses at the Universities. Much had been said about increased support from municipalities and provinces, and much attention had been given to establishing accounting systems.

The German System

In recent articles in the press there have been some aspersions cast on the German system of medical organization in universities and hospitals connected therewith.

The first big hospital in North America to adopt the German system was the Johns Hopkins Hospital at Baltimore. It has proved a success there. No better teaching has been done anywhere. The graduates from there are now leading teachers in medicine in many prominent centers in the United States.

When Osler, Welsh, Kelley and Halstead were called in from outside places and put in charge of their respective departments there was a big outcry from the local practitioners, a number of whom had been slated by their brethren for the positions—even having their names published as the ones about to be appointed.

These men (barring Welsh), were not full-time men, but did outside practise as well. Recently, however, the Hopkins decided on full time men. Barker was offered the post in medicine, but chose rather to decline, retaining his clinical professorial work and his outside consultation practice. The full success of this innovation is not yet generally known; it should work well. The conduct of such a

department as that of medicine or surgery in our larger universities requires the whole time of one man.

At the Charity, Berlin, in 1911, there were two chiefs in medicine in charge of two large hospital services—men of equal status. These men had a goodly staff of residents, assistant residents, and house officers, as may be seen at the Hopkins. These residents are men who serve several years and do a good deal of the routine and subsidiary work for their chiefs.

In each of the services at the Charity there are special laboratories—chemical bacteriological, pathological and X-ray. The diagnostic work is done very thoroughly.

For a long time London and Edinburgh excelled in bedside teaching. That excellence has been widely copied in America.

Our newer American and Canadian hospitals are following the best of the German and British ideals. In nursing attention our Canadian hospitals excel.

The resident system is right and should be introduced in our largest teaching hospitals.

In Toronto, the system of having clinical assistants to the chief—not resident—but doing part time at the hospital and practising privately the remainder of the day—each dealing with certain divisions of medicine, is being tried out.

The results of the present plan are not yet very apparent. Time will tell. The unitary idea of organization is the only one. The American College of Surgeons recognizes this.

A Princely Bequest

One of the largest bequests known to have been made for hospital purposes is that of the late Lord Mount Stephen, who died in November last. The greater part of his princely fortune was left to the King Edward Hospital Fund. The bequest amounts to something over three million dollars, which, added to contributions to the same Fund made during his lifetime, brings a magnificent total of over five million dollars.

Lord Mount Stephen made his money in Canada, therefore the Canadian press have expressed a measure of regret that the fortune thus acquired should have been devoted so entirely to charities in England, when Canada affords such extensive opportunity along similar lines.

The large public hospitals of England are organized on an entirely voluntary basis, wherein, doubtless lies their appeal to the individual benefactor. The King Edward Hospital Fund was organized with the primary purpose of meeting the annual deficiencies of the London hospitals, and in the years

since its inception it has become a strong influence in the systematic administration of these institutions.

One of the marked values of the Fund lies in the fact that it constitutes an authoritative corporation to which legacies may be left for hospital purposes, with the assurance that, not any favored one, but all the hospitals within its jurisdiction will be benefitted by it. Some one or two princely legacies just previous to 1914 ennabled the Fund to carry on during the war.

The past year or two has been a time of acute crisis for the great London voluntary hospitals, and this latest and greatest bequest of the Canadian millionaire will relieve a great anxiety on the part of the administrators.

The public hospitals of Canada, while getting a measure of state aid, are still largely individualistic in method of administration and finance. The consolidation achieved by the King Edward Fund has brought all of the voluntary hospitals of London—over one hundred in number—under the skilled oversight of a Board of the foremost public men in London, who, from year to year give a great voluntary personal service to the work. Such names as the Duke of Teck, the Speaker of the House of Commons, the Governor of the Bank of England, the President of the Royal College of Physicians

and Surgeons are strong guarantee of wise, just and economic administration. And it is doubtless such assurance that makes strong appeal to men like Lord Mount Stephen.

Some similar corporate body to advise and co-ordinate the work of the hospitals might well be developed in the large cities on this side of the ocean. One result might be that large benefactions might stay in the country where they were made possible.

Radium

Chester Stone, of Brooklyn, writing on this subject in the Long Island Medical Journal, says that Radium has been employed for treating disease for 15 years, but only seriously for the past 3 or 4.

The operator should have a knowledge of the character of the rays given off, the arrangements of the Radium, the distance from the tumor, the technique of filtration, the duration of time of the exposures, the interval between the seances, the amount to be used, the form, shape and location of the tumor; also the susceptibility of the involved tissue, its embryologic and histologic origin, its pathology, the resistance of the surrounding and pathological tissues, the lymphatics, and other chemical, physiological and biological factors.

During the course of treatment the actual size of the tumor should be compared with previous measurements, the visible effects on the tissues observed, and a daily examination of the blood made.

Trained Professors

It is pertinent to inquire why the authorities of Toronto University should not insist on employing men of sound scholarship and pedogogical training as professors, lecturers, and demonstrators. They are insisting on a high matriculation standard for students. Shouldn't they insist on an arts or science graduate standing for the teachers of these students. Besides, oughtn't these teachers be taught pedagogy before joining the staff? Public and high school teachers are required to take courses of a year or so in model, normal schools, or the school of pedagogy before embarking on the teaching profession. We maintain that it is equally important that every teacher of medical students should be obliged to take at least a year's course in pedagogy before he attempts to teach.

It is an obvious fact that some of them are poor teachers, lacking in the scholarship and culture now demanded of freshmen.

It is not at all clear to the medical profession, nor to the general public on what grounds some of

these men are chosen and others more competent left in the cold; and, further, why some men—tried and tested—are dropped and others less fit are retained.

The University would not suffer if a little more openness were given to this question of the selection of its teaching staff and the matter of demotions.

At present there is a feeling of malignity and bitterness among the ill-treated and a feeling of uncertainty and dissatisfaction among certain of the staff. Some of these men are not consuming their own smoke; they are speaking out; and their wailings are not without effect among the people at large, who as a whole, like to see fair play.

Prescriptions

Last Christmas there was a booze-fest in Ontario. With Christmas good-will in the air, there was a disinclination to be hard and uncompromising. So many good-hearted medical men acceded to the entreaty of "friends (?) and signed a script.

Some of them over-did it—300 of them—and, as a result, at this writing, are denied the privilege of writing any prescriptions! What are their patients to do—those who are in dire need of a few ounces? Some professional brother will act for them,—one who practices brotherly love, relief and truth, as well as medicine..

The lesson, though severe, will be wholesome to the criminals, and admonitory to their pitying brethren.

Of course, the plan of prescribing a quart is wrong. But the practise will finally result in a **reductio ad absurdum.** Camparatively few prescriptions were given for liquor before the act came into force. No more are actually required now for purely acute medical cases. But many medical men now sign prescriptions for the aged to whom "wine is milk," and to the Timothys who have been recommended to take a little for the stomach's sake.

This the physician had no occasion to do before, nor should he be asked to do so now. Thousands of people develop colds who do not require a medical man's attendance. They have learned through medical channels and by experience that a hot dose or two of good diluted whiskey is an efficacious remedy or it may be they are suffering from a flatuated colic due to some dietary indiscretion; or they may have developed a chill through exposure and require a dose of rum or brandy to relieve the temporary indisposition. They wish to try such a remedy with the hope that a doctor may not need to be called—perhaps at night or perhaps in a place miles remote from a doctor.

Thousands of sane, temperate, God-fearing people (such as our old Scotch Presbyterian, than whom there are no better citizens), have always prior to the O. T. A. had a bottle in the house for the relief of these minor distresses. We can see no good rea-

son why they should not be permitted to have this remedy for self-administration always in hand.

But to quite a marked extent they are not in this position, partly because of their unwillingness to put up the plea of being sick, and partly because they do not want their respected and conscientious physician to stultify himself.

The abolition of the bar is an excellent thing and prohibition up to a point is good, but there should be some other plan for providing a certain amount of stimulant for those who may be trusted to use it properly than by saddling the responsibility on the doctor.

Eclampsia

In an article on this subject in No. 218 of the New York Medical Journal, Dr. B. C. Hirst, attributes its causation to presence of the fetal body, combined with a proteid diet on the part of the mother, an inactive skin, and sluggish bowels. Hence the success in preventing the trouble by avoiding toxemia through a diet light in proteids, by preserving skin action, by regulating the bowels, and by stimulating the liver every four weeks by a mild course of calomel and soda followed by a light saline laxative.

Seeing that every subject of this disease has a parenchymatons nephritis and is uremic as well as toxic, diaphoresis and catharsis are energetically employed. The patient is put in a sweat cabinet every four hours for thirty minutes and the subtracted fluid is supplied by proctolysis—a quart of water

with an ounce of bicarbonate of soda (to combat acidosis) by the drop method, midway between the sweats.

Dr. Hirst begins treatment of eclampsia by washing out the stomach to remove undigested food, and the stomach tube is used to instil the purgative—usually two ounces of castor oil with two drops of croton oil. If the patient is able to swallow concentrated doses of Epsom salts are given every half hour until two ounces are taken. If the stomach tube is not used a quarter of a grain of Elaterium on the back of the tongue replaces the castor oil. If there is much oedema 20 grains of compound jalap powder are administered. Directly after the gastric lavage the colon is also washed out to remove fecal masses.

For sedation morphine alone is depended upon—and only if the convulsions are violent and frequent. To reduce blood pressure, an initial dose of ten minims of veratrum viride and subsequently one-hundredth of a grain of nitro-glycerine every 4 hours. Venesection is done routinely to the extent of 16 ounces if the systolic pressure is at or above 180. If the woman is not delivered, puncture of the membranes brings down the pressure in a most remarkable manner. Dr.. Hirst reserves caesarian section for cases in which there have been preliminary elimination, sedative treatment, measures to reduce blood pressure, without progress in labor and without improvement.

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Society Proceedings

PROCEEDINGS OF THE THIRD ANNUAL CONVENTION OF THE ALBERTA HOSPITAL ASSOCIATION, HELD NOVEMBER 9TH TO 11TH, 1921.

The Third Annual Convention of the Alberta Hospital Association was held November 9th, 10th and 11th, in the New Medical Building of the University of Alberta, in conjunction with the Alberta Association of Registered Nurses. It opened with a public meeting under the chairmanship of his Honor, the Lieutenant Governor R. G. Brett, M. D.; Honourable Mr. R. G. Reid, Minister of Public Health addressed the meeting, explaining the general attitude of his department towards the Public Health services and the policy of the new Farmers' Government towards Health and Hospital problems. Miss Jean Browne, R. N., Superintendent of the School Hygiene, for the Province of Saskatchewan, gave a very excellent address describing fully her experiences and impressions gained while taking post graduate studies in European hospitals under the auspices of the International Red Cross Society. This meeting was also addressed by Dr. H. M. Tory, President of the University of Alberta and Reverend Father Carleton. The latter traced the development of hospitals from the Middle Ages, showing how the Church had taken the first step in providing places where sick travellers could be cared for in a medical as well as a spiritual way.

Each session of the Convention was devoted to a special subject, i.e. Business, Training School Standards, Hospital Administration and Finance, Pathology and X-Ray services for rural hospitals and a medical session.

At the business session two outstanding papers were read. One by Dr. H. C. Wrinch, President of the British Columbia Hospital Association entitled "The Nurse of the Future", created a good deal of discussion and antagonism among the nursing elements. This paper deserves special mention. It develops two important points

for consideration. It was shown how as a result of financial distress hospitals had developed the tendency of exploiting the services of the undergraduate nurse by gradually lengthening the course of study and thereby retaining her services for a maximum period at a minimum financial outlay. Secondly he pointed out the great shortage of nurses for service in the rural communities. He doubted whether the extreme training given to undergraduate nurses in our general hospitals was a necessity in carrying on such work. He asked that hospital authorities consider the matter carefully and develope the training school more along the university arrangement whereby a minimum necessary training of two years be given to all nurses in training. Then those showing special aptitude or desire for administration duties, such as government services, superintendents, could be given a further training leading to a more advanced degree. In this way more young women would be induced to enter the nursing services, and by lessening the cost of their obligatory education they would be willing to practise their profession for a lesser financial return and thereby be more available for service in rural communities. He pointed out that the official nursing organizations have accepted as one of their principal functions the professionalizing of the high and God-given calling of caring for the sick. Under the assumed necessity of maintaining and raising the standard of nursing service more and more subjects have been added, and those young women who have survived the process have been trained away from the valuable portion of the true nurses armamentorium, the sympathetic earnest desire to bring relief to the suffering.

Dr. O'Callaghan, medical officer in charge of the Junior Red Cross section of the Canadian Red Cross Society, gave an intensive study of the particular needs of his society in the province. He showed how the Junior Red Cross had assumed the financial liability of caring for numerous needy boys and girls, particularly from rural communities, and undertook to pay their hospital expenses. He showed how such cases became, without the assistance of the Red Cross, a burden on the hospitals. In view of this he moved a resolution at the Convention that the hospitals be asked to give a lower day rate to cases under the care of the Junior Red Cross.

Rev. Father Cameron, a member of the Holy Cross Hospital Board, went fully into the need of development of the rural hospital. He showed how the Municipal Hospital might be developed into

a health centre for the surrounding area. He, however, emphasized the fact that the process must not be carried too far. Such a centre must limit itself to those duties which it could properly perform. There must be the willingness to make use of the facilities available in the larger centres.

The nursing session was held under the chairmanship of Miss Eleanor McPhedran, R. N., an Overseas Nursing Sister, now in charge of Bowness Tuberculous Sanitorium. Several good papers were read at this session; of particular interest was one by Dr. D. B. Leitch, late Interim Baby's Hospital, New York City, on the "Standardization of Instructions in Dietetics for Children", with particular reference to child welfare service. He pointed out that in the development of these services he had noted a deficiency in the training given to nurses who entered such social service and suggested the need of special training for those nurses who would take charge of Child Welfare Clinic.

As a result of the growth of municipal hospitals in the Province and the difficulty which nursing supervisors have giving their graduates the necessary instructions and training to comply with the regulations of the Registered Nurses' Act, the subject of "Affiliation of Training Schools" was fully discussed at this session. Dr. Allan Rankin, a member of the Senate of the Alberta University brought forward a scheme for affiliation of training schools for the endorsement of the Convention. The plan is elaborate and will require considerable time before it could be brought into effect. At present the regulations for the registered nurses are under control of the Senate. It would be first necessary to standardize all training schools as to subjects and hours of instruction. When this had been done, hospitals of 20 beds or over would be eligible to send their pupils, after two years of instruction, to hospitals of 40 beds or over for a third year. It was felt that there were many difficulties to surmount, but that shortly it would be possible to assist the smaller training schools.

The Hospital Administration and Financial session was addressed by Mr. C. J. Yorath, Civic Commissioner of Edmonton, on the subject of hospitals financially. He developed two main points for consideration, i.e., the necessity for more extensive prophylactic measures to raise the general standard of community health thereby relieving the hospital of an excessive number of patients, and a

scheme whereby certain taxes derived from the well might be set aside to care for the sick.

Mr. Arthur K. Whiston, Secretary of the Provincial Municipal Hospitals showed how such a scheme for financing hospitals was already in successful operation in nine municipal hospital centres in the Province of Alberta. He showed how a hospital should be considered as a "public utility" and supported by general tax levy. As yet this system had only to be applied to rural communities, but as a result of the financial distress of several city general hospitals it might soon be necessary to develop the scheme in the cities.

Mr. James Findlat, a representative from the Trades and Labor Council, gave an excellent paper on "Community Hospital Service." He laid emphasis on the success of the hospital arrangements in the great war and showed how this plan might be applied in peace. Beginning with the cottage hospitals for the rural centres equivalent to the Field Ambulance, the hospital in the chief centre as the Casualty Clearing Hospital, and then the large general hospital in the city where research would be developed under Provincial and University Control. He would have a transfer of patients from a lesser to a larger type of hospital according to the needs of the given case. Similarly would he arrange the distribution of the medical and nursing services.

The Fifth Session of the Convention was largely devoted to the discussion of the requirements in regard to the X-Ray and Pathological services for rural hospitals. The idea was developed that graduate nurses might be trained in both of these subjects to an extent sufficient to carry on these services, but that some limitation should be put on the particular duty which they could safely carry out. More special work would have to be referred to specialists, and some supervision should be made of what duties they did perform. Dr. Rosamond Leacock, Pathologist of Calgary General Hospital, discussed the question very fully.

The final session was set aside partly as a medical session. Dr. Baker, Superintendent of Central Alberta Sanitorium, went fully into the question of Tuberculosis and its relationship to the community and the general hospital. He showed that the healthy adult had already developed an immunity and that the early case of tuberculosis should not necessarily be regarded as a menace, at least in a general hospital. He stated that any general hospital should accept tuberculosis cases and that their nurses required this type

of training and it could be received without particular danger to the nurse.

Dr. J. F. Brander, of Edmonton, discussed the development of prenatal clinics in connection with our general hospitals.

The remaining portion of the closing session was devoted to the discussion of resolutions and election of officers. Dr. Morton E. Hall, Secretary of the Alberta Hospital Association, criticized the present organization in that he suggested a co-ordination of all branches of public health for convention purposes. An interesting innovation at this convention was a demonstration of commercial exhibits, the exhibitors being allowed five minutes to demonstrate their goods. Another innovation was a demonstration of nursing improvements by nurses in training.

Selected Articles

NURSING IN NEW ZEALAND

Examinations were held under the Nurses Registration Act in June, 1920, and December, 1920. 241 candidates presented themselves for the examination, 212 of whom were successful, and their names are now on the State register. Sixty-six nurses from overseas have been registered.

The regulations for the registration of nurses under the three Acts for England, Wales, Scotland, and Ireland passed in December ,1919, are still awaited, and therefore applications from nurses arriving from various parts of Great Britain have to be considered apart from reciprocal registration. It is not desirable that nurses unable to register at Home should be accepted in the Dominion. It has not been found from experience that the nurses coming out have been in any way superior to those trained in New Zealand hospitals.

There is no actual shortage of nurses in the Dominion at present, though there may not be a sufficient number of those who are willing to go to the backblocks and work under the difficult conditions obtaining in places where no suitable accommodation is provided. There has been little difficulty in finding nurses where a comfortable cottage is built and furnished for their use, in spite of the isolation and lonely life. Owing possibly to the increased cost of living and consequently higher fees, or possibly to the better health of the community owing to preventive medicine, private nurses have not been so continuously employed as in the past, many having been for weeks at a time waiting for cases. Probably the work of private nurses has been largely affected by the difficulties of house accommodation and domestic help, which cause many invalids to go to private hospitals, or to avail themselves of the more open doors of the public hospitals, who would otherwise have been nursed in their homes. It is difficult to see what can be done in this matter. It is a great hardship for a nurse to be for any leng-

thened period out of work, and consequently earning nothing, but living-expenses going on. The only remedy appears to be for private nurses to be State servants on a regular salary, all fees to be paid to the Public Account. This would bring more nurses under the benefits of superannuation, and thus provide for the old age of a class of workers who can otherwise never hope to make more than a hand-to-mouth living. Nurses conducting private hospitals, in which, if successful, they can usually make a fair income and provide for the future, need not be considered, although, as more and more the public hospitals are used, these will be reduced in number.

The whole problem of private nursing hinges on the fact that in order to have anything at all approximating to the number of nurses required during times of much sickness or epidemic there must be numbers out of work in normal times.

NURSES IN GOVERNMENT DEPARTMENTS

The number of these nurses is increasing. This Department has added to its Nurse Inspectors Miss Broad, late Matron of the Hawera Hospital, to be attached to the office of the Medical Officer of Health, Dunedin, and Miss Buckley, A.R.R.C., late Matron, N.Z. Expeditionary Force, to that of the Medical Officer of Health, Christchurch. The work of these officers is chiefly in connection with private hospitals, midwives, and district nurses.

Under the Education Department school nurses were appointed, who from the 1st March were transferred to this Department, and more are being appointed from time to time. In the Education Department also are boarding-out officers and district agents under the Infant-life Act, and these are now almost entirely recruited from the ranks of professional nurses. These positions, which command a regular salary with superannuation and no night-work—the bugbear of nursing—appeal to many nurses, and there is no lack of applicants. They require to be carefully selected with a view to the difficulty of dealing with parents, and the necessity of tactful and sympathetic treatment of children. Nurses of good education, some administrative ability, and sufficient experience are needed.

DISTRICT HEALTH NURSING

Still the Department is not able to fill all the demands from country districts. As pointed out above, this is frequently because

no proper arrangements are made, by the people who ask for her, for the accommodation and comfort of the nurse. The Department is reproached for delay in complying with the demands of the people, but it must be remembered that nurses generally are not under its control, and cannot, whether they will or no, be sent where they are asked for. It is for the people who want them to offer some attractions to call forth applicants for these positions.

The Department has been gradually adding to its staff of nurses for district work, either for Natives or Europeans, and of nurses who can be sent at short notice to relieve other Government nurses or midwives, or even to relieve the matrons of country hospitals at the request of a Board. All these nurses are to be styled "Health nurses," and will be detailed to any duty required by the Health Department.

If sent to a Hospital Board district whose duty it is to supply the needs of the district the nurse is appointed a member of the Public Service, thus retaining the benefits of superannuation, and her salary, paid by the Department, should be refunded to the Public Account. Nurses being appointed to the Public Service by various Departments has led to certain anomalies and inequalities in salary which have caused some comment. A scale of pay for Government nurses in different positions has been submitted to the Public Service Commissioner, and now that the great majority of these nurses will be members of the different divisions of the Health Department a more equable method of payment and allowances and increments may be arranged.

PLUNKET NURSING

There are now fifty Plunket nurses scattered throughout the country, and the society desires to place a large number more.

Nurses have been sent over from Australia to be trained in this special work at Karitane. A supervisor of Plunket nursing is now appointed by the society in the person of Miss Pattrick, who has for years been associated with Dr. Truby King's work, and who assisted him in London in the establishment of the School of Mothercraft in London. This is a step long recommended by the Department, and should tend to greatly increase the efficiency of Plunkett nurses.

DENTAL NURSES

The creation of a new branch of nursing is due to the need of dental care for children during their school age. A division of the Department has charge of this work, and a course of instruction has been arranged on very favourable terms for young women who desire to take it up. Trained nurses are to have preference in appointments, but beyond the knowledge of asepis there is not a great need for the full training of a qualified nurse. The course is to be for two years with a possible reduction in the case of registered nurses, and during that time an intelligent woman should be able to master the technical details of the class of dental work she will have to undertake. Dentists assistants would be very suitable for this further training.

SUPERANNUATION FOR NURSES

The Bill prepared last year as an amendment to the National Provident Fund unfortunately was not brought forward last session. It is hoped that it will be passed this year. A clause in the amendment to the Hospital and Charitable Institutions Act, 1909, makes a partial provision for superannuation, in empowering the Hospital Boards to pay a pension after retirement after ten years' continuous service of any officer or servant of the Board. I am glad to record the action of the Waikato Hospital Board in taking advantage of this clause and awarding the full pension allowed to the Matron, Miss Rothwell, who retired in May after almost thirty years' service.

The Nurses' Memorial Fund has served a very useful purpose in assisting nurses who from ill health or age are unable to earn a living and have insufficient or no income. There are now nine annuitants under this fund who receive an equivalent Government subsidy. The amount on the estimates for this purpose should be at least double what is now granted; and it may be pointed out that, in the absence of a superannuation scheme for the nurses other than those who are Civil servants, the subsidies to this fund merely meet in a small measure the demand which has been made, both in Parliament and outside, for some years past for this provision for nurses. The Memorial Fund now amounts to £9,000, and when the Mackay bequest of about £8,000 is paid over it will be in a position to do more in assisting the many other nurses needing help. The income only of the fund is used for grants or annuities.

HOME-NURSING LECTURES

These lectures have been carried on during the year chiefly under the auspices of the Women's National Reserve. The classes have been numerous and well attended in some centres; but the call for this class of teaching, which originally started after the influenza epidemic in 1918, has not been maintained with the enthusiasm with which it started. It is intended to include such teaching in the activities of the Red Cross organization, and probably with the ordinary lectures and demonstrations given for years by the St. John Ambulance Society the need of home-nursing instructions will be filled.

NEW ZEALAND HOSPITALS

In a report in the Journal of the Department of Public Health, Hospitals and Charitable Aid on the subject of National Medical Service, the following appears:—

Hospitals

We are of opinion that while the State control of hospitals should be largely increased, yet it would be unwise to abolish the local Hospital Boards.

Stipendiary staffs of hospitals, as at present constituted, should be appointed and controlled by the Health Board, local Hospital Boards having power to make recommendations in this respect to the Health Board.

There should be no honorary staffs, but the work done at present by the honorary staffs should be adequately paid for on a part-time basis.

While adequate provision is at present made for patients who may be classified as unable to pay for private medical attention and nursing, there is a large and important section of the community who are able to pay for such services who find it increasingly difficult to get suitable accommodation, and who must at present content themselves, in some cases, with inadequate arrangements in their own homes, or with, in other instances, imperfect arrangements dependent on the enterprise of private hospitals.

The necessity for adequate operating-rooms and appliances, X-ray, electrical, and other specialist treatment, and new diagnostic

methods make this difficulty a matter of urgency. The present system too often is unjust to the patient as well as to the medical adviser, who cannot provide the full service which he conscientiously desires to supply.

To meet this end we recommend what may be called the Canadian or Toronto scheme, which, briefly summarized, is this:—

(a) A building or buildings in the general hospital grounds, or in some other location not too far remote from the general hospital, should be provided for private patients of the class alluded to.

(b) The charge for accommodation, maintenance, and nursing will depend upon the room provided, as regards position, aspect, and so on.

(c) The patient will select his own doctor.

(d) The fees paid for nursing attendance will be on the private-hospital scale.

(e) The fees to be paid to the doctor will be a matter between him and his patient.

(f) The profits arising out of the maintenance of these patients will be used in the finance of the general hospital.

The committee urgently advocates this reform in view of the large amount of hospital abuse which exists at present, more particularly in country districts, and which shows no signs of abatement. This cannot be satisfactorily accomplished unless provision is made for hospital accommodation of patients who are well able to pay, and who will make their own arrangements for adequate payment for medical and surgical service with the medical attendant of their own choice.

This is by no means a new and untried scheme, being at present in practice in Canada, America, various hospitals in the United Kingdom and the Continent, and in maternity annexes in this country.

THE NURSING SITUATION

J. Allison Hodges, in the Virginia Medical Monthly, sums the matter up as follows:

In the solution of a matter which, like this, touches so many angles of social and professional life, naturally there will be differences of opinion. For instance, in an informal inquiry among

the hospitals in Richmond, it was ascertained that the owners and managers of ten of the twelve hospitals in the city were in favor of a two-year course, while, on the other hand, a decided majority of the superintendents of these same hospitals favored a three-year curriculum.

This question, being largely professional, has, so far, been discussed mainly by the medical and nursing professions, who are naturally best acquainted with all the points involved.

The physicians contend—

1. That too much time is expended in a three-year course of training for nurses, in comparison with the average length of time that they practice their profession.

2. That too much time is devoted to the science of medicine, and not enough to the art of nursing, and that this has had a tendency to result in special graduate nurses instead of practical cases of illness.

3. That the period of time in calendar months necessary for graduation is exactly equivalent to that now devoted by young physicians to their education; in the one case, twelve months in three years, and in the other, nine months in four years.

4. As a result of this, and other conditions named in the general consideration of this subject, pupil nurses are decreasing.

The nurses claim—

1. That at present too little time is allowed for the acquisition of the necessary knowledge to fit a nurse properly for her profession.

2. That small hospitals and hospitals not properly equipped with adequate facilities for training nurses in their training schools are the vital cause of a decrease in pupil nurses.

3. That hospital training schools which are properly equipped are now having an increase in the number of pupil nurses, it being reported that 50 per cent. of the training schools in the State now have a sufficient number of students.

It is unnecessary to give statistics to prove the present shortage of nurses, or even the approximate percentage of decrease as compared with former years, but the common and insistent report throughout the State, substantiated by the confirming voices of many sufferers, seems to be self-evident proof that this condition does exist, and is constantly increasing.

Whatever may be the cause, the fact remains that the problem confronting us is a very present and urgent one. The work of the nurse, in her sphere, is almost sacred in character and should be ennobling, for its cardinal principle, devotion to service for others, should cause humility in its rendering, and(as in the case of the single-hearted and high-minded physician in a larger sphere, should bring contentment with its performance and not ambitions out of alignment with higher purposes, and, if at times, one in the ministration of duty should forget her obligation, we should not indict the entire profession for this dereliction, but strive the more to make the servant worthier of the high ideals of professional practice.

The remedy sought, and the method adopted, should be one that will not lower the standards of nursing, but, on the contrary, one that will elevate the profession by inviting a better qualified element to enter it, and also one that will adjust and equalize the training courses with a view of better fitting the nurse to meet the actual and necessary duties of practical nursing, and of properly and successfully applying the physician's daily instructions. In this plan, the fullest justice must be accorded to the nurse, and the future interests of the patient, which are paramount, must also be conserved.

A MODEL HOSPITAL

Within recent years there has developed a definite movement in the medical profession which recognizes that a patient may possess a soul and a mind as well as a body.

That the patient has psychic rights is the theory upon which has been built the new Fifth avenue hospital, now nearing completion at 105th street, New York. Dr. Hugh Cabot, professor of surgery at Ann Arbor, Michigan, recently said that "the effect on a sick, sensitive person of being projected into an atmosphere which reeks of disease is a shock even to a sturdy temperament. We have so accustomed ourselves to the machinery of surgical operations that we forget the effect they must have upon our patients. I am convinced that the practice of bringing a patient into the operating room conscious is a gratuitous insult to his nervous system and the not uncommon parade of gowned and bemuzzled nurses, assistants and surgeons, suggestive of a butcher shop rather than a delicate therapeutic procedure, produces lasting impressions."

In the Fifth avenue hospital from the moment a patient enters to the time of his departure there will be nothing to stress the fact that he is in a hospital. He will hear nothing, see nothing, smell nothing to suggest the tragedy of illness. The entire handling of the patient has been planned with consideration for his mental and nervous state. In every step of his progress through the hospital he is to be guarded so that in curing his physical ill shis psychic health shall not be injured.

When a patient is admitted there will be no awe-inspiring waiting room. He will be conducted immediately into a small private apartment. For ambulance cases there is a special entrance in the rear, with a covered driveway. No one can see or hear the ambulance arrive or leave. The elimination of wards is a notable feature. It has been found that patients frequently store up, subconsciously, the symptoms and ailments of those about them. In the Fifth avenue hospital every patient will have a room to himself. He will not come in contact with any other patient, nor be worried by others' suffering. There will be 340 rooms in all.

A model room has already been completed. It seems almost unbelievable that it can be a hospital room. Just such a well appointed bedroom might be found in any home of good taste. The softly tinted walls are a pleasant background for the few well chosen pictures of neutral effect. Rugs and curtains properly supplement the artistic furniture. Gone are usual bleak walls, the white enamel bed.

By concentrating all surgical instruments and equipment upon one floor, the patient will be spared the sight of any machinery of medicine. In his progress to the operating room the patient will make his first stop in the anesthetic department, and not until he is well off into the land of dreams will he be conveyed to the operating table.

Throughout the entire hospital deadeners have been used between walls and floors so that not a sound can penetrate from one room to the next. Further, that insidious smell of drugs and deodorants which it is now believed causes a damaging psychological reaction on the average patient will be eliminated.

The hospital will open early in the spring. The sum of $750,000 which remains to complete its $3,000,000 building fund will be raised this fall. The new hospital will fill the need of the average man and woman of moderate means for a hospital, for its

rates have been placed at "from nothing up," according to the ability of the patient to pay.—N. Y. Tribune.

THE MEDICAL HOSPITAL IN LONDON

"There have been many exchanges suggested to promote English-speaking comity and a deeper amity," says an American writer, "but it is plain that a great hospital, dedicated to the relief of suffering and to the promotion of the art and science of healing, meets the situation as few other war memorials can or will."

In the words of the board of governors: "The American Hospital in London is intended to act as a link in binding together the two nations for the advancement of medical science as affecting the welfare of humanity."

Plans for the building have already been drawn up, and steps are to be taken to raise an endowment fund of several million dollars. The Hospital will serve as the American headquarters in Europe for all Americans who seek to advance their medical knowledge overseas. It will be provided with laboratories, libraries, and other facilities for post graduated study.

The American Committee includes Dr. G. W. Crile, of Cleveland, Dr. W. J. Mayo and Dr. C. H. Mayo, of Rochester. This committee will act in conjunction with the English Medical Committee, consisting of Sir Arbuthnot Lane, Sir Humphry Rolleston, Sir John Bland-Sutton, Sir John T. MacAlister, and Mr. Philip Franklin.

THE POEMS OF A PATIENT

Lieutenant J. C. Amcotts, R.N., who had a severe bout of typhoid fever, for which he underwent a lengthy course of treatment in the Seamen's Hospital, has put his experiences during that time into an excellent series of poems which he has had printed. In a note, he tells the "London Hospital Gazette" that the majority of these poems were written during his convalescence, but others refer to other naval hospitals. Though there is little to cavil at in them, the author says they must all be taken cum grano salis. The "Gazette" is indebted to the author for permission to publish any of these poems or extracts from them, and they are reproduced here. A fair example is the poem entitled "Typhoid," which is reprinted in full:—

"Typhoid"

"I went to bed, and Doctors came
And bade me show my tongue,
And having looked upon the same
They listened to my lung;
Then told me there was little hope;
And folded up the stethoscope.

"The Sisters were not quite so terse;
And didn't give me up;
When daily I grew worse and worse
They fed me from a cup;
And frankly told me to my face,
That mine was 'such a topping case.'

"For that's the pleasant little way
They look on the diseased;
The worse you grow from day to day
The better they'll be pleased,
For if you're really very ill,
They get a chance to show their skill.

"And they were skilled without a doubt
At sponging one at night,
With water that was just about
At Zero (Fahrenheit),
And then they asked their friends to come
To hear my quaint delirium.

"For when they thought my little life
Had almost ebbed away,
I talked about 'my rosey wife'
For one entire day,
'A pleasant occupation for
A highly susceptible'—bachelor.

"And once without apparent cause,
At ten o'clock at night,
I told the Sister to form fours,
Which gave her quite a fright;
Of course, poor thing, she couldn't see
How possibly to humour me.

"And then it nearly made her swoon,
She was of speech bereft,
When I commanded 'Form Platoon'
Upon the right or left;
She also jumped when told at first
To 'rest upon her arms reversed.'

"And so for eight long weeks I lay,
Upon my water-bed,
And tasted little else but whey,
So wasn't overfed;
I grew, in fact, so thin and small,
I really had no flesh at all.

"But nowadays, when so to speak,
They've let me convalesce,
I'm putting on a stone a week—
A great expense in dress;
Already, such a lot I eat,
My former waistband will not meet.

"My kind relations love to chaff,
And make amusing jests;
They talk about my 'fatted calf,'
And ask my size in vests,
And what on food I daily spend,
But oh! wherever will it end?

I quite expect the Sister tribe'll
Shortly have me up for libel"

Hygeia

I am Hygeia,
Daughter of Aesculapius and Epione
And child of the full-fruited hills of Greece.
I am Hygeia, Goddess of Health;
Come, follow me up the mountainside
From the valley of sediment to the summit of purity.
I will put the breath of the lilac in your nostrils;
I will make your eyes like the windows to a cloudless morning;
I will pour the fresh roses of dawn in your blood.

I am Hygeia,
And I come wherever men call me.
I walk in the gutters and give them the beauty of meadowlands
Flaming with flowers. I knock at the hovel
And turn all the windows to casements,
Its doors into portals. I hang on its walls in the sunlight
The rich tapestries of clean thoughts.
I am Hygeia,
Give me the prose of the city,
And I will set it to exquisite music.
Give me the wombs of the mothers
And I will banish forever the darkness of birth.
Give me the limbs of children
And I will give them a power a fleetness
That shall outdistance all sickness,
And folly and woe and the travails of childhood.
Give me the youths and the maidens
That I may turn all their cravings toward wisdom.
Give me the mothers and fathers
And I will transform all their gardens to kingdoms,
Their homes into palaces. I am Hygeia,
Goddess of Health, crying ever and clamoring
To regain once more the lost multitudes.
Will you not walk with me?
Will you not aid me?
Despair, despair—away forever:
Hygeia comes—the old sores are healing,
The hopeless smile again, the outcast starts anew.
O blessed offspring of Aesculapius and Epione,
I walk with thee to a new heart.

"The Christmas Dinner" also strikes a very human note:—

"In a corner lay the Patient, who was daily growing thinner,
And it looked as though his bones were coming through;
He was absolutely famished, and was dreaming of his dinner,
Shortly due.
Would they give him goose or turkey? he was hoping for the latter,
Though he wouldn't mind whiche'er the Steward brought,
Or perhaps a mutton cutlet—still it really didn't matter,
So he thought,

He would manage to consume it with a glass of beer or porter.
Then the Steward came and fed him with some nice albumen water."

Here is a verse from "The Sisters":—

"If you've only got a headache, or are just a bit neurotic,
They come and take your temp'rature, or feel your pulse with grace,
But of course that's only child's play, and is somewhat idiotic,
You are not at all a thrilling or an interesting case.
Then the medicines they bring you set you spluttering and coughing,
The filthier the better from the Sister's point of view,
And they're full of bounce and bustle when the Doctor's in the offing,
And pretend they're very busy, and have lots of work to do.
Then, of course, there nothing worse is
Than to call the Sisters nurses,
That's a thing that you must never never never never never do."

—Prince Alfred Hospital Gazette.

My Anatomical Museum.

A Patient's Soliloquy.

By Harry Nelson Jennett, M. D.

Observe each mottled sample
In bottles on the shelf!
My record is quite ample
In the scars I wear myself!

The bottle labeled No. 1
Is my dear adenoid.
I spoiled it crying in the sun,
So it is null and void.

And No. 2 are tonsils that
Hypertrophied, and so
The doctor said, "You are too fat
And snore,—so out you go!"

The 3rd is my appendix worm,
The surgeon's pride and joy.
For its removal he stood firm
Since I was a small boy.

4 holds my baby teeth, and 5
Contains my second set;
And, still, I'm glad that I survive
The rheumatism yet!

And 6, in cotton white, behold
My gallstones, 84!
Doc says, "They're worth their weight in gold!'
"I'll say they cost me more!

Ah, 7!—preserved in alcohol—
Is my dear thyroid gland,
What memories it doth recall!
The doctor was just grand!

In 8 I show my nasal stunts—
Polyps and spurs and such;
My septum had also two shunts,
My bridge a slight retouch.

Ah 9—oh! 9's my treasured urn,
I prize it as my life—
Organs and all—done to a turn—
The ashes of my wife.

10—that's my cow—I idolize!
She jumped over a trough
And spoiled her chance for any prize—
She cut one tit quite off.

NEW BRITISH HOSPITAL SCHEME

Similar in most respects to what is known as the Sussex Scheme is the scheme drawn up for London by the Organizing and Executive Committee of the National Provident Scheme, of which Dr. J. F. Gordon Dill, the originator of the Sussex Scheme, is the hon. secretary. An explanatory pamphlet has now been issued, and this, it will be seen, gives full particulars of the scheme.

The Problem

The great and increasing cost and complexity of medical services beyond the attendance of a general practitioner have made it impossible for a large majority of the population to obtain full advantage of the progress of medicine, although it is obvious that many cases cannot be properly dealt with unless the doctor in charge has all modern facilities at his disposal. It therefore becomes a choice of either having to do without them or of accepting them wholly or in part as charity. Further, the voluntary hospitals are already obliged to charge for their services, and have to ask all their patients to contribute, as far as they are able according to their means, to the outgoing cost of their maintenance and treatment.

Hospital Co-operation

But it has now been made possible, by the help and co-operation of the following hospitals, to meet these difficulties by the establishment of a provident scheme which will supply its members, free of cost (beyond their subscriptions as members), with practically all the highest resources of medicine which are available—viz., the London Hospital, St. Thomas's Hospital, and the Royal Free Hospital.

Scope of Scheme

The Provident Scheme, it is explained (1) has nothing whatever to do with the National Health Insurance or any other organization for medical benefit; and (2) does not provide its members with ordinary medical (i.e., general practitioner) attendance, or other benefit to which they are entitled from the State or from local authorities, or under the National Health Insurance Acts; but (3) is for the benefit of

those who, irrespective of class or occupation, are in a financial position which makes them eligible for election as members.

No preliminary medical examination is required before the admission of an applicant for membership.

Facilities Provided by the Scheme.

Except where otherwise stated, members will receive without charge, beyond their subscriptions to the scheme the following advantages:—

Consultations.

The medical attendant of a member may arrange, by appointment, for individual consultations at any of the co- operating hospitals, and such treatment as he and the consultant may jointly think advisable wil l be undertaken (at the hospital if this should be necessary.)

For those members who are unable to leave their beds and who reside within a radius of four miles of Charing Cross, the services of visiting consultants may be secured by appointment. For members outside this area, but within the Metropolitan Police area, who are unable to leave their beds, free consultation may be obtained by appointment, subject to the payment of the consultant at the time of consultations of a charge of 10s. 6d. per mile (i.e., equal to one-half of the usual mileage rates) beyond the four-mile radius.

Nursing.

The services of the "Queen's" and other visiting nurses will be available within the boundaries of the City and the Metropolitan Police areas for members at their own homes at the request of their medical attendants.

Dental Services.

(a) Treatment in hospital: Such dental treatment as may be considered necessary for a member whilst under medical or surgical care in a co-operating hospital. (b) Consultations: The dental surgeon in attendance upon a member may arrange by appointment for consultations at the dental department of any of the co-operating hospitals.

Laboratory.

All the resources of the pathological laboratories of the co-operating hospitals will be available for the benefit of members after consultation, including bacteriological and pathological investigations and examinations beyond the province of general practice, Wassermann and Widal tests, etc., blood examinations and counts, the preparation of autogenous vaccines, etc.

X-Rays.

Examinations (including opaque meals) will be available where found necessary after consultation, and a report will be supplied to the medical attendant of a member. Treatment by X-Rays will be given when, after consultation, it has been considered advisable.

Massage.

Will be provided by appointment for members in whose cases it is prescribed after consultation.

Electrical Treatment.

I.e., galvanism, faradism, high-frequency, ionisation diathermy, etc., will be administered by appointment, after consultation, in suitable cases.

Hospital Treatment.

Urgent cases will be admitted to hospitals, as at present; other cases requiring operation or other hospital treatment will, after consultation, be admitted to hospital in due course, but a member will not take precedence over more urgent cases, and the ordinary hospital routine will not be disturbed. Members of the scheme conforming to the rules will not be subjected to any almoner's inquiry or to any charge at the hospital.

Radium Treatment.

If, as the result of a consultation, it is decided that treatment by radium is necessary in the case of a member, such treatment will be provided by arrangement with the Radium Institute.

Ambulances.

Will be available at the request of the medical attendant or of the secretary of a co-operating hospital for the transport of "stretcher cases" within the boundaries of the City and the Metropolitan Police areas.

Membership

Cards of membership, bearing the date, will be issued for the first day of each month to those whose applications have been made during the preceding month, and the benefits begin on the date named on the card, and continue for one calendar year. These cards must be produced as evidence of membership at the end of one year from the date of issue of the membership card, the benefits cease unless the subscription has been renewed. Fourteen days' grace will be given for renewal (during which none of the services provided will be available). When the number of members has reached the limit of the capacity of the co-operating hospitals the list will be closed. In order that members may be fully assured of the promised services, and also that the capacity of the hospitals may not be strained, the Committee have decided to limit very strictly the numbers of those admitted to membership. Applications from those wishing to join the scheme will be dealt with in the order in which they are received until it is necessary to close the list.

Committee

The Committee consists of Sir Arthur Stanley, Lord Dawson of Penn, Sir Alan G. Anderson, Mr. W. McAdam Eccles, F.R.C.S., and Dr. J. F. Gordon Dill, the hon. secretary. All applications and inquiries should be addressed to the Hon. Secretary, 77 Cambridge Terrace, Paddington, London, W. 2.

The Hospital Gazette in commenting on the scheme says:

"The Provident Sheme which has been put into operation in Sussex is from November 1st to be adapted to the needs of London. From that date St. Thomas's, the London, and the Royal Free Hospitals will work in conjunction with each other, to supply certain medical services to the members. It would appear that there is nothing haphazard about the selec-

tion of these hospitals. They are not in a group, but are situated in widely different localities, being at each angle of a triangle, the basal line of which runs from east to west, while the apex is in the north. It will thus be seen that the co-operating hospitals, from the point of view of accessibility, cover practically the whole of Greater London. In addition, they are all hospitals with medical schools, are all equipped with special departments, and are all in the foremost rank amongst the voluntary hospitals of the metropolis.

As in the Sussex scheme all persons insured under the National Health Insurance Acts are eligible for election as members. Those not so insured are eligible if their income does not exceed the limits which are set forth in the explanatory leaflet which has been issued.

The services which are provided are of a comprehensive nature, including not only hospital treatment, but nursing in their own homes, and, if need arises, the services of visiting consultants.

Unfortunately, although great pains are taken to explain carefully and fully the extent and limitations of these schemes, it is very easy for a wrong impression of them to get abroad, with the result that dissatisfaction, which has really no justification, is expressed by the beneficiaries when their cases do not come within the operation of the scheme. We think, therefore, that it cannot be too strongly emphasized that although members of the scheme will have a right to hospital treatment, this right is qualified to some extent by such conditions as suitability of case (although this does not seem to be expressed very clearly in the leaflet), and the availability of accommodation at the time. It is not intended that the members should have the right to treatment which could be adequately supplied by his private or panel medical practitioner. Doubtless this will be fully impressed upon the member when his application for membership is accepted.

At the same time steps will no doubt be taken to admit without undue delay those members who are fully eligible, and it would be interesting to know whether any, and if so what, percentage of beds it is proposed to allocate for the purpose. Obviously this can scarcely be done satisfactorily until the

scheme has been in working for some time. A great deal may depend upon the condition of health of the member and of his family at the time of joining, so that, as there is to be no medical examination as a preliminary to membership, it may well be that, unless the scheme immediately takes the popular fancy, a higher percentage of those joining will require a hospital treatment than would otherwise be the case. When the scheme has been working for some time a fairly reliable figure should be arrived at. It is, however, satisfactory to know that the membership is to be very strictly limited according to the capacity of the co-operating hospitals.

With regard to finance, the scheme undoubtedly aims at placing the hospitals on a sound financial basis, and thereby saving the voluntary system. It remains to be seen whether the London Scheme meets with the response which it deserves, and which is confidently hoped for from the general public. The number to which the membership is to be limited is not divulged, so that it is impossible to say what amount will annually be placed at the disposal of the hospitals, even if that number be reached. Neither are we told how the money will be allocated amongst the various services which the scheme provides. Although there can be no guarantee that a patient should continue his membership after undergoing a successful course of treatment, there is no reason to apprehend that the membership will dwindle if the scheme proves to be as satisfactory in its working as is anticipated.

The London venture will be watched with a great deal of interest and sympathy, and if it proves workable will no doubt ere long be followed by similar schemes throughout the country.

"PENROD" TO BE SHOWN BED-RIDDEN PATIENTS IN HOSPITALS THROUGHOUT THE COUNTRY

Marshall Neilan is arranging for the presentation of "Penrod" with Wesley Barry before bed-ridden patients in hospitals throughout the country.

The success of an experiment along these line at the California Hospital, Los Angeles recently in which Mr. Neilan and Dr. A. C. Thorpe arranged for the presentation of an unfinished print of

"Penrod" on the ceiling of one of the large wards containing confined patients, resulted in the present plan to duplicate the idea in every city.

The idea came to the movie producer recently when he visited a friend at a hospital who told Mr. Neilan that the most unbearable phase of the bed-ridden patient is the long enforced idleness without the usual form of entertainment and relaxation the healthy person is accustomed to.

Inspired by his friend's remarks, the producer experimented with a small suit-case projecting machine and an unfinished print of "Penrod," now being produced for First National theatres. Wesley Barry, hero of "Penrod" operated the machine and explained to the patients the action of the missing scenes.

The presentation of "Penrod" in hospitals will be particularly desirable in view of the nature of this famous story by Booth Tarkington. It is a human story of American boyhood with plenty of laughs that will make the sufferers forget their troubles.

First National theatre men in every city will co-operate with the plan so that the picture will appear before the confined patients who cannot go to a theatre, simultaneously with the presentation at the theatres.

The arrangements for such presentations are very simple as the small machines of which there are several types on the market, are run by electricity from any wall socket.

This idea opens up a new field for the motion picture as it is believed by various prominent physicians that special movies produced under scientific supervision and shown to bed-ridden patients would materially help their speedy recovery. Such pictures having certain psychological thoughts which would be impressed upon the mind of the patient would tend to place the patient in a mental state that would materially help the doctors in restoring health.

PLAN NURSE MILITIA TO FIGHT EPIDEMICS

A nation-wide movement to interest cities in building up a reserve of nurses to cope with future epidemics of influenza or other diseases is being considered by physicians who have followed the work along this line accomplished by Dr. John Dill Robertson, Health Commissioner of Chicago. After

experiencing the difficulties of the authorities of this and other cities in obtaining nurses to care for the thousands stricken with influenza, Commissioner Robertson developed a training course which not only cost the Chicago government nothing to give, but enabled the city to boast of a nurse militia, as it was called, of 10,000 trained women ready to step in and aid in future epidemics.

While in New York a few days ago, Commisioner Robertson discussed his work, which has aroused the attention of such medical leaders as the Mayo brothers of Rochester, Minn., as well as the health authorities of many cities. He believed the adoption of his plan was a health-conserving measure of no mean value. He cited Chicago's lowering death rate as proof of the value of a nurses' reserve.

"The shortage of nurses during the first influenza epidemic we had in Chicago gave me the idea of training women of the city to care for the sick," Commissioner Robertson said. "The greater part of the people of a city cannot afford to pay the prices commanded by nurses, even if the supply of professional nurses were adequate. As an economic problem, the desirability of having a trained member in every family able to care for the sick needs no argument. And that is what I set out to do.

"Of course, my efforts met with the opposition of professional nurses, who did not understand what I was trying to do. That was to be expected, but I went ahead just the same and the results have proven the wisdom of my action.

"I interested prominent physicians and public-spirited citizens in the idea of providing an eight weeks' course in nursing. The announcement of the opening of a school brought a gratifying response. The classes from the start have averaged 700 and on our reserve list we have 10,000 names. Sessions are held in the afternoon and evening, thus suiting the convenience of the students.

"The school is headed by a nurse of wide experience and the teaching staff includes some of the most prominent physicians of the city. Half of the course is devoted to health education and the remainder to practical nursing. Textbooks, which become the property of the students, are used and the students repeat in chorus the principles which have been touched upon by the instructor. Upon completing the course the student receives a certificate.

"An enrolment fee of $5 is charged. The school has been financed chiefly by a health show, the first one of which netted

$92,000. Women graduates of the school sold 125,000 tickets. Two bands were formed by colored and white members of the reserve and together they raised $16,000.

"With the funds provided we were also able to run a free hospital with twenty beds, where the students could receive first-hand training. There have been only three deaths among 1,400 patients treated in a year. Members of our reserve have aided in 12,000 homes outside of their own. We have a nurse in every block of the city and the end is not in sight. Chicago's death rate is lower than New York's and I believe this is attributable to the training of our people. Our students come from every walk of life, many of them school teachers."

Commissioner Robertson said that Bishop Samuel Fallows, Mayor Thompson and Mrs. Edward Hines were among the members of the Board of Directors.

—New York Times.

TORONTO HOSPITAL FOR SICK CHILDREN

It was with a good deal of regret that a short time ago it was learned that Superintendent Florence J. Potts, of the Toronto Hospital for Sick Children, after nineteen years of service, had resigned her position. Miss Potts has been looked upon as one of the most able Superintendents in Canada, if not in America, and it seems a very great pity that, no matter what the reason is, she should feel it necesary to withdraw from the position she has ocupied with such ability. THE HOSPITAL WORLD expresses the hope that she will see her way to reconsider her decision and be once again found on duty in the splendid building on College Street.

BEQUEST TO HOSPITALS AND OTHER INSTITUTIONS

Toronto General Hospital, The Hospital for Sick Children, Victoria College and the Salvation Army will share equally in the residue of the estate of the late Dr. Moses Aikins, after certain legacies to a number of nieces, nephews and other relatives, amounting to $275,000, have been paid. Men's General Social Work, Women's Rescue Work, Fresh Air Camp and Children's Homes are some of the purposes for which the endowment to the Salvation Army is to be used.

KINGSTON GENERAL HOSPITAL

The General Hospital Board of Governors want Dr. A. T. Ross to remain as Medical Superintendent of the Institution. When the Doctor entered the recent Federal contest as Conservative candidate, he tendered his resignation, and prsssed it after being elected member for Kingston. The Governing Board, however, want him to fill the two posts and it is understood that Dr. Ross is considering the matter.

NEW HOSPITAL PROJECTED

A municipal hospital for the East End was the principal subject of discussion at a well-attended meeting of Ward Eight Ratepeyers' Association, held in St. John's Parish Hall, Woodbine Ave., recently, with the president,F. B. Bentley, in the chair, and a resolution was adopted endorsing the principle of such an institution being established east of the River Don, and requesting the co-operation of all Ratepayer's Associations in Wards One and Eight to further the project.

Ald. F. Maxwell said a hospital municipally controlled was one of the urgent needs in the eastern section of the city. No special legislation was necessary, and the City Council could proceed with the project. The alderman said that the city spent $1,000,000 last year on hospitals, for which the taxpayers received no benefit, and that the City Council had no control whatever over the expenditure. The cost per day for city patients was $3.65, which was considered excessive, and the patients were mostly foreigners, and many of them not naturalized.

WORK ON BURNED HOSPITAL HAS BEEN ALMOST COMPLETED

Work on the Orchard House, Ontario Hospital, Hamilton, destroyed by fire some time ago, is about completed and the patients who were transferred to Toronto after the fire, have been brought back. Accommodation for the others who were sent away after the fire is about completed, and they will be brought back in a short time, it is expected. The new addition is a duplication of the plans of the old headquarters, except that it is entirely fireproof.

TO BUILD NURSES' HOME AT BROCKVILLE HOSPITAL

Increasing business of the Brockville General Hospital necessitates the consideration of providing more accommodation it was pointed out at the annual meeting of the Board of Governors and members on January 18th. During the last year the hospital cared for a total of 1,091 patients, an increase of 63, while 420 received outside treatment.

To overcome the crowding difficulty it is proposed to take the present Nurses's Home for private wards and construct a new nurses's building outside the hospital.

The surplus for the year was $3,862.36. Officers elected were the following: President, J. H. A. Briggs; Secretary, D. A. Cum- R. J. Driver, Judge Dowsley, Robert Craig, Dr. Robertson, Rev. mings; Treasurer, H. P. White; Board of Governors, A. C. Hardy, J. A. MacKenzie, A. D. McDougall, W. J. Chapman, Wm. Hamilton, S. R. W. Hamilton, F. D. Woodcock, A. E. Kelly and G. W. McCall.

SEEK GOVERNMENT AID

Strong arguments for Government aid in the erection of a new marine hospital at Goderich were put before Hon. H. C. Nixon, by a deputation from the Goderich district on January 18th. At the present time, the hospital operated for the care of sailors is a small antiquated building that is not adequate for the demands made upon it and the proposition is to build a $60,000 hospital. The Government is invited to put up one-half of this amount, the municipality and kindly disposed citizens having undertaken to find the rest, part of which will be secured from the sale of the old building.

Hon. Mr. Nixon was sympathetic and sent the deputation away convinced that some assistance would be given, but he was careful to emphasize the fact that a $30,000 grant was rather a large order.

Among those who called were: Mayor W. R. Wigle, Dr. J. Hunter, J. M. Govenlock, M.P.P. for Centre Huron, Senator Proudfoot, Dr. Fraser, District Officer of Health, Dr. H. S. Stevenson, M.P.P., and Rev. Canon Hill, the latter presenting the appeal for aid.

Book Reviews

The American Hospital of the Twentieth Century. A treatise on the development of medical institutions, both in Europe and in America, since the beginning of the present century. By Edword F. Stevens, Architect, Member of American Institute of Architects; Member of Royal Architectural Institute of Canada; Member of American Hospital Association. Revised edition, illustrated. New York: The Architectural Record Company. 1921.

Mr. Stevens is to be congratulated on bringing out a second edition. At the suggestion of Dr. Babcock he gave up general work and devoted himself to building for the sick. He visited Europe on several occasions: once in company with Dr. John N. E. Brown, who made side by side an inspection of the institutions visited from the superintendents' point of view; again with Mr. Pliny Clark, another superintendent. This joint work was profitable to the superintendents and architect. Mr. Stevens was well trained in the office of Taylor and Kendall, who did hospitals especially well. He took into Canadian partnership Mr. F. C. Lee, of Toronto, who, with Dr. Brown did the major part of the original planning work of the new Toronto General Hospital. Mr. Stevens' ability was apparently recognized in Canada to a much greater degree, than in his own country. It is usually the other way: the Americans seek out our bright Canadians (too often overlooked by our own Educational Hospital and Business Boards) and appropriate them. The author has deserved well. He is an ardent worker in the American Hospital Association and has ,at a good deal of sacrifice helped out in programs of the Canadian Hospital Associations.

In all his travels—American or European, to hospitals, to conventions, Mr. Stevens carries his camera and his note book. Everything new which is practical he makes a note of or photographs. He is most industrious and sympathetic.

As a result this new book is filled with original descriptions and pictures of hospital plans, landscapes, exteriors, interiors of wards, operating rooms, sink rooms, kitchens, ward plans, equipment and apparatus of all sorts. As was to be expected, many of the American and Canadian building illustrations are of Mr. Stevens and Mr. Lee's own work. They are choice and show much study and thought. Mr. Stevens is most ingenious, and his Canadian partner, along with his wide practical knowledge, has a keen artistic sense. Witness the new addition of the Royal Victoria Hospital, Montreal.

The book is beautifully printed on calendered paper and, as we have intimated, profusely illustrated with first class photographs.

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The Psychology of Dostoievsky

Joseph Collins contributes a very readable and informative article on Dostoievsky in the January "North American Review." Collins says it is not as a photographer of the body that this author is a source of power and inspiration in the world to-day, and will remain for countless days to come, for he has depicted the Russian people as no one else save Tolstoi, and his pictures constitute historical documents; but rather as a photographer of the soul, a psychologist. Collins continues: "Psychology is said to be a new science. A generation ago there was much ado over a new development called "experimental psychology," which was hailed as the key that would unlock the casket wherein repose the secrets of the mind, the windlass that would lift the veil that since man began concealed the mysteries of thought, behavior and action. It has not fulfilled its promise. It would be beyond the truth to say that it has been sterile, but it is entirely true to say that the contributions that it has made have been naught compared with those made by abnormal psychology.

Some contend that the only real contributions of value have come from a study of disease and deficiency, and their contentions are granted by the vast majority of those entitled to an opinion."

According to Collins, Dostoievsky is the master portrayer of madness and of bizarre states of the soul and of the mind that are on the borderland of madness; that not only does he depict the different types of mental alienation, but by an intuition peculiar to his genius, by a species of artistic divination he has understood and portrayed their display, their causation, their onset—so often difficult for the expert — and finally the full development of the disease. He forestalled the descriptions of the alienists.

"They call me a psychologist," Dostoievsky says; "it is not true. I am only a realist in the highest sense of the word, that is, I depict all the soul"s depth. Arid trivialities I have long ceased to regard as realism—it is quite the reverse."

The essayist states that it is part of the mission of psychology to depict the soul's depth, the working of the conscious mind; and as the interior of a house that one is forbidden to enter is best seen when the house has been shattered or is succumbing to the incidences of time and existence, so the contents of the soul are most discernible in the mind that has some of the impenetralia ruined by disease. It was

in this laboratory that Dostoievsky conducted his experiments, made his observations and recorded the results from which he drew conclusions and inferences."

"In my works," writes the novellist to a friend, "I have never said so much as the twentieth part of what I wished to say, and perhaps could have actually said. I am firmly convinced that mankind knows much more than it has hitherto expressed in science or in art. In what I have written there is much that came from the depth of my heart." Collins adds: "What he has said is in keeping with the science of to-day, and is corroborated by workers in other fields of psychology and pyschiatry."

That Sixty Per Cent.

"Sixty per cent. of the free patients in The Toronto General Hospital are foreigners, while the 'white' population sweat blood trying to furnish the income necessary to keep the institution on its feet" grumbled a well-known Canadian weekly, recently. "What are we going to do about it?"

We are fairly safe in saying that Toronto is not alone in this experience. Other Canadian cities, and probably most American cities of large population are able to make the same showing. And there is nothing to be done about it as far as the hospitals are concerned.

A sick man is a sick man, be he foreign or native born. If he has no means we cannot allow him to die on a doorstep, or lie in a building where he becomes a menace to the community. The free bed, medical care and nursing must be provided in the interests of public safety, if not for humanity's sake.

The problem is only one small corner of that very large question of immigration, even, in a measure, the vaster one of international relationships.

On entering the country, the foreigner presumably undergoes strict health test by the authorities, together with a money test that must enable him to produce $250.00.

If his health remain, and employment is forthcoming, the country is enriched by his arrival; but new conditions, in food, climate and housing, together with loneliness, and possibly meagre scale of living, exercise a generally deleterious physical effect that brings him at an early date within range of hospital help. And how long will $250 last the foreigner, if he be entered as a pay patient at present hospital rates?

What are we going to do about it? Something might be done in the readjustment of the present system of hospital upkeep and management.

We taxpayers do 'sweat blood' trying to furnish the wherewithal to support our hospitals. The burden has become too heavy.

Is it possible that a certain recent visitor to our shores,—a noted surgeon from India—gave the key to the solution, when he commented on the heavy overhead expenses of our public hospitals with their elaborate and expensive outfits and furnishings. Is it possible, as he asserted, that simpler outfits and smaller staffing would produce just as good curative results?

Again, is the present hit-and-miss system of upkeep of many of our hospitals the best in this day of efficient finance,—partly voluntary, partly municipal, and as much out of the unfortunate private patient as their income can stand? The tax payer wonders.

Hospital Development

Hospitals are passing through a state of transition. To begin with they were practically boarding-houses for the sick. The visiting doctors took week about "admitting" patients and attending them. Their methods of examination of patients were rather rough and ready; there treatment crude. The attendants were rude untrained people. With the advent of training schools for nurses, patients began to be looked after better than before. They were bathed, fed regularly, had pulse and temperature taken and recorded, medicines administered—all in a more kindly and humane fashion than before.

With the introduction of Listerism and Asepsis more care was needed by doctors and nurses. Hospitals instead of being places to be dreaded on account of the mortality in them due to erysipelas, gangrene, began to be places to be sought by the sick.

In the larger hospitals medical schools developed and this led to better study and diagnosis of cases and better treatment. Doctors who taught were obliged to read, study and reflect. This tended to benefit the patient. With the introduction of medical records further improvement took place. Physicians and surgeons, remembering that the "written word remains" felt they must be more careful still in diagnosis and treatment.

The introduction of autopsy work still added to the efficiency of the medical and surgical staffs: their diagnosis was being checked up in the dead house.

Another feature of hospital work which has signallized advancement is that of social service work. The officials in this department who are in touch with the patient and his friends, do much to keep attending doctors and nurses, orderlies and cleaners up to the mark. These folk are being watched—not unkindly, but if the patient does not get well cared for the powers that be get to learn of the delinquency

and seek at once to rectify any mistakes through carelessness or wilfulness of underlings.

One of the newest and best phases of hospital work is the regular monthly meetings of the whole medical staff. At these open confessions are made of failures or errors, kindly admonitions and suggestions are offered. Histories are gone over and inter-departmental discussions take place which are very helpful to all concerned.

The Influence of the Hospital on the Home

There are many lessons being carried from the hospital to the home; not only by patients and their friends, but by doctors, nurses and other members of the hospital personnel who are constantly going from the hospital to home. These visits in a large city number into the thousands. More and more should our hospitals be thrown open for public inspection by the people. Here are to be seen embodied the latest ideas in building construction,—ventilation, heating, refrigerating, cleaning. Visitors note, among the hundreds of notable things, the coved corners, the unpanelled doors, the door and wooden jams flush with the plaster—no lodging place for dirt. They see clean beds, walls, windows, floors, shining utensils. The wards are full of light; the air is sweet and fresh—coming as it does through

opened windows or washed and warm through conduits into the building. They see daintily set trays with plain nourishing food upon them. They should see the kitchens, utensil and appliance rooms, spotless, all in apple-pie order—a place for everything and everything in its place.

But most and best of all they see pleasant-faced busy, nattily uniformed nurses deftly carrying on their ministrations to patients—quietly and with despatch. These visitors are received with courtesy and kindness and feel the influence of the hospice—that it is a hospitable place.

When they return home, they logically inquire, why can't our houses be built without dirt catching ledges, why shouldn't our homes be built so as to be easily cleaned and kept clean, why cannot our houses have large window panes? Why cannot we have tidy, cleanly, orderly homes? Why cannot we have good plain food nicely served? Why cannot we keep our sinks and dish cloths as spotless as those at the hospital?

Then, too, best of all, no doubt these hospital visitors may and do carry away some of the intangible things of the hospital—the spirit of kindness, graciousness, faithfulness and self-sacrifice they see manifested in the institution.

Obstetric Practise

H. D. Fair, of Muncie, Int., writing in the Medical Record, No. 2668, says that for the past 15 years, he has been trying to improve the quality of his obstetric practice. His experience warrants him in making the following observations:—

1. No primipara with a full-sized fetus can expel the head with the occiput posterior without sustaining serious damage to the vaginal and perineal structures.

2. It is bad practice to allow a patient to suffer for hours or days, as sometimes happens, when a simple twist of the wrist may end her labor in a few minutes.

3. Never leave a puerperal woman till you have done all you can to place her as nearly in the antepartum condition as possible. Nearly every day we examine some woman with a gaping vulva who tells us that her obstetrician assured her she was "not torn a bit."

4. Never begin any deliberate obstetric operation until you have all the instruments and equipment you are likely to need, within easy reach.

5. Never start any obstetric operation until you know what ought to be done and have formulated a plan as to how you are going to do it.

6. Never start anything you cannot finish. Be certain of your limitations.

7. If you are not certain that your act will result in success, be sure it will do harm.

8. If you intend to send for a consultant, be fair with him and do not increase the complications before he arrives. Do not ask him to assume responsibilities for a blunder you have made.

9. On the other hand, when complications do arise the wise obstetrician will seek the assistance of a friend who will share both the burden and the risk.

10. If your time is worth anything get after your occipito-posterior cases early in the game, and let it be known that your prompt action is worth while.

Post-Graduate Study

Many American doctors have been attracted to Vienna to take up post-graduate work. Why do they pass old London and Edinburgh? With their wealth of clinical material and with professors using the English language, it would seem natural that our American brethren would be attracted to Great Britain. There is a post-graduate course in London, an dwe feel sure there is good teaching done there. In what respects is it behind that of Vienna? For one thing, the London course has not been advertised as widely as the Vienna one. Then there are many practitioners of foreign extraction in the United States, particularly in the large cities, who

are attracted to Vienna and Berlin; they know the German language and can therefore understand the Viennese and German professors. The German and Austrian scientific medical men kept up their original researches during the war to a much greater extent than did the British, we believe. For instance, in X-Ray work the Germans developed the use of X-Ray in treating cancer to an extent that is just being appreciated in America and Great Britain. Von Pirquet has developed the subject of Infant Feeding to an extent undreamed of by the English speaking medical fraternity; to mention but two lines of endeavor.

We should like to see a strong Post-Graduate school in old London which would pay special attention to publicity, and we should like to see it patronized by many medical men from all the British Dominions as well as by those cousins of ours across the border.

Also, for those who cannot afford even a trip to London, larger and more attractive courses should be arranged for in two or three of our Canadian centres.

Inadequate Teaching.

In a recent address at Cambridge, Sir Clifford Albutt stated that the medical curriculum could be substantially lightened by better teaching. Many

teachers were admirable. Almost none of them had been taught to teach. Few were in a position to compare the methods of others with their own. The mind of the master moves much quicker than the pupils. Sir Clifford confessed that it had taken him years to lecture decently. A good instructor could have put him in the way in 3 weeks.

This Journal has made this criticism of certain medical teachers in the past. The same holds good to-day. Certain men who are teaching know little or nothing about the way to teach medical students. Our normal schools and faculties of education aim to teach men and women how to teach in primary and secondary schools; but the boy and girl who enters the university is not taught by men and women specially trained as teachers.

It is painful to witness the efforts of certain good men who are medical teachers—well posted in medicine—endeavoring to impart to their confreres at society meetings some of the technicalities of their work or to expound some of their theories. They are unable to present the subject clearly and impressively—they lack the ability to instruct and educate.

The big medical associations might do well to establish a college for training teachers for medical colleges. The effort would be worth while.

Hospitals and Doctors

Sir Squire Sprigge in his new book on Physic and Fiction, writes a chapter on "Some Public Developments of Medicine," in which he discusses the establishment and future of the Ministry of Health. A reviewer of the book writing in the "British Medical Journal," says: "Sir Squire makes it clear that the claims of the public to be associated with any exhibition of medical authority are all for the good. The prophecy is hazarded that soon there will be no class of general practitioner separated off from hospital physicians and surgeons, from specialists and from officials, and that the principal hospitals, becoming local centres of scientific medicine, will be officered by men who, by fusion of duty with the general practitioners of the neighborhood, will make of the whole of medical energy the general scheme for the good of the populace, the practitioners having hospital beds and sharing in the teaching of students, as Sir James MacKenzie has urged.

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Original Contribution

*PURCHASING FOR HOSPITALS

By GEORGE STOKER, Municipal Hospitals, Winnipeg

Mr. President, Ladies and Gentlemen:—

The question of purchasing for hospitals is one of prime importance. Just how it has been conducted is reflected in the annual statement in the per capita cost, but more particularly in the impression carried away by patients and the subsequent advertising (favorable or otherwise) which your Institution will receive through them.

It leaves an awful dent in one's armor of righteousness and fair dealing to be assured by an ex-patient that whilst our hospital is, in all other respects a most excellent and worthy institution, the food is nevertheless, rotten. An hotel could not long survive such a reputation and a hospital should never acquire it.

However I am not going to dilate on this apparent truth and am taking it for granted that all we want to know is how, where and when to buy to the best advantage as regards both quality and price.

Specifications. I am convinced that, with the exception of a certain few items, the best way is to call for tenders, provided you select the right time to do so. But even a tender is only a schedule of prices and means very little unless you have it backed up and supported by an agreement which embodies a specification clearly setting forth what you expect and intend to get from the Contractor during the life of his contract. Otherwise you haven't even a scrap of paper to fall back on in the very probable event of dispute.

Many of you are permitted to buy as you see fit and have certain firms whom you call up as a matter of course any time you

* *Read before the Manitoba Hospital Association at its First Annual Convention, Winnipeg, Nov. 7th and 8th,* 1921.

want anything. But no matter how well established their reputation and your confidence in them they will, nevertheless, simply price your goods at the prevailing prices of the day, instead of figuring out, as they would have to do under the competitive system of calling for tenders, just how much less than that price they could afford to let you have those same goods at.

Being municipal hospitals we have no option under the City Charter but to call for tenders for everything over $500 in value unless we can show good cause for doing otherwise and I am convinced every year that this is the right way to buy. This necessitates the preparation of specifications of different kinds and I want just to give you one or two examples of what these have meant to us.

A coal contract which we had some time ago required, from the specifications, a certain British Thermal Heat Unit Value for the coal. Well, during the life of that contract (six months duration) we deducted over $2,800.00 from their account for coal below B. T. U. value and $468.00 for excess of ash, and there was nothing more to be said about it because the entire transaction was covered by a specification.

Another case had to do with a purchase of upholstered furniture. It was duly delivered, inspected, and rejected. The subcontractors at first took a bold stand and stated that every thing was according to Hoyle. A piece which had already been opened was referred to and the specifications called for. The result is that the entire shipment, worth in the neighborhood of $2,000.00 is being taken back and replaced without another word.

I am citing these examples to show what can be saved by having specifications and the necessity of them, and to those who may not have had occasion to draft these I would take the liberty of offering them copies of ours, not in the belief that they are perfect but rather in the hope that they may serve as guides to those contemplating buying in this way.

Coal: Reverting to coal, I am not going to pretend to prescribe just what grade of coal is best suited for your particular plant—that will depend on a lot of things and your Engineer will know best—but I will state that the best way to buy whatever grade you decide upon is by tender, on a B. T. U. basis if possible and, in this country, before the railways start hauling grain in the fall. At that time cars are plentiful, summer rates prevail on the rail-

roads, and dealers are beginning to think about their trade during the approaching winter and the tendency to increase its volume by the expediency of cutting into prices a little is sometimes too much for them—at least we have had competition of this kind.

Furthermore, if you use a grade of say American Slack Coal, you will find that the accumulation lying at the docks then, when the end of the shipping season is approaching, is of such dimensions as to compel dealers to turn it into money.

Milk: We do not buy pasteurized milk but the raw product of a tuberculin-tested herd. Our specifications prescribe the minimum standard or score to which a dairy must attain before it can tender. The minimum is such that only a tested herd can qualify and is high enough to keep out any except those whose methods are approved. The specifications also cover methods of handling, keeping, and time of delivery after milking. The best time to contract for milk is when pasturage becomes plentiful and the dairies have ceased to pay out money for winter feed for their stock. In other words the time to get the best prices are when supplies are most plentiful. The City Dairy Inspector should be your guide, counsellor and friend in this respect. Our milk specifications provide that any infringement of the City Dairy By-Law may constitute a breach of contract with us, and we have been able to make several adjustments in milk accounts because of this provision.

Butter: There is a special time to buy this important article of food. It is in the latter end of June or early in July, depending on the season, when pasturage is at its best and the quality of cream is consequently the finest. The Manitoba Dairy Commissioner will, if you keep in touch with him, advise you definitely just when to jump into the market and will also grade the butter for you before you pay for it.

In buying butter it is wise to purchase the grade known as Manitoba Specials, the highest grade produced here. It has to be made from thoroughly pasteurized Cream and score approximately 100 per cent. in flavor, color, texture, incorporation of salt, manner of packing and so forth.

Because of these stringent requirements in its manufacture it has distinctly better keeping qualities and for years our supply has been coming out of storage in the year following its purchase just as pure and wholesome in every respect as when it went in. This

would not be the case with lower grade butter which has invariably to be "made over."

Eastern and European buyers all purchase Manitoba butter on the Dairy Commissioner's grading and you will find his department very much interested in doing what they can for hospitals in respect to their supply. Call them up when in doubt about the butter market and make use of the Department. You are entitled and at the same time welcome to his advice and we have found it well worth taking.

Eggs: "Eggs is Eggs" as the poet said and I move that we offer up a prayer for the dawn of the day when every egg will require to be indelibly stamped with the date of its production and sold by weight. Some time ago a New York paper sent out tracers after a case of eggs bought at an Indiana town at 23 cents a dozen and found them finally sold, seven months afterwards, to consumers in New York as strictly fresh eggs at 55 cents a dozen. In the meantime they had changed hands I think something like fourteen times, one dealer alone passing them through his warehouse three times, involving six transactions—three profits for himself and three for the parties from whom he bought them.

But to get down to something definite about eggs it may be stated at the outset that for the purposes of large hospitals in urban communities, using a lot of eggs, there is no such thing as the "new laid" variety. The only exception to this is where a large hennery may be located conveniently distant from the hospital, either operated by the hospital or by private enterprise with the hospital as its principal customer, having first call on its product. Otherwise what is the history of the average new laid egg. It is this. It lies around the farm house with others under varying temperatures until the farmer has enough to justify a little deal with the country grocer. The grocer then takes these eggs and dumps them into a crate amongst others of questionable age and origin. Irrespective of their age he will when he thinks he has enough, try and come to terms with the wholesalers in town, if prices are right. If not he will hold them for an indefinite period until prices come right. And remember that all through this time these eggs have been improperly stored.

After the wholesaler or jobber gets them he passes them on to you and you have the satisfaction of being able to accurately compute their age from then on.

I am of the opinion that storage eggs gathered at the proper time of the year, rightly candled and graded as "firsts" and stored in cases containing clean new fillers, will come much closer to the requirements and yet cost you much less than the so-called "new laid" variety. The time these eggs should be gathered is in cool weather. With us, from some time in April to the middle of May, depending on seasons. Buy what you need then to keep you going until September and then again enough to see you through until February. From February to May again buy in the open market because with early warm weather to the South of us shipments will begin to come in from there in February and what eggs you have put away in September have, by February, been in storage long enough anyhow. The minute these eggs start coming in from the South storage eggs here are more or less of a drug on the market.

My last word about eggs then is to buy those produced in cool weather and in support of this advice I would point out that Canadian eggs command a better price than United States eggs in the Eastern markets for this very reason. Buy in April and May. June and July eggs have been subjected to too much heat. Eggs should never be allowed to get wet but as this is a factor we cannot control we need therefore lose no sleep over it.

Groceries: So many articles come under this heading that I cannot attempt in this brief address to cover them all. Markets fluctuate all the year around in such things as teas, coffees, sugar, etc., and I would either advise your consulting from time to time with a good wholesale grocer or following the advice of a trade journal such as the "Western Grocer" or preferably both. But canned goods is a big item with all of us and there is a best time to buy these.

In the early Spring the packers, both Eastern Canadian and Californian, have their representatives around booking orders for delivery at opening prices. Delivery of these goods will commence in the early Fall as each crop matures and is packed and yours will be billed to you at opening prices, below which they are not liable to go. The supply will never be larger than it is then but an excessive demand from some unforeseen quarter may at any time seriously deplete it with a consequent inflation of prices. Furthermore, here in Manitoba the wholesalers stock up in canned goods before the freeze-up and their stocks will only deplete from

them throughout the Winter and with depleting stocks you may safely look for increasing prices.

Canned goods are divisable into three grades—Fancy, Choice and Standard. As you doubtless know the Californian product in Peaches, Pears, Apricots, Royal Anne Cherries, Pineapple and Spinach is to be preferred and the buying of their "Fancy" goods is recommended as being really "Fancy."

The "Fancy" grade in the Eastern Canadian crop is not so "fancy" and is little if any better than the "choice" grade, although costing considerably more.

By placing your order for canned goods in the Spring you not only gain the advantage of opening prices but you will get the large No. 10 (or gallon) tins which is also a saving as you pay for less tin, solder and labor and get more fruit. This size tin is only packed specially for institutional and hotel trade to the extent indicated on the orders in the hands of the packers at the time packing commences.

If buying canned goods on specification by tender, jump into the market just as opening prices are announced. You will, however, have to take your chances in getting the large sized cans. To be sure of this latter feature orders must be placed in the Spring to be booked at opening prices and after all you probably won't do much better than this unless competition is plentiful, your order of fairly large dimensions, and you can get the sizes you want if you call for tenders.

Meats: Meat prices of course are governed very largely by export demands but generally speaking they should be at their lowest ebb here just at this very season because of the plentiful supply of live stock coming in. Farmers often have made no provision for the wintering of their stock and dispose of their surplus before the necessity of housing them arises.

Carcasses of beef are divided into seven grades—Choice, Good, Medium, Fair, Poor, Canning and Boning. The only ones a hospital need consider are the first two. The meat of a steer grading "choice" is liable to be just a little too fat for your clients and although the favored cuts in it are likely to be very choice the rest of the carcass will be no better than that of a steer grading "good." But you cannot feed everybody on club steaks and for all round purposes a carcass grading "good" is probably the most economical

to buy without jeopardizing the quality of your food. This is a case of where the best may be a little too good.

If you cannot visit the abattoirs and select your particular fancy you need have no fear of accepting the grading of the men who classify them as they pass into the coolers. They see more carcasses in a day than you or I would in a few years and they have to know their business. If you have any doubts or wish information about dissecting any carcass of meat you can procure some very excellent charts on this subject, similar to this.

In calling for tenders for meats our specifications cover all the different cuts from the entire carcass down so that in the event of our having to buy any particular cut to meet an emergency we will know what it is to cost. Otherwise we buy almost entirely in carcasses and sides.

Furthermore, if you do not feel any too confident about selecting and grading meat yourself, spend a few hours now and again with the grader in some good abattoir, study his methods, and you will be surprised at how much you will learn in a short time.

Vegetables: We have had little experience in the actual buying of vegetables. Almost everything we use in this line is grown on our grounds.

It is obvious, however, from the fact that very few here have adequate Winter storage for vegetables that a large percentage of our usual bountiful crops are put on the market before the freeze-up. Doubtless many of you would and could advantageously buy your entire supply then, but for the question of storage.

Three summers ago we had more vegetables than we could store in our regular root-houses. The result was that we had to improvise outside storage such as I will describe and am passing on to you for what it is worth.

A pit of rectangular shape and about nine inches deep was made. Around this a wall about a foot high projecting above the surface level but a few inches; a plank on edge being very suitable. On this is built a crude gable roof of plank or heavy brush, each piece set far enough apart to give a maximum amount of ventilation without letting the covering material sift through.

A foot of dry straw manure is laid on this roof with two feet of dry coarse cinders over it.

Rough ventilating shafts about three feet apart run from the floor through the roof with a couple of inverted shingles on top

to shed rain. At the bottom of these shafts small holes should be dug to receive any moisture which may drip down them. The shafts should be of open-joint construction permitting ventilation from all sides all the way up. They may be of fagots tied in narrow bundles long enough to reach from floor to roof if planks are not available. Such a pit kept the surplus of our crop that winter (which was one of the most severe in years) in ever better condition than in the permanent store houses.

Much intelligence and care must, of course, be displayed in preparing vegetables for storage. Roots should be thoroughly "sweated" in piles for some days, cabbage turned upside down to run the moisture out of them, and so on.

Drugs: We do not recommend calling for tenders for drugs. We have tried it and it is not a success. The reason is that the manufacturers will not tender for fear of bidding against one of their own customers who may be after that particular part of the hospital business. But, on the other hand, manufacturers are quite ready and willing to treat hospitals as legitimate wholesale trade and deal with them direct in the regular way and as you cannot get further back than the original source of supply of an article you need not fear much criticism if you buy in this way.

But it is appalling how many hospitals buy their drugs, rubber goods, etc., from the local retail druggist and just here I want to emphasize the fact that this is wrong and that the manufacturers or at least the wholesalers of almost all the important articles used around a hospital have special prices for hospitals and consider them as good and even better business than many of the retailers to whom they sell. Rubber goods, malted milk, bovril, etc., may all be bought directly from the manufacturers and for years we have been buying a particularly fine grade of rubber sheeting from an English Mill.

Cotton and Gauze, etc.: Many of you are buying through jobbers when you ought to be on the mailing lists of the manufacturers who will circularize you from time to time about the trend of the markets. Being so far removed from the source of supply we cannot here do much else than follow their advice which is, however, usually reliable.

Dry Goods: Where buying in quantity for a new institution you can easily interest the manufacturers in the East and in Britain

and elsewhere through their agents here. We bought wool blankets in 1911 and more in 1914 and they are just as good to-day as when they came. That comes of buying the best. We were criticized then for buying such good mattresses although they came to us direct from the factory and cost very little more than the prevail-price of poor mattresses. Excepting for an accident to two or three last month, through a burst steam pipe, we have not had to discard a single mattress and most of them have had almost continuous use. Their shape is as good to-day as ever because they're made right.

The theory of buying cheap mattresses and often, is poor economy. Even though a good mattress gets soiled it can be washed as well as a blanket, and, if properly manufactured, the lay of the cotton will not be disturbed thereby at all. The ticking will fade a little in the wash—that's all.

Relatively small quantities of sheeting, etc., can often be bought to better advantage from large departmental stores than from wholesalers. That sounds strange but it is not to be wondered at when one considers the fact that the cash buying powers of the latter is often tremendous. Although ostensibly retailers you'll find them, nevertheless, quite interested and prepared to quote attractive prices and values on an order of wholesale dimensions.

It is somewhat difficult to buy dry goods by tender because of the fact that no two mills or dealers can meet exactly the same standard. We have, however, twice placed large orders in this way. What we did was to set our own standard by displaying one article of each of the things wanted and telling them to match or equal it. These articles are given a number corresponding to the number on the specifications and of course the specifications give all other details as to quantity, size, color, markings, delivery, etc.

Just the other day we received a letter from the Canadian agents of large blanket mills, the first paragraph of which was the following announcement:—"We wish to say our mills have directed us to announce they will fill orders direct from hospitals."

Paper Goods: Toilet paper, tissue napkins, etc., can be bought direct from the tissue mills on the Great Lakes and they will welcome your enquiries.

It is a practice with us not to buy over the heads of those responsible for the different services using the goods. The dietitian

should be consulted about foodstuffs; the engineer about coal and oil, etc., the laundry foreman about soda and soap, and so on, and unless you have very good reasons to the contrary you ought to buy the grades most preferred by them. Then if you have any criticism of their work they cannot complain on this score. You will, if you are as fortunate as we are, find these good people just as concerned about efficiency and economy in their respective departments as you are in respect to the Institution as a whole.

Finally, let me respectfully remind you that prompt settlement of accounts is a most important factor in establishing your status with those from whom you have to buy and let it not be forgotten that the first thing a sales manager does before he answers your enquiry and dictates prices is to look up and see just how long you took to pay for the last lot of goods you had and, if your standing is good you will also have no difficulty in persuading them to extend their usual cash discount period to cover the time that it takes your accounts to get through committees. But if accounts are not all rounded up regularly each month and paid, you will find, if you enquire closely enough, that you are paying for the delinquency.

In this little talk and the short time at my disposal I have only been able to hit a few of the high spots and deal with the essentials in buying some of the important items.

There is much left unsaid, and a lot of detail left out for purchasing is not an exact science like accounting and requires ceaseless study and continuous vigilance. If what I have said will be of just a little assistance, particularly to the smaller hospitals, I will be very glad indeed. I hope, at any rate, that these few remarks will stimulate discussion. I thank you.

Selected Articles

SOCIAL WORK IN HOSPITALS—ITS EDUCATIONAL VALUE

GERTRUDE KNOWLTON, Milwaukee, Wis.

As a background for considering the educational function of Social Service in hospitals, I must tell you what a social worker is, in the strict sense in which the term is used, and how and why she comes to be attached as a part of its regular therapeutic equipment.

A social worker is a person who has been trained in the best methods of helping needy persons or families.

The needy are not always those below the poverty line where financial aid is necessary, but they do lack some essential required to keep them in a reasonable condition of health, self-support and happiness. They may be ignorant or handicapped by accident or poor heredity; they may be victims of bad habits or a wrong social order.

The profession of social work, contrary to the belief of many, is one governed by principles as scientific as any other profession and the notion that any person of intelligence and right motive can undertake it, without training, has brought about a great deal of harm to the very people whom it was hoped to help.

In the past few years so much emphasis has been placed on the important part which social environment plays as a cause of disease that the use of social workers in charitable or semi-charitable hospitals and dispensaries requires little explanation as to purpose. It is clearly a waste of time and effort to treat with medicine alone diseases which are only presenting symptoms of poverty, ignorance, bad housing or vicious habits. It is quite as obviously futile to give advice as to the remedying of these contributing causes when the advice carries to the patient's mind no possibility of accomplishment.

We all see every day, if we have not grown blind through much seeing, patients who have received the most skilled and expensive care in our hospitals through the acute stages of disease, go back to such conditions at home that complete convalescence is impossible, and relapse very probable.

In the out-patient department the need of providing for the doctor some control of his patient's physical surroundings and habits is even more important than in the hospital where food, shelter, clothing and fresh air, if not "freedom from worry" are assured for the time being at least.

Do we not all know the dispensary patient who keeps her prescription behind the kitchen clock for ten days until she gets the money to pay for having it filled? Or the child being treated for heart trouble, who lives up two flights of stairs, carrys her baby brother up and down, and loves to roller-skate?

I remember a girl of 21 years being treated for persistent headache and anemia, who was found to be practically living on bread and coffee and working three nights a week in addition to her day's work as stenographer, to support a dependent aunt and a feeble-minded brother.

What chance has the doctor alone to cure patients like these by seeing them once a week at the dispensary? Is it any wonder that he finds little satisfaction in the heavy routine of clinical work when he never knows what becomes of his patients, and is it strange at all that the patients themselves wander from one hospital to another in search of relief?

In the case just mentioned, the social worker, after one or two interviews, succeeded in winning the confidence of this reticent girl and discovered what a burden she was bearing. Her employer was seen and agreed to double the time of her vacation; a seashore vacation house for girls was found where she could have the best of food and cheerful companionship; the 14-year-old feeble-minded brother, who had been a great care was sent to the State School for the Feeble-Minded, and the aunt temporarily cared for by a charitable agency. When the girl came back she was no longer a nervous, despondent invalid.

The organization of a Social Service Department needs very careful planning in order that patients most needing its care may receive it. Beginning with a single worker in a hospital it is sometimes best to select a few types of cases, such as the tuberculous or

unmarried mothers, and after working on these for six months to change to other problems. In this way a finished piece of work is better demonstrated to the doctors than when a few of many kinds of cases are taken over the whole period of a year. As other workers are added, they usually specialize on definite problems that they may acquire a skilful technic in handling them.

In the large out-patient departments it is being more and more considered the most efficient method to put a worker into the clinic itself, where she may see and talk to all patients as they come and go; find out whether they understand their directions from the doctor and what the chances are of their being carried out. In this way she helps the doctor in selecting the cases most needing her assistance, sees that all patients return when asked to do so, and in general, finds out what are the difficulties and needs of that particular clinic from the social standpoint, and how they may be met.

In the medical clinic there are patients suffering from cardiac and kidney diseases who need special diet and employment, and debility cases for whom rest and good nourishing food are necessary.

The gynecological clinic brings to light the problems of the unmarried mother who must not be left to face alone the consequences of a sad mistake; of venereal disease with its danger to other members of the family, and to the community of women needing surgical operations who lack a knowledge of hospital resources or the courage to go to them.

In the mental department one finds insane and feeble-minded patients who should have custodial care, borderline cases needing prophylactic measures at once, and neurasthenics requiring re-education and employment.

The children's clinic, being the most hopeful of all places for the expenditure of effort, is usually among the first to be given the full service of a worker.

Following this same idea of organization, in the small dispensary, the first social worker can usually best help the greatest number of patients by being at the admitting desk during clinic hours, using the remainder of the day for visiting.

The social worker sees the patient not as an individual, as the doctor does, but as a member of a family, and the members of a family are so bound together as to interests, affections, health and financial circumstances that several may need to be helped in one

way or another in order to bring about desired results with the one patient. The best thing we can do for a sick baby sometimes is to cure a sick mother or see that father gets a job.

The social worker relies upon the assistance of every agency for constructive work in the community and does not duplicate their efforts. She asks the child welfare nurses to supervise the feeding and hygiene of babies, the associated charities or public relief department to take care of relief problems, and refers to the juvenile court such cases as belong to them. The social service department acts as the clearing house of the hospital for these patients needing the community's assistance, and directs them with a careful and sympathetic hand.

There are three important phases of hospital social work which are educational. The first is teaching the patient the relation of hygienic living to good health; how to use well the resources of the city which he needs for recreation, education, health, work and financial aid when necessary. Especially the worker strives to root out old superstitions as to medical practices and the dread of a hospital as a fearsome place. In the hospital's zeal for good service and efficient management it sometimes comes about that it is a place where, as one man puts it, "we can be surer that patients will be treated aseptically than tenderly, better technically than humanly." Patients mistake our red tape and business-like manners for lack of sympathy, and these things need to be explained away.

The social agencies of the community form a second group which needs our aid in interpreting the *real* meaning of diseases with long names and what relation these bear to social conditions which they are trying to remedy.

Reporting back to outside agencies the doctor's diagnosis and advice for treatment is one of the most helpful things that the social service department can do. To illustrate:—

The associated charities sent to the dispensary a man who just had a severe attack of rheumatic fever. They sent also a note saying that the man was very anxious to go to work, as his family had been in destitute circumstances for several months and he was loath to accept charitable assistance. A report of his condition was requested. The doctor's examination revealed a heart lesion, necessitating complete rest for an indefinite period of time, preferably in the country. The man should report once a month at the dispensary. Prognosis good if directions followed. This report was

given to the society through the social service department and the plan carried out. Each month when the man was re-examined the society was informed of his progress and at the end of six months he was able to resume his usual occupation.

Good records of cases in which better social legislation was needed to make a remedy possible are necessary to those who must have evidence to back up a plea for better laws or enforcement of those already existing.

Abundant material for medical social research in occupational disease, border-line feeble-mindedness, sex problems, alcoholism, etc., is found in every hospital and dispensary, but rarely is it rendered available for practical use because complete records have not been kept, and the individual problem has not been interpreted as a part of the greater one of the community.

The third educational phase of social work in hospitals is the instruction of the medical student. Dr. Charles P. Emerson seems to have been the first person to appreciate the value to them of a knowledge of social work. He says: "It was partly to aid their education that in 1902 some of the medical students of Johns Hopkins University organized the first student board of the Charity Organizations' Society of Baltimore. They visit one poor family or at most two families assigned to them by the society, for weeks, months, or even for years. They do what they can to improve the conditions in these households. No effort is made to select for the students families in which there is sickness. The students learn how the poor man lives, works, thinks, what his problems are, what burdens he must bear. They learn the intimate relationship between the ills of the physical body and the home environment. They learn also how easy it is to give very good advice which will add burdens which cannot be borne. They find out that the poor man is not always a self-convicted sinner or a self-confessed ignoramus, and that he has his own ideas as to the necessity and especially as to the possibility of his following advice.

The poor man loves his vices as truly as does the rich man and will not abandon them at the off-hand suggestion of a strange doctor. The students find that to effect a much needed reform—e. g., to keep the windows open, they must first win the confidence, next the love of the poor patient, and then stick to him closer than a brother to prevent relapses.

In some of the hospitals having social service departments arrangements are made for the worker to give a few lectures to medical students, and in the out-patient department each might be given one or two patients to follow through really to the finish of the medical problem observing the method of doctor and social worker, working in co-operation on a plan of treatment.

The nurse as well as the medical student needs to know something of the broader aspects of medical work. The Massachusetts General Hospital allows a few of each year's graduating class, especially selected as to fitness, to have three months' experience in the social service department. This is not in any sense regarded as a training for social work, as the time is far too short, but it gives the nurse a chance to gain some insight into the growing field of public health activities and will make her work much more intelligently as a nurse.

The New York School of Philanthropy has recently offered a combined course in medical and social work. By co-operation with Belleview Hospital Training School, the course offers two years' training at the hospital and one year at the School of Philanthropy. The graduation diploma is not given from the hospital until the year at the School of Philanthropy is finished.

The question of whether or not a person without nurse's training but with social training is as well fitted for medical social work as a nurse with social training is a much mooted one. A medical social worker must, of course, have a working fund of medical knowledge; but personally I feel, though I am a nurse myself, that the worker trained socially gets this information as well and with less waste of time by instruction and supervision in the social service department of the hospital as in its training school for nurses. It surely ought not to be necessary to spend three years, or even two, in learning care of patients, administration of medicine, and operating room technic, etc., in order to get the comparatively simple, practical facts about disease, hygiene and treatment which are what the medical social worker needs to know. Any intelligent person with the help of a few good medical books, including a dictionary, and actual work in a clinic under the supervision of an experienced worker, very readily acquires the necessary knowledge. The hospital social worker's function is not that of a nurse.

Preventive medicine is largely a matter of individual and public education and the hospital through its social service department

has one of its best opportunities for really reaching the people and giving them practical medical knowledge in a form in which it can be used.

HOSPITAL DELAYS

(By Dr. A. J. Collins, D S.O., M.C., Medical Superintendent.)

A common source of complaint against the public hospitals is the delay to which patients seeking treatment are occasionally subjected. Members of an industrial population live at high pressure, and have few spare moments in the day. From sunrise until evening there is little leisure—the men being occupied with their wage-earning occupations, and the women with their highly exacting domestic duties. It, therefore, entails a certain sacrifice for such individuals to visit a hospital at all. Take as an example the average labourer's wife, who has been "feeling run-down for months" and at last decides to snatch a few hours some morning in which to hurry off to the hospital. She generally locks up the house and brings the baby with her. Arriving at hospital, she is shown into the casualty waiting room. When her turn comes, the casualty surgeon finds her complaint is something which cannot be relieved by "advice and medicine." It may be that he recommends her for immediate admission. More often, however, specialist advice is necessary, and he explains to the woman that she must go to the out-patient department to see a specialist. This is the first blow, for it means waiting until afternoon. She is accordingly given the necessary ticket, entitling her to admission as an out-patient, and is told to wait until 2 p.m. Fortunately, at the Royal Prince Alfred Hospital, she is enabled to get her lunch in the hospital tea-room, where the ladies of the Auxiliary work voluntarily each day. After lunch the specialist is seen. Here again, delay frequently occurs, for the specialist sometimes requires the aid of the X-Ray department or the pathological department, to help him in arriving at a diagnosis. So the woman is sent to whichever special department is necessary for such further examination, and is then returned to the original specialist, who may recommend her for admission. By this time she is in a frenzy of exasperation, thinking of the house she has left locked up, of the work waiting undone, and of the evening meal for her lord and master, which is now sure to be late. When she finally arrives at the superintendent's office,

with her recommendation for admission, she gives vent to her impatience, and complains bitterly of having been kept waiting all day, being sent from doctor to doctor and "getting no satisfaction." The superintendent is obliged time after time to pour oil on such troubled waters, always feeling that his explanation is not accepted.

As a matter of fact, such a woman has had an immense amount done for her. Had she belonged to the leisured classes it would have first been necessary for her to see her family doctor, at his convenience. He would have arranged a consultation with a specialist at the latter's convenience—invariably some days later. The specialist would have demanded X-ray or pathological investigation. This would mean a trip to MacMarie Street on the following day at the earliest, where a further wait would be necessary. Then another consultation with the family doctor or specialist would have followed in the logical sequence, the total time expended being possibly a week or two. For all these visits there would also have been ample fees.

It should be plain, then, that the hospital patient is the more fortunate of the two, having had her case thoroughly investigated in one day. This is really but one more example as to how immensely better is the provision for medical attention among the poor than for such as can afford private treatment.

Fortunately, most of our patients are appreciative of our efforts on their behalf—a fact which compensates for the most querulous of complaints.—Prince Alfred Hospital Gazette.

TORONTO JEWS TO HAVE OWN GENERAL HOSPITAL

Toronto is to have something that is quite unique in the annals of its history—a Jewish general hospital.

The Lyndhurst hospital building, 100 Yorkville Avenue, has been bought for the purpose and in May it will be completely renovated. In July it will open its doors to fifty Jewish patients—forty adults and ten children.

The Ezras Noshem, or Jewish Daughters' Society, are the founders, but the original idea developed through Mrs. S. Greenberg, 20 Grange Avenue. When she first came to Toronto she could scarcely speak English, and one day she was suddenly taken ill and rushed to the hospital.

While there she could'nt make anyone understand her, and numerous mistakes were made. There was nothing very serious but the experience set Mrs. Greenberg thinking.

"There must be hundreds of other cases similar to mine," she said to herself, and later she found that there were. "The doctors cannot understand me; the nurses do not know what I am taking about, and certainly my understanding of them is no better."

The food was another thing that worried Mrs. Greenberg. "Our religion allows that when Jewish food, ritually prepared, cannot be secured, then we can eat the food of Gentiles," she said in explanation. "And Jews in Gentile hospitals are an example. I tried, but I could not eat the food. So my family prepared it at home, according to the Jewish custom, and brought it to the hospital. There the hospital authorities let them serve it from the pantry. And I was not the only one. There were many other Jews doing the same thing.

"But what difficulties," I thought. And then the idea came to me like a flash while I was lying on my back: 'Why cannot the Jewish people of Toronto have a hospital of their own?'

"As soon as I recovered I began to formulate my plans. I have received such wonderful co-operation from my fellow beings that now we have bought the Lyndhurst hospital building for $35,000. We have collected $12,000 among the Jewish population of Toronto, who are now very enthusiastic about the scheme. This cash now lies in the bank and the remainder will be collected later.

"In May we take over the building, and it will be entirely remodeled. The kitchens will be made suitable for the food which is to be prepared after the Jewish manner.

"Our nurses will be Jewish, and so will the doctors. In fact, everything about the hospital will be Jewish—even the cooks. I cannot tell you more than that, for I do not know the exact details. They will be planned later. But the hospital will be a haven for the orthodox Jew in times of sickness, and the bulk of the Jewish population in Toronto is orthodox."

The officers of this Jewish hospital association include: chairman, Mrs. S. Greenberg; vice-chairmen, Mrs. B. Papish and Mrs. R. Miller; treasurer, Mrs. D. Katzman; trustees, Mrs. D. Close and Mrs. F. Havelock; and secretary, Mrs. F. Goldman.

UP-HILL WORK

During the past year the Western hospital went behind $27,471.77. This deficit, reported in the annual statement of the hospital to the Toronto City Council, is attributed unavoidably, by Superintendent H. C. Tomlin to the number of its public wards.

"The position of the hospital," says Mr. Tomlin, "is that over two-thirds of the bed space is devoted to public ward patients, and it is impossible for the financial condition to be any different. If we had more accommodation for private and semi-private patients the financial condition would be very much relieved in connection with the hospital."

CATHOLIC HOSPITAL ASSOCIATION OF THE UNITED STATES AND CANADA

The 1922 Convention of the Association will be held at Washington, D. C., in the Catholic University, June 20, 21, 22 and 23 (Tuesday, Wednesday, Thursday, Friday.)

From now on our slogan should be:

"On To Washington."

The accommodations at the Catholic University are excellent for the work of the Convention, the housing of the Sisters and the clergy, and for the Commercial Exhibits.

In due time, all details, as regards reservations for the sisters, and the clergy, doctors and nurses, will be announced from this office.

The plan of the program of the 1922 Convention aims particularly at what is practical. This year there will be Clinics for the Doctors. More emphasis will be placed upon the Conferences for the various phases of the hospital's work. This means fewer general meetings.

Firms planning to have exhibits at the Convention should communicate directly with Dr. John M. Cooper, Catholic University, Washington, D. C.

For all other information regarding the Convention, address Secretary-Treasurer, Catholic Hospital Association, 1212 Majestic Building, Milwaukee, Wisconsin.

The 1922 Convention promises to be an epoch-making meeting in the history of the Association.

B. F. McGRATH, M.D.

NATIONAL HOSPITAL DAY

Hospitals of all sizes and types are showing an increasing interest in National Hospital Day as the date for the second annual observance of this movement, May 12, approaches.

National Hospital Day was originated last year for the purpose of acquainting people with hospitals and hospital service, and brought many unexpected benefits to the 1500 institutions throughout the United States and Canada which took part in the pioneer movement. There were innumerable donations of money, supplies and equipment, while a large number of applications were received from high school girls and other young women to whom the "day" so clearly presented the ideals and opportunities of nursing.

The National Hospital Day Committee under whose direction the program for the day is being developed includes the following:

Dr. Lewis A. Sexton, Chairman, Superintendent, Hartford Hospital, Hartford, Conn.

E. S. Gilmore, Vice Chairman, Superintendent, Wesley Memorial Hospital, Chicago.

Asa S. Bacon, Superintendent, Presbyterian Hospital, Chicago.

P. W. Behrens, Superintendent, Toledo Hospital, Toledo, O.

Pliny O. Clark, Superintendent, Presbyterian Hospital, Denver, Colo.

Dr. Hugh S. Cumming, Surgeon General, U.S.P.H.S., Washington, D. C.

Dr. Malcolm T. MacEachern, General Superintendent, Vancouver General Hospital, Vancouver, B. C., Can.

Rev. P. J. Mahan, Active Vice-President, Catholic Hospital Association, Chicago.

Norman R. Martin, Superintendent, Los Angeles County Hospital, Los Angeles, Cal.

Dr. W. P. Merrill, Superintendent, Charity Hospital, Shreveport, La.

Dr. Harry J. Moss, Superintendent, Peoples' Hospital, New York.

Dr. C. W. Munger, Superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich.

Dr. Geo. O'Hanlon, Superintendent, Bellevue Hospital, New York.

Dr. J. E. Sampson, Greater Community Hospital, Creston, Ia.

Mary C. Wheeler, R.N., Superintendent, Illinois Training School for Nurses, Chicago.

As may be seen, the foregoing committee men represent the leading institutions throughout the United States and Canada. They are being supported by state and provincial committees representing every state in the United States, the District of Columbia and every Canadian province. These state and provincial committees are lead by an active hospital executive, and include from a half dozen to a score of progressive administrators in each state or province.

The National Hospital Day Committee has prepared a leaflet detailing the most successful ideas for programs and publicity which were carried out last year, and copies of this material will be sent free to all hospitals which will request it of the Executive Secretary, National Hospital Day Committee, 537 S. Dearborn St., Chicago.

HAZELTON HOSPITAL

Last year's report of this hospital is received. Owing to closing down of local industries, and a consequent exodus from the camp, work diminished some 20 per cent. below the previous year; hence a decrease maintenance cost.

Dr. Wrinch says: Our Hospital does not differ greatly from the average hospital in our Province. Their viewpoint as to finances is by no means bright. The constant struggle to keep down costs and to find the wherewithal to meet the absolutely unavoidable expense of maintenance and upkeep of our institution absorbs a very large proportion of the thought and effort of the executive officers. This ought not to be, for it means a very large amount of energy diverted from channels through which the efficiency of the institution and its value to the people might othewise be very greatly increased.

More and more the hospital executive and boards of directors are reaching the conclusion that some radical change in the method of financing hospital must be speedily brought into effect. The people in general want the hospitals kept up to a high state of efficiency. Every thinking person is willing to bear his share of their upkeep. The great problem confronting the hospital world to-day is to devise and bring into effect the best and most equitable

method of enabling the people to provide the funds required to properly finance these indispensable institutions.

In the meantime we are continuing the struggle to give the best possible service permitted by existing conditions.

In dealing with the problem of hospital finance, we believe that relief will be hastened through the efforts of our provincial organization of hospitals, which has been in existence nearly four years, and has unified the work and effort of the hospitals to a remarkable degree.

The British Columbia Hospital Association is devoting a great deal of time and effort in endeavoring to solve this question. It is a force that can not be ignored. It believes that our most valuable national asset, the health of the people, is, to a large extent, entrusted to the hospitals. Viewed from this standpoint, surely there could be no policy more shortsighted than one that would parsimoniously limit the service and efficiency of these institutions. The Hospital Association has a standing Committee on Finance, which is following this question closely. We have faith to believe that it will not be long before the people will rise to the occasion and demand a good and sufficient hospital service.

Our our Hospital has held membership in the Provincial Association ever since its inception four years ago. This year we have no less than fourteen individual members also in this association. There is no better way of showing that we mean business when we ask for reasonable support for our institution.

HOSPITAL ADDITION CORNER STONE LAID

Corner stones for an addition to Grace Hospital, Crawford avenue and London street west, Windsor, conducted by the Salvation four public wards, eight semi-private wards, and 36 beds for patients who prefer more privacy. The X-ray rooms will be located Army, were laid by Mayor Wilson and Commisioner Charles Sowton, head of the Army in the Dominion. The building will have in the basement . The new wing, running back 40 feet, will have a frontage of 168 feet on Crawford avenue. In addition to Mayor Wilson and the Commissioner, Gordon M. McGregor and O. E. Fleming, K. C., who assisted the project, made short addresses, congratulating the Army on giving additional hospital accommodation to the city.

CHILDREN'S HOSPITAL, LONDON

In September, 1919, the Imperial Order Daughters of the Empire, of London, Ontario, initiated the idea of a war memorial Children's Hospital and formed a committee from all women's organizations of the city. An executive committee was formed consisting of Mrs. H. H. Smith, Convener; Mrs. F. J. Greenaway, Honorary Secretary; Mrs. C. T. Campbell, Treasurer, and Mrs. E. H. Young, Assistant Secretary. Plans were laid to raise

War Memorial Hospital for Children (completed building)

$100,000; $180,000 having previously been guaranteed. Since September, 1919, the ladies have raised $186,046.53, the most of which has been paid in.

Under the chairmanship of Col. W. M. Gartshore, President of the Hospital Trust, and J. J. Foote, Esq., Canvass Convener, and with the assistance of the Chamber of Commerce, the Rotary, Kiwanis, Lions' and Advertising Clubs, a campaign was put on in the

city a few weeks ago and in the Western end of the Province to raise the balance required.

London Council gave a grant of $50,000; Middlesex Council $12,000 and the Provincial Government $20,000. The city of London donated the site and will maintain the hospital in conjunction with Victoria Hospital and under the same management.

The Hospital will provide 100 beds with private and public wards for medical, surgical, orthopedic, eye, ear, nose and throat patients; also an out-patient department with special arrangements for child welfare and pre-natal clinics.

War Memorial Hospital for Children of Western Ontario (under construction)

On the lower floor are the receiving rooms, etc., detention ward, out-patients' department, kitchens, milk department, refrigerator, heating equipment, electric elevator, clinics, etc.

Second floor—Main offices, waiting room, utility rooms, several private rooms, 2 very large wards, and 2 sun porches. 2 bathrooms.

Third floor—All private rooms with the exception of 3 bath rooms, utility rooms, 2 wards and 2 porches.

Fourth floor—2 operating rooms, creche, superheated or premature room, all in conjunction with operating rooms, private rooms, bath rooms and 2 sun porches.

The electric elevator goes through to the roof garden.

ADDITION TO GRACE HOSPITAL, WINDSOR

After outside construction of the new $125,000 addition to Grace Hospital, Windsor, now nearing completion, no provision other than through the generosity of Border citizens has been made to equip the Institution. Last Autumn Windsor taxpayers voted $50,000 toward the fund to build the addition, which is under the direction of the Salvation Army. Building was begun a month ago. The workmen employed on the building have agreed to furnish a room out of their earnings. The cost to equip a room is placed at $300.00. A brass plate bearing the donor's name is to be placed in each equipped room.

ASKS COUNTY FOR $50,000 TOWARD MEMORIAL HOSPITAL

An influential deputation from the city, headed by Mayor C. E. Raven, waited on the Elgin County Council and asked for a grant of $50,000 toward the proposed Elgin Memorial Hospital, which is estimated to cost $200,000. The city has already granted $100,000 toward the project.

Book Reviews

Materia Medica and Therapeutics. A text book for nurses by Linette A. Parker, B. Sc., R.N. 3rd edition, thoroughly revised. Illustrated with 30 engravings and 3 plates. Lea & Febiger, Philadelphia and New York. 1921.

The author endeavors in her work to give only the important and practical points which form a foundation for an intelligent handling of drugs. The study is undertaken by systems—those which act on the nervous, muscular, circulatory and other systems. The usual chapters are devoted to weights and measures, solutions, pharmaceulical preparations; the nature of acids, alkalies and salts; active principles of plants.

Therapeutic measures are also discussed—psychotherapeutic, hydro-therapeutic, etc.; vaccines and ray therapy.

This clever book we would commend to all nurses—graduate as well as undergraduate. It would form a good primer for medical students, and would also be found interesting to those of the laity who would like to acquire an elementary knowledge of drugs.

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Editorial

Staff Conferences

The writer of this article had the privilege recently of attending two medical staff conferences in one of our large Canadian city hospitals. There were probably thirty doctors present—representing all the chief departments—medicine, surgery, pathology, radiology and also the special departments. A leading surgeon was chairman and a junior surgeon was secretary. At these conferences the following matters among others, were discussed:—

(1). Why was there as much post-operative pneumonia? One speaker averred that nurses with sore throats or other infections were on duty, concealing their indisposition from the nursing Head. These were a menace in the operating room and to patients recently operated upon. The nursing Head, who was at the conference, would make inquiries and see to it that nurses even slightly ill would be kept off duty—or at least away from this class of patient. One of the surgeons stated that he did not like the way certain anesthesias were given. First of all a quantity of Ethyl Chloride was squirted on to the inhaler; in a few moments the patient was unconscious. Then ether was poured on—even he had seen—from two bottles until the patient was smothered with it. This method of administering the anesthetic may have had some-

thing to do with causing pneumonia. The chief anesthetist was not present at the meeting. He will hear of this criticism, no doubt and will instruct house-men that the above described method is not the way to put the patient under. Another surgeon stated that one of his cases developed pneumonia. On the day the patient was sent back to the ward he had learned that the maids, doing the dusting and cleaning, had opened the windows of the ward for a period of time. He was afraid his patient had suffered from cold and developed the trouble that way. While he was talking the superintendent of nurses and the housekeeper were observed to be taking notes.

The head of the Obstetric Department reported a couple of cases of sepsis. He and his assistants had made a careful inquiry into the technique of labor. Gloves had been used where necessary, examinations had, for the most part, been made per rectum, all instruments had been boiled, dressings sterilized and the usual precautions taken, yet there was sepsis. It might have been auto-infection; they were not sure. Would the staff make any suggestions? To the Committee on Health and Sanitation the problem was referred for investigation and report.

One member reported that a patient had been admitted to the hospital under his care and he had not been notified of the admission. The superintendent made a note of this delinquency—there had been an oversight on the part of someone. Hereafter, the House Officers concerned would report the admission of patients to their Chiefs, informing them of the condition of the patients, the provisional diagnosis, what had been done—in case immediate aid was necessary—and instructions would be asked for.

The Committee on Histories had various complaints to make: daily progress notes had been omitted in several instances; one of the surgeons had omitted putting down on the operation sheet what condition his opening the abdomen had revealed and what he had done in the way of dealing with the abnormality found. The Nose and Throat men had not, in some instances, written any histories. Another complaint was that the radiographer had not described in his report the lesion found in a case of fracture. The radiographer replied that on the history sheet he had written "see plate." An examination of the plate on the X-ray storage room would be better than any verbal description.

And so on for an hour and a half; the visitor was much entertained and gratified at this free and frank confession of failures and oversights and the kindly spirit in which suggestions and mild reproofs were given.

This is a sample of what is going on all over the American continent. It augurs well for the future of hospitals and will redound to the general welfare.

Anesthetics

The writer, who has given anesthetics covering a period of thirty years, has a few ideas on the subject. In the early nineties of last century, chloroform was almost universally given by him and his associates. Some of them were taught to pour it on the inhaler; others used the drop method. After those who poured had had an accident or so they poured no more, but adopted the drop method. During the last decade of the nineteenth century ether came to be the anesthetic of choice, being

found to be ten times as safe as chloroform. For some years the writer used it by the closed method, using a Clover inhaler. He never recalls having any trouble with this apparatus; of course ether was not given to patients with colds, bronchitis or other respiratory disease or to those with nephritis.

This closed method, in time, fell into disuse. The apparatus was difficult to keep clean; there was danger of transmitting contagion, and the patient was re-breathing his own exhalations to a great extent.

The open method is now used mostly outside hospitals. In one of the larger hospitals, in Toronto, nitrous oxide with oxygen is almost universally given and with good results. Crile, of Cleveland, has been using this combination for years.

A nurse administers it. Nitrous oxide and oxygen is a very expensive anesthetic, the cumbrous apparatus cannot be conveniently used by the private practitioner, and it requires expert knowledge to give it.

The writer is also chary of ethyl chloride, one needs considerable training to give it safely. It, too, is too expensive for the ordinary patient to pay for.

We understand that Chloroform is in favor still in Auld Reekie—*given drop by drop.* It acts nicely in young children (in very small amounts drop by drop—only a few being needed in infants), in nephritic or bronchitic troubles, in eye and brain operations and in labor. But in nine cases out of ten, we would say, ether is the anesthetic to use. We prefer it given by the open method from the first—drop by drop—gradually thickening the small towel folder as a cone over the gauze inhaler. It takes five to ten minutes to get the patient under, but here is one precedure wherein it pays to hasten

slowly. The man who gives ether should give only the *best* ether. It will pay him to stick to this brand—if he can—and use no other. Let the other anesthetist take the other brand—if he likes it—and stick to it.

There is a reason. Some of the weak, diluted stuff will fool you after using the simon pure of the reliable makers.

Hospital Students

In the first decade of the 19th century the hospital system was very imperfect, as is pointed out by Holmes in his Life of Brodie. The students were pupils of the individual surgeons (we hear but little of the physicians) and, when the masters were punctual and interested in teaching, their pupils got what they paid for. This was the case with Everard Home whose preceptor was so occupied with other things that he became negligent of his hospital duties, and, of course, his pupils must have suffered. The same became the case at a later period with Home. There was at that time no medical school, the pressure exercised by whose students and teachers (the latter his hospital colleagues) must tend to keep the most negligent decently regular, at least, in the discharge of his duty—no watchful Board of Governors certain to hear very soon of any irregularity, and to inquire sharply into its cause. Nor was the work itself pursued with the method and thoroughness of modern times.

CO_2 as a Preservative

Wonders will never cease. Thirty years ago students of sanitary science were taught that carbonic acid gas was inimical to health. Even in small

quantities in a crowded room it was said to render the air unfit for respiration. This theory has been exploded and it is now known that the principle thing in ventilating a room is to keep the air in motion and in a certain state of moisture in order that the inmates' skins may respire; in other words the aim is to prevent the formation of a sort of aural shroud around the body which prevents evaporation of heat from it.

The pendulum has swung the other way; and today CO_2 is actually used as a food preservative. It is taking the place of certain chemicals such as boric acid, salicylic acid, etc. Morever it is harmless to the individual. It even supplants heat as a preservative. Everyone knows the danger of destroying the vitamines by heat, and how easily milk which has been heated, decomposes after exposure.

This process of treating dairy products, fruits, and other perishable foods is called Heathization. It simply consists of eliminating all the air and replacing it by CO_2 under pressure. In some way it is held, but bubbles of air act deleteriously on the globules of butter or other dairy product, and produce rancidity. This form of decomposition never happens if CO_2 is used.

In 1910, the M. O. H. on board a ship from Southampton via. Havre to Quebec with immigrants, had a barrel of milk treated. After a voyage of 41 days he took the milk to the B. M. Association for examination. It was absolutely sterile and as fresh appearing and tasting as if it had just been drawn from the cow!..*Mirabile Dictu.*

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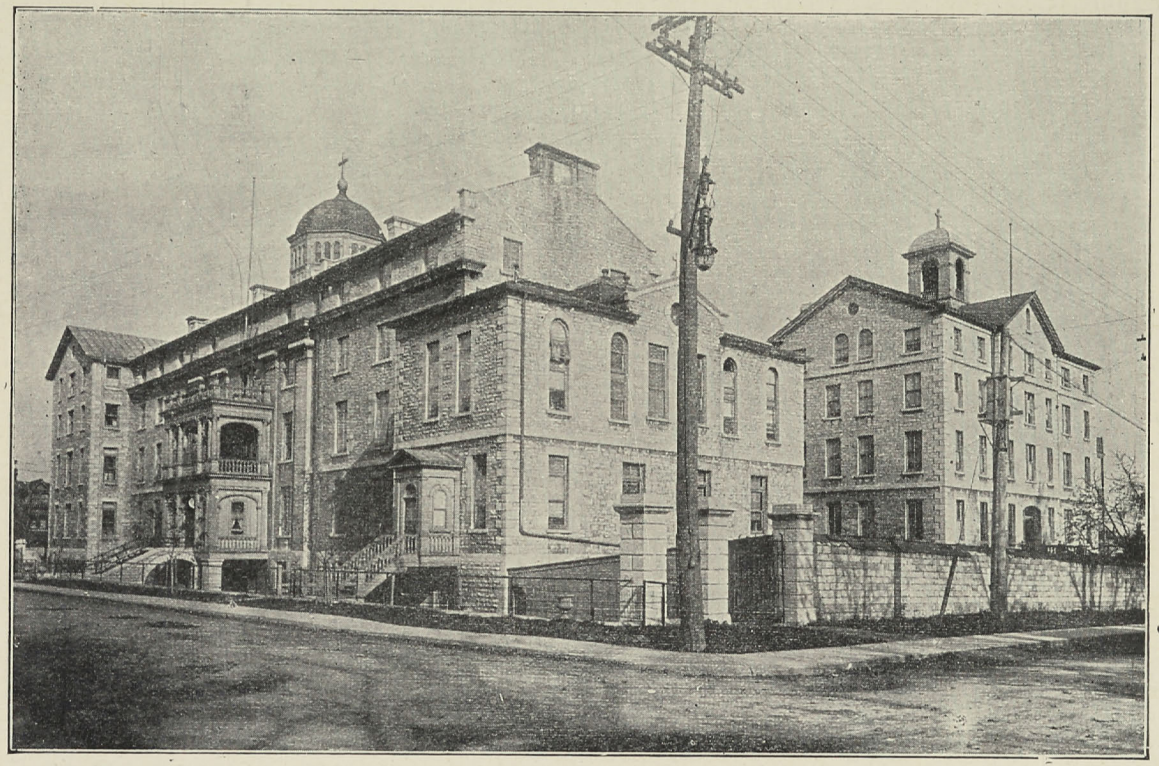
THE HOTEL DIEU—PAST AND PRESENT

By H. R. Fleming, M.A., Kingston, Ont.

The Hotel Dieu Hospital was established in the City of Kingston on September 1, 1845. This institution has the honor of being the first outgrowth from the Montreal Mother House of the Sisters in Canada. Kingston had been made an Episcopal See in 1826—Bishop MacDonnell being its first bishop. The population was scattered and there were but few Catholics, these being mainly of the poorer class. To establish a Sisters' Hospital in Kingston under such adverse circumstances seemed like courting failure. But the claims of the sick and needy always find a responsive chord in the heart of a true religious and the Rev. Mother Mesiere found it impossible to voice a refusal when the many pathetic stories reached her ears of the miseries suffered by the poor sick left almost without succor—dying in miserable sheds or even by the roadside. She therefore consented to aid the infant diocese.

The Sisters were under no illusion as to the mission they were undertaking. "You must depend solely upon Divine Providence" said the episcopal superior of that day. The Sisters arrived at last on a beautiful September evening and after a rest of a few days with the Sisters of Notre Dame Convent, they proceeded to their Cloister House to be known for many years as the "Old Hotel Dieu, Brock Street." On September 5, 1845, the hospital was opened with solemn Pontifical Mass, by the Bishop of Kingston. The day was one of memorable significance. Many prominent citizens called to express their kindly interest in the new foundation, promising hearty co-operation which time has proved so sincere. By September 12th the little hospital was filled to overflowing.

Reverses are nearly always a foregone conclusion of new foundations and this in Kingston was no exception to the general rule. The lack of sufficient accommodations and the intense cold of the long Canadian winters were severe trials. The first crisis that the Sisters were called upon to face was an epidemic of the "Ship Fever" among the poor Irish immigrants, who were forced from the land of their birth by the oppressive penal laws of England. Many of these typhus-

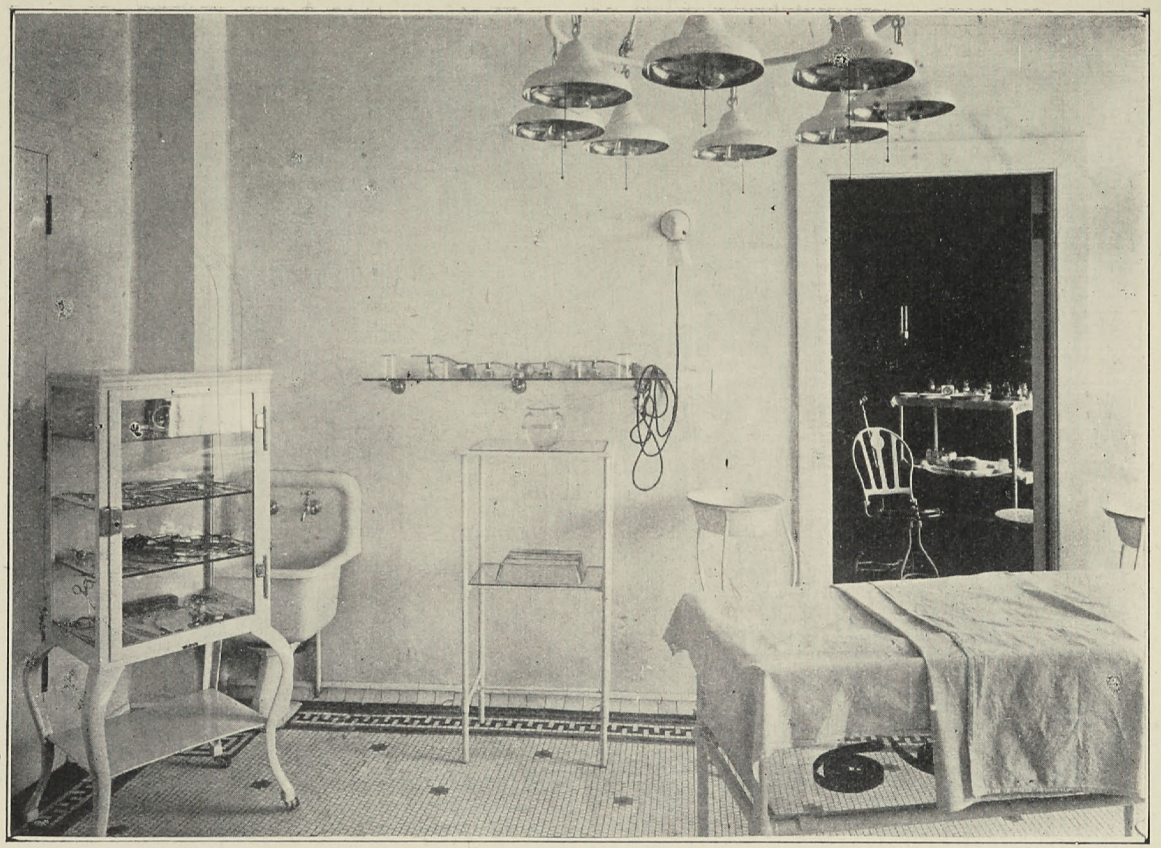


GENERAL VIEW, HOTEL DIEU HOSPITAL, KINGSTON, ONT. Rev. Mother Farrell, Superintendent.

stricken victims arrived in the City of Kingston, where hundreds perished. For weary weeks the Hotel Dieu Sisters combatted the epidemic, going from shed to shed soothing the fevered brow and moistening the parched tongue, oblivious of their own personal comforts and danger, and when all hope was gone performing the last sad offices of the dying and the dead. It was several years later that a severe type of smallpox swept the city and district. Still later, after the lapse of a quarter of a century, diphtheria, so deadly in those days, was an unwelcome visitor. And during these scourges the good Sisters of the Hotel Dieu performed their duty with characteristic heroism. The pandemic of Spanish Influenza of 1918, which proved extremely severe in this part of Ontario, found the Sisters of the Hotel Dieu of this generation worthy compeers of another time in the presence of a dangerous plague.

The Giver of all good gifts had signally blessed the work of the Hotel Dieu of Kingston. Each succeeding year brought added appreciation from the public, and the Sisters reluctantly realized that their beloved home on Brock Street was no longer adequate for the accommodation of their many patients. In the summer of 1891 it was therefore decided to purchase Regiopolis College and grounds, a fine city property occupying an entire city block and centrally located. The necessary arrangements having been made with the Episcopal Corporation the work of transforming the college into a hospital was undertaken at once. For six years the new hospital was used as a hospital and Sisters' home, but it also became too small, and in 1897 a new monastery for the Sisters was built. The work of the Sisters grew from year to year and in 1909 it was found that a new wing should be added to provide accommodations for clinical laboratory, X-ray, electro-therapy, and private rooms.

In 1918 the Hoted Dieu Hospital joined the Catholic Hospital Association of the United States and Canada, and since that time there has been a marked change in the upbuilding of a modern scientific hospital. The Hotel Dieu Hospital has felt the impelling force of that spirit of progressiveness, which was a source of the formation of the Catholic Hospital Association—that spirit which recognized that in a world of economic and civic development the hospital is an institution



CORNER IN THE EYE, EAR, NOSE AND THROAT SURGERY, HOTEL DIEU HOSPITAL

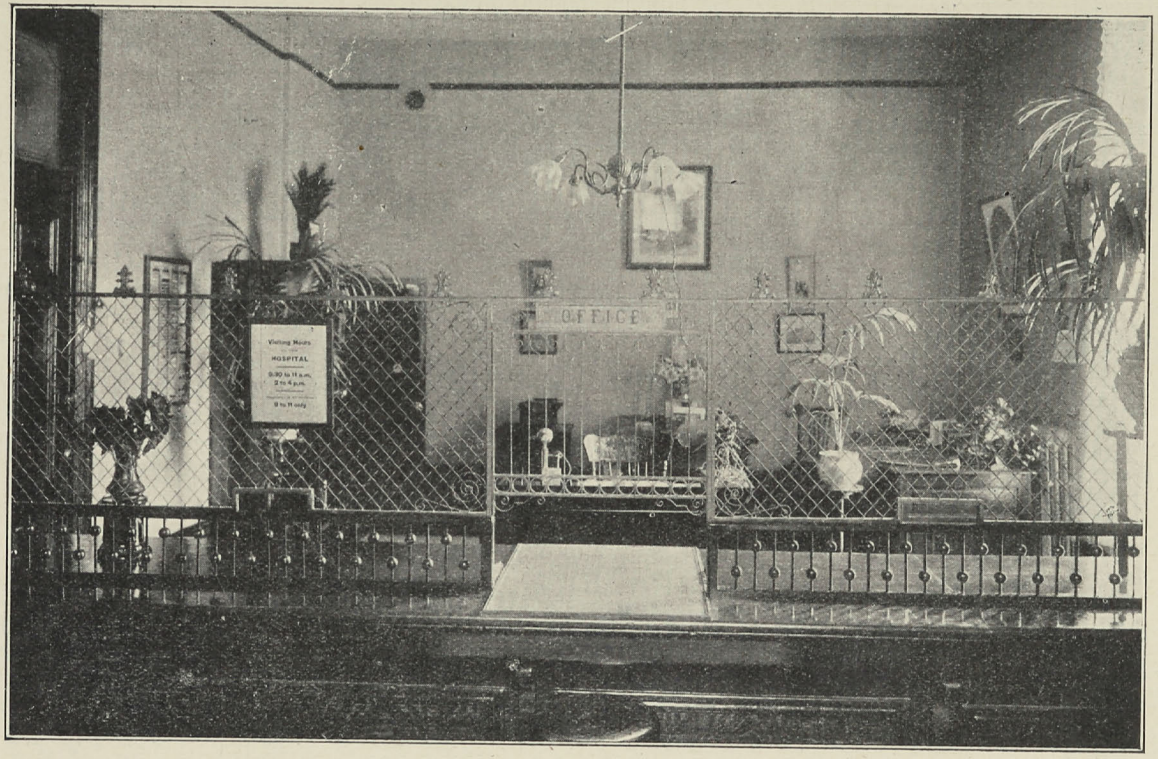
of service had not kept pace with the advancing life of modern civilization.

In order to comply with the minimum standard as outlined by the American College of Surgeons, a staff was organized in 1920. Further reorganization along more comprehensive lines occurred in 1921 and is at present working admirably. The staff is made up of all the doctors of the City of Kingston who attend patients at this hospital. It consists of the following departments: Surgery, Chief of Staff, Consultant and Associates; Medicine, Chief of Staff, Consultant and Associates; Obstetrics, Chief of Staff, Consultant and Associates; Gynaecology, Chief of Staff, Consultant and Associates. Chief of X-Ray Department, Chief of Eye, Ear, Nose and Throat; Chief of Pathology and Bacteriology, Chief of Neurology.

The following is a brief summary of some of the outstanding departments of the Hotel Dieu Hospital with a short resume of the progress that they have made in the last few years.

Maternity Department.

For a long time the patrons and doctors of the Hotel Dieu had been requesting the good Sisters in charge to open their doors to obstetrical cases, knowing that the same success which had marked their handling of surgical and medical patients would prevail in this department. Not until 1911 did they see their way clear to undertake this field or hospital activity. During the decade of years that has elapsed, the demand of the public upon this service has steadily and constantly increased. From a small beginning, the obstetrical department now occupies one entire floor in the main building and promises in the near future to rival, if not surpass, the old services of surgery and medicine. In the early days a semi-private ward of six beds and the possibility of four private rooms—which were available for short-stay surgical cases as well, were allotted to maternity work. To-day the service consists of a large well-lighted ward containing regularly nine beds with space for two or three more —a semi-private ward with six beds, and four private rooms all very large and three of which are equipped with two beds each. There are two separate nurseries, one for semi-private and private cases; the other at the other end of the corridor



ADMINISTRATIVE OFFICE, HOTEL DIEU HOSPITAL, KINGSTON, ONT.

for ward cases, each with its own linen, medicine and bath equipment.

All patients are delivered in a most fully equipped lying-in room. There are bath-rooms, sterilizing plant, diet kitchens, and linen closets on the floor for exclusive use of this service. From September 1, 1920, to September 1, 1921, one hundred and sixty births were registered—an increase of fifty per cent. over the previous year. A complete system of history and record keeping is in operation; an interne is assigned especially to this service for a four months' term, while the nurses are especially instructed, and are expected to handle one normal case alone before leaving the service. The whole floor is under the direct supervision of a very experienced Sister with a younger Sister as companion. A Hesse incubator has recently been ordered and when installed will practically complete the equipment necessary to make the Obstetrical Department of the Hotel Dieu at Kingston, second to none on the continent.

Clinical Laboratory.

The Clinical Laboratory is equipped with the proper facilities for the carrying out of the work of clinical microscopy and also bacteriological and pathological examinations. The director of the laboratory is the assistant professor of pathology of Queen's University, and the technicians are two Sisters who have been siutably trained. In addition, the interne of the hospital take their turns in laboratory service. Two nurses-in-training are detailed for duty in the laboratory to observe and assist the work for a period of three weeks and this service is required of every nurse before she leaves the training school.

Hotel Dieu Electro-Therapy Department.

The electro-therapy department is perhaps one of the best equipped in Eastern Canada. Four rooms are set aside on the first floor of the new wing for this work. The equipment consists of a Wappler Transformer, Victor Tables, Victor Stereoscope, Coolidge Transformer and Tube and the usual dark room apparatus such as tubes, red-lights, chemicals, developing frames, etc. Provision is made for the Fluoroscope

THE PHARMACY, HOTEL DIEU HOSPITAL

as well as plates. Patients who are admitted to the Hospital for Electro-therapy treatment are allotted rooms in close proximity to the X-Ray department. In connection with the Electro-Diagnosis and Electro-therapy branch of the medical service a Wappler High Frequency Machine, a McIntosh Generator and Bristow Coils are used. The department is under the direct supervision of an X-Ray specialist, who is chief of staff of this department, and who does the X-Ray work of the whole city and district. He is assisted by one of the Sisters who is trained technician in this work.

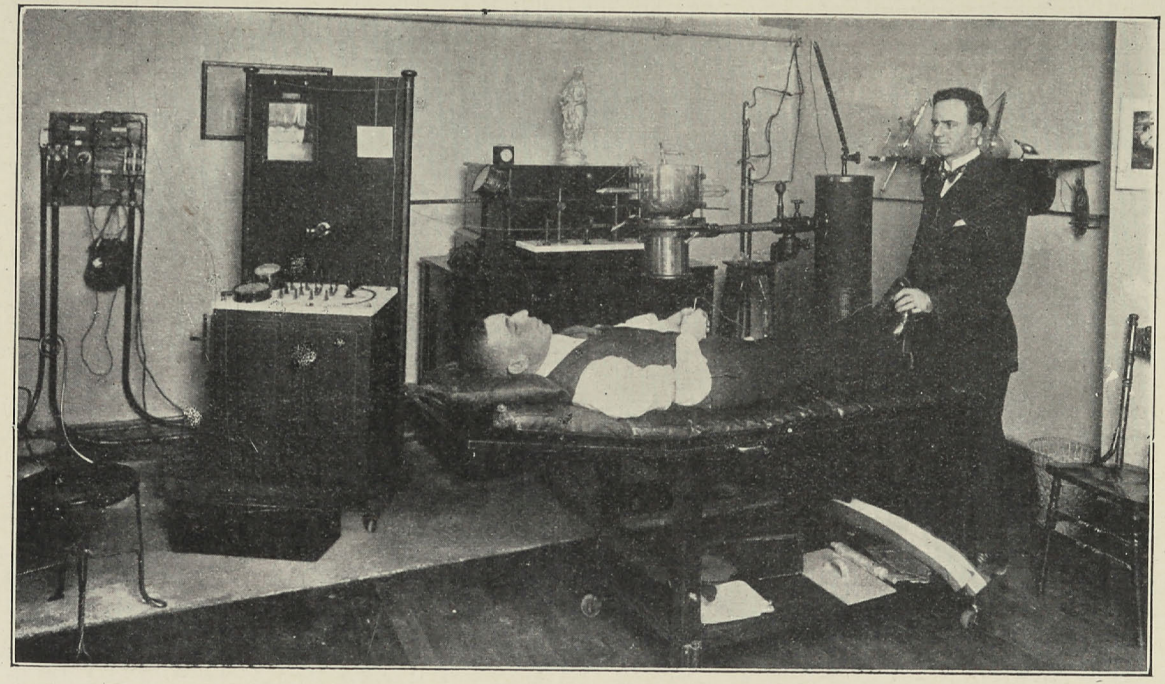
The Medical and Surgical Department.

These two departments of the Hotel Dieu are well up to the standard of excellence demanded by the careful critic. Three wards are set aside for the medical cases and the same number for the surgical. There are also well furnished private rooms in the new wing, especially allotted for medical and surgical patients.

There are three operating rooms, two in the main building for general surgery, and one on the top floor of the new wing for eye, ear, nose and throat work. These rooms have white tiled floors, walls and ceilings. This renders the whole easily and thoroughly cleaned and with practically no danger of injuring the furnishings. The instrument cases are not cumbersome and are easily moved by the nurses. They are white enamel with glass shelves. The Bartlett No-Shadow Lite is the artificial light that is used. The West and South exposures give excellent natural lighting. The main operating room is fitted up as an operating theatre, and the medical students from Queen's University observe the different operations and are given clinics by the various Professors of Surgery. One operating room is exclusively used by the specialist in eye, ear, nose and throat work. It is perfectly equipped for all delicate eye work.

The Hotel Dieu Training School for Nurses.

There was a great dearth of trained nurses in this district, and the Sisters realizing this opened a training school for nurses



X-RAY DEPARTMENT, HOTEL DIEU, HOSPITAL

in their Institution in 1912. In this Hospital the nurses have the advantage of intimate association with the men and women from whom they learn their profession. They enjoy the confidence, advice and friendship of their teachers, more so than in larger Institutions, and consequently they enter broader fields with more ambition, more loyalty and a keener sense of their responsibilities than they otherwise would. This personal contact and interest tends to bring out the latent talents and inspires the nurse-in-training to action. These may seem small matters but they go far towards turning out capable, competent women.

Those who do not leave the district to take up more advanced training, still remain a decided asset to their neighbors by becoming veritable apostles, spreading the gospel of proper living and health in their homes and home town.

The Hotel Dieu will admit to their training school every worthy young woman who is desirous of making their future life one of service to their fellow-man in that great calling, "Caring for the Sick." The course extends over a period of three years in general and obstetrical nursing. Lectures in the various branches of surgery, medicine, etc., are given by the Staff Doctors. The superintendent of the nurses is one of the Community Sisters who has had special training for this work of Superintendent of Nurses. If the student nurse is successful in the examinations given periodically, she is awarded a diploma, entitling her to practice as a registered nurse in Canada.

Improvements in the Hotel Dieu in the Last Year.

The general condition of economic depression which came as an aftermath of the war, affected in many ways the finances of the Hotel Dieu. The operating expenses were increased by the high cost of supplies of all kinds, and the number of cases which of necessity had to receive free treatment, was greatly augmented owing to the increase of the unemployed. Only the most careful administration of the resources of the Hospital made it possible to stand this adverse condition, which wrought so much havoc in the industrial and commercial life of the country. Despite, however, the many disadvantages under

FOUNDING OF HOTEL DIEU HOSPITAL IN 1642.
Mural Painting in the Entrance Hall of Hotel Dieu Hospital, Kingston, Ont.

which the Hotel Dieu Hospital Sisters were working, they made many radical and progressive changes in the building and in the administration of the Hospital—changes which will be lasting and beneficial and which will ensure better service to the patients.

The old ice house which was each year filled with ice out of the harbor, was found to be in a useless condition. After careful deliberation and at an expense of $7,458.85 a complete refrigeration and ice-making plant on the Line System, was installed. This plant, which is giving excellent satisfaction, is a valuable addition to the Hosptal and will bring permanent, sanitary and scientific results.

An electric service to the various floors was installed to replace the old, cumbersome hydraulic one. The new service which cost $2701.60 is a model of convenience and efficiency.

Two years ago the insurance underwriters condemned the electric lighting system and raised the premium. Last year they refused to renew the policies until the building was wired in accordance with the most modern and safe methods. The huge task of re-wiring the entire Hospital was undertaken, and after five months' continuous labor has just been completed. This improvement entailed an outlay of $12,000. From the viewpoint of actual illumination and of safety, the Hotel Dieu is undoubtedly one of the best lighted buildings in Kingston.

MEDIAEVAL HOSPITALS †

Dr. Heber Jamieson.

The hospital, originally, was a place for the entertaining of strangers. The word hospital comes from *hospus*, which means a guest or host. As social progress took place the hospitals were transformed until we see them what we consider, more or less, medical institutions.

From 925 to 1170 travelling was very dangerous and these so-called hospitals were largely erected for giving refuge and protection to travellers from wolves and other beasts.

From 1170 to 1270 there were great pilgrimages taking place and for that reason they had to have some refuge called *Domis Dei,* a Latin term, later called the *Hotel Dieu.* In

† Read before the Alberta Hospital Association Meeting, 1921.

this period pilgrimages were largely responsible for the changes taking place in hospitals.

In the third period, 1270 to 1470, the pilgrimages were largely over, but there were many vagrants going about the country and it was necessary to have somewhere for their accommodation; so after that period there sprang up two kinds of institutions, one in which the traveller was only privileged to have accommodation for the night, and the other for accommodation for a longer period for those who were ill or infirm, so in the course of time two institutions instead of one were formed.

From 1470 to 1547, which is the end of the time we are going to consider, there was a further change. Inns began to multiply throughout the land and people of wealth were able to get accommodation in them, so the hospitals were more or less used only for sick, maimed or wounded soldiers, and for those who were unable to work, and in that way we find there was a distinct change in the hospitals. At this time alms houses began to make their appearance. Leprosy was very common, and a great many hospitals were put up for the accommmodation of lepers; two hundred were for lepers alone.

Now, I am going to show you something about the architecture of these hospitals. There were five forms of hospital built in the early days and all of them originally developed from the church form found in the old Greek days. One of the first hospitals was in the form of a church with a large hall with a chapel at the end. Another form had a large hall with a chapel attached; another that of a cross. (Pictures of ancient hospitals shown on screen and explanations given.)

There were several things to be considered when a hospital site was chosen. One most important was to have it near a running stream, and many were built on the banks of rivers. You have already seen that the Hotel Savoy was on the Thames, and the Hotel Dieu was on the Seine, and the hospitals of Italy were on the principal rivers. Some were built over streams and one built in Cairo, in 1272, was built so there was a spring in each ward so that water flowed through and out of the wards. Other hospitals were built within the city

irrespective of having near water, and others outside of the city where there was less spread of contagion and more air.

Concerning the staff of the hospital, in the Hotel Dieu we find that the nurses and servants were ignorant women, many of them widows, and they were very intemperate and not at all satisfactory. It was not until the end of the 17th century that any great improvement took place, when the term "sister" was introduced and religious orders had a great deal to do with them.

In 1598 the Hotel Dieu had one hundred beds, but was able to accommodate five hundred, because each bed accommodated five, or, when crowded, six; three one way and three the other. Many of the titled ladies, on account of the impossibility of getting help, came daily to the Hotel to nurse the patients. (Pictures.)

There were ways of raising funds. First of all endowments and royal alms; second, by bequests; third, profits on trade (St. Bartholomew's Fair was one source); by demand, and voluntary contributions. It is of interest to know that theatrical performances were given for the Hotel Dieu in the 17th century.

THE MUNICIPAL HOSPITAL AS A PUBLIC UTILITY †

Arthur K. Whiston, Esq.
Secretary Municipal Hospital Department, Government of Alberta.

The municipal hospital means an institution operating under the provisions of The Municipal Hospitals Act of the Province of Alberta.

What is a public utility?

Public.

If we refer to the dictionary I think the best definition of the word "public" is the following: "The people collectively, or in general, as of a general locality, state or nation, or of the world at large; also all those persons who may be grouped or considered together for any given purpose."

† Read before the Alberta Hospital Association Meeting, 1921.

Utility.

In "Political Economy" J. M. Gregory describes the word "utility" as "the fitness to supply the natural needs of man, or the quality of contributing to his comfort, prosperity and happiness; that serviceableness which is the basis of the value of a thing."

The philosophy of the word "utility" means happiness—happiness of mankind—the greatest happiness of the greatest number.

Briefly, then, a public utility means the effort of a people collectively or of a general locality grouped together for the purpose of providing a quality and character of serviceableness which will bring happiness—the greatest happiness for the greatest number.

This application is truly fitting to hospital accommodation and service, as there would not appear to be any basis for argument; but that one of the noblest works engaging the attention of the people of this Province is that of preserving the health of the people.

As the hospital is to provide the greatest good for the greatest number, then it must of necessity have, as its object, serviceableness which is necessarily linked up with the cost of service.

Classification.

Hospitals may be classed under two headings: First, an institution which depends upon its successful financing by the application of a schedule of fees, and where deficits are made up either by vountary contributions through philanthropy, or by the municipal treasury, to be charged against the general tax rate of the next year, if sufficient has not been provided within the current year.

This class of hospital, in order to be financed successfully, must necessarily depend upon receiving and treating so many sick persons at a fixed rate per hospital day and collect from these patients the charges for the services rendered.

The second class is the municipal hospital.

The basis of the financial success of the institution is that of direct taxation; supplementing the revenue derived from

taxation by a schedule of fees, namely, one dollar per hospital day, covering all classes of services rendered at the institution to persons liable for hospital taxes.

Service is also extended to persons other than ratepayers, who, upon the payment of a sum of money fixed by the board and paid at a time set by the board, become eligible to receive for themselves and the members of their family hospital service at the same rate as given to those persons whose lands are liable for taxation.

In the first class of hospital accommodation is provided, or in a great many instances at least, for three classes of patients: The public, semi-private and private, and the scale of fees increases in accordance with the better service offered. Consequently, persons of wealth may avail themselves of the best class of accommodation at the institution because of his or her wealth, and not necessarily because of the nature of his or her illness.

The municipal hospital provides equal accommodation to all, rich and poor alike, and the terms public, semi-private and private are unknown, or at least not used, for the principle employed is that the nature of the illness and not the wealth of the patient determines the class of accommodation provided.

In the municipal hospitals, the burden of the financing of the hospital rests upon all the people, who, by taxation, pay a small annual tax and thus provide the means for keeping the institution open, ready at all times to receive patients and to give service.

The sick, or the patients at the institution, if ratepayers, or, because of the payment of a stated sum annually, become hospital supporters; pay the small amount of one dollar per day for all the service of the hospital, but the burden of the sick is borne by the well, and the fear of the cost of hospital services and running into debt is almost entirely eliminated.

Hospitals of the first class are usually governed by a board. This board may be composed of appointed representatives from certain classes of society, but they are not elected by franchise.

A board may also be composed of aldermen, who, among the many other duties of their municipal work, undertake to direct the affairs of the hospital.

The boards of municipal hospitals are elected by ballot at the time of the municipal election in the municipal district, city, town or village which forms part of the municipal hospital district, and the people of the contributing area may each year change the personnel of the board by their ballot.

The board of a municipal hospital is responsible to the people and they are elected as members of a hospital board for the sole purpose of directing the affairs of the institution.

The first class of hospitals being governed by boards, not necessarily elected, work out their destiny in a manner which, in the opinion of the board, best serves the institution and are not governed by any Provincial Act which is not also binding upon municipal hospitals.

The municipal hospital boards are governed by the Municipal Hospitals Act, the provisions of which bind the board to the necessity of efficiently running the institution, and there is an uniformity of control and management which is clearly apparent in every institution operating under the Act.

In the first class of hospital, people are not inclined to be particularly interested until overtaken by sickness, and the use of the hospital depends upon the ability of the sick person to finance at that time. The people cannot be said to have a personal interest in an institution where the members of the controlling body are not elected by ballot and where they do not contribute, except through fees when sick, or by a general mill-rate to the deficit of the previous year. This condition easily kindles criticism, and criticism that is destructive in its nature and very often offers no consructive basis for improvement.

In a municipal hospital district the people pay, by taxation, for the maintenance and operation of their institution, and the board being responsible to the people who elect them must, of necessity, successfully carry on the institution and maintain the same uniformity existing in the other municipal hospitals before they can reasonably satisfy the ratepayers.

Philanthropy has no place in the municipal hospital system. The people pay their tax and a small rate when they become sick and this is sufficient (proof of which is the successful operation of the municipal hospitals of this Province) to maintain, operate and pay the capital charges, and the in-

terest of the people of the district is increased because it is their institution—built, owned, managed and controlled by their elected representatives—offering to the people of the district, alike, the same opportunity of reduced hospital fees when sick, for the payment of a small hospital tax, but by the spreading out of the cost of the maintenance, operating and capital charges over the many, the few who require hospital services, obtaining the same and at an expense to themselves which is easily and conveniently borne.

The Municipal Hospital Act, under which municipal hospitals are created, represents the voice of the people. The people of this Province, more particularly those living in the rural portions, have for some years past been giving expression to their lack of appreciation of the cost of hospital service under the present system.

It is generally admitted that the greater number of the people of the Province of Alberta are not wealthy, and, to the majority, serious illness which should have hospital attention undoubtedly meant going in debt.

It is not unusual to find that cases which should have received hospital treatment have not been able to take advantage of it because of the cost of the service. In some maternity cases hospital care and attention have not been given and it is reasonable to suppose that the lives of many mothers and children have been lost because of the lack of this service.

The motto of the Alberta Hospital Association is "To Make All Hospitals of More Community Service." If a municipal hospital stands for anything it represents community effort for community service, due to the fact that when the district is first established it is due to the activity of the people in the district. The movement starts with the people.

The scheme is prepared by a board and is voted upon by the people and is only ratified when two-thirds of the people actually voting have done so in the affirmative. Consequently, the people voluntarily undertake to provide for themselves a hospital which they, by ballot, declare they will undertake to finance by direct taxation, thus distributing the expenses for affliction and suffering over all the people that the few of their number who *do* require and who *will* require hospital service may benefit by collective contributions and effort.

The municipal hospital is an outstanding example of "applied brotherhood."

An institution conducted under the Municipal Hospitals Act offers, to the people of the district which it serves, the maximum of service at the minimum of cost, and the records will prove to doubting ones the wisdom of the movement.

The municipal hospital *does* bring happiness to the mind of the expectant mother, and the institution receives her and renders service to her, and the people of the community which the hospital serves look upon the institution as the centre of their health activity, representing to them in health matters what the school does in the education of their children.

THE HOSPITAL SITUATION IN BRITISH COLUMBIA †

by E. C. Arthur, M.D., Victoria, B.C.,
Inspector of Hospitals, Province of British Columbia.

Now so far as the financial situation of the hospitals in British Columbia is concerned, it is decidedly bad and they are crying out for more revenue.

As Mr. Yorath in his paper suggested, I think a considerable amount of the hospital deficits is due to what I will simply say is bad business management. I will give you a few statistics a little later on, that seem to indicate that, in reference to some of our hospitals. I may say that Mr. Yorath stole a considerable portion of my thunder. He states that British Columbia bears a heavier burden for hospitals than any other Province in Canada. We sent out a questionnaire some time in the early part of this year and the information we got thereby showed that we paid in proportion to our population much more than other Provinces of the Dominion.

Now the hospitals of British Columbia—you have to go back about thirty years, as there is no history collected as yet—probably thirty years ago there would be one or two small hospitals at Vancouver and Victoria and probably one at Westminster and at Nanaimo. Now that would about cover the hospitals of British Columbia, and I believe there were about two hundred beds in the whole of it. To-day there are about

† Read before the Alberta Hospital Association Meeting, 1921.

3,500 to 4,000 beds. The Vancouver General has about a third of them. They claim 1,300 beds, but in that 1,300 is included Marpole Annex, which is the branch to which they send the incurable cases, and is really their ward for incurable cases. That, of course, includes 35 beds for T.B. and infectious diseases. The Vancouver General treats all infectious cases of the city.

These hospitals have sprung up over the Province in some places too many, in others not enough, but there are only one or two instances where there are too many. In one part of the interior there are, or were last year, three hospitals within twelve miles, and that is not as the crow flies, either. One hospital, the middle one of the three, is large enough to take care of all the hospital cases in that whole area and has been for the last twenty years; but local jealousy and things of this kind have allowed the establishing of these other places with consequent drain upon the finances of the community and repeated calls to the Government for assistance, which they nearly always get.

In one or two places, such as Barkerville and Wymer, where hospitals were built some years ago, they were justified absolutely at the time by being located in the centre of population; but the centre of population has changed, moved away for some miles in the case of Wymer. The hospital was built at a cost of $4,000 or more, and to-day could not be built for less than $10,000; but there are not 250 people within eight miles of it. That is one of the vicissitudes of a mining community.

Now last year the Government contributed for 64 hospitals (there are about 70, but five or six are not open for one reason or another) in 1921, $377,000. Of that amount the Vancouver General received more than $152,000; that is, the other 63 got a little over $225,000 distributed amongst them.

Mr. Yorath told you that the Government gives a flat grant of $1.00 per day for the treatment of tuberculosis. Each hospital is supposed to receive or have available 10% of its beds for cases of T.B. This is a regulation which is more honored in the breach than in the observance. It is difficult to get most of the general hospitals to receive cases of T.B. Of course they cannot legally refuse, because under our Act any hospital that receives a Government grant is bound to receive

all cases presented, excepting smallpox. Out of the 64 hospitals there are 25 receiving grants for T.B., $25,852, pratically an average of about one thousand each. One of them, again the Vancouver General, receiving over $14,000. Then, in addition, the Government, during that year, that is the present year, have taken over the sanatorium at Troquille.

The Government gives an occasional special grant. There is a widely prevailing belief throughout the Province that the Government aids to the extent of dollar for dollar. Perhaps some Government did, but the present Government has not and will not do so as they have not got the money. In some instances they get a third, and I heard the Minister tell an applicant the other day that 25% was the most they could expect. Last year a special grant of $32,450 was made.

Mr. Yorath referred to the big year of 1919. I might explain what put that year's expenditure so much above other years was the special grant made to hospitals on account of flu. Some hospitals got four and five thousand dollars. Then, in addition, the Government spent half a million on municipal hospitals; that, of course, does not touch the general hospital question.

Now the hospitals of British Columbia only fall into three classes. The Vancouver General is in a class by itself. It has nearly one-third of the beds. It treats presumably about one-third of the patients, and is far and away larger than any other we have in the Province. Then there are the second class, 50 to 250 beds. There are about eight or nine of these, the Royal Jubilee, Victoria; the Royal Columbia, Westminster, Kamloops, Revelstoke, Nelson, Cranbrook, Prince Rupert, etc. I think that covers the 50 beds or more and leaves us the other 50 hospitals of under 50 beds, and some as low as six or seven beds. Mr. Yorath gave you our much complicated system of distributing our per diem grants, It never seemed fair to me that if you occupy the most expensive private ward and you are paying for that, that the Government should pay exactly the same grant as for an indigent patient in a public ward that pays nothing. That is our system at the present time. I hope it will change.

When Dr. Jamieson gave us his interesting paper on mediæval hospitals he stated that hospitals were built on five

different plans. I wish there were only that now. In British Columbia there are no two hospitals built on a similar plan. We have no standardized plans, something we need very much for the older hospitals on Vancouver Island, particularly hospitals in mining districts like Cumberland, Chemanis and others that were built years ago. When the requirements of the community demanded enlargement an excrescence was put on there, a few years later a further enlargement, with the result that they are most unsightly. They are expensive to operate; in fact, it is impossible to operate them efficiently and economically.

Another thing, some of the difficulties in hospital buildings: For instance, in one of the biggest hospitals in the interior, built at a cost of $133,000, they have one lift, which frequently goes out of order, and there is not a stairway wide enough to get a stretcher up or down. Another hospital was a three storey frame building in a place where there was no water pressure and no fire escape.

We have in the Province no home for incurables. The Vancouver General has Marpole Annex to which they send incurables, but the Province has nothing, and we are very badly in need of it. I hope in the near future the Government may find the funds necessary to provide. The result is at present that throughout the hospitals there are a good number of patients who are incurable and not suitable for general hospital patients; but there is no other place and they have to keep them. We have a very good home—this is not in the line of a hospital—for aged men. It is very comfortable and well operated, and the old men are very well looked after and very comfortable there.

That covers our general hospitals pretty well. We have, in addition, a number of private hospitals. There were thirty-four licenses issued this year. I recently made an inspection of these, or nearly all. There are some very good institutions doing general hospital work, taking medical, surgical and obstetrical work. A large percentage of them are operated as maternity homes by women who are not graduated. Our Act calls for the licensed hospital at all times to have as a superintendent upon the premises, which may be licensed, either

a qualified medical practitioner or a graduate nurse. Another rule more often honored in the breach.

Last year we sent out a form asking for an annual report, and wanted it in early so as to get statistics compiled before June, when the House closes, but when I got in forty I prepared a summary for the Minister of the cost which averaged $3.76 a day. That average cost is too high. That was the actual average cost, but in these forty were included three small hospitals where the cost in one was $11.00, and the other $8.85, and the other something over $8.00; but these should not properly have been included in the statistics. The average cost last year was probably between $3.12 and $3.25, nearer $3.25 per diem . . .

I was very much pleased last evening to hear Miss Browne in her very edifying address tell us that there is on the face of the earth a place where the pupil nurse is not exploited. I hope the day will come when that leaven will reach to British Columbia. I might just say, in our Province I took that matter up in reference to these hospitals. One hospital charges as low as $12.00 a week for the public ward; three are charging $14.00, and these all have training schools. The one charging $14.00 has two trained nurses and 12 pupil nurses; another, two trained nurses and six pupils; another, three trained and 12 pupil nurses. The most of them charge $17.50 per week, which is the amount allowed by the Workmen's Compensation Board. I submit that the two hospitals having two trained nurses is not in proportion to the number of its pupil nurses. Also, their public ward charges are, in my opinion, below actual cost. In other words, these hospitals are being operated at the expense of the nurses-in-training, who cannot get the careful supervision of trained nurses. I would suggest that no hospital that charges less than is allowed by the Workmen's Compensation Board should be allowed to operate a training school. The hospitals showing a profit in operation were largely those staffed by trained nurses.

Now, just one more point. My view of a hospital is that it is a public utility, the same as electric light or water works, and that the functions of government in regard thereto are not to pay the cost of operating, but to provide the necessary machinery whereby each community (I would make these

communities very large) may provide itself with such hospital treatment as it may be willing to pay for, the Government paying only for indigent patients. In reference to outside patients coming from municipal hospital districts I would charge back the bill of that patient to his home municipality at the rate of $2.50 per day.

If there is any point I have omitted I shall be glad to give it if I can, and answer any questions if anybody has anything to ask.

COMMUNITY HOSPITAL SERVICE †

JAMES FINDLAY, ESQ.

Member Edmonton Board of Public Welfare.

The provision of complete and sufficient hospital accommodation throughout the country is a public obligation, the free use of such accommodation should be the right of every citizen.

A state medical service should be free and open to all, because:

(1) Disease is no respector of persons, and science in dealing with its prevention and cure, cannot afford to be so.

(2) Health is of national concern, and disease is a national danger, hence the health of every individual, rich or poor, is of national importance and its preservation should be undertaken by the nation collectively.

(3) Modern methods of diagnosis and treatment are becoming so elaborate and costly that only the rich can afford to purchase their advantages.

(4) The importance of institutional treatment is becoming more and more recognized, and under present conditions most of the middle classes are excluded from its benefits for the simple reason that the salary or wages paid in our industrial system is seldom above the bare subsistence line. A case in point is the case of the wife of a small salaried clerk, who was admitted into the Royal Alexandra Hospital in Edmonton, suffering from a serious case of bust infection.

† Read before the Alberta Hospital Association Meeting, 1921.

After being a patient until her hospital bill ran over one thousand dollars, a very little of which had been paid, the superintendent reported the case to the hospital board, and in the discussion which followed, the question was not what could be done for the patient, but whether or not she should be allowed to remain in the institution. I mention this case to show man's inhumanity to man, which makes countless thousands mourn.

(5) The medical service should be in a position to treat disease in its earliest possible stages, to preserve health and to watch over contacts in cases of infectious diseases, all of which are impossible under any system of private practice in which the doctor has to await the call of the patient, who may be far advanced in illness and possibly a danger to others before he thinks fit to send for help. Many a patient has lost his life through trying to save a doctor's bill.

Public hospitals, when established, should become the health centres or institutes of each local health authority and should provide accommodation within their walls for all medical activities. Wherever possible the officers of the public health services should be transferred to the hospital so as to encourage co-operation between preventive and curative medicine. School clinics, when not held at the school themselves, maternity and child welfare centres and dispensaries for the prevention of venereal diseases should be housed within the health centre. At all the larger hospitals there should be diagnostic laboratories and research departments. Finally, at all the health centres there should be physical training rooms for the correction of infirmities and deformities, and a lecture room for teaching the patients and the public generally the laws of healthy living.

While from the point of view of the individual sick person all hospital treatment must be regarded as having as its sole object the speedy and effective cure of his disease or injury, from the point of view of the community generally the hospital has various functions. Roughly, these are, first: To secure an increase of knowledge of disease and its treatment so that advances in methods of prevention and cure may be con-

stantly made. Second: To secure the education of the future practitioners of medicine so that they may be skilled in the prevention, diagnosis and the treatment of disease. Third: To secure the progressive experience of all specialists and medical practitioners either upon the staff or working in the neighborhood, so that they may maintain and increase their power of serving their patients. To secure these aims for the community without detriment to the interest of the individual patient it will be necessary to maintain a distinction between different types of hospitals. There should be four varieties of hospitals namely: First, national; second, district; third, local or cottage; fourth, receiving stations.

National hospitals should be situated in university cities, or otherwise centrally located, and should be maintained and administered directly by the portfolio of health and should not be a charge on the local rates; they should be the chief centres of medical education and should be important centres of research. The British North America Act may have to be amended to allow this to done, but it should be as easy to build and maintain national hospitals as national armouries.

District Hospitals

In every area there should be one or more large district hospitals, according to the geographical nature and the size of its population. Each should be fully equipped with surgical, medical and special departments of all varieties and manned with the necessary medical officers. They should not only serve the town in which they are situated, but should receive cases referred to them by the local cottage hospitals within the area, with which they should keep in touch. The medical and surgical consultants and specialists should not only attend cases admitted to these hospitals to which they are attached, but should act in a consultative capacity to the general practitioners within their area, visiting the local hospitals and patients in their homes at the request of general practitioners.

Local or Cottage Hospitals

In every town of about 6,000 or a corresponding area there should be a local or cottage hospital. The staff should be com-

posed of the general practitioners of the neighborhood, and each member of the staff should be entitled to admit and attend to his own cases. These hospitals should be in the telephonic communication with the district hospitals, and arrangements should be made for the easy transference of patients from one to the other. The staff of a local hospital should have the right to advice and help from the staff of the district hospital.

Receiving Stations

In selected centres there should be receiving stations comprising a well equipped surgery or treatment centre, a staff of district nurses and a suitable number of beds for the reception of acute cases and accidents. The case of a little girl eighty miles north-east of Edmonton during this last summer, who had one leg cut off and the other one mangled by the binder, who had to be taken to Edmonton by horse conveyance before receiving medical attention, shows the great need of stations of this kind. Patients should be transferred from receiving stations to the nearest cottage or district hospital when their conditions render it advisable, with as little delay as possible. Some say that we have practically what I have been advocating or as much of it as the people will stand for. We have municipal hospitals in the large cities which are municipal in name only. Take Edmonton, for instance: The Royal Alexandra, the South Side, and the Isolation Hospital are all under municipal control, yet it costs as much or more in these institutions as it does in the public interest and as such the public is entitled to pay an immense deficit.

The Edmonton board of 1920, believing the patient suffering from infectious disease, who undergoes quarantine does it in the public interset an as such the public is entitled to pay the hospital bill. It was generally conceded that that arrangement was fair and just. But sorry to relate, the board of 1921, being made up of men who vision apparently extends just beyond the end of their nose, reverted to the old system of penalizing people who are unfortunate enough to catch infectious or contagious disease, and who undergo quarantine in the public interest.

The rural municipal hospital scheme has some merit. A portion of the cost of maintenance is a tax of about three cents

per acre on all assessable land followed by a day charge while a patient is in the institution. Also sending the nurses out into the wilderness is good as far as it goes, but it is absolutely inadequate.

The present industrial conditions shorten life very markedly. Statistics will prove that of those who survive fifteen years of age, the average life of the purely industrial worker is forty-nine years; of purely agricultural workers, sixty-seven.

Take the medical aid scheme in connection with the Alberta Compensation Act. Forty thousand workmen come under its scope; thirteen thousand miners, and twenty-seven thousand other industrial workers. Amongst the miners one in five met accident; other industrial workers, one in eight.

There were eighty-one fatal accidents; thirty-three in the mines, and forty-eight amongst other industrial workers. One in three hundred and seventy-five miners prove fatal; one to six hundred other workers.

The total receipts under the medical aid scheme for 1920 was: $65,000 disbursement; $49,000 for medical and hospital aid to workmen injured in industry. One cent per day's work is deducted from each workman outside the miners, and two cents from each workman in the mines to make up this fund. It will be noted that the men who work at the most hazardous occupations are again penalized for so doing. It should also be noted that under the medical aid plan, workmen are only protected when injured while working.

The miners in this Province have private contracts for medical aid which covers their entire family, including maternity, which costs them about $2.25 per month. These contracts come under the Compensation Board for review only, though there has been agitation from time to time from the miners for the board to extend its medical aid plan to cover all members of a workman's family.

Also the executive of the medical men's association have agreed to the principle of extending the medical aid scheme, though the rank and file have not done so as yet unanimously. All of which goes to show that there is an inarticulate desire for something adequate in hospital and medical service.

It might also be shown the extravagance of the present system. In Alberta for 1920 about $450,000 dollars were

paid in premiums into private companies for sickness and accident insurance; only about 35% have been returned in indemnities.

Labor takes the stand that the health problem has only been flirted with as yet, and will have to be grappled with in earnest before long. At the Dominion Labor Congress held in Winnipeg this year, nationalization of the health services was endorsed by special resolution.

The care of the sick is generally conceded to be a social undertaking, and as such the financing of same should be done in a corresponding way; that is, by general taxation, the healthy as well as the sick to pay for the upkeep of efficient services, and thereby keep the command, "Bear ye one another's burdens."

The establishing of an efficient research service with all its necessary branches is one of the most difficult tasks ahead, requiring many years of work. Money must be spent freely; but this alone will not provide the genius capable of original research which is even more important than money. Means must be found for seeking out the right type of person, and the first step should be a radical alteration in the whole system of medical education and in the method of selecting those who are to be the doctors and scientists of the future. It must be remembered that there is no monopoly of genius in any one class of the community, and that the science of medicine owe much of its present broad basis to Louis Pasteur, the son of a French peasant. If sufficient men and women endowed by nature with power to advance science are to be found, the door of our universities and medical schools must be thrown more widely open.

In closing, I would like to interject one word of caution; that is in the adoption of any scheme, provision be made for public interest to be given scope for participation, either by forming advisory boards made up of representatives of all classes of society, or by other suitable methods, so as not to have a repetition of the farmer driving into the city forty or fifty miles to notify the authorities of a hole in the road in front of his gate, which he might have filled with a shovel in five minutes time.

Hospital Items

VICTORIAN ORDER OF NURSES—ANNUAL MEETING HELD

"As we look into the future we cannot but foresee a constant and ever-wider extension of the order in many fields that are now neglected," said Major Harley Smith, in his medical report. There had been very little sickness among the members of the nursing staff during the year, he said, and the annual "stock-taking" had given reason for intense satisfaction with the progress of the order.

His Honor the Lieutenant-Governor and Mrs. Cockshutt were present, attended by Colonel Fraser. Referring briefly to the accomplishments of the order, his Honor said: "What we put into life, we will get out of it, and our compensation is not thanks, but it is the satisfaction of seeing that we are doing some good to humanity."

Other speakers included Dr. N. A. Powell, Miss E. Dickson, General Fotheringham, Mrs. J. C. Hannington, General Superintendent of the Victoria Order for the Dominion, Rev. Father Minehan, Rabbi Brickner, Rev. Dr. Tovell and Dr. G. C. Pidgeon.

For the ensuing year the officers are Chairman, Hon. W. A. Charlton; Vice-Chairman, Arthur Hewitt; Honorary Secretary, H. H. Love, and Honorary Treasurer, A. R. Capreol.

HOSPITAL AND MEDICAL SERVICE IN THE COUNTRY

Dr. Guy Noyes contributes an article on this subject in the Journal of the Missouri State Medical Association. He says in part:—

The larger cities appear to be over hospitalized and they are also over-supplied with doctors. Roughly speaking, the ratio for St. Louis is one doctor to 450 and for Kansas City one doctor to 350 of population. The county-seat towns of Missouri have a ratio of one doctor to 300 people.

COBALT MINES HOSPITAL IS FACED WITH DEFICIT

A special assessment of $5,271.58 on the various companies contributing toward the upkeep of the Mines Hospital at Cobalt was necessary last year, according to the annual report of that institution, just issued. Even then there was a deficit on the year's operations of $424.80. During 1921 there were 150 cases treated, 72 medical and the remainder surgical, and there were two deaths. The average number of patients per day is given as 4.96, compared with 11.63 in 1920. The cost per patient per day was $6.87, against $5.01. The total earnings, $14,054, show a drop of over $3,000. The average number of men paid for monthly was 1089.5.

NATIONAL HOSPITAL DAY

President Harding, in endorsing the Second Annual observation of National Hospital Day, May 12th, has written the following to the National Hospital Day Committee, which is in charge of this movement:

"I was pleased to learn from your letter that you are going to celebrate National Hospital Day again this year, on May 12th, the anniversary of the birthday of Florence Nightingale.

"One of the finest and most humane products of our civilization is the modern hospital, and every activity which aims to assure its advantages to an increasing number of people, deserves all possible encouragement."

The National Hospital Day Committee, 537 S. Dearborn St., Chicago, Illinois, will be glad to forward suggestions for a programme to any hospital which has not yet made plans for National Hospital Day. It is pointed out that one of the most successful celebrations last year was that of a California hospital, which did not learn of this movement until May 6th. In six days this institution arranged, and carried out, a programme which brought material benefits in the way of an aroused and interested community.

Book Reviews

Harvard Health Talks—Pneumonia—by Frederick Taylor Lord, A.B., M.D., Visiting Physician, Massachusetts General Hospital. The Harvard University Press, Cambridge. 1922. Price $1.00.

The author discusses this most wide-spread and fatal disease. He claims that there is a hopeful prospect of partial success in its prevention and treatment, resulting from a study of the pneumococcus, its manner of life, variations, its contagiousness as overcrowding increases its prevalence, that should be avoided. Many lives have been saved by the use of antipneumococcus serum where the pneumonia is caused by Type I.

A Form of Record for Hospital Social Work, Including Suggestions on Organization—by Gertrude L. Farmer, Director, Department of Social Work of the Boston City Hospital, Boston, Mass. Philadelphia, London and Montreal: The J. B. Lippincott Company. Price $1.50.

This book on record organizing in Hospital Social Service is welcome because its author's scheme for case histories lays special stress on the thinking that must lie behind thorough social case work. Emphasis in such work quite naturally tends to fall upon doing rather than upon thinking.

The author presents a scheme of recording which has already appealed to many both as more practical, more economical, and more efficient for hospital social work than those ordinarily in use. The introduction of this form of record, work in a uniform system of case recording and the gathering of statistical data throughout the country.

The Hospital World

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Editorial

Dying Statements

Trouble having arisen on more than one occasion between the Crown officers of Toronto and the authorities of the Toronto General Hospital, because of alleged negligence on the part of the latter to convey to the former information made by certain dying patients who had met with foul play or maltreatment, Hon. Justice W. R. Riddell was asked by the Attorney-General to preside over an informal but representative committee to consider the proper practice in cases of apparent crime.

Inter alia it was agreed that it would be of advantage that a simple and practical statement as to "Dying Declarations," "Ante mortem Statements" or "Evidentiary Declarations" should be prepared for the guidance of medical men generally and those in hospitals particularly.

In respect to declarations as evidence, Judge Riddell states that the general rule of our law is that only what is said under the sanction of an oath (or its legal equivalent) can be received as evidence.

But for about two hundred years, the English law, which our law follows, has made an exception in what have been called "Dying Declarations," or "Ante mortem Statements"—sometimes "Evidentiary Declarations."

General Remarks

When a judicial investigation is being made into the death of any person by homicide, statements made by that person respecting the circumstances resulting in his death, are admitted in evidence, if such statements are made by him when under the influence of a conviction that his death is impending.

Sometimes such evidence is of the very greatest importance, since frequently no third person was present. It is, of course, the duty of every good citizen to disclose crime and to preserve evidence of it. A medical man, therefore, attending a patient likely to die under circumstances indicating a crime by act of omission or commission which directly or indirectly caused his death, should endeavor to obtain such evidence from him as is available; and this sometimes is as useful to protect the innocent accused of crime as it (more frequently) is to convict the guilty.

This is not (as it is sometimes offensively put) to act the part of a detective, but to act the part of a good citizen and it is called for only in cases of apparent homicide where there is reason to suspect that the condition of the patient is due directly or indirectly to crime, foul play or criminal negligence.

Speaking generally, it is always wise for the doctor, as soon as he thinks that a case is hopeless, to inform the patient of the fact—he may have affairs to settle, a will to make, directions to give, etc.

Difficulties may sometimes arise as to which it is impossible to lay down any fixed rule—for example the patient may be of such a temperament that a statement of this kind would probably cause death sooner than it otherwise would occur, etc. Medical men are always conscious that (speaking generally) their first duty is to the patient, and that consequently nothing which can be reasonably and properly avoided should be done which is likely to harm the patient; and yet, exceptional cases may occur in which the private must give way to the public good. The medical man must face the situation, if and when it arises, and determine as his conscience and sense of public duty dictate. Cases of this kind are exceptional; and in no case should fanciful or captious objections be raised; in all cases of *real* difficulty, the Crown Attorney should be at once consulted.

Rules of Law

To make a declaration evidence, there must be in the mind of the patient an impression of impending death—if he believes that his case is hopeless, but that there will be a prolonged continuance of life, a declaration is not admissible. There must be an expectation, a hopeless expectation, of death near approaching. It is of no importance that the physi-

cian, or any other than the patient, thinks he may or will recover—the important thing is the expectation of the patient. Nor is it of any importance how this expectation is induced, whether from the patient's own observation, statements of medical men or otherwise—the essential matter is its existence, however induced.

This expectation, impression and conviction that death is impending, may be manifested by the patient in any of several ways—he may say so in so many words or he may indicate his conviction of impending death by changing countenance and appearing distressed or terrified when he is informed of it, etc. He may do this without any words of apprehension; and still make his conviction clear.

It is of great importance for the ends of justice that the attending physician should not only make the state of the patient unmistakably clear to him, but also that he should, if possible, obtain unmistakable evidence that the patient was convinced and without hope.

Direction for Taking Declaration

Where there is ample time, the Police and Crown authorities may be communicated with to take the Declaration; but no chances should be taken whereby the evidence may be lost.

The doctor should satisfy himself that the patient understands what is said to and by him.

The Declaration may be elicited by questions put to the patient.

Everything said by him in respect of the circumstances causing death should be noted, even if it may seem to be immaterial.

It is very desirable that the Declaration be reduced to writing; where circumstances permit, it should be read over to the patient; and if he is able he should be got to sign it; witnesses present should also sign as witnesses. Magistrates sometimes examine a patient on oath and the examination is signed by both—this is permissible.

It is, however, not absolutely necessary that the Declaration be reduced to writing at all. If circumstances do not permit of a written Declaration, an oral Declaration should be obtained. In that case, all present should take full notes of what is said, so that the memory may be refreshed (if necessary) when evidence is to be given of the Declaration. (Such notes are, however, not evidence in themselves.)

If the Declaration be reduced to writing and circumstances prevent its being signed by the patient, the witnesses should sign it after making certain that it is accurate—the absence of the signature of witnesses is not fatal to the Declaration but such signature is always advisable.

Practical Rules

1. A Declaration is admissible in evidence only concerning the circumstances resulting directly or indirectly in the death of the patient himself.
2. It must be made under the influence of a conviction in the mind of the patient that his death is impending.

3. It may be made to anyone.
4. The doctor should not imperil the obtaining of such Declarations by waiting for the Police or Crown authorities.
5. Where there is ample time it is well to communicate with Police and Crown authorities.
6. A Declaration may be obtained by questions; and when the statements of the patients are not full, it is often well to supplement them by information obtained in answer to questions.
7. Where possible the Declaration should be reduced to writing, read over to and signed by the patient—if it is also signed by witnesses, this is the ideal Declaration.
8. But a written Declaration without signature is admissible.
9. An so is an oral Declaration.
10. In case of any difficulty at any stage, the Crown officers should be at once consulted.
11. In all cases of doubt, the Declaration should be taken, leaving it to the Court to determine its admissibility and value.
12. Crown and Police authorities generally prefer to take the Declaration by stenographers—these rules are however, not intended for the guidance of such authorities—but for medical men or laymen who can seldom obtain stenographic assistance.

All hospital authorities in Canada would do well to keep this article handy—to be read by every house surgeon and head nurse.

Hospital Economies

Nurses, orderlies, maids, cleaners and other workers in a hospital can do much to promote economy, by being observant, painstaking, careful and thoughtful. Gas and electric light bills may be measurably reduced if care is taken to turn off fires or lights when not in use. Too often these workers will pass thoughtlessly by burning gas or electric lamp. It may not have been they who were responsible for turning them on; yet it should be made a part of their duty to turn them off. Sometimes a nurse will forget a catheter that is being sterilized by boiling over a gas ring with the result that the catheter is burned, the gas is wasted and the bottom of the basin scorched.

In dish-washing great care should be enjoined on all maids who attend to this work—to handle the dishes carefully and as quietly as possible in order that chipping and clatter may be avoided. Nothing looks worse than to see chipped or cracked dishes on a patient's tray. The dish pantry is not always beyond sound range of the wards. Lucky is the hospital where the pantry noise is inaudible to the sick folk.

The bed linen and blankets need special care. The blankets ought to be so protected that it will be unnecessary to wash them frequently; since in this process they are frequently injured, unless much care is taken. They should be stored in a separate room from the other bed things, as they frequently have a slightly heavy odor. Tears and

other holes in linen, should be attended to promptly. Any articles having marked repairs should be withdrawn from ward use and utilized by the personnel or given other services.

Rubber goods require special care. They should not be over-boiled; they should be kept free from oil and grease and not punctured with pins, needles or other sharp instruments. Care should be taken to see that the proper stop is furnished each water bottle and ice cap. Thus one source of leaking will be avoided. Rubber sheets ought not to be dried on hot radiators.

Watch must also be kept on the stationery supplies. Nurses ought not to use history sheets for note-writing or for any purpose other than that for which they are intended.

Care should be exercised in opening and closing doors and windows. This should be done gently. There should be no slamming, since in addition to injuring the locks, the noise is very objectionable. Often panes of glass are broken by careless closing of windows. Stretcher bearers should go carefully through doors, which of course, ought to be wide—4 feet at least. Even through doorways of this width, stretchers occasionally rub against the jambs. Even though the jamb may have a steel shield and the stretcher frame a rubber protector, the jolt against the corner shocks the patient, wears the rubber and tends to rub off the wall paint.

All carriages, trucks and waggons should run easily and quietly. There should be no creaking or

rumbling of wheels. Bearings should be snug. Gudgeons should fit sockets accurately and plenty of oil should be used to prevent any squeaking. The elevator grooves should also be be kept well greased. It ought to run noiselessly.

A key board should be kept in the carpenter shop with a duplicate of all keys and trace should be kept of the same. As soon as one key is lost the loss should be reported. Many doors do not need keys, and the use of the latter should be reduced to a minimum. In at least one modern hospital even doors in private wards are keyless.

The plumbing ought to be respected. Taps should not be left running, especially those supplying hot water. In many places the self-closing type may be used with much profit. In the surgeons' washup, the mixers may well be so set as to supply water of just the right temperature and a spray of a degree of firmness, sufficiently abundant, but not too lavish. Surgeons do not require gallons of hot water to wash their hands and arms. Leaky taps ought to be reported and repaired promptly.

The toilet seat bowls should not be made the receptacles for rags, newspapers, orange peels and the like. Often too much of the engineers' assistant's time is taken in clearing out choked pipes. Patients must be warned and watched in regard to this iniquity. Such stoppages with consequent overflows are very exasperating and often do much damage.

Sources of Income and where the Money Goes

It is well for readers of hospital and other journals and particularly for hospital workers in whatever department, to be informed as to sources from which the money comes which is used to build and support the institutions in which they work.

Hospitals like Guy's, in London, Johns Hopkins, in Baltimore, owe their origin to their founder whose name they bear. Other hospitals are the product of a joint effort on the part of small groups of philanthropic folk, whose benevolent effort is seconded by the municipality or the state or by both. Other hospitals have been founded by various religious denominations. In America, the Catholics and the Methodists, probably, have exceeded the other denominations in this class of charitable work.

In the newer parts of Canada and the United States, the provinces, states, territories, counties or municipalities have taken the initiative in providing hospital facilities for the people. This movement is one of the manifestations of the rise of democracy; and indicates the trend of the times.

This Journal has always held that this last method of building and of maintaining hospitals, is the best method; that it is better that hospitals for the people should receive their support from all the people (by taxes) rather than be built and supported by a few of the people.

The various classes of receipts may be mentioned:—

1. From private and semi-private ward patients.
2. From subscription.
3. From interest on property owned by the hospital.
4. Government or municipal grants, and
5. In teaching hospitals, from students.

A Hospital Motto

An application for a further grant of money to a city hospital recently called forth from a disgruntled and economic alderman the remark that, like the horse-leech, the hospital cry is always "give-give," and like the grave, it is never satisfied.

The city official was doubtless unaware that he had described the ideal condition for any public welfare institution,—namely, a condition of growth.

The words of the late Dr. J. S. Billings at the opening of Johns Hopkins hospital thirty-three years ago are as applicable to-day as at that time, and we do well to recall them.

"A hospital is a living organism, made up of different parts, having different functions, but all these must be in due proportion and relation to each other, to produce the desired results. The stream of life which runs through it is incessantly changing; patients and nurses and doctors come and go; to-day it has to deal with the results of an epidemic, to-morrow with those of an explosion or fire; the

reputation of its physicians or surgeons attracts those suffering from a particular form of disease, and as one changes so do the others. Its work is never done, its equipment is never complete; it is always in need of new instruments and medicines; it is to try all things and hold fast to that which is good."

Because Johns Hopkins has lived up to that conception of its duty, it occupies a first place among the hospitals of the English-speaking peoples.

No hospital can afford to stand at ease. Its motto must be always and ever "advance."

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Society Proceedings

HOSPITAL AND HOME WORKERS CONFER

Methodist Episcopal Physicians, Nurses and Superintendents Counsel Together.

Doctors, nurses and superintendents of Methodist Episcopal Hospitals and Homes spent Wednesday and Thursday, February 15 and 16, in conference and discussions concerning the problems and progress of their work in these institutions of the Church. They met under the auspices of the National Methodist Hospitals and Homes Association, which was organized in 1919 by a little group from this host of workers which were pioneering the way toward a better recognition of this type of work by the Methodist Episcopal Church.

Out of their labors has come the Board of Hospitals and Homes of the Methodist Episcopal Church which is counselled in its labors by the discussions participated in at the Annual Meeting by those doing the actual work. Vision is broadened, knowledge is increased, and a solidarity is made possible among these institutions of the Church by democratic gatherings of this type.

The meeting was opened by President Mr. E. S. Gilmore, Superintendent of Wesley Memorial Hospital, Chicago, who outlined some of the values that have accrued to hospital and home workers themselves because of their fellowship and frank exchange of views. Reports of the officers indicated a more serious attention to making Methodist institutions of this character of A-1 Grade.

The great need of medical missionaries who will go into rural sections and build up the health of the people was stressed by Rev. C. M. McConnell, of Chicago, who gave comparisons of the health of the 12,000,000 rural school children and the 12,000,000 who attend city schools, demonstrating that those in the city are taken care of much better than the school children of the country. He also urged the need of the visiting nurse to visit the homes and teach people how to live and what to eat, thereby avoiding the common diseases, and advo-

cated an emergency hospital in country districts with nurses and modern equipment, such as is being built at Pittman Centre, Tennessee, by the Board of Home Missions and Church Extension with Centenary funds.

The American White Cross, which more and more is appealing to the hearts of Methodists, was presented by Dr. L. O. Jones, field secretary, who reported that thirty-eight Annual Conferences are now organized, or in the process of organization, for carrying on American White Cross work, including two-thirds of all Methodist Episcopal churches in Ohio.

Dr. W. H. Jordan of Minneapolis, emphasized the value of raising the quality, efficiency and standard of all of our institutions. In discussing nurse problems, Dr. C. S. Woods, Indianapolis, Indiana, urged the nurse's helper as a partial solution for the shortage of nurses. Such a helper would do some of the routine work, giving the nurse more time for her studies and practical experience in nursing which is to fit her for later Christian service.

"Complete organization covering relation of hospital or home to the General Conference, Annual Conference, and all internal problems relating to management, staff organization, education, nurse training, and other administrative problems, is most necessary for the successful operation of any kind of institution," declared the Rev. N. E. Davis, corresponding secretary of the Board of Hospitals and Homes. "The strength of the organization will determine the character of the results to be accomplished as they relate both to the Church and to the public at large. Hospital and Home administrators should be wise in the promoting of policies, sympathetic in the care of those with whom they deal, and kindly disposed in their treatment of the public. The institutions of the Church are to serve the Kingdom of God in the world," he said.

Some of the problems of Children's Homes were discussed by Dr. S. W. Robinson, of Williamsville, N. Y., and Mrs. T. W. Asher of Normal, Illinois. They brought out the problems of child-finding, child-placing, finance and administration. It is notable that the demand for children from our children's homes is greater than the number of children available for such placement. In the words of Mrs. Asher, "the world is waking

up to the fact that the child should be the centre of all of its activities." She further stated that "a child should never be placed in any home except where both the man and the woman are consecrated active Christian workers with ability to train and love a child and are financially able to meet all its needs and give it a good Christian education."

Problems of Homes for the Aged were discussed by Rev. W. H. Underwood, of Blair, Nebraska, and Mrs. W. S. Phillips of Chicago, Illinois, both of whom pointed out the almost infinite care and love that is necessary to make the Home for the Aged a real home so that those who are guests in these institutions may not sit down to brood over days gone by and things long since forgotten.

The fact that the religious life of our hospitals and homes is kept uppermost came out in a paper by Mr. E. S. Gilmore, on "Personal Relation of Hospitals to Patients" which was a revelation of the democratic atmosphere of our Methodist Hospitals. Dr. Dillman Smith, of DesMoines, Iowa, in discussing religious work in hospitals said, "the patient in the hospital must be made to absolutely believe and feel that loving attention never ceases, and that this loving Christian attention is to produce the radiance of hope, the inspiration of joy, the restfulness of peace and the life-giving element of happiness .... There can be no such thing as 'religious work in the hospital' unless every department in that hospital is in absolute and perfect accord with the spirit of Christ." Rev. Emerson Karns, of Tyrone, Pa., gave somewhat in detail what may be done in the way of religious instruction and ministration in the homes for children and the aged.

Dr. Willard C. Stoner, Director of Medicine at St. Luke's Hospital, Cleveland, Ohio, read a most constructive paper on "The Hospital Problem in Relation to Modern Medicine."

Among other things, he said, "The advance in scientific medicine and the rational application of the same have been phenomenal in the last twenty years. These advances have been of a nature that demand hospitalization very largely for a complete realization in medical practice. The old ideas of medical practice are being supplanted by the new. It is obvious that, under most circumstances, home conditions will not permit

of improvised hospital facilities. It is impossible to bring hospital facilities to the home so that it has become necessary to hospitalize more and more in order that we apply in diagnosis and therapy that which modern medicine affords. . . .

". . . .The hospital is being reorganized as a workshop where there are facilities that represent the last word in scientific medicine, and workers who represent the best in training and skill that modern medicine affords. The public is coming to realize that a hospital is a community problem, that it should have community support and should serve everyone, the poor, the rich, and the great middle class on whom a great hardship will come by reason of the tremendous cost of medicine, if it is not afforded them by an institution at a cost which will not make it prohibitive.

"The establishment of hospital facilities in the rural communities must be the rational solution of medical practice in these districts."

Dr. Stoner's emphasis on the importance of amplifying hospital facilities, of making the hospital a complete workshop in order that medicine may be marketed to the public at a price which is not prohibitive, (as contrasted with the private co-operative clinic established on a commercial basis), was based on a general survey of hospital organizations such as represents the organization of St. Luke's Hospital, Cleveland.

Dr. William J. Davidson, in speaking on Life Service, said, "The nurse of to-day who seeks at all to realize the great objective of Christ, as a nurse may share in the realization of that objective, but she must be one who sets supreme value on finding and doing the will of God for her life, and who discovers that, other things being equal, she does her maximum work as a nurse only as she maintains her maximum life as a Christian. And steadily giving life of that kind in such work is true life service."

"Prayer is the power that will move all of our institutions forward in Christian Conquest," Dr. W. A. Robinson, Cincinnati, reported, and F. C. English appraised the value of getting hospital interests before the people. The Treasurer's report was read by Dr. Jordan.

Publicity and Printing for Hospitals and Homes was discussed by Dr. Ralph Welles Keeler, who illustrated his constructive criticism from printed matter received from Methodist Episcopal hospitals and homes. A new Hospital and Homes hymn of service, "Through Ministry of Love," dedicated to the Hospitals and Homes of the Methodist Epicopal Church, and written by Dr. Keeler, was adopted by the Association and tune 701 in the Methodist Hymnal voted as the tune to use with it.

The following officers were elected: President, E. S. Gilmore, Superintendent, Wesley Memorial Hospital, Chicago; First Vice-President, and Chairman of Publicity Committee, S. W. Robinson, Executive Secretary, Methodist Homes for Children, Williamsville, New York; Second Vice-President and Chairman of Finance Committee, J. A. Diekmann, Superintendent, Bethesda Deaconess Hospital Association, Cincinnati; Third Vice-President and Chairman of Nurses Training Committee, Miss Blanche M. Fuller, Superintendent, Methodist Hospital, Omaha, Nebraska; Fourth Vice-President and Chairman of Committee on Homes, W. H. Underwood, Superintendent, Crowell Memorial Home for Aged, Blair, Nebraska; Treasurer, Mrs. W. S. Phillips, Superintendent, Methodist Home for Aged; Secretary, W. J. Jordan, Executive Secretary, Asbury Deaconess Hospital, Minneapolis, Minnesota.

A Summary of the Findings of the Hospital Study of the Public Health Committee of the New York Academy of Medicine.—Dr. E. H. Lewinski-Corwin made this presentation, which was illustrated by lantern slides. He stated that the study of the hospitals of this city was made possible by a grant from the Commonwealth Fund; the study covered a period of almost a year. The survey was both extensive and intensive. Some of the important facts brought out in the preliminary report were: (1) That 32,000 hospital beds in this city were sufficient to meet the present demands of the community because one hospital bed was available for every 200 of the population, and on the basis of the approximate number of sick one bed was available for every fourth sick person. The average utilization of available bed capacity did not exceed 70 per cent. There was a need to create a central hospital bureau through which

the utilization of the beds in many hospitals could be increased. The study showed that in the general hospitals 8 per cent. of the cases were private patients and 9 per cent. semi-private, and this was for all the hospitals, including the municipal hospitals. He thought the private pavilion should not be looked upon as a milch cow to sustain the wards. The present need seemed to be for more of the inexpensive private and semi-private beds for the people of moderate means. The private pavilion of the hospital should, however, not be expected to earn money for the hospital beyond the cost of maintenance. (2) There was a distinct need for the expansion of facilities for the care of convalescent and chronic disease cases. (3) The immediate needs of the hospitals were ampler funds for maintenance purposes and for the employment of larger nursing and other professional staffs; also for the extension of laboratory and x-ray facilities. In most of the hospitals the provision for nursing care was utterly inadequate, and particularly so in the municipal hospitals. There was need of reorganization of the training schools to attract a larger number of pupils. At the present time only 57 per cent. of our nursing done in hospitals with training schools was done by pupil nurses. The need of the extension of the training of nurse attendants was likewise very great. In some of the hospitals, however, the percentage ran above 80 per cent. (4) Hospitals should be utilized to a greater extent for medical research and teaching than was being done at the present time. The scientific work of hospitals was hampered by the hostile attitude of the public toward post-mortem examinations. In the Kings County Hospital autopsy was performed in only one-half of 1 per cent. of deaths; in Bellevue in 15 per cent. Hospitals in which autopsy was done in 25 per cent. or more of deaths were the New York, St. Luke's, Greenpoint, and Beth Israel. At the Peter Bent Brigham Hospital post mortem examinations were made in 65 per cent. of deaths. (5) A change in policy was indicated which would admit larger numbers of physicians to the opportunities of hospital practice. At present only a little over 40 per cent. of the physicians in this city were associated with hospitals. (6) There was a distinct need for a more uniform method of statistical and financial accounting in hos-

pitals, likewise for more co-operative business arrangements on the part of hospitals to ensure greater savings in buying. The hospitals in this city expended annually for maintenance $35,000,000. Sixty-eight per cent. of the cost of maintenance came from pay patients and 19 per cent. from endowments. There was $78,000,000 invested in hospitals. Of this amount approximately 43 per cent. was invested in private hospitals, 33 per cent. in city hospitals, and 25 per cent. in private special hospitals. In 37 per cent. of the hospitals the land was considerably in excess of the value of the buildings. In order that the manifold problems of the hospital should be kept continuously before the public, a Central Hospital Bureau should be established, which would act as an exchange of experience and a storehouse of information. Among the various ways in which such a bureau would be valuable were the following: It would contribute towards a better distribution of the patients among the hospitals; it would bring about the unification of hospital reporting; it would be a repository for information on morbidity; it would be an aid to the public in forming an opinion as to the needs of the institutions; it would supply information to benefactors, trustees, and architects, and it would stimulate efficiency of hospital work and organization.

Dr. George B. Wallace said that in this extensive study of the New York hospitals, made by Dr. Corwin and his associates, one of the features looked into was the data concerning the immediate care of the individual patient. Inquiry was directed to the recorded facts brought out in establishing the diagnosis—that was, the history and the physical and laboratory examinations, the course of the disease or injury, the treatment, and the condition of the patient at the time of discharge from the hospital. It was assumed that such an inquiry would not give an absolute but still a fairly definite idea of the character of the medical work done in the hospital. Indeed, with those making the study personally acquainted with a very small percentage of hospital physicians, the patient's record was practically the only definite criterion of the medical works done in any particular instance. As might be expected, the inquiry showed the most marked variation in the matter of patients' records. At the one extreme the record consisted of a filling

out of the printed headings on the record sheet and practically nothing else but the nurses's notes. At the other extreme, where certain types of cases were being intensely studied, the records contained the minute and detailed data that one associated with the accurate recording of facts in experimental research. The conclusion was properly drawn, Dr. Wallace thought, that the records of the first type were almost useless except for the purpose of compiling the annual hospital reports, and that those of the second type, admirable as they were, represented an amount of work not practical in the ordinary hospital with its limited staff. Obviously some mean between these two extremes should be selected as a working basis. In considering what was the general purpose in keeping an individual record, and what might be the value of such a record, two points especially presented themselves. The first had to do with the immediate welfare of the patient. Certain procedures, such as the obtaining of a proper history, a thorough physical examination, certain laboratory examinations were necessary for a diagnosis, using this term in the broadest sense. Subsequent examinations were equally necessary for a knowledge of the course of the disease. Yet in some hospitals such facts as were necessary for an understanding of the case either were not recorded or were recorded only in part. For example, one record gave the diagnosis "typhoid fever," with no statement of the presence or absence of an enlarged spleen, or rose spots, or mention of a Widal test or of a blood or other culture. Another containing the diagnosis "chronic nephritis" had no urinary examination recorded. These omissions did not necessarily prove that the necessary examinations had not been made, but it was manifestly impossible for any one to carry accurately in his memory the history and the findings of each patient in a ward. Again, without a record, the following of the course of the disease and the recognition of complications became more difficult. Further, in many hospitals there were sudden shifts in the staffs, and the newcomers, with inadequate past records to guide them, were often quite at sea regarding any particular case. In order to avoid mistakes, therefore, and to be able quickly to refresh the memory on any question arising, a written record was indispensable. The accep-

tance of a hospital appointment carried with it the obligation on the part of the physician to do all he could for the welfare of the patients under his charge. Since the keeping of a proper record had a great deal to do with the patient's welfare it became a duty to see that the proper record was kept. Failure to perform this duty rendered the hospital open to criticism that the medical work was not well done, and since so many hospitals were dependent upon private contributions for their maintenance it might well follow that discriminating donors would hesitate to make contributions to such a hospital. A second point brought out was the educational value of the record. There was no doubt that an accurate recording of clinical facts instilled a spirit of carefulness and thoroughness on the part of the recorder. Such a spirit was of great value in self-education. Another aspect was that the advance of clinical knowledge was not dependent solely on laboratory research work, as some seemed to think. Our knowledge of disease was based largely on the careful observation of patients. It was an obligation of hospitals, with their wealth of clinical material, to add to this knowledge. One way of doing this might be to render the ward more accessible to those who wished to study certain diseases. Certainly one way was to keep case records which were sufficiently comprehensive to have the desired facts clearly set forth. When it was considered to what use records of the large number of patients passing through the average hospital in the course of a year might be put in furthering medical knowledge, the failure to supply these records seemed inexcusable. In considering what constituted a proper record, Dr. Wallace said it was obvious that there could be no standard record for all hospitals and all patients. Generally speaking, there was this minimum requirement. First, every record should contain all the facts necessary for a diagnosis; this included a complete history and physical examination, the latter showing not only what was abnormal but what was normal, together with certain routine laboratory examinations, such as the urine and blood; second, besides notes describing the progress of the case, a full account of any complications or unusual features arising; third, an adequate statement of any therapeutic measures employed; fourth,

the nurses' notes on pulse, temperature, etc., and finally, a statement of the patient's condition on discharge, based either on recorded facts or a final general examination. With this minimum established there was no limit to the additions which might be made in cases which were being especially studied. In concluding Dr. Wallace put forth the following suggestion: They frequently met in Bellevue with patients who showed scars of previous operations, who gave histories of definite illnesses or injuries, who told of having blood examinations or injections made. On inquiry they were ignorant of what the operation was for or what was found, or what the illness was, or what the blood test showed. In a study of dispensaries made some years ago there was shown a small book, slipping easily into the vest pocket, which each patient in one of the dispensaries was given. This little book which was kept by the patient, contained very brief statements, over a doctor's signature, concerning the complaint from which the patient suffered. It was worth considering whether it would not be advantageous for hospitals to see to it that each patient on discharge had some such similar book containing the proper entries. If this system became general it would result in time in a large number of patients having an accurate record of their past medical history.

Dr. S. S. Goldwater said he would be ungrateful if he did not express his profound appreciation of the splendid report which Dr. Corwin had presented. Before coming to the meeting he had felt that Dr. Corwin was facing an impossible task. Conditions existing in New York hospitals had never before been presented so graphically. He had been asked to say a few words about the private room and the ward; the professional and economic problems involved. One might start by defining what was meant by private room and ward. When one spoke of a ward it might be taken to mean the thing that formerly existed in some hospitals and still existed in some places, a large barrack, sometimes lighted, at others very poorly lighted, sometimes ventilated, sometimes not ventilated, with no facilities for classifying patients and no way of changing the environment of the patient. Sometimes there was no receiving department and an absence of special examin-

ing rooms. This was the type of hospital that lacked decency and where all the surroundings were what they should not be. So there were wards and wards. To-day one found, even in the municipal hospitals, 20, 30, 40, and even 50 per cent. of the ward capacity in the form of one, two or three room ward units and every facility for separating patients. Usually there was in addition a veranda which provided for outdoor treatment. The condemnation of the large ward had now led to the other extreme with a tendency to have many single rooms which meant a great increase in the cost of construction and maintenance. In this connection the experience of the Boston City Hospital was of interest. There was a great outcry against the absurdity of putting a pneumonia patient and a nephritis patient in the same ward under the same conditions. So a small hospital of 80 beds, each having a separate room, was built. A nurse, when asked how she liked the new arrangement, answered that it would be all right if she had some means of seeing what was happening to the patients. The same nursing force that could care for 40 patients in a ward could not take care of those same patients in separate rooms. The result of this experiment was disastrous. Then Boston City Hospital swung back when another addition was built, and there was not a single quiet room and even the service room was separated from the ward by a glass partition. Both of these extremes were wrong. Private rooms should be provided for ward patients only where it was an advantage to the patient to have a separate room outside the ward. The private room of course had the advantage of preventing contagion provided other measures directed to that end were also employed. However, if the doctor and nurse put on a gown and gloves and then passed from one room to another without changing or sterilizing them, as he had seen done on one occasion, this advantage was nullified. Other advantages of the single room were that the light could be adjusted, there was more quiet, and one could show more attention to the individual patient in the matter of contact with his family. Dr. Goldwater said one was shocked in Japan when he found males and females being treated in the same ward, but one had to consider their temperament and

manner of living. When one found the female friends of the male patient spending a great deal of time in the ward one came to realize that classification into male and female did not mean anything anyway. In Pekin the average Chinaman wanted at least four or five of his family with him day and night. In Hong Kong the hospital was constructed with anterooms for the patients' servants. Coming to a consideration of the economic side of the question of private rooms and wards, the difference in the cost of construction of a good type of private room and good accommodations for a patient in a ward was about 100 per cent. The difference in the cost of maintenance was also very great: for instance, the cost of cleaning the same space was double in a private room what it would be in a ward, for there was not only the ceiling and floor but four walls and many more corners. When it came to the nursing side a greatly increased nursing force was required for private rooms. There was an adequate number of private rooms in the hospitals of this city. If these private rooms were turned over to persons of moderate means for the small price they would be able to pay the hospitals would be unable to carry on unless they were provided with stiff endowments. There was at present a shortage of nurses and if more private rooms were operated this shortage would be still more acute. A larger force of domestics would also be required. All this would mean that the hospital would have to have larger funds. Dr. Corwin had spoken of a hospital having a surplus of $150,000. That was a most exceptional and fortunate hospital. He thought that if they looked into the affairs of that hospital they would find that it employed an overwhelming amount of pupil nursing, and that a large percentage of ward patients were paying their way. One also had to take into account the fact that the proportion of ward patients paying their way was influenced by different conditions as the rise and fall of wages, and changed conditions of living which made people go to a hospital because they did not have room in their homes to care for a sick person. He could not agree with Dr. Corwin that the ward patient should pay no more than merely the cost of his care. One ought to see that the private pavilion earned at least the in-

terest on the capital invested and anything over and above that should be applied to the free wards. The report showed that only 17 per cent. of the total number of patients in the hospitals of the city were private or semi-private full pay patients. It was true that the vast majority of decent working people did not have the sort of incomes which permitted them to pay their way; when sickness came they needed help. The deficiency in the cost of maintaining free wards might be met by charitable gifts and such gifts ought to be far larger than they were. He did not see why givers should make a difference between municipal and private hospitals. The poor person in a municipal hospital was just as much entitled to help as when that same patient was in a private institution. Of course he thought the taxpayers should listen with more open ears to the needs of the city hospitals. He felt that Commissioner Coler had not had a fair deal. A much lower standard was permitted there than in other hospitals. Dr. Goldwater expressed the hope that the central hospital bureau which was proposed would be established.

Dr. W. Gilman Thompson said, in part, that it had long seemed to him important that a city which had 182 hospitals and which was constantly erecting new ones or reconstructing older ones should have a central bureau of information where any and all practical facts concerning existing hospitals might be attainable for guidance, either in organization, construction or management. Had such a bureau existed a generation ago, we might have developed a much less heterogeneous assortment of hospitals than we had with these institutions as they now existed, founded many of them on a basis of religion, language, of sex, age, of some special organ of the body, or even of some one disease, like a recent hospital for cutting out tonsils. All this might be desirable in the individual case, but it had unquestionably led to an overlapping of interests, a poor economic situation and a general lack of scientific co-operation. Meanwhile the cost of hospital construction and equipment had increased by leaps and bounds. There was a certain economic unit of size for a hospital. Much of the personnel, for instance, required for a hospital of 50 beds could as well care for

a service of 100 or more beds. Much of the equipment now regarded as essential for every well organized hospital for accurate diagnosis, like x-ray apparatus, or good clinical laboratories, might serve a hospital of any reasonable size without duplication. With this pioneer work accomplished and a bureau once established, it would be relatively easy to keep the information always timely, through a well-organized active bureau. Municipal hospitals were dependent for maintenance upon a budget system which often suffered through reductions made by those in authority who might be poorly informed and quite inexperienced in modern hospital requirements. Comparison between the service rendered and the results obtained in the municipal and privately supported hospitals, respectively, which might readily be procurable from an impartial bureau might be utilized to great advantage in securing adequate appropriation from city funds. Dr. Thompson traced the development of the modern hospital from little more than a boarding house for the sick to the modern institutions like great hotels with elaborate engineering, laundry, kitchen and diet kitchen departments equipped with all modern machinery and economic devices, and with laboratories, physiotherapy facilities and all the elaborate paraphernalia of the operating department, and showed that the modern hospital building must be studied architecturally as a factor in treatment. It was a very serious problem to construct a modern hospital or even to devise an addition to an existing one. The first thing to do was to collect all the composite information possible from the experience of others. A hospital bureau would be prepared to furnish all this information. It would be prepared to answer questions on a large variety of subjects as, for instance, "Do you pay your internes? Do you continue to pay your nurses when on prolonged sick leave? How much did your complete x-ray department cost? Are your visiting staff permitted to retain fees paid by accident insurance companies for operation? Do you have an elevator man at night? What is your per capita meat bill? Have you occupational therapy? Have you a special workshop? What is the salary of your teacher? What is the relation of your social service department to the medical staff?" Scores of ques-

tions like these were constantly arising which a central hospital bureau could be prepared to answer. The organization of such a bureau need be neither elaborate nor expensive. The personnel that would be needed would consist of a competent director and possibly an assistant, two investigators to visit hospitals and obtain information, a stenographer and two clerks to file and keep records, compile statistics, tabulate data, and answer correspondence under dictation. In summing up, Dr. Thompson outlined the functions of the proposed Hospital Information Bureau as follows: (1) To collect information of all kinds regarding the details of hospital construction, organization, maintenance, and administration. (2) To tabulate and report this information on request. (3) To publish from time to time information regarding important facts concerning the general hospital situation in the city as, for instance, whether the hospital beds were adequate and properly distributed in reference to the population, etc. (4) To collect architect's plans of existing new hospitals, and also the general literature on the subject. (5) To furnish information especially for those who were contemplating new hospital construction. (6) To aid in equalizing and balancing hospital service in many ways as, for example, in securing uniformity on hospital record forms and preventing overcrowding in some institutions while others were practically empty. In order to illustrate the principles of economy of service which should be an important function of the bureau to bring about, it should preferably be inaugurated under the direction or patronage of some existing organization concerned with general hospital affairs.

Mr. Bird S. Coler, Commissioner of Public Welfare, spoke briefly for the municipal hospitals. He said they knew the weak points in these institutions. One of these was a shortage of nurses and there were other defects but on the whole they were doing fairly well. It had been said that propaganda stood in the way of progress, and we had had an illustration of this in educational lines. For a time every fad that came along was introduced into the educational system until these fads became such a burden on the budget that when the question of medical education came along, they said "take

it off." So the facts in reference to hospitals must be properly presented to the heads of the city government if the hospitals were to receive sufficiently large appropriations. It must be remembered that private hospitals were receiving appropriations from the city to aid them in the care of charity patients. Dr. Thompson, in the course of his address, had spoken of obtaining money from foundations. Mr. Coler expressed the hope that they would not accept money from a foundation because the foundations were going to have full time teachers in the medical schools who would do nothing but teach. The medical schools being closely related with the hospitals this was a question that would affect the hospitals. He believed that a teacher should be able to *do* the thing he was *teaching*. Again the refinements of standardization might be carried to extremes and sometimes that was worse than having no standardization. They might, for instance, carry the standardization of nurses to the point where only a post-graduate collegian could qualify for a nurses' training school. Commissioner Coler strongly emphasized that the city was working intensively in co-operation with the Academy of Medicine and the Public Health Committee and was interested in this study of hospitals. The place to have this proposed bureau was here in the Academy of Medicine. Those interested in the medical school work in public hospitals knew what tremendous advances could be made where there was a proper co-operation between these institutions. If they could have this co-operation between great public hospitals, the Academy of Medicine, the private institutions, and the medical schools, it would be possible to develop a post-graduate medical work which would make New York City the great medical centre in this country, but foundations must be kept away so that they would not standardize things—so that they would be ineffective before they were fairly under way. He assured the Public Health Committee that in establishing a Hospital Information Bureau they would have the co-operation of the city hospitals.

Selected Articles

A PATIENT'S POINT OF VIEW.

By William Rittenhouse, M.D., Chicago, Illinois.

A sojourn of nearly five months in a modern hospital affords to the sojourner opportunity for some interesting observations. One of the first things to strike the observer is the contrast between the hospital patronage of to-day as compared with that of twenty years ago. Then, most hospitals were making efforts, more or less strenuous, to keep their beds filled; to-day, most of them have their beds engaged for days ahead—a waiting list. The impossibility of getting competent help at home, compels numbers of people to go to a hospital when they are taken ill. The public, generally, also recognize the fact that better care and better equipment are at their disposal in a good hospital than in any private home.

The Cost.

One soon learns, too, that the cost of being ill has held its own in the race with the high cost of living. After one's pocketbook has come in contact with the hospital bookkeeper a few times, one looks at the people who crowd the wards and rooms and wonders: "Where do they get it?" just as one wonders the same in regard to the buyers of silk shirts and fur coats and twenty-dollar shoes. That this thing must bring up against a stone wall, sooner or later, seems inevitable; but, when?

The Nurses.

The scarcity of nurses is something that gives food for reflection as to the future prospect for hospitals and sick people in general. A certain hospital, that normally ought to have at least 20 probationers, had one, last December; she became appalled at the overwork and quit. Later, another

one was found and then a second. Another hospital, that should have in training a class of 100, now has about 20, I am informed. The result is, that all nurses on duty are overworked and this fact makes it very difficult to get probationers. Young women can command such large salaries in the commercial world, and get them at once, that they are not attracted by the prospect of giving three years of their lives, without pay, to prepare themselves for a laborious profession, which, when they have attained it, is not as well paid as stenography. A good many thinking observers are coming to the belief that the three-year course for nurses is a mistake. Any young woman who cannot be made a good nurse in two years, is not likely to in three. If she lacks the traits of character necessary to make a good nurse, she is pretty certain to lack them after any amount of training. A course of training will not change human nature.

Not all Trained Nurses are Efficient.

During the past few months, I have had the opportunity of observing, at close range, the work of about a dozen three-year graduate nurses—all holding the degree of R. N. About half of them could truthfully be called efficient; the remainder were inefficient—constitutionally so—from various causes, such as lack of brains, conceit over a little knowledge, lack of conscience, carelessness and so on. Some of them had no scruples about substituting their own views in place of the doctor's orders. One of them expressed herself regarding the doctor's opinion in a matter of surgical procedure in these words: "I don't agree with him!" She had graduated a month previously. One of them would, in nine cases out of ten, inject a bubble of air with a hypodermic of morphine. When her attention was called to the fact, she dismissed the matter lightly with the assertion that it did not do harm.

Of course, when the supply of nurses is normal such individuals are gradually eliminated because no doctor will employ one of them the second time; but, at present, the scarcity of nurses of any kind, good, bad or indifferent, is so great that we have to do as housekeepers do with their help (when they can

get any), namely, look pleasant and put up with shortcomings. I have quoted the instances mentioned, to show that a three years' course of training will not make good nurses out of poor material.

It is difficult to imagine what hospitals are going to do in a couple of years from now when their present classes have graduated and gone.

The Registered Nurses' Association has some of the undesirable features of labor unions. The incompetent nurse gets the same pay as the efficient one. Membership is no guaranty of efficiency. Of course, an examination is required, but, an examination is a very imperfect test. I saw a proof of this fact a short time ago. A nurse who had been in the war and who was competent and experienced, failed in the examination because she had been too busy to study much. Another nurse who had just graduated and who had a greatly exaggerated idea of her own knowledge, passed. The latter was the one mentioned who "did not agree" with the experienced surgeon.

Six Weeks' Training Course not Enough.

The plan of giving a six-weeks' course in nursing to a promiscuous lot of women and then allowing them to call themselves nurses and charge all that the traffic will bear, will not solve the nursing problem, either from the standpoint of the patient's welfare or from that of justice to the educated nurse. These would-be nurses know that few people will ask to see their diplomas and many of them are posing as graduates; they do not say of what.

Two or Three Years of Training.

An increasing number of physicians are of the opinion that it would be the part of wisdom for all hospitals to cut down the course of training for nurses to two years, and then refuse diplomas to those who do not show positive evidence of being competent, with special reference to the practical care of patients. This would work no hardship if they were warned, from the beginning of their training, that efficiency would

be absolutely required as a condition of graduation. In other words, the possession of a diploma and the right to use the degree of R. N. ought to mean something reliable; at present, they do not.

The Problem of Waste.

One of the things that strikes an observer in most hospitals is, the waste of good food and other supplies. A well-loaded tray is carried to each patient; often, the food is scarcely touched and it goes to the garbage can. When we think how many hungry people there are in the world to-day, and even in our own city, it does seem as if human ingenuity ought to be able to devise some plan of utilizing this wasted food.

Zones of Quiet.

The ordinance establishing zones of quiet around hospitals is a joke. It seems as if the chauffeurs of motor trucks take especial pleasure in showing their contempt for the law by opening their mufflers and producing the most deafening noises in passing a hospital. It is the old story—pass a law and then expect it to enforce itself. One hospital is located a stone's throw from a police station. The police ambulance and the patrol auto never fail to give a very noisy account of themselves when arriving or departing. When the police are such serious offenders, themselves, it is no wonder that they do not try to check other offenders. The hospital authorities say that they have frequently complained at the police station, but without result.

A hospital is rather a noisy place in any case. There are many noises, that seem unavoidable, originating within the institution—the ringing of bells, the noise of elevators and dumb-waiters, the groans of those in pain or of those partially under anesthesia. The helpers who do the menial work of the institution are not always as careful about noise as they might be. They do not submit readily to discipline because they know their power and do not scruple to use it. The scarcity of unskilled labor in this as in all other lines makes it necessary for employers to overlook a good deal. On the whole, the lot of the hospital superintendent to-day is not a happy one.

Canadian Hospitals

THE ONTARIO GRADUATE NURSES.

The 19th Annual Meeting of the Ontario Graduate Nurses Association was held at Brantford, where in the 16th century, Father Damian records in his letters, the Indians were even at that early period adeptly practising surgery.

This association has been organized for the advancement of educational standards for nurses; to further legislation in the interests of nurses, hospitals and physicians; to enable nurses to know one another better; and to enable them to think provincially instead of locally.

HISTORY OF THE G.N.S.O.

Miss Julia Stewart read a paper thus intituled:

A bill for registration of all graduate nurses was first introduced in 1906. The press assailed the measure as trade unionism of the worst type, and representatives from small hospitals were strongly against it.

One result of this effort that had failed brought training schools up to a higher standard and began the spread of an enlightened opinion, not only with the general public, but among the nurses.

The first chapter of nurses was founded in 1908 in Hamilton. In 1906 "The Canadian Nurse" became the national magazine. In 1900 the association was incorporated. One of the efforts of the association was taking care of a former Ontario nurse who had been bed-ridden and penniless in Detroit.

Membership by organization came about in 1914. Some instances of hospitals below standards were cited, one hospital with a daily capacity of 80 beds and 85 operations had no graduate nurse in charge.

A standard curriculum for nurses was drawn up which included such items as a probationary term of three months and a date of entry for probationers, a maximum of 63 hours a week work, superintendent to be a graduate nurse, two paid

resident instructors, daily average of 25 beds and the giving at least a two years' course.

Miss Stewart outlined the efforts made to secure legislation in regard to registration. In 1915 a Royal Medical Commission was appointed on the matter. Able women had been appointed as chairmen of this legislation committee. The British nurses were nearly 30 years in securing legislation.

During the 18 years of its existence the association had seen the evolution of the public health nurse, the school nurse, the tuberculosis nurse, the venereal disease nurse, the child welfare nurse, the orthopedic nurse, the beginning of the university course for nurses, and the nursery in the Great War.

RED CROSS.

Miss V. M. McDonald spoke on Relief work which might be carried on by the Red Cross, membership in which should be sought by all graduate nurses. In case of an epidemic or big disaster it was up to them to bring personnel and supplies into the quickest possible use; an elaborate system of the location of same, would be available at the headquarters of the society. Other aims of society were the prompt rescue of the injured, clearing of the debris, destroying epidemic, disposal of the dead and medical aid in hospitals. "Always keep in mind the possibility that the hospital may be rendered useless and have the facilities of an emergency hospital at hand," she urged.

The part the nurses would play was of most interest to those attending the convention. Nurses must first be registered for such work and be able to handle all situations arising out of a disaster, for pneumonia epidemic, mental and nervous cases were a product of a disaster of large proportions. These all required prompt attention, which could only be given when an able organization was in existence. This would be a reality if all nurses, whether retired or active, showed their interest in such a dire need by giving their assistance and enrolling their names. The whole-hearted cooperation of nursing profession would bring that into being.

Miss Jean Brown spoke on the Junior Red Cross.

To teach citizenship was one of the most important aims of the society. Give them a knowledge of life and living conditions in their own country, teaching the Brotherhood of Man. All the good work the Junior Red Cross expected to do, depended on the co-operation of the teacher. Without it, nothing could be accomplished. Children should not be considered things, to be divided into two departments of body and mind. It was impossible to dissect those two factions. The one was completely essential to the other and should be thought of as an entirety and dealt with uniformly.

Four provinces were already fully organized for Junior work, and the others would soon follow. It was important to keep in mind that 60 per cent. of the children of the land were attending rural schools, where hygienic and literary facilities were only fair, thus making health education a more difficult matter than in the city.

The nursing profession could not help being interested in such a great work, and next to the teachers themselves, could do most to promote Junior Red Cross work at a time when it was most needed.

ASSISTANCE TO RURAL NURSING.

An important matter brought from the executive to the general meeting was the granting of a scholarship for 1922 to a nurse who would be a graduate outside of the city of Toronto, and who would be willing to take up rural public health nursing for some time, at least. Most of the alumnae associations of Toronto already have provided scholarships. Mrs. Bowman and Miss Edge proposed a resolution and it was left to the executive to appoint a committee to arrange the conditions.

PROVINCIAL REGISTRATION.

The matter of provincial registration of nurses was introduced in a lengthy paper by the convener of the standing committee on this matter, Miss E. MacP. Dickson, superintendent of the Toronto Free Hospital. While the registration

is now in the third reading, there has been no publication made of the regulations that the Ontario Legislature will lay down in the bill, so no discussion took place at the convention of the Graduate Nurses of Ontario.

NURSES' PENSIONS.

As a matter for later serious consideration, Miss Edge, president of Grace Hospital Alumnae of Toronto, spoke strongly in favor of a pension fund for nurses. So many had come under her notice who were too advanced in years or who were afflicted with some disease, to carry on their work. As a kindly suggestion, Miss Jamieson asked the nurses if they were not a little improvident, so many nurses went into rich homes and became a little extravagant. In a train conversation a young farmer had said to her that he paid $25 a week recently to a trained nurse. Miss Jamieson said she refrained from telling him that he only wanted her for a short time, but then he wanted her very badly and at the close of her employment let her go. Nurses were not employed continuously.

"Now that we are a body of women with the vote, let us study carefully what legislation is going through in the Dominion and the Province. Let us stand together in the interests of the association," said Miss Jamieson, closing the meeting.

NURSES' TRAINING AS SPECIALS.

Resolutions arising out of the conference were adopted as follows:

"That hospital superintendents be asked to discontinue the practice of placing student nurses on cases and charging for their services while graduate nurses are available, as this practice is not in the interests of the student nurse, the patient or the profession."

"That the matter of special clinics for private nurses as outlined a year ago at the annual meeting be referred to the provincial duty committee for their consideration."

This provides a "refreshing course" for nurses, no matter when graduated.

The nurses assembled agreed to the idea of erecting a monument on Federal Hill, in Ottawa, as a memorial to the nurses who fell in the Great War. This will cost some $50,000, about half of which amount will be raised by the Ontario nurses. This will mean a levy of about $8 per nurse!

NURSING IN THE NORTH.

Miss Grenville told of some of her experiences on the northern frontier of the province—that great district north of Lake Superior of 3,000 square miles, with Sault Ste. Marie the only city, and the towns largely mining, lumbering or railway centres, and in these the introduction of health ideas was very difficult. The M.O.H., often the only doctor in the district, was an aid. Systematic introduction was necessary. Cases were so extreme that Miss Grenville so often felt herself well repaid.

One woman at Gore Bay came to Miss Grenville very much excited and called her in to see an accident case, where one lad had accidentally shot his brother through his shoulder. The woman was appalled at the sight of blood. The doctor permitted her to do any nursing possible. She had the camp bed reinforced with jute bags, gave the boy a bath, put a sheet on the bed, secured a pillow case; the change was very evident and the members of the family were given a health talk as she worked.

One case of diptheria had been allowed to develop for five days and two other members of the family had contracted the disease, because the parents had not taken any precaution. The family was terribly disturbed, particularly the father.

"It was a task to get the father to see that all responsibility did not lie with the mother," said Miss Grenville. "It is often very difficult to bring the fathers to see that it is not always the mothers' fault when things happen. It was a task to even get the young children to bed. I gave a good deal of advice to the mother and quite a lot to the father, who, I felt, needed it, for the mother's sake.

Miss Grenville described graphically some of her motor experiences, for she drives her own car over the great distances between centres. All discouragements—and there often was a feeling that it was all utterly impossible despite the effort one puts into it, was much repaid by the results. Her whole address was of an optimistic spirit and showed a very kindly interest in her work.

The Brantford folks gave the nurses a welcome reception and very hospitable treatment:—an informal dance by the Rotary and Kiwanis clubs, assisted by the local medical association; the Governors of the city hospital, and the local alumnae society of nurses; the Chamber of Commerce tendered them a motor trip to the Mohawk Institute, to the School for the Blind and to the Golf club, at which last mentioned place they were entertained by the Women's Hospital Aid and the Local Council of Women.

NEW DIRECTORS.

The newly elected directors are: Mrs. A. C. Joseph, of London, Miss J. I. Gunn, of Toronto, Miss E. Gaskell, of Toronto, Miss H. Carruthers, of Toronto, Miss A. Malloch, of London, Miss E. H. Dyke, of Toronto, Miss M. I. Foy, of Toronto. Of these, Mrs. Joseph, Miss Foy and Miss Dyke are re-elected.

There are 21 directors, seven to be elected each year and to hold office for three years. All of the 21 will meet to-night to elect their officers.

NEW OFFICERS.

President, Miss E. J. Jamieson, Toronto; 1st Vice, Mrs. A. C. Joseph, London; 2nd Vice, Miss Jean Gunn; Secretary-Treasurer, Miss B. Ellis, Toronto.

ESSEX COUNTY SANITARIUM.

Ground will be broken immediately for the new Essex County tuberculosis sanitarium. Contracts for the work have been awarded to the Prost, Ford & Westell Construction Com-

pany of Windsor. The hospital, which will replace the old building at Union-on-the-Lake, burned two years ago, will be located on the Huron line near the Prince Road, Sandwich.

FIRST GRADUATION AT PICTON HOSPITAL.

The first graduation exercises in connection with Prince Edward County Hospital were held in the Methodist Church at Picton, on March 20th, Mr. R. Davison, President of the Directors' Board, occupying the chair.

The immense crowd that filled the auditorium of the church demonstrated the enthusiasm of the people of the country toward this worthy institution.

Diplomas were granted to the three graduating nurses—Miss Evelegh, Miss Teavitt and Miss Arthurs—by Rev. Alfred Brown, and addresses were delivered by the medical fraternity, Rev. F. L. Barber, Rev. D. A. V. Brown, and Mayor Newman.

NEW DIRECTOR FOR RED CROSS.

Dr. Fred. W. Routley, of Maple, Ont. was recently appointed Director of the Ontario Division of the Canadian Red Cross Society, and has taken over his duties at the office of the Division, 410 Sherbourne Street, Toronto.

Dr. Routley graduated in Medicine from the University of Toronto in 1907, and has had an extensive general practice at Maple, Ont., for thirteen years. He is a brother of Dr. T. C. Routley, Organizing Secreary of the Ontario Medical Association.

Dr. Fred. Routley has been active in medical circles, having been largely instrumental in organizing York County Medical Society, of which he held the office of President for six years; he has also served on the General Purposes Committee of the Ontario Medical Association. As a Fellow of the Academy of Medicine in Toronto, he has kept in touch with the latest developments in medical science.

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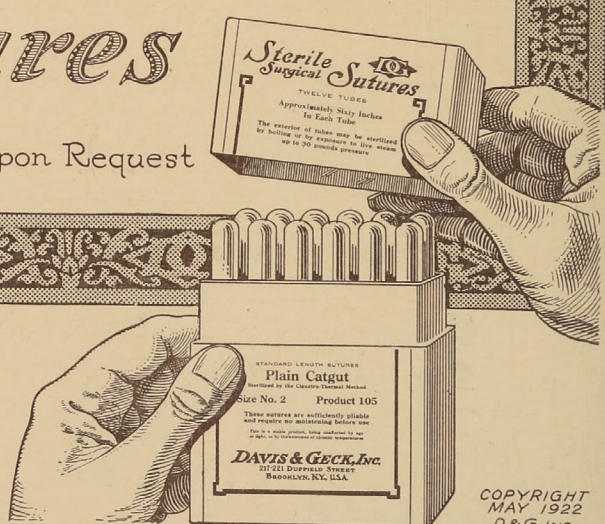

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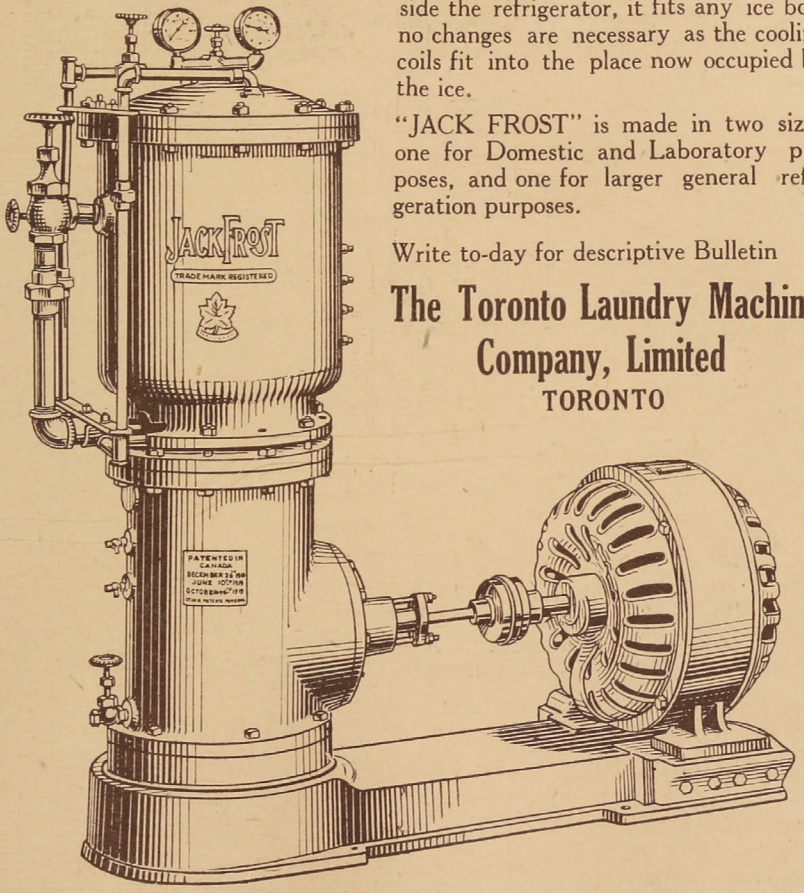

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