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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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Published in the interests of Hospitals & the Medical & Nursing Professions.

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TORONTO, CANADA

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Editorial

The Medical Staff and the Hospital

In the discussion of this subject we are including in the medical staff, not only the honorary or consulting staff, the indoor attending staff, the out-door staff, but all of the doctors who send patients into any hospital and who are allowed to treat them there. In the west, and in many country towns, hospitals are open to all reputable doctors; there the doctors are all on the staff. As the democratic idea grows we shall likely see practically all public hospitals open hospitals.

The honorary or consulting staff is usually an emeritus one, and ordinarily its members have no functions to perform. They have commenced at the out-door department, continued on the indoor staff, and have finally been relegated through age to the retired list. It would appear to me quite proper to eliminate this class of hospital doctors, particularly if they do not consult. There should be no objection to calling them honorary, however.

The Out-Patient Staff

In many hospitals having out-patient departments the custom has been to put young, inexperienced men in charge of the various divisions. This custom comes in for just criticism; for the type of patient who visits the out-patient department is often one who is suffering from the beginnings of disease, the symptoms and signs of which often require men of wide experience to elucidate, or is one suffering from some chronic complaint which has already baffled various medical men, and which requires the study of men who are expert in the line of diagnosis and who know well how to treat such cases.

Every man has not the gift of healing; and even while a patient is having his case investigated—which may require two or three seances—he ought to be given something to relieve the symptoms which are distressing him and for which he has sought advice and help.

Too often the older members of the medical profession look with a sort of mild contempt on the work of the out-door department, and consider it *infra dignitate* to accept a position in this department. They ought not to do so; for there is no better field for the exercise of a man's diagnostic acumen and therapeutic ability than among out-door patients.

As a rule, acutely-ill patients are admitted directly to the wards of the hospital as bed patients—their signs and symptoms standing out so prominently that a diagnosis is relatively easy. Once the diagnosis is made the treatment is often routine. It will thus be seen that no higher skill is required in the wards than in the out-door clinic, if as high.

It is important that men appointed to care for the patients who come to this free dispensary work shall attend regularly and be prompt. Too often we see patients wait an undue length of time for the appearance of the doctor. This is quite unfair. If a man find he cannot be present on his day or that he cannot be on time, he should secure a substitute so that the work may be carried on without delay. The hospital executive, if tactful, can usually see to it that some arrangement for supply can be made with his staff.

In dealing with cases of default it must be remembered that these doctors are working in the hospital without money and without price. The default can be remedied satisfactorily if the approach is made tactfully and in the proper spirit.

We look forward to the day when our medical men will be paid for their services to our hospitals; just as other professional men and officials are paid for their help. The laborer is worthy of his hire. Economic conditions in the professions are becoming such that its members must receive more than prestige and eclat for their work in hospitals.

The hospital executive should see that men serving in the out-door—indeed, in all departments—have proper personal accommodation in the way of cloak rooms, toilets and basins. The clinic should have all the necessary waiting rooms, dressing rooms, examining rooms—all apparatus and equipment needed for the examination and treatment of patients and for the administration of first aid. The hospital should provide, too, sufficient clerical, nursing, and orderly assistance. And the work of the clinic should be carried on in a business-like way,

not forgetting that the patient is a real bit of suffering humanity. Put yourself in his place. The staff should exercise due care in using hospital instruments and supplies. Delicate and costly apparatus should be used with the same care by the doctor as though it were his own.

The Attending Indoor Staff

In the larger hospitals the unitary system of organization should prevail; and so far as possible in the smaller places—in so far as public ward patients are concerned. This means that one man is responsible for the work in each division: medicine, surgery, obstetrics, etc. To make this head responsible for the corresponding work in the out-patient department would appear to be logical. These chiefs of services with the medical superintendent should form a medical board which may meet regularly and discuss medical and nursing administration. When nursing topics are up for discussion the superintendent of nurses should be called in. Reports of these conferences should be forwarded to the Trustee Board, not pigeon-holed for seven years as happened not long since in a Canadian Hospital.

Members of the attending staff should serve continuously until the age limit, providing service and conduct are satisfactory. They should be given two or three months respite during the summer; their places being taken by competent assistants. These men should attend the hospital at a certain hour daily and remain long enough to see that all patients under their care are being properly studied and treated. Any grievances should be taken up with the Administrator at once.

The staff can do much for the hospital trust by painstaking, conscientious work, kindly consideration of patients and of patients' friends. They can be of great service in the teaching and training of internes and nurses, teaching them correct methods of approach, the skilled use of the five senses, and thoroughness in carrying out their responsible duties.

The Interne Staff

These young men, in the larger institutions, should serve in rotation on all services. They may then focus attention on one particular department, and later advance to the resident staff—if the resident system is in vogue; then on to the out-door or to sub-positions on the indoor staff. Smaller hospitals will have to modify this arrangement, depending on the size of their institution, and the amount of money they may have to spend.

It would be well for all young graduates in medicine to receive a practical training in every type of hospital, if even for a short time—general, mental, children's, orthopedic and the like. Internes are usually provided with room, board, laundry and white suits. In certain hospitals they are now receiving small salaries. Hospitals should seek to choose men of the best type, men who not only know their medical work sufficiently well, but men of kind hearts and gentle manners.

Standardization

Since the advent of what is not very properly called "standardization," additional work has fallen to the medical staff. Besides the work of diagnosis and treatment they are expected to hold regular

meetings to discuss medical administration, review work done, confess their mistakes, to see that proper histories are made of the ailments of their patients; that progress notes are kept; needed laboratory and X-ray work done; hold consultations before undertaking serious operations; secure as many autopsies as possible; and refrain from the secret division of fees.

Why the onus of fee-splitting should be placed on hospitals has always been a query to many. Is it not time that this phase of hospital standardization should be removed from the jurisdiction of the hospital and taken in hand by the medical societies, the College of Physicians and Surgeons or by the profession at large?

In spite of the criticisms one hears of hospital standardization, the reputations of hospitals generally have been greatly enhanced by the carrying out of several of its recommendations. This has been due to the team work of the medical staff. By consultation many unnecessary operations have been left unperformed; and many necessary operations have been more carefully performed; and the writing of histories as naturally led to closer study of cases, with the result that treatment has been more intelligent and successfully administered. The regular staff meetings have also created an *esprit de corps* among its members, unknown in pre-standardization days.

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Selected Articles

WHAT CANADIAN HOSPITALS DID IN 1923

By Malcolm T. MacEachern, M.D., C.M., Chicago,
Formerly General Superintendent, Vancouver General Hospital, now Director, Hospital Activities, American College of Surgeons.

The care of the sick has become a well recognized community responsibility in every part of Canada. There is to be seen an ever increasing interest in this matter and more time and study is given by lay, professional and state groups to the problems connected therewith. The year just closed witnessed a better working together of all for the common cause, and with this co-operation has followed great accomplishments in the field of hospital service.

Public Knows More About Hospitals

During the year there has been a gradually increased amount of publicity given to hospitals. This has been of an acceptable educational nature. National Hospital Day has been, no doubt, responsible in a great measure for stimulating a campaign of education of the public as to hospitals, and in laying down the procedure or suggestions for its successful carrying out. The hold which this movement has taken on the people generally was well illustrated when at Glace Bay, a mining town in Cape Breton, Nova Scotia, the mines closed down for the afternoon on that day and some 8,000 citizens participated in the programme arranged by St. Joseph's Hospital, an institution of 107 beds. Instances similar to this were repeated all over Canada.

From my knowledge of the Canadian hospitals I know they are sincerely grateful to the National Hospital Day Committee and *Hospital Management* for making this day possible and promoting it so successfully. Through an all-round better

understanding of the hospital functions and its value in the community the administrator benefits through a greater appreciation of his difficulties when presented to authoritative bodies.

A Year of Greater Efficiency.

Advances have been made during the year in every phase of hospital activities. Through better medical and nursing services and business methods the patient has secured more efficient diagnosis and treatment; through a closer working together of the superintendent and staff with the attending doctors and the board of trustees there has been brought about a much more definite understanding of each other's problems in the daily routine. This is an important factor, not only in promoting good co-operation, but also in bringing about a better co-ordination of the various services and functions which go to make up hospital management. There has been introduced improved methods of administration, more up-to-date equipment, better organized diagnostic and therapeutic departments under more competent supervision. There has been greatly increased attention given to end results which, after all, is the only true way to appraise the hospital service rendered.

Hospital Legislation.

A few years ago we heard but very little of hospital legislation; in fact, it is only in recent years our governing bodies have taken a real interest in hospitals.

There is very little Federal legislation or interest in hospitalization outside of the military, marine and quarantine institutions. I regret that the Federal Government does not include an active hospital bureau in its already well organized and efficiently managed health department at Ottawa.

The various provinces each have their own hospital and health legislation which, without exception, is of a very sound character and is working out well. In this respect the Hospital Act of Saskatchewan is an outstanding example. Saskatchewan and Alberta have good legislation.

Legislators appreciate the views and information supplied through the various hospital associations. Only through such an organized body as the hospital association can uniform data and opinion be secured.

Hospital Associations

There are at present five active hospital associations in Canada. These, in the order of year of formation are: British Columbia, Saskatchewan, Alberta, Manitoba, Ontario. The first four mentioned held two-day conventions in 1923. The following subjects received major attention: hospital financing, especially the question of provincial and municipal aid, workmen's compensation, contract work and cost accounting in hospital; purchasing; publicity; hospital standardization and nursing standards.

In December the Ontario hospitals held an organization meeting in Toronto, when a very promising association was formed under the leadership as president of a great hospital veteran, Col. W. M. Gartshore, trustee, Victoria Hospital, London. The Association is most fortunate in having a very active secretary in Dr. Fred Routley, medical director for the Canadian Red Cross of Ontario. Dr. Routley has been devoting his attention for some time past, as he is also at present, to the hospital needs of the outlying districts.

I cannot emphasize too strongly the value of such associations. Every Province in Canada and every State in the Union should have a well organized active hospital association. All hospital administration heads of departments, trustees and others connected directly or indirectly with the work, should be members of a provincial or state association and attend the annual convention. Further, every member of the provincial or state association should be a member of the national or international, and thus enjoy the privileges of the entire hospital field. Without the national or international contact we become markedly local or provincial in our views and our activities and thus retard the best kind of development in our institution. Membership in both associations is within the reach of all and the benefits that follow are legion.

Hospital Standardization.

The most satisfactory progress has been made in hospital standardization by the American College of Surgeons in its continent-wide movement for better hospitals. A complete survey of active general hospitals of fifty beds and over in Canada was made during the year, and the following is a summary of the results:

NUMBER OF HOSPITALS MEETING THE MINIMUM STANDARD

Canada	100 or more Beds			50 or more Beds			All Hospitals over 50 Beds		
	No. of Hospitals	Approved		No. of Hospitals	Approved		No. of Hospitals	Approved	
		No.	Per-cent.		No.	Per-cent.		No.	Per-cent.
Alberta	7	7	100	4	2	50	11	9	81.8
British Columbia	6	6	100	7	4	57.1	13	10	76.2
Manitoba	6	6	100	2	1	50	8	7	87.5
New Brunswick	1	1	100	8	8	100	9	9	100
Nova Scotia	3	3	100	8	8	100	11	11	100
Ontario	25	16	64	31	13	40	56	29	50.9
Prince Edward Island	0	....	.....	3	3	100	3	3	100
Quebec	11	9	81.8	9	3	33.4	20	12	60
Saskatchewan	5	4	80	7	4	57.1	12	8	66.7
Totals for Canada	64	52	31.8	79	46	58.2	143	98	68.5

The hospital, nursing and medical professions and the public generally are showing an ever-increasing interest in the movement. In Canada the following reactions have been met generally: First, the people are demanding to go to the approved hospital when ill; second, young women contemplating training for nurses show noticeable preference for the recognized institution; third, interns invariably decide to take their training in the approved hospital; fourth, governmental bureaus, municipal departments and philanthropic organizations and individuals generally refer to the Approved List of hospitals when making appropriations. These reactions are only natural when one realizes that the standardized hospital means better organization, better equipment and personnel, as well as proper check-up and control within as to the quality of service rendered.

Probably the most outstanding feature of the hospital standardization movement in Canada is the fact that 100 per cent. of the institutions in the Maritime Provinces surveyed are on the Approved List, and have not only fulfilled the requirements in all cases but are going far beyond them. The smaller hospitals of this section, or those under fifty beds are making an incessant demand on the American College of Surgeons to extend the survey to them.

As a result of the 1923 survey, when follow-up work was urged and set forth in an illustrated lecture by the writer, two hospitals have established social service departments for the purpose primarily of "follow-up" of patients discharged. One of these hospitals, St. Joseph's, at Glace Bay, Cape Breton, Nova Scotia, has a capacity of 107 beds, and the other, Hotel Dieu, Chatham, New Brunswick, has 60 beds. Hotel

Dieu, Campbellton New Brunswick, a hospital of 80 beds, has had a good follow-up system for the past two or three years.

The small hospitals of Canada have thus made a wonderful showing along the lines of standardization during the year. The increase in the number attaining the approved list has been over 16 per cent.

It is a great community pride when the name of their institution appears in the continent-wide list of approved hospitals each year. No hospital can now afford not to be on the list. However, it must be remembered at all times that the hospital standardization movement is a voluntary one, free entirely from any attitude of compulsion or dictation, and further, that the entire service is given without cost to any institution.

Hospital Financing.

Canadian hospitals to-day may be divided into five groups so far as financial support is concerned. These are—public, private, municipal, provincial and federal. The private hospital takes care of its own finances from earnings. The municipal, provincial and federal institutions are charges on the budgets of the municipality, province and Dominion respectively. The public hospital depends mainly on five sources: (1) fees from patients; (2) earnings from hospital departments; (3) municipal per diem aid or grant; (4) provincial per diem aid or grant; (5) donations and endowment revenue. In most cases, however, these sources are quite inadequate to meet the whole cost of operating. Supplementary revenue must be found either from increased grants, community financial campaigns or other sources.

Hospitals find valuable assistance in collecting their accounts through the workmen's compensation boards of the various provinces, who generally pay $2.50 to $3 per day for public ward service. There are excellent workmen's compensation boards or allied arrangements for industrial cases in each province. Generally speaking the doctor, the patient and the hospital are well satisfied with the arrangement. Adjustments, however, must naturally be made from time to time and friction may arise, but usually this is easily removable. In British Columbia the Provincial Medical Association during the year has been studying the problem of voluntary health insurance, a scheme for extending the principles of the Workmen's Compensation Act to all persons having an income under

a certain amount. The scheme to which they are directing their attention will, amongst other advantages, provide for all non-pay cases in the hospital, thus wiping out the main cause of deficits. At the same time it will leave with the patient the choice of doctor and hospital when ill.

Interns

Much greater interest is manifested by hospitals generally in the intern problem. Hospitals realize that if they want this service there is an obligation to fulfil on their part. The Council on Medical Education of the American Medical Association, through its hospital and intern department, has given very definite information as to what are the fundamental requirements for a proper intern service in a hospital. If we can give the intern a well organized service properly supervised and experience competently directed and augmented by more advanced clinical instruction, then he will not only benefit most himself but will give the hospital a much more satisfactory service. While there is a scarcity in the number of interns available, yet this number can be materially increased by paying more attention to the experience they are getting from the hospital, and every time we encourage an intern to spend one more year in the hospital we are thus increasing the available supply by one.

Interns and Open Hospitals.

It has been very difficult to retain an intern service in the open hospital in Canada, due to the fact that he has a difficult position to fill and often may be left to go his own way alone, owing to the very nature of the hospital. Here each doctor attends his own cases and it is impossible to attach him to any particular service.

The best solution to the problem of the intern in the open hospital in Canada is that which has been worked out by the Medical College, University of Manitoba. The college selects a number of hospitals where they can send their interns and keep them under direct supervision. It may be an open, semi-closed or closed hospital. It must be approved by the American College of Surgeons and meet the minimum standard requirements as to organization, procedure and facilities for diagnostic and therapeutic purposes. Further, it must be approved by the Medical College as a satisfactory institution for interns. An extra-mural professor is appointed in the hospital

where the interns are going and it is his duty to look after them while they are attached to that hospital. He must supervise their experience, instruction and service rendered to the hospital. This is well illustrated in the case of the Vancouver General Hospital, an open institution of approximately 1,000 beds and over 200 attending doctors on the staff. Here a group of interns from the Manitoba Medical College are securing their internship under the direct supervision of an extra-mural professor in that city and that hospital, who has been appointed by the Medical College, University of Manitoba. It is his duty to supervise these interns as to service received and service rendered, direct their experience and provide clinical instruction in the form of clinics or lectures of a more advanced applied nature. The choice of professor has been very satisfactory to the hospital also, who in this case is Dr. J. M. Pearson, a leading internist and one who has always taken an active interest in the hospital life of the intern. The hospital indeed is glad to have him assume similar supervision over all the interns, regardless of what school they come from.

Nursing Applicants Increase.

Year after year the nursing profession advances, keeping well abreast of modern day requirements. Higher standards have brought in every instance an increased number of applicants to train as nurses. I do not know of any school, large or small, which to-day is finding it difficult to secure satisfactory applicants for training.

Nursing in Canada has been greatly assisted by the passage of splendid registration acts in each province, providing for more or less uniform standards of study and instruction, and encouraging competent training school inspection. Such inspection has not only proven valuable in helping the training schools to develop better teaching methods and improving health conditions, but has had a beneficial influence on the hospital in many ways. The visit of the inspector and her sojourn for a day or two brings her into contact with the various groups in the hospital, especially the trustees and medical staff. In this way she can be of constructive assistance to the hospital, especially if she herself has been a superintendent.

The affiliation of the training school in the smaller hospital with that of the larger has also proved a great advantage to the former.

Nursing in Canada is thoroughly organized, commencing with the local societies, then the provincial and finally the Canadian National Association of Trained Nurses, which is very active and doing a great work. With it is affiliated the provincial association and, in fact, this splendid, complete organization is one of the factors which is responsible for the high standard of efficiency that nursing in Canada has attained.

Dietetics of Greater Importance.

This branch of hospital service is receiving increased interest and attention each year. It is recognized as having an important bearing on the success of the institution from economic and scientific standpoints. The dietetic department until quite recently was regarded chiefly as an administrative department, but in the last few years has assumed an important place in the more scientific or therapeutic phase of the hospital. Hospitals fully appreciate that a well organized department of dietetics under a competent dietitian is essential for a properly balanced service.

The dietitian has also become an important factor in the hospital. In her triple capacity as supervisor, teacher and scientific worker, she must manage her department economically and efficiently. The numerous activities bring her into close relation with all the other departments of the hospital. Her latest and most scientific relation is that which has been established with the laboratory worker through recent advances in blood chemistry, metabolism, insulin and diet-therapy. Many of the well organized departments in the larger hospitals offer post-graduate courses to pupil dietitians from the various colleges. This has assisted very materially in the training of hospital dietitians. The problem of teaching dietetics in the small hospital is being solved by such co-operative arrangements as travelling instructors or through the assistance of domestic science departments in technical schools and colleges when available. Dietetics, theoretical and practical, now form an important part of the training school curricula.

Social Service Grows.

In 1923 a few additional social service departments were opened in different hospitals throughout the Dominion. Many of the smaller institutions in Canada are making a serious and successful effort to establish such a service. We recognize more than ever during the present day that we cannot separate

the social aspect of the patient from the scientific findings and requirements. Hospitals believing, as they do, that follow-up work is entirely essential for the appraising of their service rendered, find that this can be best promoted through the social service department in charge of a competent, trained worker. In her capacity as such, the trained worker co-operates with the doctor through the hospital, the dispensary or his office, and the patient is properly and scientifically followed up after having been treated in the institution. In this manner only are we able to judge the results of medical treatment administered.

The social service department is being used in many instances for the affording of experience to nurses in training. The nurse in her third year should have a few weeks of social service experience under the direction of the trained worker or, if this is not available, with the district nurse. No nurse in training should graduate without this experience; in fact her training is not well rounded off unless she has an opportunity to study the social aspect of the patient before, during and after treatment. Only in this way can she advantageously adapt her nursing knowledge when practising her profession. Some hospitals have made arrangements for this branch of work to be carried on by existing agencies in the community, which has been quite satisfactory in most instances.

Insulin.

The discovery and development of insulin by Banting and his co-workers in Toronto, has been of intense Dominion-wide interest. Hospitals have co-operated wonderfully in providing the necessary facilities for administration. Many very excellent clinics have been established during the year in connection with the leading hospitals. The results from its administration have already been marvellous. It is no doubt regarded as one of the greatest scientific discoveries known in medicine. Let us urgently hope that all our hospitals will do everything possible to assist these scientific workers in making progress in their further investigations. Each hospital can do its share to help by recording carefully and accurately such data as will be of worth to the scientists. It is in the hospital that reliable data should be found. In this way at least, hospitals can co-operate in the development of not only this discovery but others that are yet to come. It is gratifying to note that most of the provinces and municipalities have made provision for the

supply and administration of insulin possible to those who cannot afford to meet the expense arising therefrom.

Physiotherapy Proves Worth.

Physiotherapy is a rapidly developing therapeutic agency comprising the following types of treatment: massage, electrotherapy, hydrotherapy, heliotherapy and mechantherapy. The direct value of physiotherapy rests chiefly in the hastening of convalescence and making the results of treatment more permanent in nature. Indeed it is a very important factor in the reducing of the days' stay of patients in the hospital. A number of the larger hospitals in Canada have this therapeutic department, but not as a general rule developed to the extent of the broadest range of treatment as indicated. An efficient physiotherapy, hydrotherapy, heliotherapy and mechanotherapy. The equipment, and should be under the supervision of a competent medical director with the necessary trained workers in each service of the department. All hospitals should give this subject serious attention during the coming year.

Greater Progress Forecast.

The attainments in the Canadian hospital field during 1923 should act as a stimulus for greater progress and development in 1924. The opportunities for service, teaching and science, are without limit and await initiative and leadership. Primarily, the hospital must be the best place in the community for the patient, where medical science with its background of service can be rendered at all times. In addition, every hospital should be a teaching and educational centre for doctors, nurses, hospital employees and the public generally, as well as an aid to scientists, encouraging their work by supplying material and accurate data to assist them in their investigations and the promotion of scientific medicine.

Finally, with all this, keep the hospital "human," receiving and treating the patient as a member of a great family living in an atmosphere that savors of kindness, sympathy, interest and personal touch, resulting in the most comfortable and easy adjustment to environment.—*Hospital Management.*

HOW TO MINIMIZE HOSPITAL FIRE RISK

THOMAS J. DRENNAN, FIRE COMMISSIONER, NEW YORK CITY.

Many fires in institutions can be traced to defective chimneys, poorly installed stoves and furnaces, defective electrical equipment, careless handling of inflammable liquids, spontaneous combustion in accumulations of rubbish, smoking and carelessness with matches. It is, therefore, essential that the management of such institutions should realize the seriousness of the situation and contribute to the fire prevention measures by maintaining safe housekeeping conditions.

The most practical provision that can be made for egress in institutional buildings is an arrangement for moving occupants rapidly and in an orderly manner horizontally through fire walls or fire-resistive corridors, or across open bridges, to buildings or sections which are safe. Where buildings are large, they can be subdivided by standard fire walls equipped with automatic fire doors, thus dividing the building into two or more separate sections, with little danger of fire communicating from one section to the other before all occupants are safely out.

With adequate egress facilities come the education and organization of those responsible for fire safety, the provision of adequate alarms and systematic attention to fire and exit drills.

WATCH YOUR CLEANING MATERIALS.

Great care should be taken in handling of gasoline for motor-driven ambulances, trucks or pleasure cars. Gasoline should be stored in buried and protected tanks and never handled in open containers. Gasoline should not be used for cleaning purposes, especially inside of the buildings. Many of the metal polishes for brass work, ambulances and the metal work in buildings are largely composed of gasoline and benzine and are highly inflammable. Naphtha and benzine used as solvents for rubber cement applied to the mending of rubber gloves, hot water bottles, etc., are dangerous and should be excluded from buildings occupied by patients. The same restriction applies to oils, paints and varnishes, which should be stored in isolated buildings. Linseed oil should not be used for oiling and polishing floors, but mineral oil compositions, which are safer, substituted.

Cotton, wool, gauze, flannelette and bedding should be stored away from spark dangers.

Some institutions have motion pictures for the patients at frequent intervals. The ordinary type of film ignites very easily, burns rapidly and gives off a stifling smoke. Only approved machines properly installed in fire-resistive booths and attended by licensed operatives should be allowed. Articles made of pyroxalin plastic, commonly called celluloid, such as toilet articles, picture frames, toys, match trays, lamp shades and candlesticks, etc., should not be permitted inside these institutions.

Metal cans should be provided for rubbish and soiled cotton waste. All rooms in constant use should be swept daily and any accumulation of combustible material in basement and attics should be removed at once. Especial attention should be given to the removal of papers and other packing material from grocery store and supply rooms. All lockers and closets should be frequently inspected to prevent accumulations of old clothing and other combustible material.

Wherever steam pipes are found in contact with or close to woodwork of floors and walls, they should be removed or the woodwork protected. The danger lies in the heat of the steam pipes converting the wood into charcoal, which takes fire spontaneously.

Alcohol and kerosene heaters should be kept clean, filled outside the buildings and used only when necessary. Electricity or steam is much safer. Where fireplaces are used, they should be carefully safe-guarded; close-fitting screens should be provided and under no conditions should the hearths be placed over wooden floorings. Bedding should never be aired or dried before an open fire or close to a stove. Where rapid drying is desired, circulation of air by a fan is the safest method.

Clothes dryers should be of metal throughout and steam pipes should be protected by wire screening. Flames in gas mangles should be guarded. Gas irons should not be permitted. Pilot lights should be installed in circuits to all electric irons and current should never be left on when irons are not in use. Non-combustible stands with at least six-inch clearance should be provided for irons when not in use.

Twisted Wires a Source of Danger.

Although electricity is the safest form of lighting, it should be borne in mind that excessive voltage will break down insulation and fuses must be properly installed and

maintained to prevent overloading. Kinks in wiring will also break down the insulation. Gas-filled lamps become hot enough to ignite woodwork, paper or other combustible materrial with which they may come in contact. Wherever such danger exists wire lamp guards should be used. Lamps hung on drop cords should not be tied or twisted or allowed to come in contact with gas pipes, nails or other metal.

Safety matches should be used in preference to the "striking anywhere" type and metal friction lighters should be used wherever possible for lighting gas lights and ranges. Irresponsible patients should not be allowed to have matches in their possession. Smoking in bed should be absolutely prohibited.

Rubbish, waste paper and soiled dressings are frequently burned in open fires in the yards. Because of the danger from flying sparks such material should be burned under boilers or in properly constructed incinerators.

In the dark, or smoke, or under panic conditions, passage through narrow corridors may prove difficult or impossible. Corridors should be wide enough to accommodate all who will use them at one time under any condition. They should be kept absolutely clear at all times, especial attention being given to the removal of wheel chairs, spare cots and other obstructions which are apt to be left temporarily in the corridors.

All officials, physicians, nurses, attendants and employees should be carefully instructed regarding common fire hazards, the use of extinguishing equipment and the method of sending in a fire alarm. In giving such instructions especial attention should be paid to the teaching of new employees who are frequently overlooked.—*Hospital Management.*

HOSPITAL STANDARDIZATION FROM THE STANDPOINT OF A HOSPITAL SUPERINTENDENT.

Louis H. Burlingham, M.D., Superintendent of Barnes Hospital; Administrator, St. Louis Children's Hospital.

In considering the attitude of a hospital superintendent to the programme of standardization of the American College of Surgeons, let us take first the relation of the superintendent to the hospital as a whole. By hospital superintendent I have in mind the executive head of a hospital, whether man or woman, member of a religious order, nurse, layman, or doctor.

I believe that the word that best describes his function is that of co-ordination. In some respects, certainly in his own specialty, he may need to be a leader, but if the hospital has as heads of all departments persons of the proper calibre, his chief work is to so co-ordinate their activities that the result is an efficient whole. I like to think of a hospital, not as an organization with a single leader or a single driver, but with the heads of all departments, surgeons, physicians, obstetricians, the laboratory men, the specialists, the superintendent of nurses, the housekeeper, the dietitian, the mechanic and the superintendent, all pulling ahead harmoniously, each in his own line, doing his best and helping the others in all ways to do the best work that is possible. It is true that the trustees have the ultimate responsibility vested in them, but I cannot conceive of a board of trustees who would not prefer to have a hospital functioning in this way rather than in any other. To use a homely illustration, to think of the personnel of a hospital as a spirited team of many horses, all pulling steadily ahead, rather than irregularly and in different directions, and requiring a strong hand to lead or drive them.

Attempts are being made to standardize laundry practice by the Laundry Owners' Association; the purchase of supplies has been standardized by the New York Bureau of Standards and Supplies and by Hospital Councils, the intern problem is being standardized by the American Medical Association, floors and surgical dressings by the American Hospital Association, social service by the American Association of Social Workers, and nursing by the various nursing organizations. Can there be anything more logical than the efforts of the American College of Surgeons to establish standards for the more perfect functioning of a hospital? Is there any standardization which will contribute more to the general welfare of patients than this?

You are all doubtless familiar with the minimum standards which have been in force since 1919. I have never heard a valid objection to any one of the requirements, though there may have been questions as to the possibility of carrying out some of them. I wish to enumerate them briefly for the purpose of approval:

1. An organized staff. There can be no question that the efficiency of the staff of a hospital is increased by organization, as is true in business or any other human activity. Is it not

true that an improvement of an organization whether of the individuals or the quality of work that they do always has beneficial results?

2. That staff membership be limited to competent, worthy and ethical doctors, and that there be no fee-splitting in any way, shape or form. This regulation is clearly for the benefit of the patients and so for the hospital.

3. That regulation of the professional work of the hospital be brought about by rules adopted by the staff and the governing board of the hospital and providing for monthly staff meetings and a review by the staff at regular intervals of the work in the various departments. This provides for a high standard of work throughout and enables the staff to check up the work that is being done by its members and to profit by any mistakes. In business the management calls for audits and inventories at regular intervals. Can a hospital whose end product is human life do less?

4. That accurate and complete case records be written for all patients and filed in an accessible manner. This is of vital importance to the individual patient, as it greatly aids him in the proper study of his ailment and will be of great value to the patient on a subsequent admission. In my own experience I have known of a patient who, so far as his history and physical examination were concerned, would have required operation, but who was saved an unnecessary and dangerous operation by referring to his previous record in the hospital. It is of inestimable value in the study of a series of cases for statistical purposes, in regard to diagnosis or treatment.

5. That clinical laboratory facilities be available for study, diagnosis and treatment. While history and physical examination are of prime importance, if the laboratories are not employed many diagnoses cannot be confirmed and still others cannot even be made. Would an industrial concern purchase the metal entering its product by its general characteristics, or would it require a chemical analysis from its laboratories? Would it buy coal without knowing the number of thermal units per pound? I am referring to business so frequently simply to emphasize the point that the procedures the American College of Surgeons is advocating are in accord with clear, level-headed thinking.

But what has all this to do with the superintendent? The real hospital superintendent to my way of thinking must pre-

serve the proper balance in himself between idealism and practicability. He must first of all be an idealist so far as he himself is concerned; his first ideal is that of service—service to the hospital field, service to the community, service to his hospital, and above all, service to the patients in his hospital. If he is not actuated by these ideals he falls far short of fulfilling his proper function. He must also be practical, as he has to see to it that the business end of the hospital is kept at the highest point of efficiency and that the physical needs of the patients, doctors and nurses are supplied.

There can be no argument that the standards set by the American College of Surgeons contribute markedly to the attainment of ideals in two respects, i.e., in the improvement of the staff, and in the care given the patients. To carry them out may militate against the hospital superintendent's practical side, for several of them—such as the proper maintenance of laboratories and the keeping of records—call for the expenditure of money. But I contend that this conflict between idealism and practicability is not real if followed through to its logical conclusion. The practical superintendent wishes his beds kept full; for this keeps down his overhead, as it is almost as expensive to keep a plant going at sixty-five per cent. of its capacity as it is at full capacity, and as has been well said by a very successful business man, "It is the twenty per cent. additional that keeps a business going." If the public is suspicious of a hospital and lacks confidence in the staff and the work of a hospital, patients will come there only as a last resort. If, on the other hand, the public has full confidence in the staff and the work that the hospital does is of high grade, the public will flock to its doors. This will result in larger revenue directly from the charges for the care of patients, and indirectly from the gifts of grateful patients and from those who have heard of the hospital through them. It goes without saying that a prospective benefactor is not likely to give money to a hospital unless that hospital bears a good reputation both as to its staff and the work that it does. We have all seen these propositions completely proven in real life.

Therefore, I hold that the idealism of a superintendent will cause him to do all that he can to further the programme of the American College of Surgeons as this will make his hospital one of high calibre and so of the greatest value to its patients. His practical side will cause him to pursue the

same course, for it is bound to give better results so far as patients are concerned, in a better standing for the hospital, more patients, more income, opportunities for expansion, and greater service to the community.—*Selected.*

SOME PROBLEMS OF NURSING IN SMALL HOSPITALS*

By Mary A. Land, R.N., Mount Vernon Hospital, Mount Vernon, N.Y.

There are individuals who "rush in where angels fear to tread," and, not content with the difficulties of hospital management, take upon themselves the added problems of a training school in the so-called small hospital. Generally considered, the small hospital is an institution of from fifty to one hundred beds, averaging forty to seventy patients daily.

The chief function of every hospital to-day is service to the patient which includes adequate care and every possible attention to his physical and mental comfort. A hospital of 100 beds has an opportunity to train nurses, provided justice can be done the student nurse. Almost within the memory of every one present, a complete change has taken place in the attitude of the public toward the hospital. It is no longer regarded as a place from which everyone should stay away, if possible, but rather an institution essential to public service and to human welfare. The pendulum has swung the other way, and hospitals are usually overcrowded, taxing to the utmost the bed capacity and nursing service.

Boards of Managers Need Educating.

With this situation and the proposition of maintaining a training school, one of the hardest problems to solve is educating the board of managers and the public of the community as to what is due the student nurse. To many of the laity, even yet, maintaining a training school is providing nursing care at small expense to the hospital. In the mind of the public, nursing itself is generally understood to be carrying out the doctors' orders. They think of the education of the nurse as something entirely different from that of preparing students for other fields, and, therefore, cannot see the need of supporting schools for nurses as other schools are supported.

*Read at New York State Nurses' Association, Buffalo, N.Y., October, 1923.

More active and interested training school committees can help materially in this education and will also be of practical service in raising funds for training school purposes. In order to adequately care for the sick, we must abandon the attempt to assign to pupil nurses exclusively the task of caring for the patients in general hospitals, and this brings to us the problem of the graduate group for general duty.

The personnel of this group is constantly changing, for the majority seem to be affected with a restlessness which does not permit of gathering moss. Individual members are a great joy. They adapt themselves to local conditions, are interested in the student body, and speedily become part of the hospital family. However, as every hospital and training school superintendent knows, many are not of this type; they feel no loyalty to the hospital, physician or patient, and if anything unpleasant occurs, leave at a moment's notice with no consideration for patients or hospital. The necessity of employing graduate nurses for general duty adds greatly to the problem of supervision, for they come from different training schools and have different methods for the various nursing procedures, which often prove disastrous to the young student nurse. Almost all schools employing graduate nurses desire to give the student nurse the minimum of night duty but, unfortunately, it is difficult to obtain sufficient graduates to cover this service.

The problem of the special nurse is a big one. Physicians often ask the question, "What is the matter with the special nurse?" Investigation bring conclusions which are far from new. Some special nurses are beyond praise, taking excellent care of their patients, causing no friction in the hospital, and forming a splendid example to students as "a fine type of private duty nurse." On the other hand, there are nurses so negligent or so disqualified by personal characteristics that patient and institution hope they may never have to see them again. We are all familiar with the nurses who report late on duty and leave early if possible, expect personal telephone calls during duty hours, pay no attention to their professional appearance, spend a great deal of time in the chart room or corridors talking and laughing, and frequently criticize the institution and its administration even while they are registered for "hospital duty only."

They do not try to conform to hospital routine regarding special diets, care and use of hospital linen and equipment,

and yet are the first to complain to physicians and patients that they cannot obtain certain supplies or articles of food.

Personally, I think that the hours of duty should be restricted from 7 a.m. to 7 p.m., as "night specials" are almost extinct, and frequently special night nurses of whom one does not approve are employed, rather than leave critically ill patients to general floor care.

That proper instruction be given the students is one of the chief problems in the training school of the small hospital. Even where funds are provided, it is difficult to obtain qualified instructors, as the demand exceeds the supply, and the field in the large schools offers more opportunities, and is of greater interest to the instructor.

Place of the Central School.

In Westchester County, five schools have combined to form a central school to give the theoretical work of the four months' preliminary course. This central school has been given the privilege of using the educational building at Bloomingdale Hospital, White Plains, and beginning with the September class, the students have spent the mornings in their home schools and from 2 to 5 p.m., five afternoons a week at the central school. The teaching is now being carried on by a qualified instructor, and in the near future we hope to extend the work and have an additional one.

Many situations found in small hospitals are due to the difficulty of adjusting the conflicting claims of hospital management and nursing education where no special fund or endowment exists for training school purposes. However, progress is being made, and hospital directors are realizing more every day that the school of nursing is an educational institution and must be maintained for the purpose of providing the community with the services of competent nurses for the care of the sick and the carrying forward of the campaign for public health.—*The Modern Hospital.*

A YOUNG YUKON HOSPITAL

Besides the hospitals in Dawson, capital of the Yukon, there is one at White Horse, at the head of navigation and another at Mayo on the Stewart River.

The Mayo hospital now has its complete staff. Arrangements in connection with the hospital management and service have been completed during the visit of Gold Commissioner

Mackenzie here the last few days. The hospital is under direction of a local board. At the head of the staff is Miss E. McDougall, a graduate nurse of the Medicine Hat General Hospital, with wide experience in other hospitals. The nursing staff includes Miss Margaret A. Kinney, a graduate of St. Joseph's Hospital, Victoria, B.C., who was a member of the staff of St. Mary's Hospital at Dawson, the last three years. James Burns, a graduate nurse of Guys Hospital, London, with extensive experience in the war and elsewhere, also is a new member of the Mayo staff. He recently arrived in Mayo from Vancouver. An orderly and a cook complete the hospital force.

Identified with the hospital work is Dr. Sievenpiper, recently from Vancouver. In case of serious operations he has the assistance of Dr. Randy McLennan, who devotes his time mostly to other work than that requiring the service of a physician. Dr. Sievenpiper is acting this winter in the place of Dr. W. W. Chipman, who recently left for the outside for the winter.

After a conference between Mr. Mackenzie, Yukon Councillor Ferrell and the hospital board and management it was decided it would not be possible, chiefly owing to lack of funds, to enlarge the hospital this year. More accommodations are desired, but a way to find funds for increasing the size of the building did not present itself. The gold commissioner hopes to be able to have funds by the next session of the council to make some improvements to the hospital, especially in the way of enlarging the living and nursing accommodations. The hospital also is in need of an X-ray machine and a large dressing sterilizer. The dressings are now sterilized with a small device heated over a stove, and the hospital has no X-ray equipment whatever, while there is nothing of the kind in the entire Mayo district. With so much mining in the district it is likely that accidents may occur at any time in which the X-ray machine would prove invaluable in treatment, and the opinion is unanimous throughout the camp that the Mayo hospital should be provided with X-ray equipment somewhat similar to that at Dawson and White Horse as soon as possible. The Mayo hospital has a Delco electric light system, which experts say would be sufficient for driving an X-ray machine.

The Mayo Hospital is thoroughly heated by hot water. The plant is said to be one of the most satisfactory in the

Yukon. An electric washing machine also gives highly satisfactory service. A well in the boiler house supplies the hospital with an abundance of water for every purpose, including a system of running water and toilets on the two floors, with drainage direct into the Mayo River, beside which the hospital is located. The forest fires which menaced Mayo this summer burned to within a few hundred yards of the hospital, where they were stopped by strenuous efforts of many volunteers and use of the Mayo fire engine. The burned area now forms an open zone about the place which cannot burn again. A long sidewalk connects the hospital with the town, and plans are being made to keep the street and road from the main part of town to the hospital open this winter by occasionally driving "cats" or other rigs over the road.

The hospital now comprises a main building, with kitchen and heating quarters attached. On the lower floor of the main building are the office, general ward with ten beds, operating room, well lighted electrically and by sunlight; a sterilizing room, bath room and laundry. On the upper floor are four private rooms for patients, a library room, quarters for the staff, kitchen, dining room, bath room, and laboratory.

AMERICAN HOSPITAL ASSOCIATION

General Membership Campaign.

On the initiative of the President there has been consideration of the need and the present opportunity to carry on a general membership campaign. This was fully discussed by the Trustees and on proper motion the following resolution was adopted:

Whereas the American Hospital Association after twenty-five years of activity has laid a solid foundation for a much larger and more comprehensive service to hospitals than it is able to give at present, owing to lack of adequate operating income;

And whereas the American Hospital Association is the one common organization of all hospitals and serving the entire field; therefore it is the organization which should provide hospital entire field with such a larger and more comprehensive service;

And whereas the hospital field to-day is looking to the Association for such a service;

And whereas to carry on this service expert technical assistants on full time and salary must be added to the central office from time to time to make field investigations of all kinds and otherwise to carry on such a work;

And whereas the Association must depend on the revenue from membership dues for the financial support of such activities, requiring that a larger membership be enrolled in order to carry out this larger and more comprehensive service;

And whereas there are at present about 7,000 hospitals and sānitaria in the United States and Canada, of which only 579 are now institutional members;

And whereas there are at present over 200,000 executive personnel, trustees and staff members (not including interested contributors) who are eligible to personal membership, of which only 1,732 are now personal members;

Be it therefore resolved that the American Hospital Association during the coming year shall carry out an intensive membership campaign under the direction of the President and Executive Secretary, subject to the approval of the Board of Trustees and along the following lines:

1. The campaign in each state or province shall be in charge of a state chairman appointed by the President of the Association, and these chairmen shall each be authorized to appoint as many sub-committees or teams within his state or province as may seem to him advisable.
2. The Membership Campaign Committee of the Association shall be composed of the State and Provincial Chairmen appointed with the President of the Association acting as the chairman thereof.
3. The Membership Campaign Committee shall assume such activity as may be authorized by the President and Executive Secretary subject to the approval of the Trustees.
4. The work of securing new members shall be correlated in the various states and provinces through the state and provincial chairmen composing the Membership Campaign Committee reporting directly to the President and the Executive Secretary and through suggestions and instructions from the President and Executive Secretary to the various states and provincial chairmen.
5. The results of the work of each state and provincial chairman in the various states and provinces shall be from time to time announced and published as such.

THE NURSING COURSE—STANDARDIZING A SUBSIDIARY TYPE OF NURSE

Yale University has just announced the establishment there, by the Rockefeller Foundation of an undergraduate school of nursing, with a course of about twenty-eight months, in which community nursing, as well as bedside care of the individual, will be taught in an educational curriculum that will include the study of sickness in relation to heredity, environment, psychology, child development, sociologic and industrial conditions, public health. The young woman graduated from such a school will, it is planned, be fitted at once to enter public health, institutional, or private nursing, as she may prefer. While this will not be, by any means, the first nursing school connected with an American university, it will depart from the others in various features, academic and otherwise, that are foreshadowed in the report of the nursing survey made under the auspices of the Rockefeller Foundation, of which survey this new school appears to be an outcome.

The survey itself, "Nursing and Nursing Education in the United States," recently published by the Macmillan Company, makes very interesting reading, and incorporates some very definite recommendations for the education of nurses, both in the field of private care and in the rapidly expanding sphere of public health and industrial nursing. Concerning these recommendations we would speak here of the two most important, both of which represent conclusions at which, we believe, the medical profession at large has already arrived.

The first of these is that "....it is possible, with completion of a high school course or its equivalent as a prerequisite, to reduce the fundamental period of hospital training to twenty-eight months...." (The Committee believes that "superintendents, supervisors, instructors, and public health nurses should in all cases receive special additional training...."). It must be a matter of common observation by physicians in hospitals that much of the work of the pupil nurse is so repetitious and mechanical (and often unnecessarily menial) that the last few months of the course are often spent by the pupil nurse after nominal graduation in merely filling out her required time. It must be admitted that to the extent in which the pupil remains in service in a hospital beyond the needs of that service for her own training, she is be-

ing exploited by the hospital for its, rather than her, benefit. (An extreme instance of this is the observation made by Miss Goldmark, author of the survey, of a training school in which pupil nurses spent six weeks preparing operating-room gauze supplies, which, of course, they could learn to do in one). Such exploitation may be justified from the standpoint of the hospital as compensation for the opportunity for education that it affords and as a means of providing, for the benefit of its patients, a body of fairly seasoned senior nurses. The need, if there be any, of this absorption by the hospital of the time and talent of the nurse in training, can be obviated—with advantage to the nurse, to the hospital itself, and to the community—by the general establishment of the other desideratum mentioned in the report to which we wish to draw attention, viz., the proper training and standardization of a "subsidiary group" of nurses ("practical nurse," "trained attendant" or "nursing attendant").

"According to the census of 1920, there were in the United States 300,000 nurses, male and female. Of these about half were trained registered nurses...." We may assume, therefore, that there are now in this country fully 150,000 untrained, or partially trained "nurses"; and it is also safe to assume that their services are needed. Many of these are estimable persons, quite competent within their sphere; but many are ignorant, wholly incompetent and even vicious. They are unlicensed and therefore irresponsible. Many of them are women who, for one reason or another have failed to complete a regular nursing course, many are more or less self-taught, some are masseuses who have drifted into or switched to "nursing," some (men) are more or less experienced as hospital orderlies. Very few are graduates of a practical, adequate course of instruction planned for "subsidiary" nurses. The survey shows that most courses for such women are of the correspondence school type, or consist in didactic lectures and class-room exercises; and that very few hospitals indeed afford any opportunity for short courses in nursing.

The working hours of our registered nurses are very long, their years of serviceability are comparatively short, and their compensation is therefore by no means excessive. Yet the expense of two trained nurses over a long period of illness—especially when the patient is himself the breadwinner of the family—is too great for people of slender means to bear. For many mild and chronic illnesses the employment of registered

nurses is, too, an economic waste and, in times of epidemics, it unduly increases the demand for nursing service. There is obvious need for encouraging, not discouraging, a subsidiary type of nurse; but there is also need that such a type should be standardized by education and by licensure. The individual states should establish the standard and grant the license; the public should be taught to distinguish between the registered nurse graduated from a full course of hospital or university instruction, and what might be called the merely "licensed nurse;" the nurse registries must likewise distinguish between such licensed nurses and the unlicensed aid or attendant; and finally, but most important, our hospitals should establish a shorter course of perhaps eight months for the ward instruction of women of acceptable personality and intelligence, in the fundamentals of bedside nursing and the care of invalids. This might well be made the field of service of the hospitals too small for regular training schools.

Such a system would provide an adequate body of licensed and instructed women, competent to serve in many types of illness, or in periods of convalescence; with the added dignity of licensure it would probably effect a distribution of nursing service to communities where it is now scarce; it would relieve the higher type of nurse in training of much repetitious labor, give her more time for education and relaxation and permit shortening of her course without loss to the hospital; it would give the physician a definite basis for estimating the reliability of the nurse he employs. It would not—and it should not —prevent any man or woman from lending, or hiring, his or her services as an attendant on the sick; but it should make it punishable for anyone to set himself up as a "licensed nurse" who is not.

We have, and we must continue to have, a junior or subsidiary grade of nurses. Should we not teach and standardize them? Is it not a duty to the communities that support them for our hospitals to do this teaching?—*American Journal of Surgery.*

Canadian Hospitals

TORONTO WESTERN HOSPITAL HAS RAPID GROWTH

Twenty-eight years ago the Toronto Western Hospital was formally opened for business in two rented houses situated on Manning Avenue, just north of College Street. Almost the first day of operation the officials were embarrassed by the number of demands made on their modest accommodation, but embarrassment mingled with gratification, for the need which they had only guessed at was presented in tangible, convincing form.

In its quarter of a century of history the Western Hospital has seldom been able to balance supply with demand. Serving a rapidly growing section of the community as it does, it is to-day in the position of the faithful servant who has outgrown his clothes, and the citizens of Toronto have been asked to show their appreciation of continuous and conscientious effort by replying to the appeal for $250,000, the sum required for the necessary extension.

The two most urgent needs are a suitable nurses' residence and a modern and enlarged maternity section. At present there are some ninety-seven nurses, including pupils and graduates, on the staff, and they are quartered in seven houses, as many as thirty living in an unsuitable eight-roomed building. The nurse is the central figure of successful hospital service, according to A. C. Galbraith, Superintendent, and the least that can be given in return for her three years' devotion to duty is decent and attractive accommodation. It is proposed, therefore, to build a nurses' residence, to cost $150,000, at the south end of the hospital, facing Roseberry Avenue.

Plans for the new maternity wing call for a thoroughly modern two-story building connecting with the main hospital. In the basement there will be pre-natal and post-natal clinics and maids' quarters; on the first floor, public and semi-private wards, equipped as completely as the private floor, which will be at the top of the building. At the present time each private maternity patient is required to go through public corridors and wards to get to the obstetrical section, and following delivery is carried down stairs by the same route to the private rooms.

In spite of great handicaps in the way of inconvenience and lack of proper facilities, the Western Hospital each day in-

creases in its measure of service to the public. Because of its rapidly increasing importance as a people's hospital its officials are earnestly hoping for a generous response from the citizens, individually and as a whole.

Formal opening on March 13th of the fine new addition to the Toronto Western Hospital which was built recently to accommodate the emergency and out-patient departments of the institution was attended by a large number of persons including many members of the Hospital Board.

Inspection of the new addition, which includes several special operating rooms, was made by the visitors, who were received by A. C. Galbraith, newly appointed superintendent of the hospital. After this inspection a very pleasing musical programme was enjoyed by the guests.

Hon. Thomas Crawford, Chairman of the Hospital Board, presided for the earlier part of the programme, and was succeeded by Dr. John Ferguson. Hon. Mr. Crawford in his remarks paid tribute to the work of the late Superintendent Tomlin toward the realization of the new addition to the hospital. He hoped that the near future would see a fine new nurses' residence completed. A campaign for $250,000 for this purpose would soon be under way.

The Glee Club of the Young Men's Club of the Board of Trade, Mrs. Gladys Read, Alan MacLean and A. Plumstead, contributed to an excellent musical programme.

FIRE IN NURSES' HOME

Fire which started in the nurses' home at Victoria Hospital, London, on March 3rd, caused damage estimated at between $10,000 and $15,000. The home is connected to the main hospital, and a splendid battle against the flames was put up by the staff, including the office employees, internes and orderlies, so that when the firemen arrived, in response to a general alarm, the fire was found to be under control. The patients in the hospital were not seriously disturbed, and nobody was hurt.

The flames were first seen at the bottom of an elevator shaft, and the fire alarm was at once sounded. Before the hand extinguishers and the hospital hose could be brought to play, the fire had rushed up the shaft for the full four stories, and was eating its way into the attic.

A number of the nurses who had been on night duty were sleeping in the upper quarters, and they were compelled to rush for safety elsewhere. In the meantime the doctors and nurses, led by Dr. Clegg, the superintendent, prepared to remove the patients, but the prompt and efficient work of the firemen under Chief Aitken, completely extinguished the blaze in about twenty minutes. Much of the damage resulted from the great quantity of water that was thrown into the home by the firemen.

Dr. Clegg has asked Chief Aitken to make a thorough inspection of all fire-fighting apparatus at the hospital, some of the hose having been found to be in rather bad condition.

News Item

GIFT OF $100,000 FOR NURSES' HOME

The gift of a new nurses' home building, combined with accommodation for a central heating plant and other required utilities, to the General and Marine Hospital of St. Catharines was announced recently by the Board of Directors of the hospital, the donors being Colonel and Mrs. R. W. Leonard.

Since March 12, 1923, those in charge of the administration of the hospital have been at work on plans of enlargement to fit in with the handsome gift, so that a hospital plant of the most modern and efficient kind, and one capable of development in the years to come, might be launched.

The gift of Colonel and Mrs. Leonard, which will represent an outlay of $100,000, has been most carefully thought out. Colonel Leonard, before making his offer to the hospital board, purchased property adjoining the present hospital in order to secure a suitable site for a nurses' building.

Book Reviews

Mental Hygiene and the Public Health Nurse. Practical Suggestions for the Nurse of To-day by V. May Macdonald, R.N., formerly Assistant Superintendent of Nurses, Johns Hopkins Hospital. With a Foreword by Thomas W. Salmon, M.D., Professor of Psychiatry, Columbia University. Philadelphia, London, Chicago and Montreal: The J. B. Lippincott Company. Price $1.50.

This little book of sixty-seven pages is one of the very excellent series of Lippincott's Nursing Manuals and in every way creditably represents its subject.

The author has presented to her readers in simple language a clear and comprehensive estimate of the problems which come so constantly before the nurse in her daily duties as she discovers the large number of those who suffer from the early symptoms of mental disease or who are themselves unsuspected defectives. Her aim is to enable the members of her own profession to understand the serious nature of the premonitory symptoms which confront the nurse but which without this knowledge are so often overlooked. Her summary of the symptoms which should arouse suspicion covers the field admirably and her counsel to refrain from an attempt to make a diagnosis indicates a wide practical acquaintance with her chosen subject. For the public nurse or the general nurse or even the psychiatric nurse there is a fund of information which will command continued interest, and the avoidance of sensational statements and unwholesome suggestions establishes at once in the mind of the reader that confidence and regard so important for the teacher. Not only the members of the nursing profession, but lay readers as well, and especially parents, cannot fail to reap large benefits from a careful study of this unpretentious little volume.

BIOLOGIC LIVING

Fifty-eight years ago, a little band of men who believed in altruism and human progress opened a "water cure" on the edge of the little village of Battle Creek.

Ten years later the enterprise, without having achieved any considerable degree of success, was placed under the present management with twelve patients and a half dozen small two-storey buildings. This new management, headed by Dr. John Harvey Kellog, inaugurated new policies and introduced new principles and methods. The empirical methods of the old-time "water-cure" were replaced by rational hydrotherapy, and as rapidly as possible new methods, appliances and apparatus were added, in an effort to create an institution which would show in practical operation all the resources of modern physiologic medicine. At that time no institution existed which combined the comforts of the home and the hotel with the medical advantages of hospitals and the added facilities and equipment requisite for the administration of baths of every description, electricity in its different forms, medical gymnastics and other rational agencies, with careful regulation of diet.

"Biologic living," the cornerstone upon which the Battle Creek Sanitarium has been built—consists in the treatment of the sick by natural, physical means, scientifically applied. The cause of disease, not disease, is the sole object of attack.

The organized therapeutic method which has become known throughout the world as "The Battle Creek Idea" or "The Battle Creek Sanitarium System" is the result of a systematic and comprehensive effort carried forward for nearly half a century, to bring together in one place, under unified control, all the resources afforded by medical science whereby a sick man may be aided to the recovery of his health.

Since its organization, over 200,000 have visited the institution. The annual report shows that 800 patients were treated during the first five years (1866-1870) while more than ten times that number now visit the institution annually. These patients come from every state in the Union, and from many foreign countries, including: China, England, France, Switzerland, Denmark, Japan and New Zealand. Among the patients treated during one recent year more than 113 different occupations and professions were represented, including; physicians, 136; bankers, 80; farmers, 282; housewives, 2,884; manufacturers, 269; merchants, 485, and teachers, 183.

The Battle Creek Sanitarium and Hospital Training School for Nurses was organized in 1877. It has a three years' accredited course. In attendance at the present time, 172 students.

GILLETT'S FLAKE LYE.

There has been known to the world at large for some decades a product known as Gillet's Lye, which as a cleanser and disinfectant has no equal.

The word "lye" was given in colonist days to the "leach" or water extract made from the wood fire ashes which contained an alkali favorable for soap manufacture. The process of development has slowly gone forward until to-day we have a lye perfect in chemical composition which, in its flake form, is unapproachable for its uniform strength and purity. Its manufacture is under very strict laboratory control and its perfection has been reached through the scientific researches of well-trained chemists.

To the world at large Gillett's Lye is a stand-by for cleanliness and is most widely used as a cleanser and disinfectant by doctors and hospitals, who well recognize its worth. In its new flake form it is more easily soluble in water and is not so apt to pack together as the older type of powdered material.

There are many impure lyes on the market to-day, which by reason of their adulteration are not fit for general use and with which Gillett's Flake Lye is not to be compared.

To those technically trained, Gillett's Flake Lye in solution possesses the very highest possible theoretical percentage of free alkali, hence as a grease solvent and dirt remover it has the highest possible efficiency.

As Gillett's Lye eats dirt and as dirt is the cause of disease, use it freely and keep the deadly germ under control. Gillett's Flake Lye is colorless, odorless and leaves no stain, hence its use is possible in any location.

TREATMENT OF PERTUSSIS WITH INTRAMUSCULAR INJECTION OF ETHER

Cleon C. Mason, Long Beach, Calif. (*Journal A.M.A.*, Dec. 22, 1923), presents a preliminary report of twenty-six cases of pertussis treated by the deep intramuscular injection of ether as described by Genoese. Of the twenty-six patients, with ages ranging from six months to eight years, sixteen stopped coughing after eight injections and did not cough again; six were definitely benefited, i.e., the paroxysms became less frequent and less severe, and in four cases the course of the disease was not altered in any way. Of the sixteen patients in whom the cough stopped, none had whooped to exceed four days, six had whooped for the first time on the day the treatment was instituted, and the other ten had whooped from two to four days. Of the six patients definitely benefited two had vomited but had not whooped (later both of these patients developed a mild whoop), and the other four had been whooping for from four to seven days. Of the four not benefited, one had never whooped, but proceeded to develop a severe attack which massive doses of opiates did not alleviate; the other three had been whooping more than seven days. The ether injections

were made with a long, fine platinum needle, deep into the buttocks. Commercial anesthesia ether was used. The dosages used were: First day, 0.5 c.c., two injections; second day, 1 c.c., two injections; third day, 1.5 c.c., two injections; fourth day, 2 c.c. two injections; fifth day, 2 c.c., one injection; each day thereafter, the same amount as on the fifth day. These dosages were slightly reduced for children under one year. The injections did not seem especially painful. Within thirty minutes after the injection there was a decided odor of ether on the child's breath, which usually persisted for three to six hours. Several specimens of urine, collected at hourly intervals after the injection, were examined, but in no instance were the acetone bodies found. Four additional cases were treated by the high rectal injections of 6 c.c. of a 40 per cent. ether solution in olive oil. The injections were repeated every six hours. Two of these patients stopped coughing quite promptly, and two failed to respond. This method was employed in order that the treatment might be carried out at home.

IMPORTANCE OF COMPLETE EXAMINATION OF THE CEREBROSPINAL FLUID.

The most important single sign of cord compression, and by all odds the most reliable, in the opinion of William Jason Mixter, Boston (*Journal A.M.A.*, Dec. 29, 1923), is that evidence which is obtained from the cerebrospinal fluid. At the Massachusetts General Hospital, every patient suspected of cord tumor is prepared for puncture of the cisterna magna, as well as for lumbar puncture, and lumbar puncture is performed. Pressure readings are made, pulse and respiratory oscillations are noted, and the patient is directed to cough and to draw a deep breath. Next, the jugular veins are compressed, and finally a small amount (usually 5 c.c.) of fluid is withdrawn. Notes are taken on the behavior of the fluid in the manometer during all these procedures. A portion of the fluid withdrawn is tested with alcohol for excess of protein. If the information obtained in these various ways gives definite evidence of block, puncture of the cisterna magna is not done. If there is absolutely no evidence of block, either chemical or dynamic, puncture of the cisterna magna is not done. If, however, there is the suspicion of block, either chemical or dynamic, the cisterna magna is punctured, combined readings are made, and fluid is drawn from both needles for quantitative examination of protein and for Wassermann examination and study of the cells. If tumor of the cauda equina is suspected, two lumbar punctures, one usually between the twelfth dorsal and first lumbar vertebrae and the other between the fourth and fifth lumbar vertebrae are performed. Occasionally, sacral puncture with injection of physiologic sodium chlorid solution into the epidural space, with observation of dynamic changes in the lower manometer, is also deemed advisable.

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Apparel

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Bedding

Bed sheets, sheeting, draw sheets, lethotomy sheets; pillow slips, circular pillow cotton; mattress covers and quilts; pillows, etc.

Sundries

Towels, bed pan covers, etc.

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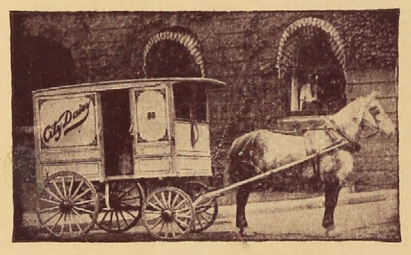

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