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The Official Organ of the Provincial Hospital Associations

The HOSPITAL MEDICAL and NURSING WORLD

CONTINUING THE HOSPITAL WORLD

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THE HOSPITAL, MEDICAL AND NURSING WORLD

TORONTO, CANADA

A professional journal published in the interests of Hospitals, and the Medical and Nursing Professions.

VOL. XXV TORONTO, MAY, 1924 No. 5

Editorial

Hospitals in the Country

We have contended for some years that the ideal place for all hospitals, except emergency hospitals, is in the country beyond the city's turmoil, dust and gloom, where the air is clear, where stillness reigns, and where the maximum sunshine is available. Moreover, in such an ex-urban site there is room for plenty of leafy trees and blooming flowers and green grass. All these advantages make for the patient's welfare and quicker recovery.

Sir Robert Jones, in a recent number of *The Practitioner*, says that it is of primary importance that both the profession and the public should realize and insist upon the fact that country open-air hospitals are essential to the adequate treatment of children suffering from chronic ailments, more especially when the disease is tubercle or rickets. The town hospital, if allowed to exist, should be utilized for emergency or urgent cases. He maintains that it is quite unjustifiable, if a choice is possible, that a

children's hospital should be built in the vitiated atmosphere of the city; and the same applies to children's wards in a general hospital. The country hospital, Sir Robert holds, should be a hospital in a true sense, not merely a convalescent home. If the welfare of the child is to be considered as paramount, no argument about convenience of staff should stand in the way. If senior men are too busy, there are plenty of young surgeons only too willing to undertake the duties wherever the hospital may be placed.

Says Sir Robert:

"I have tested by long experience the relative values of conservative treatment in cities, where the children are indoors both day and night, and in country hospitals where they are out only during the day, and in others where they are out both day and night; and this last continuous exposure to open air is by far the most salutary. The energy, vitality, and nutrition of the children are a revelation to all who visit them. Infectious disease, the bane of closed wards, rarely spreads when the beds are fully exposed to the open air, and no matter how low the temperature, the children never take cold. Indeed, the results have now passed the possibility of adverse criticism. Weak and anemic children improve surprisingly in the fresh air, putting on weight rapidly, and their sinuses heal in a way not experienced before."

The first hospitals for the complete open-air treatment of children were started in England, and there are several of them now. In none of them is it possible to close the wards. They are structurally arranged to prevent closure. No heating apparatus is used in the wards. Hot bottles are put to the feet in winter and woolen mittens on the hands. For the dressing of wounds the patients are removed to a closed side ward. A few days before an operation they are kept in the closed ward, and also for a few days after, until they recover thoroughly from the post-anesthetic stage.

Patients should wear woolen jerseys, lie with blankets next to the skin, and have a free supply of hot water bottles. The floors should be of wood.

Sir Robert points out that not a single pulmonary affection has resulted in spite of severe winters—indeed, the cold weather has been the most favorable time for improvement. A constant phenomenon is the increased appetite of the child, which must be responded to by a very generous diet.

These same principles may be applied to the treatment of adults suffering from most diseases. We might bar diabetes and Bright's disease and an occasional other ailment.

Some day we shall see our hospitals where they ought to be: out where all sensible people who can afford it would rather live—in the country.

Intravenous Anesthesia

Lehrenbecher, of Nurnberg, Germany, says the advantages of this form of anesthesia are the induction of narcosis without excitation—no anxiety, no feeling of suffocation, no unpleasant smell. A quiet sleep supervenes in about one minute and a half. Maintenance of anesthesia is very easy. A little turn of the regulating tap controls the rate of flow easily. Patients recover without discomfort. Post-anesthetic vomiting rarely occurs.

Thrombosis can be avoided with certainty when the stream of fluid is not interrupted during the entire operation, and when the venous system is washed out just before the end of the operation by infusing at least 200 c.c.m. of saline.

Narcosis is begun with 1.5 per cent. isopral solution and continued with five per cent. ether solution.

The apparatus consists of three glass reservoirs fixed 1.5 meters above the floor. Three rubber tubes are attached at the lower ends of the glasses; they are connected with each other and end in a glass cannula. A regulating tap near the cannula enables the attendant to modify the rate of flow.

The whole apparatus must be sterilized most carefully.

The infusion is made into the medium basilic vein. With the aid of novocain the vein is painlessly exposed. Two ligatures are tied around the vein, the peripheral one to fix the vein for the introduction of the cannula, the proximal one to tie the cannula in. To avoid thrombosis the holding ligature is only tied just before the introduction of the cannula.

All bubbles of air must be absolutely eliminated. This is done most conveniently by shaking the rubber tubes and lifting them above the level according to the law of communicating tubes. Otherwise an embolism of air might occur which might prove fatal.

These data are given by Lehrenbecher in the *American Journal of Surgery*. Isopral is an hypnotic resembling chloral. The infusion is given at the rate of 40 ccm. per minute, and care must be taken to avoid over-dosage. The state of tolerance being reached, ether is then used. 100 ccm. of ether is added to 1,900 ccm. of Normosal or Ringer solution. The mixture is warmed to 30° C and must be shaken very carefully. The solution first looks like milk; later it becomes clear. When the narcosis is sufficiently deep it is unnecessary to continue the infusion of ether; the Ringer or Normosal solution may be infused.

The Good Samaritan Plus

We know some men with mediocre ability who have big practices, are well-off and highly respected. *Per contra*, we know certain medallists in medicine who have been failures in general practice. Personality makes the difference—the bedside manner, the geniality, the power of inspiring faith, the warm heart—all count for much.

In some of our poorer hospitals the good-will and tenderness of the medical staff who may not be overskilful, the kindness, faithfulness and industry of the sisters or nurses often, in a measure, offset the lack of scientific knowledge and of technical skill. In some institutions, particularly in teaching hospitals, one not infrequently sees a man of fine diagnostic skill and good in treatment, who lacks the human touch. Sometimes certain nurses do their work well, but in a routine and unsympathetic manner.

The highest ideal is found in persons and institutions where the human and the scientific are combined in the highest possible degrees.

L. P. Jacks, in a recent number of the *Atlantic Monthly*, says, one can be a *good* Samaritan when one has nothing but oil and wine to pour into the wounds of our neighbor, and nothing but a tired ass to put him on. But we can be still *better* Samaritans when science has taught us the art of antiseptic surgery and supplied us with a well-sprung motor ambulance to take the poor man to the hospital. Religion would make us *good* Samaritans; with the help of science it can make us *better* ones.

Jacks says:

"We all revere the good Samaritan. But the only good Samaritan we can recognize in these days is the man who is

using all the means that science furnishes to improve himself in the part. Otherwise we miss the point of the parable. Was it not the essential feature in the conduct of that good man that he went one better than the conventional moralist who passed by on the other side? We imitate him, therefore, by going one better than he did. That is the essence of what is meant by 'go, and do thou likewise.' If you should transplant the good Samaritan, just as he was, into the twentieth century, he would be inefficient. His methods of dealing with wounded persons were the best that were then available. They represented the limitations of science in the first century, and the infinitude of man's spirit in all ages. But they would be altogether inadequate on a modern battlefield or in a slum."

The Little Foxes

Yesterday morning the writer (a doctor) took a patient to a hospital by appointment. There was no one at the door when he entered, and no one appeared in the waiting room. After several minutes the writer entered the main corridor past the waiting lobby and espied the superintendent of the hospital in consultation with a nurse. He knocked on the cross-corridor glass doors, but no move was made except a turn of heads toward him. He returned to his waiting, nervous, anxious patient, who was to be operated on within an hour. Still no official welcome. The writer then returned to the corridor, entered and explained circumstances to the superintendent, who, thereupon, came to the front and admitted the patient.

The writer admitted the other day another patient to another hospital. Some friends of the patient sent a pot of flowering daffodils to be placed in the patient's room when she came from the operating room following a serious operation. These flowers reached the ward, but disappeared within twelve hours. Someone had taken them—to the patient's disappointment and the donors' annoyance.

Another patient of the writer's was admitted to a semi-private ward in one of our city hospitals—a

medical case, not acutely ill. She was roused at 6 a.m. by the nurses, who, she complains, were noisy at their work in adjoining pantries and duty rooms, loud talkers, and lazy. Her food was served cold, etc.

These incidents are cited without prejudice, and readers can draw their own conclusions. All will admit that such "things ought not to be;" that there is something lacking in administration—a lack of system, lack of help, or lack of discipline.

In the best-managed hospitals sometimes fault may be found. But in so far as possible, delinquencies like these quoted should be eliminated. Such errors make a poor advertisement for the places concerned.

Looking Backward

In reading of pioneer days in various parts of the country, and hardships of early settlers, we realize what has been done to make conditions more helpful, and life safer and pleasanter for their descendants.

Apart from the heavy toll taken by tuberculosis which developed so frequently among emigrants under primitive conditions, and apart from the yellow fever scourge of the South, there were the various types of malaria, which while not so fatal, was particularly depressive in its frequent recurrence among the older people.

The presence of insect pests—black flies, mosquitoes and fleas—made life very intolerable in the warm months. That much of the malaria was due to these was not suspected by the pioneer forefathers with their limited knowledge of sanitary science.

To-day our health agencies are so well organized that while an epidemic is yet in its initial stage in

any part of the country, public health officials are on their way to the spot armed with State authority, scientific knowledge and equipment, so that whatever conditions have engendered the disease, are attacked and dispersed, if possible, for all time.

Drainage of swamps, testing of milk, purification of water—all that science knows and can put into effect, is placed at the disposal of the afflicted district—not merely cure for the sick only, but prevention for the well.

It is well to pause and think how far we have advanced in things that count for the welfare of the people; and how largely the pioneer districts of our country have been relieved of their worst terrors.

National Hospital Day

Baby shows and emphasis on the opportunities of nursing continue to be the outstanding items in the development of programmes for National Hospital Day, according to announcements from various hospitals throughout the United States and Canada which are being received by the National Hospital Day Committee, Matthew O. Foley, Executive Secretary, 537 South Dearborn Street, Chicago, from institutions planning on the observance of this day, May 12.

In practically every programme of which information has been received, the hospital plans to distribute printed literature telling of its work during the past year, stressing the amount of free and part pay service the hospital has rendered the community.

The National Hospital Day Committee will be glad to send suggestions for publicity and programmes to all hospital and nursing administrators interested.

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Original Contribution

SUGGESTIONS FOR YOUR HOSPITAL*

Malcolm T. MacEachren, M.D., C.M., Chicago, Ill.,
Director of Hospital Activities, American
College of Surgeons, and President,
American Hospital Association.

Follow-Up.

An efficient "Follow-Up" of all patients discharged is essential in every good hospital to-day. Only through such means can the real value of the work done therein be appraised. The following "Follow-Up" letter as suggested by Dr. Thos. R. Ponton, late assistant superintendent of the Vancouver General Hospital, may be used to great advantage as part of a good system for following up suitable cases:

Dear Sir or Madam:

For your benefit, should you be subsequently ill, and for the advancement of medical science, the hospital desires to know your condition after discharge. For this purpose we are asking you to answer the questions attached and return to the Records Department at your earliest convenience. We wish to remind you that all documents of this kind are confidential, and are shown only to a doctor attending you or on your written order.

Director of Medical Records.

1. Following your stay in hospital were the symptoms for which you received treatment, relieved?
2. If so, how long before you were completely well?
3. Has there been a return of any of your former symptoms?
4. If so, how long after leaving the hospital?
5. Have you had any further treatment for your illness?
6. If so, what and where?

*The Hospital, Medical and Nursing World will welcome all suggestions for the general good of the hospitals of Canada.

7. Are you perfectly well?
8. If not, describe your present symptoms.
9. Have you had any further illness? Please describe briefly.

Signature of Patient.

EFFICIENCY AND PERSONAL TOUCH IN HOSPITALS.

Suggestions for the outer or cover sheet of the patient's chart:

Name .....

Hospital Number .....

Ward .....

Date of Admission .....

Doctor .....

There are two main factors which make for success in hospital work: skill and kindness. Both are important. Doctors and nurses must know their work and be artists in the performance of it. They should love it for its own sake, apart from any monetary gain. Besides this, they should always remember they are dealing with people who are not only sick or wounded in body, but generally much distraught in spirit; and while they minister to the stricken body they should not fail to minister to the stricken mind. The patient is often fearful, melancholy, irritable, irrational, easily perturbed, very sensible to pain or slight. Doctors, nurses and students who are tactful and able to handle with grace patients emotionally unstable, wilful or unreasonable, and at the same time render skilful attention to the sick body, have entered the Promised Land of their profession. Such are to be congratulated; and the hospital which has the greatest number of these "top-notch" people around is the hospital to which the people will flock for help when they are sick.

The best publicity a hospital can secure and the most important factor in its success as an institution is to send all its patients home well pleased with the treatment they have received when ill. The hospital with its equipment and personnel is to assist the doctor in every possible way to bring the patient back to health in the quickest and most comfortable manner, and thus develop in the patient an appreciation of such service. To accomplish this there must be a close personal touch developed between staff and patient.

This can be obtained by a keen appreciation and anticipation of what the patient needs and prompt attention to all these needs whether large or small. At all times the question uppermost in the minds of those who serve should be: "are all my patients satisfied?" After all, the service we can render our patients is the acid test of how we are discharging the duties and responsibilities falling on us in this work.

The Staff Conference.

The Staff Conference is now the most important periodic event in the history of the present-day hospital. The following is a condensed summary of the type of agenda usually followed with success.

Section A.

(1) Meeting called to order.
(2) Roll call.
(3) Reading of minutes of last meeting and disposal thereof.
(4) Business arising out of minutes.
(5) Reports of committees: Special, Standing.
(6) New business.

Section B.

(1) Presentation of report of work for month, either on blackboard or through distribution of copies of monthly analysis sheets.
(2) Analysis of work:
    (*a*) Patients discharged since last meeting, with special consideration of:
        (1) Agreement of diagnoses.
        (2) Consultations held.
        (3) Infections occurring in hospital.
        (4) Deaths.
        (5) Unimproved.
    (*b*) Patients in the hospital:
        (1) Epidemic of bullous impetigo in nursery.
        (2) Post-operative bronchial complications.
        (3) Cases presenting intricate diagnoses.
    (*c*) Reports of committees on:
        (1) Diagnostic and therapeutic departments, as:
            (*a*) Clinical laboratory.
            (*b*) X-ray department.
        (2) Case records.

(3) Considerations and recommendations for the improving of the professional services of a hospital:
(*a*) Individualization of technique in nursery.
(*b*) Draught shields for hospital windows.
(*c*) Operative cases in hospital, night before operation.
(*d*) Need for a psychopathic section to the hospital.
(*e*) Reorganization of the physiotherapy department.
Adjournment.

Comments on the above: It is almost impossible to carry an agenda such as this through in one evening or at one meeting, and do it thoroughly. Section A, or the business portion, should be taken up in a separate meeting or by the executive. Too many staff meetings fail to carry on a good analysis of the work because they spend most of the time on business or administrative matters. It is all covered in the agenda, but in working out it is hoped it will not all be included in one evening.

The Physical Balance Sheet.

Hospitals cost money. We should know what our return is for money invested. The following physical balance sheet should be recorded each month in every hospital:

Hospital Standardization—Physical Report of Hospital for Month of....., 192...

Balance Sheet.—(A) Volume of work: admitted; discharged; transferred; died; remaining. (B) Physical assets: cured; improved. (C) Physical liabilities: unimproved; complicated; infected; died. (D) Net result—physical surplus or deficit.

Certified correct and all details thereof duly investigated by the medical staff of the hospital, this.....day of....., 192....

(Signed)

....Chairman of Staff.

Secretary of Staff.

Monthly Analysis Sheet.

The Hospital Standardization movement aiming entirely at better hospitals and better end results, recommends the following form for use in all hospitals:

Analysis of Hospital Service for Month Ending August 31, 1920.

Discharged	
Cured	48
Improved	117
Relieved	0
Unimproved	8
To return for secondary operation	2
Admitted for diagnosis only	1
Deaths within 48 hours	2
Deaths institutional	8
Released	0
Labor	42
Newborn	43
Total discharged	271

Diagnoses	
Provisional and final agree	162
Provisional and final disagree	17
Discharged with additional diagnosis	0
Discharged with no diagnosis made	8
Labor	42
Newborn	42
Total discharged	271

INFECTIONS

Institutional		On Admission	
Medical	0	Medical	0
Surgical	5	Surgical	12
Obstetrical	0	Obstetrical	0

Consultations	
Asked and obtained	24
Asked, not obtained	0
Indicated, not asked	0

Deaths		Autopsies	
Medical	3	Medical	1
Surgical	2	Surgical	0
Obstetrical	..	Obstetrical	0
Newborn	4	Newborn	0
Stillborn	2	Stillborn	0
Total deaths	11	Total autopsies	1

Causes of Death	
Retro-caecal abscess	1
Malignant endocarditis	1
Illuminating Gas poisoning	1
Tuberculous peritonitis	1
Umbilical hemorrhage, newborn	1
Stillborn	2
Premature birth	1
Infective jaundice infant	1
Strangulated femoral hernia	1
Traumatic cerebral hemorrhage	1
Total deaths	11

Unimproved	
Operation advised	1
Suspected carcinoma stomach	1
To return for operation	1
Hypertrophied tonsils, no operation	1
Hyperthyroidism and Myocarditis	1
Tuberculous peritonitis, pulmonary tuberculosis	1
Brachial paralysis	1
Fractured ulna—to return for further treatment	1
Total unimproved	8

The Protestant Hospital Association of America Strongly Endorses Hospital Standardization.

The following is a summary of the remarks of the representative of this Association at the Sectional Meetings held all over this continent annually, and recently presented to the Ontario-Quebec Sectional Meeting of the American College of Surgeons at Ottawa, Ontario:

I bring to this Clinical Congress the appreciation and endorsement of the Protestant Hospital Association of the

United States and Canada. Such a gathering as this is indeed inspiring and cannot be otherwise than helpful to every institution here represented.

At our recent Milwaukee convention the Association passed the following resolution:

It is the sense of this meeting that we most heartily endorse the standardization programme of the American College of Surgeons regarding the professional work of our hospitals, and urge all who are associated in hospital work, both in professional and non-professional capacities, to uphold and constantly live the high standards set forth by the American College of Surgeons. It is our purpose to hold our professional and scientific work on the highest plane, and also to make a definite Christian impact upon all who come in touch with our institutions.

1. We are all indebted to the American College of Surgeons for its efforts to bring order out of chaos. If we should measure the advancement made during its seven years of activities, we have only to look back to the conditions existing among hospitals a few years ago. Then, there were apparently no standards worthy of the name; now, the standardized hospitals are numbered by the hundreds. Then, very few of the hospitals had records worthy of mention; now, hospitals keeping records are numbered by the thousand. Then, neither the institution or the public had any way of determining whether certain important things were done in the care of the patient; now, we have means of checking up all along the line at every turn, from his admission to his dismissal, and even for years to follow. Then, most hospitals were independent in their work and took little interest in the workings of other hospitals; but since the American College of Surgeons insisted that hospitals should have right standards of equipment, records and service, we are brought closer together and have an interest in each other.

2. There can be no question but the setting up of *ideals that may be realized* helps us to solve our problems. However, it cannot be correctly stated that all problems are alike. Therefore, these standards and ideals become a working programme and are applicable to each locality according to the needs. We all realize that the standards set for our hospitals are not an affliction. They are not too high for any to attain. All of our trustees, staff and management should be made to see that the minimum standard required by the

American College of Surgeons is worthy of the confidence of the public and one that can be safely adopted. Our Association is strongly stressing this point. And while we believe profoundly in the minimum standard, we are confident that this must be the basis upon which we must make our efforts to reach the maximum standard. The maximum standard is that standard, which any hospital having passed the minimum standard, fixes for itself.

3. The Protestant Hospital Association was organized with the definite purpose to encourage and help all our hospitals to a larger efficiency, and a more complete co-operation with all organized hospital effort. We believe in the closest harmony with other hospital associations and in the united effort of all to bring about standardized efficient hospitals.

4. In the United States fifty-six per cent. of the counties have no hospital provision, while fully 50,000,000 people live outside of the great centres. There are 3,000,000 of people sick and in bed daily. Our survey has produced statistics that indicate that twenty-eight per cent. of the sick actually need a hospital. But there are only 475,000 beds for general hospital use, while 840,000 beds would be required. It is difficult to obtain accurate figures; but our survey found aproximately 75,000 hospital beds in Catholic hospitals; 50,000 beds in Protestant Church hospitals; 10,000 beds in Jewish hospitals; leaving 340,000 hospital beds in hospitals without church affiliation.

It is our hope that in the future building of hospitals there shall be no spirit of rivalry. When a hospital occupies the field and *can* and *will* do the required work, we should like to see everybody give it ample support.

5. Our Association is anxious to make its hospitals efficient for those dependent upon them for service. We are glad that standardization has been suggested. It gives us something to work towards, and places approval upon our efforts. We want to provide the best surgical and medical treatment for our rich and poor alike. We are anxious that the sick, living in remote places shall be informed that the best possible provision is made for their healing. We recognize that a life is a life and is entitled to the best care that we can provide. *We believe* that the baby has a right to be born perfect. The child has a right to healthy parents, a happy home and a better and healthier world to live in. All who come to the hospital have a right to the best scientific treatment, under

adequate facilities, and the latest and most perfect apparatus and complete laboratory equipment. We regard the patient as the significant person in the hospital; our chief concern is about him or her. Nothing is too good for any patient.

6. Standardization implies ideals and principles that may be reached. Principles imply system, and system means organization. If well begun is half done, then organization is that much. When the organization is complete the whole machinery should be harmonious. Harmony is the lubricating oil that takes the squeak out of the machinery and makes it ball-bearing, smooth-running and efficiency-producing. It is my belief that an efficient hospital is one in which every department and division functions to the full requirement of the standards. If the radiographer fails to read his plates correctly the surgeon may be sued for removing the wrong kidney; if the pathologist errs the physician or surgeon may be led into grievous error; if the records are poor the patient is liable to suffer. A standardized hospital must *be* all it claims to be; it must *do* all it claims; there is no place for sham or fraud in a hospital.

7. Lastly, we seek to make every hospital *a healing and a teaching institution.* We know that it should heal the sick, and that no task should seem too hard or offensive. But in every community it should become a place to train nurses; to qualify internes; and to perfect the doctor in the highest scientific skill. No longer does the doctor operate in the home, he must have all the facilities that the best equipped hospital affords. And then, the hospital becomes a teaching factor in the community. More millions are saved from disease by preventive medicine than any one has ever estimated. When we have become strong as a teaching and healing hospital, then we are beginning to fill our true mission.

THE AMERICAN COLLEGE OF SURGEONS

Hospital Standardization—Approved Hospitals of Canada, 1923.

The American College of Surgeons, an international and Pan-American organization of almost 7,000 surgeons, chiefly from Canada and the United States, with a number from South America, makes an annual survey of general hospitals of fifty beds and over in both countries. The survey is

carried on by personal visits of carefully selected investigators, who are graduates in medicine and have clinical and hospital experience. Annually a list of Approved Hospitals in both countries is published.

The survey is based on the Minimum Standard Requirements for hospitals, which is as follows:

1. That physicians and surgeons privileged to practice in the hospitals 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 practice 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 analyses.

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 fluroscopic service under competent supervision.

The above requirements have been carefully worked out to establish a universal standard of service for hospitals. They have as their fundamental principle the focusing of all hospital activities primarily on the patient in order to assure (*a*) an early and accurate diagnosis; (*b*) the most competent and effective treatment; (*c*) the best end results obtainable and the return of the patient to physical health and normal condition in the shortest time and in the most comfortable manner. All this is being accomplished through the efforts of well directed scientific medicine.

The results of the sixth annual survey of the American College of Surgeons is shown in the list of Approved Hospitals for Canada and the United States published on October 22nd last. During the year the work increased considerably, the magnitude of which can only be realized from the following statistics: There were nine visitors sent out by the College to cover the hospital field. These men did an aggregate of sixty months (or five years) of survey work in 1923. The 1,786 hospitals visited contained 237,046 beds, caring for approximately 4,758,920 patients, during the year. The estimated days' treatment for this group is 71,383,800. Out of this number of hospitals the College has put its mark of approval on 1,177 or 65.9 per cent., having a total bed capacity of 191,042 and caring for approximately 3,820,840 patients with an estimated days' treatment of 57,312,600 for the year. The visitors travelled an aggregate of 75,000 miles. There were over 3,500 follow-up letters sent out regarding findings in the hospitals visited. In addition to all this, some twenty-two sectional meetings of the Clinical Congress of the American College of Surgeons were held in various parts of Canada and the United States. At each meeting an interesting two-day programme was provided, a considerable portion of which was devoted to Hospital Standardization. Further, some twelve special meetings were held for the express purpose of promoting Standardization. Thus the hospitals of Canada and the United States have been reached not only through the personal contact and efforts of the visitor, but through group meetings covering the entire continent annually. All this

indicates the opportunity the College has through the programme of Hospital Standardization for extending its beneficial influence in bringing about better service in hospitals. The entire expense of this expert advice and service given to hospitals is borne by the College through its membership.

The growth of the Hospital Standardization movement in Canada and the United States is well shown by the following figures, relative to hospitals of 100 beds and over, during the past six years:

Year	Hospitals Surveyed	Hospitals Approved	Percentage
1918	692	89	12.9
1919	692	198	28.6
1920	692	407	58.8
1921	761	573	75.3
1922	812	677	83.4
1923	870	749	86.1
	50 to 100 Beds.		
1922	812	335	41.3
1923	916	428	46.7

Canada has made splendid progress each year. During 1923, one hundred and forty-four general hospitals of 50 beds and over were surveyed of which 87 or 68.3 per cent. were approved. In this group there were 64 hospitals of 100 beds and over of which 52 or 81.3 per cent. were approved. The second survey of hospitals of from 50 to 100 beds was made this year, and of the 80 in Canada, 46 or 57.7 per cent. met the requirements and received the approval of the college. The complete list of general hospitals in Canada of 50 beds and over meeting the requirements is as follows:

ALBERTA

100 or more beds.

General Hospital, Calgary.
Edmonton General Hospital, Edmonton.
Holy Cross Hospital, Calgary.
*Medicine Hat Hospital, Medicine Hat.
Misericordia Hospital, Edmonton.
Royal Alexandra Hospital, Edmonton.
University of Alberta Hospital, Edmonton.

50 to 100 beds.

Lamont Public Hospital, Lamont.
*Galt Hospital, Lethbridge.

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.

*Queen Victoria Hospital, Revelstoke.
*St. Eugene Hospital, Cranbrook.
*St. Mary's Hospital, New Westminster.
*Vernon Jubilee Hospital, Vernon.

MANITOBA.

100 or more beds.

Brandon General Hospital, Brandon.
Children's Hospital, Winnipeg.
Grace 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, New Castle.
Moncton Hospital, Moncton.
St. John's Infirmary, St. John.
Restigouche and Bay of Chaleur Soldiers' Memorial Hospital, Campbellton.
*Victoria Public Hospital, Fredericton.

NOVA SCOTIA.

100 or more beds.

St. Joseph's Hospital, Glace Bay.
Salvation Army Hospital, Halifax.
Victoria General Hospital, Halifax.

50 to 100 beds.

*Aberdeen Hospital, New Glasgow.
Children's Hospital, Halifax.
General Hospital, Glace Bay.
Halifax Infirmary, Halifax.
Highland View Hospital, Amherst.
St. Martha's Hospital, Antigonish.
*Sydney City Hospital, Sydney.
*Yarmouth Hospital, Yarmouth.

ONTARIO

100 or more beds.

General Hospital, Kingston.
Grace Hospital, Toronto.
Hamilton General Hospital, Hamilton.
Hotel Dieu, Kingston.
McKellar General Hospital, Ft. William.
Ottawa General Hospital, Ottawa.
Protestant General Hospital, Ottawa.
St. Joseph's Hospital, Hamilton.
*St. Joseph's Hospital, London.
St. Joseph's Hospital, Sudbury.
St. Luke's Hospital, Ottawa.
St. Michael's Hospital, Toronto.
Sick Children's Hospital, Toronto.
Toronto General Hospital, Toronto.
Western Hospital, Toronto.
Victoria Hospital, London.

50 to 100 beds.

*General Hospital, Brockville.
General Hospital, Sault Ste. Marie.
*Niagara Falls General Hospital, Niagara Falls.
Nicholl's Hospital, Peterboro.
Oshawa Memorial Hospital, Oshawa.
*Owen Sound General and Marine Hospital, Owen Sound.
*Public Hospital, Smith's Falls.
*St. Francis' Hospital, Smith's Falls.
St. Joseph's Hospital, Peterboro.
St. Vincent de Paul Hospital, Brockville.
Welland County Hospital, Welland.
Wellesley Hospital, Toronto.
Women's College Hospital, Toronto.

PRINCE EDWARD ISLAND.

50 to 100 beds.

Charlottetown Hospital, Charlottetown.
*Prince County Hospital, Summerside.
Prince Edward Island Hospital, Charlottetown.

QUEBEC.

100 or more beds.

Children's Memorial Hospital, Montreal.
General St. Vincent Hospital, Sherbrooke.
Hotel Dieu, Montreal.
Jeffery Hale's Hospital, Quebec.
Montreal General Hospital, Montreal.
Notre Dame Hospital, Montreal.
Sainte Justine Pour Les Enfants, Montreal.
Royal Victoria Hospital, Montreal.
Western Hospital, Montreal.

50 to 100 beds.

Montreal Maternity Hospital, Montreal.
St. Francoise d'Assise, Quebec.
*Sherbrooke Hospital, Sherbrooke.

SASKATCHEWAN.

100 or more beds.

Grey Nuns Hospital, Regina.
Providence Hospital, Moose Jaw.
St. Paul's Hospital, Saskatoon.
*Saskatoon City Hospital, Saskatoon.

50 to 100 beds.

Holy Family Hospital, Prince Albert.
Notre Dame Hospital, North Battleford.
*Moose Jaw General Hospital. Moose Jaw.
*Victoria Hospital, Prince Albert.

The asterisk (*) indicates that certain hospitals have accepted the requirements which result in the best scientific care of the patients, but have not yet, for lack of time or other acceptable reasons, carried them out in every detail.

HOW THE HOSPITAL DIETITIAN MAY CO-OPERATE WITH THE PHYSICIAN*

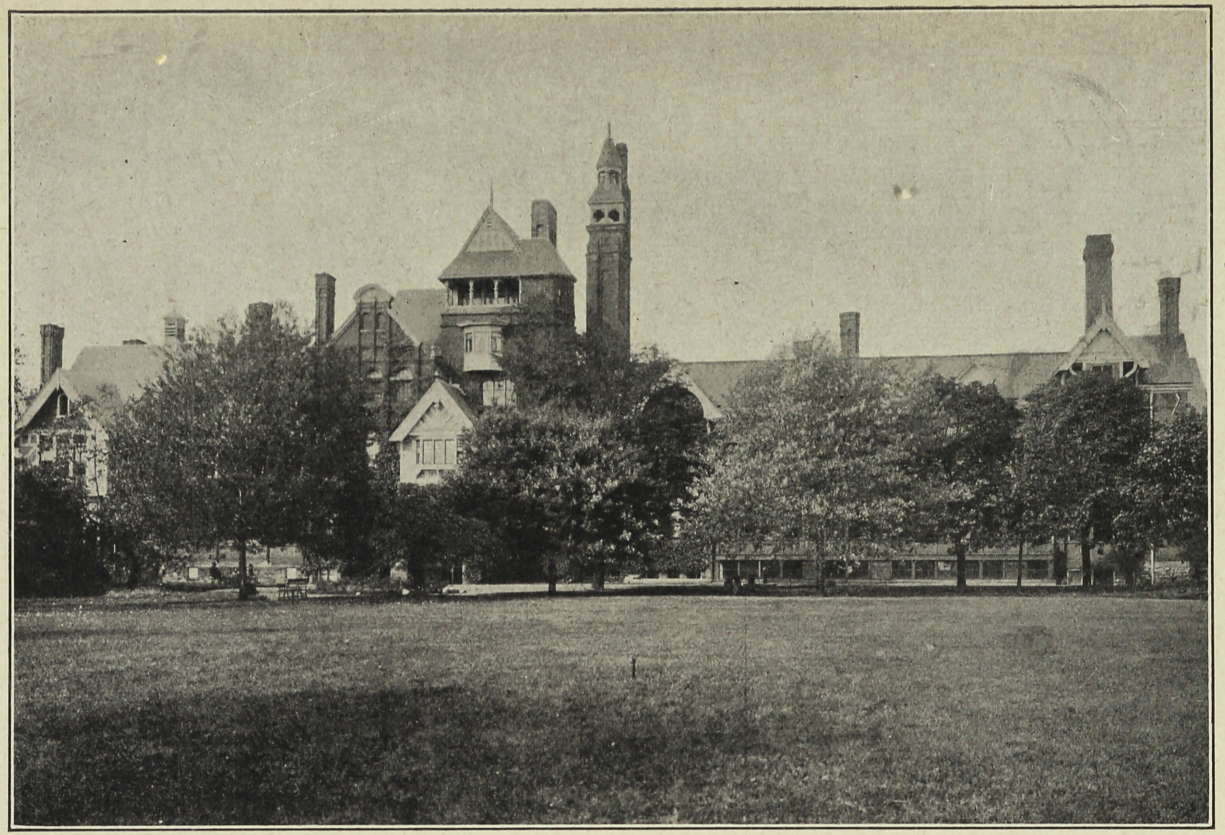
Russell M. Wilder, M.D., Division of Medicine, Mayo Clinic, Rochester, Minnesota.

The proper feeding of the sick has been regarded, from time immemorial, as one of the most important measures in the treatment of disease. Credit, I believe, is given some tender-hearted woman of the neolithic age for introducing cooked meats into common use. Food in that early period was eaten raw, but once a sick man's fickle appetite was tempted by a morsel of flesh raked from the embers, he found it good, and thereafter his fellows had food roasted, baked or broiled. It is not unlikely that many of the delicacies that grace our modern tables were designed originally for the sick room.

It is only within the memory of our contemporaries that nursing has become a profession, and that the trained nurse has taken the place of the willing and loving, but often bungling, relative or friend in the sick room, and yet so rapid is the increase in the complexity of civilization that already in this new field, areas are being set aside for special intensive cultivation, and women are fitting themselves as specialists. Since the preparation of food for the sick is such an important part of their care, it is hard to understand why it has received so little attention as it has in training schools for nurses. However, to become expert in dietetics requires more time and study than could ever be given by the general nurse, and it is well, therefore, that this special area should be cultivated as intensively as it deserves by dietitians. The effort is already yielding a harvest; the patient is benefiting, and by precept, nurses are gaining much that they have heretofore lacked.

Our institution, the Mayo Clinic, may be taken as an example of the rapidly increasing recognition that dietitians are receiving. It is true that, until very recently, the Mayo Clinic was predominantly surgical, and that now it is actively engaged in the development of facilities for the care of patients whose diseases are treated medically. In 1919 there was employed for the several hospitals in Rochester one dietitian; in 1923 there are one, or more dietitians in each of these hospitals. The student nurses in 1919 received the most perfunctory textbook instruction in special dietetics, while now, they all have

*Read before the American Dietetic Council, October 15, 1923, Indianapolis, Indiana.



THE MAIN BUILDING, TORONTO HOSPITAL FOR INCURABLES. FOUNDATION STONE LAID BY H.R.H. PRINCESS LOUISE, SEPTEMBER 18TH, 1879.

practical experience and training. The patients at that time were served with food from the general kitchens, and it was a rather common criticism that patients were operated on and dismissed from observation without advice as to their future care. To-day, in any of the hospitals, any special diet required is served, and every effort is made to instruct the patient concerning the food he should eat when he returns home.

Although the advance in the practical application of dietetics in the Rochester hospitals has been unusual, yet such practices have found their way into hospitals and sanitariums the country over, and to judge from notices appearing in your journals, the demand for skilled dietitians is now far greater than the supply. I predict that dietitians will be required to assume more responsibilities in the future than in the past, and that, with these added burdens there will come a still fuller recognition of the value of their work, and, I hope, commensurately increasing remuneration for their services.

I am certain that America and Canada are further advanced in the cultivation of this dietetic field than are the countries across the sea. Miss Foley has described the dietetic department for outpatients at the Mayo Clinic, where transient patients not requiring hospitalization can be given special diets and instruction in nutritional matters. This department is proving of great usefulness, not only in the more satisfactory results secured in the treatment of the outpatients, but in the added facilities which it provides for the practical training of nurses and student dietitians. The kitchen here has all the atmosphere of an atelier; the students and their teachers who prepare the foods are the artists. An English visitor, a surgeon of distinction, was being conducted through this establishment recently and was considerably impressed. On leaving, however, he revealed how little he appreciated what we were showing him by his inquiry: "But how much do you have to pay these cooks?"

There is every reason to expect that dietitians will soon be required to obtain certificates of proficiency from the state, which will necessitate considerable education, a collegiate degree of S.B. or A.B. at least, with specialization in such courses as home economics and the physiology and chemistry of nutrition, besides a certain period of apprenticeship in some institution where practical training is obtainable. With such a foundation, it seems to me that physicians can turn over to dietitians, with profit to all concerned, much of the detail of

dietary treatment, and nearly all of the very important business of instructing the patient on the subject of his food and diets. In fact, I have for several years prescribed for my patients in general terms, holding the dietitian responsible for the details; I find this has great advantages. It should be obvious that, in the matter of the selection of particular foods, the dietitians in charge are much better qualified than I. It is their duty, not mine, to know what fresh foods are on the market at reasonable prices. It is their duty, not mine, to contrive ways and means of making high calorie, low protein, or high fat diets palatable and attractive, and they are as much interested as I am in keeping abreast of the rapid development in the physiology and chemistry of nutrition, and are thus quite as able to secure in such diets adequate vitamins, salts and the other essentials of proper nutrition. Co-operation is the "open sesame" to the doors of success in this work. Frequent consultations between physician and dietitian are necessary. The physician must understand the dietetic problems and difficulties, and the dietitian the plans and purposes of the physician, but if this co-operation is possible, and if the dietitian is the well-trained scientific assistant that she should be, it is advantageous, I am sure, to encourage her to assume very large responsibilities.

In Rochester hospitals, not only the diabetic diets but nearly all special diets are ordered in general terms after understandings have been reached with the dietitian. The list of these diets is large; it includes fixed protein and fixed caloric diets, reduction diets, acid-free diets, high iron diets, non-fermenting diets and many others. In the hospitals the dietitian familiarizes herself with the requirements of her patients by consulting the clinical records, or by direct consultation with the physician. In the dietetic department for out-patients, the patients come from the physicians with special referring cards containing the clinical diagnosis, the condition which it is desired to relieve by dietary measures, and an order for a diet given in general terms, as I have indicated.

The clinical investigation of problems of nutrition necessitates the co-operation and assistance of an expert in dietetics. In such work, great accuracy and minute attention to details becomes imperative, and it is desirable to set aside a special ward provided with a special kitchen. An ideal arrangement may be found in DuBois' clinic in Bellevue Hospital. A similar metabolism ward exists now under Boothby's direction

in the Kahler Hospital at Rochester. The dietitian here not only supervises and assists in the preparation of the special diets that are served, but checks the composition of these in the laboratory. A good knowledge of food chemistry and familiarity with the technic of calorimetry and the other methods of food analysis are necessary for such work, but while the procedures are extremely delicate, they are not difficult to master, and the satisfaction of participating in the successful investigation of any of these important problems repays for all the pain and effort involved.

Some of you may be familiar with Boothby's observation on the food requirements of patients with hyperthyroidism. In a small group of such patients under dietary supervision, it was found that the food consumption, in some cases, amounted to 5,000 calories a day when the patients were encouraged to eat as much as they would. The basal metabolic rate, that is, the rate of heat production with the patient resting in bed, is elevated in this disease to from twenty to one hundred per cent. above that of comparable normal persons. This has long been well known, but as Boothby has shown, it is insufficient to account for the enormous quantities of food the patients consumed. The food was all metabolized, the patients did not gain weight nor store nitrogen, and it became apparent that the energy was going into work, although the amount of work which these patients were doing was little indeed, consisting only of the movements in bed. In other words such patients have relatively less effective engines than normal, and in consequence their total metabolism is increased, not only by a high basal metabolic rate, but by higher energy requirements than normal for every muscular movement. This conclusion was confirmed subsequently by short period metabolism observations with the treadmill, and the practical application of the discovery is interesting indeed. It was found by weighing the food and calculating the caloric value of the general diets being served in the general wards that the patients were not receiving more than 2,000 calories. The patients with hyperthyroidism had the same diet, and obviously, in view of their higher nutritional requirements, were badly undernourished. By serving 4,000 caloric diets to these patients, their loss in weight, which has been regarded heretofore as an inevitable consequence of their disease, was controlled, nitrogen balance was maintained, and in general the severity of the symptoms was favorably affected.

THE NURSES' RESIDENCE, TORONTO HOSPITAL FOR INCURABLES. CORNER STONE LAID BY LADY MORTIMER CLARK, JUNE, 1909. OPENED BY EARL AND COUNTESS GREY, APRIL, 1910.

The most important rôle of the hospital dietitian, however, that of teaching, I have left for the last. The realization of its importance is just beginning. I feel sure that the physician himself will soon be turning to the dietitian for special advice in dietetics, and that as the great significance of the proper nutrition of patients permeates the training schools for nurses, the demand for more intensive training of nurses in dietetics will arise, and must be supplied. Finally, it is rapidly becoming apparent that the important work of teaching patients must be left largely to the dietitian. It is physically impossible for the average busy physician to devote the time necessary properly to educate his patients. Consequently advice concerning diets which is given in the physician's office is often so inadequate as to be ridiculous. The printed diet list is the common refuge. The patient glances at this hurriedly during the last few minutes in the doctor's office, follows it perhaps for a week or two, then tiring of the monotony of his food, and from lack of any appeal to his intelligence, neglects it. Furthermore, most unfortunately, many physicians are woefully ignorant of the principles of nutrition, and the instruction given their patients is positively harmful. It is remarkable how prevalent, even among physicians, is the erroneous idea that the various brown and black breads can be fed in unlimited amounts without harm to the patient with diabetes, and how frequently gluten breads are prescribed without any appreciation of their high carbohydrate content. One of my assistants recently studied fifty diabetic patients then on the service, and found that forty-eight of them, including two physicians, had been advised by physicians to eat without restriction bran bread, graham bread, black bread or gluten bread. It is of the utmost importance that more explicit advice concerning foods and nutrition be spread abroad, and that patients particularly should be advised intelligently and in detail with regard to the planning of their meals.

Unfortunately, at the Mayo Clinic, and in other institutions, the dietitian is so occupied with other duties that it is difficult for her to find the time necessary for this teaching. This must, and will, be corrected by enlarging the dietetic staff. Patients in the Clinic are hearing lectures and receiving individual instruction, but neither are adequate. On the diabetic service, where the necessity for this instruction is the greatest, one of the physicians lectures or quizzes the patients for three hours each week, and the dietitian lectures one hour.

I wish that she had the time to give three hours to this important part of her work. Each patient also receives individual instruction, and the more intelligent patients leave the institution very thoroughly trained. The results with the less intelligent patients are far less satisfactory. In the Clinic itself, a lecture on foods and general nutritional problems is given twice weekly by the dietitian in charge or by one of the physicians. Such lectures are a valuable means of broadcasting advice, and as they have an economic, as well as hygienic bearing, they help to arouse public interest. They do not, however, replace individual instruction, every patient having particular difficulties and problems which must be met individually. The calorie kitchen, to which I have referred, is appropriately decorated with educational charts, and here the patient actually receives for several days the diet he is expected to follow, acquiring thus visual impressions and an intimate acquaintance with it. The combination of lectures, individual instruction and this practical demonstration, is, I am glad to say, obtaining splendid results. It is hard to estimate the full value of such work. The satisfaction of the patient is evident, but the broader educational significance of such efforts cannot be gauged. Undoubtedly, much good for the community is being accomplished, as each patient in turn becomes a protagonist, and carries to his family circle reliable information about foods and nutrition. It is to be hoped that hospital managements will quickly recognize the importance of such educational service, and provide a large enough staff of dietitians to ensure its continuance. To paraphrase a statement of Dr. Joslyn's, "What you feed a patient during his stay in the hospital is important, but not so important or far-reaching in its effect as what you say to him."

ORGANIZATION OF QUEBEC DIETETIC ASSOCIATION

In December, 1923, a group of dietitians in various fields of work in Montreal met to discuss organization of a provincial association. This was decided upon favorably and in January organization was completed with the following charter members: Miss Maude A. Perry, Montreal General Hospital, President; Miss E. L. Hunter, Montreal H. S. Cafeteria, Vice-

President; Miss Vera O. Sparling, Y.W.C.A. Cafeteria, Sec-Treas.; Miss Daisy Ellithorpe, Montreal General Hospital, (1st Assist.); Miss I. T. Carpenter, Bell Telephone Co.; Miss Beulah Phillip, Montreal General Hospital, (2nd Assist.); Miss Jean Crawford, Montreal Diet Dispensary; Miss Faith Mathewson, Iverley Settlement; Miss Dorothy Hodge, Montreal General Hospital, (pupil); Miss W. E. Low, The Willow Tea Room; Mrs. Alex. Ree, Child's Cafeteria; Miss Harriett Van Wort, Montreal General Hospital, (pupil).

Since then three new members, Miss B. M. Philp, Miss Winona Cruise and Miss Phyllis Clarke, all of MacDonald College, P.Q., have been admitted by application. There are several applications before the executive committee to be acted upon.

The association meets once every month. Its purpose is to raise the standard of dietetics in the province. At the February meeting each representative of the various fields of dietetics told something about her work. "The Modern Dietetic Treatment of Diabetes" was the subject of the March meeting. One social meeting was held in February at the home of one of the resident members.

The Senior Administration Class of MacDonald College and the Senior Class of the McGill-MacDonald course, accompanied by two instructors, made an inspection trip through the dietetic department of the Montreal General Hospital on March 6th.

AMBROSE KENT WING, TORONTO HOSPITAL FOR INCURABLES. CORNER STONE LAID BY SIR JAMES WHITNEY, JUNE, 1909. OPENED BY MRS. AMBROSE KENT, OCT. 26TH, 1910.

Society Proceedings

26th ANNUAL REPORT OF WORK OF THE VICTORIAN ORDER OF NURSES

"We had forty-five nurses last year, and unless we can get more money we may be obliged to reduce the staff, but we should have at least fifty nurses to give relief to the sick and suffering who so much need help." In these words Hon. W. A. Charlton, Chairman of the Executive Committee of the Toronto Branch of the Victorian Order of Nurses, summed up the position of that organization at its twenty-sixth annual meeting held March 18th at the headquarters in Sherbourne Street.

"We feel," he said, "that the work we are doing for the city is so important that a very much larger grant should be made, and at a meeting of the Executive Committee we arranged to write the Federation for Community Service suggesting that we might appeal to the City Council through the Medical Officer of Health for a large grant."

Last year, the speaker explained, a branch house was opened at 448 Ossington Avenue for greater convenience in doing work in the western portion of the city. The head office at Ottawa is anxious to establish a branch at Mimico, and possibly another one east or north of Toronto. Interesting statistics revealed the growth of the work of the Victorian Order in this city. In 1912 there were fifteen nurses, who made during that year 16,458 visits. In 1923, forty-five nurses made 91,832 visits. In 1915 receipts totalled $14,116.36, and in 1923 they were $91,910.24.

The financial statement, presented by A. R. Capreol, showed that $20,405 had been received from the Federation for Community Service, $3,320 from the city grant, and $24,662 from the Metropolitan Life Insurance Company for the treatment of their employees. Other patients paid $23,188.95. The year closed with a deficit, funds having been advanced to meet the needs of the situation.

Miss Edith Campbell, in her superintendent's report, stated that 10,105 patients had been attended by the nurses of the

Victorian Order during 1923, this being an increase of 4,147 over the previous year. The workers numbered forty-five, with a part-time staff of seventeen and forty-two University Public Health students. Infants to the number of 2,865 were cared for during the first ten days of their lives, and layettes for these cases had been supplied by various guilds, clubs and groups of friends.

Dr. Harley Smith gave assurance of the splendid health record of the nurses during the past year, and stated that the Order had continued to grow in the affection and support both of the lay public and of the medical profession. The only difficulty was in meeting the ever-increasing demands of both these classes.

A warm tribute of appreciation was paid to the woman superintendent, treasurer and office staff by A. Hewitt, and H. H. Love moved a vote of thanks to the Federation for Community Service. Mrs. A. J. Arthurs presented diplomas to ten nurses who had served the order for one year or more, five of whom were unable to be present owing to the urgency of their duties. Those who received their certificates were: Miss Ada Scott, Miss Louise Hopkins, Miss Leda Johnstone, Miss Roberts and Mrs. Campbell.

After the election of officers tea was served, and a pleasant social hour was spent by those present, many of whom had missed but few annual meetings in the twenty-six years of the Order's existence in Toronto.

The officers for the ensuing year are as follows:

Governors: Lieut.-Gov. Hon. H. Cockshutt, Mrs. A. J. Arthurs, Hume Blake, Rev. T. Crawford Brown, A. R. Capreol, Hon. W. A. Charlton, Canon H. J. Cody, Miss Dickson, Dr. W. J. Dobbie, John Firstbrook, Dr. J. F. Fotheringham, Sir Joseph Flavelle, Sir William Hearst, Arthur Hewitt, Mrs. Vincent Massey, Father Minehan, John Northway, Dr. N. A. Powell and Dr. Harley Smith.

Executive Committee: Chairman, Hon. W. A. Charlton; Vice-President, Arthur Hewitt; Mrs. A. J. Arthurs, Hume Blake, Rabbi Brickner, Rev. T. Crawford Brown, R. Connable, W. A. Charlton, A. R. Capreol, Mrs. A. R. Capreol, Mrs. H. H. Cowan, Mrs. W. Cummings, Miss Dickson, Dr. Dobbie, John Firstbrook, Mrs. J. M. Godfrey, Lady Gage, Mrs. Arthur Hewitt, Mrs. J. W. Langmuir, H. H. Love, Mrs. H. H. Love, Mrs. Vincent Massey, Col. D. H. C. Mason, Rev. Father Minehan, Hon. Justice Orde, Mrs. John A. Northway, Dr. Harley

Smith, William Stone, Mrs. John Walker and Dr. K. C. McIlwraith.

House Committee: Hon. Convener, Mrs. H. C. Cockshutt; Convener, Mrs. J. W. Langmuir; Vice-Convener, Mrs. Brefney O'Reilly; Mrs. A. J. Arthurs, Mrs. A. R. Capreol, Mrs. C. E. Calvert, Mrs. A. E. Dyment, Mrs. J. H. Godfrey, Mrs. John Hay, Mrs. E. Hay, Mrs. Hume Blake, Mrs. Alex. Laird, Mrs. J. B. McLean, Miss Nordheimer, Mrs. William Stone, Mrs. John Walker, Mrs. C. D. Warren and the ladies of the Executive Committee.

Honorary Secretary, H. H. Love; Honorary Treasurer, A. R. Capreol; Superintendent, Miss Edith Campbell.

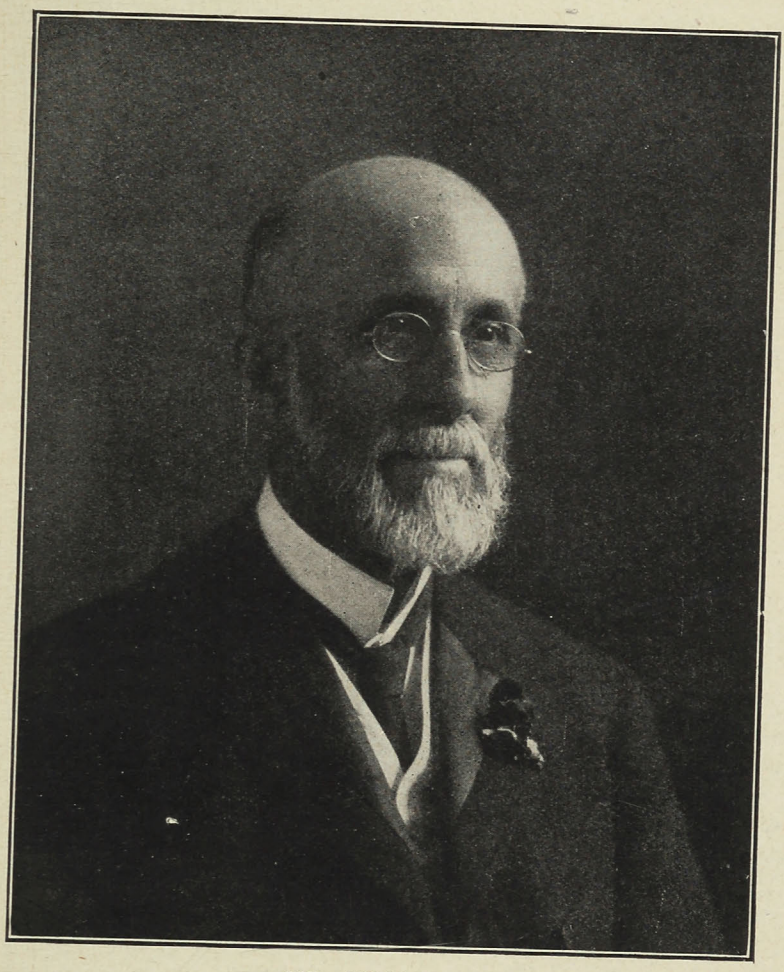
News Items

FIVE HOSPITALS CLOSED IN YEAR

Ten hospitals are being operated by the Department of Soldiers' Civil Re-establishment, according to the annual report tabled in the House of Commons in March by the Minister, Hon. Dr. H. S. Beland. The total bed capacity of those ten is 2,794. During the year 1923 five hospitals were closed —Sydenham Hospital at Kingston, Brant Hospital at Burlington, Ont.; Euclid Hall, Toronto; Jordan Memorial Sanitarium, Riverglade, N.B.; and Ste. Agathe Sanitarium, Ste. Agathe, Que.

On Dec. 31, 1923, there were on the strength of the department 3,744 treatment cases, of which 3,398 were in Canada, 116 in Great Britain, and 230 in the United States. Of the 3,398 in Canada, 3,298 were in institutions, the remainder being out-patients.

The grand total of admissions to hospitals by the Military Hospitals Commission and the department to the end of last year from July 1, 1915, was 143,637, and the total of clinical treatments was 1,258,376. The number of pension medical examinations carried out in Canada in 1923 was 39,110. There were 8,516 admissions to the hospitals in 1923, 8,635 discharged and 444 deaths. During 1923 there were 1,480 admissions of ex-service men for treatment for tuberculosis, of which 409 were primary admissions and 1,071 were readmissions.



MR. AMBROSE KENT

Elected a Member of the Board of Management, 1894
Vice-President in 1901, and has held the Office of President,
Toronto Hospital for Incurables, since 1903.

A total of 33,700 policies for insurance had been issued by the department up to Sept. 1, 1923, when the period for obtaining insurance under the Returned Soldiers' Insurance Act expired, and the total value of the policies is $75,000,000. The annual premium income is $1,390,000.

The net operating expense of the department in the nine months of 1923 up to Dec. 31 was $7,459,711.43, as compared with $13,300,534.86 for the fiscal year 1922-23; $17,614,937.58 in 1921-22, and $33,660,571.67 in 1920-21.

The total cost of pensions to Canada from April 1, 1916, up to the end of 1923 was $184,152,251.86, divided as follows: European War, $175,581,264.99; Northwest Rebellion, $209,095.08; Fenian Raid, $6,841.88; Militia Long Service, $2,467,075.79; Civil Government Flying, $992.22; Pensions Administration, $5,886,981.90.

There has been a steady reduction in the staff of the D.S.C., the total strength in 1919 being 8,126; in 1920 it was 5,779; in 1921, 4,886; in 1922, 3,823; in 1923, 3,094.

HOSPITALS PROFIT BY ROYAL MESSAGE

The sum of £800 received as the proceeds of the sale of gramophone records of messages to the children of the Empire by the King and Queen on May 24 last, will be distributed among the following institutions: Ontario, Hospital for Sick Children, Toronto; Quebec, Social Service Bureau of the Provincial Government; Nova Scotia, Children's Hospital, Morris Street, Halifax; New Brunswick, "Health Centre," St. John; Prince Edward Island, Children's Aid Society, Charlottetown; Manitoba, Children's Hospital, Winnipeg, and Children's Ward of the Brandon General Hospital (equal shares); British Columbia, fund for crippled children; Alberta, Junior Red Cross Hospital, Calgary; Saskatchewan, Children's Ward of the Tubercular Sanitarium, Fort Qu'Appelle.

The King and Queen expressed a wish that the profits from the sales in each part of the Empire should be distributed to children's hospitals or children's wards in general hospitals. Allocation in Canada follows recommendation of the Provincial Governments.

TILL TIME RETURNS A VERDICT ON THE COLON

Not so many years have raced away since the colon, to the average layman, meant nothing more than a mark of punctuation, and to physicians in general, a limbo lying just outside the known physiology of digestion. From the mouth to the ileocecal valve, science had marched with unerring tread—and stopped as though the valve were the great wall of China where progress ceased and mystery began. To this point, the chemistry of the body was known. This far, medical science could accompany the fuel that keeps the human machine working—but beyond, it had to shift for itself. Just as civilization, however, eventually broke through the wall of Chinese superstition, so did medical science bring to the long neglected colon the light of understanding. Investigation, experiment and research started an argument international in its scope. Doctors world-wide have taken sides on the usefulness or uselessness of the colon, and whether mankind would not be better off without it. Whichever way the question is eventually settled, doctors to-day unanimously agree that stern measures should be taken with this organ which is prone to function in a slip-shod manner. Corrective diets to make it work at least union hours should be applied, and this matter of correction is a job that can be approached in no half-hearted way—nor with half-hearted foods or laxatives.

With the growing understanding of the importance of the colon and its perfect functioning has grown an ever increasing appreciation among the medical fraternity of Kellogg's Bran, cooked and krumbled. The outstanding feature of this natural corrective is the fact that it is all bran. It is not a mixture, a breakfast-food combination making a number of ridiculous claims. It is bran—long known to physicians as a food which brings relief even in chronic cases of constipation. It is bran with all its cellulose—200 grains to the ounce. Every particle of Kellogg's Bran will absorb its portion of liquids, and by increasing the bulk in the intestine it stimulates better peristaltic action in a natural way. Doctors are generally agreed that only a 100% bran can be 100% effective. Kellogg's Bran by its proved results has given doctors a valuable ally with which to fight the use of habit-forming drugs and pills.

Kellogg's Bran has these three marked improvements over the old-fashioned kind: it is cooked, ready to eat; it is krumbled, which gives it a particularly inviting form; and it has a delicious flavor. In addition to these attributes, Kellogg's Bran is particularly well suited for use in cooking. It makes the *best* bran muffins, bran bread, griddle cakes and cookies. Patients who are familiar only with the flat, unpalatable taste of ordinary bran take pleasure in eating Kellogg's and follow their doctor's orders to the letter in eating it regularly. The careful checking of results over a period of time has led to a

Providence Hospital in Detroit, where Jell-O has been used for some years, the Superior (Sister M. Olympia) writes.

JELL-O has a flavor of home cooking—a delicate fruity sweetness—that is particularly tempting to invalids and convalescents. The clear colors and the pretty sparkle intrigue the appetite when all else fails. Jell-O is so light and splendidly nourishing that it may be included in even the most careful diet.

Because of the small cost and the simple preparation, Jell-O is always an economical dish. It is cheapest when you use the big box, the Institutional Package. Put Strawberry Jell-O on your trays tomorrow.

THE GENESEE PURE FOOD COMPANY OF CANADA, Ltd.
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concurrence of medical opinion that Kellogg's Bran as a corrective for the colon may be recommended with an assurance that the anticipated results will be attained.

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Many cases are on record showing that sickness and disease have frequently been the result of carelessness in the production of milk.

Fortunately, however, recent years have witnessed marked improvements in the methods of handling milk. In fact, one Toronto dairy—The City Dairy Company, Limited—has, since its inception, done everything in its power to safeguard their customers. They recognize what an important part milk can take in the maintenance and improvement of public health and act accordingly. The care exercised by them begins right at the source of supply: the cow. When the milk arrives at the dairy—a dairy equipped with the latest word in milk machinery—it is scientifically pasteurized in the Jenson Coil Pasteurizers. The processes of cooling and bottling are given the utmost attention by the City Dairy Company, Limited.

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