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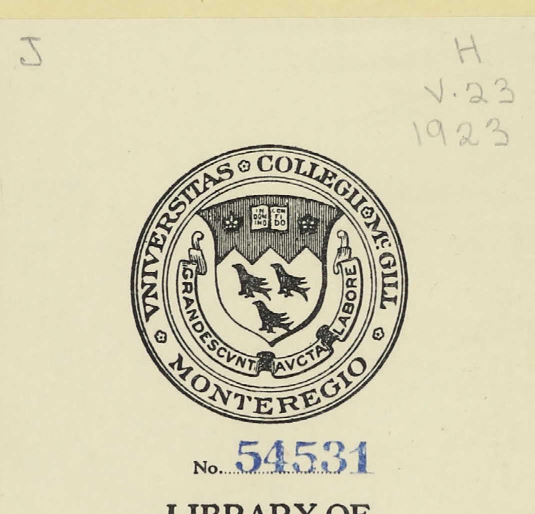

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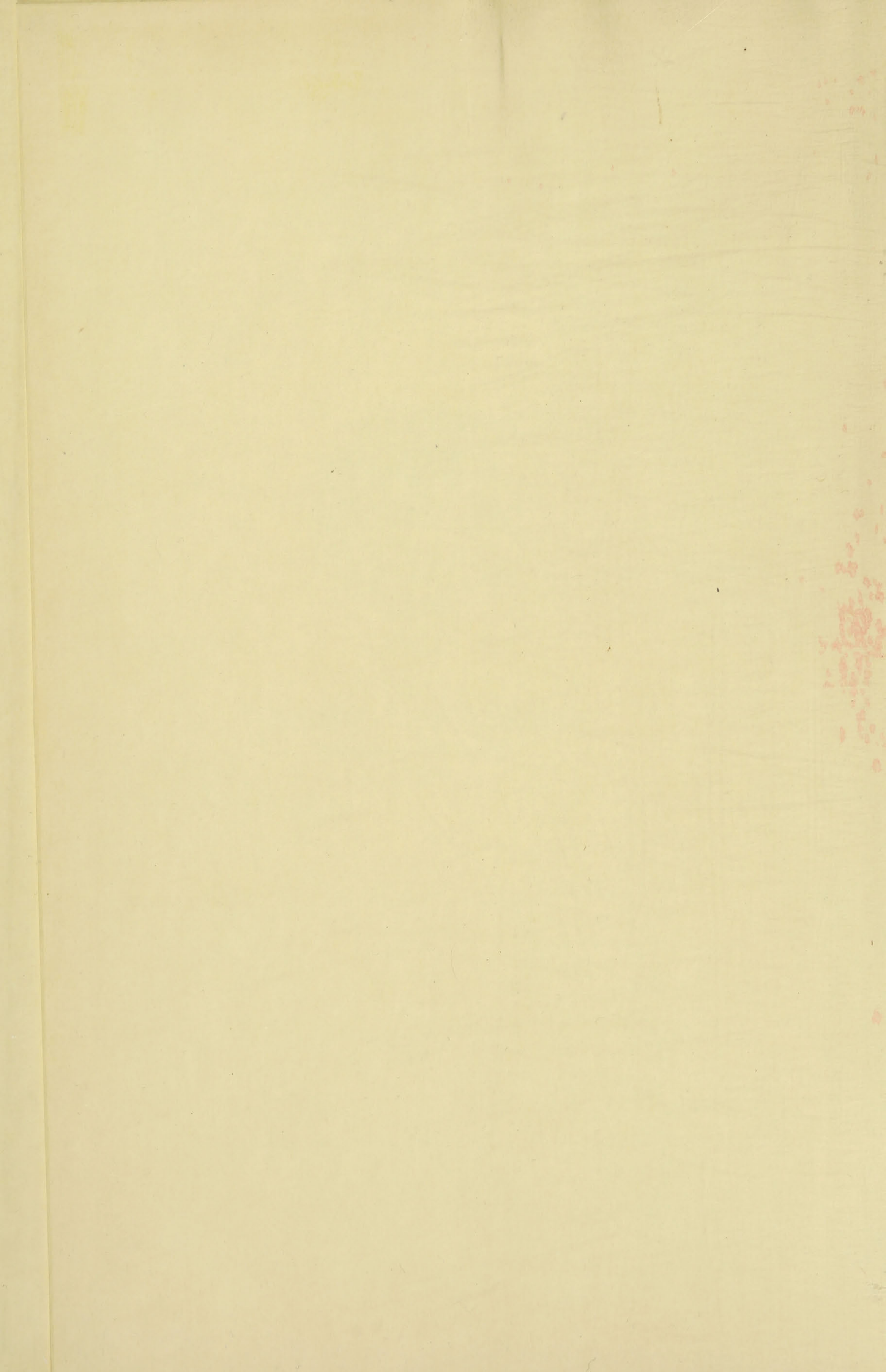

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THE HOSPITAL WORLD

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The Hospital World

TORONTO, CANADA

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

Vol. XXIII TORONTO, JANUARY, 1923 No. 1

Editorial

The Telephone Service

One of the most important posts in any hospital is that of the telephone operator. In the larger institutions, this official needs to be a mine of information. In the largest institutions he (or she) becomes often a mere perfunctory personage, merely switching the enquirer to the particular department from which information is sought. But these departmental phones need to be manned with the same sort of a person as is the main operator of a medium sized hospital, who often has to answer inquiries relative to the condition of patients, whereabouts of attending physicians and, worst of all (often), as to the location of the internes.

These officials need to be as meek as Moses, as wise as Solomon and as patient as Job. It is a nerve-racking business, particularly if they have charge of the outside system, and also of an independent house or inter-communicating system.

54531

Prompt replies to friends inquiring about patients, to attending doctors who wish to find if there is room for a patient, or a spare hour in the operating-room list, or what not, makes greatly for the reputation of any hospital.

These telephone girls (for they say girls excel boys) ought to be well paid and treated with courteous consideration, should not have too long hours and be given plenty of holidays.

Every up-to-date hospital should have, in addition to the ordinary telephone system from the outside, an inter-communicating, independent automatic phone equipment for purely inside work. A signal system for summoning house doctors is also ideal.

Worthy of Imitation

Hospitals do well to often invite members of the profession within their precints to let their visitors see and learn something of what they are doing.

The young surgeons of the Sick Children's Hospital, Toronto, recently were hosts to the surgical section of the Toronto Academy of Medicine and Surgery. Dr. D. E. Robertson presented patients suffering from osteomyelitis and actinomycosis. He wisely called attention to the importance of diagnosing osteomyelitis early. It is too often diagnosed and treated as rheumatism until irreparable injury is done to the bone, or even until amyloid disease has set in. He showed a patient suffering from the latter condition. By noting that the disease begins

at the epiphyseal junction and spreads away from the joint and also the pain, one is justified in exploring the part affected by cutting into the periosteum underneath which the pus burrows, drilling into the bone and evacuating the pus, and draining.

These patients usually show boils or sores in some other part of the body anterior to the osteomyelitis. The bone is injured, causing a lowered resistance and microbic infection is carried to this site from the other focus or foci.

The patient with actinomycosis had received a bruise on the chest from falling against the corner of a step. The wound did not heal, infection spread through the chest wall to the lung and downward over the chest to the abdomen. Iodide of potash had been given the patient in full doses, but the patient was still extremely ill. It was proposed to try salvarsan.

Dr. Bruce Robertson presented two children upon whom he had operated for pyloric stenosis. The symptoms were projectile vomiting, loss of weight, constipation, anuria and the development of a tumor. An incision through the thickened pyloris to the mucous relieved the condition.

He likewise presented a babe upon whom he had performed a subtemporal decompression on both sides of the head for cerebral hæmorrhage due to birth trauma. The wounds had healed kindly, the symptoms had completely subsided, and every hope is entertained that the untoward after effects of

such a lesion will not appear—that the child will be hereafter physically and mentally perfectly fit. Dr. Robertson also reported several cases of extensive burns in which the patients were treated by exsanguination transfusion. These children had developed the toxœmia which generally ensues after extensive burns. Some 1000 cc's of blood were withdrawn and cotemporaneously some 1200 cc's of blood administered from a donor, with a clearing up of the high fever and the nervous and mental symptoms, leaving the patients' burned area to be dealt with *secundum artem.*

Dr. A. B. Le Mesurier demonstrated on a patient the treatment of a fracture of the femur by the use of a Thomas' splint. Assisted by a house surgeon he set the supposed fracture very deftly in some six minutes. Every general practitioner should familiarize himself with this simple and successful method of handling this type of fracture. It is a marked improvement over the use of plaster paris or of the open method by bone plates. If the setting, after a day or so—even up to ten days—is found not to be quite satisfactory an adjustment and correction can be effected in a few moments. Not so with the plaster paris. Dr. Le Mesurier presented, also, a young child with its legs (one of which had a fractured femur) in a frame held at right angles to the trunk with adhesive up to the line of fracture and fastened to the top of the frame, counter ex-

tension by the body easily secured. This method he successfully uses in children under three years of age.

Equally interesting were the cases of patients shown by Dr. R. I. Harris, who were being treated for paralyses resulting from nerve injuries, and those of Dr. W. E. Gallie, who were being treated for fractures of the neck of the femur.

This was an evening *par excellence.* We are only sorry that, instead of some forty visitors—all of whom were delightfully instructed—there were not twenty times that number present.

We would suggest that this team of surgeons be asked to visit our county associations during the coming season and put on their show. It would pay.

Fine Medical Ethics

Apart from the inestimable medical value inherent in the possibilities of the new treatment for diabetes, there are one or two features in connection with its announcement that makes the Toronto profession particularly proud. The modesty of the discoverers, and their generous open attitude, through the Toronto University, toward outside medical research laboratories registers a high ethical standard.

The treatment was begun in January of the present year. When its beneficial results were sufficiently established, full information and formulæ

were forwarded to the Carnegie Foundation, and through it to large American laboratories, which were urged to immediate co-operation in the production of the insulin extract, so that a sufficient quantity might be obtained at the earliest possible moment for the use of the profession at large and the relief of diabetic patients everywhere.

The young and able discoverers who have been conducting their research under the ægis of the Toronto University, have turned over to that body their basic patents, so that when the processes are sufficiently advanced, licenses to produce will be issued, and the extract will be made available to the medical world.

In view of the very different procedure adopted concerning an alleged cancer cure of recent date, it is with the greatest satisfaction that the profession view the high and honorable course followed in this instance.

The young doctors whose research work has resulted in such great possibilities of benefit to humanity are following in the footsteps of Pasteur, Lister and other great scientists of the profession, who wrought, not for themselves, but for the world. Whether this extract proves a complete cure, an arrestment, or a palliative—and at this early date the discoverers confess themselves frankly unable to speak assuredly—at least they have given the fullest information to fellow-workers in the field and urged co-operation in procuring adequate supply.

Dr. Banting with his co-worker Mr. C. H. Best, have made their fellow members of the profession very proud indeed.

Professional Standing Orders

Under the editorship of Horace Korns, M.D., the Lakeside Hospital, Cleveland, has had published its professional standing orders and history forms. In their experience the hospital authorities have found that a system of standing orders does not tend to stereotype methods of treatment. In training house physicians, emphasis is laid by them upon the importance of fitting the system to the patient —not the patient to the system. Two years of experience with unified general orders has clearly demonstrated the superior utility of this method of administering the details of clinical work.

At the request of the secretariat of the American Hospital Association the type for this pamphlet is being held by the *Premier Press* of Cleveland. Any institution desiring copies may have them printed for it at reprint rates, substituting its name for that of the Lakeside.

This plan of presentation, the Lakeside people say, not only eliminates the constant conflict and needless reduplication of orders which inevitably occur when each service maintains for its own exclusive use a complete list of standing orders. It also represents, they maintain, a unity of endeavor among the services; and from the standpoint of in-

ternes and nurses, whose duties bring them into contact equally with all services, the advantages are obvious.

We recommend all hospital executives to write for a copy of this pamphlet. After reading it, we believe they will see the value of having such orders printed for their own use.

Why the Cults Accumulate

The Medical Faculty of the University of Toronto publish occasionally a tiny bulletin with some "bully stuff" in it. One contribution very worthy of the attention of some of our medical brethren is by the clever pen of Jabez H. Elliott, intituled "A Note of Warning." Here are two paragraphs at which the chiropractors, osteopaths, "scientists" and other such cults must chuckle when they peruse:—

"Quite recently there appeared in one of our provincial daily papers a letter from a patient under treatment in an Ontario Sanatorium. He was complaining bitterly that he was now in an advanced stage of tuberculosis with little prospect for arrest of the disease; that if he should be fortunate enough to secure some degree of improvement a long course of treatment would be necessary to fit him for even light work. Yet fully two years previously he had gone hurriedly to a physician's office when suffering from hæmoptysis and had been assured that the bleeding was from his throat. Perhaps a year later

another hæmoptysis occurred which was again passed lightly over by another physician whom he consulted. In each case without an examination of the bared chest, and with only a cursory glance at the pharynx, the "throat" was said to be the cause of the bleeding. He kept on with his usual work and it was only when notably losing weight and strength he again sought advice. By this time he had pronounced physical signs of pulmonary tuberculosis.

"Last year a man with a rather severe hæmorrhage consulted a physician, as he was alarmed at the occurrence. The physician pulled out a chart, showed him the blood vessels in the throat and lungs, explained that the blood came from a small vessel in the throat which had burst, that it amounted to nothing and that he needed more exercise. Six months later he was found on examination to be in an advanced stage of tuberculosis and in a practically hopeless condition."

WANTED

There exists a vacancy on the Canadian staff of detail representatives of the Denver Chemical Mfg. Co., which will be filled January 1st. Applicants for the position should have medical or pharmaceutical training. One who speaks French and has had some experience detailing will be given preference. Salary $2,400.00 per annum with a travelling allowance.

Applications for the position will be received at their New York City office, 20 Grand Street.

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(Incorporating The Journal of Preventive Medicine and Sociology)

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MAUDE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital, Department of Dietetics.

Original Contribution

VALUE OF A DIET KITCHEN TO A HOSPITAL*

MISS H. HUNT.

Mr. Chairman, Ladies and Gentlemen:

This subject has not been chosen because I have anything particularly new to say but because it often helps us if somebody points things out as they see them. Now what is the value of a diet kitchen? Some people look on it is an expensive luxury, others as a necessary evil. The question is the value of a diet kitchen to a hospital. By a diet kitchen I do not mean necessarily a highly equipped room, but rather a room, even a small room, a mere pantry, where special things needed for special cases may be made and that this may be of value to the hospital. That is, the whole hospital organization is teaching the community because a hospital is not merely a building to be supported and of no value to the community except for people to come in and get treated there. Hospitals are of different sizes but it may be divided into two classes, first, the training school. The value of the diet kitchen is three-fold; first, the hospital profits by the diet kitchen in the training school. I am speaking of the more elaborate diet kitchen; it provides a place where the patients' special nourishment can be prepared in addition to the ordinary diets, and it also provides a place where diets such as for diabetes patients may be prepared. Now these diets have to be very carefully prepared, very carefully measured out and sometimes the diet is weighed. In the training school there is usually a trained dietician at the head, somebody who is experienced in these different things. The second advantage or value is the diet kitchen becoming the centre for control of food, for every

*Read at the Conjoint Convention of the Alberta Hospital Association and Alberta Association of Registered Nurses.

department needs some central control, and it can be more efficiently run if there is one person at the head, rather than two or three people, and nobody just looking after things. The third value is as a food laboratory, and just in relation to the remarks that have been made about the value of training nurses, I want you to remember this very important thing: if a nurse does not get her food training, probably she is a very dangerous person to let loose in the community. A nurse in training in dietetics was looking after a diabetic patient. The diet was very uninteresting. This nurse felt sorry for the patient and gave him a piece of bread and butter; trouble immediately, just because she had not realized the importance of dietetics, and that the person on a diet was on a diet and nothing else. Does not the nurse who takes training in the diet kitchen get training in setting trays, making desserts, and all sorts of special things, in quantities for one or many as the case may be? The nurses learn how to make a great part of the food which is served to the third floor, the private patients' food, and they get to learn how to make and serve a small portion, and to do it economically without waste. They also learn how to prepare infants' foods, and that is an important part, because a nurse is liable to be called on at any time. She may not prescribe for it, but the mother may say the doctor prescribed a certain food, and if the nurse is able to translate that immediately that is the value of the diet kitchen. Some nurses take institutional positions, such as head nurse on a ward and their diet kitchen training enables them to supervise the meals their patients get, because she knows by actual preparation of the food, what food the patient should have. Then with the special nurse she may, or may not, have to prepare the food, but can efficiently do so and the matter of serving a meal becomes quite mechanical. She gets things and sets the tray, and leaves the major portion of her time for the care of the patient. Supposing the nurse is asked to prepare some special dish, and she has little or no idea how to go about it. You can naturally see she is going to become unpopular with the person who has to do the work in the kitchen. Then there is the school work, and the Victorian

Order, who come in contact with the community, at large, and she has a wonderful opportunity to show people the value of good food properly prepared, because she gets right into the homes, and in cases of sickness can prepare food and translate the doctors' orders of she has a proper diet kitchen training, so that the ordinary person can understand them.

Then, there is the other class, the hospital that has not a training school. They are of various sizes, the military and so on, and in most cases a trained dietician is in charge. She does not have to train the nurses, but there is a trained dietician in charge of the food, and in these smaller hospitals throughout the country, I would give this suggestion to them, that there be some small room where these special diets, soups and so on, may be prepared, because you probably know how difficult it is to keep on the good side of the cook; and who likes to have another person come into the kitchen and have a little pot here and a little pot there, using the very hottest part of the stove and one's own meal being kept back? So if you have a small room off the main kitchen where she can get in and make the soup or broth, or do the little things that she wishes, and not interfere with the regular meal routine of the hospital, it would be a great benefit. It takes five minutes to make an egg nog. If one person with special diet kitchen training, one person in charge of that department, and that department need not take up a nurse's whole time, because in the smaller hospital if one nurse had a definite place to work in, and a definite time to do it in, rather than each nurse having to spend a portion of her time, she could prepare three egg nogs in five minutes instead of three nurses spending fifteen minutes of the hospital time. If that is followed it means a considerable saving, in as much as several nurses making several little bits of soup, take very much more time. I think if the smaller hospital would have some little place and one person definitely in charge of these special preparations, you would find it would be more efficient and a great saving, not only in the food, because several things can be prepared if necessary for several people at the one time, and there is also the saving in energy required from the nurses chasing back and forth from the patient to the kitchen.

The value of the diet kitchen is a place for the preparation of special nourishment; saves time, energy and food and in the training school gives a place for the nurses to get their training.

THE KITCHEN*

T. J. MacIvor, London, Ont.

The kitchen serving room and dining room of an institution are so interdependent upon each other that if one is deficient it is likely to cause inefficient service. The space where the equipment is to be set up should be constructed to fit the equipment, not the equipment designed to fit the space alloted to it, and before any kitchen is laid out or construction started, have a sketch made showing equipment required for the number of people who have to be taken care of. It makes the work much easier; as often we find doors are in the wrong places, or so small that they will not allow equipment to go through, necessitating a lot of trouble when equipment is being installed. When the kitchen is made before the installation is planned for it, it often means expensive alterations. Another point; always advise that the kitchen should be made on the square; a long narrow kitchen is very hard to lay out to advantage, not only that, but it means delay in service on account of the help having to take so many unnecessary steps and in many cases are in each other's way. A small kitchen is the main trouble for so many dirty places.

The kitchen when being laid out should, unless it is unavoidable, never be placed in the basement. If it is to look presentable or be well ventilated the first floor is preferable, but in some of the hospitals it has worked satisfactorily on other floors for it is as easy to take the food down as it is up and they have the advantage of better lighting and ventilation. The kitchen should be so located that there is good ventilation through the side windows, and to be of ample size, for

*The author of this article is manager of The Kitchen Equipment Department, The McClary Manufacturing Co.

in summer even the well ventilated kitchens are warm and stuffy places for the workers. In hospitals, and hospital wards of institutions the diet kitchens are essential for the preparation of the tray's for the regular dinner, and preparing diets for patients who are not allowed the general meal from the kitchen. They should be large enough to accommodate without crowding, the equipment necessary, such as diet table, gas or electric stove, refrigerator, sink, cupboard room and tray rack, also work table, etc.

Tile for the floor has proven most satisfactory and although more expensive at the beginning it will outlast the others. Concrete floors never look well and are unsanitary. They absorb grease and small particles of food on account of being so porous.

To prevent deterioration of the range it is advisable to put the range on a two inch brick or cement base and finish the edge with a cove tile. Unless this is done the water used for cleaning the floor will run under the range and rust it. Where the floor is of wood it is absolutely necessary to have something between the floor and the range. A mat made of two sheets of galvanized iron with a layer of heavy asbestos between will be found suitable; where possible have a proper foundation built.

The Sectional Cookers, Jacketted Kettles, Potato Peelers, etc., should have a depression of at least two inches in the floor, or else a built-up curb; on a wood floor a heavy galvanized iron pan; whatever kind of construction, always have it properly drained and connected to the sewer through suitable traps. Three things which are frequently overlooked in construction are: Sufficient Serving Room Space, Ample Scullery Space, Proper Bathing Conditions. How often have you seen a wash bowl with a clean towel in the kitchen?

Serving rooms are usually cramped and crowded. Little thought is given to provide ample scullery space; the main kitchen, to look spick and span, should have a separate room for light scullery work. Rough scullery work where possible and convenient should be done in the basement; the noise of machinery is confusing in the kitchen. The items for the basement would be the Ice Crusher, Ice-cream Freezer and Potato Peeler, etc.

Canopies, where possible, are being done away with. They are only grease catchers and are very unsightly in the kitchen as so few ever think of cleaning the canopy. If the kitchen is installed with a good exhaust fan and the ceilings are fairly high, they can be eliminated. If a canopy is installed it is almost necessary to have a heavy exhaust fan in the pipe or else the heat is thrown back on the chef before it can be taken away, unless the draft in the chimney is exceptionally good.

Ranges can be supplied with a down draft connecting to the chimney below the floor. It eliminates the unsightly piping in the kitchen and operates equally as well.

Suitably-arranged and equipped kitchens, serving rooms and dining rooms will promote food conservation and will give more satisfactory service than poorly-arranged and equipped ones.

No kitchen of any size should be without a Vegetable Peeler. One of ample size should be always specified, preferably with a motor, if there is enough work to warrant the extra cost for the motor. It will do better work than the smaller machine as the vegetables have more opportunity to come in contact with the abraders of a large machine than a small one. The Sterling is about the best on the market.

Dishwashing Machines not only wash the dishes in a more sanitary manner than hand washing, but also reduce the cost of dishes through lessening the breakage. The Crescent machine seems to be one of the most satisfactory on the market. It has so many features over the other machines and yet its simplicity is the big talking point. Another one is the size; we mentioned previously that the majority of kitchens were too small and every inch of space there is valuable, so the size or floor space of the machine is a big feature and requires consideration. The double wash is another point and where the Crescent has the advantage over most of the other machines is the direct rinse supply from the boiler; a basket of dishes is rinsed with water that has not been in contact with any dishes before.

Soiled and Clean Dish Tables can be supplied any size or shape according to requirements.

In laying out the equipment related processes should be grouped as much as possible to lessen the labor. The vegetable steamers should not be at one end of the kitchen away from the cook's table, or, if a kitchen machine is part of the equipment, should be relatively close together. Dishwasher should be in a convenient corner of kitchen for the help to pass by and deposit soiled dishes and take out new orders without any extra steps.

Before laying out the kitchen endeavor to secure all particulars necessary as to the style of the meal. The equipment will depend greatly on this style and the number of meals to be prepared. In an industrial kitchen the equipment would be entirely different to equipment for a hotel or hospital, as usually this kitchen would be for only one meal at midday, or if they were working two shifts a lunch would be prepared at midnight. Then where cafeteria is the style of service the kitchen would be differently laid out than for regular dining-room service. It is better to have the different appliances a little larger than necessary, than too small. When they are too small the service is never right and the chef is always in difficulties. Of course, the chef himself has a great deal to do with the equipment as some can use it to so much better advantage than others. Some chefs would be able to operate with two ovens in the range, where others doing the same amount or less would require an extra oven besides extra pieces, such as larger cookers and jacketted kettles.

No definite data has been secured whereby any range can be specified to take care of a certain number of people, as it depends greatly on the rest of the installation what size should be put in. Provision should be left in the kitchen for future extension as we have found that when new pieces are required, suitable space has been almost impossible to procure. The kitchen has been designed for their needs at that time but no thought for any extra requirements. In a hospital, for instance, it might have been found necessary to build on an extra wing and then the kitchen has been found far too small.

Installations sometimes reflect back on the outfitter; he has submitted specifications for the kitchen as he believes it should be but the Board of Directors, Manager or whoever has the authority, has changed it to his own ideas which

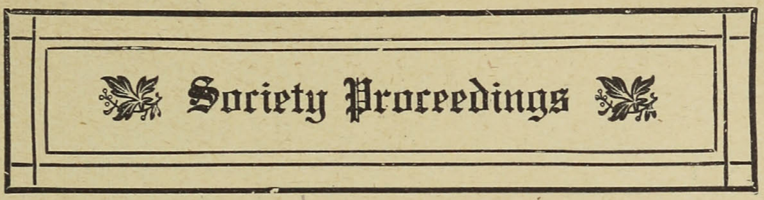
they find out later are not right; but anyone seeing this lay-out might think that the fault was with the outfitter, who was not to blame.

In many cases the specification is supplied and the outfitter is not allowed to deviate from the sizes or number of pieces.

When specifying equipment due consideration should be given to the method of heating the different units. If steam is available every advantage should be taken of it as there is usually a surplus; which will mean economy in the kitchen; not only that, but its operation is more satisfactory. A service table, commonly known as a steam table, gives better satisfaction heated by steam than gas or electricity. Urns are another article that are more satisfactory to heat by steam. Then there are pieces of equipment that cannot be installed, although necessary, if steam is not available; such as sectional cookers, jacketted kettles and roaster. A pressure-reducing valve should always be installed unless it is a low-pressure system. Ten to fifteen pounds of steam is ample for any equipment in a kitchen.

Then a modern kitchen has standard articles, such as sinks, of monel metal or galvanized iron; cook's tables, with wood or steel tops; pot racks, supported from the table or suspended from the ceiling; plate warmers, steam, gas or electrically heated; broilers, charcoal or gas; griddles; ovens for baking; baker's table, with suitable and sanitary drawers and bins; steam tables, with plate warmer below, any complement of fittings on top can be supplied. Steam cookers and jacketted kettles are other articles that are used extensively. Urns with a suitable stand for keeping cups warm, are used in a good many kitchens. Refrigerators of any size, freezers, ice crushers, butcher blocks, trucks, machines for the kitchen, both hand and power, and the miscellaneous small ware.

Not all these pieces are necessary in every kitchen but it is always advisable to have an experienced outfitter co-operate with you when you are planning out your kitchen. Blue-prints with complete specifications could be supplied.



CONJOINT CONVENTION, ALBERTA HOSPITAL ASSOCIATION AND ALBERTA ASSOCIATION OF REGISTERED NURSES

(*Continued from last issue.*)

WEDNESDAY, AUGUST 6th, 1922.

PRESIDENT.—We have represented at the Convention the following institutions and organizations. Lethbridge, the Galt Hospital and we also have Commissioner Freeman representing His Worship, the Mayor of Lethbridge. The General Hospital, Calgary, the Holy Cross Hospital, Drumheller, High River, Royal Alexandra, Edmonton, the Beulah Home, Lamont College of Physicians and Surgeons, the Society for the Prevention of. Tuberculosis, the Alberta Medical Association, and we have a representative of the Alberta Nurses' Association from the Provost Hospital. It is well for us to realize we have a number of hospitals and institutions represented here. I may say that on behalf of the Minister of Health I am personally acquainted with Mr. Reid. He is a man whose sympathy in health matters is not excelled by any person in this Province. He is in sympathy with everything pertaining to the health movement and particularly I know he is interested in anything pertaining to the welfare of the hospitals of the Province. He is in sympathy, I am quite satisfied, with the movement of the Hospital Association, that has to do with hospital accommodation. I say this because following our discussion yesterday there was some discusion and talking that might lead us to offer some criticism which might be unfair, and I think as far as Mr. Reid is concerned he is not one of

that body. If you know him personally you will find him one of the most careful, sympathetic men you may meet. I say that in order that we will have a kind feeling which we should have toward the head of a Government.

If you will allow me to make my position as delegate clear, I would like to do so, as my position as delegate was also called in question. I may say I am here as a doctor, but apart from that I am a member of the governing body of the Holy Cross Hospital, and have been a duly appointed delegate by the Holy Cross. I am also a delegate of the Society for the Prevention of Tuberculosis, and am also here as President of the College of Surgeons of the Province, and in the fourth place I am here as your duly elected President, elected at your regular Convention last year, so I doubt if any delegate here can claim any better right of being here than I have myself.

It has been suggested that we could have the programme altered a little and go ahead with the consideration of those resolutions. Does that meet with the approval of the meeting?

Moved by Mr. Stickney, seconded by Mr. Williams, that the programme be altered as suggested by the President. *Carried.*

Resolutions from the Resolution Committee read by Mr. Dutton.

No. 1.—Resolved that a committee be appointed to be known as "The Special Committee on Legislation." This Committee to consist of: Dr. Smith, Edmonton; Dr. Archer, Lamont; Mr. Williams, Drumheller; Mayor Hardie, Lethbridge; H. B. Stickney, Drumheller, and with power to add to their number.

Moved by Dr. Lafferty, seconded by Dr. M. E. Hall. *Carried.*

No. 2.—Resolved that "The Special Committee on Legislation" appeal strongly to the Workmen's Compensation Board to revise their schedule of hospital fees so as to make the minimum fees conform to the actual average cost per patient per day of operating the hospitals of the Province for the year 1921.

Dr. Smith.—I would like to move the adoption, striking out "for the year 1921."

Seconded by Mr. Freeman.

No. 3.—Resolved that "The Special Committee on Legislation" appeal to the Provincial Government to enact such legislation as may be necessary to allow municipalities to keep in suitable homes within their own territory aged and incurable persons, and that the Provincial Government make the usual Government grant for such cases as is allowed for the hospitals. This to be a temporary measure until such time as the Government or the municipalities can make more satisfactory and permanent provision.

Mr. Freeman.—I wonder if that is quite clear. I understand there are certain homes for old people for which there is a certain grant. In order to put these people into a regular hospital you have to have a doctor's certificate that they are put there for senility care or actual sickness. It is a question whether a doctor could give a certificate for them to be put in a hospital. Now to send these people to these homes requires the spending of money out of your own town to support these people in other places. It was estimated they could be taken care of in a suitable home rather than a hospital, and the idea I had in my mind was we would get the same grant as is given to other homes for these people. The resolution calls for the same grant that they give to the hospitals for this purpose. Now do they give a grant for this purpose to the hopitals? You have got to get them into the hospital by certificate that they are there for some reason, possibly only senile decay.

President.—I understand fifty cents a day is the grant for an aged incurable person sent to McLeod.

Dr. Laidlaw.—The ordinary hospital grant is fifty cents. If they come from a municipality the balance is paid by the municipality, and if not, it is paid by the Government. You are asking the Provincial Government to give a larger grant towards the keeping of aged people than any other province. The Province of Ontario makes a special grant to the hospitals of that description paying 20 cents a day.

Chairman.—Are the Government not allowing fifty cents a day to the McLeod Hospital?

Dr. Laidlaw.—Yes, that is the case.

CHAIRMAN.—The idea was, we could take care of these people at home, and ask for the same grant.

DR. LAIDLAW.—It was considered necessary to keep that hospital open. The only way that it could be kept open was to send incurables there and pay so much. Otherwise from the looks of things in that district, that hospital would have to be closed.

DR. SMITH.—What is actually happening now is in a great many cases, they are being kept in the regular hospitals and the Government is paying 50 cents a day for these cases who go to the hospital, and they are a great expense to the municipality.

DR. LAFFERTY.—I think this Association should go on record as to how they should be looked after, and should make recommendations as to whether the patient should be a charge against the municipality, or against the Province as a whole.

MR. FREEMAN.—The idea is to take care of these patients in the most economical way. It is not difficult to find somebody who is willing to open up a home and take care of them at a minimum cost. Furthermore they can be near their own people. All we ask is that the grant the Government is now giving, that they give the grant to these people being taken care of in any other way. If you build a home for these people there is the capital expenditure and all that; and there are homes now that will take care of them and all these people need is some place to sleep and eat, and to be properly taken care of and there are lots of good people willing to take them in as sort of boarders.

PRESIDENT.—What do you wish to do with the resolution?

Moved by Mr. Freeman, that the resolution be amended by adding the words, "now receiving such grants" after the word "hospitals." Seconded by Dr. Lafferty. *Carried.*

No. 4. Moved by Mr. Stickney, that the resolution be taken clause by clause:—

"WHEREAS, under the present Act known as "The Hospitals Ordinance," the hospitals of the Province of Alberta are under a serious financial burden owing to the fact that they frequently find it impossible, by any reasonable means, to

collect accounts for services rendered to patients from other municipalities, many of whom are ratepayers of those municipalities, and

WHEREAS, it is obviously unfair, that municipalities which are already providing hospital accommodation for the care of their own sick, should have to carry the burden of the care of the sick of other municipalities, and

WHEREAS, certain rural municipalities have a much larger percentage of residents who are not ratepayers, than have others, and

WHEREAS, the municipalities are in a position, by reason of their own present legislation, to make collection of any such accounts from patients who may be ratepayers of their own municipalities.

THEREFORE BE IT RESOLVED:

1. That "The Special Committee on Legislation" respectfully request the Provincial Government to alter the existing legislation that,

(a) Any hospital, after having exhausted all reasonable means of collection of their accounts from the ratepayers and their dependents from any other municipality, may collect such accounts from the municipality in which the patient is a ratepayer.

Mr. Freeman.—Is that too ambiguous? What do we mean by "reasonable means?" To the extent of suit? Who is going to decide as to what is reasonable means?

Mr. Williams.—I should think the Department of Public Health, should do that.

President.—You are dealing with principles now. You cannot expect to frame the Act for the Government but you give them the principle which you hold and if they consider favorably the principles they can have the act amended.

Dr. Hall.—The idea is for indigents up to $200 but for ratepayers the whole.

Mr. Stickney.—"From any other municipality" that also is ambiguous. There should be a definition to show that the hospital district takes in many municipalities. "Com-

ing from municipalities in any hospital district, that they collect such accounts from the municipality in which the patient is a ratepayer."

MR. WILLIAMS.—Why discriminate against the municipality? Why not say account collected from the ratepayers within a hospital district? I think all ratepayers, whether coming from our municipality or some distance, should be on the same basis.

PRESIDENT.—They are now, according to the Act, can they not collect from their own ratepayers?

MR. WILLIAMS.—The act has reference to indigent patients.

Clause (b). That any hospital, after having exhausted all reasonable means of collection of accounts from patients who are not ratepayers in any municipality, shall be reimbursed by The Provincial Government, for the amount of such accounts at a stated specified rate per diem.

PRESIDENT.—This is, the Government would undertake to reimburse the hospital for those not tax payers, and to reimburse their own treasury, the suggestion is made that they secure their funds by taxation.

Clause 2. That this Association respectfully suggest to the Provincial Government that a Health Tax be levied upon such adults within the Province, who are not now contributing by other taxation.

AND FURTHER:

Clause 3. That this Association would be in favor of the Provincial Government appointing an official to give careful oversight and inspection of all such cases whose accounts are chargeable to municipalities or to the Government in accordance with the provisions of this resolution, with a view to

eliminating from the wards of the hospitals any cases that are not actually in need of hospital care.

Moved by Mr. Freeman, seconded by Dr. Lafferty, that Clause 1(a) be adopted. *Carried.*

Clause (b) "That any hospital after having exhausted all reasonable means. . . ."

Dr. Laidlaw.—The question of the appropriations is one that is rather unsettled. There has never been any agreement or understanding as to what the 50 cents a day is given for. In British Columbia the Government grant is on a sliding scale of 45 cents to $1.50. The city of Vancouver gets 45 cents a day per patient, and in their hospital they take care of all the transients, also the patients from unorganized districts. They accept the Government grant and that is their understanding. In the Province of Saskatchewan the Government grant is supposed to be for the care of all transients, all those not domiciled in the Province. I am strongly in accord with the movement to get this thing settled, and settled in a way fair to the hospital. The larger the hospital the more incurables it gets and the municipalities, I regret to say, are very loath to accept any responsibility and I have been urging the Government to take some action against the municipalities, to bring stated cases and force legal decision as to the responsibility of the municipalities for their patients. It is rather difficult to get the Government to do that, but of course they are only human, and they get more support from the municipalities than they do from the hospitals. Moved by Dr. Smith, seconded by Mr. Cousins, that clause (b) be adopted. *Carried.*

Clause 2. "That this association respectfully suggests. . . . ." Moved by Mr. Stickney, seconded by Mr. Williams. *Carried.*

Clause 3. "That this association would be in favor. . ." Moved by Mr. Cousins, seconded by Dr. Smith. *Carried.*

Moved by Mr. W. T. Henry, seconded by Mr. Stickney, that the Resolution as a whole be adopted. *Carried.*

ROUND TABLE CONFERENCE.

CHAIRMAN: MR. WILLIAM DRUMHELLER.

MR. WILLIAMS.—I do not think there is any municipal hospital in the country who would think that they are absolutely supreme, and could not learn anything from the city hospital. Surely because we live in the country we are not going to be so small that we think we know it all, and I sincerely trust that any idea in regard to that may be dropped. The idea is to discuss matters of interest to the country and municipal hospitals, and if the members of the city hospitals will help us we will be grateful to them.

In regard to the membership at large I think this organization should be far better attended than it is. Dr. Hall has done everything he could do, and I think Dr. Hall and the present executive are entitled to a great deal of credit.

In regard to the municipal hospital, there are a few points I would like to mention, and which I might develop in the discussion later on. My idea is that there should be a taxation zone, with the hospital as the centre. I think that people living ten miles from the hospital, provided the right accomodation is given, should be charged at a higher rate than people living twenty miles away. The question of Poll Tax has already been dealt with by the Resolutions Committee, and the Convention at large. Then there is the question of enabling the municipal hospital to finance on a surer and safer basis. At the present time we levy taxes in exactly the same manner as the town and city. We cannot demand from the municipality a certain amount of money, on a certain date. The school districts are in far better shape than we are. If the municipality levying the tax consider that they cannot raise that money by that time they are allowed to make allowance for non-collection of taxes. The municipality is also given power to finance for the school. At the present time the Provincial Government have assisted us materially through the issue of debentures against the outstanding taxes to the extent of 50%. This is a great assistance for the present but I am afraid, much afraid, it is going to lead us into serious difficulty, as we are not in a position to create a proper

sinking fund, and the first thing we know the municipal hospital board will be collecting a lot of money, and spending for current account, whereas it should be going into a sinking fund. In other words, you are going to spend your assets and let your liabilities go. The question of a Government grant has been dealt with, and in regard to the Government grant it was suggested that a poll tax be levied to assist the Government in assisting the municipality. This Poll Tax could be collected through the municipality and returned by the municipality to the Government, and then it could be given out to the hospital giving special indigent care. In that way the country people would be relieved, and the people made to pay, themselves, and the hospital would not be in constant fear. We compel people to pay $4.00 a year for education, why not make them make a small payment for the protection of their health.

Dr. Hall.—As I understand it, you would have the employers—that is, each man would carry a card which would show he had paid the health tax, wherever he went, so he would not have to pay the second time.

Mr. Cousins.—Who collects the tax?

Mr. Williams.—The municipality, in the case of an organized; and in the case of the unorganized, the Department of Municipal Affairs in the Government, and they remit to each treasurer.

Delegate.—How about the finances when the taxes are not coming across?

Mr. Williams.—In our district we had a large number of unpaid taxes. We have received on several occasions assistance from the Department of Public Health, and advice on any matters in which they can help us. Last year we found the situation as Dr. Stanley states. Suppose there was $25,-000; in making the estimate, we figure that amount is going to be collected. We suggested to the Provincial Government that they impose some system of taxation, that the municipality would be compelled to pay us whether they collected or not. The Department thought that was rather drastic but helped us to this extent, that they allowed us to borrow by way of debenture the sum of 50% of the amount outstanding, as

at December 31st last year. The only difficulty I can see is that there is no way of creating a proper sinking fund to take care of the money, and a case might arise where a municipal board would spend that money, and would have no provision to meet their payments, which of course would amount to a considerable sum when you figure the interest.

Mr. Henry.—Is your assessment made on the basis of expenditure.

Mr. Williams.—We are limited to $3.50 an acre, and 3 mills on the dollar in urban municipalities. In our municipality we have the town of Drumheller, three other villages and several hamlets. We make an estimate, and figure the same as a municipal council. I follow the same principle as in the case of a municipal council, and so far it seems to work out well.

Mr. Henry.—If you only secure 50% of the unpaid taxes and the estimate is based on the whole expenditure, what do you do with the balance.

Mr. Williams.—It gets down to the fact that we cannot estimate exactly. We estimate our expenditure on a liberal scale and I think it is the only safe way to do.

Dr. Stanley.—Would valuation on the basis of assessments not be fair.

Mr. Williams.—No, the hospital is not always located in the centre of the district. These municipal assessments are made according to the distance or proximity to their own little towns. In the case of Drumheller property, good land is assessed at a higher figure than land closer to the hospital district, but not so close to the railway centre. The value of assessment in my opinion should not be in regard to the market town, but in accordance to the proximity of the hospital. At the present time these taxes are levied by us on an acreage basis but collected by the municipality on an assessment basis.

Mr. Cousins.—There would be a lot of land only good for pasture.

Dr. Stanley.—Is it not a fact in most of these rural districts, that it is the outlying patients that use the hospital a great deal more. You take a hospital located in an old established town, in one of our rural towns, where they have

homes fairly well equipped, is it not a fact that the people use the home and keep the patients there, and the people in the outlying districts and pioneer homes are the ones who do use the hospitals?

Mr. Williams.—Yes, and there is the question of medical attention. If a man is away out on the edge of a district the doctor cannot go all over and look after the people at home, but at the same time these people are not in such large numbers as they are in close proximity to the hospital. The hospitals have been built in the closely settled districts.

Dr. Stanley.—What do you do with contagious cases?

Mr. Williams.—We have prepared a small isolation hospital.

Q.—On what basis is the charge?

A.—Just the same.

Dr. Laidlaw.—What is your policy with regard to cases that cannot be treated in the hospital?

Mr. Williams.—We generally refer them to the Department of Public Health for special advice. In the event of a case requiring special hospital attention and specialized care it seems reasonable enough that the patient should go on their own responsibility to where they are better equipped.

Dr. Laidlaw.—Supposing that patient had to go to Calgary. Do you pay the difference?

Mr. Williams.—No, we pay nothing at all.

Dr. Laidlaw.—Where they go to the city should they pay the difference?

Mr. Williams.—I think the municipal Hospital District establish their own welfare, and I think the responsibility absolutely rests with them as to the type of hospital they erect. I do not think if they put up a small hospital, that the hospital should provide special service.

Dr. Stanley.—Should they not pay that $1.00 per day? A patient goes to the Holy Cross, taken from your hospital because there are not the facilities there. If he stayed there he would have that for $1.00 a day. Do you not provide for or make any appropriation for these cases in any shape or form?

MR. WILLIAMS.—No we do not. I do not think we are morally or legally compelled to do so. Speaking generally I think the Municipal Hospital District establishes itself. The ratepayers know what they are doing and what hospital treatment they will get. We can hardly expect them to pay special rates. It could be carried so far.

DELEGATE.—If he has a right to that $1.00 a day he does not cease to be one of your members and if he has to go to another hospital for treatment, should he not have a right to that $1 a day?

MR. WILLIAMS.—I think to the extent that that hospital can give him.

DR. LAIDLAW.—This Association recommended the principle, to the Government, of the municipalities paying for their patients coming in to the hospital. Would you agree to your municipality paying for the patients going to the other hospitals?

MR. WILLIAM.—Not unless we could not look after them ourselves.

MR. COUSINS.—According to the resolution made the patient would be a charge against your district.

MR. WILLIAMS.—In the municipal hospital.

DR. STANLEY.—There is still an obligation. Supposing your place is crowded. The patient is not able to secure accommodation and has to go to some other hospital and he has to pay excess charges by reason of the fact that your hospital cannot provide accommodation. Perhaps your accommodation is taken up by outside patients up to 50% and yet why should the ratepayer when he cannot make sure of the hospital have to go somewhere else and pay a higher fee?

MR. WILLIAMS.—Absolutely. I consider we are under contract with every ratepayer to give them treatment according to the established hospital. If the hospital could not take care of any ratepayer and had to send him to another institution, I certainly think that hospital is financially responsible.

MR. COUSINS.—In the event of having many cases of that kind you would not have money enough to pay.

MR. WILLIAMS.—We would ask for a larger hospital.

Delegate.—If the patient goes to the city hospital the charge is against the municipal hospital, who gets the money from the ratepayer, and the municipality is responsible. Somebody is getting the money and the fellow who has got to pay it does not get it. According to the resolution we asked that the municipality be responsible for patients coming from that municipality to the hospital and have suggested a Poll Tax. The hospital collects this Poll Tax and figures they can be taken care of by the hospital there, but the municipality has got to pay the bill if the man goes outside that district. The Municipality has not collected any extra money; the hospital has, through the Poll Tax, for the purpose of maintaining this expense that we are talking about. The municipality has not got that money, and they are responsible for them.

Mr. Wiliams.—If the Poll Tax comes in, the responsibility will be taken by the municipal district for the indigent patients.

Mr. Cousins.—It would not be taken by the municipality because the municipality would be compelled to pay the bill, but if by making the hospital people pay the bill, you would have legal redress against the municipality but not against the hospital.

Mr Williams.—I think in the case of overcrowding or being unable to fulfil your contract, then the hospital Board should undertake payment of the account.

Mr. Stickney.—These gentlemen seem to be under the impression that the Health Tax would go direct to the hospital. The idea is to have the Health Tax paid into a special fund and then distributed pro rata to the different hospitals according to the number of indigent patients, so that relieves the municipality of all responsibility in caring for indigent patients.

Delegate.—It seems to me the question of responsibility is the broader one as to whether the hospital guarantees anything. They establish a hospital and vote on the size.

Mr. Williams.—Naturally, according to the hospital scheme, it is voted on by the ratepayers and it is practically

their charter. They have an estimate of maintenance and size and they vote on it. Any hospital accommodation required further than that cannot be met.

Dr. Hall.—There is no guarantee to the citizen that they will receive any further accommodation than they can take care of and why should they pay.

Mr. Williams.—In the case of ratepayers you undertake to give accommodation at a certain rate.

Dr. Hall.—Only up to the extent passed by your by-law.

Mr. Stickney.—It is not a thing that would occur very often. If it were a regular occurrence we would immediately put up the proposition of enlarging, but if it occurs occasionally, particularly during certain seasons, it is merely an obligation upon the ratepayer.

Dr. Hall.—Can you enlarge your hospital without a further vote? Supposing you have 100 and only have room for 75? What is your Board going to do, do they have a re-vote for the extra 25 beds?

Mr. Williams.—You have to take into consideration the probable number of sick people which figure in the first scheme. If you take in too much hospital district the same thing would happen. You cannot send a boy on a man's errand. I think any hospital in a municipal hospital district should be compelled to take care of its own contract patients?

Dr. Hall.—What do you mean by contract patients?

Mr. Williams.—We have a number of special contract people. Anybody can pay $10 a year and be entitled to the same advantages as a ratepayer. If they come to the hospital we charge a dollar a day and in addition we have a number of miners, twelve or fifteen hundred, who pay a proportion in to us every month. We are compelled under contract to take care of them and they assist us to finance very materially.

Dr. Hall.—Is that a legal contract?

Mr. Williams.—Yes, a mine contract has been approved by the Workmen's Compensation Board. It is absolutely under contract.

Dr. Hall.—The contract with the ratepayer is the first call.

Mr. Williams.—We have to be careful not to take on more than we can take care of. If we took on 2,000 and could only take care of 1,000, we would be in serious trouble.

Mr. Cousins.—The Medicine Hat Hospital was established entirely through subscriptions, and at that time we had an arrangement whereby anyone on becoming a member of the Hospital Association was entitled to free hospital service for a certain length of time. That would be much the same way as making arrangements with your miners.

(*To be completed in next issue.*)

ANNUAL CONVENTION OF THE PROTESTANT HOSPITAL ASSOCIATION

Atlantic City, Sept. 23, 24, 25, 1922.

Great events were staged for the hospital workers in Atlantic City during the meeting of the Protestant Hospital Association.

The General Secretary wrote: "We feel that in coming together in this city we have come to the right place to take the 'tired' out of our bones, the 'dull' out of our brains, and the 'sag' out of our souls. And if there is anything else we need to get out of our systems we can drown it in the briny deep. Here, along the Board Walk and in Convention rooms and halls, interest will be at boiling point every minute.

Our chief interest gathers around a greater efficiency and potency of Christian work in our hospitals. We are interested in all other hospitals, of course, but are assigned to a task which none other can assume for us.

The correspondence with my office the past year reveals the faith of good men and women in developing the work to which we have addressed ourselves. They believe that the influence of a Christian hospital is a fountain of good, from which a perennial stream of healing flows. They maintain that our purpose should be to develop the scientific training

of nurses, strong Christian characters for leadership, beneficent principles for action, and efficient hospital service for every patient.

The Protestant Hospital Association is functioning to this great end. Already a number have written that they have been specially helped by our publicity and efforts.

For Example: Our Educational Programme. The General Secretary has endeavored to reach all Protestantism through articles sent to the leading church papers of all communions. There are 112 church papers on my list, and most of their editors have printed these articles, while a few have placed them in that little drawer where they keep things too sacred for the human eye.

Our Association has made the first direct attempt to interest the 171,000 ordained protestant ministers and 26,000 lay preachers of America, as a whole body, in hospital care of the sick. If it be charged that they ought to be interested anyway, the answer is, they cannot be interested until the facts are placed before them. The Scripture reads, "How can they hear without a preacher, and how can they preach except they be sent." The Christian press is a powerful preacher. Clergymen do not read hospital journals to any extent. Very little hospital news ever reaches church papers, hence there has been a lack of information to the clergy and laity. The Protestant Hospital Association is now endeavoring to supply the need and demand for such information. We can do this best through the church press.

To show their appreciation some of the largest church papers have asked us for our articles; the one having the largest circulation in the middle-west has recently requested us to write a fifteen hundred word hospital article; others are writing us for stories illustrating the character of work done.

The educational programme is inclusive. We are trying to educate the public to use the hospital. When we remember that more than fifty million live outside the large centres; that fifty-six per cent. of the counties in the U.S. have no hospital provision—though Canada is better supplied with hospital and dispensary care in the larger provinces—and fully

three millions are sick and in bed daily; that twenty-eight per cent. of the sick, or 840,000, should have hospital care, with only a probable bed capacity at present of 460,000; that we have 400,000 crippled and deformed children; we are brought face to face with conditions requiring methods for healing and human reconstruction never yet employed.

We are therefore charged with the responsibility to awaken and create a Christian conscience for the healing of the sick. The people must be told what our hospitals are doing and what they are prepared to do for the sick; and special interest must be taken to provide healing for the poor and otherwise neglected.

One special purpose of our educational programme is to reach the sick and afflicted poor, living in remote places. Thousands who are sick or crippled do not know there is a possibility of being cured or improved. We want our 197,000 clergymen and ministers thoroughly informed of our hospital provision for the unfortunate; we want to co-operate with them in the commission "To heal the sick"; we are endeavoring to create a larger sympathy for God's afflicted children, and have included this as a definite part of our programme.

The Needs of the Hospital. Our educational programme includes the giving to the people a better understanding of the needs of the hospital. Through our publicity we have endeavored to promote the Kingdom of Heaven through local Christian hospital service. We find that as the community realizes its hospital is serving their sick and needy in a wholesome manner, the people are cheerfully giving of their substance to maintain it. We are trying to show them that our hospitals are actually giving this service; that our hospitals have needs; that unless the people respond to such needs the work of healing must be limited; and we are necessarily depending upon the public, the entire public, without regard to the particular religious preference, to help the local hospital.

There is no sectarian way of administering mercy. We are urging all churches and Christians to unite in each field in the hospital ministry of healing.

The Education and Training of Nurses has received special attention. We have sent a call for student nurses covering all America. We confidently expect all of the more than 7,000 hospitals of our country to share the benefit of this nation-wide effort to secure the required candidates for nursing.

But we are very anxious about the educational preparation and moral training of our nurse pupils. We are calling for the best girls to give their lives to this, the noblest of professions. Our Association is concerned about the moral and spiritual surroundings of these girls while in school. It cannot be denied that in many hospitals and nurses' schools the standards for deportment are not as high as they should be. All cigarette smoking, profanity, coarseness and irreverence should be stamped out. The Protestant Hospital Association has no higher mission than to inculcate the highest standards of Christian morals in its own and in all other hospitals.

Through our publicity and other methods of working we are emphasizing the spiritual needs of nurses while in training and after their training. Furthermore we are stressing the importance of a true missionary spirit versus a mercenary spirit.

We believe also that every hospital should render a spiritual ministry to its patients. It is a part of our programme to reach out into every state, county, municipal, and private hospital and training school, and extend the Church's spiritual ministry to all patients, nurses, internes and all connected therewith.

This is a stupendous task but we believe the Christian churches will stand with us and that by their aid we shall be equal to the task.

A World Programme. It may be a little too early to announce that we are looking to a world programme. Surely Christian America has responsibilities to the whole world. We need to train doctors and nurses with the spirit of sacrifice for our foreign hospitals, and we should not expect to escape the responsibility of doing our share to provide healing for the afflicted throughout the world.

Our Survey has discovered much Unoccupied Territory. We hope that the responsibility for these needy fields will be divided so that each church organization shall do its full share in making ample provision for the care of all sick. The call is loud for a close affiliation and co-operation of all denominational hospitals as well as the Christian workers in all hospitals.

There remains much to be done in the rural districts. They have never been adequately provided with medical healing and hospital facilities. We believe that all the churches within the horizon of a practicable working area should unite in establishing and maintaining an efficient hospital service. Here are great possibilities for the members of our Association.

Our hospitals and Christian management should not lose the opportunity, for they will suffer if they are left behind in the forward movement for hospital development.

It is the purpose of the Protestant Hospital Association to create a common bond and to quicken an interest among ourselves. Our united effort is a testimony of our faith. My office has made its strongest efforts to bring about these conditions the past year.

Our Association has accomplished much in the two years of its life. The first year we had one hundred members. We close the second year with a paid membership of one hundred and seventy. The past year I have sent out from my office 5,135 letters. We printed 4,000 copies of our Constitution and by-laws, also 4,000 copies of a pamphlet explaining the purpose and functions of this organization. Our personnel department is rendering constant service to institutions and executives in placing each in direct communication with the other. Our officers and trustees have served as advisers to many. In several instances weak institutions have been strengthened. Facts have been provided hospitals to aid them in their financial campaigns. In every possible manner we have sought to be co-operative with all other organizations. Our official relations with other hospital associations have been pleasant, and their official attitude toward us has been cordial.

In every respect we have sought to make our hospitals more efficient and their service more effective. We fully realize that we have problems all our own. The purpose of this convention is to discover our own needs and more perfectly to provide the remedy.

A careful study of our Constitution and Declarations makes it clear that we are operating in our own field, and in obedience to the Divine command to "heal the sick." Therefore, any subject connected with the work of these institutions is within our own province and entirely wholesome. We invite the co-operation of every protestant Christian worker and executive in any hospital, and particularly those connected with our church hospitals.

I want to thank those of you who have helped me place the facts before the people. We want every one enlisted in this work so that all the people may know the facts. We want them to know that we are promoting well organized and efficient hospitals; that we are endeavoring to conduct these under Christian management; that we will treat the unfortunate and sick to the extent of our limitations; that where our limitations end we invite them to assist and enlarge our facilities; that we look to a friendly public to provide the means of support so that none may be neglected; and that we purpose the finest Christian relations with all other bodies.

Assuring you of my confidence in our great undertaking, and the true mission we have outlined, I assert my purpose to do all within my power to promote the cause we have pledged ourselves to support.

FORMALLY OPEN NURSES' HOME IN HAMILTON

Under auspicious circumstances, the new Nurses' Home of the General Hospital was formally opened on October 18th, in the presence of many citizens. The building is the last word in modern construction, and nothing but praise was accorded the Board of Hospital Governors for their foresight in erecting such a fine home.

T. H. Pratt, who presided, as Chairman of the Hospital Board, said that criticism had been raised at what was felt to

be the high cost of the building. He recalled the opposition that was experienced by the Board before it succeeded in having the plans approved so that each nurse would have a room to herself. Those who passed through the home would be impressed, he believed, that the Board was not astray in insisting that the single room idea be carried out.

Col. Gartshore, Chairman of the London Board of Hospital Governors said the home was a revelation to him. London would soon commence construction of a new nurses' home for the General Hospital there, and he ventured the opinion that the Hamilton home would be copied from basement to roof. It was the finest nurses' residence he had ever seen, he said. Others who spoke were: Sir John M. Gibson, Dr. Douglas McIlwraith, Mayor Coppley and Dr. Walter Langrill, Medical Superintendent. The home has 109 single rooms and four double rooms. It also has a fine swimming pool, the halls are wide, and there are many cheerful living and recreation rooms.

THE DEFICITS OF TORONTO HOSPITALS

The hospitals of Toronto have been applying annually at the city hall for grants of money which will enable them to meet their deficits. Such grants are in addition to the per diem allowances from city and province—allowances which fall short of meeting the cost of maintaining public patients. The city auditor has now performed a valuable service in outlining a new set of bookkeeping conditions to which he considers the hospitals should conform in calculating the deficits the city is asked to meet. The effect would be to reduce the amount which the city is annually required to pay.

Mr. Scott would achieve this end in two ways: first, by limiting the type of deficit to which city hospital grants would be applicable; second, by applying to the reduction of these deficits certain subscriptions and bequests which are now set aside as an endowment.

Allowance for depreciation is the largest item which Mr. Scott would eliminate from the calculation of hospital deficits.

He would permit a replacement fund, being the amount expended to take care of repairs and current wear and tear in hospital equipment. But that is quite different from a fund, wherewith to replace hospital buildings and equipment when they become obsolescent or otherwise unfit for use many years from now. Mr. Scott says:

"If the city is willing to adopt the policy of meeting this charge for depreciation, the funds so handed over must be set to one side, and accumulated and used only for the construction of new buildings and equipment after those now in use have served their purpose."

If depreciation charges are to be included in the hospital deficits which the city is annually required to meet, the suggestion made by the auditor is a quite proper one. But it is not clear that the city should permit these charges at all. It is not clear that this generation of taxpayers should accumulate a fund to provide new hospital buildings at some future date. When these are needed, the taxpayers of that day may well be asked to contribute towards their erection. In dealing with the deficits claimed by the hospitals for 1921, Mr. Scott eliminated the amounts charged to depreciation. That is probably the wisest course.

The other issue of importance which Mr. Scott raises is the application of hospital donations to endowment fund, instead of to the reduction of current deficits. As to this he says that donations not specifically earmarked for endowment purposes by the contributors should be applied to current expenses. Again the auditor is right. But there will naturally be a systematic earmarking to endowment of such funds by the donors if the city insists upon deducting them from the deficits unless so earmarked.

Incidentally Mr. Scott points out two injustices to the Toronto taxpayer; first, that if he goes to a hospital as a private patient, he may be called upon to contribute more than he costs the hospital, the balance going towards the upkeep of public patients, to whose maintenance in the hospital the

same ratepayer contributes a second time in his taxes; second, the patients from municipalities outside Toronto are helping to create the deficits of Toronto hospitals, which deficits are then passed on to the Toronto taxpayer to meet. These are both important points, and should be discussed while the excellent report which Mr. Scott has made is under consideration.

OSLER ON FULL TIME SERVICE

Osler held that in any plan the hospital should form the unit or centre about which the general practitioners should unite. They were preparing for the change, and within a few years there should be a thoroughly practical working combination of the voluntary agencies with the state (Britain). The country hospitals—others, too—had already placed their services most generously for the work in tuberculosis, in syphilis, and in child welfare. To come into a national scheme there would have to be certain radical alterations in the arrangement of the staff. In many, the tuberculosis officer, the syphilis expert, the neurologists, the maternity doctor, the infant-welfare doctor had been recognized and special departments opened. The difficulty would be with medicine and surgery, if there were to be paid consultants attached to the hospitals. "Let me speak of medicine only," said Sir William, "as, nowadays, we can grow surgeons anywhere. Not so the modern physician, who has to be a man of much broader gauge, and is much harder to cultivate. Let us recognize frankly that in any new scheme there must be a reduction in the number of attending physicians. To grow a consultant. . .take a physician of thirty or thereabouts, make him a half-time man with a good salary, give him 80 to 100 beds, with control of the out-patients and a staff of paid assistants. His job would be in the hospital from nine to one, seeing the special cases sent from neighboring doctors, making the ward visit and directing the work in the clinical laboratories. The afternoon would be occupied in private consultations and in country visits at fixed rates. What a godsend such a man would be in every county!

One would suffice. Even under present circumstances such men exist; but we all know that pure medicine, as a study, has not of late been fostered in our county hospitals, some of which are still without the essential clinical laboratory. Such a man, too, would be in daily touch with the other departments—tuberculosis, syphilis, children. And one thing he would be expected to do—make the dispensary a living force in preventive medicine. He would be the centre of the social service work, which makes the out-patient department the strong arm of the hospital in its relation with the public. As that pioneer, Richard Cabot, says, the dispensary work is radical, fundamental, and preventive; and hits the problem of disease at three vital spots—rooting out foci in families or districts by following home the clues presented in the person of the patient, checking disease in its incipiency, and preventing chronic patients from relapsing into a discouraging and vegetative existence. The very best men in the country would be glad to make this their life-work; and in any national scheme I sincerely trust that the profession and the hospital authorities will deal with existing difficulties in a generous spirit.

BEAUPORT ASYLUM DAMAGED BY FIRE

Beauport Asylum, caught fire at an early hour on November 17th.

The flames broke out in the workshops behind the main building, and threatened the entire asylum. Fire fighters were immediately on hand, however, and the fire was under control without any panic among the inmates.

The damage is estimated as fifteen thousand dollars and is confined to the workshops.

PLAN NEW HOSPITAL

The Kitchener and Waterloo Hospital Board has decided to make 1923 a hospital year in the two towns, when it is hoped to raise the necessary money for the erection of a new modern hospital building. Plans for the new structure will be drawn up immediately as the accommodation in the present seventy-bed hospital is inadequate for the needs of Kitchener and Waterloo.

Book Reviews

Clinical Medicine, Tuesday Clinics at the Johns Hopkins Hospital, by Llewellys F. Barker, M.D., LL.D., Professor of Medicine, Emeritus, Johns Hopkins University; Visiting Physician to Johns Hopkins Hospital, Baltimore. Illustrated. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. 1922. Price, cloth, $7.00 net.

It is with more than usual pleasure that we have been accorded the privilege of reading this volume from the pen of our esteemed collaborator, Dr. L. F. Barker, Professor of Medicine, Emeritus, at Johns Hopkins Hospital, Baltimore, Md. Dr. Barker's emigration from his native land to our good neighbors to the South, was a very distinct loss to Canada, but it was but a loan, as we hope he will ere long see his way to return to the fold and once again be a real Canuck. "Clinical Medicine" is a book of unusual interest to us. It is a splendid resume of what, to a vast army of students, became familiarly known as "Barker's Tuesday Clinics," at Johns Hopkins. Perhaps at few hospitals in the world has such a successful system of clinical teaching been carried on for years as at Johns Hopkins. When the reviewer was at college, it was his privilege to follow his teacher around the wards and listen to a didactic lecture on the different patients,

not being accorded the advantage of participating in any way in the physical examination of the case. At "The Tuesday Clinics," each and every student is his Teacher's assistant, the method of inculcating knowledge, being based on the idea that "the way to learn is to do." The clinics in this volume are essentially practical and visualize Barker's teaching splendidly. We believe that this book will be, as it should, an incentive to every hospital who so far have not enlisted each student as a clinical assistant, to do so from now on.

Modern Methods in Nursing, by Georgina J. Sanders, formerly Assistant Matron at Addenbrookes' Hospital, Cambridge, Eng.; formerly Superintendent of Nurses at the Polyclinic Hospital, Philadelphia, and at the Massachusetts General Hospital, Boston. Third edition, thoroughly revised. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. Price, $3.00 net. 1922.

It must indeed be gratifying to any author to find it necessary to publish a third edition of a book in as short a time as the author of "Modern Methods in Nursing" has had to do. We congratulate Miss Sanders upon her new volume. It is a distinct advance upon the preceding edition and should find a ready sale.

The Causes of Heart Failure (Harvard Health Talks), by William Henry Robey, Assistant Professor of Medicine in Harvard University, Visiting Physician to the Boston City Hospital. The Harvard University Press, Cambridge, Mass. 1922. Price, $1.00.

This little volume of forty-five pages is one of a series of Harvard Health Talks. It is a book which is quite safe when put into the hands of the general public. There is nothing in it that is new to a practitioner in medicine, but any practitioner delivering popular lectures would find this full of useful hints.

The Hospital World

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Editorial

Cancer

The profession has to thank the surgeons principally (we believe), for the introduction of Hospital Standardization and the establishment of Cancer Week. In this they do well, for the public and incidentally for themselves.

Too much stress cannot be laid on the early diagnosis of the cancer plague, which, according to most authorities, is much on the increase. Most authorities claim that the disease is not contagious and not hereditary, and most of them say that at first it is a purely local affair; opposed to this last statement is the contention of Bulkley that it is constitutional, and can be treated by diet and proper internal medication. The Medical Health Officer of Montreal quotes evidence to show that it is contagious: he calls attention to its great incidence in certain houses and certain streets of the city.

Opinions vary as to whether it is caused by micro-organisms. Some say yea, some nay.

Our knowledge of the disease is yet too nebulous for anyone to speak dogmatically. Both parties to all the above contentions may be right.

Gaylord, of Buffalo, says cancer is a multiform disease. If this be granted, then some may be purely local, and some constitutional; some may be caused by micro-organisms, others by certain systemic dyscrasias, trauma, or deficiency conditions. Some may be contagious—some not; some hereditary—others not.

Granting our ignorance on all the above points, we do know, or ought to know, certain things about cancer which should lead us to act, and that promptly and forcefully.

All ulcers, warts, moles, chronic inflammatory areas, scars and breast bruises, should be caarefully scrutinized, palpated or otherwise investigated, treated and kept under continuous supervision, and at the proper time, if necessary, eradicated or destroyed by knife, radium or X-ray, as may be deemed best. If the general practitioner is in any doubt about the nature of any of these conditions he should speedily call for consultation with a specialist—skin, gynecological, surgical, or radiological.

Sunlight and other Lights

Much is being said and written about the therapeutic value of sunlight, ultra-violet rays, X-rays and the rays of radium. Rollier's work has been followed up by other experimenters, and there is no

question of the great value of prolonged exposure to sunlight over long periods, to patients suffering from bone and joint tuberculosis, tuberculosis of the skin, glands and lungs. The belief is held that the virtue of sunlight lies in its good effects on metabolism. Hess has proven that sunlight will cure rickets.

About a year ago this journal reported the great success of Harris, of Toronto, in bringing about cures of tuberculous spinal disease in some two dozen returned soldiers, treated by him at Christie Street Hospital, Toronto. The men wore plaster casts, but the sites of the lesions were exposed to the sun. The patients were kept at absolute rest, and, doubtless, were well fed. But Harris maintains, and doubtless rightly, that the sun was the principal agent in the cure.

Other workers are trying out the ultra-violet ray and finding it useful too, as a curative agent. Among its advantages over sunlight is that it can be given day or night and in any sort of weather, and without exposing the patient to cold, damp or frost; though we surmise the breathing of cold, pure air is a useful adjuvant to the sun cure.

Every thoughtful person can make a valuable deduction from all the above work: if sunlight works such wonderful cures, how important it is that all well people should expose themselves as much as possible to the sun's rays in order to prevent the inroads of tuberculosis, rickets, anemia and many other diseases which probably afflict them because of their lack of sunlight.

Impetus to Public Health Nursing

Since the war closed, 20,000 or more nurses on this continent have had to seek avenues of employment. The Red Cross has done much to make openings for these heroic women by planning for rural nursing. Over 1,300 nurses are so employed in the United States. We are pleased that an effort is being made in Canada to send well-trained all-round nurses into the country districts.

The public health nurse who goes out among farmers, lumbermen and the people generally, in the smaller towns and villages, needs to know much. She ought to be able to teach the folk how to handle a case of pulmonary tuberculosis, how to feed the baby, how to keep the premises sanitary, how to perform the simple nursing duties, such as feeding and bathing patients, and sterilizing, by boiling, utensils used by patients, and the like.

Her duties first commence in the school, and this requires special knowledge and training. By degrees she can insinuate herself into the homes of the children when she will find ample scope for her missionary zeal and tact. She will have to advise the pregnant mother, examine the child with diseased adenoids and tonsils or with heart disease or what not.

She must be strong and courageous for these duties. Transportation is often difficult. She will be exposed to inclement weather and will miss many of the comforts and conveniences of the city.

This job almost requires a super-woman to fill it adequately.

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Original Contribution

HOSPITALS AND THE COMMUNITY*

D. A. Craig, M.D., now Assoc. Director American College of Surgeons, Chicago. (Late of Halifax, N. S.)

A good hospital is pointed out with pride by the citizens of any community. It is standing evidence of a most commendable public service which is seldom, if ever, questioned. The public hospital is an essential community investment, and returns on that investment are largely in terms of restored health for those citizens who have been so unfortunate as to have become ill. The restoration of health means the re-establishment of the working capacity of the individual; hence, the lessening of the economic loss to the community. The economic value of every person in any community can be recorded in terms of dollars and cents. We know what it costs to keep up our hospitals. Do we know on the other hand what is our economic return? What is the percentage working capacity of our patients on discharge from hospital? In other words, one might say what dividends in the way of restored health are our hospitals giving to the citizens of the community for their investment?

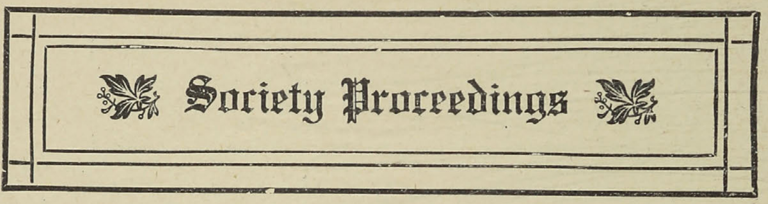
Hospital standardization means a better service to the patient, the advantages of a thorough and scientific investigation and treatment; hence, better returns to the community.

Standardization requires good case records, which are essential to every hospital. Our present day knowledge of scientific medicine is built upon records of the past. What we know of the old masters of medicine and surgery is given us from the records they have left behind them. We in our turn must provide the foundation for future development of scientific medicine by the careful observation and records of our cases. The fact is that our hospitals owe to future generations the records of their present experiences.

*Synopsis of talk given at Hospital Conference at London, Ont., October, 1922.

Besides the repair work in our hospitals, there is always the possibility of an educational function. There is an opportunity to make our hospitals centres for the emanation of health education. It is very questionable if many have realized this possibility. We utilize hospitals for the training of our nurses and medical students. Should we not also utilize them to some extent in teaching our people the simple rules of healthful living? In training medical students and nurses, we must insist upon the principles of thoroughness; consequently our hospitals must be thorough in their work and as efficient as it is possible to make them. In other words, we must practise what we preach. An institution which is simply a brick and mortar container for sick people is not in the true sense of the word a hospital. It may look like a hospital, and it may smell like a hospital, but it is not a hospital. Why are we here addressing you to-day? Because, after a careful study, we thoroughly and firmly believe that hospital standardization means better hospitals, more efficient medical and surgical service to our patients, better teaching facilities for our medical students and our nurses, and better community and public service.

We, of the medical profession, cannot hide behind a veil of mystery. Our gradually increasing standards of general education have developed in our people the spirit of inquiry after truth, and a demand for a most efficient service from our doctors, our hospitals and our nurses. It is up to us to render that efficient service if we are to fill our proper place in the community, and to maintain the confidence and support of our people.



CONJOINT CONVENTION, ALBERTA HOSPITAL ASSOCIATION AND ALBERTA ASSOCIATION OF REGISTERED NURSES

(Completed from last issue.)

Mr. Stickney.—Did your contract holder have a voice in the election of your Board?

Mr. Cousins.—Yes, they have a voice in the election of the Municipal Board. They are hospital supporters.

Mr. Stickney.—All the miners under contract?

Mr. Williams.—Yes, but under special arrangement, made if they are living in the town of Drumheller. If not Drumheller men in the municipal district they have not that. It entitles them to vote.

Mr. Stickney.—What is your opinion of election; is it preferable to appointment by municipal council?

Mr. Williams.—I think the Hospital Board should be elected by the public at large, and I think their standing is much greater if they are answerable to the public and not to the municipal council. I think a Hospital Board is quite as important as a municipal council, because I have handled in a good many cases a good deal more money. They have problems that are much more intricate. I think that a municipal hospital Secretary-Treasurer has his hands full. I think when the hospital board is elected by the people the status is much firmer and much more thought of than if appointed by some individual council.

Mr. Cousins.—Don't you think that the tax is much too low to meet the needs of an efficient rural hospital?

Mr. Williams.—I do not think so when you consider that fees are collected as well. I think if a member of their hospital, it certainly would be, but when you collect the hospital fee as well, the tax should be sufficient because, if you make it higher, it is really a burden, especially as levied on the assessment. Some men will pay $15 and some $2, and that is something we intend to get rectified if at all possible.

Dr. Hall.—How about the $1 a day, do they pay that very well?

Mr. Williams.—We have very little trouble with ratepayers. I should judge that possibly three per cent. of the ratepayers could not straighten up their accounts on leaving. Sometimes we have to wait a while until the crops are assured, but I do not figure we lose one per cent. of our ratepayers' fees.

Mr. Henry.—How do you come out at the end of the year?

Mr. Williams.—We find that our financial matters come out on the right side.

Dr. Stanley.—I think Mr. Williams has given us an excellent talk in his leadership of the round table conference, and no doubt has given some city representatives some insight into the administration as well as the difficulties of the municipal hospitals, which they have to face. We are glad to welcome to the Convention Mrs. Manson and Miss McPhedran, representatives of the Alberta Association of Registered Nurses and Dr. Baker of the Central Alberta Sanatorium, who will take a place on this afternoon's programme. Shall we proceed with the organization?

Dr. Hall.—Last year I acted as Secretary of the Alberta Hospitals Association and I only took it over about six weeks before the Convention. This year I did not take such an active part, in fact very little part, but I would like to say that I have observed the need of more permanent organization with an active organization going on throughout the twelve months of the year, not an organization which gets busy about three or four weeks before Convention time, and many of us are probably not very familiar with the subjects and have not worked up properly our ideas, and have not fully gone into

the necessary means to gain the ends which we have set out to do. We must recognize in dealing with public health matters, that these matters have to be considered by the Department. Many come with little axes to grind, and have not worked the matter up for long enough beforehand, then we pass a number of resolutions which we have not time to get up in proper shape, and I think a step has been taken this time in the formation of a legislative committee to get definite resolutions. Last year the Department paid no attention to the resolutions passed by this organization. I would like to suggest in the Hospital Association two definite elements which have to be taken into consideration, the professional side, the nurses, and those dealing with the training of nurses. In the past the Convention has been divided into three sections, and those who have been asked to give talks and papers have been obliged to talk on the same subject before one organization and go the next day and give practically the same paper. I do not see why the professional side should be dealt with solely under the auspices of the Alberta Registered Nurses. We have in this Province around fifteen municipal hospitals, and besides the professional element in these hospitals we have the other element; similarly in the city hospital we have practically the same element to deal with. They are not so interested in the professional element, and where money has been spent, there have been certain influences which have tended to destroy this Alberta Hospital Association, and as I say, we have to recognize this group, this non-professional group who are vitally interested in the financial administrative and detail. Now, there has been an attempt, whether intentionally or because of misunderstanding, I do not know, but there has grown an idea with the municipal hospital administration, officials, secretary-treasurers and Boards of Directors that they are not wanted in the Alberta Hospital Association, or vice-versa, that these representatives, who are numerically much greater than the city members, do not want to meet in the Alberta Hospital Association with the city members. I have a letter here in

my pocket from a member of the Government service directly in control and he says: "I have made enquiries from my municipal hospitals and I do not find the officers are interested in the Hospital Convention to be held on the dates mentioned." I only want to say, ladies and gentlemen, that my personal opinion is that the members of the Boards and the secretary-treasurers of the municipal hospitals would gladly unite and be with us if we were properly organized as a Hospital Association. I do not believe the members of the municipal hospitals are antagonistic to the Alberta Hospitals Association. I believe their problems are exactly the same as ours, and the organization next year must be such that these gentlemen will be brought in and they will take a very active part.

Mr. Henry.—Cannot they come in now?

Dr. Hall.—Right now there is an attempt being made to organize another Hospital Association.

Mr. Henry.—By whom?

Dr. Hall.—Either by a group in the Government or the municipal hospitals.

Dr. Smith.—As Secretary of this Association, shortly after I was asked to assume the responsibility of this office, six or eight weeks ago I secured a list of the hospitals of this Province, municipal, city and otherwise, and I wrote to every hospital. I have received replies from almost every hospital in the Province, and no hospital from whom I received replies expressed any such ideas as Dr. Hall feels are prevalent. I may say I was delighted with the replies, and from the list we have here this morning that Dr. Stanley read, I feel we have a fairly good representation at this Convention. There are a lot of hospitals not represented. Some are not represented because of the fact that they did not feel they should spend the money to come in. One hospital is at Grand Prairie, another at Peace River, another at Athabasca Landing, and one at Fort McMurray, and then south to as far as Cardston, and they are scattered far and wide over this whole Province, and often cannot spend the money, and your Executive waited on the Department of Public Health and asked the Minister if it would be possible this year for him to be able

to pay the expenses from these hospitals in this Province. Mr. Reid took the matter very seriously into consideration and showed that he was interested in this proposition, but did not feel, for this year at least, that it would be possible for him to do that. Now another matter, seeing Dr. Hall raised this question, which is more serious than anything he has raised, and has more to do with the small attendance than anything else; while in session to-day there is another Convention being held in the city of Regina, and no doubt every hospital received notice of this Convention, which is being held in association with the Alberta and Saskatchewan divisions of the American College of Surgeons. This is unfortunate and I have not been able to find out how it came about that that organization should meet in Regina at the same time as this one, and I wrote at once to some of the authorities. Now I think that is a matter that we should get away from, and I hope next year, when the Alberta Hospital Association meets, the Alberta College of Surgeons for this Province will meet at the same time, and not attempt to divide this thing into two parts, Mr. Chairman. I feel as Mr. Williams said, that the problems of the smaller hospital are very similar to the larger hospital, and what we need is to go on with the organization we have and broaden out our work and take in and get hold of this section of the American College of Surgeons. Nothing has been said about standardization and very little has been said about the professional side of hospital work, and I think next year more emphasis should be laid on that.

President.—In regard to the attitude of the Department of Health I do not think there should be any misconception with regard to that. As far as the Minister of Health is concerned his sympathies are here, and there is absolutely no opposition coming from that quarter. The matter has been brought up through the Executive to find out if there is any hostility or action on the part of the officers of the Department to cause estrangement between the city and rural hospitals, and if there has been, it is the duty of the Association to inform the Minister of the matter, because I am certain of this, that the Minister would certainly take no part nor permit any official in his Department to do it, and such a letter as

this, it would be well to draw to the attention of the Minister himself. I am glad Dr. Hall has introduced it, as it has given us an opportunity of bringing into the open some of the things that have been gossiped around the halls, and next year we can undertake to bring together a larger and more representative body, but let me say this, I am not discouraged with the Convention. It has not been large in numbers, but I have known conventions twenty times as large that got nowhere and did very little compared with what we did here yesterday and to-day, and I am satisfied that the representatives we have had here discussing hospital matters have shown more intelligence, and come to conclusions that have more sanity, than in some larger conventions, and am safe in saying that a convention of this kind appeals to the Government, especially to a gentleman like Mr. Reid.

Dr. Hall.—I can say in contradiction to Dr. Smith that the 15 municipal hospitals have plenty of funds, and there is not one could not have afforded to send a delegate, their head nurse, or their secretary-treasurer. It is not a question of funds whatsoever. I am quite certain of that, and I would like to ask Mr. Stickney to tell us just exactly what the difficulty is, as I believe he knows.

Mr. Stickney.—That is a pretty large order. I agree with what Dr. Hall says with regard to the attitude of the municipal hospital to this convention. It is not lack of funds, but lack of interest. Last year, I think, was the first of these conventions I had the privilege to attend. The trouble with this convention as I see it was this. Most of the members of the Municipal Hospital Boards are farmers, and those not farmers are generally residents of the smaller towns or villages. We came up here last year, and no doubt it was the first time the majority had been here, and I am sure in the case of Drumheller we felt honored and gratified to receive the invitation. We came up and did not know exactly what we were coming to. It was quite different from any conventions we had been acquainted with. We could hardly see what benefit could be derived from it. Most conventions are rather informal, and they feel like expressing themselves and talking on any subject that come up, but last year we sat up in that hall. No doubt

it was all right, but you cannot get the viewpoint, you doctors and nurses, you cannot possibly get the viewpoint of the ordinary farmer. We meet farmers mostly and, as a rule, you will find they are not very good at mixing informally with other people. It takes a certain length of time to wear off that feeling of being a little out of place. We got up there in this hall with a lot of doctors and nurses, no doubt all good fellows, but we had the feeling that we were a little out of place, but there did not seem to be any part of the programme arranged for matters concerning municipals hospitals. Someone would read a paper, someone from Saskatchewan or British Columbia, a doctor or a nurse, and I am sure they were interesting papers, but they had very little to do with our problems, the problems connected with the municipal hospital. I consider this convention infinitely superior to the one last year, for as one fellow said "What do you know about this, did you ever see such a frost in your life, these fellows ain't human, we sure ran into something that time." I suppose that expresses the feeling of the delegates from the municipal hospitals better than anything else could. About this matter that Dr. Smith brought up about the Department being entirely in sympathy with this Association is right to a certain extent. I believe the Minister, if not influenced, is entirely interested, but I believe there is an influence at work in regard to this Association. One of the officials of the Department of Health expects to have a Convention of the municipal hospitals this winter and I do not believe that lack of funds will keep them away. Unless we can do something to counteract this influence in regard to this convention as far as the municipal hospitals are concerned, I am afraid we cannot figure on very much support or co-operation, and I am sure it is something to be deplored greatly, because as some gentleman previously remarked, the problems of the city and the small town are the same. The chief object, of course, is the care of the sick and, of course, there are other problems that take up more time and discussion than that, but the problems are the same, and I think a great deal could come out of this Association with the two different classes of hospital, or three if they can see it all alike, and get together and try

to work in harmony, so the different problems of the municipal hospital will be discussed here, and probably some of the things will be entirely clear to you people from the city hospital, for you have discussed them before and have dealt with them before, and I am free to admit, you will know more about it. I also feel that there would be a possibility that you ladies and gentlemen representing the city hospital might possibly receive suggestions from the delegates of the municipal hospitals that would be of value to you. I am sure you would not receive as much except, perhaps, on organization or along the lines of establishing a municipal hospital in your city which we need not consider at the present. I believe we can organize this thing so as to finally make it a success. My idea would be to have part of the Executive elected from the representatives of the municipal hospitals. This would relieve a certain amount of suspicion of the municipal hospital being against this Association if part of the executive were representing municipal hospitals, and of course you would need to get together and frame up some policy. I know farmers and everything connected with them, and you have got to appeal to them in the right way, and if you could show that only four of the municipal hospitals were represented this year, but that they were well enough satisfied for some of us to be on the executive, it would be a good thing for the hospitals in Alberta. My idea would be to have two different organizations, the municipal hospital under the care of part of the executive which consists of the municipal representatives, and have the secretary of the municipal part of it write each one of the hospitals and the small rural hospitals, a letter explaining our attitude, I think very much good could be derived from it, for we would have the advice of men who have been in this thing for years and years, and of course could show them that these men representing the city hospitals were only too glad and too anxious to have them come in as the larger the Association the more beneficial it would be. I am sorry if the Department, or anyone in the Department of Health uses any influence to split up this organization because it is entirely out of their province. The municipal hospital is locally controlled by Boards, and we have entirely the right to do what we wish as long as we have the funds, and I

think it is very advisable for some member to put the thing up to them just the way I have been putting it up to you here, showing the benefits to be derived from the larger organization instead of a narrow-minded attitude in forming a smaller organization.

PRESIDENT.—I would like to make the suggestion that we add Mr. Stickney's name to the Legislative Committee, and have him approach the Government along with the other members. I am quite sure with an exponent such as Mr. Stickney, you will be able to show the Honorable Mr. Reid the standpoint which we take.

Moved by Mr. Williams, seconded by Mr. Henry, that Mr. Stickney's name be added to the Legislative Committee. *Carried.*

MR. HENRY.—Just before you leave this point. It seems after hearing Mr. Stickney that there is some movement against this organization in the Department of Municipal Affairs or Health. I think it only fair to the Minister not to give it undue publicity, but to go to the Minister and have a heart to heart talk, and lay before him in an informal manner what we feel, but if an official of his Department is antagonistic to us, it is just as well to let the Minister know in company with that official, and I would suggest if the legislative committee does not do it that some other committee interview the Minister.

No motion recorded.

Seconded by Mr. Cousins, "That the legislative committee interview the Minister to-day at the earliest possible moment in regard to this matter or any other matters on which they wish to confer."

MR. WILLIAMS.—Might I move that this be a special committee, consisting of the President and Secretary. I think that the Legislative Committee will be meeting later on, and I think this matter calls for more or less urgent action, and a small committee would probably be better. Seconded by Mr. Cousins "That the incoming President and Secretary interview the Minister of Health." *Carried.*

Moved by Mr. Cousins, seconded by Mr. Dutton "That we proceed with the election of officers." *Carried.*

Honorary President.—Hon. R. G. Reid.

President.—Father Cameron.

Moved by Dr. Hall, seconded by Mr. Henry, that Mr. Stickney be Vice-President. *Carried.*

Moved by Dr. Hall that Mr. Williams be elected as Secretary-Treasurer. *Carried.*

Executive Committee.—Miss McLeod, High River; Dr. Smith, Royal Alexandra, Edmonton; Dr. Stanley, Calgary; Miss Edy, General Hospital, Calgary; E. E. Dutton, Galt Hospital, Lethbridge.

THE TRAINING SCHOOL FOR NURSES.

MISS FRANCES MACMILLAN.

As Superintendent of the Training School for Nurses in connection with the Royal Alexandra Hospital, I have much pleasure in being present at this, the first conference of the Alberta Hospitals, Alberta Medical and Alberta Registered Nurses' Associations.

The University of Alberta as an education centre makes a very fitting background for this gathering. The existence and presence of these very fine buildings represent the realization and appreciation of the need for higher education in this Province. Some person exclaims "Think of the cost." The uninitiated may reply "The student pays his way."

Approximately speaking, when it costs the student $30 tuition per year in Arts, it costs the Province of Alberta some $375 per year or, generally speaking, every Arts student owes the Province over $300 per year for his education.

The medical student who pays more, as much more expensive equipment is required for him, owes to the Government around $1,000 per year.

The student in Science and in the new Department of Agriculture will have as great a debt or greater to the Province.

But do we question the Government in this wise expenditure? The most conservative individual realizes that all greatness depends on education; the trained men and women graduating from our colleges pay back to the community life of the Province a thousand fold what has been expended on them.

Now education to-day comprises the welfare of the people generally, as emphasized so recently by the Hon. Perren Baker, Minister of Education, when he spoke of the four-fold standard of development in our school curriculum of to-day—the physical, the mental, the spiritual, and the service side of life.

This four-fold standard is and has been the fundamental feature in every Training School for Nurses.

To this understanding audience there is no need to explain the strenuous life of the nurse-in-training, the great strain put upon her physical well-being, the need for a keen mind to assimilate the theoretical part of her daily lectures after a hard day's work on the ward.

Glimpses of her spiritual self shine through infinite patience in the most exacting situation, and she gives service to all with whom she comes in contact in the Nursing School, and later to the community at large.

The lay person to-day is prone to consider that our hospitals exist but to care for the sick, when we who are in close touch with hospital life know that they exist as well for the education of our medical students and pupil nurses.

A college graduate who had recently applied for admission to a Training School was asked why so few college women had similar plans. The answer was "Too few hospitals seemed to offer their students a reasonable home life with normal opportunities for relaxation and recreation." Speaking for Alberta, I fear this is but too true—yet we do not complain of our various Hospital Boards. We feel that at heart they consider nothing too good for the pupils under their care. However, the matter of finance is a large question. Hospitals are not self-supporting, and the sick must receive their first attention.

A patient requires around 133 cu. ft. of air space in order to live under healthy conditions, yet some pupil nurses in Alberta are permitted to rest, study, sleep and keep most of their personal belongings in less than half that space.

I am afraid some of our living quarters would hardly stand the inspection of a Public Health Office, and yet at the completion of their training our pupils are asked to go out to teach public health in various parts of the Province. To-day, 27 of these are employed by our Provincial Government.

We expect that our pupils be not only physically fit, but that they be super-women radiating enthusiasm for their patient as well as themselves—and to be ever ready to answer to our S.O.S. call "Service," as often as is necessary.

As educationists we are agreed that we must safeguard the health of our people in this our Province of Alberta. As the confines of our Province extend we must be able to develop our hospitals and increase our supply of rural nurses, if we can hope to do our part in the Provincial scheme of affairs. We must have sufficient nurses—our output of trained nurses must meet the demand of the settlers in the most remote districts as well as of those in the urban centres.

To this end, I would ask this organization in convention to approach the Provincial Government of Alberta to consider, when making out their estimates for the year 1923, to be as liberal as possible in providing a grant to the Training Schools for Nurses in the Province.

I have no hesitancy in making this request because we all know the interest that this Government has devoted during their short tenure of office towards improving the educational conditions in Alberta.

President.—I think that paper is quite provocative of discussion.

Miss McPhedran.—It has always been a source of mystery to me why such a very important educational branch should be neglected to the extent it is. I am afraid we sometimes get the idea that the student nurses in the hospitals are there for service only. When she leaves the hospital there is the education of the public in health matters, and no one in the whole community is better able to teach the public at large on health matters as the nurses are, but if the educational part of their training is neglected then it reacts on the public at large.

Miss McLeod.—I think if we paid a little more attention to the housing of the pupil nurse and recreation, we would get a higher standard of women entering the nursing force, and if we could get the co-operation of the Government to give us a grant we would benefit as a professional body.

Dr. Smith.—The Provincial Government as we are all aware, makes quite a liberal grant to all public schools throughout the Province, so much per teacher, so much per room, and I think in the technical school it is higher. So far they have never seen fit to do anything for the training school for nurses. As a matter of fact I believe our Government considers that the grant they make to the hospital of 50 cents per patient per day really covers this obligation. Now, as a matter of fact it does not do so for this reason: they make the same grant to all hospitals whether they have training schools or not. Now it has also been said by some that the hospital that has a Training School for Nurses really receives from the undergraduate as she goes through her course the kind of service which repays the hospital for any extra expense in having a school there, but when you come to actual figures, the figures are rather startling. Last spring in connection with the Royal Alexandra graduating exercises, I took occasion to look particularly into this question, and I gathered a considerable amount of data on just how much it cost us to operate the Training School, putting a value on the services of the undergraduate nurses as they went through the hospital and putting a price also on her board and room and that sort of thing, also putting a value on the time of the nurses who trained these pupil nurses. Now, we found out at our hospital that the graduating class of twenty nurses cost us over and above anything, they rendered the hospital $1,000 per nurse. In other words, by the time a class of twenty nurses got through the hospital they were indebted to the hospital to approximately $20,000. Now I have met several nurses who are interested in this work in training young ladies in the nursing profession and had them go over this question and so far these figures have not been contradicted. Several heads of training schools that I have spoken to have been surprised when they came to figure out just the amount of time given to the training of the

undergraduates. Now from the moment they come in, these nurses have to be watched and followed around for fear that they will do something that will do more harm than good. They do not know anything about hospital work, and for days their working service is of no value to the hospital for they have to be watched.

Dr. Stanley.—The point has already been made, and I think it is well worth while emphasizing, that the nurse is not simply for service she may render in nursing the sick directly, but apart from that she has a very important duty to perform in many instances. The point should be emphasized that she is a teacher. We must have training schools in our Province that are going to give information and instruction and training to young ladies who are going to act as teachers for nurses yet to come, and these nurses are being taken by the Public Health Department of our Province and are being used for teaching the public. Now that is a thing that seems to be overlooked by the general public, the value of the training school in educating our nurses to be used in public health work by the Department of Public Health. Those in charge of Training Schools should see and insist that those who are taken on as probationers should have sufficient preliminary training to make them students in the Training School, and it should be emphasized as a policy on the part of our Government that a standard should be set for preliminary education; particularly would I urge it in regard to the term "R.N." I believe that the preliminary standard should be sufficiently high to ensure that a nurse who will come to receive university training should have a sufficiently high academic training to ensure she will be able to take a position that a degree of that kind warrants her to take.

ADDRESS.

By Honorable R. G. Reid, Minister of Health.

I am glad that the Chairman has mentioned the fact that I am a very busy man because it will prepare you for the extreme brevity of the speech I am going to make to you to-day. I do not have any great message for you. I wish to welcome you

here to-day and trust that your deliberations here will be profitable, that you will go home benefited by the discussions, and that the discussions which you will have will also be profitable to the Province as a whole.

I like to hear the remark which Dr. Smith made about the Public Health nurses. I am proud of these Public Health nurses; in fact Dr. Smith expressed a good deal of my own thought in connection with them. I always think these girls going out doing this work are preaching the evangel of good health, and before many years we will see the fruit of their work in a concrete way.

Now in connection with the problems and the questions you are most intimately connected with, and for that reason most interested in, hospital work, I have a little to say.

There are so many things enter into the successful operation of a hospital. You, in your discussion which has just been closed, I believe have been dealing with the necessity of a higher standard in your training schools. In addition to that, of course, we all know that we depend more or less on the medical men, but there is one thing more considered and mentioned than all, and that is the financing of that hospital. We see so frequently throughout the Province, hospitals doing splendid work for a time and then they get into difficulties and probably their usefulness is gradually or absolutely done away with. I am interested in two ways; I am interested to see the hospitals in as high a state of efficiency as it is possible to bring them, and for that reason alone I am anxious to see them on a strong stable financial basis, because we find when hospitals get into financial difficulties they immediately apply to the Government. Prior to the time I accepted office we had a special department of the Health Department which was known as the Municipal Hospital Branch. I found there was no such thing as a Hospitals Branch. We had paid attention to the municipal hospital, but there was no branch particularly devoting attention to hospitals other than municipal. I made a little change and we instituted a new policy, and in connection with the institution of that policy, and to show you how we poor mortals are always misunderstood, some good

friends immediately jumped to the conclusion that I was ascribing powers to myself and going to interfere with the management of hospitals unduly. No such thought was in my mind any more than placing expert advice and experience at the disposal of any hospital who wished to apply for that assistance. I thought when I made that change that it would fill a real want, and the experience of one year has shown that was the case absolutely. I am not going to recite the history but simply instance one case. There was one hospital in Red Deer, and I am quite frank to admit before I start to tell you, it was an outstanding case, and probably in all the time of the administration of the new branch they will not have a case to equal it again, but we found when we went there, at the request of the City Council, that they had accumulated a deficit of $8,000 in one year's operation. For an institution of that size you would think they had been sitting up nights to see how they could manage to make it, but undoubtedly that was the deficit they accumulated that year. After investigation, a report submitted and that report having been acted upon, now having four months under the new conditions we find a saving has been effected in that time of over $4,000. Now if we can save at the rate of $1,000 a month in that small institution, then I believe there is some justification in the action I took in making the Municipal Hospital Department a Hospitals Department.

Now before I conclude I would just like to say this to you, that the betterment of our conditions in hospitals and otherwise is going to be brought about, not by the Government, not by the Nurses' Association working on their own initiative, not by the individual working here or there, but is going to be brought about by the bringing of these forces together, working in a close, harmonious way, with the one objective in view of making this Province not only an outstanding Province in health matters, but a pattern to the whole world.

Moved and seconded that a vote of thanks be extended to the Honorable Minister. *Carried.*

RELATIONSHIP BETWEEN THE CENTRAL ALBERTA SANATORIUM AND THE OTHER HOSPITALS OF THE PROVINCE.

By Dr. Baker.

Mr Chairman, Ladies and Gentlemen: I must apologise first because the short paper I have prepared is not absolutely along the lines which the programme states. It was originally prepared for the Alberta Medical Association, then Dr. Smith got after me and said it had to be given here, so it is not absolutely according to the title on the programme. I propose to make a few remarks on T.B. sanatorium work.

Some Phases of Tuberculosis Sanatorium Work.

It is significant that there are meeting in this city to-day, associations of physicians, nurses and hospitals. All are bent on the relief of suffering and the prevention of disease. With these forces co-operating and taking the public into their confidence, as regards health and disease in so far as this is practicable, we can enthusiastically look forward to definite progress in health matters resulting from this spreading of available information. A little learning is a dangerous thing, and right now there are signs that intensive instruction in questions of health and disease is needed if we are to prevent unfortunate disasters which follow in the wake of wrong and insufficient information and of immature decisions.

The rapid disappearance of typhoid fever in epidemic form has not been accomplished by any specific remedy. The widespread knowledge of the nature of this disease and of its control has lead to the practical enforcement of such habits of living, involving the expenditure of millions of dollars for a clean water supply and for proper sewage disposal, that already typhoid fever is the exception where formerly it was the rule. Similarly we have no specific for tuberculosis, but by broadcasting what is now known of this disease, it is to be expected that public opinion will demand such practical measures, involving the expenditure of money, as will tend to reduce the morbidity and mortality of the Great White Plague.

And even in this supposedly healthy country there is room for improvement. Upon the basis of the Framingham Health Experiment, approximately one per cent of our population is suffering from active tuberculosis, and an equal number from arrested disease. Ferguson has recently reported on 1,346 representative public school children in Saskatchewan, that 56.6% showed signs of previous infection; slightly less than one per cent. of the 1,184 white children had active tuberculosis and needed treatment, and 2.5% of the white children showed signs and symptoms more or less suspicious of activity. I am informed that in this Province there are 123,328 white public school children, and on the basis of the Saskatchewan report we may assume that among these there are 1,035 active cases of tuberculosis and 3,083 very suspicious cases.

What is the place of the Sanatorium in the anti-tuberculosis movement? Its primary importance lies in its value as an educational influence in health matters, particularly of tuberculosis. A practical daily demonstration is given to patients in the ordinary sanitary requirements of houses as regards heat, ventilation and light. Patients soon discover that their feeling of well-being are increased by hygienic living, and definitely diminished if the latter be neglected. This leads to frequent inquiries as to how the individual home can be so arranged to afford the best possible living conditions. Emphasis is laid on the fact that cleanliness of person, clothes and living quarters is essential. Without it contagion, sickness, suffering and death are bound to increase.

There are many cases where a real cure is not to be expected and it is important to show these people how they can continue to live and still be useful. There are certain activities in which they may engage, there are others which must be avoided if a feeling of well-being is to be maintained. Great time is not required to convince the average person, that safety first lies in a rational, balanced life as regards food, rest, work and play. But to develop the habit of so living may require longer. The desired state where a patient can keep his expenditure of energy within the limits of his supply can be attained, but to maintain this under modern living conditions requires considerable experience and foresight.

One sees so many, who, both before being admitted for treatment and also during residence, can maintain a moderate degree of health, but who persist in such expenditure of energy as to prevent any real cure or satisfactory arrest of the disease. Many of these fail, I believe, through lack of proper instructions and of persistent observation to keep them going well. In addition to the personal interest and help given to patients by members of the staff, there is a good influence of other patients, and many who might otherwise fail in their effort to get well, are carried along by the massed institutional will to get well. It is easier to take the cure where that is the daily custom, than where one plays the lone game among healthy people, who are apt to encourage too much, or censor too severely.

Definite training is necessary in methods to prevent spread of infection. "Learn to do by doing" is a safe principle. Suitable pressure is required to develop careful habits in many. Some people constantly study themselves so that they may be of no danger to others, while there are those who require compulsion. The former class can safely be treated almost anywhere, while the latter class will be a dangerous source of infection unless constantly watched, which is impossible unless in an institution or under the direct care of a trained attendant whether professional nurse or other.

The medical staff in addition to frequent individual instruction has, through periodic talks to groups of patients an opportunity of spreading needed information. Suitable subjects are the facts of infection, the reason for treatment, the proper routine for home life, the symptoms of an approaching relapse of the disease, the evidences of possible early attacks of T.B. among friends, the advantages of periodic examination and observation of people most likely to become victims of this disease, and other health matters.

The results of such educational work are that nearly every patient becomes more intelligent, reasonable and conscientious in his or her endeavor to get well and to be as useful as possible. I am sure that a patient well informed on tuberculosis, conscious of the nature of his disease, is a greater asset to his community than the same person unaware of the fact

that he suffers from a communicable, costly disease, and ignorant of the many facts that all so handicapped should know, as thoroughly as they do the three R's. This patient carries into his home, into the community, the leaven of knowledge regarding tuberculosis and respiratory diseases, which will continue to work until the whole of our population has the pertinent facts regarding this disease. And when this day arrives public opinion will insist on the expenditure of money in preventing disease, as a profitable investment.

Every discussion of sanatorium usefulness would be very incomplete, if mention were not made of the desirability of giving to the nurses-in-training experience in tuberculosis work by having them serve a few months in sanatoria. While this is being carried on comprehensive lectures on tuberculosis—the common disease—should be given. The graduate nurse comes into such intimate association with the general public, that her opportunities for spreading useful and accurate information of disease are unparalleled—and likewise because of her position of confidence, she can do much harm, nor can we entirely blame the nurse for the fostering of myths and fancies, if through our training schools and sanatoria we fail to give the latest and best instruction.

We are proud of the fact that a Western Sanatorium, i.e., that of Manitoba, through the influence of Dr. Stewart, has been the first to give a definite course of training in tuberculosis to medical students. Through mutual arrangements the university and the sanatorium have been able to give the Manitoba medical students several weeks' residence in the sanatorium for intensive study.

The medical care of the sick is not to be minimized. This is a distinct phase of sanatorium work in contrast with the educational. Favorable cases diagnosed early and given proper treatment, can be put well on the road to recovery, provided they have the intellect to grasp the requirements of the road to health and the normal stamina to live up to these day by day. Others who enter the sanatorium only when they no longer can work, or when they can no longer take care of themselves, need scarcely hope for more than improvement and a delay in the progress of this disease. Both of these

groups profit wonderfully through thorough education in the laws of this disease and in methods of withstanding it. The apparently hopeless and terminal cases need, and should have the best of care and every small attention, which can be given them, so that their unfortunate condition can be made as easy as possible. Frequently the comforts of hospital or sanatorium life surpass those found in the homes of this country. Nor does the benefit of institutional treatment of these hopeless cases rest solely with the patient, but extends in a more far-reaching and essential way to the community at large in reducing the opportunities for exposure of the healthy to massive contact in the homes. As a public question, the state can scarcely afford to have the infants and children, daily exposed as they are bound to be in homes with advanced cases.

The sanatorium should function as a centre for diagnosis of respiratory diseases. To this end it should be equipped with every known aid in diagnosis, and staffed with those capable of giving the public the advantage of everything known in this branch of medical science. Those cases requiring special study, or those who have not facilities near them for special examinations, can enter the institution for such a period as is necessary to determine the presence or absence of clinical tuberculosis. Many citizens have easy access to hospitals, and to physicians for this period of observation, but there are many in this Province not so favorably situated, and to them especially the sanatorium can offer help. The sooner our hospitals and sanatoria become more definitely centres for diagnosis, as well as for treatment, the greater service will they render the public. I am convinced that more stress should be laid on the desirability of periodic examinations of those specially liable to develop this disease, and of those clinically inactive. It is the prevention of the disease as a clinical manifestation, that we must work for, and not the ultimate elimination of all infection. I have mentioned only three phases of sanatorium work, the educational, the care of the sick, and the diagnostic. There are others which it is not my purpose to deal with here.

These aims will be realized, according as patients from all parts of the Province and from all classes of the community can be reached and instructed, and then returned to their homes to

have greater or less influence. If this educational work, so briefly mentioned, be worth the expenditure of money involved in sanatorium treatment, we need as patients, all that can be accommodated, and preferably those not in the hopeless or terminal class. It is the early case, or at least the one just diagnosed, which has on the one hand the greatest life expectancy, and therefore the most helpful influence on the community, or on the other hand the greatest life expectancy and therefore the greatest possibility of spreading this disease provided he is not well trained and thoroughly watched. From all standpoints if training be advisable, the early case is the profitable one.

It is quite true that nearly all cases recover from their first attack, and that others have periods of remission from symptoms whether being treated at home or in a sanatorium, but, are the facilities in the homes such that the patient is forced to learn how to take care of himself and how to protect others? From what I have seen I fear they are not. One frequently hears a patient who has had this disease for several years express regret, that he had not known at the beginning of the fight, what he had learned when hope of great improvement was gone. Tuberculosis is probably the most curable of all chronic diseases. Proper treatment aims to cure, but still is amply justified if it can prevent the train of suffering and disaster which follow the steady progress of this disease. The desirable length of time for sanatorium treatment varies with the individual and his home environment, and even if a sufficient time for satisfactory subsidence of symptoms cannot be afforded, a few weeks properly spent will result in the broadcasting of useful information.

One frequently hears it stated, both by patients and others, that their disease is not far enough advanced to make sanatorium treatment advisable. This is a wrong impression, provided we believe that such treatment is ever indicated. There is no doubt that the time to treat any chronic disease is at its very first manifestations. One may not want treatment, but that in no way minimizes the fact that he needs it, nor lessens the benefit which the State derives from his having it. To the man who has just been diagnosed as tuberculous, and who

hesitates to take treatment because he does not feel sick and weak, we should say: "Now is the accepted time and now is the day of salvation."

Dr. Smith.—I would like to introduce to you Dr. Hepburn of the Medical Association who has come to bring greetings from that Association to this Association.

Dr. Hepburn.—Mr. Chairman, Ladies and Gentlemen. I have just had this honor thrust upon me. This, I believe is the first occasion when the three organizations have combined to hold their annual meeting at one time. Now probably the arrangement this time has not been perfect. I have no doubt we will find as time goes on that we might have arranged our programme to better advantage. However, it requires experience and in drafting the medical programme I was a little at sea as to what would really interest the hospital people. There was a time when the medical men did not consider the hospital people, when the medical profession considered themselves the important people, and the hospital authorities and nurses were side issues. However, it is very different now and things have taken a change and greater prominence is being given, greater publicity is being given hospital work. The general public is now taking an interest in hospitals and nursing matters and we found that during the last year several times the question came up not of how people in the outlying districts could receive attention from a doctor but how they could receive nursing, and hospital accommodation which rather indicates that the public is being educated to the proper proportion, the proper relation of the medical man to the hospital and the hospital to the medical practitioner, so I hope in future we will be able to arrange our programmes so that there will be no confliction and probably we will be able to attend more of the meetings of the Hospital Association and the Association of Registered Nurses and probably some of our meetings might be of interest to you people. I think the lecture I have just come from, given by Dr. B—— Professor of Surgery in McGill University would have appealed to the nurses and lay men, and I have no doubt in future the meetings can be arranged so they can be attended by the representatives and the members of the different organizations.

I do not wish to keep you any longer but just to say that it is the wish of the Medical Association that this arrangement should continue and we may develop it to our mutual benefit.

FATHER CAMERON.—I can assure you, doctor, that you have struck a reciprocal chord in our hearts and the representatives will give fitting response to the words of greeting you have brought from the Medical Association.

Vote of thanks to Miss Hunt, moved by Mr. Cousins, seconded by Miss McPhedran.

DR. SMITH:—There is a matter I would like to take up. It has been customary I believe, ever since the Alberta Hospital Association was organized, to have a report of the proceedings, including the papers presented, and the discussions and resolutions, and all that, printed in a special publication, and then distributed to the various members of the association. This has been done at considerable cost. I have not the exact figures here, but I believe last year the cost was three or four hundred, and one year it ran as high as six or seven hundred. Now just recently I had a communication from Dr. Brown, in Toronto, who is editor, I believe, of the *Hospital World,* which is the Canadian hospital publication. It occurred to me we might be able to make arrangements with that magazine, for them to publish all papers presented, together with resolutions and reports, discussions and that sort of thing, if we forwarded this material to that magazine. This could not naturally all be put in one paper, but will be spread over probably six or eight publications. It would not cost the hospital association anything at all, and most hospitals do take this magazine, and those who do not probably may be induced to do so. The subscription is a matter of three or four dollars a year, and it would relieve us of this heavy financial burden. To that end I would like to move

> "That the Executive Committee be instructed to have all papers, reports and resolutions published in the *Hospital World,* instead of making a special publication which would involve the expenditure of three or four hundred dollars."

Dr. Lafferty:—I have much pleasure in seconding that motion.

President:—I do not know that there could be any objection, except on the part of those who are good enough to prepare papers for the meeting. I do not know whether they wish to copyright them or not.

Dr. Smith:—I had a communication from Dr. Brown in which he wanted a report of this convention. Instead of writing him a report I would send him the whole thing. The Secretary is not here just now, but I think it is customary for the retiring secretary, to get these matters cleaned up. *Resolution carried.*

Dr. Smith:—I would like to move, "That all the resolutions which have been referred to the special legislative committee be submitted to the Alberta Medical Association, now in convention, and the Alberta Association of registered nurses for their endorsement." I am sure these two associations would back us up in these resolutions.

Dr. Lafferty:—I believe the college of surgeons and physicians will be very glad to co-operate in this movement and I would include their name in this resolution. *Carried.*

EVENING SESSION: PUBLIC MEETING.

Chairman: Father Cameron.

Ladies and Gentlemen:

I regret very much that we have not the Lieutenant Governor with us to preside at this meeting, because the Lieutenant Governor is always so fine; he is an old medical man himself, and is interested, and the meetings of the medical profession always appeal to him very deeply. . . . In a way I feel highly honored to preside at this meeting tonight, because it is the first time in the province of Alberta we have had the three organizations of public health, the medical association, the hospital association and the nursing profession all united together to discuss their common and interlocking problems. That in itself would make this an

auspicious occasion, but when we think that, in the domain of public health, Alberta leads not only all the provinces of the rest of this fair Dominion, but is a leader of great parts of the world in public health utilities, I consider it is an exceptional honor to preside here to-night. We have with us to-night the Minister; we have the president of the medical association, the president of the hospital association and we are to receive addresses from them. We also have with us the supreme magistrate of the city, representing mayor Duggan, who has come to-night to bid us welcome—Mr. Bury. I asked Dr. Smith how I should introduce him, whether Free State or Republican, but he said he had not diagnosed his case yet.

Mr. Bury:—Now, the official reason why I am here to-night is because the mayor is not. I do not mean "Is not" in a Biblical sense; I mean he is not here officially. He is not here, because he has gone to Ottawa, to make what preparation he could, so that the citizens of Edmonton during the coming winter, who might otherwise find themselves without work, can have something provided. That is the official reason for his not being here. Since I have had to discharge the duties which appertain to his office, if it were not that I did not wish to speak evil of dignitaries I would be inclined to think, though officially gone to get employment for other people, he went to escape employment for himself. However, since I have to take his place, it naturally lies on me to do what I think he would do. I know he would pour a libation before the altar of convention, by expressing his pleasure that the convention had been able to hold its gatherings in the city. . . . I wish to express on behalf of the citizens and the council and the absent mayor, the gratification we have, that you have been able to hold meetings in this city. . . . and we want to express to you, gathered here, the hope that your convention gatherings and meetings will be a source of pleasure to those of you who have come up from points outside of Edmonton, not merely pleasure in the immediate associations and gatherings of the convention but that source of sweeter pleasure, which comes from distance of memory, as the Scotch put it, of the experiences

which you have had here in Edmonton; and our hope is not only that you will enjoy yourself, but that the gatherings of the convention shall be full of profit alternating with pleasure.

Some of you come from far distances and your lot is largely cast in solitude and you experience in your own spirits the monotonous, paralyzing drudgery of maintaining the routine of the professional service and you long occasionally for the greater development and more active life of your brothers and sisters practising the profession in Edmonton. To those of you who come from such scenes as these, such gatherings must be an inspiration, a source of new ideas, a source of stronger aspirations to do the service that belongs to your noble profession. . . . Health is no longer a private matter but a public concern, and all public concerns occupy the minds of public men, and there is no matter with which they are more vitally concerned than the matter of public health. There is no matter in which the Minister, in which Parliament have a right to take an interest or a more imperative duty, to do what they can than in the domain of public health. . . . Now there is one other thing I would like to say before I close, and it is this; that I am glad to be here because these conventions are held in this University and the time is not far distant when this University will be in a position to contribute to the health service, the medical service of this Province that to which it is properly fitted to contribute. The medical service will send out, to serve men and women, men trained in medical and surgical science and every other department connected with sanitation and health. I think if the heart of the President of this institution were opened we would find traced there the strongest aspiration that the medical building which has been erected in these grounds, shall be a medical school which will render it unnecessary for any parent in Alberta to send down his child to get his education in the east or any of the older universities of Europe or the Old Country, but that this university shall meet all the medical and health needs of the Province.

PRESIDENT.—On behalf of the Association I wish to thank the Acting Mayor for his remarks of welcome, and I am sure that we who come from the quiet cities of the south should enjoy ourselves in this fine city.

Vocal solo, Miss L. Hunt.

Paper: Everyday Pediatrics, Dr. F. W. Stockton, Calgary.

ADDRESS: HON. R. G. REID, Minister of Health.

Mr. Chairman, Ladies and Gentlemen:—

There is one regret I have in connection with this series of meetings and that is that I cannot be present at every one for they are dealing with subjects I have always been interested in, and now that they are within my reach I find the pressure of public duties does not allow me to take advantage of them.

There is something responsible for this gathering. What is it that causes it? This enthusiasm on the part of individuals from different parts of the Province, enthusiasm for the cause, enthusiasm for their duty, and while that enthusiasm exists and is manifest in this way I think that the future, the outlook for the care of health conditions in this Province is distinctly good, for I feel always and at all times that the problems of public health are, with all problems of education, for the people, to be educated up to the point where they realize the necessity for better health conditions; then it is public health conditions will automatically materialize. The politicians usually set out to make good fellows of themselves and to make themselves the most popular. Still to-night we have two lengthy speeches before us, so I think I will not endanger my popularity. I have nothing further to say except repeat the happy sentiments expressed by the Acting Mayor. On behalf of the Province I feel it my duty to welcome you here—it is a pleasant duty—and to wish you all success in your endeavors and wish that you will go back to your homes feeling you have profited by the experience, and feeling you have added something to this important public health which we are all striving to build up.

The meeting closed with the singing of the National Anthem.

Canadian Hospitals

NEW ISOLATION HOSPITAL, EDMONTON, ALBERTA

For several months the question of choosing a site for the new Isolation Hospital in Edmonton has been under discussion, and at a meeting of the Edmonton Hospital Board, a month ago, it was definitely decided to recommend that it be erected on lands adjacent to the present site of the Royal Alexandra Hospital, which is a general hospital of two hundred and seventy beds. The Edmonton City Council has approved of this location and it is expected that the work of construction will commence in the early spring.

At the last meeting of the Edmonton Hospital Board, held November 24th, a special committee *re* New Isolation presented the following recommendations:

(1) That the new hospital be of the block type, three storeys high—

(*a*) Because it would be more in harmony with the present buildings on this site;

(*b*) The block type is very much more economical to operate than the other;

(*c*) The block type, from a scientific standpoint, has been proven to be satisfactory;

(*d*) That the block type is more economical to erect, providing both were estimated as modern fire-proof buildings.

(2) That this building be of modern fire-proof construction.

(3) That it be erected north of the present administration building, parallel with 112 Ave., and about seventy-five feet south of the south side of 112 Ave.

(4) That each floor of this hospital be in two sections of eighteen beds each:

(*a*) Each section to have two wards of six beds each.

(*b*) Six observation wards.

(*c*) Each six-bed ward to have a toilet, wash up basin for doctors and slop sink.

(*d*) Each single or observation room to have wash basin and also slop sink.

(*e*) Each section to have the following: small serving kitchen, linen room, nurses' room, doctors' room, clothes chute, baths, small utility room for cleaning utensils, discharge room and balcony.

(*f*) The basement to be three or four feet below ground level and laid out to make provision for receiving rooms, X-ray, small emergency dressing room, sleeping quarters for help, dining room for help, dining room for nurses while on duty, main linen room, entrance to clothes chute, entrance to dumb waiter, store room.

The New Isolation Hospital building to share in common with the present hospital:

(1) One central refrigeration plant.

(2) One central main kitchen.

(3) One central laundry—to be erected entirely above ground level, so as to insure adequate and proper ventilation for employees while on duty.

(4) One central heating plant.

(5) One central nurses' home—the present nurses' home to be enlarged so as to provide:—(*a*) sixty additional single bedrooms; (*b*) dining-room, 1,600 square feet of floor space.

THE TORONTO PREVENTORIUM

"The Daughters of the Empire in Toronto may well be proud of their magnificent work in connection with the Preventorium," declared Mrs. John Bruce, Treasurer, at the tenth annual meeting of the I.O.D.E. Preventorium, held in the Board Room on November 30th. As represented in actual dollars and cents, the scope of the Preventorium's activities had increased in an unusually satisfactory manner. At the end of the fiscal year, closing on September 30, 1922, the total worth of land, building and equipment assets, endowment fund and balance from the maintenance fund, stood at the enormous sum of $252,708.

During the past year a sum of $14,722 was paid to Mr. A. E. Gooderham, thus completing repayment of his loan of $27,000 used to purchase a nurses' residence. Small honorariums, amounting to $600, had been given to the young doctors who had so kindly assisted the institution with their services.

Among the interesting items in the maintenance expenditures were: Meat, $994; butter and eggs, $1,457; flour, bread and meal, $750; milk, $4,127, and drugs, $256. Total maintenance was $52,112, with total absolute expenditure of $40,408.

Dr. Harold Parsons, in his report as medical adviser, stated that 214 children had been treated during the year. On September 30, 1921, there were seventy-five children in residence; in the following twelve months 139 had been admitted and 142 discharged, leaving a present enrolment of seventy-two. The average period of residence was 128.6 days. All the children had been exposed to tuberculosis contact and many were more or less infected. In most cases the home conditions of the children were far from desirable. As an illustration, Dr. Parsons told of one family where the mother had just been sent to the Weston Sanatorium, leaving six children, all under ten years, and all infected.

One child had gained twenty pounds in six months; another twenty-two pounds in nine months and still another six and a-half pounds in four weeks.

Dr. Dixon had joined the medical staff, to take charge of the skin disease cases. Dental treatment was given by the Department of Public Health of Toronto, and Dr. C. K. Clarke had made a mental survey of the children. Dr. G. A. Davis, who has charge of the babies' wing, reported forty-seven admissions, with only one death during the year. As to the general improvement of the children during their stay in the Preventorium, there could be absolutely no question, he said. Dr. Elliott also spoke briefly, referring to the continent-wide fame of the institution.

Miss Fraser, in her report as Superintendent, stated that it was the aim of the Preventorium to give every child all possible benefits through the extension of the work, yet without losing the personal touch. A new laundry, costing $7,000, had been a much-appreciated addition to the equipment.

Officers for the ensuing year are: President, Mrs. E. F. B. Johnston; Vice-Presidents, Mrs. W. R. Riddell and Mrs. John D. Hay; Recording-Secretary, Mrs. A. E. Gooderham, Jr.; Treasurer, Mrs. John Bruce.

Victorian Nurses' 25 Years' Service in Splendid Work

The auditorium of Gage Institute was packed on November 28th for the lecture given by Dr. M. T. MacEachern, Director-General of the Victorian Order of Nurses, who told of his survey of Canada from coast to coast for the purpose of studying the conditions under which the Victorian Order is working and of making recommendations for an extension of its activities and a strengthening of its influence all through the land.

The speaker, who was introduced by the Chairman, Hon. W. A. Charlton, stated that there was nothing but success ahead of the order, that it stood for service, co-operation, coordination and efficiency, and that its representatives were beloved by the people wherever they worked.

The Victorian Order, declared Dr. MacEachern, desires that its status be understood; that it does not wish to usurp, oppose or in any way interfere with other organizations, but will co-operate fully with all other agencies working in the interest of health, whether they be voluntary, State or municipal. All health organizations, he said, must get together, shoulder to shoulder and hand in hand, so that there may be a clear-cut, whole-covering policy for Canada. He recommended a local health agency in every community, a Provincial Health Council with a representative from every local agency, and a Dominion Health Council with a representative on it for each Province.

The Victorian Order, he explained, has grown fifty times in size since its inception, and the work is eleven times greater than finances at head office can provide for. There are in Canada 400 nurses belonging to the Victorian Order. This last year they ministered to 60,000 people and made 600,000 visits.

By means of lantern slides the speaker showed the multiplicity of ways in which the nurse serves. Not only is she found in the lonely sick room, giving bedside care, but she holds clinics, gives health talks to children, conducts classes in mothercraft, imparts pre-natal advice, watches over babies during their first year of life, and gives generous social service to needy families. Some of the slides illustrated rather eloquently the value of the nurse to the foreign immigrants who scatter through the Western Province and settle far from centres of civilization.

The Order, the speaker averred, had been much too secretive during its twenty-five years of service. Its duty is to tell the public of its activities. Everything connected with the order should be extended, and more supervisors and organizers are required in the field. The rural districts particularly need nurses, and there lies their greatest opportunity.

The speaker expressed the hope that the day might never come when voluntary and philanthropic effort would give way to State aid. The ideal condition is Government, municipal, philanthropic and voluntary agencies functioning together in the best interests of the public weal.

A NIGHT FIRE PATROL

The destruction of St. Boniface College, Winnipeg, by a night fire, with the loss of ten lives, mostly students, is only one of many of a like kind spread over the last forty years or more in Canada, in asylums, jails, poorhouses, schools, hotels, factories, or business blocks used as dormitories or living quarters.

Reckless talk about arson, or bigotry, has followed some of these fires and losses of life; but the almost invariable attendant fact is that there was not a single person awake in the building to raise alarm when the fire occurred, or even a fire alarm system installed to awaken the inmates when the heat rises above the safety point. Let there be less talk of incendiarism as a cloak of what is criminal neglect on the part of someone.

And there are scores of these fire-traps in use all over our country as soon as winter sets in. What is still worse, many of these semi-public institutions employ showy or dangerous architecture: mansard roofs, domes, wooden columns to look like stone. Even fireproof construction is not to be depended upon without patrol.

One man, even a woman, to patrol the institution during the night on a time-recording system—better still, in connection with a local fire system, is the only security. And this patrol can do some work as well.

Our Provincial Legislature should investigate and frame up protective laws, and the provinces of still colder climates ought to be even more active. No public building of twenty inmates without a fire guard should be allowed to carry on. And a stricter building law, at least for all semi-public institutions, should be enacted and enforced.

FERGUS WELCOMES PRINCELY OFFER

The offer of Dr. S. Groves to dedicate to the town of Fergus, as a free gift, the finely equipped Royal Alexandra Hospital, which he founded and has conducted with conspicuous success, will be submitted to the ratepayers at a public meeting to be called by the City Council. The generous offer has been greeted with enthusiasm.

Speaking of the gift the Fergus *News-Record* says: "What is without a doubt the greatest gift ever offered to Fergus, or, for that matter, to any place outside of our largest cities, was made to Fergus Council, when Dr. Groves, the Medical Superintendent of the Royal Alexandra Hospital, here, magnanimously offered to deed to the town this building and complete equipment, worth, at the lowest estimate, some $50,000, without the payment of one cent therefor.

"Dr. Groves has been a medical practitioner in Fergus, his home town, for over half a century. He has won for himself a widespread reputation as a surgeon, equalled by few in the Province. Some twenty-two years ago he decided, for

the benefit of mankind, to open up a hospital here. Many thought a hospital in a small town could not succeed. But Dr. Groves put his indomitable energy and skill into the venture, and, as a result, the Royal Alexandra Hospital was established, and to-day takes a place excelled by none of its size anywhere.

"During this time about 9,000 patients have passed through the hospital, the death rate being exceedingly low. Over 100 nurses have graduated here, and many fill most important positions in hospitals throughout the Continent."

ASK $125,000 GRANT TO ADD TO HOSPITAL

President Ambrose Kent, E. J. Lennox, Col. Noel Marshshall, W. A. Baird and Dr. Edmund King, of the Board of the Hospital for Incurables, Dunn Avenue, Toronto, asked the Board of Control, recently, to recommend a grant of $125,000 to assist them in erecting an addition to cost $250,000, to accommodate from 125 to 130 patients.

Mr. Kent said that when the hospital applied for a grant of $50,000 on building account twelve years ago, they agreed to take care of at least fifty city patients. "Since then," he added, "the city has grown almost double and the demand for our institution has grown, and to-day we have not a building to cope with the demands made on this hospital. We have to-day, on orders given by the medical officer of health, 170 patients and we undertook to pay for fifty. We have over thirty waiting for admission. It is impossible for us to take them."

The deputation said that they hoped to get the Government to assist the hospital. Eighty per cent. of the patients, some bedridden for years, seventeen being cancer cases, came from the city.

The application was referred to the City Hospitals' Commission for a report.

HAILEYBURY TOWN WILL HAVE HOSPITAL

Through the co-operation of the I.O.D.E. and the Ontario Red Cross Society the fire-stricken town of Haileybury will be immediately provided with hospital service, under the Permanent Hospital Building and Site Committee. By a Dominion-wide contribution the I.O.D.E. has raised funds to purchase a desirable property in Haileybury, on the lake shore, with a house suitable for equipment as a ten or twelve-bed hospital.

Immediately after the fire of October 4th, which burned to the ground the existing hospital, the Ontario Red Cross offered to Haileybury a ten-bed emergency hospital unit, to be equipped and operated by the Red Cross until such time as permanent arrangements could be made by the town. Through the action of the I.O.D.E., Haileybury is enabled to accept the offer of the Red Cross Society, and it is hoped that the hospital will be opened at an early date.

Mayor LeHeup, of Haileybury, recently visited Toronto to meet representatives of the I.O.D.E. and Red Cross, and expressed the cordial appreciation of the citizens of Haileybury for this co-operative effort on their behalf.

"ANCRUM BRAE" PARTIALLY DESTROYED BY FIRE OF UNKNOWN ORIGIN

Fire from an unknown source partially destroyed "Ancrum Brae" private hospital at Stratford on December 3rd, entailing thousands of dollars' damage. The blaze, which started in the attic, was discovered about 10.15, and had evidently been burning for a considerable time. Fortunately only two patients were in the institution, and they were carried to safety and later removed to the General Hospital.

While the firemen fought the flames, willing assistants succeeded in getting most of the contents of the downstairs rooms to places of safety.

The fact that the nearest hydrant is almost half a mile away from the burning building caused some delay, but, despite this handicap, the firemen succeeded in confining the flames to the attic. The second story and ground floor were badly gutted by water.

The institution was purchased only a few months ago by Dr. Steele, of Tavistock, and had just been thoroughly renovated.

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Editorial

The Winnipeg Meeting of the Manitoba and Western Canada Hospital Associations

The Manitoba Hospital Association and the Western Canada Hospital Association held a joint convention in Winnipeg on Nov. 13th, 14th and 15th, just before the meeting of the Manitoba Medical Association. The meetings were attended also by members of the Western Canada Catholic Hospital Association which was holding a convention in St. Boniface at the same time. Among the visitors from a distance were Dr. Richard Olin Beard of the University of Minnesota and Dr. M. T. McEachern who, to use the stock phrase of all chairmen, "needs no introduction to this audience." Dr. McEachern reported formally on hospital conditions throughout Canada and discussed hospital organization, which was referred to more formally in discussions and in questions and answers throughout every session.

The address of welcome was given by the Hon. F. M. Black, Provincial Treasurer and acting Premier, who discussed the assistance already given by the provincial government to hospitals in Manitoba and laid stress on the need of economy.

The sessions were occupied largely by round table discussions on such topics as "Standardized Equipment," "Standardization of Surgical Dressings," "Reclamation of Gauze," "Hospital Publicity," "Publicity through the Annual Report," and "The Relation of the Hospital to the Press," "Hospital Costs," "Affiliation of Nursing Schools," "Training School Records" and "Class Room Equipment."

Among the more formal papers was a full and interesting report on the hospital situation in Saskatchewan by Dr. F. C. Middleton of Regina, Provincial Medical Inspector, Department of Public Health, Saskatchewan. This dealt with some of the problems of hospital care in sparsely settled communities and led to a discussion especially of the type of municipal hospital organized by a group of municipalities.

A paper by Miss Cotter of Dauphin on Social Service in small hospitals brought forward the needs of social work in small communities both in and out of the hospitals. In the discussion it was suggested that a solution might be found in public health nurses having smaller districts to cover, thereby being able to work more intensively than they can now.

A committee appointed in 1921 with Mr. H. G. Marton of Winnipeg as convenor, reported fully on Methods of Hospital Accounting, the findings being favorably criticised by Mr. J. D. Reid, C.A.

Laundry principles and practise was the subject of a particularly interesting address by Mr. P. H. Hammond, Manager of one of the large Winnipeg laundries. Miss Jessie Purvis of Portage la Prairie, discussed very fully laundry equipment and supplies as applied to a small hospital. Food service was discussed by Miss Gretta Lyons of the Municipal Hospitals, Winnipeg, and Miss Margaret Speechley.

The equipment necessary for laboratory work even in the smallest of hospitals was demonstrated and discussed by Dr. Nicholson of the General Hospital, Winnipeg who, in fifteen minutes, with the minimum of apparatus, actually carried out most of the essential tests.

At a public meeting, Dr. Beard of Minneapolis discussed exhaustively the report of the Rockefeller Foundation on Nursing Education. With this report in the main he agreed, but argued that the shortage of nurses to be remedied by the measures proposed by the Foundation did not actually exist. He considered the report, however, as one of the biggest events since the Rockefeller report upon Medical Schools, and likely to have an influence upon nursing education corresponding to that of the former report on medical education.

Dr. Stewart, president of the Manitoba Hospital Association, in an opening address, said the care of the sick, which had been at first a charity, was now becoming more and more a community function. It should never become entirely a community function as sickness or health were, in part at least, the results of personal care or lack of care. The small and large hospitals differed in the scope of work that might be undertaken, but in the work each set itself to do there should be one quality only, the best. That did not mean over-elaborateness in equipment. Non-essentials and unnecessary expenditures were especially out of place at the present time. All hospitals should teach, not medical students and nurses only but, perhaps chiefly, the general public. The hospital should be a centre for the health instruction of the community.

Among the resolutions passed were the following:

That the Manitoba Hospital Association endorse the principle of the supervision by the University, of standards for the teaching and training of nurses in the Province of Manitoba.

That this Hospital Association recommends for the consideration of the next executive the principle of having a central Advisory Board and Intelligence Bureau for hospitals within the Province.

WHEREAS: The American Hospital Association is international in scope—comprising Canada, the United States and all America.

And whereas: Provision has recently been made for affiliation of geographical sections, whether provincial, state or district in nature—

And whereas: Such affiliation would have many advantages to our hospital people in being part of, and closely in touch with this, the largest hospital association in the world—

Be it resolved: That a committee be appointed to bring in a report on the advisability of such affiliation and that this committee report at the next annual Conference.

Another resolution fully endorsed the movement for hospital standardization.

On the social side of the convention, the big event was a reception at Government House by the Lieutenant-Governor and Lady Aikins. Sir James Aikins was, during the past year, the honorary president of the Association and since its inception has taken a keen interest in its welfare. On the first full day of the convention, lunch was served to the delegates at the General Hospital and on the second day, at the Municipal Hospitals.

A very good exhibit of hospital equipment was in place which was much appreciated by the delegates.

Dr. C. A. Baragar, superintendent of the Hospital for Mental Diseases, Brandon, was elected president of the Manitoba Hospital Association for the coming year and Miss S. G. Johnson, superintendent of the Brandon General Hospital, secretary. It

is likely that the 1923 meeting will be held in Brandon. The future of the Western Canada Hospital Association was discussed. Some thought it had done all that was necessary when it had brought into being western provincial organizations and that it might now be dropped. Others considered it should be continued. The old executive was continued with instruction to gather opinions and make the decision.

Operating in Homes

Nurses may be called upon at times to prepare for operations in private homes. An occasional doctor does most of his operative work in the home. Some wealthy folk, in deference to their sick one's whim, arrange to have a room especially fitted for the operation. In remote country districts and in villages and towns where there are no hospitals, the doctor is often compelled to operate in the house. The nurses in the Royal Victoria Hospital, Montreal, are given special lessons on operating technique as adapted to private homes. We hope the custom is general in training schools.

Grace Rankin relates, in a contemporary, the experiences of a nurse friend who was spending a vacation on a Colorado ranch. The local doctor requested her to help him in a curettage. The cabin contained but two rooms. There were only two clean towels and two clean sheets. A number of cotton flour sacks were found. The dish pan

was well scrubbed and scalded, filled with boiling water, covered with one of the scalded flour sacks, and put out to cool. A tea kettle full of water was boiled and kept hot. This made the supply of sterile water. A bread mixing pan with a flour sack in the bottom served for the sterilization of the larger instruments by boiling in water, the instruments being lifted out by means of the sack. A thoroughly cleaned milk can covered them while boiling. A second milk can was used in which to boil the surgeon's gloves, a fountain syringe and some pledgets of cotton, these being covered by another pan. Baking and cooking dishes were not used. After the boiling, four sterile containers were ready for use—the pans and the covers. The instruments on their sack were placed on an up-ended box which had been covered by a flour sack over which a very hot iron had been passed. Flour sacks, scalded and pressed with a very hot iron, followed by careful wrapping, were used to bind the patient's legs. Layers of newspapers covered with similarly prepared sacks were improvised so as to be used as a Kelly pad is. (The doctor, however, had a Kelly pad with him.)

The kitchen table was used for the operation. A rolled sheet, passing behind the patient's neck with ends tied to the legs, did duty as a leg-holder. The doctor used a kitchen chair as his stool. The "calf bucket" caught the waste. Kitchen chairs and a

box held the scrubbing up and solution basins. The doctor brought his hand brushes, which were boiled in an enamel basin.

Miss Rankin adds that a steam-sterilizer can be improvised from a common wash boiler with a tightly-fitting cover. A brick or two are placed on the bottom of the boiler at each end. A few strips of narrow board are placed upon the brick reaching from one end of the boiler to the other. Articles to be sterilized are *loosely wrapped* in gauze or pieces of linen cloth and placed on the slats. The boiler is filled one-fourth full of water. When boiling begins, move the boiler to the back of the stove or lower the fire, so that the steam continues to form, but vigorous boiling is avoided. One hour is allowed for such steaming. Dry the articles in a hot oven, but do not scorch the linen.

Miss Rankin once used a dining table for an operation. Drawing the table out to the fullest, two extension boards were placed lengthwise across the opening. On such a table a cotton quilt or clean blanket can be used as a table pad. The table end at the surgeon's right will hold the instruments; the opposite end will answer for the anesthetist's stand. For rectal or vaginal operations the table, of course, should be shorter.

Glass fruit jars will do for cold sterile water, being covered with pieces of cotton cloth tied over the tops. They are placed in a milk pan, partly filled with water, boiled for an hour and then set aside to cool. Normal salt solution may be similarly prepared.

A folding ironing board may be used, when needed, as an instrument table.

A meat platter can be sterilized and used to hold scalpels and small instruments.

Federal Hospital Bureau

Hospital Workers—trustees, superintendents, principals of training schools, and members of the medical staffs of Canadian hospitals, would do well to consider the statement of Dr. Bow, Superintendent of the Regina hospital, made at the last meeting of the Western Canada Hospital Association in Winnipeg, when he advised that there should be some federal department, whose business it would be to co-ordinate the work of institutions and hospitals in Canada. He said he appreciated the work done by the American College of Surgeons in the work of standardization, which had reflected only good on the hospitals concerned. But there was a demand for some central Canadian organization to function as a control bureau on hospital matters.

The HOSPITAL WORLD quite agrees with Dr. Bow and would suggest that this central federal hospital bureau be placed under the Department of Health, Ottawa. We would also advise the resuscitation of the Canadian Hospital Association which should meet yearly, in Ottawa (say), at which meeting representatives of all the provincial associations should be represented for the co-ordination of hospital activities in Canada.

An Ontario provincial hospital association should be formed at once to deal with all subjects in which hospital folk in Ontario are interested. We should like to see the Department of Hospitals of the Ontario Government take the initiative in this matter. Dozens of volunteer workers all over the province would hold up Dr. McKay's hands, if he but called a meeting to initiate the movement.

Each provincial association might nominate one member to a federal board. These might meet at Ottawa, as above suggested, once yearly, under the chairmanship of the Deputy Minister of Health and thrash out all national hospital problems.

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Original Contribution

THE PHYSICIAN, THE NURSE AND THE HOSPITAL*

DR. STANLEY.

Mr. Chairman, Ladies and Gentlemen:—

Each one of the speakers before have cut out of their address many illustrious thoughts and I shall do likewise.

The question left to me is a live one, and I have promised myself fifteen minutes to give it to you in. I want to deal with the three great agencies of scientific medicine, the physician, the nurse and the hospital. Dr. Archer has given to you what we expect of a physician to-day and his position, and what he has done, and I do not think it necessary for me to repeat it, except to say that to-day you expect a physician to be a trained man, trained in the knowledge of his science, but a man with such preliminary education as will make him a student that will continue to train himself in his profession. That is what you expect of a physician, and that is what you have in a large measure in the medical practitioner in the Province. Let me say this: Professor McPhedran, one of the outstanding men, visited our Province a couple of months ago and in writing back to the president of the Medical Society he said "I have visited many associations of medical men in various countries, and I want to say this, that the medical men of the Province of Alberta are more interested, seem more up-to-date and are more actively looking for knowledge than any other group of medical men in all my experience." I can say that because I believe he meant it. It is to be expected of him that he will be a trained man. He will be able to use his own senses and this is emphasized by many of our leading men, but also he will be able to use all the facilities which scientific medicine provides to him to-day. Now probably you don't expect a general practitioner to be a specialist in all diseases, but you certainly do expect him to

*Read at the Convention, Alberta Hospital Association.

have a general scientific knowledge of scientific medicine, and the best specialist to-day in any line is the man who has a general training and a general scientific knowledge that will enable him better to practise the specialty which he chooses. I might take considerable time in going into the knowledge required by a medical practitioner to be a technician; the use of the X-ray; the use of the various laboratory facilities for examination and diagnosis of such troubles as syphilis, and the diagnosis of tuberculosis, but that would take up a lot of time, so let me go on further to repeat what Dr. Archer said in regard to surgery and the advance that has been made, and what is expected to-day of a surgeon and of a physician. He is not any more simply a dispenser of medicine, but a man who uses all means to cure the disease. Medicines have their place and in the last generation there have been many therapeutic advances in the use of medicine which we would do well to remember. But this making use of drugs scientifically is now not the only necessity, there must be absolute knowledge on the part of the physician as to what each will do. He will also use every other method. Take diet for instance. You hear of men using this particular fact of scientific medicine and stretching it to unreasonable limits in order to draw big fees from the public. The physician to-day is an expert in diet for various individual cases; he is an expert in the use of massage, of electricity and of all other various systems and means which are being used regularly as well as irregularly. But let me go on from that and repeat what Dr. Archer said in regard to preventative measures. Smallpox, yellow fever, diphtheria and various other epidemics of that kind have practically been conquered.

Now let me pass on from the position the physician holds to the position which the nurse holds. The nurse is one of the good partners in scientific medicine. Let us get that into our minds right now, she is no longer simply a nurse helping in the home. The nurse is demanded by the public and belongs to the trio which forms scientific medicine to-day; one thoroughly and scientifically trained to be of assistance to the physician. She is trained in the use of drugs, not that she

prescribes, but she knows the drugs that are being administered. She is trained in surgery; she knows the principles of surgery, so that in the operating room in the various dressings and in many other ways she is thoroughly and scientifically trained, so she is indispensable in surgery and scientific medicine, and she is trained in the use of various other means such as massage and electricity. Then I might call attention to this fact on the part of the nurse and the part of the physician: that there is being given a great deal more attention to-day to the fact of the mental condition; so to-day the physician is trained to analyse the mind, and so the nurse is trained to apply the remedy as prescribed by the physician along this line. We demand of our nurses that they have preliminary education so that they will be able to continue to study, to be able to inform their minds and to keep up with the advances in scientific medicine; for the nurse who is no longer a student is as dangerous as a physician who is no longer a student. Let me say this in regard to the nurse. She is a teacher. We are training our nurses to-day in order that they may take their part in the training school in the hospital or that they may help in the endeavor to carry on the Public Health Department, municipal and provincial; and the nurse is one of the most important factors in the health endeavor being carried on in the municipalities and throughout the Province; so, as part of a scientific medicine, she is indispensable.

The third factor is the hospital. I would like to impress this very strongly if I have the time. These hospitals are an absolute necessity for scientific treatment of the sick. It is impossible for the physician to act without the nurse, or without the hospital. I do not mean to say that every sick person should go to the hospital, but I do say this, the physician must have at his disposal all hospital attendance and all facilities in order that he may be provided with curative means and have at his disposal diagnostic facilities contained in these hospitals; so if I give you no other thought I would like this impressed as part of the scientific measure and as an early necessity for progress along health lines—the hospitals must extend. Hospitals are the centre of our health endeavors. They should be in every community; that is in every

district so that from the hospital will radiate a knowledge of health, a publicity centre if you want to use the term; an important health centre of the community. For diagnosis a properly equipped hospital must be at the disposal of the physician, in order that he may make a proper diagnosis, which must be made before a disease can be treated properly. The research work which has been going on in this generation and the generation preceding has been carried on in the hospital and, because of the research work scientific medicine had advanced to where it is to-day, and that has only been because of the facilities the hospital offered to the medical man to make these research studies, that they have been able to advance medicine to the point where we find it to-day.

Now then we have these three factors, these three great agencies forming scientific medicine. There must be full and complete understanding and co-operation between the three: the physician, the nurse and the hospital. One cannot do without the other. I had the privilege of addressing the graduating class of the Holy Cross Hospital, and in part I brought out that part in these words, using a parody upon the Bible: "The hospital, the nurse and the physician are co-partners in the science of medicine and from their nature, and necessary nature, are still separate members of this one body. For the body is not one member but several members and the nurse cannot say: because I am not of the physician I have no need of thee; nor can the physician say: because I am not of the hospital I have no need of thee, and because I am not of the hospital I am not of the body; the physician cannot say of the nurse: I have no need of thee. Nay, much more, those members of the body which seem to be more feeble are necessary. That there should be no schism in the body; but that the members should have the same care one for another. And whether one member suffer all the members suffer with it or one member be honored, all the members rejoice with it. No, these three must not be separate; the physician, the nurse and the hospital must work in complete co-operation."

Now as President of the Hospital Association I would like to deal with a position we find ourselves placed in in regard to the hospital. Let me say this before I commence dealing

with that, that we have advanced in this Province probably more rapidly in the matter of hospitals than in any other Province in the Dominion of Canada proportionately speaking, and let me offer words of praise in connection with the administration of the hospital department in this Province, and the endeavors being made by the Honorable Mr. Reid in conducting the Department of Health and particularly conducting the Hospital Department, the rural hospital as organized, having done magnificent work. The rural hospitals in this Province are doing a magnificent work and filling a great need. I say this because when I follow up with the remarks I am going to make in a moment, I do not want you to understand I am offering any criticism but simply offering suggestions of what can be done for the future, setting out some future endeavors and ideals to which we may reach out and which we can hope to attain within a few years, and perhaps not so far off as some might imagine. The point is this, that if the physician, the nurse and the hospital are unquestionably factors in scientific medicine, then in all fairness the hospital should be available to all citizens on fair and equitable terms. I think that is reasonable. Something that perhaps cannot be attained this year or next year, but it can be attained within the life of most of us sitting here to-night.

What is the position in this Province to-day? The citizens of this Province cannot obtain hospital facilities on fair and equitable terms, and they will never attain them until we have a Provincial system which shall place at the disposal of every citizen the hospitals of the Province. What is the position to-day? We have our hospitals, the larger hospitals in a few of the larger hospital cities, Edmonton and Calgary, Medicine Hat and Lethbridge. We have another number of hospitals, I cannot say how many, privately owned by various organizations and conducted by them upon philanthropic and charitable contributions. Then we have the municipal hospital which is carried and financed by the fees that are paid in and by taxation which is imposed. Now here is the point: supposing a person lives just outside the municipality or just outside of a rural municipal hospital district. Then he is charged a prohibitive rate in order to obtain hospital facilities.

For an outside patient wishing to come into the general hospital he finds a charge of $4 a day for the public ward, and he finds there a double rate for the use of the laboratory, the use of the X-ray and the rest of the diagnosing facilities. He finds a large fee for the use of the operating room and so on. Then you take in regard to the rural hospital. If a person is fortunate enough to be within the confines of the rural hospital, then he receives the facilities at $1 a day, and if across the road then he has to pay, I think it is, $5 a day. $5 is prohibitive almost to the ordinary settler. Here is the way I see it. I am not offering criticism, but I am pointing out the position in which many citizens find themselves to-day. What is the remedy? Before I take that let me point out another fact in regard to the pioneer people and those living in foreign districts. We hear cries for medical service and there is no question, it has got to go back to what I have already told you and you will see the almost entire futility of sending a medical man away into the pioneer districts, absolutely shut away from the use of the hospital and the nurse, to go out and try to carry on his profession and assist these people. He could probably give some assistance in some cases, but generally speaking, his efforts are wasted, so that as a matter of fact the medical practitioner who goes away out to the outlying district, goes in a missionary spirit and very often is wasting his time. He might do far better work at some other point. I am not trying to discourage the medical man, but I do want to emphasize this: that it is in these pioneer districts that the hospitals need to be provided so these districts may have the use of the hospital, in a small way no doubt on the start, but will enlarge as time goes on. Now what is the system? I would say a Provincial system. I am not advocating, and I am not going to say anything to-night about the free hospital; we hear so much about free this and free that, but some person has to pay the bill; that is another question—when I speak of the Provincial system I do not necessarily mean all must be municipal hospitals, but I do mean this, that the Provincial Department of Health should take such control over the administration of the hospitals of the Province so that they would be able to administer and classify to some extent these hospitals, so as to

provide for any one particular local district and for the Province as a whole. Take the rural districts, the hospital districts under the Municipal Hospitals Act. They throw a boundary around themselves and no person is allowed—they are allowed but not invited to come in—that is for the ratepayers within that municipality. The point I am getting at is this: the Department of Health should have sufficient administrative authority to be able to locate the hospitals throughout the length and breadth of the Province and should be able to classify these and define the work they will do. That is a large question; suffice it to say this—when it comes to a matter of dealing with contagious disease, when they come to dealing with tuberculosis, that brings you to the point where you have got to have certain expenditures, certain facilities, that cost a great deal of money. It is not necessary for each district to provide for all of this, but with one system of distribution by the Department of Health these could be provided so that the whole Province be provided for in a fair way. That does not obtain at the present time. If this district wishes to have diagnostic facilities going to cost a great deal of money, they must buy them and put them in there; the same thing with the next one and maybe you are duplicating. You will be duplicating time and again this expensive work. Now you say that costs money. Yes it will. Would it not be better to centralize entirely in Edmonton or the larger cities because the municipalities object to the Federal or the Provincial Government taking any of their power from the municipal authorities? We realize that, but the central department of health certainly should have central administrative authority in order that they will be able to make our system so that every person in the Province will be able to receive hospital facilities on fair and equitable terms. If the central department of health takes authority they will certainly have to give the municipal authorities some financial reimbursement by making good the authority taken from them. We have done it in regard to the schools. Schools have local administration with certain restrictions which are retained by the Department of Education. The hospital will have local autonomy under certain restrictions which will make that a complete Provincial system

harnessing the work into a system which will be set down for the care and accommodation of the sick. How can that be done? It will be done by a system of grants. Let the hospital which renders certain facilities receive a grant for it. Then what? It will mean that it will be a tax. The Provincial Government cannot get money out of the ground; it comes from your pocket and mine, and it will have to be raised from the taxpayers of the Province. That will mean a health tax, but I do say this, people in this Province will be quite prepared to pay their share, and it will be necessary to give hospital accommodation to the people of the Province so that every person will receive hospital accommodation on fair and equitable terms.

HOSPITAL RECORDS*

Roy Kingswood, M.D., Chief Resident Surgeon, and George A. Ramsay, M.D., Registrar, Victoria Hospital, London.

A hospital may be described as a public utility filling a position of need. As such, its function is to give efficient service. In that service how do records function?

The patient has the priority of claim and has the right to expect such thoroughness as is included in an effective record.

The physician fulfils a duty to himself in giving to the patient such study of the diseased condition as is outlined in a record.

The public, whose institution the hospital is, has a right to feel secure that the procedure therein is thorough, painstaking, logical, in order that conservation of life may add to community assets.

The institution needs to know that it is discharging its full duty to the community through its staff and officers, to the end that efficient service may become its tradition in perpetuity.

* Read at the Clinical Congress of American College of Surgeons, Boston, Mass., October 16th, 1922.

These are axioms, and, it is with their application that we are concerned.

Records are financial, social and medical. With these last, I propose to deal. While mindful always of the requirements of the standards set by the American College of Surgeons, I want to warn against records kept merely as so much manuscript, with no attempt at application. Likewise would I add my protest at any attempt to make the hospital fit the record, and not the record to blend with the character of the hospital.

In arriving at what might serve Victoria Hospital, London, we made an analytical examination of at least thirty sets of hospital forms and chose what seemed most applicable to a municipal hospital of 400 beds for public and private patients, comprising the whole series of types of service, selecting what seemed to be our particular needs, discarding much and here and there contributing some little thing that appeared to warrant a trial. There was an effort made to link in harmonious union with hospital records those documents required in dispensary and follow-up social service. We had the satisfaction afterwards of seeing almost an identical system described for a hospital that compared with ours in size and service.

The requirement which guided the adoption of any form was that it should be simple in legend and complete in the outline which should guide the investigator, leaving always scope for individuality. I protest against such efforts toward standardization as would stamp out individuality. Again, in the interests of economy, of time and money, we endeavored to secure such procedure as would make every single effort at record, from admittance slip to discharge certificate, a constant working tool, and a permanent document. It is easy to carry system to such a degree that it enslaves. Re-duplication may weary and discourage even the most energetic.

The end purpose of a record is a diagnosis demanding complete, prolonged, and detailed study of the patient from physical, mental and psychological view-points. In this evolution of analysis the record should always be a guide to investigation, an adding machine of daily and hourly obser-

vations to the ultimate totalization of a diagnosis of the patient, not alone of his disease. Nor does it stop there. Treatment follows on the conception of the cause, course, and expected outcome of the condition and is varied to meet its changing phases. If then, it gives proof of intelligent endeavor, it requires a record, and if it fails, simple honesty likewise requires a record of what has been tried and found wanting.

I wish to quote Dr. Emerson's definition of a record. "It is not our imagination or our memory of past events, but a painstaking entry on imperishable human documents of what is at the same time the glory and the humility of medicine, the truth as we see it, when we see it, the facts as our faltering and unskilled senses take note of it, whether in the immediate presence of suffering humanity, or at the operating or autopsy table, while still the echo of the laboratory test is knocking at our conscience. The present is ours to record. To-morrow belongs to the past." The terse definition by Father Moulinier is that a record is a collection of facts that you find, filter, focus, and then face fearlessly.

I wish to acknowledge the pioneer work of the late Dr. J. L. Stapleton in laying the foundations of our record system in Victoria Hospital, London. This was carried on by Dr. J. R. N. Childs and I acknowledge gratefully also the sympathetic support of trustees, staff, internes, and record clerks in making the effort possible.

Our method of procedure at Victoria Hospital may be best explained if we take an actual case and follow it through the hospital from the time of admission until discharge from the hospital.

History. Mr John Doe enters the hospital on July 3rd, 1922. The necessary notification to the attending physician, interne, etc., has been given. The interne visits the patient—shortly after admission, not with a huge pad of record papers in one hand and a fountain pen in the other, but purely to meet the patient, become acquainted with him, and to make sure that his wants are being supplied. This gives the interne his approach to the patient. Then sometime, within a few hours, he is able to obtain a history which is a real record of the patient's condition.

The history embodies his (1) chief complaint; (2) mode of onset of disease, which is really the explanation of his chief complaint; (3) short past and family history. We ask that these statements be concise and bear directly on the case.

Physical Examination. The interne then proceeds to his physical examination of the patient. We require this to be complete and if there are any findings in his examination which are indefinite we ask that he call in one of the senior men to assist him. We suggest that the interne start his examination at the head and proceed downward to the feet, taking the various systems in order. Probably the two most important items upon this form are (1) Working or provisional diagnosis. This is the interne's honest, working diagnosis of the case after he has completed history and physical examination. We ask that he hold to his opinion until someone with more experience proves that he is wrong. We do not have to have this diagnosis absolutely correspond with our final diagnosis, but in his discussion of the case he obtains his training and the patient may benefit by more careful investigation. (2) Read by Dr. .... This is written on the bottom of the chart after the visiting doctor has read the history and physical examination. This shows the interne that the doctor has been sufficiently interested in his findings to at least have read what he had written.

Progress Notes. This is a record of the patient's general and post-operative condition, and explains the healing of the wound, etc. It also gives the opinion of any doctor who may have been called in consultation on the case. These progress notes are to be written at least every three days, and more often in serious cases.

Operative Record. This is a detailed record of the procedure, technique, pathological findings, etc., at the time of operation. Dictation is carefully given by the surgeon or senior assisting interne immediately following the operation. On a busy morning the stenographer takes the dictation in the operating room.

X-ray Report. A report from the department of roentenology would be found on case of renal calculus—a miniature reprint of the plate is shown in the upper half of the X-ray form, with the dictation below.

Laboratory Finding. The laboratory findings are recorded on the usual printed form and include, urinalysis, blood and serological report. The work of the laboratory technician is supervised by the interne on service. The Institute of Public Health and the Western University Medical School laboratories co-operate with us in the more difficult laboratory findings.

Nurses' Record. A record written by the hall nurse of the patient's general condition, medication, treatment, doctor's visits, etc., is carefully kept. Too much cannot be said for the nurse who carefully observes the patient and then records her observation. She has a greater opportunity than either the visiting physician or interne.

Dental Record. To make our record complete we have a record of dental examination, extractions, prophylaxis, etc., as advertised at our Wednesday morning clinic.

Chart Foldery. These are in two colors—yellow for female patients and white for male.

On the discharge of the patient from the hospital the interne is responsible for checking the chart to make sure that all records are complete. It is then placed in the chart folder, properly filled in, the discharge diagnosis completed and presented at the record office for the approval and signature of the Director of Records. The charts are then filed by the record clerk, according to our number and cross index, according to disease.

Our record of histories secured for the months of September and October was 100 per cent. on each of staff wards, semi-private wards, private wards.

Just a word as to how we obtain our records. The interne on the ward is responsible for the history and physical examination. By his gentlemanly and professional approach and by making sure that the patient has become partly acclimatized to the hospital he wins the confidence of the patient. We require that a nurse be present at the examination of all female patients and that the patient be draped in such a manner as to insure thorough examination and yet not offend the delicacy of the patient. In this way our private patient

co-operates with us. We also have convenient places, such as sun-parlors, etc., where internes may write their records without being disturbed. Many discussions take place here which prove beneficial to internes, and we trust, to the patient.

Our record office is not a spacious or palatial room. It is small and compact, but often a busy place. Here, the operating and other important dictation is given to a stenographer. Here, also, are the completed charts numbered and filed in cabinets for future use.

We consider our internes as one of the spokes in the wheel which turns our machinery. But, perhaps, your hospital has not the facilities for obtaining internes to carry out record system. Perhaps the doctors, themselves, do not think a record system necessary in your hospital of fifty, seventy-five, or one hundred beds. Perhaps they are busy men and have not the time nor inclination to record their diagnoses, observations, and treatments. We realize that many of the smaller hospitals, not as favorably situated as Victoria Hospital, have at present difficulties which we have not encountered. Nevertheless, every hospital no matter what bed capacity, in fairness to the patient, doctor, medical profession, and the community at large, should at least make an honest attempt to meet the requirement of the minimum standard of the American College of Surgeons.

We make the suggestion that hospitals of fifty beds or more could unite their visiting doctors in the form of a hospital staff under the direction of a chief of staff. The details of the minimum standard could then be placed under their jurisdiction. A stenographer could be retained who would have charge of the record room, taking dictation, filing charts, etc. A graduate nurse could also be obtained if it was thought inadvisable to procure a graduate doctor as interne at first, who could, under direction of the physician, obtain the history, write progress notes, etc., and even perform certain laboratory technique. Doctors will find the Public Health Institutes of the Province eager to assist them in any laboratory investigation and graduate nurses from the Department of Public Health prove valuable hospital executives. The physical findings could be given to the nurse or stenographer by the visiting doctor. This would at least be a step in the right

direction and the expense would be very little, in consideration of the advantages to both patient and doctor.

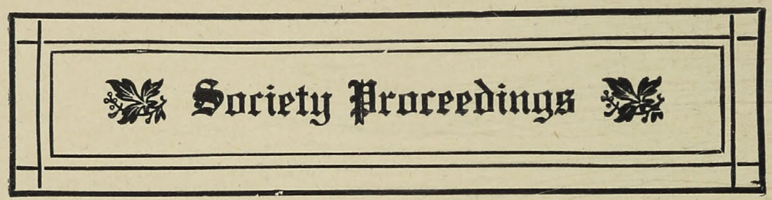
The advantages of a record system might be briefly mentioned. The staff can meet at stated intervals to discuss cases, either discharged or at present in the hospital. This leads to staff-conference analyses and the promotion of scientific research.

On the re-admission of a patient who has had a previous operation it is of decided advantage for the doctor to be able to refer to the previous operating-room report for concise details.

A patient who has been treated in a hospital in another city moves to your location. You are called to see the patient who explains that she has been under treatment at such a hospital. How satisfactory to you to be able to obtain her diagnosis, treatment, etc., from that institution. How much valuable time is lost to the patient and to you if such a record has not been kept carefully. The advantages of a record from medico-legal aspect must not be forgotten, also.

But someone has said our record system must cost considerable money. We have worked out our per capita record cost and find that it averages fifty-one cents per patient.

We, therefore, put the question before you: Is it worth while? Does it pay?



HOSPITAL JOINT CONVENTION

This meeting was held in Winnipeg in November last, under the presidency of Dr. George F. Stephens of the General Hospital in that city. Hon. F. M. Black welcomed the delegates. "When we measure the progress of our own nation," he said, "and the so-called Christian nations against those who have not that Christian faith, we then see at once what a real progress has been made . . . We are justified in considering your profession the second greatest, allowing those who attend to the spiritual interests of mankind as the highest."

"In four years past the Province of Manitoba has paid out in grants to hospitals $528,000, and in building subsidies, $177,200, of which the Winnipeg General Hospital has received $80,000. The Province allows about ten per cent. to the cost of every new building erected.

"How long are we administrators of public funds likely to continue to make such grants, in view of the avowed intention of the public not to pay any more taxes?"

Dr. M. T. MacEachern gave a lantern talk illustrating various phases of hospital, health and welfare work. He also gave an address on Annual Reports. These reports, he said, should give an account to the public of what hospitals are doing, particularly of the good done by the money spent. The statistical portion of reports—the value of which some people questioned—he was not sure should be included. Social Welfare work and Ladies' Auxiliary doings should be recorded.

Dr. Barrager, Superintendent of the Manitoba Hospital for Mental Diseases, Brandon, said: "Our reports practically never reach the public—they are not of sufficient volume to send about."

Dr. Barnes, Superintendent of the Manitoba Hospital for Mental Diseases, Selkirk, thought that the ignorance of the general public in regard to mental hospitals was the most lamentable thing in Canada. "Our hospitals are forty per cent. overcrowded. The public should be made to realize this, in order that conditions might be amelioriated."

Mr. Hartism, a trustee of a small hospital, said in his hospital the report contained the financial statements, and some statistics regarding patients, but thought that pictures of the actual work carried on would be a good thing to add. "If there is any lack in the hospital the public should know of it."

Mr. Darrow, a trustee, stated that the technical information in reports was of interest merely to the medical and nursing staffs. The report should be printed and circulated throughout the hospital's constituency. It should also be published in the local newspaper, even if such had to be paid for.

Dr. Bow, Superintendent of Regina Hospital, said the attitude of the public to the hospital was one of indifference. This was due largely to the attitude of the hospitals. Too often the press was left in the dark as to what was occurring in the hospital. In addition to the annual reports, supplementary reports of Trustee Board meetings might be given the press.

Mr. MacNeill, trustee of Dauphin hospital, stated that for the first ten years of their hospital's existence reports were gotten out, but "they got it into their heads that it was costing more than it was worth." He was afraid they had made a mistake—the public should periodically have before it a picture of what the institution was doing.

Dr. Stewart said when writing his reports he kept three people in view—the man a thousand miles away engaged in the same sort of work, a member of the hospital board who needs educating, and the general public. Perhaps we should have two reports instead of one—one technical and one popular. An Eastern hospital headed its annual report "The Story of Such and Such Hospital;" a note worth striking.

The press has a right to news, but it doesn't want any dead, uninteresting stuff and it is not a free advertising agency. The press is a gentleman; the press is a lady, and if that fact is kept in mind hospital executives will get in better with the press than if they lose sight of this fact.

If there is some story that is apt to get into the press and you want to keep it out, the best thing to do is to tell it to a newspaper man and tell him all about it and the cause. The worst thing you can do is to try and kick him out of the door.

Dr. Bow recommended that hospital executives should take the press into their confidence. There were many stories of human interest that could be published in a professional way which will reflect credit on the hospital and arouse the public interest. Hospitals have only themselves to blame if the local press fails to take the proper attitude toward the institution. If a hospital has a deficit, that can be featured. The success of an institution cannot be measured by the fact that it is operated with a surplus. The public should be shown what the hospital has done for the money expended. A deficit usually represents the cost of caring for non-paying patients. The financial aspect of the hospital should be presented in a very clear-cut manner; not that it is being run for a profit, but organized and equipped to give the highest possible service; that it costs money to do this, and if it does this work the public must not expect the hospital to be a big revenue producer.

The work in the children's and maternity departments may be featured in connection with women's organizations.

Mr. Darrow thought every hospital should have some discreet person whose business it is to prepare items for the press. There were certain discreditable happenings in hospitals which should not go before an undiscerning public.

Dr. Stewart thought the giving out of news ought to be the work of the superintendent of the hospital.

The meeting then discussed some questions. Someone asked for the best method of sterilizing cutting instruments. Sister Charles of Vancouver, replied that in her hospital they soaked these instruments for ten minutes in pure carbolic acid. Two minutes in boiling water was sufficient. In reply

to a second question, should a patient suffering from tetanus be isolated? opinion was divided. Further answers to questions were: An X-ray technician if injured is personally responsible unless the hospital has neglected the requisite safety precautions, or has employed an incompetent man.

Members of the staff in Brandon Hospital are paid salaries of three or four weeks' duration. If the sickness is more protracted the official is sent home and his pay stopped. More consideration is given to employees who have been long on the staff than to those who have only been employed a short time.

Dr. Berrager said that in his hospital all employees have sick pay for a month and permanent employees up to one year.

Mr. Stoker, Secretary of the Hospital Commission, Winnipeg, said that anybody who had been with them for twelve months was entitled to twelve days sick pay in the year—unless the illness was of a contagious nature, in which case a maximum of thirty-five days was allowed.

Mr. Darrow said he thought something ought to be done to induce laymen to come into the hospital association. This could be done if the professional element would come down to earth and talk to those who do not understand professional terms in words they knew the meanings of. Instead of being only associate members of the Association, the speaker was of opinion that trustees should be eligible to active membership. These trustees were the bone and sinew of the whole hospital body. Having to do the financing, they were surely worthy of full membership.

Dr. Nicholson was asked to specify some of the principal items for the equipment of a small laboratory. He mentioned first a glass slide and illustrated the process of securing a smear. He next described the method of staining, and of using a hemiglobinometer. He said the Burroughs and Wellcome Company put up stains in a very convenient form for use. They published a small pamphlet concisely describing how the stains were to be used. A microscope was needed for making examinations of specimens. A centrifuge was not an absolute necessity. By standing, fluids would form a sediment. Material and glass tubes needed for testing for albumen and sugar were indispensable. The technique for kid-

ney-function tests was then described. Dr. Nicholson pointed out that laboratory work could be done in a small side room. A good standard blood counting apparatus should be procured.

The Chairman commended Dr. Nicholson for demonstrating to trustees present that a great deal of very useful laboratory work can be done with very simple and inexpensive equipment.

Miss Edith Moffat described the technique employed in the operating room of the General Hospital, Winnipeg. The room is thoroughly ventilated. Every ledge and article of furniture is washed with a two per cent. lysol solution. The floor is scrubbed with lots of soap and hot water. Linen and dressings are sterilized in an auto-clave, for one hour under a pressure of twenty pounds of steam. Charts show the number of inches of vacuum, time of each sterilization and number of pounds pressure used. Diack's sterilizer controls are also used, one tablet being placed in the centre of each drum sterilized. A ten-inch vacuum is insisted upon, which means 14.7 degrees under atmospheric pressure. Without a vacuum one might as well not sterilize at all (the speaker maintains) as "steam will not penetrate where air pockets exist." The water is stone filtered and sterilized by boiling. Talcum powder is sterilized in a large open tray for one hour every day, before using it for powdering gloves or filling shakers, when it is re-sterilized. Saline solution is filtered three times, then sterilized three times, twenty-four hours elapsing between each sterilization. Silk, linen and silk-worm gut sutures are sterilized for one hour and preserved in alcohol. They use Perfection catgut. It is boiled in the tubes for half an hour before being used. Instruments are boiled for seven minutes. Knives are wiped off with alcohol and boiled for one minute. Instruments which have been used in septic cases are washed under running water and boiled from fifteen to twenty minutes. Linen used in septic cases is soaked in a solution of lysol for one hour, before being sent to the laundry; and all furniture, cushions and floors, are washed off with lysol.

The operating room is not fumigated. Soap, water and sunshine aplenty will do instead.

Surgeons and nurses scrub their hands and arms for seven minutes, then wash off with alcohol. Then cap, mask, gown and gloves are put on. Gloves are washed, boiled for three minutes, dried, mended, tested, packaged and sterilized for fifteen minutes under twenty pounds steam pressure. The gauze used in the operating room is not washed and re-used there. Gauze in clean cases is saved, washed in the laundry and sent to the wards. Woollen blankets are not used on account of the fluff and lint. The temperature of the operating room is kept at seventy-six degrees.

Dr. Stephens said there was no reason why reclaimed gauze should not be used for dressing purposes. Indeed, surgeons in some places asked for washed gauze in the operating room. The reclamation process consists in sorting out the gauze, soaking it five minutes in cold water to loosen the blood clots, placed overnight in a soda bath; then it is given a rinse and boil; then put in warm soapsuds for twenty minutes; then with a light soapsuds and a bleach it is boiled; then given one lukewarm rinse and two cold rinses; thence to the gauze sterilizer; thence to the wards.

Miss Johnston said she had observed one of Diack's controls which did not fuse, when two others did. Miss Moffatt had observed this also, but when the control was put back a second time it fused.

In discussing standardized equipment, Miss Johnston thought it would be an economy to discover one type of each article of hospital equipment—the best, and use it everywhere. The Fowler bed, she found very satisfactory, as an example.

Dr. MacEachern suggested that a committee be formed to study and report on standardization of equipment.

Dr. Stewart suggested the appointment of a committee on hospital planning and construction.

Dr. Stephens queried whether it was wise to have a Western Canada Hospital Association or separate Provincial bodies. A scheme might evolve whereby representatives of the various Provincial bodies would come together yearly as at present, in association with the local meetings. While many problems were identical that of legislation was for each Pro-

vincial body to settle for itself. Also the suggestion that these Provincial bodies might be considered geographical divisions of the American Hospital Association might be considered.

"There is (I believe), a National Association in Canada which was organized some years ago, but which, if not dead, is at least hibernating somewhere in the vicinity of Montreal or Toronto."

Dr. Stephens then discussed the question: Why is hospital treatment so expensive? With the growth of medical science hospitals have been compelled to add new departments and this meant added cost; until nearly all hospitals were laboring under financial difficulties. In spite of this, criticism was often made of the type of service—were the patients receiving the benefit of those scientific aids to diagnosis and treatment they had a right to; and were nurses receiving adequate training?

In Western Canada the allowances made under present legislation made it extremely difficult to keep up standards of service.

Hospitals should keep within their income. To do this one was faced with two alternatives—either to curtail the service or increase the income (a far more desirable thing to do). And here was where publicity came in. The public should know why hospital treatment costs so much. Let the public behind the scenes. The ordinary hospital visitor gets only a superficial glimpse of the work of the hospital. He sees the patient, the nurse, the doctor, the medicine, the food tray; but not the kitchens, the food distribution, the storerooms, the purchasing, the operating suite with its personnel and technique, the laundry, and the power plant.

The press was the broadest and farthest-reaching publicity medium and was always ready to give legitimate publicity to hospital work. Movies are an ideally educative medium and afford an easy method of reaching a large number of people in a telling manner. Hospital exhibits at local fairs are useful. Direct visitation to the hospital should be encouraged on special days and on National Hospital Day in particular.

WINNIPEG HOSPITAL CONVENTION

At the meeting of the Western Canada Hospital Workers (partly reported in our last issue) Dr. Middleton, Assistant Commissioner of Health, Saskatchewan, gave a review of the hospital situation in Saskatchewan. During 1921, forty hospitals provided accommodation for treatment, receiving financial aid from the Government. This includes the sanatarium at Fort Qu'appelle and the Pas in Manitoba, the latter receiving patients from the Cumberland House district. The hospital at Big River closed, owing to the cessation of mining activities. The Robsart Hospital was closed, but re-opened with the assistance of the Red Cross. Red Cross outposts in several outlying districts are being assisted. These consist of small houses fitted with two or three beds for maternity cases. The Government hospitals furnished 2,116 beds: general 1,502, isolation 218, tuberculosis 396—one bed for every 358 of a population. The Saskatchewan hospitals admitted 29,944 patients in 1921—one in twenty-five of the population. Twelve thousand three hundred operations were performed, 2,025 being gynecological. There were 3,662 abdominal operations. Three thousand five hundred and twenty-four maternity cases were cared for—about one birth in six taking place in hospital. One thousand and thirty-two deaths occurred in hospitals—3.5 per cent. of total admissions. There were 121 deaths from puerperal causes in the Province, forty dying in hospital. The government grant was $255,215.50, $8.50 for each patient. The average length of stay was 16.7 days per patient.

Only fifteen hospitals conduct training schools for nurses. Eight nursing housekeepers graduated from the smaller hospitals. There are seventeen nursing housekeepers in training. Several hospitals have introduced the eight-hour day. The result is much less time off by sickness. Some of the smaller hospitals have affiliated with larger hospitals for nurse-training. It is probable that all pupil nurses in training will receive a part of their training at a tuberculosis sanitarium. It has been urged upon the Government that hospitals receiving government aid should be required to set aside ten per cent. of their beds for tubercular patients. This would enable the sanitarium to accommodate a larger number of cases

from unhospitalized areas than at present. More sanatoria are needed. In 1921 general hospitals cared for 184 cases of pulmonary tuberculosis.

The cost per day per patient for 1921 was $3.15. In British Columbia it was $3.35. Costs are going down somewhat. Steps have been taken to have all hospitals adopt a uniform method of accounting. The Government suggests costs be apportioned thus:—

(1) Operating—salaries, wages, provisions, fuel, light, power, medical supplies, sundries.

(2) Maintenance—buildings, grounds, furniture, equipment, dry goods, sundries.

(3) Administration costs—salaries for this work, office expenses, sundries.

Forms as supplied and monthly statements as above are sent in. Comparative statements are made and mailed to the chairman of each Union Hospital Board; this enables the different hospitals to compare various costs.

On May 12th—National Hospital Day—there were inspections of hospitals and nurses' homes; graduation exercises for nurses; baby competitions and pamphlets issued describing services rendered.

An endeavor is being made to introduce standardization. Staffs are being organized. Memberships thereon are being restricted to competent and worthy men who will not divide fees; and the holding of staff meetings—a clinical audit—insisted upon.

There are five hospitals of 100 beds and over, four of which have fulfilled the requirements of the minimum standard. There are six of between fifty and 100, four of which have standardized. In Manitoba, there are two hospitals of between fifty and 100 beds, one of which is standard; six of 100 beds; four of which are standard. In Alberta there are two hospitals of between fifty and 100 beds, one of which is standard; six of over 100 beds all of which are standard. In British Columbia there are six hospitals of fifty to 100 beds; one is standard. Six of over 100 beds and over, all are standard.

Since 1919 twenty Union Hospital Districts have been established, but in only nine has a vote been taken. Of the remaining eleven, seven will be dis-established at the request of the Hospital Board without a vote.

Two new hospitals are being built—a twenty-five-bed union hospital at Unity and a twenty-bed at Hafford. The eleven union hospitals serve thirty rural and thirteen urban municipalities.

In reply to what "union hospitals" meant, Dr. Middleton said they were eleven hospitals of from twelve to forty beds built in rural districts, operated and maintained by as small an area as two municipalities and one urban centre, which issue debentures and build the hospitals. The average actual capital cost is eighty-eight cents per quarter section. To provide hospital accommodation for those who have entered into the union hospital scheme, they pay as high as two mills on the dollar on their assessment for hospital purposes; so that the people who have entered into this scheme—husbands, wives and children—who live in that area get their complete hospital accommodation as they do their schooling. This does not include medical attendance. Patients may choose their own doctor. The plans of projected hospitals and of alterations must be approved by the Commissioner. A special set standard of equipment has not yet been demanded. This is being aimed at. The Government contributes fifty cents per day per patient. The plan is working out very well. The smaller hospitals are designed more particularly to do maternity work; it being thought wise to refer major operative work to the larger hospitals. Patients from outside the district are required to pay. If the patient is indigent, the secretary of the hospital sends the account to the municipality from which he comes. The work goes on in these union hospitals much as it does in the ordinary community voluntary hospital. In many districts there would be no hospital were it not for this scheme for union hospitals. In establishing new hospitals care is taken to see that they do not encroach on the territory of a hospital already established. These hospitals are all inspected yearly by a government representative.

Canadian Hospitals

GRADUATION OF NURSES—ROSS MEMORIAL HOSPITAL, LINDSAY, ONTARIO

The graduation exercises of the Ross Memorial Hospital, Lindsay, were held in the Academy of Music, on Thursday evening, November 3rd, 1922, when a class of seven nurses received their medals and diplomas.

The popularity of the Ross Memorial Hospital and the community interest in the training school was clearly demonstrated when the large auditorium was crowded long before the time set for the programme to commence. It was of particular interest to Lindsay to have one of its former boys back to give the graduation address on this occasion, in the person of Dr. Malcolm T. MacEachern, General Superintendent of the Vancouver General Hospital, and now Director General of the Victorian Order of Nurses for Canada, at present engaged in making a survey of Canada for that body. In addition, he had recently been made President-Elect of the American Hospital Association, one of the highest honors in the hospital world. For many years his name has been closely associated with the hospital standardization movement, and he has done much to improve our Canadian institutions of this nature.

The following nurses received their medals and diplomas:

Mabel Amy Flinn, Marion Jean Murray, Lila E. Ward, Florence L. Greaves, Amy N. Spence, Aileen Flett, Bessie B. Cresswell.

The stage arrangement was a most impressive sight. The chair was occupied by Mr. J. D. Flavelle, Chairman of the Board of Trustees. The medals were presented by Mrs. Thomas Stewart, and the diplomas by the Chairman, Mr. Flavelle.

Many interesting addresses were given by various representative speakers, including His Worship, Mayor O'Reilly, Senator McHugh, G. F. Sandy, Esq., M.P.P., the Very Rev. Dean Whibbs of St. Mary's Church, Canon Marsh of St. Paul's Church, who represented the Ministerial Association.

and Dr. Blanchard for the medical profession. All speakers referred with enthusiastic praise to the high degree of efficiency of the Ross Memorial Hospital and its training school. Many references of a eulogistic nature were made to Miss E. S. Reid, Superintendent of Nurses, a graduate of the Ross Memorial Training School and a young woman showing remarkable leadership.

The address to the graduating class by Dr. MacEachern, the speaker of the evening, was extremely interesting, and was followed with the keenest interest by every member of the vast audience. It was indeed a fitting exhortation to send them on their way.

The speaker opened his remarks with reminiscences and congratulations—the former on account of the pleasant associations with the town, where he received his fundamental education, the latter on account of the splendid Ross Memorial Hospital and Training School for Nurses, and above all, for such splendid men of service guiding its destiny, as Mr. J. D. Flavelle and Mr. R. J. McNeilly, Secretary, both outstanding men of vision, public spirit and community service.

Following this he briefly and logically traced the various steps in the history of hospitals and nursing through many difficulties and dark ages to the present day of modern development. The speaker said: "Nursing is as old as creation, but trained nursing is a development of the past century. We now find splendid training schools all over our country, filled with the flower of Canadian womanhood. Not only have you been admitted to this profession because you wanted to enter it, but the hospital has accepted you as a member of the training school after careful investigation, morally, mentally and physically, and further, after you were obliged to demonstrate your fitness for such work. Therefore, you are a select group." The speaker emphasized the importance of the nursing service in the hospital if it is to render the right kind of service in the community and thus retain the confidence thereof. He said: "As a hospital administrator for twelve years, I cannot emphasize how important I consider this nursing service rendered for the success of the institution. It

must be a service anticipating and meeting the patients' needs at all times. It must be a service which satisfies. Our hospitals stand or fall on the type of service which we render to the patients therein."

In conclusion, the speaker addressed his remarks particularly to the graduation class, as follows: "We have watched your careers during the past three years with interest and pride, and now at the end of this period your apprenticeship in the greatest profession that woman can claim solely as her own, is ended. On the threshold of your graduation I congratulate you and wish you great things indeed.

"Completion of your course and graduation marks another beginning or commencement in your lives, and from now on you will be much less guided than in the past three years when you have been under the caring eye and direction of your training-school officers and the hospital administration generally, by virtue of you being a member of this large family to which you will always belong.

"Let us reflect for a moment on the three years which have so quickly and so happily passed and what you have really gained from the vast experience that you have had during this time. You have accumulated an abundance of technical knowledge to equip you to take care of the sick in an intelligent and efficient manner so far as nursing of them is concerned. This knowledge is yours and is something which no one can ever take away from you. Your training, however, has done more than this for you. You have developed qualities of character, of disposition, and of culture not common always to other groups of women outside of your profession, and all this through your intimate relationship and experience with human life in all its phases. You, as no other group of women, have had an opportunity to study human nature at close range and by intimate contact with its impatience, its failings, its eccentricities, its peculiarities and other characteristics. You have come in contact with the experiences of life which mould and develop character-producing, outstanding qualities which make you better, bigger and nobler women in every sense of the word.

"Your experience has given you a trained mind to think clearly and to act precisely, and has taught you to be human, to be kind, sympathetic, tactful, honest and optimistic in the performance of your duties and your daily routine, and to take the bitter with the sweet, the difficult with the easy, and all with a glad and cheerful heart at all times. You have observed that your duties as a nurse are not only to carry out explicitly, accurately and immediately all orders and instructions in the care of the patient as given by the doctor in charge, and the routine as laid down by the hospital authorities; but in addition you must minister subconsciously from your own being, through your personality, something which has a substantial part in the care of the patient—bringing in particular mental comfort and happiness. This can be done by a personality clothed with qualities as already mentioned.

"You have learned what industry means and have practised it throughout your training. You have learned what a life of service means, and have exemplified it throughout your career while training. You have come through trying moments when judgment and responsibility weighed heavily on you; but all this has only tended to make your natures softer, more refined and broadened in perspective.

"In leaving your grand old training school and Alma Mater, do not forget all this as you go forth into the world and enter fields of ever-broadening service. It may be private nursing, public health, teaching or hospital administration. Grasp the opportunities that are presented and always measure up to your undertakings by keen application and by giving the best service in you possible for that particular work. Many of you, indeed perhaps all of you, have undiscovered latent abilities awaiting the opportunity to be developed. Do not cease to advance your knowledge and practical experience by reading, by observation and by post-graduate study. And finally, remember your opportunity for real service to needful humanity when skill with kindness, sympathy and mental comfort is needed.

"In your new fields of endeavor I wish you every good thing that is possible and hope that you will never forget your old training school and Alma Mater who will always stand back of you ready to help you at any time, and who will ever keep a watchful eye over you in your future career.

"And finally, let me charge you to always keep in mind that whenever or wherever there is life to be tended, nursed or cared for, whether that life be yet unborn or newborn, young or old, regardless of social status, race, color or creed, there is the field for the noblest of womanhood exercising the great function of nursing, a profession unsurpassed in opportunity for service and consequent satisfaction in endeavor, by providing means of utilizing science and goodwill to make life worth living for every man, woman and child."

A very unique feature of the evening was the presentation to Dr. MacEachern of a copy of the London *Lancet* one hundred years old. Dr. Blanchard, in presenting this, said: "Some time ago Mrs. Thomas Adams, a former resident of Lindsay for many years, gave me this one-hundred-year-old copy of the *Lancet* to be presented to the first distinguished physician who visited Lindsay. As you (Dr. MacEeachern) fill that bill, I am going to present it to you."

On the conclusion of the programme a vote of thanks was moved by Dr. White, seconded by Mr. L. V. O'Connor, highly applauded by the audience and tendered by the chairman, Mr. J. D. Flavelle, to Dr. MacEachern.

Following the programme a reception was held at the home of Dr. Blanchard, in honor of the graduating class.

While in Lindsay Dr. MacEachern was the guest of the Hospital Board. During the morning he made an extensive tour and inspection of the Ross Memorial Hospital in company with the chairman and secretary. After this he, with the doctors of the town, were guests of the Board at luncheon at the Benson House, at noon.

EXTENSION TO STE. JUSTINE'S HOSPITAL MONTREAL

Ste. Justine's Hospital, 1879 St. Denis Street, Montreal, was opened for inspection, under the direction of Mrs. E. P. Benoit, wife of Dr. E. P. Benoit, president of the hospital. A new wing has been added, making it possible to accommodate more than 150 children, where eighty were previously taken care of. The cost of the new building was $300,000, which is $170,000

more than was raised in the campaign of 1920. Another important feature of the building is the dispensary quarters on the main floor. Large numbers of the children can be brought every morning for attention and treated and then allowed to remain for a short time in the dormitory which has been provided. Dental rooms and quarters for surgical operations, such as for tonsils, and other throat diseases are also located on the main floor. Twenty-one private wards have been set apart on the second floor and operating cases are located on the third floor. The fourth and fifth stories are reserved for nurses' quarters. Large open verandahs on each floor above the second make it possible for the children to be wheeled out into the sunshine and fresh air. Bishop Gauthier gave the benediction for the formal opening of the Hospital.

FIRE IN UNIVERSITÉ DE MONTREAL

Another fire broke out in the Université de Montreal on November 14th, and the loss is estimated at about $300,000. This is very much to be regretted, as the reconstruction work of the building had just about been completed since the fire in 1919. The fire broke out in the top floor of the building, which was used by the anatomical, pathological and biological departments and included an up-to-date chemical department. A number of the directors of the Université were at the fire soon after its discovery and discussed the extent of the damage and the work which the reconstruction of the twice-damaged building will entail. There had been a meeting of veterinary surgeons the evening before and they stated there was no sign of fire when they left the building at 9.30 p.m. By a freak of chance the body of the French-Canadian giant, Beaupre, which has been in the possession of the Université for several years, and which escaped cremation in the fire of 1919, again came through the flames untouched.

BYRON SANITARIUM

A session in tuberculosis was held at the Byron Sanitarium on Tuesday, October 3rd, the programme consisting of demonstrations dealing largely with diagnosis by Dr. F. H. Pratten and staff.

QUEBEC HOSPITALS

Hospital service to the public in Quebec has shown a marked advance in the past year, according to the fourth annual report of the American College of Surgeons issued. The report is based on a survey which includes personal visits to each hospital of fifty beds or over in the United States and Canada. The following hospitals were given a place on the "approved" list: Children's Memorial Hospital, Montreal; General de St. Vincent Hospital, Sherbrooke; Hotel Dieu, Montreal; Jeffrey Hale's Hospital, Quebec; Montreal General Hospital, Montreal; Montreal Maternity Hospital, Montreal; Notre Dame Hospital, Montreal; Royal Victoria Hospital, Montreal; Ste. Justine pour Les Enfants, Montreal; Sherbrooke Hospital, Sherbrooke; and Western Hospital, Montreal. The last two hospitals named have instituted measures which ensure scientific medical care to their patients, but have not realized them to the fullest extent to date. For the first time this year hospitals of fifty-bed capacity and upwards have been surveyed. These institutions in Montreal and Quebec show a marked improvement and place Quebec in the forefront of states who are active in medical progress. Quebec is to be congratulated on its splendid showing and on its medical men; and its hospital superintendents and trustees who have made this advance possible.

HOSPITAL BUILDINGS RAZED BY BIG BLAZE

Fire which is supposed to have originated in the power plant in Sydenham Military Hospital, Kingston, on January 3rd, swept the power and heating plant, the canteen and billiard rooms, part of the office department, the gymnasium and the Vetcraft building, leaving them smoking ruins. No one of the one hundred and thirty inmates or staff of about fifty nurses and attendants was in danger at any time, though five nursing sisters, whose sleeping quarters were in the Vetcraft building, were forced to make hasty exits.

The fire for a time threatened one of the hospital buildings. Volunteers hastily removed the contents from this building, and the efforts of the firemen saved it.

Of the one hundred and thirty patients in the hospital, about ten were more or less confined to their beds, but they were not in danger, as their sleeping quarters were not threatened till later on, and the patients were removed to other quarters temporarily, and later still were taken to Mowat Hospital or to Ontario Hall in the city buildings, which were immediately placed at the disposal of the hospital authorities by the corporation.

The destruction of the power house cuts off the heating plant, and all the other patients, as well as the staff and nurses and attendants, are being provided for at the General Hospital, the Hotel Dieu and the Mowat Hospitals, and in the city buildings.

The damage will not be estimated until an investigation is held.

Book Reviews

Feeding, Diet and the General Care of Children. A Book for mothers and trained nurses by Albert J. Bell, A.B., M.D., Assistant Professor of Pediatrics in the Medical Department of the University of Cincinnati. Illustrated. Philadelphia: F. A. Davis Company, publishers, 1923. Price $2.00 net.

Just what the general practitioner, mother, nurse and medical student need. The "why" and the "wherefore" are emphatically explained. Every effort is made to impress the principles for the prevention of disease. Stress is laid on the relation of food to the teeth. Sample diets for the first twelve years of life are given. Four-hour feedings for infants are strongly advocated. A fine little up-to-date work, supplying a real need.

Nursing in Diseases of the Eye, Ear, Nose and Throat, by the Committee on Nurses of the Manhattan Eye, Ear, and Throat Hospital, New York City. Third edition thoroughly revised. Illustrated. Philadelphia and London: The W. B. Saunders Company. 1922. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. Price $2.25 net.

This work should serve as a practical guide for nurses in the management of eye, ear, nose and throat cases. The subject is fully covered, clear and definite instructions given throughout, and the volume is well illustrated. This work should prove to be a most useful text book for the nursing profession, and is adapted for both classroom and post-graduate study.

The Doctor in War, by Woods Hutchinson, M.D. With illustrations. Boston and New York: Houghton Mifflin Co., 1918.

This is a book of special interest to physicians. The author is a doctor of high reputation and as a result of his having spent a considerable time in the front lines, he speaks with authority. The volume is divided into twenty-five chapters and is freely illustrated. Some of the chapters have such titles as: The Triumph of the Doctor; The Superb Health of the Armies; A Day in a French Field Hospital; The Risks of a Red Cross Nurse; Healing the Wounds of War; The Drinking Water of the Soldier; The new Diseases of the War, etc. Even to the army surgeon, who went through hell itself with his Division, the book will be most fascinating.

The Breaking Point, by Mary Roberts Rinehart. New York: George H. Doran Company.

This is one of the most attractive stories we have read in quite some time. It will help to wile away a winter evening or too, so, as our friends the Yankees say, "Go get it."

The Hospital World

TORONTO, CANADA

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

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Editorial

A Journalistic Loss

Miss Charlotte Aikens has resigned the editorship of *The Trained Nurse*, which she filled so acceptably for eleven years. Of Miss Aikens, Canadians have a right to be proud. Educated at the Ontario public schools and at Alma College, St. Thomas, Miss Aikens trained at the Stratford City Hospital, taking post-graduate work at the Poly clinic, New York.

Since 1902 Miss Aikens has been doing hospital and nursing journalistic work. She has published several fine works on nursing, which have had a wide sale. Miss Aikens is full of her subject and is able to concisely and clearly express herself. She has been a most enthusiastic supporter of the American Hospital Association, and has had considerable to do with the moulding of its policies.

In 1912 she was chairman of the committee of the association, on the grading and classification of nurses. *The Trained Nurse* says she attempted a thorough analysis of the situation. The final report of her committee, that organ says, perhaps laid insufficient emphasis upon the function and scope of the public health nurse, but it enunciated many principles which are gradually being put into legislative form, including the following:—

(1) That all training schools be registered.

(2) That all nurses, in order to practise their profession as trained nurses, be required to register.

(3) That the terms "Registered," "Graduate," "Trained," "Certified" and "Professional," as applied to nurses, be limited to those receiving training in hospitals complying with reasonable standards.

(4) That reciprocity be arranged between states and provinces.

(5) That supplementary training be planned for nurses who are needed in the care of tuberculous, nervous and mental, contagious and other patients, and that special nurses be required to cover at least one year of training in a general hospital.

(6) That means be used to strengthen the training schools in small or isolated communities with a view to providing adequate community service.

(7) That plans be made to secure adequate distribution of the nurses available, preferably in state units, and that greater nursing forces be made available through the encouragement of undergrad-

uate nurses in the completion of their courses—during their stay in the training school or after they have withdrawn.

(8) That the situation be still further improved by the utilization of nursing aides trained to meet the needs of the community and supervised through service centres.

Some three years ago, Miss Aikens made a survey of the leading hospitals of South America. The story of her trip interested and instructed many readers of her journal.

Miss Aikens was one of the organizers and trustees of the Detroit Home Nursing Association, which, under the able superintendency of Miss Agnes Carson, demonstrated how independent people of moderate means could secure adequate nursing at rates they were able to pay, through the co-operation of trained and practical nurses.

Miss Aikens is an ardent Sunday school and church worker. Her brother is one of the leading Canadian divines.

Miss Aikens lives in Detroit, the wonder city of the west—the city of live wires, and efficiency experts. She has a lovely home and, although unmarried, has a most interesting foster family, whose education she is successfully supervising.

We wish Miss Aikens long years of happiness, and hope *The Trained Nurse* will secure an editor, who will not only be able to fill her boots, but her hat as well.

Diabetes

The discovery of insulin by Banting has awakened great interest all over the English-speaking world, but particularly in Canada; in Toronto, very particularly, owing to the over-publicity given to the discovery in the lay press.

Dr. Banting is the most modest of men, and to hear him, (as the writer did the other night), one would suppose that all the work was done by the other fellows and the credit due to certain higher-ups who looked on.

Cammidge and others in a recent *Lancet* cannot be said to boom Banting, nor the insulin treatment, when they say:

> "Although the extract of the islands of Langerhans, named 'insulin' prepared and experimented with by workers in Macleod's laboratory recently, has no doubt certain advantages over similar preparations previously employed, it suffers from the same disabilities of only having a brief and temporary effect on food tolerance and requiring to be injected intravenously or subcutaneously, oral or rectal administration having been found useless. It seems unlikely, therefore, that this method will prove of great clinical value, excepting in emergencies where it is necessary to tide the patient over a crisis."

The ordinary practitioner, in reading the various recent articles on Diabetes may feel somewhat abashed when a patient comes to him with glycosuria or diabetes mellitus, on account of the frequent elaborate chemical investigations on blood and urine, which seem necessary in the investigation and treatment of such a patient. He ought not to be; he should try his hand on it, rather than turn it over to some one else.

To treat a patient intelligently, the practitioner should provide himself with certain books—certain simple laboratory glassware and a few reagents. The books should comprise, say, "The Starvation Treatment of Diabetes," by Hill and Eckman (W. M. Leonard, Boston, Mass.) which contains a description of the ordinary tests; and "A Dietary Computer," by Amy Pope (Putnam Sons, New York). If he wishes, he may also buy Joslin's primer or the primer by Wilder, and others of the Mayo Clinic, (W. B. Saunders Co., Philadelphia).

One may use his every-day Fehling test for sugar, or the more delicate Benedict, formula of which may be taken from one of the forenamed little books. To get at the quantity of sugar, he may use the fermentation test (see Hill and Eckman's book), or he may use Carwardine's saccharometer, which he can carry to the bedside or home kitchen and in five minutes make a quantitative test. The writer has found this apparatus very useful. It is made by Archibald Young and Son, 57 Forrest Road, Edinburgh.

The Allen starvation treatment is described so specifically and clearly by Hill and Eckman that any practitioner will be able to prescribe it easily.

Care must be taken to examine the urine twice daily, for sugar, acetone and diacetic acid, until one feels all danger from ketosis or hypoglycemia are past. Complete 24-hour specimens should be secured for one of the daily analyses.

A little study and assistance from the doctor will enable the ordinarily intelligent housewife to manage the diets. A weigh scale is considered essential, but by reference to the diet lists given in the small books, a measurer equivalent to the stipulated weights is indicated, so that the poorer patients, perhaps, may be handled without having to pay $16.00, the price asked by the dealers for a diabetic food balance. To be sure, a simpler balance may be secured with the avoirdupois weights. In such case the food dispenser must be taught to translate metric-weights and measurements into avoirdupois.

The above applies more particularly to the treatment of the early cases. But we believe, after the practitioner has tried out the above treatment in the less severe cases, he will be encouraged to enlarge his laboratory equipment to enable him to make estimations of blood sugar and the like, and tackle the more severe type of the malady.

Commitment of Insane

While the Ontario Government is considering the erection of another asylum to accommodate the increased number of patients, public attention is being focussed on the lax method of commitment of alleged insane persons. It is being openly asserted that many of those so committed are not strictly insane, but are the helpless victims of an interested relation plus the concurrence of two compliant physicians, following a much too hasty medical examination.

In spite of the present day vogue of psycho-therapy as an active factor in medical treatment, and the vastly enlarged mental variant thereby revealed, it is rather surprising that no corresponding advanced step has been taken by the state regarding compulsory asylum commitment.

Without entering into the question of private motive in dealing with individual cases, it is pertinent to ask whether the patient gets a fair showing in the short time and necessarily brief observation permitted by the law preceding commitment.

In Ontario, forty-eight hours is the time limit allowed for medical men to make definite pronouncement concerning a patient's sanity, and to place upon him the indelible mark of compulsory confinement within asylum walls. In Quebec province the commitment may take place immediately.

The State of New York does better than Canada. The law fixes ten days as the limit in which to determine whether a person is insane or not. Yet the New York Commissioner of Public Welfare says: "There should be a change in the law allowing patients to be held such a period of time as the doctors may think necessary. From my own study of this matter, and it has been very intense, I believe from twenty to thirty per cent. of the people now sent to insane asylums need not go."

As a result of this protest, there is now in New York a strong movement to arrange for such legislation as will give any unfortunate charged with insanity as much chance for freedom as that given to an ordinary criminal.

Psychiatry is not an exact science; it is only on the threshold of its own dim and shadowy territory, which in present development is not to be defined by fixed boundary lines. Therefore, the authority to pronounce a person insane to the extent of depriving him of his liberty, should be most carefully guarded by legislation. As Dr. Coler says, "The proper handling of the subject to my mind is one of the most important matters before the people to-day."

Nurses and Tuberculosis

Dr. Stewart, acknowledged as an outstanding tuberculosis expert, says that we have medical men going out into the practice of medicine, and nurses going out to nurse (trained in general hospitals for the most part), with practically no knowledge of a disease which is responsible for one death in ten. "Do you think," he said to a gathering of hospital workers in Winnipeg recently, "that it would be right for doctors and nurses to go out and practise medicine without a knowledge of typhoid fever?"

Dr Stewart went further: "not only do nurses know very little about tuberculosis, but what they know, they know wrong." This was not the fault of the doctors. A general hospital could not teach tuberculosis; it must be done in a hospital devoted to tuberculosis. Some nurses were frightened to go among the tuberculous. "There is no nursing staff in any country which has been freer from

tuberculosis than the staffs of sanatoriums treating tuberculosis," declared Dr. Stewart. "There have been many more suspicions among nurses who graduate in Manitoba hospitals than at the Ninette Sanitarium. For fifty years there have been sanatoriums for the treatment of tuberculosis and there is no case of a nurse who has contracted it from nursing in sanatoriums.

"Nurses in tuberculosis hospitals are learning how to treat chronic and convalescing patients."

Dr. Stewart would welcome the undergraduate nurses from all of the Manitoba general hospitals if they came regularly.

It is time all nurses training in general hospitals had at least six weeks' experience in a tuberculosis sanitarium, unless they receive such training in a general hospital which treats cases of pulmonary tuberculosis.

CORRECTION.

We gladly accede to the request of Dr. H. R. Smith, medical superintendent, Royal Alexandra Hospital, Edmonton, who writes to make a correction in the figures which appeared on page 64 of the February number of this journal, reading as follows:

"Now, we found out at our hospital that the graduating class of twenty nurses cost us over and above anything they rendered the hospital, $1,000 per nurse. In other words, by the time a class of twenty nurses got through the hospital they were indebted to the hospital to approximately $20.000."

These figures should be: "cost us over and above anything they rendered the hospital $500.00 per nurse" and "they were indebted to the hospital to approximately $10,000."

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Original Contribution

ADDRESS*: Dr. Archer, Lamont, Alberta.

It is a very great honor and privilege to address you to-night as representative of the Alberta Medical Asociation. It is obviously my privilege at this late hour to leave out a considerable part of what I had intended to say to you. There are a few things I wish very much to say on behalf of the Medical Association, and I am going to try and say them very briefly, leaving out much of the material which I had prepared. I want to make a few remarks in order that we may see and remember to-night some of the changes which have occurred in matters relating to public health, not only in this Province, but in the world, as a result of the activities in medical science in the years which have passed.

Let us think for the moment of the smallpox. In 1888 Osler stated that the death rate from smallpox was 25%. We realize that there was a very great deal more smallpox at that time than this; this as a result of a fairly universal use of vaccination. There was an epidemic in the city of Philadelphia seven or eight years ago, and of the unvaccinated there were 2,800 with 1,500 deaths. Now that gave the higher death rate of 44%. In the vaccinated cases there were 2,100 with just 28 deaths or a little over one per cent, and then as we saw the smallpox it was in a largely attenuated form. Going to the case of diphtheria a few figures: in Boston in 1888 to 1894 the average death rate was 44%. Antitoxin was then introduced and the death rate fell to 15% in the succeeding ten years, and in 6,080 recent cases the death rate was only 7%, a drop from 40% to 70% in some instances over a period of a few years after the use of antitoxin. In 1920 in this

*Read at the Convention of the Alberta Hospital Association, and the Alberta Association of Registered Nurses.

Province there were 608 cases of diphtheria with 82 deaths or about 13%. In the city of Edmonton there were 284 cases with a death rate of 7% and that leaves a death rate to the rest of the Province of 19%, and because it is so very remarkable I wanted to give it to you in public meeting to-night, because we want everyone to realize that we are getting the death rate from diphtheria reduced to a small minimum and that is by giving antitoxin early in the disease. In a city like Edmonton the case is seen early and the death rate is small. In the rest of the Province—I am not referring to the vicinity that Calgary is in because, as it happens, there were very few cases in Calgary that particular year, so the rest of the cases occurred largely in the rural districts, and not being seen early the death rate was about 19% against 7% where the cases were seen comparatively early.

Take tetanus, or lockjaw, which was a terrible plague. In 1903 there were 406 deaths from lockjaw, but since the use of the serum in 1909 the number dropped to 150; in 1910, to 78; in 1911, to 18; in 1912 to 7 deaths in the whole of the United States from lockjaw as a result of the use of this prophylactic serum. In the first year of the war the results were very unfortunate, and a good many cases affected the wounded until a uniform habit was adopted of inoculating all wounded men, and after the first three months it almost disappeared as a cause of death in wounded men.

Typhoid fever with a death rate given in the Indian Medical Service as 25% in 1899; with the use of a protective vaccine in the army, commencing long previous to the war, the number of cases of typhoid were very few and the death rate became very small. The same experience was proven in the recent war. The waste in the South African war from typhoid was a very prevalent cause of death among the soldiers. Typhoid fever is invariably checked by the inoculation of the men with typhoid vaccine, and yet, in this city not very long ago, to a great audience and with a good deal of applause, a speaker ridiculed the idea of what he called the "germ theory" of disease. It is all based on fact, and yet people still talk of the germ theory of disease, and I have

something to say about the responsibility of the medical men to the whole community which I do not think they have lived up to. I think that the whole community is not cognizant with some of these facts, lies at the door of the medical profession.

Referring to the surgical side and the development that has occurred, I would like you to think of one picture in the life of Lister. About 75 years ago the great Scotch surgeon was operating and it was the first time that anesthetic had been used in England. It had been used in the United States and was known as a "Yankee dodge for making people insensible." At that time operations were largely limited to amputations. There were no abdominal operations being done before the days of Lister, who introduced the use of carbolic acid. In this room where the operation was performed the floor was covered with sawdust, and I think that was a very realistic touch; the students were standing around and Lister came in dressed in an old frock coat with his sleeves rolled up, and told them he was going to try this "Yankee Dodge." At that time speed was the essence of skill. At that time operations were done with a man fully conscious, and one thing necessary was the man with the stop watch, and his student was present with the stop watch to keep time. At this particular time after the man had received the anesthetic the time was 47 seconds; he had amputated the leg in the middle of the thigh. In those days the wound was not closed, because all wounds were not closed, just the bleeding points tied up. They could not close them because all wounds were infected, so they were left open to drain well. Now that is one picture.

Then there is the familiar picture in "Rab and his friends," but in these days that dramatic situation could hardly be possible because the dog would not be allowed in the operating room. That operation was performed by Symes, who was a contemporary of Lister. Those things were only seventy-five years ago, and those familiar with operating-room technique of to-day can realize what a long way we have gone. It is not very many years since abdominal operations first began. The most familiar friend of all, I suppose, is

the removal of the appendix, and it was only in 1877 that the first operation for the removal of the appendix was performed. Sir Frederick Tree and Norton, of Boston each removed an appendix, one in the year 1877, and this year in a medical meeting, the gentleman who was delivering the address said that he remembered his Professor in Anatomy saying, "This is the appendix; it is not interesting, because it is a vestidial organ which has no function and no disease."

Now I want to mention two only of the phases which have developed of recent years, and upon which great emphasis is being laid in modern medical science. The first I wish to speak about is the great stress which is being laid to-day upon the necessity for accuracy in diagnosis. It seems with us in the medical fraternity that it is absolutely fundamentally important. It is obviously necessary to find out the trouble and to locate that, it is absolutely necessary there shall be a correct diagnosis. Take the illustration of the appendix once more. We must realize, most of us, how very frequent and how much dreaded, inflammation of the bowels was a few years ago. A doctor forty years ago was satisfied with making a diagnosis of inflammation of the bowels. The doctor to-day is not satisfied until he has found what has caused that peritonitis, and he is not satisfied with knowing what particular organ in the abdomen is causing that; he wants to know at what particular time that particular organ got into trouble and so he goes back; is it an infected tonsil, infected pyles? There is usually some infection still farther back, and I am going to take that one illustration to show how the art of diagnosis is going back farther and farther trying to get these facts on an absolutely firm foundation, so it will be possible for the medical man to know what causes that condition. There was a time when the doctor went into the house and the evidence of his skill was that he could, without ever examining the patient at all, without history of the sickness, immediately tell what the trouble was. Maybe there are some medical men so skilled still living; I have never met them and we do not think such a medical man would claim to-day to be scientific because he knows such a claim is absolutely impossible. When we think of the many aids to diagnosis which

are necessary; the worth of chemistry, the many forms of complicated and technical examination which are necessary to enable the medical man to establish a firm knowledge as to what the particular trouble with his patient may be, then we realize we have reached a long way towards scientific knowledge of disease. We have not got to the end of the road. A great deal of the spice of practice is in the continual increase of knowledge which we make from day to day. What does this mean? It means that the whole of the subject of the investigation of disease in any particular individual is too complicated to be completely done by any one man. It is no longer a one man job; that is, an isolated individual cannot in all cases establish absolutely a correct diagnosis. These various branches of the work are so technical that many have to specialize; they have to perfect themselves in these particular lines of investigation and treatment, and so we come to the other point in the development of modern medical science, and that is the tendency towards specialization.

There has been the tendency to make considerable mirth over the tendency to specialize. I am not going to say anything more about it at the present.

Now I think also there is a certain amount of confusion in the minds of the public and the medical men owe it to the public to do all in their power to set the public straight in their thought of the various specialties, and owe it to the public to call to their aid their colleagues, the specialists in certain types of work, because no one man is in a position to do all that may be done for all cases to-day. If these things are true what shall we do in this Province? What may be done in this Province to enable the profession to meet the responsibility which is before them? I realize that the medical profession have two responsibilities, two types of responsibility. One is for the establishing of a diagnosis and treatment, and the other is for the dissemination of knowledge with regard to the care and prevention of disease and the maintenance of health. With regard to the first I think the medical men are doing conscientiously day by day their utmost. With regard to the second I do not feel the medical men have lived up to their opportunity. Do you realize in

the Province of Alberta in 1920, there were 139 women died from childbirth, and that there were over 1,000 babies died, 411 still births. I am just mentioning these figures. The death rate of babies in one year was 93 in 1,000; in 1920, which is only a few years ago, the percentage was 140 in 1,000. The death rate in sunny Alberta, where there is lots of fresh air and lots of fresh milk, is larger than in the number of American cities with slum conditions and difficulty in getting pure milk. The death rate, through lack of knowledge, is larger than in many of the large American cities.

There is one thing the medical men are planning to do with the co-operation of many organizations, and I want to draw your attention to it. This fall they are planning to put on a public health week in this Province, and it is for the purpose primarily of fulfilling this second responsibility that I speak. I think the Medical Association feels they have not lived up to their whole responsibility to the public for the dissemination of knowledge for the care of certain diseases and for the prevention of other diseases and of the maintenance of the public health of the Province, and this public health week, with the co-operation of the other Associations—and a number have signified their desire to co-operate and help—will take up such subjects as tuberculosis, venereal disease, child welfare, and give a great deal of publicity, all that is possible for them to obtain, to disseminate information along that line.

I am very glad the Minister is here to hear these assurances because I know he is interested in this particular phase of our Medical Association, taking steps to put at the disposal of any organization in the Province all the speakers on this same subject at any time that an organization anywhere in the Province may require such service. We are trying to measure up to this responsibility. We realize it is a very vital question and we want to supply information and to help to still further improve the health conditions of this Province.

Just this one other word. If in these complicated conditions where diagnosis is difficult and where treatment is specialized, if we are going to be able to give that kind of diagnosis and that kind of treatment all over the Province

where there are so many people living with very few doctors, for 264 doctors in this Province are in the four larger cities, and 262 doctors are in the rest of the Province and now, if we are going to be able to meet the needs, the health needs of the rest of the Province, it is only by there being a health centre and by a health centre I mean the hospital. The institution of the municipal hospital system must come if this problem is to be satisfactorily solved. Dr. Stanley will have something more to say along that line, with the municipal hospital extending in smaller units if necessary, to make a weak district to get into line to have a hospital with two or three nurses and a doctor. Let a little group grow up around these institutions, not to do largely specialized work, but to work efficiently and well around one of these hospitals. This is an ideal for which we must hope and struggle. I thank you.

HOSPITAL DIETETICS

Miss Maude A. Perry.
Supervising Dietitian, Montreal General Hospital.

In the organization of a department of dietetics in any hospital, large or small, a knowledge of the real meaning of dietetics is essential. It is the science of correctly feeding an individual or a group of individuals, in sickness or in health. From this, it may readily be seen that the field of work of a dietary department of any hospital is a broad one. While one never loses sight of the fact that the primary purpose of the hospital is the care of the sick, hospital superintendents and everyone interested in the management and upkeep of these institutions know that this is only one phase of the work of their hospitals. Likewise, the feeding of hospital patients is only one of the duties of the dietary department.

A properly organized department of dietetics should control everything that has anything to do with the supply, preparation, service, or storage, of all food stuffs used in the hospital. This does not mean that the dietitian shall necessarily personally buy or distribute the foods, but foods should not be bought nor distributed without her approval if she is to be held responsible in any way for these.

I am not going to attempt to outline any plan that would be an invariable standard for the organization of a department of dietetics in all hospitals. I do not believe that any one can do this successfully. Different types of hospitals must be governed in this by their size, purpose, location, financial condition and many other factors.

In many small hospitals, the dietetic department combines the duties of dietition and housekeeper. This person has charge of kitchens, dining rooms, supplies, and of all help employed in connection with these. In larger institutions where both private and public patients are received, there is a greater diversity of work. If the dietary department is well organized, it supervises public kitchens, diet kitchens, dining rooms, stores, service of food on wards for private and public patients, menu planning, care and renewal of equipment, employment of help; and it has many other duties, not always easily tabulated. This department also teaches both theoretical and practical dietetics to nurses, gives personal attention to special diet cases, and collaborates with physicians who wish to avail themselves of its aid. In hospitals where children are patients it supervises the milk station or prepares the formulated feedings in the diet kitchen.

Anyone who has studied the expenditure of hospital finances knows that a large part of this is incurred through the purchase of food alone. Hence an insistent demand has arisen in the United States and in Canada for well-trained people for the work of the dietary department. The American Dietetic Association, which numbers among its members nearly all of the leading dietitions in Canada, including those engaged in hospital and educational work, realizes the urgency of the need of good training. The members of this association have established standards for training of dietitians which will make it possible for hospitals to obtain competent people if they wish them.

In various parts of Canada, schools, which formerly educated their students for teachers of Domestic Science only, are adding courses of study which are planned for those who wish to do hospital work. Some hospitals are taking these students upon graduation for an interneship of six months of

Two urinometers with cylinders.
One microscope, B. & L., B.B.H., or equivalent.
Two casseroles, capacity 150 c.c.
Two forceps, dissecting, with fine points.
Two forceps, dissecting, medium heavy, straight points, 115 m.m. long.
Two forceps, coverslip.
Four pencils for writing on glass (Blaisdell).
One colorimeter (Dunning).
One platinum loop.

This includes equipment only; supplies are not included. —*Exchange.*

THE HOSPITAL PROBLEM IN RELATION TO MODERN MEDICINE*

Dr. Willard C. Stoner,

Director of Medicine, Saint Luke's Hospital, Cleveland, Ohio.

The advances 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 demands hospitalization very largely for the 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 well-trained surgeon no longer performs surgical operations in the home. The well-trained internist no longer attempts to diagnose obscure conditions in the home, much less manage them. The well-trained obstetrician no longer cares for the expectant mother in the home, which too often may be at the expense of both the mother and child. The public is being educated and appreciates the importance of hospital care.

*A paper read before the National Methodist Hospital and Home Association, Chicago, Illinois, February, 1922.

The Hospital a Workshop.

The hospital no longer stands in disrepute as a place to go to as a last resort which generally ended in death. The hospital is being recognized 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 shall have community support and shall serve everyone, the poor, the rich, and the great middle class on whom a great hardship has come by reason of the tremendous cost of medicine if it is not afforded them by an institution at a cost which shall not make it prohibitive. The public is coming to realize that hospital practice by the medical profession shall not be abused, that the hospital shall not exist for a select few physicians of a community, but shall be accessible to all well-trained medical men.

It is obviously unfair to the young man who has thoroughly trained himself in modern medicine and satisfactorily met all the prescribed standards of qualifications to be turned loose in a community to try to practise that type of medicine which he has been trained to practise, without hospital facilities. It must ever be true that a certain percentage of illnesses do not require hospital care; this is especially true of the acute illnesses where the diagnosis is obvious and definite and where the course of the disease is likewise definite. Under such circumstances, good care can well be improvised at home and the well-trained physician who does home work suffers no handicap other than that of time in carrying into the home that necessary medical attention.

We had it well demonstrated in the army service in large numbers that a large percentage of acute illnesses require no particular medical attention other than good care, encouragement of elimination, and a proper diet. Nature is a good doctor and has more specifics for the cure of disease than is generally credited.

We must come to look on a hospital as a complete workshop, that is not a place to hospitalize bed-ridden patients alone, for diagnosis and treatment, but as a workshop for diagnosis wherein to advise treatment in the ambulatory case such as is being done in our free clinics and part-pay clinics.

The same principle in diagnosis must be applied to all material. It is a well-recognized fact that present-day medicine is organized to care for the destitute and the very well-to-do, but the great middle-class is unable to buy modern medicine. Fortunately the numbers whose conditions demand this type of medicine are in the minority so that society suffers only in a limited way.

Co-operative Clinics.

The development of co-operative schemes of work, that is the co-operative clinics such as are being developed all over the country, demonstrates the advantages of this complete workshop where the obscure acute, sub-acute or chronically ill may go for diagnosis and treatment. Obviously this affords the advantage of complete findings in an individual case with a single fee which is supposed not to be prohibitive to the individual. Unfortunately these private schemes of work represent a commercial basis as most medical men are not philanthropic to the extent of rendering service for which they do not have a regular return. These co-operative clinics have their advantages and disadvantages. The outstanding advantage is the completeness of work without a prohibitive fee and the outstanding disadvantage is the lack of personal interest in the patient and the failure properly to evaluate findings. Obviously these clinics do a certain amount of unnecessary work in order that necessary work be not overlooked. The complexity of modern medicine demands this sort of practice, hence the co-operative clinic is here to stay; but it can never represent the whole of medical practice and, if it did, it would be detrimental, robbing a large percentage of medical men of individual initiative and resolving medicine into medicine methods.

If we accept that the hospital represents a complete workshop for the hospitalizing of cases, and there is great advantage in having such a workshop in order that we apply modern scientific medicine, then we must accept that the hospital shall furnish the other portion of the workshop, namely, the diagnostic clinic where means are afforded for a proper diagnosis of all diseases such as our free clinics represent. Why shall we not look to the hospital as the complete workshop

where all cases difficult of diagnosis shall go and be investigated at a cost prohibitive to no one, where all worthy practitioners of medicine may take their cases for diagnosis and then have advantages of suggestions as to proper therapy? Life and health should not be made prohibitive to any one, and medical practice should see to it that it be within the reach of every one in so far as scientific medicine affords. Many of the co-operative clinics compete with the whole profession, that is, they not only take cases for diagnosis, but also for treatment. This will tend to lower the standard of medical practice, as it will take from the worthy man in general practice his best clientage and not afford him hospital facilities.

Hospital practice is a great incentive to do good work. Standardization of hospital practice such as is being done by the American College of Surgeons is tending to elevate the standard of medicine generally. Fads, quackery and sectarianism will thrive less when the people generally are educated as to the value and limitations of modern medicine. The facts of modern medicine rationally applied will bring a proper respect for medicine, greatly alleviate human suffering, prevent disease and eliminate a great waste. The hospital must ever be the important means of making these facts accessible to the public.

Need of Rural Hospitals.

The establishment of hospital facilities in the rural communities must be the rational solution of medical practice in these districts. The investment in the modern training in medicine is too great to make rural practice inviting to-day. Better conditions must be the solution. Good roads and our present means of transportation make the establishment of hospitals in the larger towns in rural communities practical. It will be less and less necessary for the acutely ill to be taken to the larger centres for diagnosis and treatment, which is often at the expense of the well-being of the patient.

The hospital must have a larger responsibility in the education of nurses who shall enter the fields of preventive medicine and public-health nursing. The hospital must emphasize more and more the importance of regular complete exam-

inations for the purpose of detecting the development of diseases that are insidious in onset. It must afford health clinics where the facts of medicine may be obtainable to every one. The story of disease would be quite a different one if diagnosis were made early always, and the proper therapy applied. The hospital must furnish the same workshop that the industrial world furnishes for the man-made machine, *e.g.*, the automobile motor. May we not think it reasonable to have inspections of the human machine in the same way? Modern medicine affords a means of diagnosing early. Disease diagnosed late generally represents either indifference on the part of the patient or a failure to properly apply the means that modern medicine affords, or perhaps both.

Organization and Correlation of Hospital Service.

The satisfactory work of a hospital depends in part upon proper organization and correlation of the administrative, professional, nursing and social service functions of the hospital. It is well to have the professional service divided into the two great groups, viz., medicine and surgery, with a director of each division. Under each division shall be classed the departments which by nature of work shall be determined either medical or surgical. It is well to have the director of medicine serve as head of the department of general medicine and the director of surgery as head of the department of general surgery. Each department under the medical or surgical division shall have a departmental chief who shall be directly responsible to the division director.

A medical council is made up as follows, viz., superintendent of hospital, the director of medicine, the director of surgery, and a fourth member who shall be selected by the department heads, not including general medicine and general surgery, and shall serve for a period of one year. The medical council shall determine or initiate all matters of policy and standards of professional efficiency which shall be subject to the approval of the board of trustees. Upon invitation a representative of the professional services chosen by the medical council shall meet with the executive committee of the board of trustees.

The medical council meets weekly to consider all matters that have to do with the professional services of the hospital. The professional services of the out-patient department are organized in the same manner as professional services in the hospital. All visitants to the hospital have professional responsibility in the out-patient department. The department chiefs are directly responsible for the type of service rendered in the out-patient department. The superintendent of the hospital directs the administrative function of the out-patient department, which work is under the supervision of the director of the out-patient department.

The medical personnel of the out-patient department has access to the open ward cases and certain responsibility in the routine care under the direction of the department chief.

The out-patient department is open from 8.30 a.m. to 10 a.m., which gives the medical staff the advantage of completing their hospital work early in the day and does not necessitate their return to the hospital for an afternoon clinic. The out-patient department is patterned after a semi-private clinic and has facilities and equipment to make it a complete workshop such as modern medicine affords. The work in the medical and children's clinic is done by appointment which enhances the appreciation and co-operation of the patient. Time is thereby controlled, and loose, hurried-up, incomplete work is not done. All medical men, either staff or non-staff, must limit their hospital practice to one specialty in order to encourage the highest standard of hospital practice.

The social service department determines the social status of every patient applying to the out-patient department for professional service. The medical clinic department determines all diagnoses and classifies accordingly. The social service department keeps a follow-up system and, where failure to report at a stated time, a card or letter is mailed or, if necessary, a home call is made. A daily record of all ward entries is furnished the social service department, likewise a report of all discharges.

Reports of the work of the out-patient department, the house staff, and nursing service are made to the medical council weekly.

The medical staff meets monthly, or oftener, for the purpose of holding clinics and discussing matters of professional efficiency. Then the personnel of a modern hospital is organized into a great working force having in mind a single purpose, the rendering of skilled professional care, and emphasizes at all times the humanitarian side of scientific medicine.

Hospital treatment of the sick must ever represent skilled, sympathetic care which must never be at the expense of the patient's rights, arbitrarily taken from him because of undue authority on the part of the nurse or physician.

In conclusion, let me emphasize the great need of amplifying hospital facilities everywhere. That the hospital must be made a complete workshop accessible to all reputed physicians; that it must represent all that modern medicine affords in preventive medicine, research medicine, diagnostic medicine, curative medicine and social service; that it must be an institution of learning where nurses, physicians and social workers shall be trained in every phase of scientific medicine; that it must render service to every one at a cost that shall never be prohibitive; that the institution shall realize, as the medical profession realizes, according to responsibility and service rendered.—*Exchange.*

A METHOD FOR INCREASING EFFICIENCY WITHIN THE HOSPITAL

Franklin R. Nuzum, M.D.,

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Outside the hospital many agencies have developed whose aim is the uplift of medicine. But within the hospital there is no special agency or department whose chief duty is the elevation of the plane of medicine practised in that institution. If hospitals are to keep pace with the demand for better medicine, they must assume responsibility for the patient's progress. They must also assume responsibility for the four functions long attributed to them, namely: (1) the care of

the sick; (2) the education of future personnel; (3) research and medical science, and (4) serving the community as the centre of all health promotion activities. [1]

Up to the present, comparatively few hospitals have made special efforts toward assuming these duties or becoming more than mere nursing institutions. One way in which this plan may be accomplished is here suggested.

There should be established within the hospital an agency whose chief duty is the prosecution of a never-ending campaign for better medicine in that institution. For this work the full-time service of a medical man should be procured, who, for want of a better name, may be called the "medical director." His first duty is the organization of laboratories. With these well equipped and manned, he then calls the attention of the visiting staff to the benefit that may accrue to the patient from the proper use of the laboratory facilities.

He effects the proper staff organization with the various sub-groups. He brings before them regularly the various medical and surgical problems that arise in the institution. He keeps in touch with the especially ill patients in the house, and with those in whose cases it is difficult to arrive at a diagnosis. He discusses the situation with the attending man, offers suggestions if possible, and advises further consultation, if indicated. The accomplishment of a smoothly functioning staff, with team play developed to a high degree, with its members aiding one another by suggestion and example to obtain from the laboratories and other equipment all the help possible in diagnosis and treatment, would stand out in sharp contrast to the manner in which physicians practise in most hospitals at the present time. The co-operation and spirit of helpfulness which it is possible to establish among members of a staff, especially when one man, such as a medical director, makes it his business to effect such harmony, results in creation of a postgraduate school in that institution.

Such a staff would eliminate the competitive element of present day medicine within the hospital.[2] In its place would be substituted the newer ideals of specialization, team play, and thorough intensive study of individual patients. These ideals are spreading rapidly throughout the country because better service is rendered the public. Such a hospital will

gain the confidence of the community and serve as an educational institution in that community—the thing most needed to combat the propaganda of state medicine, social insurance and the numerous quacks.

Another of the difficult problems of the day is that of effecting a plan whereby the newer procedures in the practise of medicine may be taken up more quickly by the practitioner of medicine. Even after an excellent procedure has been worked out in the experimental laboratory, and its application to clinical medicine has been definitely established, there is a lapse of a long period of time, usually of years, before it is adopted by the profession at large. Here is another opportunity afforded the medical director. He has established a library in the hospital and, through a journal club or some similar agency, the literature in a large group of journals is abstracted and discussed at regular intervals by the staff. He suggests that certain of the newer procedures be tried. He provides the equipment, and trains a technician if necessary. The method, thus tested, will soon demonstrate its worth. If it is of no value, it can easily be dropped. If it is of value, that group will profit by its use over a period of several years before they would otherwise have become familiar with it.

The advancement of research and medical science, the third field of endeavor of the medical hospital, has a value so well recognized that it calls for no discussion here. Since most hospitals have not recognized their opportunity in the field of research, they have made no provision for such persons on their staff. This, again, would come under the scope of the medical director.

Two difficulties come to mind in putting into operation this plan of medical director. The first is in selecting the proper man for the position. The success of the undertaking is intimately associated with the character of the man who shall act in such a position. Naturally, he must be well-trained, broad-minded, sympathetic and co-operative, if he is desirous of making the plan a success. A narrow-minded, selfish man, be he ever so well qualified personally, would make a failure of the undertaking.

The aim of the medical director is one of help and of services to help the hospital provide adequate equipment for all diagnosis and treatment; to help the individual physician in making use of the equipment for the good of the patient; to help the staff by promoting a spirit of team work among them. In such a position a man has an unlimited field.

The second difficulty attendant on adding a new agent to the hospital staff is the financial question. Two means of financing such a department merit attention. In one instance the fees collected from the laboratory, after the laboratory was reorganized and the attention of the staff had been called to the importance of routine laboratory tests, very nearly bore the expense of the new undertaking. A second method lies in interesting some philanthropic individual who will personally meet the added expense.

Conclusion.

Hospitals should represent the best in medicine and surgery. Outside the hospital, specialization, group practice and health centres [3] are becoming popular because they are an advance in the demand for better medical practice. In order to be progressive, hospitals must meet new conditions as they arise. The time is at hand when a patient entering a hospital should have an assurance that he will receive careful study and adequate treatment. This cannot be done under the regimen of a nursing hospital. It means that hospitals must become medical institutions and that there must be in their organization the same elements of team play and co-operation among the various specialists and men on the staff that obtain in group medicine outside the hospital.—*The Journal of the American Medical Association.*

Reference Notes:

[1]Warner, A. R.: Medical Care is Measure of Hospital's Real Service, Med. Hosp., 16: 325 (April), 1921.

[2]Mayo, W. J.: The Medical Profession and the Public, J.A.M.A., 76: 921 (April 2), 1921.

[3]Billings Frank: The Future of Private Medical Practice, J.A.M.A., 76: 349 (Feb. 5), 1921.

GOVERNMENT GRANTS TO HOSPITALS

The decision to make the distribution of the Government grant to the hospitals conditional upon the raising of an equal amount of new money has met with almost universal disapprobation among those interested in hospitals. The Ministry of Health, however, has taken a very firm stand in the matter, and the cogency of the arguments in the letter which Sir Alfred Mond contributed to *The Times* a month ago cannot be gainsaid.

It is common ground that the country as a whole demands, and has the greatest right to expect, the strictest economy in all Government expenditure. When, however, the cutting down process begins, each interest which is attacked is at great pains to show that it at least should be spared. Nothing is gained by viewing such a question from purely partial and, therefore, biassed premises, although in the case of hospitals there may be some justification for this attitude. Undeniably, during the war they rendered great services to the State, for which they were very inadequately remunerated, and which had a disastrous effect upon their financial position. At the same time their work for the general public had perforce to be curtailed, with the result that long waiting lists were compiled, and the leeway has still to be made up.

When the Cave Committee recommended a grant of £1,000,000 from the Treasury to meet the deficiency, the hospitals were buoyed up with the hope that they were in a fair way of being placed on their feet again. Their hopes, however, were speedily dashed to the ground when the prospective grant was cut in half. Later, the "pound for pound" bombshell was dropped in their camp, and those hospitals who have exhausted all their ingenuity in the past two years in exploiting new sources of income are wondering where the new money is to come from to enable them to claim what in other circumstances would be a fair share of the grant. Unquestionably, some hospitals on this basis of distribution will fare worse than others, and through no fault of their own.

Nevertheless, we have much sympathy with the Minister of Health in the action which he has felt compelled to take. It is quite clear that he is a firm believer in, and supporter of, the voluntary principle, and we believe that the feature

which is most closely identified with that principle in the minds of the general public is derivation of income of the hospitals purely from voluntary sources. Already that conception has been modified by the substitution of the word "mainly" for "purely." To go beyond that would be to obliterate this feature entirely, and we should have to fall back upon the other definition of a "voluntary" hospital, namely, that it is one which is under voluntary and independent management—a meaning which carries with it the suggestion that it is immaterial, so far at any rate as the voluntary principle is concerned, whence the income is derived or in what manner it is expended. Sir Alfred Mond says, and we think reasonably, that if he were bent on the abolition of the voluntary system, no surer way could be devised than for the Treasury to make unconditional grants. No one will deny that, if at all possible, it is to the interest of the hospitals that they should work out their own financial salvation. Efforts to secure new income must not be relaxed, but the temptation to do so when there is a certainty of a State subsidy surely cannot be overlooked by any practical man of affairs.

The new money may be either "raised or in sight." Already there is a considerable amount earmarked for the hospitals by many of the approved societies. This is expected to amount to over £100,000 a year, and is a source of income which may conceivably prove much more valuable as time goes on, and although it may have an effect upon patients' contributions, at least it substitutes a certainty for an uncertainty. Much may reasonably be hoped for from the local hospital committees in their attempts to systematize and co-ordinate methods for the collection of money. Sources of income which have proved so prolific in some areas are waiting to be tapped in other areas, and there are few districts but have their distinctive Pactolean stream only waiting for the enterprising bather. The news that that great philanthropist, Lord Mount Stephen, who during his lifetime gave half a million pounds for the same purpose, has bequeathed the residue of his fortune to the King Edward's Hospital Fund for London comes as a reminder, if reminder were needed, at the end of a trying year for the hospitals, that the country still possesses generous benefactors who believe in the future of the voluntary hospitals.

Even a successful economy campaign in the Governmental departments must in the long run benefit the hospitals, for, undoubtedly, the hand of many a potential benefactor is stayed because of the ruinous taxation.

All this makes us feel that although much is being said about the "tragedy of the hospitals," the turning of the tide is at hand, and the new year opens with a gleam of hope that the *dénouement* of the tragedy will be such a relief from financial worries as will enable the voluntary hospitals to forge ahead to fulfil their high destiny.—*English Exchange.*

TORONTO GENERAL HOSPITAL

The Toronto General Hospital closed the year 1922 with a deficit of $68,702, exceeding the deficit of the previous year by some $4,000. As compared with 1921 figures the 1922 receipts and expenditures both showed decreases. Last year's operating expenses were $960,479; those of 1921, $1,001,342. Revenue for 1922 totalled $911,777; that of 1921, $937,251.

These figures were handed out at the conclusion of the annual meeting of the Hospital Board of Trustees, held behind closed doors in the main building of the hospital.

After some discussion the board decided to make representations to the Special University Committee in connection with the controversy that recently raged between the University Medical Faculty and the General Hospital.

Although the members approached were not disposed to discuss the question, it is understood that the board is definitely opposed to any considerable alteration in the methods and personnel of the present administration of the General Hospital, and that the memorandum to the Special Committee of the Legislature will take that attitude.

This is borne out by the board's adoption of Superintendent C. J. Decker's report, in which he said: "In my mind this institution is rendering a service to its patients and to humanity in the teaching of medical students which has never been excelled in its history. It is doubtful whether we will find anywhere more efficient service than is now being given through our professional organizations in the hospital."

Executive officials of the board were re-elected, as follows: chairman, C. S. Blackwell; vice-chairman, Dr. D. Bruce Macdonald, and secretary, C. J. Decker.

Statistics presented by the superintendent indicated comparatively small changes in the volume of the hospital's work during 1922, as compared with 1921. Patients admitted totalled 10,393; in 1921 the total was 10,938. Number of out-patients treated: 1922, 61,108; 1921, 59,963. Total collective days' stay of in-patients: 1922, 221,683; 1921, 225,466. The in-patients remained in hospital for an average of 18.2 days. Operations numbered 6,745.

Of the in-patients 53.6 per cent. were Canadian, 21.6 per cent. English, the balance being made up of thirty different nationalities. Jewish patients were 4.5 per cent. of the total.

CONJOINT CONVENTION OF THE WESTERN CANADA, THE MANITOBA, AND THE WESTERN CANADA CATHOLIC HOSPITAL ASSOCIATION

A joint meeting of the Western Canada Hospital Association, the Manitoba Hospital Association and the Western Canada Catholic Hospital Association was held in Winnipeg, November 13th, 14th, and 15th, and will go down in history as being one of the most successful and inspiring hospital meetings ever held. There were many outstanding features of the meeting which are well worthy of mention, but here are just a few:

First—The wonderful and inspiring address of Dr. A. D. Stewart, President of the Manitoba Hospital Association, full of outstanding features throughout.

Second—The clear-cut and complete exposition of the Saskatchewan Hospital System by Dr. F. A. Middleton, assistant to Dr. M. M. Seymour, Commissioner of Public Health for Saskatchewan.

Third—The splendid representative attendance, embracing a large number of members of governing boards, doctors, hospital officials, nurses and others. Every session was filled to the theatre's capacity.

Fourth—A sound, practical programme, with few long papers or addresses, but all sessions taken up mostly with round-table conferences for the discussion of the common every-day practical problems. In the discussion almost everybody present took part.

Fifth—The practical and instructive exhibit, with many demonstrations of technique and procedure, which accompanied many of the subjects discussed.

Sixth—The announcement of Dr. Fred Bell, Secretary of the Medical Faculty, Manitoba Medical College, that a closer study would be made of the smaller hospitals in an endeavor to extend interneship to the various institutions throughout Western Canada, providing that satisfactory arrangements could be made with the hospitals. In this work the approved list of hospitals, as issued by the American College of Surgeons, will be used as a guide.

Seventh—The resolution passed by the joint conference endorsing hospital standardization, which reads as follows:—

Whereas the American College of Surgeons, composed of over six thousand of the leading surgeons of Canada and the United States, is international in character and in functions;

And whereas this organization has initiated, developed and carried out an invaluable constructive programme for the betterment of our hospitals;

And whereas this programme has, even in so short a space of time, effected an enormous improvement in the professional services of our hospitals;

Be it resolved, That we, the Western Canada Hospital Association, assembled here in convention, representing the four western provinces of Canada, namely, Manitoba, Saskatchewan, Alberta and British Columbia, again reiterate our very hearty endorsation of this great work and service, unparalleled in the history of hospitals, and leading to such an improved efficiency; and we hope that such work may be continued and carried on actively in the future as in the past, till every hospital in Canada, regardless of size or type, meets the requirements;

And, further, be it resolved, That this Association, as well as each of its component units, pledge themselves to render all the assistance possible to those charged with the duty of carrying on such an important and excellent work.—*Carried unanimously.*

There were many other outstanding features which should be mentioned herein, but a fuller account will appear later. The convention demonstrated the great inspiration and stimulation that is aroused by the various provinces getting together in the discussion of problems which are common to all their hospitals.

ISOLATED DISEASE OF THE SCAPHOID

Four new cases of isolated disease of the scaphoid are reported by Barclay W. Moffat, New York (*Journal A.M.A.*, Jan. 13, 1923.) The clinical picture is that of a child of from four to eight years, giving a history of trauma varying from a turned ankle to a crushing injury beneath an automobile. The symptoms, which are occasionally entirely absent, are a slight limp and discomfort at the sight of the scaphoid, increasing often to actual pain at night. The signs, which are also inconstant, are enlargement of the scaphoid, as shown by palpation, and tenderness. Abscess formation never occurs. The treatment is rest or immobolization in plaster for from three to ten weeks. A mechanism of the disease which would seem to account for all the facts is the following: Through trauma, or possibly some unknown factor, the bone is enlarged. This is demonstrable by palpation and would also account for the abduction of the fore part of the foot found in these cases. In weight-bearing, this enlarged bone, as the keystone of the arch, is subjected to anteroposterior pressure, resulting in a flattening and spreading out laterally of the soft, newly formed osseous portion. The biconcave appearance presented would thus be accounted for. As the constituents of the bone—cartilage and osseous material—are still present, conversion of cartilage into bone continues as in the normal bone. The subsidence of the symptoms corresponds in time roughly to the re-establishment of bony architecture throughout all of the portion made visible by the roentgen ray.

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Editorial

Hospital Standardization in New Brunswick

The standardization of the St. John hospitals necessitated the revision of the conditions under which physicians practised in them. A committee was appointed and formulated the regulations.

These stipulated that there should be no secret division of fees; that autopsies must be held wherever possible and records of same filed with the case records; also that the pathological, bacteriological and X-ray findings must be filed with the case records. Physical examinations are to be made and recorded by the house officer, but in all cases the attending physician and surgeon shall be held responsible for the records of their patients. A tentative diagnosis is to be made within forty-eight hours of the patient's admission. In surgical cases the surgeon's pre-operative diagnosis must be posted before the operation. The post-operative diagnosis must be recorded immediately after the

operation; and all tissues removed are to be sent to the pathological laboratory for report. Follow-up records shall be kept by a record clerk. Throat smears and other examinations as to infections shall be made of all children admitted. Vaginal smears are to be made in suspicious cases. The chiefs of service must instruct the house officers at the bedside upon the salient points of diagnosis and upon the management of cases. The superintendent must keep a record of the house officers as to their personal conduct and professional ability.

A committee of five is to be appointed annually by the commissioners on the recommendation of the staff, to see that proper methods of efficiency are maintained throughout the hospital.

Monthly meetings of the medical staff are to be held. Failure to attend three meetings renders the delinquent liable to dismissal. At these meetings a review is made of the clinical experiences of the group in the various departments. A summary of deaths, infections and complications is to be prepared and presented for discussion.

The staff shall consist of all registered practitioners in St. John City and County who subscribe to the regulations and have obtained the privilege of treating patients in the hospital.

The staff officers are chairman, vice-chairman and secretary. The chairman and secretary are members of the hospital medical board. A record of attendance at staff meetings is kept. The officers

are elected by nomination and ballot at the regular December meeting and assume office at the first meeting in January.

The order of business is (a) Presentation of interesting pathological material collected during the previous month, with remarks by the pathologist. (b) Reading the casualty report and discussion of same by the physicians and surgeons responsible. (c) Report of cases of special interest.

The Voluntary System

A conference representing 112 metropolitan (London) hospitals was recently held to discover the best means of improving the financial condition of the voluntary hospitals. The chairman favored the preservation of the voluntary principle. The crisis through which they were passing threatened the very life of the voluntary system, and with it the most valuable institutions incorporated in that system. The Government had given half a million pounds and the public an equal amount, but in spite of this help, many London hospitals were facing serious deficiencies. Parliament should be invoked for a further grant. First and foremost an organization should be developed which would ensure that every member of the community contributed a share for the upkeep of the hospitals. The Manchester scheme, whereby all workers in the city made contributions, was worthy of emulation.

Hospitals should be exempted from rates and duties on legacies, and individuals who gave considerable and regular donations should be relieved, to the extent of those donations, from income-tax.

Dr. Gordon Dill recommended the inauguration of a policy which would relieve the hospitals from the anxieties attendant upon their haphazard and hand-to-mouth mode of life. The necessitous did not constitute 25 per cent. of the patients at any hospital in these days, and yet hospital services were an ultimate necessity to the remaining 75 per cent. and could not be obtained elsewhere. Hospital patients were invited to make voluntary contributions, but the average of these was at most 12s. a week. The balance had to come from charitable funds.

How could it be made possible for the people to whom the hospitals were a necessity, but who were not themselves necessitous, to pay the out-of-pocket cost to the hospital of the services they received? The only possible solution was that while in health they should individually become regular annual subscribers of a definite amount which would suffice collectively to pay for those of them who were admitted to hospital in the course of the year.

The above suggestion corresponds somewhat with the idea of Mr. Richard Bradley, a philanthropist of Boston, who recommends a form of insurance to meet the need.

Safety First in Anesthesia

Hoag, of Pueblo, Colorado, makes a contribution to the anesthetic supplement of the *American Journal of Surgery* in which he inquires of his brother anesthetists, *Are you taking part in the nation-wide safety-first movement in anesthesia originated by the National Research Society?* If not, he says, you are missing a valuable opportunity of placing your specialty upon its proper plane. Hoag points out that this movement is based primarily on Miller's conception of determining the surgical risk of the patient by means of the blood pressure rules of Morts and McKesson. Once the surgical risk is known are you in a position, he inquires, to examine the patient before the operation, and, have you the privilege of selecting the anesthetic and dictating preliminary medication? If not, he maintains, you are in an awkward position with regard to practising a specialty, and the sooner you can convince your surgical associates that your knowledge in these respects exceeds theirs and that your judgment is more to be relied upon the sooner you will be recognized as a consultant. *To achieve this rank* (the italics are his) *it devolves upon you to become proficient in making and evaluating every possible method of differential diagnosis, and it is in this respect that the anesthetist must be an all-round physician.*

You must keep yourself and the operator (he continues) informed as to the patient's condition throughout the entire operative period by continu-

ous attention to all the signs and symptoms of anesthesia. The charting of signs and symptoms as recommended by McKesson, Guedel and others is of material assistance, but even more important is the five-minute blood pressure readings to determine if the patient is still in the zone of safety, or has entered one of the three degrees of circulatory depression. All patients, too, should be watched postoperatively as to their blood pressure reactions.

Training School Needs

Sister Bartholomew, writing in *Hospital Progress*, states that a training school should have a general class room with desks and chairs, plenty of blackboard space, anatomical and obstetrical charts, a stereopticon with numerous anatomy, histology and pathology slides illustrating sections of tissue. There should also be a manikin, a skeleton and first-aid charts.

It should also contain a dietetic kitchen with proper tables, cupboards, hot plates, bake oven, dietetic and meat charts in a spacious room, as well as a complete dietetic laboratory. In this laboratory the student should be taught the testing of cow's and mother's milk. There should also be scientific laboratories for teaching chemistry, pathology and bacteriology; each student having one month's practical work in urinalysis, blood counting, and other essential procedures.

There should also be available a pharmacy in which student nurses may receive training in the preparation of medicines.

There should also be a library, open at all times.

A demonstration room is also needed, equipped with a chase doll and bed, and with all other facilities for teaching nurses. Here the tray system is prepared and used for demonstrations of every kind, such as:

Catherization and cystic lavage. Douches: External and vaginal. Enemata: For all purposes, including the Murphy drip. Gastric: Lavage, gavage and nasal feeding.

Hypodermoclysis: With sterile graduated irrigator and attachment ready for use.

Thermometer basket.
Blood pressure outfit.
Various surgical trays.
Articles for baths, packs.
Mustard, flax-seed poultices.
A cupping set.

The Hospital World

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Original Contribution

AMERICAN COLLEGE OF SURGEONS

Hospital Standardization.

A high ideal of hospital service, a vision of community responsibility, a method by which this responsibility can be met efficiently day by day—this is Hospital Standardization. The following pages contain a report for 1922 of the progress of this movement—that of giving to the public the best service known to the science of medicine. It stands as a tribute to the idealism and the service of the combined medical and hospital professions.

For the past decade, American hospitals have been passing through a state of change. The development of modern surgery and medicine, the advancement in diagnostic procedure, the forward strikes of pathology and roentgenology, made severe and confusing demands upon hospitals. In addition, medical men, hospital executives, and public health officials began to conceive of the hospital in a new light; that of an institution which centralizes in itself every department of modern medicine; which makes itself not only the clearing house for treatment, but also the headquarters of community health activities. Some such conception came to the minds of medical men and hospital executives, who were striving to give their communities the best in modern medicine. And this widening of responsibility was altogether natural. Hospitals, founded on a basis of service, had as their dominant motive the inherent desire to improve this service and to extend it to the entire community. The standardization programme of the American College of Surgeons became the medium through which these ideals of the hospitals found adequate expression. It proposed a programme of hospital service which voiced the needs and the ideals of hospitals them-

selves. Small wonder, then, that such a programme has been adopted so rapidly. The soil had been prepared, the minimum standard was the seed, and better hospital service was the fruit thereof.

Hospitals ten years ago, as to-day, varied in size and scope from the clinical teaching organization of the large cities to the tiny hospital often owned and operated by a pioneer surgeon in an outlying town. Could every hospital, irrespective of size and financial condition offer reliable, honest service to its patients? Were there any fundamentals for hospitals applicable to every type of institution found in the American continent?

The determination of these fundamentals and their practical application clearly constituted the first step toward improvement. By correspondence and by actual visits to hospitals, the leading medical and hospital minds of America attacked this problem.

These men were not idle theorists—rather they were successful medical men of broad vision and hospital executives who were coping with actual conditions day by day. After careful consideration they elaborated four fundamentals without which no institution is worthy of the name of hospital. Later, these fundamentals became known as the minimum standard for hospital service, and under the leadership of the American College of Surgeons this standard has been adopted by the majority of hospitals of the United States and Canada.

The success of this movement is one of the most fascinating stories in the annals of American medicine.

Soon after its organization, the American College of Surgeons felt the urgent need of improving hospital records, as applicants for admission to the College were required to submit as a part of their examination one hundred case records of major operations. These records were so incomplete and fragmentary in many instances that the College became thoroughly convinced of the necessity for a wide-spread campaign to improve them. This was the initial germ causing the hospital standardization movement; as it developed, other factors in hospital betterment presented themselves, such as the need for more adequate laboratory service and more efficient

staff organization. Accordingly, hospital superintendents, members of boards of trustees, and physicians of national repute were consulted in the endeavor to determine the best plan for instituting the necessary improvements.

Although, in general, the hospitals of the United States and Canada were very commendable institutions, no far-seeing individual could deny the existence of certain weaknesses which needed correction. It was decided in 1918, therefore, to send out questionnaires to all the general hospitals in order to obtain complete information concerning the existing status of the following fundamentals: the type of staff organization, the extent to which hospital results were analyzed, the abolition of the practice of fee-division, the status of the case records, and the extent of the laboratory service. Replies to these questionnaires strengthened the growing conviction of the College that a personal survey of hospitals was imperative.

Next, a standard was needed upon which to base the survey, and leading authorities in the medical and hospital world were consulted further with this end in view. It was decided that the standard should be confined to the fundamentals which would insure the best hospital service; that it should be broad enough to be applicable to all general hospitals, and still detailed enough to avoid misinterpretation of the principles involved.

The hospital staff quite naturally was selected as the first essential to be considered in the standard. As a man often may be judged by the company he keeps, so also may a hospital be judged by the character and ability of its staff members. Restriction of staff membership to the ethical and competent, therefore, was admittedly necessary in order for a hospital to live up to its community trust. The necessity for some definite type of staff organization was mentioned because organization leads to efficiency, and lack of efficiency is inexcusable where human lives are concerned. The practice of fee-division was denounced as absolutely incompatible with honest hospital and medical care; physicians buying and selling patients should have no place on a reputable hospital staff. Hospitals were urged to adopt a constitution and by-laws with specific reference to professional care, the keeping of records, and the

attendance at staff meetings, because most hospital constitutions included no mention of such important essentials. Above all, the fundamental importance of regular staff conferences to analyze hospital results was especially emphasized. Failure to hold such meetings, besides being the chief reason for staff disharmony, was responsible for the lack of realizing the full benefit from the hospital's vast clinical experience.

The basic importance, also, of complete case records needed strong emphasis. Realizing that the majority of physicians kept relatively meagre office records, the hospital was considered the logical repository for the medical records of the community. It was a regrettable fact that many hospitals could furnish little evidence as to the amount of study made of each patient before treatment. From an economic standpoint alone, the value of the procedures carried on in the hospital was too great to permit of their being lost by failure of being recorded.

The rapid strides made by clinical and X-ray laboratories called for a more complete use of these important departments. There was a general deficiency in the quantity and variety of laboratory tests performed in hospitals. The operating room and pathological laboratory needed a closer correlation; each patient was entitled to more routine laboratory service.

With these considerations in view, the minimum standard was evolved in 1919. Whether it has stood the test of time is best answered by the fact that it has not been modified since its inception.

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

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

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

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

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

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

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

Designed as a universal, as well as a minimum standard, it must be restricted to the basic principles underlying the best hospital service. There are many variable factors such as size, type, and location, which influence a hospital's procedure in carrying out certain policies. To meet these varying conditions, the standard omits any detailed description of how its principles should be enacted. It leaves this for each hospital to decide in accordance with local needs. Where there are several equally efficient means to an end, dogmatism in insisting upon one method hampers hospital initiative. This limitation to fundamentals, and avoidance of unnecessary detail, gives the standard sufficient elasticity to meet varying situations. The viewpoint of the College looks toward certain end-results, rather than upon specific methods to be used in securing such results.

The College recognizes the importance of many features not mentioned in its standard; these lack, however, sufficient uniformity in various hospitals, states, and provinces to warrant an equitable basis for comparison and rating. The published report of approved hospitals must be just. And the more complicated the standard, the greater will be the likelihood of error in selecting the list of institutions meeting it. It is believed, furthermore, that in the careful observance of all the principles of this standard, the various unmentioned features will be cared for automatically.

The first consideration in the minimum standard, and rightly so, is the hospital staff. It is unfortunately true that organization in hospital effort has not advanced to a degree comparable with its development in other technical lines. Surely there is no excuse for the human repair shop—the hospital—to fall behind in organization, always all important in promoting the highest efficiency. Responsibility for the various activities of the hospital must be centred in certain committees or individuals. The programme for the staff meetings, the case records, the laboratory service, the nursing care, and the interne service, are but a few of the important activities, the responsibility for which should be centralized.

As the strength of a chain varies with its individual links, so the status of a hospital rises and falls with the strength or weakness of its component staff members. Restriction of hospital privileges to the ethical and competent, therefore, is essential.

The goal of the organized staff, and indeed the aim of the standardization programme, is the analysis of the hospital's results. As expressed by Mr. John G. Bowman, "the staff meeting is the pivot upon which the success or failure of hospital standardization turns." It is the medium, through which this entire campaign finds expression. Without it, a hospital's efforts, to a large degree, fail.

The form of this analysis varies according to the type of organization. Whether combined staff meetings or departmental conferences are held is immaterial, so long as all the special activities of the hospital are represented.

The staff conference, perhaps more than any other factor, has improved the tone of hospital service during the past few years. It is the feeling of the College that these meetings should be devoted largely to a discussion of the so-called casualties, including deaths, infections, complications, and unimproved cases. Occasional hospitals still adhere to the belief that such meetings violate the confidential relationship existing between the physician and his patient. One naturally assumes that all the physicians present in a given staff meeting are ethical and competent; if not, they have no place on the hospital staff. Granting this assumption, all that occurs in this meeting is held in strict confidence by each physician present. The names of the patients are not divulged during the confidence. The discussion is impersonal, being an analysis of a clinical event, and the relationship of that event to the hospital. Even if the patient's name be known to a few it should have no bearing subsequent to the meeting.

Experiences encountered in hospital practice probably exceed in value those occurring in any other line of endeavor, and their true value is not approached, unless they are portrayed in the staff conference. The confidential relationship between the physician and his patient is not violated; it is elevated to the much broader conception of a confidence reposed in a frank, co-operative group of fellow practitioners—the hospital staff.

One of the great advances in modern medicine has been in the direction of laboratory aid in diagnosis. Indeed, this constitutes one of the greatest distinctions between the practice of medicine to-day and that of our forefathers. Hospitals owe their patients the benefit of this advance in medical science. The laboratory in no sense, however, should be considered as a short-cut to diagnosis, supplanting the careful taking of a history and a painstaking physical examination. Combined with the latter, however, it furnishes an invaluable means of assistance, often making clear an otherwise obscure diagnosis.

The necessity, then, for making careful arrangements for adequate laboratory service, needs no argument. As a minimum, hospitals should have facilities for the examination of urine, blood, exudates, bacteriological slides, and for the growth of cultures. It may be impractical, however, for some hospitals to have equipment for the more technical examinations, such as serological and histological tests. Arrangements

must be made with a reliable laboratory for accurate and prompt service for these more detailed examinations. Where material has to be sent outside of the hospital, there is an unfortunate tendency to reduce the number of specimens sent. As a result, laboratory service suffers. Unfortunately, the number of qualified pathologists and serologists is too small to supply each hospital individually, and as inaccurate laboratory reports are worse than none, the only recourse at the present time is the practice of sending certain specimens to adjacent laboratories.

To help obviate this difficulty it is customary to employ technicians. Adequate provision for their supervision, however, is often neglected. If a pathologist is not available, some staff member versed in laboratory work should be selected for this purpose.

Even in hospitals with complete laboratory facilities, one frequently finds laboratory service markedly deficient, due to the insufficient quantity of tests performed, especially for private patients. This is due largely to two causes: first, the system of charging an individual fee for each test performed; and second, to the apathy of many staff members toward the laboratory. It cannot be too strongly emphasized that almost without exception, hospitals which charge individual fees for their laboratory tests, perform a relatively small number of tests per patient. Under such conditions, naturally, the hospital cannot assume a definite routine of laboratory service, as an immediate objection to the cost would be raised. The only solution apparent at the present time, is the adoption of a flat-rate fee. This allows the hospital, and rightly, to assume the responsibility of having each patient receive adequate laboratory aid. The uniform success of this plan has been proved in so many instances, that it can be accepted as an established fact.

The installation of X-ray equipment has proceeded so rapidly that the supply of roentgenologists can scarcely meet the demand. Although technicians may become proficient in many phases of the work, the problem of adequate roentgenological interpretation is more difficult to meet. Each X-ray department should have a qualified roentgenologist in charge,

if only in a part-time, supervisory capacity. Patients, in general, do not receive uniformly competent service if interpretations are relegated to individual physicians.

The College makes no specific recommendations concerning the number of routine laboratory examinations to be employed by hospitals. A routine urinalysis, of course, is performed in the majority of hospitals. Many perform a routine hemoglobin determination and leucocyte count also—a practice to be strongly recommended. Some hospitals have a routine Wassermann test in certain wards or services. Fortunately, the practice of having a routine examination of every tissue removed in the operating room is becoming quite prevalent. This is a factor of paramount importance. Every specimen from the operating room should be sent to the laboratory automatically; this should be as rigid a part of the operating room technique as the sterilization of instruments. Every specimen should be examined by the pathologist, who submits at least a gross report of his examination and has a histological examination made whenever possible. Data of tremendous scientific value are becoming available due to the practice of sectioning practically all specimens from the operating room. Furthermore, this practice gives the hospital an insight into its operating room service that can be obtained in no other way.

The absolute and fundamental importance of case records is a commonly acknowledged fact and needs no argument here. A careful study of the history of a patient's illness and a painstaking physical examination are procedures of such great importance that their value must be preserved. Failure to record these data, constitutes a tremendous economic loss and waste, to say nothing of the future bearing on the welfare and lives of the patients. How then, can the possession of a complete record system be facilitated? Its accomplishment requires the mutual co-operation of the hospital and its staff members.

The duties of the hospital in this connection consist, first of all, in supplying adequate personnel to secure the records. In the absence of internes, record clerks are essential. Even the small hospital is entitled to a full-time historian, although it is quite common for these historians to devote part of their

time to other activities of the hospital. It is because the responsibilities and many duties of the historian are so little realized that so small an amount of time is allotted to her. With careful training she can record many of the essential points of the personal history; the physical examination records should be taken by dictation from the physicians. This relieves the staff members of considerable time and labor. In addition, the historian should keep close watch of the current records to see that they are recorded promptly; she notes whether the history, physical examination record, and working diagnosis are recorded before operations; she keeps in close touch with the progress notes, which explain the course of the patient's illness; and she checks over the records carefully to see that they are complete before filing.

An efficient record committee is a necessary adjunct to the historian's work. In this committee is vested the responsibility for the interpretation of the records. Other of its functions are a persuasive stimulation of the physicians to improve their records; a periodical review of the charts of the discharged patients; and the selection of the records to be analyzed at the staff conference.

Many hospitals fail to provide adequate space for the record department. For this purpose a room large enough to contain the records of many years should be set aside, adjacent to the hospital office. All plans for new hospitals should bear this important feature in mind. This department should contain standard filing cabinets and card indices for names and diseases; for each record must be immediately accessible. The cost of this equipment is slight in proportion to the value received; perhaps no expenditure is more warranted.

After supplying the equipment and personnel needed for a modern record department, the hospital can expect the physicians to insure the accuracy of the records. Although much of the time and labor in securing records can be borne by the hospital, the responsibility for the records themselves lies with the physicians. Unless constantly checked and supervised by the staff members, the records will contain many inaccuracies. In many small hospitals the physicians write all the records personally. Whether recorded by internes, historians, or dictated to clerks, however, the physicians should scrutinize the

records closely and signify their approval in writing before the charts are filed. Physicians too often take no interest in the records of their patients written by internes; as a result, the records are frequently inaccurate and brief. Staff supervision is a great stimulus to internes, the character of whose work reflects the interest displayed in it by the staff members.

Personal study in over sixteen hundred hospitals during the past four years has shown a progressive improvement in the records. Certain prevalent shortcomings, however, are worthy of special emphasis. Extreme brevity is a common fault, coupled with a tendency to dismiss important regions of the body from consideration, by too promiscuous use of the words "normal," or "negative." A tendency to a stereotyped form of history and physical examination record is encountered frequently. Such charts have little individuality or clinical value and result from two causes: failure to record the data until shortly before or after the patient's discharge; and lack of supervision of the records by the hospital staff.

The importance of having the working diagnosis recorded early is insufficiently realized. This, in itself, will correct many existing difficulties in connection with other phases of the records. Operation records are almost universally weak in describing the exploratory findings and operative technique. The solution for this seems to be the dictation of these data during or immediately following each operation.

Case records are not to be filed and forgotten; if so, most of their potential value is lost. Inseparably linked with the staff conference, the records form the only basis for a true analysis of a hospital's results. The depth of this analysis varies in direct proportion with the detail and completeness of records. Many treasures are buried in hospital record rooms for lack of discovery and analysis. Unquestionably, one of the greatest future advances in hospitals will be in the direction of statistical, analytical research based on complete records.

The hospital surveys of the College are *personal* surveys. Experience has shown that a study of hospital conditions through correspondence and questionnaires leads to many inaccuracies. The College surveys are conducted through a trained corps of hospital visitors, all of whom are graduates in medicine. The number of visitors employed in any year has never

exceeded ten. Since the uniformity of a survey varies in inverse proportion with the number of men employed by using relatively few visitors, all similarly trained, the College obtains strictly uniform reports. As an additional safeguard, each visitor covers a large number of states and provinces in order that he may obtain a general, rather than a local viewpoint of hospital conditions. This uniformity in the reports is an absolute essential to a just rating of hospitals. Upon such detailed personal surveys, the College is dependent for an accurate estimate of each hospital's status relative to the minimum standard.

The purpose of the visitors is to explain the minimum standard, to interpret its application to each hospital, and to offer constructive criticism and helpful suggestions to remedy any existing shortcomings. This campaign is one of suggestion only; there is no element of coercion entailed. It succeeds through the sanction and approval of the hospitals themselves.

Other organizations interested in hospital betterment have played a prominent rôle in advancing hospital standardization. The programme of the College has been enhanced greatly by the endorsement of such organizations as the American Hospital Association, the American Conference on Hospital Service, the Canadian Medical Association, the Catholic Hospital Association, the Conference Board of Hospitals and Homes of the Methodist Church, the Medical and Surgical Section of the American Railway Association, the Methodist Hospital Association, the Protestant Hospital Association, and numerous state, provincial, and local organizations.

Internes and nurses are using the approved list of the College as a guide in the selection of institutions in which to pursue their training. The public is making increasing use of it as a means of determining which institutions offer safe and competent hospital care. Benevolent foundations employ it in deciding upon hospitals which are worthy of financial aid. The American Railway Association has recommended that all railroad employees, wherever possible, be treated in hospitals meeting the minimum standard. The United States Government, in its selection of hospitals for the treatment of its disabled veterans, utilizes the information furnished through the surveys and approved lists of the College.

Four annual surveys of the general hospitals in the United States and Canada have been made. Of the institutions having one hundred or more beds, eighty-nine were found to meet the standard in 1918; in 1919, 198 fulfilled the requirements; in 1920, 407 or fifty-seven per cent. met the standard; in 1921 the number of approved hospitals grew to 579 or seventy-six per cent.; and this year 677 or eighty-three per cent. of the 812 hundred-bed general hospitals are on the approved list.

Of the 811 general hospitals having a capacity of between fifty and one hundred beds, 335 or 41 per cent. are approved, an excellent showing in view of the fact that previous lists published by the College have not included these smaller institutions.

Grouping together the 1623 general hospitals having fifty or more beds, there are 1,012 or sixty-two per cent. meeting the requirements of the standard.

Although the College has been surveying the smaller hospitals since 1920, it was deemed advisable to withhold their publication on the approved list until sufficient time had elapsed to give them an opportunity to familiarize themselves thoroughly with the standardization programme.

The smaller hospitals are under greater difficulties than the larger institutions. Many are forced to be practically self-supporting; the physicians are more prone to develop personal rivalries which retard staff organization; it is difficult for them to obtain internes; and sufficient laboratory service is often a serious problem. In spite of these difficulties, however, the small hospitals have welcomed the minimum standard with the same spirit manifested by the large institutions. Indeed, it is in these small hospitals where the greatest change in hospital service has been manifested. It requires patience to establish a complete case record system; to organize a harmoniously functioning staff; and to arrange for adequate laboratory service. These small institutions are to be especially commended, therefore, on the excellent showing which they have made.

In the United States and Canada there are 811 general hospitals having between fifty and one hundred beds. Of these, 335 or 41 per cent. are on the approved list. This exceeds the percentage of hundred-bed hospitals which met with approval at the time of the first survey.

The surveys of the College have demonstrated that the hospitals of this continent are receptive to any means of improving their service to the public. As the sphere of hospitals has widened, so have their responsibilities increased. Sensing these ever deepening responsibilities and obligations, hospitals looked forward to a means of satisfying their broadened conception and ideals of community service. The minimum standard and the standardization programme of the College furnished a concrete method by which these aspirations could be reached. The future will see the further elaboration by hospitals of the principles of the minimum standard and a fuller realization of the spirit embodied therein.

List of Approved Hospitals.

ALBERTA

100 or more beds

General Hospital, Calgary
General Hospital, Edmonton
Holy Cross Hospital, Calgary
Medicine Hat Hospital, Medicine Hat
Misericordia Hospital, Edmonton
Royal Alexandra Hospital, Edmonton

50 to 100 beds

Galt Hospital, Lethbridge
Lamont Public Hospital, Lamont

BRITISH COLUMBIA

100 or more beds

Provincial Royal Jubilee Hospital, Victoria
Royal Columbian Hospital, New Westminster
Royal Inland Hospital, Kamloops
St. Joseph's Hospital, Victoria.
St. Paul's Hospital, Vancouver
Vancouver General Hospital, Vancouver

50 to 100 beds

Vernon Jubilee Hospital, Vernon

MANITOBA

100 or more beds

Brandon General Hospital, Brandon
Children's Hospital, Winnipeg
Misericordia Hospital, Winnipeg
St. Boniface Hospital, St. Boniface
Winnipeg General Hospital, Winnipeg

50 to 100 beds

Victoria Hospital, Winnipeg

NEW BRUNSWICK

100 or more beds

General Public Hospital, St John

50 to 100 beds

Chipman Memorial Hospital, St. Stephen
Hotel Dieu, Campbellton
Hotel Dieu, Chatham
Miramichi Hospital, Newcastle
Moncton Hospital, Moncton
St. John's Infirmary, St. John
Victoria Public Hospital, Fredericton

NOVA SCOTIA

100 or more beds

St. Joseph's Hospital, Glace Bay
Salvation Army Maternity Hospital, Halifax
Victoria General Hospital, Halifax

50 to 100 beds

Aberdeen Hospital, New Glasgow
Children's Hospital, Halifax
General Hospital, Glace Bay
Highland View Hospital, Amherst
St. Martha's Hospital, Antigonish

ONTARIO

100 or more beds

Carleton County Protestant General Hospital, Ottawa
General Hospital, Kingston
General Hospital, Toronto
Grace Hospital, Toronto
Hamilton City Hospital, Hamilton
Hotel Dieu, Kingston
McKellar General Hospital, Ft. William
Ottawa General Hospital, Ottawa
St. Joseph's Hospital, Hamilton
St. Joseph's Hospital, London
St. Joseph's Hospital, Port Arthur
St. Luke's Hospital, Ottawa
St. Michael's Hospital, Toronto
Sick Children's Hospital, Toronto
Victoria Hospital, London
Western Hospital, Toronto

50 to 100 beds

General Hospital, Brockville
General Hospital, Sault Ste. Marie
Niagara Falls General Hospital, Niagara Falls
Nicholls Hospital, Peterborough
St. Francis Hospital, Smith's Falls
St. Joseph's Hospital, Peterborough
St. Vincent de Paul Hospital, Brockville
Smith's Falls Public Hospital, Smith's Falls
Welland County Hospital, Welland
Wellesley Hospital, Toronto
Women's College Hospital, Toronto

PRINCE EDWARD ISLAND

50 to 100 beds

Charlottetown Hospital, Charlottetown
Prince Edward Island Hospital, Charlottetown

QUEBEC

100 or more beds

Children's Memorial Hospital, Montreal
General de St. Vincent Hospital, Sherbrooke
Hotel Dieu, Montreal
Jeffery Hale's Hospital, Quebec
Montreal General Hospital, Montreal
Notre Dame Hospital, Montreal
Royal Victoria Hospital, Montreal
Sainte Justine Pour Les Enfants, Montreal
Western Hospital, Montreal

50 to 100 beds

Montreal Maternity Hospital, Montreal
Sherbrooke Hospital, Sherbrooke

SASKATCHEWAN

100 or more beds

Grey Nuns Hospital, Regina
Regina General Hospital, Regina
St. Paul's Hospital, Saskatoon
Saskatoon City Hospital, Saskatoon

50 to 100 beds

Holy Family Hospital, Prince Albert
Notre Dame Hospital, North Battleford
Prince Albert Municipal Hospital (Victoria Hospital), Prince Albert
Providence Hospital, Moose Jaw

FOOD SERVICE IN HOSPITALS

Maude A. Perry, Supervising Dietitian, Montreal General Hospital.

Many complaints concerning food in all hospitals could be avoided if more attention were given to the service of the meals. When one realizes the difficulty of pleasing sick people, robbed by illness of a normal desire for food, it is natural to expect that even good, well-cooked food, improperly served, may fail to appeal to their capricious appetites.

The problem of food service in any hospital depends upon the equipment in the kitchen and on the ward, upon the distance to be traversed between these two, and upon the method by which the food is conveyed from one to the other. To make good foods attractive, it is absolutely necessary to serve hot foods hot and cold foods cold. It is easier to serve the cold foods than the hot ones in most cases. The food served in public wards must of necessity be plain, but it may be well cooked and properly served.

Several plans of food service are being successfully used in different hospitals to-day. Some of these have been adopted from necessity, where economy is the main thing to be considered, some from choice of some hospital official, or perhaps architect. Perhaps the oldest method is the service of food from containers sent from kitchen to ward in hot water boxes. Unless the boxes can be placed upon stoves and unless the meals can be served in courses, it is difficult to give to every patient in a large ward good hot food. As this service must be from the ward kitchens, it takes a great deal of time and labor on the part of the nurse to get out the meals satisfactorily. Nevertheless, it can be done if the food is served on previously heated plates conveyed to the patients as soon as served. It cannot be done well if delivery to patients is not accomplished until a carrier of ten or twelve trays have been served.

In some institutions the food is served in the main kitchen into insets which fit into the steam tables found in each ward kitchen or serving room. When this food is sent hot from the kitchen and placed immediately in the heated steam table awaiting it, one may find good service from this method. Unfortunately, sometimes the food is not served hot from the

kitchen or because of the distance which it must go, it does not arrive hot at the place of service. In such case, reheating of food properly, depends upon the one who has charge of the food after it arrives in the ward-serving pantry. If this person is more interested in the welfare of the patients than in "getting the meals out" this service may be very good. If, as sometimes happens, this care of the food is left to a maid who is careless about properly regulating the steam table, or if one attempts to serve too many trays at one time, patients will almost surely receive what should be hot foods, luke-warm or cold.

Probably the newest method of food service is by heated or insulated conveyors. These are sent either to ward kitchen or directly to the ward for meal service. Hospitals which have this method are quite enthusiastic in its praises. Certainly the conveyor which takes the food directly to the patient has solved a big hospital problem. These conveyors are either constructed on the fireless-cooker principle, which retains the heat for a long time or they are electrically heated. The carts having the separately built and insulated compartments are particularly valuable. Heat is retained longer, odors do not mix, and hot and cold foods may be sent by same wagon. As this conveyor may be wheeled around the ward it is never necessary to serve any patient any food which he will not eat. Surely this is much better than serving every plate for every patient, on similar diet orders, exactly the same, regardless of idiosyncrasies of different individuals.

This plan of service is economical for the institution as food waste may be reduced to a minimum. Any food remaining in the conveyor after all patients have been served, may be returned to the main kitchen in good condition. It does not dry out nor lose flavor in the fireless-cooker conveyor as it never needs to be reheated. For the same financial outlay, more variety in foods may be allowed and even public patients given some choice, especially of vegetables. Cold foods, as well as hot, may be nicely served to patients in a large ward, so a complete meal from soup to pudding may be served from one carrier in much less time than required by other methods and with much less confusion and labor.

In any plan of food service, the meals for sick people should be served by a nurse as she knows the patients and naturally has a greater interest in their welfare than anyone could have who is not familiar with them. She is vitally interested in anything which aids in their convalescence and she cannot help but see to what extent food alone contributes to this. Furthermore, this is a part of the nurse's training in most hospitals, just as truly as the administration of medicines or various forms of treatment to be given.

THE NURSE'S PRAYER

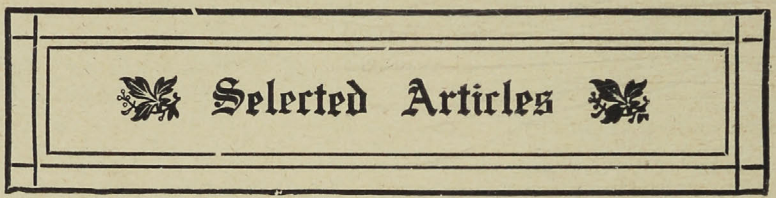
Rev. Otto Brand, Field Secretary and Chaplain of the Methodist Episcopal Hospital, Brooklyn, N.Y.

O holy Father, to Thee my heart inclines, to Thee my fervent prayer ascends. Behold me, Lord, a nurse—just only one—amid this vast world's suffering. To the sweet task of pain's alleviation, the life-task of my choosing, I would this day re-dedicate myself. Supplement, I pray, with wisdom from above, my training of long years, that more and more, through Thy direction, it may become effectual in causing disease and misery to give place to health and happiness. So that the tide of death may be oft-times backward turned, and the day of mourning long postponed, help me in the art of nursing to excel, the holy art by angels taught.

O Christ, Thou Great Physician, instruct me also in those deeper things which to the sacred calling of our sisterhood belong. O Holy Spirit, Nurse of this dying world, minister through me to hearts that are sick as well as to bodies cruelly racked by pain. May my feet, O God, be ever swift to obey Thy slightest bidding. May these two prayer-clasped hands be found always willing to minister in tenderness to a fellow-creature's need. May the light of honest, human love so shine in these eyes of mine that they who suffer shall be convinced that one other heart, at least, can feel the sharpness of their pain. So control my spirit, Lord, that never from these praying lips shall fall one single harsh or bitter word, to cause an added twinge of pain in those committed to my care.

O Father, for all I ask, mine own unaided strength will not suffice. Thy gracious help I need, or else must surely fail. In my weakness aid Thou me, my Teacher and my God. By Thine own compassionate love inspired, Christlike would I live and serve to-day.

And when, dear Lord, my earthly course is run; when Thou shalt have no longer need of me; when other feet and other hands shall minister where mine no longer may: then, O God, unworthy though I be, grant, in mercy unto me, the sweet and happy rest of Heaven. Assist my earth-worn spirit to wing its homeward flight, until, in Heaven, Thy dwelling-place, its destined goal is reached. Thy voice it was that sent me forth, a nurse, upon my holy mission of relief. So again, dear Lord, at last recall Thou me, and cap me for that larger ministry of Heaven, reserved for those who serve Thee faithfully and well on earth. Amen.



THE FINANCING OF HOSPITALS

To those of us in Canada who are so deeply interested in the financing of our general hospitals, the report just brought in by Lord Cave on hospital financing in the Old Country is exceedingly interesting, in so far as it is the first attempt on the part of the British authorities to rectify the serious financial condition of the English hospital situation of to-day. Hospital conditions in England have been so entirely different from hospital conditions in the New World that one can find very little in this report of Lord Cave that may be of practical assistance to those of us in Canada. The chief cause of the serious state of affairs in England is not difficult to find. Since their foundation extending back over hundreds of years, the custom in the large English hospitals has always been to treat every patient free of charge. No effort has at any time been made to investigate the patient's financial status in the community. At the same time it must be said, in all fairness, that the majority of the patients that have filled the wards of hospitals in England in the past could not have paid more than a tithe of the cost of their upkeep. It is probable, however, that a considerable percentage of the patients now occupying their public wards could afford to pay a small portion of the cost of their hospitalization, and one wonders why the English authorities have been so tardy in demanding from such, a definite contribution. While this would be regarded as a great departure from the traditions of the Old World, nevertheless, unless some radical movement along these lines is undertaken, it is doubtful if the Government will come forward and continue to bear the entire cost of the annual deficits.

For several years it has been the practice in Canadian hospitals to make a small charge for the public ward patient in cases in which upon investigation by the social worker such a charge seems warranted. This not only tends to instil into the patient a spirit of independence, as opposed to one of pauperism, but it becomes at the end of the year great assistance to the finances of the hospital. By way of example we may state that in looking over the records of one of our Canadian hospitals we note that in 1917 the revenue from the public wards of that institution was in the neighborhood of thirty thousand dollars. Little or no effort had been made at that time to collect, where possible, even a small sum from the patients. That hospital was slowly committing financial suicide. With the ever-increasing cost of maintenance it became apparent that some means must be taken whereby the revenue might be increased. An energetic movement was started and each patient's account was carefully scrutinized. The result of this was that in 1920 the revenue from the same public wards was over ninety thousand dollars. By such means the income of many hospitals may be increased, and it is reasonable to think that Governments will be induced to listen to the pleas of those institutions that are endeavoring to help themselves, and come forward with some plan whereby hospital finances may be placed on a sound basis. Many authorities, however, are of the opinion that the only relief which the future holds for the financial condition of our hospitals is a general per capita tax made on all residents in each city or Province, out of which tax, assistance shall be rendered to our hospitals on the basis of the quantity and quality of the medical attention given to the poor; while at the same time philanthropic citizens who desire to perpetuate their own name or that of some relative or revered friend will have the opportunity to give or bequeath funds sufficient for the erection of the buildings made necessary by the steady growth of our cities. While the serious financial conditions of the English hospitals are demanding the earnest consideration of all in England, Canadian institutions realize that steps must be taken in advance to prevent this misfortune occurring here. Unfortunately the character of assistance rendered by the Provincial and municipal governments has

in the past been very uncertain. It is our hope that the time is not far distant when under federal or Provincial guidance, financial assistance will be rendered to all accredited hospitals, for surely the supervision of the health of our citizens is quite as important as the upkeep of roads, canals, police and other departments that have become recognized as necessary to the safety and well-being of our country.—*Canadian Medical Association Journal.*

HOSPITAL PUBLICITY

The American Methodists work out their publicity campaign as follows:

Let us first list up some of the channels of publicity open to a local hospital or home, whether it be for the regular or general publicity or for campaign publicity. Among these are the following:

1. The newspaper.
2. The Church Press.
3. The institutional monthly paper.
4. Annual reports.
5. Booklets and leaflets.
6. Occasional bulletins.
7. Personal and circular letters.
8. Lantern-slide lectures.
9. Moving pictures.
10. Personal presentation.
11. Pulpit presentation.
12. Epworth League and Sunday school institutes.
13. Camp meetings.
14. Local Church Societies—Ladies' Aid Society, Epworth League, Brotherhood, etc.
15. Use of special days—Hospital Sunday, Mothers' Day, etc.
16. Preachers' meetings.
17. The Annual and District Conferences.
18. Area gatherings.
19. Medical and Hospital and Homes publications.

With this list must go your fields to cultivate:

1. The Bishop of the area.
2. The District superintendents and pastors of your territory.
3. The physicians of your territory.
4. Wealthy members of Methodist Episcopal churches.
5. The churches in your territory, including all their organizations.
6. Patients who have been served by the hospital, especially those of wealth.
7. Nurses trained by the hospital.
8. Families who have adopted children from church homes.
9. Friends and relatives of the old folks in Homes for the aged.
10. Wealthy people locally in the immediate community served by the institution.
11. The local community generally.

Then decide absolutely just what your publicity shall be for. The following suggests the scope:

1. To keep the church and public informed and to create background.
2. To secure workers.
3. To secure inmates or patients.
4. To develop personal interest.
5. To secure money.
6. To secure supplies.

Manifestly it is impossible to discuss all of these phases of publicity in the time available. But those phases which are discussed, point in many ways to the possibilities of those untouched.—*Selected.*

FEEDING SICK INFANTS

In the care of sick infants not only do those suffering from some form or other of digestive disturbances amount to more than one-half the number of cases where the services of the nurse will be required, but, inasmuch as an undisturbed metabolism is of paramount importance for the happy ending of any illness of babies, the nurse must be familiar with the

most common modifications of cows-milk, their purpose, action, and preparation. No less should she be acquainted with the composition of the widely used, and much advertised, proprietary baby foods. No less must she master the theory and practical carrying out of breast-feeding, which, in far too many cases, seems impossible or impracticable for the simple reason that the young mother, in her inexperience, does not know how to do it, and that the nurse is unable to show her. Furthermore, the nurse should have all the arguments why breast-feeding is best for babies on the tip of her tongue, so that she will be able to contradict all those more or less vague objections against it, brought forth by grandmothers and other members of the family, or even by meddling neighbors. Thus the nurse must know that the milk will sometimes not be present in abundance until as late as the sixth week after the birth of the child, and she must be convinced of the fact that only in very rare cases is the quality of the mother's milk at fault, but that it is mostly the quantity of the milk given to the infant which is to blame, as can readily be proven by careful weighing of the baby before and after nursing. In this connection. I would like to request the nurse to use her influence with prospective mothers, whenever she is consulted in time, against their wasting good money on spring-scales for this purpose as only balance scales weighing at least half ounces, but better still quarter ounces, are of any use.

The most important in the feeding of sick infants and children, and one which the nurse must always hold before her mind's eye, is this—that next to oxygen, water is the most important requirement for the organism. While everybody is aware of the fact that the human body can survive a very short time only when deprived of air, few seem to realize that desiccation of the body due to insufficient amounts of water, is also fatal within a relatively short time; the younger the individual, the shorter. During illness, the output of water, through respiration, perspiration, through the excreta and defecta, and in consequence of fever, is considerably increased and this must be replaced correspondingly. The young infant requires three ounces of liquid for each pound of body-weight, up to one quart in twenty-four hours, and in older children this amount of water is the least with which

they can carry on the most essential physiological functions of the body. The nurse must, therefore, be an adept in the administration of water, which may vary in every given case, be it by gavage, by the Murphy drip, by mouth, or rectum, by enema, or subcutaneously; and this amount of water must not only be administered, but actually retained.—*Selected.*

THE USE OF LIGHT IN HOSPITALS

A most interesting paper was read by Mr. John Darch at the discussion upon the use of light in hospitals, arranged by the Illuminating Engineering Society.

Speaking first of the hospital ward, Mr. Darch advocated a light that should be quiet and pleasing, best obtained by a system of general lighting combined with local lighting. The general lighting need not be great, anything from one-half to one-foot candle, well diffused and without glare. The light should be spread evenly over the ceilings and friezes. Each patient should be provided with his own local light, giving him three foot-candles upon his book. This may be set on a short, smooth bracket close to the wall so as not to be in view of the patient. It should not be in the centre of the bed-head as usual, but about fifteen inches to the patient's left so as to avoid heat on his head and gloss on his book.

Local lighting is also necessary on the sisters' and nurses' tables, and each should have one or more well-shaded table-lamps adjustable so as to give an average of four-foot candles. The decoration of the ward is an important factor in its illumination. Although ward and ceilings and walls are frequently to be found varnished, there should be no gloss above the dado. The ceilings and friezes should be white, the walls below are better of a quiet and restful color, darker or lighter according to window space and aspect. As regards the operating theatre, whatever arrangements are made, the highest possible degree of asepsis should be maintained, yet the fittings suspended over the tables are often thickly coated with dust. One should admit the greatest possible angular expanse of glass without admitting direct sunlight, and the glass should extend nearly the length of the room. The ideal light for operations should be made to approximate to that found quite away in the open under a clouded sky.

The illumination should not be less than five-and-twenty foot-candles, and the light should be so thoroughly diffused that it should be difficult to get the shadow of one's hand upon the work. No exposed light sources should exist within the field of vision. The color of the light should be as white as possible, and it must be uniform and steady. In special circumstances the surgeon can use an electric forehead light.

The author has seen nothing better for the purpose of illuminating the operating room than the white flame arcs we had before the war. He specially mentions the method more in favor abroad than here, viz., that of projected beams of light converging on the table from several points.—*Selected.*

SOME ADVANTAGES WHICH NURSES ENJOY

With calls for trained nurses coming from all sorts of new places every year; with new institutions being opened every week, with the great unworked fields in foreign lands calling for help—for the service that only trained nurses can render—it behooves every reader to help in recruiting the right type of woman for the schools of nursing to train.

There is no occupation or profession without its disadvantages, and nursing is no exception to this rule. But it has advantages of no mean order over a great many other occupations which now freely offer open doors for women to enter. First, it does not require anything very big in the way of finance and is thus opened to many young women who could not secure a professional or technical education if they had to be entirely responsible for every item of expense during training.

Second, nursing is pre-eminently a woman's occupation. Men do succeed in it, but the highest positions in the nursing world are not open to men, and the average nurse has little, if any, competition from male nurses. The field for male nurses is limited, while the demand for women nurses is constantly increasing and the field is practically unlimited.

Third. The well-trained nurse who is willing to serve and who can adapt herself to varying situations can always find work. Whether she goes east, west, north or south, she will encounter human need and the right sort of woman will find her services in demand.

Fourth. The training which a nurse receives is an excellent preparation for a great many other lines of work, so that if one tires of nursing, it is not difficult to take an excursion into the business world, nor to find an entrance to many kinds of social service.

Fifth. If she wishes to marry and establish a home of her own, her training is an excellent preparation for home-making and motherhood.

Sixth. The financial rewards are fairly good, and the average nurse who has been industrious in her early years, and sensible about the way she spent her income, should be able to have an income from her investments before many years.

These are only a few of the considerations which should be presented to the possible candidate who is facing the choice of a vocation.—*The Trained Nurse.*

REDUCING THE LOSS OF HOSPITAL LINEN

1. Have a careful system of marking linen. A blunt pen with indelible ink, pressed in with a hot iron, is the simplest plan, and is more durable than rubber-stamp markings, though these may also be used. Linen for the operating room, for the out-patient department, for nurses' rooms, for the private pavilion, should be marked with the symbol of the department.

2. Take an inventory of the linen supply at stated intervals, so that loss may be detected. This is not a tedious task if wisely managed. It can be done in an hour in the ordinary hospital if proper blanks are used for records. No linen should be changed or moved from one room to another while the count is going on. When new linen is added to the supply in circulation a list of the articles should be added to the inventory. Stringent rules against employees appropriating worn or old linen for use in cleaning should be enforced.

3. A central linen room is an economy. It definitely places responsibility for the giving out and checking of linen, and once the system is established, few institutions would care to do without it. A roomy basement room can be easily fitted

with the necessary shelves, cupboards, drawers, tables for sorting, etc. An extra room for sorting all soiled linen should be close by. The matron of the linen room is responsible for collecting and counting. The person in charge of the laundry must receipt and account for linen delivered to him, his receipt being returned to him when clean linen is returned.

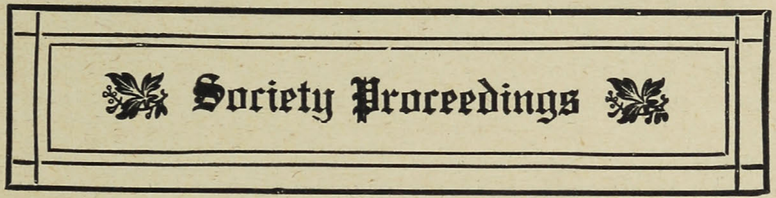
4. Linen to be discarded should be listed and checked off the inventory.

5. Linen is distributed to the different departments by an exchange of as much clean linen as there is soiled linen taken away. Additional linen should be issued only on requisition of the head of the department and should be receipted for.

The high cost of cotton goods of all kinds for the past few years has made strict economy a necessity and this is only possible when a careful system of accounting for linen is in use. If it is not possible to secure and pay a full-time seamstress for mending and making up new supplies, it is nearly always possible to secure volunteers from the Ladies' Aid Society of the Hospital to donate one day each week to assist the hospital in this way.—*The Trained Nurse.*

EGG AS A SOURCE OF VITAMIN B.

By extraction of egg yolk with water, Thomas B. Osborne and Lafayette B. Mendel, New Haven, Conn. (*Journal A. M. A.*, Feb. 3rd, 1923), secured a product comparatively rich in vitamin B, the daily dose required for a 100-gram rat being considerably less than that of the most potent dried yeast hitherto examined. The contents of the egg yolk in vitamin B is not large, a daily intake of at least 1.5 gm. of the fresh yolk being required when it furnishes the sole source of vitamin B to a 100-gram rat. The whole egg is accordingly not exceptionally rich in vitamin B, when contrasted with other foods already investigated. Judged by the comparative trials on rats, the average sized hen's egg is equivalent in vitamin B potency to about 150 c.c. of cow's milk, or a quart of milk and six or seven whole eggs of the average sort have an approximately equivalent vitamin B value.



THE NATIONAL HOSPITAL DAY COMMITTEE

E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, and vice-chairman of the National Hospital Day Committee, has been appointed chairman, succeeding Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn. Dr. Sexton, who was first chairman of the committee and who directed the observance of first and second National Hospital Day, remains as a member of the committee, although increasing responsibilities as president of the New England Hospital Association, and other activities, prevent his again serving as chairman.

The new chairman is widely known throughout the hospital field, having been active in national association hospital affairs for several years. He is a founder and the four-time president of the National Methodist Hospitals and Homes Association. At the 1922 convention of the American Hospital Association Mr. Gilmore conducted the section on building in a most efficient manner. Dr. Malcolm T. McEachern, general superintendent, Vancouver General Hospital, Vancouver, B.C., who is on a year's leave of absence to conduct a survey of Canada for the Victorian Order, succeeds Mr. Gilmore as vice-chairman. Dr. McEachern, who is president-elect of the American Hospital Association, continues as Canadian director for the movement.

Two new members have been appointed to the committee for 1923: C. J. Cummings, superintendent, Tacoma General Hospital, and Dr. Albert S. Hyman, superintendent, Mt. Sinai Hospital, Philadelphia, Pa., succeeding former members who are now out of the hospital field.

In addition to the foregoing, the personnel of the 1923 National Hospital Day Committee is:

Asa S. Bacon, superintendent, Presbyterian Hospital Association; P. W. Behrens, superintendent, Toledo Hospital, Toledo, Ohio; Rev. P. J. Mahan, S. J., Loyola University School of Medicine, Chicago, acting vice-president, Catholic Hospital Association of the United States and Canada; W. P. Morrill, M.D., superintendent, Charity Hospital, Shreveport, La.; C. W. Munger, M.D., superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich.; George O'Hanlon, M.D., general medical superintendent, Bellevue and Allied Hospitals, New York; F. E. Sampson, M.D., Greater Community Hospital, Creston, Ia.; Mary C. Wheeler, R.N., superintendent, Illinois Training School for Nurses, Chicago; Hugh S. Cumming, M.D., surgeon general, United States Public Health Service, Washington, D.C.; Norman R. Martin, superintendent, Los Angeles County Hospital, Los Angeles, Cal.; Matthew O. Foley, 537 South Dearborn Street, Chicago, executive secretary.

The National Hospital Day Committee has issued the first call for names of hospitals which plan to observe third annual National Hospital Day, May 12, 1923, and will be glad to send to all interested institutions suggestions for a programme and other information concerning the movement. Write to the executive secretary for this material.

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*Hospital News

FINISH GERMAN HOSPITAL

Work on the German Evangelical Hospital at Morgan Street and 54th Place, Chicago, is being rushed, following the recent laying of the corner-stone. The building will cost $350,000 and will accommodate 125 patients. It will serve as an addition to the old Deaconess Hospital, long since grown inadequate. Rev. Joseph A. George is chairman of the building committee of the hospital; William Giesecke is president of the board of trustees and the Rev. H. Brodt is superintendent. German Evangelical churches throughout Chicago will contribute to its support.

*We are indebted to "The Modern Hospital" for the items under this Department.

A Colorado woman, Mrs. Marie Talcott, has leased the building and equipment of Denison Hospital at Denison, Iowa, and is now in charge of the institution. Mrs. Talcott, who is a graduate nurse and a woman of some experience in hospital administration, has had the building redecorated throughout and has made numerous improvements. The Denison Hospital is beautifully situated on a hill overlooking the Boyer river valley.

The new Gary Methodist Hospital, Gary, Ind., which has been under construction for nearly two years was completed early in February. The hospital cost approximately $400,000. Construction was delayed several times on account of the shortage of funds.

Construction work on the new county tuberculosis sanatorium north of Crown Point, Ind., will be started this spring. It is expected that the building, exclusive of furniture and equipment, will cost $300,000 and it will accommodate 250 patients.

As a memorial to their daughter, Mr. and Mrs. Harry Bedell of Marion, Ind., recently provided funds for the establishment and equipment of a laboratory in connection with Grant County Hospital. A building is to be remodelled and furnished with new laboratory equipment. It will be known as the Barbara Bedell Memorial.

Miss Anna Bertha Conrad, of the Missouri Baptists Sanatorium, has been selected as superintendent of the new Dickinson County Memorial Hospital, Kansas. Miss Conrad has had five years of nursing experience, including eighteen months in the army nursing service during the war. She was graduated from the Missouri Baptist Sanatorium in 1917 and has served there since in various supervisory capacities.

The Knights of America, a fraternal organization, is soon to build a sanatorium near Panchatoula, La. Accommodation will be provided for twenty-four patients.

ST LOUIS WANTS $5,000,000 FOR HOSPITALS

Included in a proposed bond issue of $76,000,000 which city officials of St. Louis, Mo., propose to present to the voters is a $5,000,000 item for extension and improvement of hospital facilities. The director of public welfare at a recent hearing declared that 300 patients are sleeping on the floors in the City Sanitarium; the City Hospital is overcrowded, and the Kosh Hospital for the tuberculous, built to house 100 patients, is now caring for 1,000. With the $5,000,000, the city hopes to build an addition to Koch Hospital and the City Sanitarium; to continue the development of the Training School for the feeble-minded; to make additions to the City Hospital; to erect a new morgue, a manual training school for Bellefontaine Farm, a building at the Girls' Farm, a Negro Hospital and a smallpox isolation building.

STATE SANATORIUM OPENS

The state of Mississippi recently opened a modern tuberculosis sanatorium at Magee. The completed plant has a capacity of 960 patients, and the buildings and equipment represent an expenditure of something like $1,2000,000. The work was begun in 1918 and some of the buildings have been in use for some time. Accommodations are provided for both white and colored patients. The principal buildings are the white infirmary, the service building, nurses' home, power house, laundry, negro infirmary, and administration building. Provision also is made for offices of the field service and extension department. A farm of 388 acres is operated in connection with the sanatorium to provide fresh milk, eggs and other foodstuffs for the patients.

Bids have been taken for the erection of a new sanitarium in Baton Rouge, La., to be known as Our Lady of the Lake Sanitarium.

The Newark Maternity Hospital has purchased a plot, 50 x 260 feet, in Newark, N.J., which it will develop at an early date with a three-storey building, containing 100 rooms.

New York Hospital, New York, has opened a clinic for the treatment of goitre and other diseases of the thyroid gland.

The new United Israel Zion Hospital of Brooklin, N.Y., has as its superintendent, Mr. Boris Fingerhood.

The building of the Laura Franklin Hospital, New York, one of the institutions which consolidated in the new Fifth Avenue Hospital, was recently sold to Dr. Morris Less of New York who will remodel it and conduct a private sanatorium.

The village of Carthage, N.Y., has a ten-bed hospital with the opening recently by Miss Rillia McNeil, a graduate of the Sisters' Hospital in Watertown, of a remodeled residence.

Dr. J. A. McComb, of Springfield, Mo., has sold his interest in the Ozark Sanitarium at that place to Dr. W. R. Summers, his partner. The hospital was founded eight years ago and is for the treatment of persons with nervous and mental diseases.

Freeman Hospital at Joplin, Mo., is to be enlarged by the construction of an annex. As soon as the annex is completed, the hospital plans to conduct a training school for nurses. The proposed improvement will cost approximately $100,000.

Plans for a new 100-room home for nurses at the Kansas City General Hospital are being considered by the hospital and health board of Kansas City. The cost of the building is estimated at $100,000. P. J. Morley, architect, has drawn the preliminary plans for the structure.

A two-storey addition is to be erected at the Japanese Hospital, Los Angeles, Cal. The building will be fireproof and modern in equipment.

Formal opening of the new Antelope Valley Hospital at Lancaster, Cal., took place on October 15th, and was largely attended.

Construction work began on the $250,000 sanatorium to be built in Alameda, Cal. It will be a three-storey building to be erected on the site of the present structure.

Dr. John A. Reily is again superintendent of the Southern California State Hospital at Patton, following his recent resignation as director of the state department of institutions.

The successor to Dr. Edouard S. Loizeaux, who recently resigned as medical superintendent of Sacramento Hospital, Sacramento, Cal., is Dr. Henry Morrison.

Dr. Edward A. Schaper was recently named superintendent and resident physician of the Kern County Tuberculosis Sanatorium at Keene, Cal.

GIFT FOR NURSES' HOME

The directors of the Brattleboro Memorial Hospital at Brattleboro, Vt., recently announced a gift of $10,000 from Mr. and Mrs. George L. Dunham of that town toward the erection of a nurses' home on the hospital grounds. Mr. and Mrs. Dunham previously had given the hospital $15,000 toward this home as a memorial to their daughter. The later gift will mean that work can begin at once.

$250,000 SANATORIUM FOR RICHMOND

A building permit has been issued at Richmond, Va., for the Johnston-Willis Sanatorium to erect a new $250,000 hospital building. The new hospital building will face the Confederate Memorial Institute, commonly known as the Battle Abbey. It will be six storey high and strictly fireproof.

TO ERECT FRENCH HOSPITAL

Efforts to establish a French hospital either at Pawtucket or Central Falls, R. I., have progressed to a point where interested citizens have organized, collected the nucleus of a fund and obtained a charter from the secretary of state. This institution will be officially known as the Notre Dame Hospital.

RAILROAD PLANS NEW HOSPITAL

A $150,000 hospital containing 125 beds will be built in Little Rock, Ark., this year by the Missouri Pacific Hospital Association. The building will be three stories high and modern in every respect. The river front along the site of the hospital will be beautiful and the grounds considerably improved. The railroad plans to make the building and grounds one of the most beautiful spots in Little Rock.

Dr. P. P. Salter of Eufaula, Ala., has purchased the old Moulthrop Home on the Bluff at Eufaula and is having it converted into a modern hospital building.

PROPOSE MEMORIAL WING FOR ALBANY HOSPITAL

Friends of the late Dr. M. W. Murray of Albany, Ala., are sponsoring a movement which has as its purpose the erection of a maternity wing to Albany Hospital as a memorial to Dr. Murray. The estimated cost of the maternity annex would be $50,000. Dr. Murray lived for thirty-two years in Albany and was recognized as one of the leading obstetricians in the state.

Obituary

LIEUT.-COL. ALEXANDER MACKAY

We regret to chronicle the death of one of our editors, Dr. MacKay, Inspector of Provincial Hospitals, who died on the 18th of February, in Wellesley Hospital, Toronto, after a five days' illness from gallstones. The immediate cause of death was heart failure.

Born in Creemore, Dr. MacKay attended High School, and then Trinity University, Toronto. At eighteen he joined the 36th Peel Rangers, which he left in 1916 to go overseas with the C.A.M.C., but later rejoined, being gazetted lieutenant-colonel in August, 1922.

Chief Medical Inspector of the Toronto Public Schools until he went overseas, when he returned, that office was under the jurisdiction of the Ontario Board of Health, so he was appointed Inspector of Hospitals.

Overseas he was M.O. in Orpington Hospital, later going to France, where he was at several base hospitals.

Surviving are his widow, three daughters, the Misses Reno, Beth and Evelyn, two brothers, John C. and W.G., one sister, Mrs. W. J. Jebb, all of Toronto, and his father, who is County Court clerk, as well as local registrar of the County High Court, resident of Barrie.

Dr. MacKay succeeded the late Dr. Bruce Smith, in the office of Hospital Inspector, and was of the same kindly disposition.

Our sympathies are extended to Mrs. MacKay and family.

Book Reviews

How We Resist Disease. An introduction to immunity. By Jean Broadhurst, Ph.D., Assistant Professor of Biology, Teachers' College, Columbia University. 138 illustrations and 4 color plates. The J. B. Lippincott Company, 201 Unity Bldg., Montreal. 1923. Price $2.50.

A scholarly annual, showing both a large knowledge of the subjects treated and a due sense of the requirements of the student entering upon a subject so large and so constantly enlarging. The pupil nurse can hardly, it is thought, require anything like so extensive an introduction into subjects so abstruse, but for those nurses or others who are specializing in post-graduate directions, the text-book would seem not to be of undue proportions.

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Editorial

Nurse Training

Sister M. Bernice, R.N., of St. Joseph's Hospital, Milwaukee, contributes to *Hospital Progress* an instructive article on hospital training-school problems. She maintains that Sisters should co-operate with student nurses, who should be taught to co-operate with the hospital, the training school and the patient. By co-operation is meant a union of forces, a working together for the same end, all having the same principles. All erroneous self-seeking should be eliminated. When a student is corrected, the principle of the correction should be impressed upon her. She should not get the idea that the correction proceeds from personal feeling of the teacher. Nor must the impression be given that the student has to do a certain thing because the teacher wants it done. She must be taught that teacher as well as pupil must conform their actions to accomplish the same end. A reason should be

given the nurse for correctional action taken. The teacher should not force her method in the pupil by sheer will power and superiority of position. When a student makes a mistake the teacher should wait until her irritability is subsided, think over the matter a little, and then point out the error and why it must never be repeated. A heated reprimand sets a bad example of imperfect control.

Words of encouragement and appreciation should be given to students when they do well.

Both sides of a story should be listened to before corrections are administered. Corrections should not be made in the presence of patients, doctors or others.

Careful study should be given to individual students; they should be approached at the proper angle. They cannot be treated all alike, irrespective of their peculiar traits.

Are we constantly suppressing the student, for fear she will become too forward? Or, do we correct and develop her tendencies, rather than destroy them?

If a nurse timidly makes a suggestion, it should not be smothered. It should be taken up, thought over and then accepted or gently refused.

The teacher should not misuse authority to interfere with student nurses' strictly private affairs. Students should be shown respect. We cannot demand respect and consideration from others unless we give them in generous measure. We cannot force respect from students, but must merit it.

Do students hesitate to come to us and open their hearts, because we make no effort to understand them or consider their point of view?

Can we hope to teach nurses ethics and psychology, if we are not teaching and practising both in our daily lives?

Sister Bernice continues:

"We hear so much about student government; isn't that a nuisance? Should it not be student co-operation? Would students be able to govern themselves wisely? Why not utilize, in co-operation, the forces which the nurse, at the present time, is likely to utilize against us? If students are given a little freedom in expressing ideas to us, are they so likely to criticize when out of our hearing? If we are tolerant and understanding, will they have any reason to feel resentful? The nurses' attitude to us will be patterned very much after our attitude to her."

The Sick Middleman

Sir Alfred Yarrow, who has recently given £100,000 to the Royal Society for the purpose of promoting scientific research, has endowed a convalescent hospital at Broadstairs "for the children of professional and well-educated people in poor circumstances." Prof. Will. Mayo says that he likes to think that in the Mayo hospitals "is one place in God's green earth where the sick man of middle income is as well treated as the sick rich man and the

sick pauper." Both of these gentlemen thus give expression to a generally recognized, and sadly unjust, state of affairs in connection with hospital treatment. Here and there effort is made to rectify the injustice, but in the main we know that it is the sick middleman who bears the heavy burden—one out of all proportion to his means.

For the rich man, sickness is not a pecuniary burden. Equally this is true for the pauper. For the honest, self-respecting, self-supporting rank and file—the people who count in life's onward march—there is no unburdened place in sickness, since hospital nursing and medical costs are away beyond the reach of their average daily living.

This condition has been demonstrated, recognized and discussed over and over again, and yet, thus far, nothing is being done about it except in such isolated instances as the above.

Hospitals are usually crying out for funds. Many of the larger ones are waterlogged with debt. They come annually to the state or municipality to supply their deficit. Yet the cost of treatment to the average sick citizen is so much out of proportion to his means that it constitutes, as Dr. Mayo phrases it, " a heavy burden."

That the hospital is the best place for the sick average citizen is generally acknowledged. The reasons are compelling and obvious. But a large proportion of sick citizens are being inefficiently treated in the home because of the burden of cost.

Physicians know this and would gladly see a way out. A large proportion of our best citizens cannot afford the present cost of hospital treatment. Our hospitals are showing deficits and crying for funds. The problem has not yet been solved.

Hospital Planning

It is important in planning any hospital, to have not only the general features embodied in the plan, but also all the minutae in so far as possible; because, if construction is once commenced, any alterations afterward are tantalizing and costly. This particularly applies to conduits required for service installations. It is an easy matter to make provision for any equipment if foresight is exercised.

Such apparatus as is required in the kitchen, laundry, laboratories, X-ray department and special rooms should all be indicated in the plans so that "roughing in" may be carried on *pari passu* with the building. To this end it is wise not only to know where the various apparatus are to be placed, but also to know the particular make of apparatus which is to be installed. This may mean that contracts for such apparatus should be made before building operations begin. Often, of course, where funds are short, this plan is not followed: The *corpus* of the building is erected and the equipment contracted for later when funds are available. This course is not ideal; the first suggested above being preferable.

Quite often one make of sterilizer (for example) requires a different sort of roughing in to that which another sort requires. The same may be said of some of the plumbing fixtures. Hence the importance of always deciding in advance, if at all possible, on the particular sort of apparatus, plumbing fixture, laboratory equipment (fixture) or X-ray apparatus which it is contemplated shall be used.

Such foresight often saves hundreds, and, in large institutions, thousands of dollars, and an untold amount of mental friction.

Nurses and Nurses

Much discussion has taken place within recent years on the question of grading and classification of nurses. One element in the profession is totally opposed to any such procedure, insisting that no woman should call herself "nurse" or be allowed to call herself a nurse unless she is graduated from a hospital nursing school where a full term training of two and one-half to three years is given. Any others, they maintain, who care for the sick, i.e., nurse the sick—and they constitute about 75 per cent. of such workers—should adopt the name of "attendant." But this would not "go down;" these underlings would not accept the nomenclature nor would the public who employed them. Failing in this, these nominators hit on the term "nursing aides." (Vide the special Rockefeller report on

nursing). But this effort will be as futile as the other proposal. The second suggestion does admit that these women really do nursing. The terms which have naturally by custom grown up with the work of these women have been "practical nurses" and "experienced nurses." These expressions do not meet with the approval of the powers that be in the nursing world, and we believe that any endeavor to force a name upon a body of women, many of whom are doing a splendid sort of work among the sick who cannot afford to pay five and six dollars a day to a trained nurse, will meet with failure.

We well understand the reason actuating the profession of trained nurses: they fear their field of activity will be trenched upon by these lesser-educated women.

We should like to see these efficient, practical nurses formed into a union for their own protection and the promotion of their own interests.

A New Plan

Mr. Richard Bradley, of Boston, who has done much toward the introduction of a way for the independent family of moderate means to secure adequate nursing service, says that "the hospital trustee and the nursing organization committee should pass around the hat with intensified effort to meet their mounting deficit. Their endeavors, in too many cases, fall short, and have the added disadvantage of undertaking to fulfil a vital function that cannot be adequately discharged by the contribution method. . . . The point of attack is the

business and financial people, who are responsible for hospitals and nursing organizations. What is needed from them is less philanthropy and cheque drawing and more of the business brains that they give to other things. They must organize insurance and benefit payments, so that the people's needs can be met out of their own pockets. . . . They must do this just as they must reorganize the finances of their own hospital and surgery work, so that the ordinary independent citizen can pay for what he needs to have supplied. Otherwise—and they are beginning to know it—they will have it taken over by the state and thrown into politics. In the Missouri Valley Hospital, Kansas City, an attempt is being made to enable people of moderate means to finance their emergency service from their own pockets. . . . It is no more possible to supply the people by our present methods than to pay for their fuel and groceries by passing around the hat, or to expect them to meet the cost of occasional fires out of their current income. The whole therapeutic system is debauched by outworn charity traditions, that impede its true progress."

Mr. Bradley's idea is worth trying out. Who will lead the way in Canada?

The Hospital and Public Health

A good many thinking people maintain that the hospital should be a health centre or a link in a chain of health activities. One such advocate voiced her sentiments at the last meeting of the

American Hospital Association, by saying that such a status of the hospital was desirable and essential because of (1) the prevalency of physical defects in so many people; (2) the place in the family life accorded physicians and nurses by a society still indifferent to its health needs; (3) the scientific equipment as possessed by hospitals and their personnel now used in dealing with health defects, and the increasing use of hospitals in maternity work; (4) the continued and extending use of hospitals as laboratories for the preparation of health workers of various types.

To accomplish this work, this authority maintains that the hospitals will have to re-construct their programmes, methods and systems. The family must increasingly be taken into account if we wish (1) to substantially reduce sickness and death-rates; (2) to progress toward the goal of making every individual a strong, able-bodied citizen over a considerable number of years.

The first step the hospital should take in this direction is to "look to hum."

The entire personnel must experience that sort of life that will impress the essentials of health habits for their personal life, not less than for the lives of the patients, *e.g.*, to start with, consideration should be given to the internes' homes, housing and diet; and the training of nurses in central university schools.

The Insane

For some years our asylums have been crowded. After reading a report of Henry Cotton's work at Trenton State Hospital for Insane, we wonder if similar work might not be carried on in our institutions, with a view of curing a certain percentage of the inmates, thus making room for necessitous cases. It may be claimed that the asylums are undermanned with medical officers. This lack is easily corrected. There are one thousand practitioners in Toronto; it would not be difficult to get twenty of them to go on at each of the asylums in or near Toronto, Queen Street, Mimico and Whitby. These men might represent the various specialties including laboratory and X-ray work. In a few months they would discover in how far Cotton is right when he says that many cases of insanity are due to the presence of foci of infection in some part of the body, the toxins from which are causing the alienation.

In a recent journal we saw it recommended that asylums shall be thrown open to the medical profession to practise in them. Why not? The young graduates now are receiving more or less training in abnormal psychology, and a good few of them serve as "clinics" at these hospitals. These men might well be placed on the staffs of our provincial asylums. Every patient should receive a careful clinical examination, and, in case of discovery of foci of disease in teeth, tonsils, appendix,

sinuses, or where not, these foci should be removed by competent hands. Cotton has had a large percentage of cures.

We commend this plan to Hon. Mr. Nixon.

Pay of Anesthetists

It would seem a poor policy, says Hoag in one of our contemporaries, to go on salary or to allow the hospitals or operators to collect your fee. At the present time those interested in hospital domination of the practice of medicine are using the flat-rate charge and salaried employment to control and socialize the practice of medicine and all its specialties. Salaried positions (the author claims) are being used as part of a wedge game to get the anesthetists in the grip of hospital control, compel them to train nurses and then to let them out by reducing their income and establishing nursing anesthesia as the routine. Such methods, Hoag declares, must be fought to the last ditch or the specialty of anesthesia is doomed to annihilation.

There is every reason, he continues, for charging an extra fee for difficult and prolonged anesthesias, especially when patients can well afford to pay, and, under certain circumstances, it is folly for an anesthetist to leave anyone but himself in charge of the patient post-operatively when life hangs in the balance.

Who Shall Anesthetize?

A writer in a recent number of the *American Journal of Surgery* accuses certain clinics, surgeons, and hospitals of determining to put nursing anesthesia across. To combat this it will be seen that the anesthetists have a large legislative problem before them, if they wish to offset the activities of nursing anesthesia advocates. The writer says that unless political support and financial means are provided to make a legislative fight wherever required, it will be impossible to conserve anesthesia as an inviolable part of the practice of medicine.

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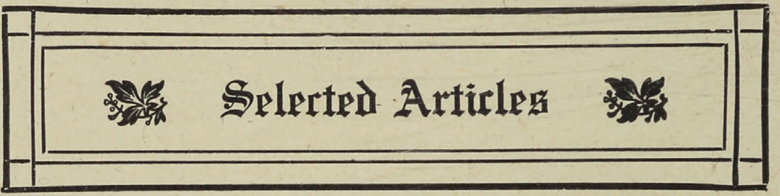


THE HUMAN TOUCH IN THE HOSPITAL*

E. S. GILMORE, SUPERINTENDENT, WESLEY MEMORIAL HOSPITAL, CHICAGO.

When a very young man, occasionally I had to pass a hospital and as I looked up at it I used to shudder and think that if only those walls could talk they would say much about suffering, sorrow, neglect, abuse, and medical experiment. In common with most people of the day, I had a special horror of hospitals. The opinion generally of people seemed to be that a hospital was the last step on the way to the grave-yard. This prejudice was founded somewhat in justice.

Hospital managements were quite inclined to believe, since patients came to the hospital not for the fun of it, but because they had to, therefore, it was quite proper they should take their medicine, whether it be drug, knife, or nursing, without demur. The friends and relatives of the patients, who even yet can be depended upon to make more trouble than the patient, were considered legitimate prey for the sarcasm and innuendo of the hospital employees. Visiting hours were limited to one hour a day and one day a week. Apparently, mothers were not supposed to love their children, nor wives their husbands, or, if they did, it wasn't for the patient's good that he be subjected to manifestations of sympathy or that he should receive news regarding the home life he had just left. Something might have happened there to disturb his serenity. Private rooms were few and were an affectation of extreme sickness combined with extreme wealth.

*From a paper read before the fourth Annual Convention of the National Methodist Hospital and Homes Association, Chicago, February 16, 1922.

Some Old-Fashioned Practices

Patients were permitted to die in a ward. The other patients were not supposed to notice this event or, if they did, it was good for their Christian fortitude and gave them opportunity to consider their own souls' welfare and prepare for their own probable deaths. Notices were conspicuously posted commanding silence of all, the better to impress one with the awful solemnity of the occasion. Patients were forbidden to converse with one another concerning their ailments. They might as well have been forbidden to breathe. Nurses were taught, actually taught, that it was unprofessional to give attention to a patient not assigned to the individual nurse. The patient might suffer for a drink of water, but ethics were ethics. Physicians still hover dangerously near this conception of what is ethical.

But hospitals have changed and changed for the better. To-day the properly managed hospital will see that an entering patient gets immediate attention. He will be made welcome and impressed with the fact that his interests are to be uppermost in the thoughts of everyone in the hospital, that his welfare is to be the hospital's first consideration. The necessary office record and financial arrangements should be made promptly and as pleasantly as possible. He should then be escorted to his room by someone, preferably a nurse. The head nurse of the floor should make it her duty to call upon him immediately to answer any questions he may wish to ask and to see that his room is in proper condition. An interne should wait upon him at the earliest possible moment, that he may know his physical condition is under early consideration. A hospital also should be provided with a recreation or living room where patients may go and converse with one another, getting away from their beds and forgetting their troubles temporarily. Hospitals in large cities or hospitals located where restaurant facilities are not convenient, can well afford to have a small dining room for the use of the friends of patients who may be present during the meal hours. This dining room probably will not pay expenses except in an indirect way. No one can compute the value to a hospital of the good will of the patients and their friends. Anything which will make for the increasing of this good will should be adopted.

The Reputation of the Hospital

The attitude of the internes, nurses, and employees in the hospital will determine in very large measure the reputation of the hospital. People who are sick physically are usually sick mentally. They may be more grouchy, more unreasonable, and more demanding than when well or they may be more susceptible to sympathy, more desirous of winning the esteem of those about them. In the former case the hospital must disarm suspicion, must overcome prejudice, must win the patient in spite of himself. In the latter case the hospital has an opportunity for doing good that is rarely equalled in any other walk of life. It should be the constant desire of everyone in the hospital so to conduct himself that when the patient leaves the hospital he will gladly say it was good to be there. The hospital management should always keep this in mind and both by example and precept, impress everyone in the hospital with the thought that each patient is the guest of the individual nurse, interne or employee. If each person in the hospital fully realizes that he is the host of the patient and that he should treat the patient as he would a guest in his own home, the hospital has gone a long way towards making the patient happy and increasing its own popularity.

No hospital management has a right, however, to expect that this condition will exist automatically in the minds and hearts of the hospital personnel. It is the business of the management to implant it by seeing that the conditions in the hospital are such as to make the helpers thereof part of the hospital and desirous of doing all they possibly can to assist the patients. This means the best possible accommodation for the nurses, for the internes, for the help. The time once was that the nurses were domiciled in some nearby dwelling house that had been converted into a nurses' home by the simple expedient of setting aside the parlor as a reception room and then crowding the nurses into every other room in the house, including the kitchen and pantry, filling each room with as many beds as it would hold. The employees were usually housed in the cellar and the attic of the hospital, generally called "basement and top floor," to salve the conscience. The internes were crowded into just as few rooms

as possible and were generally impressed with the idea that they were not physicians and men, but incorrigible boys, who could always be expected to do the wrong thing at the right time.

Entitled to Good Living Conditions

All these people, internes, nurses, and employees, are entitled to the best living conditions the hospital can afford. You may be sure the patients will receive exactly the same kind of treatment that the hospitals give to those who care for the patients. If the nurse, for example, is well housed, well fed, contented, if she receives thoughtful consideration, if she gets a thorough training and is treated as a woman, in the very nature of things her soul will sing within her and the patient will receive thoughtfulness, sympathy, and intelligence mixed into his care. If, on the other hand, a nurse receives none of the things which make her happy and contented, but is made to feel that she is a child, more or less under suspicion, unless she is a moral phenomenon, she is going to work out her moods upon her patients. A hospital may not justly expect to recruit into its ranks none but moral phenomena. The best way to get the golden rule into the hearts of the hospital personnel is for the hospital management itself to adopt the golden rule and live by it.

Home-like Conditions an Asset

It has been divinely said, "man does not live by bread alone." It is equally true that man does not live by sympathy alone. It is the duty of the hospital to see that meals are well prepared and well served, being as warm and tasteful as possible. The rooms should be made home-like. The days are past when the medical profession felt that germs were roosting on the picture frame, the curtain, etc., just waiting for an opportunity to jump off on to the patient. The medical profession is now convinced that the pleasant surroundings of the patient will go far towards aiding in his recovery. Walls should be pleasantly decorated, windows prettily draped, furniture suitably designed, and floors covered with rugs. One should get as far away as possible from the institutional idea and make everything as home-like as hospital conditions

will permit. It is taken for granted that the hospital will have all proper laboratory facilities for skilful, scientific care of patients, else it is not a hospital.

It is my belief that the hospital superintendent cannot do better than to set aside a portion of each day for the visitation of patients. This takes time, but time can be found if the superintendent resolutely determines to find it. Some patients still come to a hospital with a chip on their shoulder, expecting to be misused and ill-treated, laboring under the thought that the hospital desires only their money. If such a patient is called upon the day of his arrival by the superintendent and in a few words given to understand that it is the hospital's desire to aid him in his recovery in every way possible, making his surroundings pleasant and giving him the best of attention, he is at once disarmed and he says to himself that things may not be as he had expected.

If that visit is repeated every day in only a short time the patient looks forward to the coming of the superintendent and there is a warm personal feeling existing between the two. Grievances are no longer nursed by the patient, but unless important, are quite likely dismissed with the thought that the untoward happening is not in accordance with the wish of the hospital, but against it. If, however, the grievance is of sufficient importance to warrant attention, the visit of the superintendent gives the patient opportunity to make known his objections directly to the superintendent, and the trouble, whatever its nature, can be adjusted easily and amicably. The fact that the superintendent makes daily visits also is known to the personnel of the hospital and the knowledge that any dereliction on its part will come to his attention, makes for better service. But by far the most important thing is that the patient feels someone in authority is interested in him and his heart will glow with appreciation and into his mind will steal a sense of relief, aiding materially in his recovery. Hospitals have it in their power to do much to make this old world better.

Another thoughtful thing for hospitals to do is to provide complimentary meals for an immediate relative of each patient at Christmas time, Thanksgiving, New Year's, or on a wedding or birthday anniversary. This may not be possible

in crowded wards, but it is possible in private rooms and a day which might otherwise be given over to self-pity and the sorrow consequent upon absence from a loved one at a time generally given to family reunion becomes a day of exceptional pleasure and lives many years in memory.

Don't Forget Discharged Patients.

Patients ought not to be forgotten immediately they leave the hospital. It is pleasing to the patient and is of value to the physician, for the hospital at some stated time, say three months after the patient has left, to send a letter or return postal card to the patient asking after his present condition, if his operation or treatment has proved successful, if there are any complications, etc. This affords the patient a welcome surprise in the thought that the hospital is still mindful of his interests and it affords the physician a check upon his effectiveness.

A hospital doing any considerable amount of work among the poor should also have a social service department. A nurse from this department should visit the homes of the poor while they are in the hospital to see that those left behind are properly cared for and to aid them, through charitable organizations, when they stand in need. She should also visit the patient occasionally upon his return to his home. to see that he is making good recovery or in the event of a return of his trouble or complications, that he is returned to the hospital for further treatment.

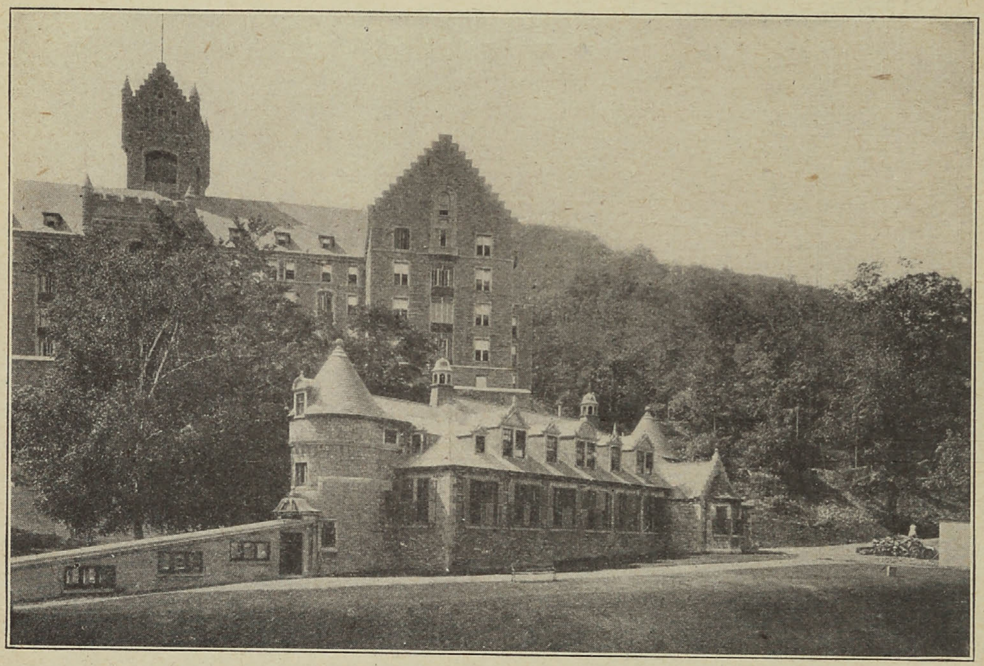
Towns large enough to have a hospital are large enough to have a library. There should be no difficulty in making the hospital a branch of the library. The latest books can then be taken to the patients at their bedsides, and many an otherwise weary hour may be profitably and pleasantly spent.

These are some of the things which make hospital service something more than a means of earning a livelihood.—*Hospital Management.*

ROYAL VICTORIA HOSPITAL'S METABOLISM SERVICE*

E. H. Mason, M.D., and H. E. Webster, Superintendent,
Royal Victoria Hospital, Montreal, Canada.

The metabolism service of the Royal Victoria Hospital was organized in 1917 and housed in a remodeled separate building previously used as an isolation ward. This building is connected to the hospital by a short, covered corridor at the



The metabolism service at Royal Victoria Hospital is housed in the small ward in the foreground, formerly used for isolation purposes. It is connected to the hospital by a short covered corridor.

central part of the main building, thereby making the ward convenient to all parts of the hospital.

The general appearance and floor space is well shown in the accompanying photographs. In detail the total floor space is divided as follows:

*We are indebted to "The Modern Hospital" for the use of the half tones appearing in this article.

Through the centre of the building there is a main corridor with rooms opening upon both sides. At the back is the laboratory. The respiratory laboratory, a part of the metabolism service, is located in another part of the hospital, at a point convenient for the transfer of bed patients.

The division is as follows:

1 office.
3 private rooms (1 patient per room).
4 public rooms (2 patients per room).
1 kitchen.
1 dispensary and instruction room.
2 bath rooms.
1 scale room.
1 linen room.
1 laboratory.
1 stock room.

The kitchen is twice the size of the bedrooms. The laboratory extends off to one side from the end of the ward, opening into the main corridor. Across from it is the stock room. The dispensary is the size of a bedroom and in addition to its use as an outdoor diabetic clinic, it is employed four mornings each week for instruction.

The personnel working on the service consists of: one doctor, full time, in charge of the service; one doctor, half time, in charge of diabetic instruction; one resident house officer, full time; two girl technicians; and one laboratory orderly.

The day nursing staff consists of one head nurse and three nurses in training. On the night staff are one nurse in training and a ward maid.

The total personnel consists of twelve workers, all except one being full time. This makes more than one per patient, the maximum number of patients that can be accommodated being eleven.

The equipment installed outside of the regular hospital equipment is as follows:

Kitchen.

2 Chatillon food scales No. 126½, 500 grams.
1 steamer for vegetables.
1 Torsion balance.
Individual dishes.
Granite cc. measuring cups.

Ward.

1 Scale, (height and weight).
1 typewriter.
1 telephone.
1 ophthalmoscope.
1 blackboard (dispensary).

Laboratory.

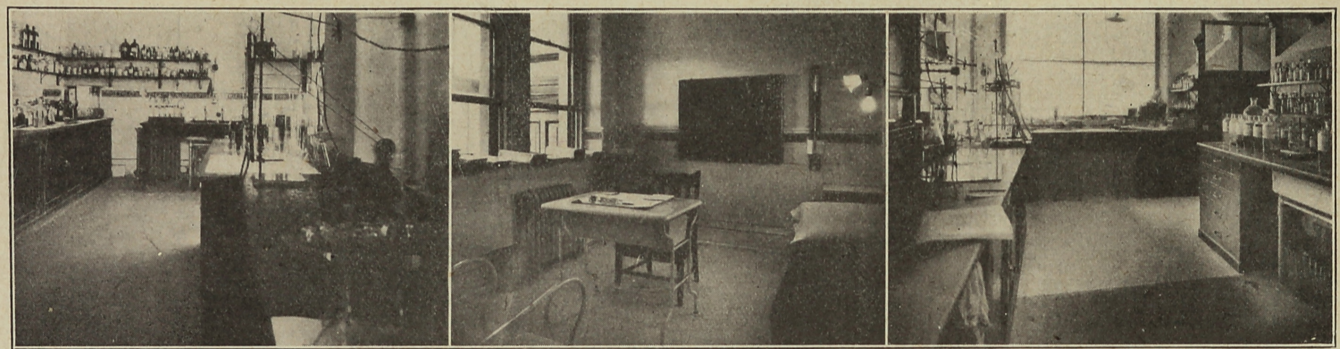
1 water still.
1 electric hot air oven.
1 Kjeldahl digesting stand.
1 Kjeldahl distilling stand.
1 steam water bath.
1 set of six electric plates.
1 ice box.
1 autoclave.
1 centrifuge.
1 barometer.
1 microscope.
2 Dubocq colorimeters.
1 fine balance.
1 balance.
2 vacuum pumps.
2 Van Slyke CO_2 apparatus.
Usual glassware, porcelain ware, stands, tripods, etc.

Basal Metabolism.

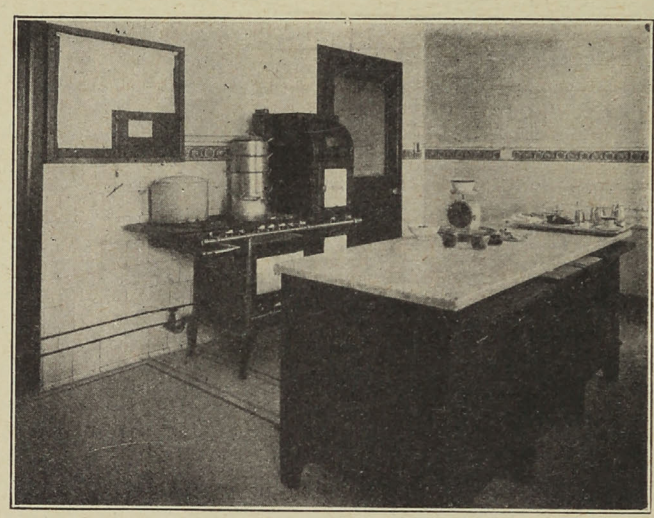
2 sets metabolism apparatus.
1 Tisot gasometer.
2 gas analysis apparatus.
1 barometer.

Type of Work Undertaken.

To date, the main function of the metabolism service has been to handle all cases of diabetes mellitus admitted to the hospital. In addition extensive studies have been made on a large series of nephritic patients, and at times others problems have been investigated, such as the fasting treatment of epilepsy and special dietetic treatment in various types of hyperthyroidism. Further, an interesting series of obesity cases have been handled and chemical problems in many isolated diseases have been studied. The laboratory, in addition to handling all the work from its own ward, does all the blood chemical determinations for the other wards of the hospital, both private and public.



Two views of the laboratory (left and right) and a corner of the dispensary and room for instruction (centre).



The metabolism service kitchen

The respiration laboratory completes all the basal metabolism determinations for the whole hospital, the thyroid work being done in close combination with a thyroid group which has been functioning for the past year.

The metabolism service uses several forms which are peculiar to its department, being as follows:

In ward:

Large laboratory record sheet.
Daily diet form.
Kitchen sheet.
Food value sheets (for instructions).

In laboratory:

Daily urinalysis sheet.
Nephritic test meal report.
Urea and chloride excretion report.

In respiration laboratory:

Test sheets (2).
Basal metabolism report.

In dispensary:

Case record.
Weekly report sheet. (Entered upon main record and then destroyed).

Instruction of Patients Emphasized.

A special effort is made with all diabetic patients to teach them so that upon their discharge they are able to figure diets upon ordered food values, examine their own urine for sugar and the acetone bodies, and prepare weighed diets. Also some knowledge of their disease is given to them so that they will appreciate the importance of living upon a weighed diet. In our experience diabetic patients do well largely in proportion to the thoroughness of their education. Upon discharge the hospital provides them with the following equipment, for which they pay:

1 Chatillon food scale No. 126½, 500 grams.
1 granite cc. measuring cup.
6 test tubes.
Fehlings solution.
5 per cent. ferric chloride solution.

The organization, as previously outlined, has been found to work very satisfactorily. Our staff is busy all of the time and will have to be enlarged if the department expands. The main fault in the floor space is that the laboratory is not large enough for the work undertaken.—*The Modern Hospital.*

CHOOSING THE ANESTHETIST

Isidore Josephson, M.D., New York.

Ever since general anesthesia was first introduced into surgery the choice of an anesthetic was the field of experimentation and investigation. At the present day the value of each has been tested and proven, and the choice of one for a certain operation and patient is easily determined. The value of ether, chloroform, nitrous oxide, ethyl chloride, etc., as a general anesthetic has been fully determined and very little can be added in our present state of knowledge.

Choosing the anesthetist to decide whether it shall be the nurse or the intern, the experienced physician or the novice, is a matter still in the experimental stage.

A well known surgeon once said that if he were to be operated on his first question would be, "Who is going to be my anesthetist?" The apprehension which the layman experiences as regards his anesthetic is only too well known, and

the majority fear this part of an operation more than the operation itself, the surgeon himself, more than anyone else, appreciating the importance of the anesthetiser. In spite of this, this important task is often entrusted to some underling, who pursues his task unconscious of its importance, and it is surprising that so many surgeons tolerate this.

Anesthesia, as an art and science, is a comparatively new study and it is only within recent years that it has been elevated into the realm of specialties. Thus there are now specialists in anesthesia just the same as there are specialists in any other medical specialties. Numerous books have within recent years been written on the art and science of anesthesia, and the literature on the subject is voluminous—for the administration of the anesthetic is become more and more to be considered next to, if not of as equal importance, as the operation.

Now the practice of any specialty implies a preliminary thorough groundwork in general medicine. In spite of this fact the administration of an anesthetic is often entrusted to individuals who have never even seen the inside of a medical school, particularly the trained nurse, and working on the supposition that anesthesia is a specialty of medicine it is hard to understand why the trained nurse, after more or less instruction in anesthesia, should be permitted to practise this specialty. Surely no one would expect a trained nurse or any other non-medical individual to become a competent opthalmologist or gynecologist or specialist in any other branch of medicine, no matter how extensive the period of training nor how competent the instructor. P. J. Flagg, in his preface to *The Art of Anesthesia,* says: "How can a lay person intelligently form an opinion upon such vital matters as acidosis, toxemia, carbon dioxide, stimulation and depression? How can he unravel and relieve the untoward symptoms which might arise in a case complicated by respiratory obstruction, morphine depression and reflex inhibition?" No one can deny that these factors must constantly be uppermost in the mind of the individual officiating at the head of the table if he is really in earnest about his work, but earnestness does not imply a medical education.

There is one other medical specialty practised extensively by non-medical individuals, and which can be given here in comparison, namely, obstetrics. We all know of the havoc wrought by the midwife. The medical profession is beginning to realize the gravity of permitting poorly trained women to attend a woman in labor, a procedure that sometimes assumes the proportions of a major operation. Shall the science of anesthesia also be permitted to be practised by those who are not competent?

The fault, no doubt, lies in the fact that in both cases some degree of mechanical skill is involved, a skill easily acquired, but with forgetfulness at the same time that there are a great many fundamental principles of medicine and surgery at the bottom. An individual cannot be called an anesthetist when just able to guide a patient through an anesthetic by virtue of certain signs which he has been taught to recognize, any more than a woman who has been taught how to make a vaginal examination and can guide the head over the perineum without getting a tear, can be called an obstetrician.

The medical man to whom the ether cone is most often entrusted, is the hospital intern. The advantage in having the intern administer anesthetics is that he possesses a medical training. Still, there are some disadvantages unless his work is supervised by competent anesthetists. Most hospitals do have regularly appointed visiting anesthetists, for the purpose of acting as instructors to the interns, and the system would be ideal were the instructor always present on operating days. He very often fails to make his appearance and the intern is left to get along as best he can. I maintain that no intern should be permitted to administer an anesthetic without the presence of the visiting anesthetist. Since no house surgeon is permitted to perform an operation without the presence of the attending surgeon, no exception should be made as regards the anesthetist.

A surgeon who is constantly diverted from his task in worrying about the anesthetist, cannot give full measure of his skill to his patient, and without co-ordination between surgeon and anesthetist the patient is deprived of both their individual attention, the burden most often falling upon the ward patient.

The average intern when left to his own resources, and after having overcome the first difficulties of his art, acquires a certain degree of contempt for this part of his training, whereas the more experienced and thoughtful man ever acquires a greater respect for his work. To quote Flagg again: "A thousand anesthesias instead of leading to crudeness should make one a thousand times more careful." The intern, however, considers this part of his training as something to be soon over, and it is a common thing to hear interns say, when speaking among themselves, that they are tired of "slinging dope." It takes a great deal of experience and practice to become an expert anesthetist. The intern changes his service every three or four months. Just about the time the surgeon is beginning to have confidence in one man, his service changes, and the surgeon finds a new one to cope with. Naturally every surgeon expects good work, and many surgeons are cranks on anesthesia, and properly so. The poor intern is, of course, crude in his work, and is often the butt of the surgeon's remarks. The latter forgets that the intern is placed in a peculiar position, namely, that of a novice endeavoring to do the work of an expert.

My chief argument is in behalf of the general ward patient, who is the usual one to suffer. The private patient can choose his own anesthetist. The surgeon usually sees to it that only an experienced man will act in this capacity for his private cases, for it is a great source of comfort to him. But the patient in the general hospital ward has no choice in either operator or anesthetist. As far as the surgeon is concerned no patient need fear, for most surgeons on the attending staffs of our free hospitals are appointed only after demonstrating their worth. The same should apply to the anesthetist. Nurses as anesthetists should be entirely eliminated. An intern should act in this capacity as part of his training only in the presence of and under direct supervision of the attending anesthetist. In this way the surgeon's peace of mind would be preserved, the operation pursued with greater despatch, and the patient's welfare thereby safeguarded.—*New York Medical Journal.*

HOSPITAL SERVICE IN THE UNITED STATES

Statistics have been published (*Journal A. M. A.*) regarding 6,152 hospitals, sanatoriums and related institutions in the United States. The figures are based on reports from superintendents, directors or other executives of the hospitals or of the government hospitals, from the officers who are in position to give the facts.

The statistics deal mainly with the most important group of hospitals: the private, general or special hospitals open to the public for the general care of the sick. A list of the 2,926 having twenty-five or more beds each is published, in which, for each hospital, are given the name of the institution, the name and population of the town or city and the name of the county in which it is located, the total bed capacity, and the average number of beds in use. There are also, 1,087 hospitals in this group which have less than twenty-five beds each. The names of these are not published, but the total number in each state is given, together with the total bed capacity and the average number of beds in use. Following the list for each state are given the number and names of the counties in which there are no hospitals for the general care of the sick.

Of the 2,926 hospitals providing general service having twenty-five or more beds, 483 have been approved for the training of interns. The fact that a hospital is not approved for the training of interns should not be misinterpreted to mean that the hospital is not providing satisfactory care for its patients. On the contrary, there are many hospitals rendering a very excellent service to their patients, which do not seek or utilize interns, and which are undoubtedly worthy of approval as non-intern hospitals.

Four factors must be considered in the study of these statistics to determine accurately whether or not a district, state or community has an adequate supply of hospitals. These are the ratio of square miles of area to each hospital; the ratio of hospital beds to population; the percentage of beds on the average in use, and the percentage of counties which have no hospitals. There are at present 4,013 of these hospitals in the United States with a total of 311,159 beds—one bed

to every 340 persons—and of these beds 206,024, or 67 per cent. are in use. There is one hospital on the average to every 741 square miles, ranging from one to every 42 square miles in Massachusetts to one to every 5,780 miles in Nevada. The situation in Nevada appears to be less serious, however, than in Mississippi, where there is one hospital to every 1,104 square miles. The latter state is more thickly populated and has only one hospital bed to every 1,054 persons, while Nevada has one bed to every 139. Of the 3,027 counties in all states, 1,695, or 56 per cent. have no hospitals. The North Atlantic district is fairly well supplied with hospitals as compared with the South Central and the Western districts. But a study of the figures shows that in the North Atlantic, as well as in other districts, owing to a poor distribution, some portions have an abundance of hospitals.

As to the adequate proportion of hospital beds to population, estimates by hospital experts state that there should be one bed for from 300 to 500 persons. These statistics show one bed to every 340 persons; but since fifty-six per cent. of all counties are without hospitals, it is evident that the distribution is at fault. With a proper distribution, furthermore, it is probable that the proportion of beds in use would be much larger than sixty-seven per cent. as shown in the statistics. Another evidence of poor distribution shown by these statistics: For example, an investigation of the supply in Delaware shows that the seven hospitals in that state are all located in the extreme north end—a part where the public has also the easiest access by rail to the hospitals of Baltimore and Philadelphia—while four-fifths of the state have no hospitals.

The lesson to be learned from these figures is that in the establishing of hospitals hereafter, communities should be selected which are not already abundantly or over-abundantly supplied. These statistics will be of service in showing which communities are in greatest need of hospitals.

THE DUTY OF THE DOCTOR TO THE NURSE

W. L. Helms, Taylor, Texas.

At first thought it seemed this subject would be a very easy one to discuss, but the more thought that I have given it the more difficult it seems to be. It is a subject upon which nothing has been written, therefore I could refer to no bibliography for aid. What I shall say is therefore entirely original and some of us have very little originality.

In various books on nursing ethics we find there is plenty written on the duty of the nurse towards the doctor. It seems that there has been a great amount of thought about this special duty of the nurse, but very little of the doctor's duty toward the nurse.

Nursing is to be looked upon as a profession and an honorable one. The time was when the nurse was thought of as a kind of servant, was not respected as a member of an honorable profession, even in the minds of many was considered a "questionable" character, but conditions or sentiment, I rather believe, has changed so materially that we have entering our training schools and through them into the nursing profession as noble, intelligent, pure and accomplished girls as enter any other profession or calling in life and they are more appreciated now by both the medical profession and the laity than ever before. They are welcomed into the best of homes with a heartiness equal to any.

Sometimes yet, however, the family fails to understand the duties of the nurse and expects many things of her that do not pertain to her duties toward the patient. The doctor should, in a tactful way, try to correct such erroneous ideas and protect the faithful nurse in every way possible. A nurse should not be criticized in the presence of others. It is very rarely necessary to reprimand one and should criticism become necessary we should exercise the fine art of finding fault pleasantly.

We should express appreciation of the services rendered by the nurse. Many times, as each of you well know, an expression of heartfelt gratitude is a greater reward and is appreciated more than any monetary remuneration.

One should see that the nurse gets a sufficient amount of rest. For one to do her best work it is necessary that she should be allowed to get plenty of sleep and time to divert her mind from the nursing duties each day.

Many of the mistakes charged up to nurses and the inattention to the little details of nursing are no doubt due to long hours of work. However, in our loyalty, should one prove to be unreliable and untrustworthy, she should not be upheld.

A nurse in charge of a case should be informed of the nature of the case and the treatment used. She should, in case some special treatment is being pursued, be informed of what the physician is expecting to accomplish and forewarned of any complications that are liable to arise. This, of course, in order that she may be better prepared to anticipate and meet such complications as they arise.

The duties of the doctor to the nurse after all, may be expressed in this simple phrase, "treat her right." She is a great help to the physician in many ways and not infrequently is she able to help the physician to keep his impatient disgruntled clients, who without her influence would shift to another doctor. She is in every way worthy of our respect, cooperation and support.—*Practical Medicine and Surgery.*

FAULTS IN OUR SYSTEM OF TRAINING NURSES

The demand of the army for nurses is draining trained nurses from civil hospitals and from private practice. The proposal of Doctor Goldwater that provision be made for training volunteer nurse aids in the nurses' training schools, while good, does not go far enough. The trouble is fundamental and to cure it would involve a complete revolution in our nursing curriculum.

The present system of training nurses is radically wrong in two respects. The length of time spent by the pupils in training is too long, and the cost of the training to the hospitals is too high. If the curriculum for the trained nurse were

dissociated entirely from the question of maintenance for the nurse and was placed upon a businesslike, and at the same time scientific basis, it would be found that two years would be ample in which to train a nurse for registration.

Such a curriculum would require more hours of study by the nurse, a better type of instruction than is given in many institutions, and would involve a greater outlay than is usually allotted for the conduct of the training school. For this instruction the nurse should pay a moderate fee. The training school should not be required to house or feed the pupils without charge. The best solution of the problem might be the requirement that the pupil should pay for her board and lodging at about cost to the institution, and pay a fee equivalent to about the cost of maintaining a teaching staff, being in turn paid for the number of hours of service rendered to the institution; the rate of this pay being changed every six months commensurate with the value of her services.

A somewhat similar method is followed in some of the State agricultural colleges. There tuition is furnished free by the State, the pupil pays for his board and lodging at actual cost, and this is very little, and is given an opportunity to put into practice what he is being taught, by laboring in the fields, the hothouses, the gardens, or the stables of the institution, and is paid by the hour for the amount of time devoted to doing this.

The advantage of such a general plan would be that there would be a clearer comprehension of the relation of the different phases of the nurses' training to each other and of the nurses to the institution.

Such a two years' course would afford ample time not only for the basic general training of the nurses but for the specialization in the particular field in which the nurse proposes to enter.

One of the basic difficulties under the existing system is the confusion of issues brought about by the practice of paying nurses, or at least of supporting them during their tutelage. In order to recoup themselves for this expense, the hospitals require of the pupils much menial labor which should

be performed by maid-servants drawn from a wholly different class from that which supplies pupil nurses. Such a reorganization of our system of instruction would bring into the field a great many desirable pupils of superior intelligence who are now shut out of this work by a curriculum which involves an excessive amount of purely menial service.

Of late there has been much criticism of the tendency to expand the curriculum along purely theoretical and scientific lines which have no immediate bearing upon the duties of the nurse. Much of this criticism is undoubtedly well founded. But the main trouble with the curriculum is the confusion of issues which is incident to the erroneous system now followed of paying pupil nurses and making them earn this pay by doing menial labor ostensibly as part of the necessary drill. —*Selected.*

PIGS IS PIGS

But the Kind Required to Keep Lady Patients Warm Stumped the New Hospital Orderly.

D. A. McGregor.

A new and entirely original demonstration of the old theorem that "pigs is pigs" was furnished, quite unconsciously, a short time ago at the big Hospital for Consumptives at Tranquille, near Kamloops. The hospital, which is situated in the British Columbia "dry belt," emphasizes very strongly the open-air treatment. In the great wards there are windows everywhere and they are always open. The weather is always bright, and even in winter usually pleasantly warm, but the patients are encouraged to endure the coldest spells without retiring to the unhealthy atmosphere indoors. There is heat in the buildings, of course, but that is partly for the sake of appearances and partly to keep the water pipes from freezing. The patients are not supposed to have any interest in it.

A week or two before Christmas winter descended on the West with unusual suddenness and severity, and there was much shivering about the sanatorium. In the women's ward a call went up for more comforters, and an orderly was despatched post haste to the administration building for a "pig"

for each bed. The orderly was a new man, who had not yet acquired a command of hospital slang, and, seemingly, at the administration building, he encountered a clerk who was in the same condition.

"No, we have no pigs here," he was told. "Wonder what they can want them for?"

"The ladies are cold," the orderly confided. "The nurse said I was to bring a pig for each."

There was some further discussion of the situation, and then a great light dawned on the clerk.

"The nurse must mean guinea pigs," she decided. "They have a lot of them over at the laboratory."

So through the snow to the laboratory Mr. Orderly tramped. There wasn't anyone about to interfere with him. So he selected a warm, fat guinea pig for each shivering lady patient, and, with his trophies in a sack, started back to the women's ward to play Santa Claus.

It is too bad to spoil the story. But the furry little animals never reached the ladies' beds. One of the ubiquitous head nurses caught the messenger in one of the corridors, boxed his ears metaphorically, and sent him scurrying back across the snow for a load of stone hot-water bottles.

Items*

SUPREME COURT DECISIONS

A recent decision of the supreme court of Ohio upholds what is known as "the pay-patient law," the claim being made by Hamilton County that the law is unconstitutional, violating the rights of the defendant.

The sections of the general code (1898 Art. 1815-12) in force during this period of the proceeding, provided specifically "that the cost of support of any county's inmates at the institution for feeble-minded youth should be charged against such county," presenting the manner of requisition and payment.

It is contended that the provision violates the state constitution reading, "Institutions for the benefit of the insane, blind, deaf, and dumb shall always be fostered and supported by the state; and be subject to such general regulations as may be prescribed by the general assembly."

It was contended that the state is ordered to support such institutions and that the legislature can neither authorize nor order a county to levy a tax to meet the expense.

As early as 1822 in the state the constitutionality of a somewhat similar provision was challenged. Since that decision "provisions have been enacted requiring persons liable for the support of one committed to such an institution to pay a portion of the expenses of the maintenance of such a person, but, in the case of indigency, the several counties are required to make payments for the maintenance of persons committed therefrom to such institutions. If the requirement that individuals liable for the support of a person committed pay a portion of the expense of maintenance, or that it be realized out of the property of such person himself, is not in conflict with the constitutional provision referred to, it is difficult to see how a requirement that in the event of indigency the county from which the patient is committed shall bear such expense, is violative of such constitutional provision.

*We are indebted to *The Modern Hospital* for these items.

The institution is fostered and supported by the state, notwithstanding the requirement that those able to support and liable for the support of a patient committed thereto be required to contribute to such expense, and that where such conditions do not obtain the county from which the patient is committed be required to do so."—*State vs. Hurve, 137 N. E. 167.*

The supreme court of the Mississippi on November 21, 1922, stated that the "hospital conducted for private gain is liable for injuries to a patient resulting from the negligence of its employees. The business of such a hospital carries with it an implied obligation to give the patients therein reasonable care and attention."

It seems that a child of eight who had an attack of appendicitis was taken to the hospital for care and was there operated upon. Shortly thereafter when there was no attendant in the ward, she fell off the bed on which she was lying and soon after died. The court adds that the liability of the appellee is a question for the jury to decide and consequently a previous decision was reversed and the case remanded. —*Maxie vs. Laurel General Hospital, 93 So. 817.*

The hospital in this case, prior to 1921, was managed by five trustees, three officers being ex-officio members, and two being selected from the employees by the president. That year an action was brought by the state against the hospital association and its trustees, challenging among other things the validity of the method by which the two trustees were chosen. It is unnecessary to go into the details of the case, it being sufficient to say that where the stipulation entered into, provided that "all trustees shall be persons of good moral character," the supreme court of Kansas, November 4, 1922, held that the possession of a good moral character becomes

an essential qualification to hold office. It was held that one of the trustees who had recently committed embezzlement "is not eligible thereto, unless upon a showing of reformation, and his ineligibility is not affected by the fact of his having received a plurality of votes at the election."—*Hempstead vs. Atchison, Topeka and Santa Fe Hospital Association.*

THE SEASIDE HOME, NEW JERSEY

The property of the Seaside Home, owned and used by a corporation of New Jersey for charitable purposes, was held by the supreme court of the state, November 8, 1922, to be exempt from taxation, although not in actual use on the date of the assessment.

The question was: "Was the home actually used within the meaning of the statute, as a home, at the date of the assessment? The property was used exclusively as a summer home for eighteen or twenty years. It is solely adapted for summer use. The particular purpose and use of the property is a summer home for children and old persons supported by charity. There is no question raised as to the charitable purpose of the home."

The taxing statute under which exemption was claimed states: "All buildings actually and exclusively used . . . for religious, charitable or hospitable purposes. . . ." The state board, it seems, held that the words "actually used" means in actual use on the day of the assessment. This interpretation the court declares too rigid, ignoring the spirit and purpose of the statute. "The test of exemption cannot be made to turn upon the fact of an accidental closing of the home depending upon the weather, sometimes earlier, sometimes later in the season." On the other hand the court distinguishes this case from certain others in which property "intended to be used for a charitable purpose," but which had never been used for such purpose, and was not in use on the date of assessment, was taxed. "Intention to use property cannot be made the test of exemption from taxation, under the statute."—*Seaside Home vs. State Board of Taxes, 118 At. 705.*

HOSPITAL SERVES LARGE TERRITORY

The recent dedication of the new Lakeside Hospital at Rice Lake, Wis., attracted persons from points throughout all northern Wisconsin, it is said. The new building with its equipment cost $175,000 and it claims the distinction of being the only modern hospital in an area of 100 square miles. The hospital overlooks the lake and has five acres for lawns, orchards and gardens surrounding it. The present capacity of the institution is sixty beds, but it has been constructed with a view to adding two additional stories when they become necessary. Miss Eva C. Greisen is superintendent of the hospital. Six students are enrolled for training in the school which will soon be opened in connection with the hospital.

HOSPITAL IN CONFLAGRATION

St. Mary's Hospital, at Astoria, Ore., was damaged by the conflagration which swept the business section of the city on December 8th. The patients of the institution were early removed to the high school building for purposes of safety. Although the fire later reached the vicinity of the hospital, it was untouched, except for the destruction of the windows by dynamiting and explosions of gasoline tanks. This building alone of all the important buildings in the business district, escaped destruction. The hospital contains 125 beds and is conducted by the Sisters of Providence.

NEIGHBORHOOD HOUSE DISPENSARY

A neighborhood dispensary has been approved for Auburn, N.Y., by the State Board of Charities. The corporation is formed under the auspices of the Women's Educational and Industrial Union for providing dispensary care for residents of the city unable to pay for medical treatment.

HOSPITAL RECEIVES BEQUEST

The Supreme Court of Illinois, in refusing a rehearing of the case concerning the will of the late Charles E. Haines of St. Charles, has brought to a close the fight for possession of a $600,000 estate brought by relatives of the deceased. Mercy Hospital, Chicago, which under the will was given two-thirds of the estate, will now receive its share.

NEW HOME FOR NURSES

St. Joseph's Hospital, Lancaster, Pa., has purchased a large apartment house which will be converted very shortly into a nurses' home. The building is located directly opposite the hospital, three stories high, and contains sufficient space for 150 nurses. The purchase of the home has been made necessary by the recent enlargement of the hospital, which will eventually double the number of patients cared for. The new nurses' home contains at present 63 rooms and 18 baths, exclusive of the janitors' quarters. Extensive remodelling will be undertaken.

HOSPITAL DONATIONS

St. Mary's Hospital at Minneapolis, Minn., has received an endowment of a free bed in memory of the two sons of Mrs. Elizabeth Gilroy. Mt. Carmel Hospital, at Columbus, O, has received a gift of a marble statue in memory of Sister Brendon, former superior of the institution, from members of the hospital staff.

ORGANIZE ADVISORY BOARD

An advisory board for Hotel Dieu Hospital, Chatham, N.B., was organized on October 16th. The members of the board are as follows: Honorary President, Bishop Chiasson; Honorary Vice-President, Mgr. M. A. O'Keefe; President, W. Cassidy; Vice-President, Geo. McDade; Secretary, Howard McKendy. The remaining members are W. N. Walsh, C. P. Hickey, J. L. Martin, Dr. Losier.

The Surgeon General at Washington, D.C., has announced the opening of a new surgical hospital, to be known as Surgical Hospital No. 16, at Houston, Tex.

By the will of Mrs. Hannah Duryea the St. Louis University at St. Louis, Mo., has been bequeathed securities valued at more than $50,000 to be used for dispensary purposes in connection with the medical school.

Book Reviews

Essentials of Surgery. A Textbook of Surgery for Student and Graduate Nurses and for those interested in the care of the sick, by Archibald Leete McDonald, M.D., The Johns Hopkins University. With 49 illustrations. Second edition, revised. The J. B. Lippincott Company, 201 Unity Bldg., Montreal, Quebec. Price $2.50.

This book covers the general principles of surgical diseases and the pathological changes which result. The more important surgical lesions involving special regions of the body are considered. Discussion is made of causes, local tissue changes and effects. The natural course of the disease is presented and of spontaneous attempts to control the condition as well as factors in prognosis; then full indications for treatment and general principles of same. This new edition eliminates descriptions of technique. A new chapter is added on operative gynecology.

A Text-Book of Obstetrical Nursing. By Alice Weld Tallant, A.B., M.D., Professor of Obstetrics, Woman's Medical College of Pennsylvania, etc. Illustrated with 116 engravings. Lea & Febiger, Philadelphia and New York. Price $2.25. 1922.

Of the several books on obstetrical nursing which have appeared in the last few years, this is the shortest and most concise. It covers the subject adequately from the nurse's standpoint, and there is no unnecessary padding. As the

author points out with emphasis, if there is any time in a nurse's career when she should give scrupulous attention to establishing and maintaining asepsis, it is during labor, for the patient's life may, and often does, depend upon it. Further, the sympathetic insight, which should constantly underlie the work of the professional nurse, will be needed at the crucial time of labor, in its finest sense. We are glad to see the human side of obstetrical nursing stressed as in this book.

Nutrition of Mother and Child, by C. Ulysses Moore, M.D., M. Sc. (Ped.) Instructor in Diseases of Children, University of Oregon Medical School. Including menus and recipes by Myrtle Josephine Ferguson, B.S., B.S. in H. Ec., Professor of Nutrition, Iowa State College, Ames, Ia. With 33 illustrations. The J. B. Lippincott Company, 201 Unity Bldg., Montreal, Quebec, 1923. Price $2.00.

One-fifth of all deaths occur during the first year of life, and more than half of these are directly due to nutritional disturbances. Many mothers who realize the necessity of a well balanced and properly regulated diet do not comprehend what constitutes such a diet. This is not surprising when we consider the rapid progress recently made in nutritional knowledge. A study of good factors and the metabolic requirements of the human body is here presented, beginning with the old established facts of nutrition and co-ordinating with them the newer discoveries of recent years. This small book can be wholeheartedly recommended to all who are, or ought to be, interested in the welfare of mothers and children. The ideas presented are not such as advanced by faddists, but are facts accepted by schools of accredited standing. Emphasis has been placed upon breast feeding, vitamins and the mineral content of the diet. The sick child has been only casually considered, the purpose of this book being to teach mothers how to render their families less subject to disease. The book has also been so arranged that it may be employed by nurses and social workers for instruction of mothers in the home. Altogether a commendable little volume.

Transactions of the American Hospital Association. Twenty-fourth Annual Conference held at Atlantic City, New Jersey. Vol. XXIV, 1922. Published by the Association, Chicago, Illinois.

Those of our readers who are not members of the American Hospital Association will find some very up-to-date reports and addresses on administration, construction, dietetics, social service, dispensary work, book-keeping and other hospital topics. A perusal will be found well worth while.

Text Book of Anatomy and Physiology for Training Schools and other Educational Institutions, by Elizabeth R. Bundy, M.D. Fifth edition, revised and enlarged by Martha Tracey, M.D., Dr. P. H., and Grace Watson, R.N. With a glossary and 266 illustrations, 46 of which are printed in colors. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. Price $2.50 net.

The object in writing this book was to sort out of the mountains of anatomical and physiological facts, the few with which nurses ought to be familiarized. This has been satisfactorily done—briefly and clearly. The characteristics which have a practical application are emphasized. The chapter on digestion has been revised to accord with the newer knowledge in nutritional physiology. More is given on ductless glands, and the reproductive systems.

Principles and Practice of Infant Feeding, by Julius H. Hess, M.D., Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine. Illustrated, third revised and enlarged edition. Philadelphia, F. A. Davis Company, publishers. 1922. Price $4.00 net.

No one is better known than Hess. His work in pediatrics is outstanding. The work is designed for teachers and students for clinical conferences. Much of the subject discussed is illustrated by clinical cases and case-records. After dealing with the anatomy, physiology in the alimentary canal of infants and the subject of metabolism, he describes the bacterial invasion. Under "nursing," he discusses the natural, wet, weaning disturbances in the breast-fed and the methods of feeding prematures.

Dr. Hess tells of recent advances in artificial feeding and describes the adaptations of cow's milk, carbohydrate additions, the cream and skimmed milk mixtures, and outlines the dietary in late infancy and early childhood.

The next section of the book is given to a discussion of nutritional disturbances on artificially-fed infants. Chapters follow on rickets, scurvy, acidosis, spasmophilia and the anemias of infancy. There are numerous, fine pictures and a score of tables for the edification of the practitioner.

Physics and Chemistry for Nurses, by A. R. Bliss, Jr., A.M., Phm.D., M.D., and A. H. Olive, A.M., Ph.Ch., Phm.D. With 70 illustrations. Third edition, thoroughly revised and rewritten and conforming to the requirements of the Standard Curriculum (1922) of the National League of Nursing Education. The J. B. Lippincott Co., 201 Unity Bldg., Montreal. Price $2.50.

I consider this text book too technical and too elaborate, as the great majority of pupil nurses in any training school have had little or no chemistry before entering. It does not seem possible to cover as much work as is here assigned in each chapter, to a class period.

Nursing in the Acute Infectious Fevers, by George P. Paul, M.D., C.P.H. (Harvard.) Director of the Department of Hygiene and Industrial Health, Antioch College, Yellow Springs, O. Fourth edition, thoroughly revised. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. Price $1.75 net. 1923.

A practical volume for nurses. Great stress is laid on the subject of Care and Management of each disease. The book deals not only with the general aspects of fever, but discusses causes, symptoms, course, prognosis and management of all the acute infections. The later part of the work treats of procedures and information necessary in the management of the above diseases; subjects are clearly and concisely discussed.

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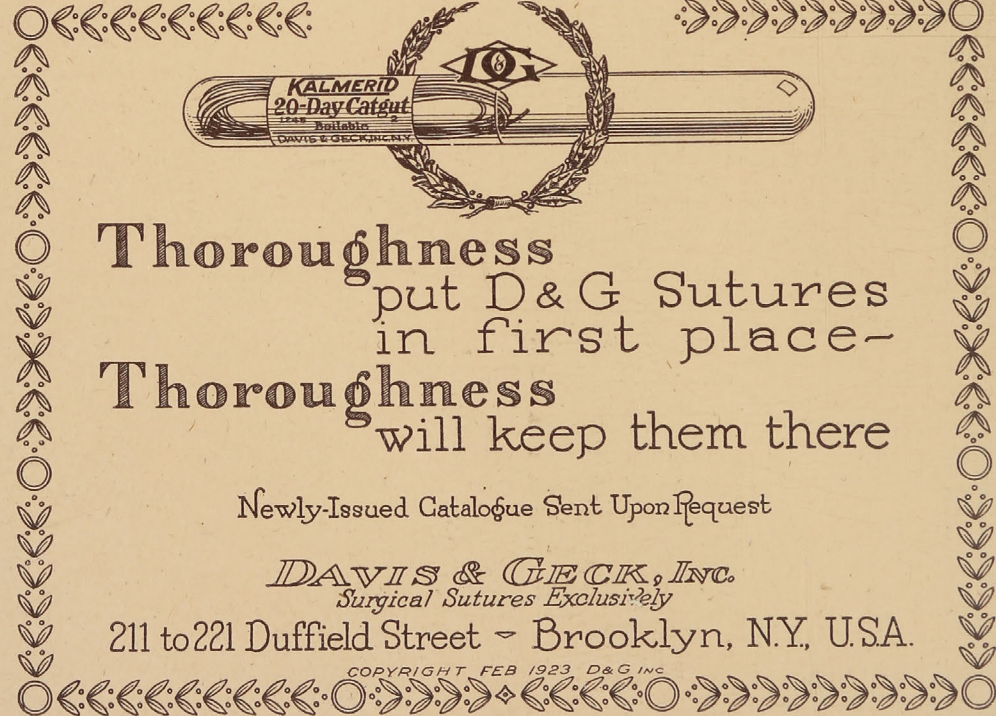

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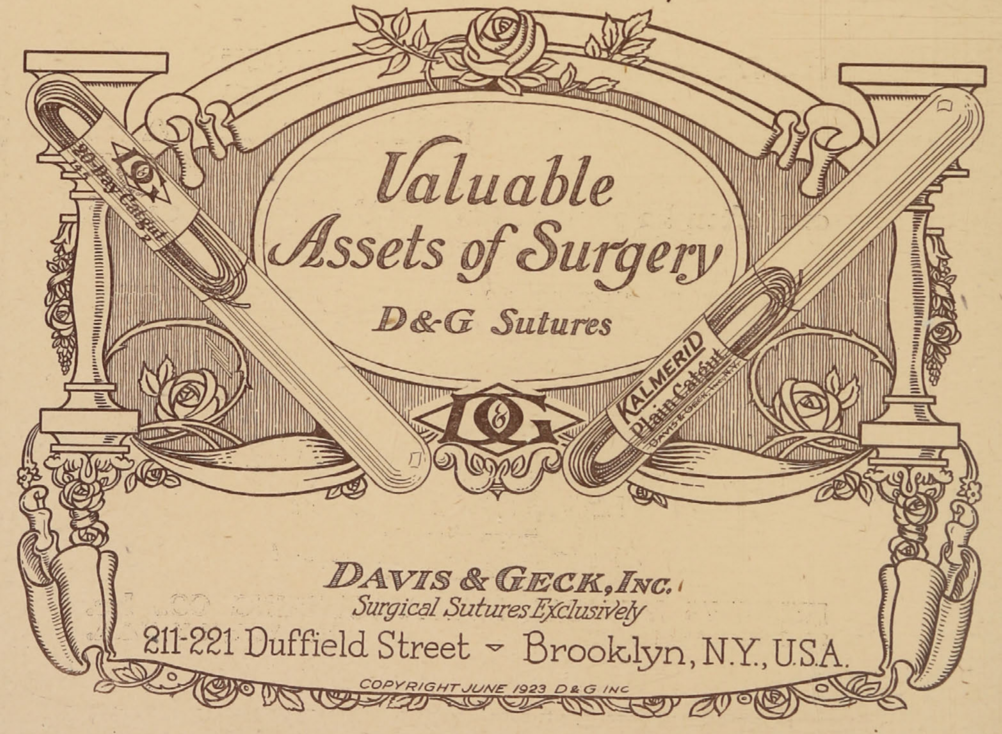

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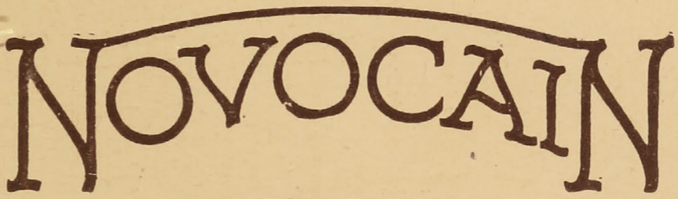

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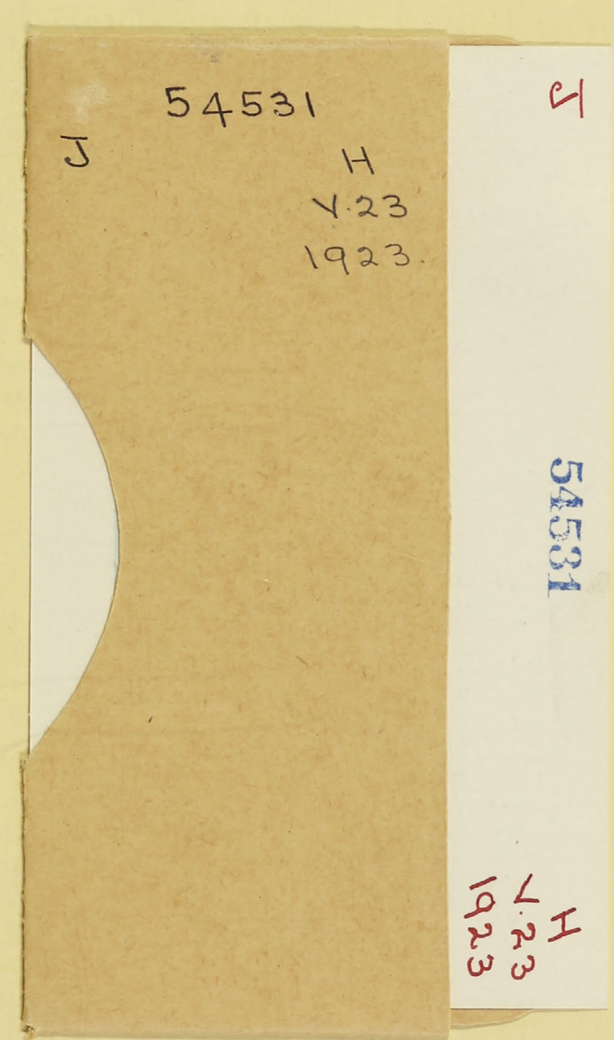
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