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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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Contents.

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CENTRAL — DATE DUE

Miss	Dyke	12-11-24
"	Moore	
"	Keefer	12-11-24
"	Beith	8-12-24
"	Johnston	13-12-24
"	Clarke	26-11-24
"	Nicol	20-12-24
"	Emory	2-12-24
"	Brown	2-1-25
"	M. Martin	

SPECIAL ATTENTION IS DRAWN TO

DISTRICT — DATE DUE

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Moss Park	
University	
Broadview	4-5-25
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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. XXVI TORONTO, NOVEMBER, 1924 No. 5

Editorial

Ontario Hospital Association

The first annual meeting of this body was held by courtesy of the Academy of Medicine, in Osler Hall, October 2nd and 3rd. The attendance was good and discussions earnest and profitable.

The Chairman of the Committee on Papers hit upon the happy idea of securing by questionnaire to the members what subjects they would like discussed. Their answers constituted the programme, which was an excellent one.

Col. Gartshore made an ideal president. Though a busy business man he made several visits to the executive meetings in Toronto during the year, and it was to the spade-work done preliminarily that the fine success of the convention was due. Dr. Routley made an excellent secretary and deserves sincere praise for his efforts in awakening so much interest.

Perhaps the most outstanding feature of the meeting, economically considered, was the decision on co-operative buying, dealt with in papers by the purchasing agents of the Christie Street and the Toronto General Hospitals. It did not require much discussion to enable the hospital executives to see

that a great deal was to be saved by purchasing a good many supplies through a central purchasing bureau as has been done by New York hospitals for some years past. The matter was referred to the Executive Committee.

It was unanimously declared that the Workmen's Compensation Board patients' fees were not adequate, so the Association, through its Executive, purpose doing what the medical profession felt compelled to do—and did do—induce the Board at least to pay the cost of maintenance. The Executive Committee is authorized to take action with a view to bringing this desideratum into full effect as soon as possible.

The pernicious habit of employing special nurses to care for patients, who do not really require them, came in for criticism by the Executive Secretary. The ordinary middle-class family couldn't stand the expense. Their tendency to call for such attendance—probably because some of their neighbors had done so—ought to be discouraged by the hospital executives and head nurses.

The Secretary also claimed that private ward accommodation was too expensive; and the general concensus of opinion was that in many hospitals the private ward patient was exploited in order to meet deficits in caring for the public ward patients. Moreover, it was also felt that municipalities should pay more than they are doing for indigent patients —something nearer the actual cost of maintenance. The Secretary gave a resume of a questionnaire on costs and tariff which he had sent out—this showed that per diem costs varied greatly and that private ward rates were far from uniform; in some of the larger hospitals these rates seemed excessive.

Miss Jean Gunn dealt with nurse training school records, showing slides of those used at the Toronto General Hospital. We would like to see this card system introduced into all hospitals, since its adoption would be of great value to the hospital, the nurse, and registration, collegiate bodies or private institutions inquiring for her record—not only her standing in all subjects, tests and departments of the hospital, but also as regards her preliminary education.

Too much praise cannot be given to Mr. Galbraith and Miss Ellis of the Western Hospital, Toronto, for the demonstrations given there of laundry work, country operating technic, performance of blood transfusion and also for the courtesy extended the visitors in serving afternoon tea.

Dr. W. J. Dobbie handled the round table conference incomparably well; there was a freedom of discussion participated in by all and sundry on live, everyday topics, delightful to listen to. Reports of this conference will appear in our columns shortly.

These are only a few of the main features of this splendid meeting; and we are sure Col. Gartshore, Dr. Routley and their enthusiastic associate workers feel proud of this, the first meeting of the Ontario Hospital Association.

The luncheon in the Yellow Room of the King Edward was thoroughly enjoyable. The address of Dr. J. C. Routley, the Secretary of the Ontario Medical Association, outlining how that body had made so great a success, gave a hint as to the lines along which the Ontario Hospital Association should proceed in order to attain like success.

The Hospital, Medical and Nursing World was adopted as the official organ of the Association. The JOURNAL will report the Association proceedings as

fully as possible, bearing in mind that publication in detail will probably cover several issues.

Edmonton Hospitals

A census of the Edmonton Hospitals, kindly forwarded to us by Dr. Thos. Whitelaw, M.O.H., follows:

Royal Alexandra Hospital: General wards, 233 beds; maternity wards, 22 beds; children's wards, 45 beds; total, 300 beds.

General Hospital, General wards, 154 beds; maternity wards, 21 beds; total, 175 beds.

Misericordia Hospital: General wards, 143 beds; maternity wards, 25 beds; children's wards, 12 beds; total, 180 beds.

University Hospital: General wards, 184 beds; children's wards, 6 beds; total, 190 beds.

Isolation Hospital, 100 beds.

From our valued contributor we learn that during the last year splendid additions were made to the General, Misericordia, University, and Royal Alexandra Hospitals which have not only greatly increased the bed capacity of each, but have put each of them on a very high basis of efficiency. In addition a new isolation hospital of 100-bed capacity has been completed. This is of the block type and is specially designed to carry out the modern principles of aseptic nursing and care of the communicable diseases, as advocated by Dr. Chapin, of Providence, R.I., and so long successfully carried out by him and others, who regard contact infection as practically the only way in which the ordinary infections are communicated. This hospital is adjacent to and operated by the Royal Alexandra Hospital.

Edmonton has now probably as fine and well equipped a system of hospitals as any city of 60,000 population in the world. It would appear probable also that few cities of 60,000 population have 950 hospital beds which seems much above the average per thousand of population. It would be of interest to have statistics on this point from different cities for purposes of comparison. As regards Edmonton, it should be pointed out that it has to provide accommodation not only for its own people but for a very large country area almost an empire in extent, particularly towards the north, as far as the Arctic Circle, or approximately one thousand miles.

Vaccination of Hospital Personnel

One of our editors, who includes in his work as a medical health officer the supervision of an isolation hospital, says:

"A matter of interest to hospitals generally is the question of protecting as far as possible the nurses and other employees against infectious disease, to which they are on occasion unavoidably exposed, through errors in diagnosis or secondary infections of patients admitted while in the period of incubation. On different occasions, cases diagnosed as influenza have been admitted to general hospitals, which have later proved to be smallpox. In one instance in Edmonton, nurses who had never been vaccinated contracted smallpox from a patient who was admitted on a diagnosis of la grippe, became suddenly well on the fourth day and was discharged. Several weeks later it was discovered that an eruption had been noticed on her forehead the day of her discharge, which was undoubtedly smallpox. As a result of experiences of

this kind, the various hospitals in Edmonton have been circularized by the medical officer of health, strongly advocating the compulsory vaccination of all employees, including nurses, as a condition before being taken on the staff of the hospital.

"It would be greatly in the interests of all hospitals if the principle were adopted generally, that all employees, including nurses, should be required to be immunized against smallpox and typhoid fever, and also Schick tested and inoculated if necessary to give immunity against diphtheria. Probably many hospitals have already begun to enforce such regulations, but the advantages of having them generally adopted, cannot be too strongly emphasized."

Progressive Blue Noses

In September a fortnight's post graduate course for physicians was held under the auspices of the faculty of Dalhousie University. Men as far remote as Kamloops, B.C., went down to take the course.

Sir Henry Gray, surgeon-in-chief of the Royal Victoria Hospital, Montreal, took an active part in the programme. Clinics were conducted by Drs. Hogan, A. G. Nicholls, D. J. and Kenneth Mackenzie.

There were no fees charged and all practising physicians were welcomed.

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(Continuing the Hospital World)

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Original Contribution

PRESIDENTIAL ADDRESS
THE ONTARIO HOSPITAL ASSOCIATION*

"In presenting the first Annual Report of the Ontario Hospital Association I am assured by the encouragement already received that this organization will prove most helpful to all concerned.

"Since the organization meeting held at Toronto, December 13th, 1923, the reception we have met with, both by correspondence and personal visits, has been most gratifying, and its development, I am sure, will be of great value to the management of all hospitals, providing a medium for executive to discuss their methods and difficulties.

"The larger hospitals can 'shift' for themselves, having more or less complete staff, and have to an increasing extent, availed themselves of the opportunity offered at the annual meeting and exhibition of the American Hospital Association. The smaller hospitals, however, are not so favorably situated in this respect, as it is not always possible for their executives to attend these meetings. Consequently, it is felt that the Ontario Hospital Association can be of great service, by a comparison of methods; exchange of experience; co-operation in buying; standardization of equipment; comparing what others are doing.

"Through this channel also a clearing house will be formed, where information will be available, and in this I am sure we can depend on the co-operation of the larger hospitals—whose experience will be available for the benefit of those not so favorably situated.

"It has been suggested that co-operative purchasing can be done with advantage, by smaller hospitals sending in their estimate, and pooling their requirements.

"The question of having an exhibition of equipment and supplies in connection with the annual meeting was considered, but it was decided to defer this to a future occasion when we

* Delivered before the Ontario Hospital Association, Toronto, October 2, 1924.

shall be more firmly established and have more time to make arrangements.

"I am sure we can depend on the sympathetic co-operation of the Department of Health in the event of any legislation under consideration affecting hospitals. The Association would be the proper channel of communication between hospitals and the Department, in the event of any changes being applied for, and these should be fully considered by the Association before being presented to the Minister.

"We are very much indebted to the Honorary Secretary, Dr. F. W. Routley, for his valuable services, and to the Red Cross Organization for the use of their head office for our committee meetings. It is a common saying, 'If you want anything done, go to a busy man.' In this connection Dr. Routley's services have been of great value in the early stages of this organization.

"With the co-operation of all concerned, I feel that we have got off to a good start, and we may expect most helpful and gratifying results."

TO WHAT EXTENT ARE PATIENTS CHARGED FOR DRUGS, ETC.—ARE PUBLIC WARD PATIENTS CHARGED FULL VALUE OR PORTION?*

A. C. Galbraith, Superintendent Toronto Western Hospital

In answering this question I am giving the procedure followed at the Toronto Western Hospital, which I think is fairly in line with those of other general hospitals in Toronto.

The first broad division is into two services, *Out-patient* and *In-patient.*

Out-patients

Our Out-patient department is established for people who presumably cannot afford to pay for private medical advice and service. Out-patients can again be classified into two classes—firstly, those who are absolutely without funds or who cannot spare from their modest resources any amount, however small, and secondly, those who can afford to pay partial cost of medicines and dressings. The first class is greatly in the majority and receive careful care and attention, together with what medicines their conditions require, without payment of any kind. The second class, while they still

* Read before the Ontario Hospital Association, Toronto, October 3, 1924.

cannot afford to pay a medical adviser, can manage, and many wish to, to repay to the hospital an amount to partly cover at least the cost of medicines, etc., prescribed.

When dealing with our out-patients it has been found from long experience that a nominal charge covering seventy-five per cent. of the cost of medicines will be paid when possible, but full cost, or cost plus ten per cent. being charged results in nothing being collected—the difference being just above the average out-patient's ability to pay.

In this connection I think all will grant the justice of a small charge where it can be afforded. The patient will value the services more when some payment is made and the fact of making some payment tends towards keeping that certain feeling of independence or self-support which it is so wise to cultivate.

Were the patient to take the prescription to a druggist the charge would be made on the generally accepted tariff of twenty cents per ounce, regardless of cost ingredients.

Figuring 75 per cent. of cost as mentioned above, one can readily see how very reasonable the charge is, more especially when it is only requested from those who are able to bear the charge.

The City of Toronto allows a grant of thirty-two cents for each out-patient visit, which goes a certain way towards meeting the cost of the out-patient department, but even with this grant the department is conducted at a heavy cost to the hospital and any additional revenue, however small, is much to be desired.

In-patients

Distributed over the various wards and services we have our private, semi-private, semi-public, compensation, public pay, city and county orders and free patients.

The last two classes are entirely without ability to pay, and receive every service without charge of any kind.

Public ward pay patients are composed of patients who can afford to pay the public ward rate of $10.50. These are patients who cannot afford the higher charge for semi-private accommodation or who are quite content with the accommodation afforded. If these pay-patients cannot afford to pay for specially prescribed medicines or other special services, no charge is ever made. However, they are in a position to pay the charge based on eighty-five per cent. of cost of same, they are requested to do so. This applies to charges for special prescriptions; all medicines commonly kept in the Ward Medicine Room are not charged for. These are comprised as

follows: Heart stimulants, narcotics, cathartics, expectorants, tonics, sedatives.

Private, semi-private and semi-public patients are charged for all medicines, etc., at cost, with the exception of drugs commonly stocked in the Ward Medicine Room, for which no charge is made.

When speaking of the cost of drugs and medicines, we figure the cost of ingredients, plus 35 per cent. to cover departmental overhead, bottles, labels, etc.

While having the opportunity of addressing the members of the Association I would like to extend a cordial invitation to anyone interested who would care to go into this subject more fully either at the hospital or by letter. We will be pleased to discuss the methods used in preparation or manufacture of various stock medicines or preparations, procedures followed in the department, sources of supply and the ever-important matter of prices.

Ward Supplies

Heart stimulants—Caffeine sod. brom.; strychnia, by mouth and hyopdermically; digitalis, by mouth and hypodermically; strophanthus, hypodermically; camphor in oil, hypodermically.

Narcotics—Morphia sulph., by mouth and hypodermically; heroin, hyoscine hydrobrom, morphia and atropin, codeia, hyoscine morphia and cactoid.

Cathartics and purgatives—Pills: Vegetable laxative A. B. S. & C., aloes bellad and nux., cascara, castor oil, paraffin oil, mag. sulph., calomel.

Expectorants—Routine expectorant, terpo dionin, stimulating expectorant.

Tonics—Easton's syrup, chemical food (Parrish).

Sedatives—Pot. bromide, sod. bromide, triple bromide.

SUGGESTIONS AS TO RAISING MONEY FOR HOSPITAL DEFICITS*

Miss McKee, Brantford General Hospital

Dr. Dobbie, in his letter, asked me to relate my personal experiences as superintendent of the Brantford General Hospital. In this matter I believe Brantford is quite unique in that the hospital does not recognize or carry a deficit. The constitution prohibits the incurring of debt, the issuance of bonds

* Round Table Conference, conducted by Dr. Dobbie, Friday, October 3, 1924.

or borrowing of money. At the beginning of each year the City of Brantford appropriates a sum of money for current expenses and so far the hospital has been able to keep within the appropriation. Over and above the appropriation the city this year paid $62,000, which had been carried as a debenture debt by vote of the ratepayers, for an additional wing to the hospital. The Brantford General Hospital does, however, raise money for constructive work, and this is partly done by an extremely active and efficient organization, "The Women's Hospital Aid." This organization, since its inception twenty years ago, has raised over $125,000. It has purchased for the hospital since that time, an ambulance, an electric elevator, laundry machinery, etc. It has furnished several wards, has built and furnished the nurses' residence, and now partly maintains it. During the past year this organization assumed full responsibility for furnishing and equipping the new wing at a cost of $15,000. This sum has already been raised and at the last meeting it was decided to alter and equip the delivery room in the Obstetrical Department with the most modern equipment, and to add a sterilizing room with four-piece sterilizer equipment. This work to be proceeded with at once.

Methods Used by the Woman's Hospital Aid to Raise Money

Annual Tag Day (*Rose Day*). The last Saturday in June is granted by the city annually. This is the only public appeal for funds for the hospital. A careful subscription list comprised of the manufacturers, business houses, business and professional men and wealthy citizens is prepared, and the week preceding Rose Day a complete canvas is made. The total receipts this year amounted to $3,700.

An annual rummage sale is held as another method of raising money. In furnishing the new wing the Woman's Hospital Aid appealed to local organizations, e.g., several chapters of the I.O.D.E., the Young People's Associations of various churches, and other philanthropic organizations, clubs, etc. A number of individual citizens furnished rooms or cubicles.

For some years the school children of Brantford have taken up an annual collection for the hospital; the money had not been used, as an objective had not been decided upon. The new children's wing with twelve cubicles, accommodating thirty children interested them, and this year $2,000 was handed over to the W.H.A. to buy equipment. The collections

each year will now be used for constructive work in that department.

So much for personal experiences in raising money for hospitals.

Suggestions as to Raising Money for Hospital Deficits

The subject as it reads is a very large and important one with much room for controversy.

My first suggestion is that we omit the word deficit, except as applying to the excess expenditure over income for any current year, and discuss means of raising money to meet our current expenses and to provide for the necessary capital outlay such as additional buildings, equipment, etc. A hospital should not recognize a deficit. The problem is not that of deficit, but the collection of money owing to the hospital for work rendered to the community. The city, town, or municipality pays prevailing prices for materials and supplies it needs. It would seem only fair that the hospital should at least receive payments of actual cost for hospital service rendered.

In Ontario, for instance, we may assume that the average minimum cost per patient per day is about $3.00. Of this the patient contributes directly through the various types of wards about $1.25. The provincial grant of 50c averaged among all the patients amounts to about 30c, so that income from these two sources amounts to about $1.50, leaving an excess of cost over income of $1.50. Where are we to obtain this? Obviously from the community which is served. For instance, in our own case the County of Brant does not contribute directly to any capital outlay, but it does pay the difference between the money received from the above two sources—and the cost per patient per day as of each year.

One of the difficulties which every hospital meets is the patient coming from some other community. Here, the loss to the hospital, except in the case of the more expensive private wards, is definite and apparently unavoidable.

I would not recommend appealing to the public at large for funds to meet what is generally known as "annual recurring deficit." If an expenditure is incurred due to permanent outlay, substitute the word "debt," which would indicate that the money was spent on capital account for the betterment of the hospital. Few people indeed would want to make a contribution to a hospital knowing that it was used to pay old deficits with the result that after the money had been obtained and paid by the hospital the institutions would be little better off.

If the hospital wishes to conduct a campaign a local newspaperman should be employed by the hospital. He should be

furnished with facts concerning free and part-pay work done by the institution and with some definite instances of how some little child, poor widow, or some sick father had been restored to health and happiness without a cent of cost to the patient.

The plan and scope of such a campaign would, of course, depend on the amount to be raised, the size of the community, etc. For instance, if a few thousand dollars were needed and the hospital located in a small town, it would not be necessary to call in one of the professional campaign organizations, but the campaign could be carried on by various committees of the trustees or a woman's auxiliary. Publicity in newspapers, in store windows, in theatres, churches, schools, street cars, buses, etc., and before all local organizations should be resorted to.

Where a larger amount is required and where a community is larger the most satisfactory way of handling such a campaign would be by turning it over to one of the reputable fund-raising organizations whose representative would make a study of the hospital and its service, of the community etc., and would take over the entire responsibility of an organization of various committees, publicity work, teams, etc.

An article in *Modern Hospital* relates the success of a community chest, the article stating "The adoption of the community chest method was the result of the rapidly-increasing deficits in two hospitals under former methods of financing." The hospitals referred to are in a city of 17,500 inhabitants. The yearly budget of these two hospitals together with those of other charitable organizations in the city form the objective. The result of this method, the writer states, is most gratifying, it has educated the people to the superiority of federated financing by gaining their confidence and is developing a spirit of good-will toward community enterprises. In collecting from the public in such an enterprise, there are three important points to lay stress upon.

1. That there will be no other appeal for the current expenses of any of the federated organizations, directly or indirectly, during the year.
2. That subscriptions will be taken to be paid monthly, quarterly, or any other terms satisfactory to the subscribers.
3. If a citizen has a particular interest in some hospital or charity and wishes to continue to support it, provision can be made whereby the donor's subscription can be so designated.

Federated organizations are becoming quite popular. In Winnipeg there is an organization known as the "Federated Budget Board." This plan is also adopted in Montreal and

known as the "Federated Charities." An intensive "Drive" is organized in which publicity and advertising plays a large part. The entire city is systematically canvassed.

In one large city, after the war tax on theatres and amusements was removed the tax was continued by public request for hospitals.

Recently several hospital in different parts of the country, including the Vancouver General Hospital, have resorted to a somewhat new form of campaign in which wealthy citizens of the community were asked to take out life insurance policies naming the hospital as the beneficiary. In these instances the campaign was carried on with very little expense to the hospital, since insurance companies were glad to co-operate and prepare literature, list of prospects, and furnish personnel to solicit the policies.

It is now generally recognized that publicity, through which the good-will of the community is won and maintained, is the backbone of the subject of hospital financing. Every hospital should take advantage of the numerous opportunities which are presented to it to get its service and importance to the community before the people in a legitimate and ethical way. National Hospital Day is an outstanding example of such an opportunity.

The suggestions which I have mentioned have been gathered from many sources, and to my knowledge have been successful. They may, however, contain problems which through lack of personal experience I have not considered. I would be very glad if there are among those present at this convention some who have tried these suggestions, and would discuss them freely, stressing particularly their weak points so that hospitals contemplating raising money may benefit by their experiences.

CHECKING RECEIPTS WHEN TREASURER IS OTHERWISE ENGAGED*

George A. Reid, Business Manager, National Sanitarium Association, Toronto..

The subject on which I have been asked to speak to-day, is to my mind one of very great importance, for though the proper accounting of moneys received is not the only factor in business success, the misappropriation of funds will certainly bring any venture to a speedy and disastrous end.

In organizations of a public or semi-public nature, such as most of our hospitals are, more than ordinary care should be taken to safeguard the funds entrusted to us.

*Read before the Ontario Hospital Association, Toronto, October 3, 1924.

Confining ourselves to the problems of the treasurer who has other duties to perform, and who, therefore, must to a great extent depend upon subordinates, no check, however painstaking, can be adequate unless the records on which accounts are based, are known to be correct. The point I wish to make here is the difficulty of detecting systematic pilfering, if the assistant on whom we rely is dishonest; for given the opportunity, a system of fraud may be evolved which may take a long time to bring to light.

To illustrate, let me relate one or two experiences. In an organization in which the official treasurer, because of other duties, rarely, if ever, handled actual cash, practically the whole office routine was managed by a bookkeeper, an employee of long standing, highly respected and well thought of by all. Working under what was thought to be an efficient audit, his books were always up to date and seemed correct in every detail. However, when serious illness befell him, necessitating the placing of some one else temporarily in charge, it was discovered that in addition to the usual charges for maintenance, etc., going to make up patient's accounts, other moneys were from time to time being paid in from irregular sources, which were never recorded and which never got beyond the man's own pocket. Known sources of revenue could be and were carefully audited, but because this man had charge of both debits and credits, these items were unknown. Another instance was where an ingenious chap worked the duplicate receipt system, by simply inserting a plain piece of paper under the carbon sheet, writing the correct amount on the patients' form, afterwards filling in the duplicate for such an amount as he felt disposed to allow, pocketing the difference. All such tricks will eventually be discovered, but they take time and a very considerable amount may be lost in the interim.

Personal integrity is a fundamental of business success, and to a very great extent we must rely on the individual, but the responsibility of the treasurer of corporate funds is far too great to take a chance.

The best method I know of for removing temptation, is to divide the responsibility as far as is possible—make the bookkeeper a recorder rather than a creator of original charges.

Admission and discharge registers should be maintained and one person, preferably the head nurse, be made responsible for the entries therein. For other departments from which charge service to patients is given, separate journals should also be supplied in which every transaction should be care-

fully noted by the departmental head. (In larger hospitals it may be advisable to have two sets of books for use on alternate days.) These records, passed on to the bookkeeper, are authority for charges to patients' accounts and may be checked with assurance by the auditors. A cash book also should be kept, and to complete the scheme of security another employee, empowered to give receipts, should be responsible for this. A duplicate book for receipts is advisable from which all credits can be entered by the bookkeeper, the cash being turned over to him for deposit in the bank. This, of course, is merely an outline. Every hospital would need to work out its own details.

For the treasurer's peace of mind, I would suggest that all employees handling or having access to cash be bonded by some good Security Company; that efficient auditors be employed and that audits be made at regular periods, and last, but not least, that the bookkeeper be required to furnish a weekly statement of outstanding accounts so that the treasurer may be constantly in touch with this department.

HOW TO COMPEL MUNICIPALITIES TO PAY FOR INDIGENT PATIENTS*

Major Moncrieff, Charlotte Englehart Hospital, Petrolia.

We take as our text Sec. 33, s. s. 1, of the Hospital and Charitable Institutions Act, the gist of which is, "The Municipality in which an Indigent Person . . . is at the Time of his Admission Resident Shall be Liable to Pay."

I. Attitude of the Law Towards Indigent Persons Receiving Hospital Care.

Firstly, the legislation and the authorities recognize it to be the clear purpose that every indigent person in this Province, requiring hospital attention, shall be taken care of and that the institution which provides the care must be paid. The late Chief Justice Sir William Meredith, in the case reported in 1917, of Toronto Free Hospital for Consumptives against the Town of Barrie, 29, O.L.R., with regard to a patient, Hazel Thomas, makes use of these words:

"The words 'is . . . resident' should be given their ordinary meaning, and, having regard to the charitable purposes of the enactment in which they occur, should be given a wide meaning among 'indigent persons' so that they may not be deprived of the benefit of the legislation which *must have been*

*Read before the Ontario Hospital Association, Toronto, October 3, 1924.

intended to comprehend all indigent persons in every municipality in the Province."

And, in an action tried by His Honor Judge Vance, in the autumn of last year, brought by Collingwood Hospital against the Township of Vespra, a case about which there was much public controversy and some rather bitter feelings excited, the Judge quotes with approval and verbatim, the language of the Chief Justice to which I have just referred.

The following also was contained in the judgment of one of the Judges above quoted:

"In leaving the meaning put upon the word 'residence' in the Thomas case it was no doubt assumed that municipalities would be fair to one another and to the hospitals. The latter are not money-making institutions, but they are doing good work and have quite a struggle to make ends meet financially."

And further from the same judgment:

"If the hospital authorities in Collingwood had refused admittance to Dunn until some municipality would acknowledge liability for the charges, then the charitable purposes intended by the enactment might have been defeated."

And the wide and charitable meaning intended to be given the word "indigent" is manifest in the words of the Regulations to which we shall presently refer:

"Having regard not only to the patient's available means, but also to those dependent upon the patient at home."

We start off, therefore, on a firm basis—that it is the intention of the present law that for every indigent person who receives hospital care, some municipality must pay.

II. What to do in Actual Practice.

At the outset may we suggest that if a person arrives at your hospital unaccompanied, or his maintenance is not vouched for, or you have any doubt as to his possessing sufficient means to pay, it would be better to assume him to be indigent and follow the procedure to which we later refer, as to notifying a municipality.

What Constitutes an Indigent Person.

"Indigent" is defined by the dictionary as destitute, unable to support himself. An indigent is defined in the "Official Regulations" approved by Order in Council, as:

"One without means to pay at least $1.50 per day . . . having regard not only to the patient's available means, but also to those dependent upon the patient at home."

If the indigent patient arrives in charge of the Reeve, a Councillor or other officer of a municipality, get the signature of one of the officers as authority for admission. For this purpose, we have prepared a form in use by the hospital with which we are particularly associated, as follows:

(A) If your hospital is in a city of 100,000 or over, and this applies only to two cities in the Province, it is not only desirable, but it is indispensable, that you get an order signed by the Reeve or other officer before you can charge a municipality. This provision was added to the Statute in 1919 and is found in Sec. 23 (1a).

In any case, where the indigent person arrives of his own accord, question him. Ascertain where he has been residing, his age and any other particulars that will serve to identify him. Then follow the procedure as to giving notice, which is set out in the Act, and with which every superintendent is familiar. This form of notice is contained in the Official Regulations issued by the Department. For convenience, we shall refer to it as the "residence notice." The directions in the Act are (s.s. 3).

"The Superintendent . . . shall by registered post notify the Clerk of the Municipality of which such patient represents himself as being a resident that he has been admitted. . . ."

At this point I have this suggestion to offer: Patients are frequently brought in with or under instructions of a physician. It may be a man run over—an emergency case: no opportunity to get in touch with any authority. Or the physician is called in to attend a patient in a dilapidated house, without conveniences, etc., and determines he must be taken to a hospital at once if he is to have any reasonable chance of recovery. In such case, you will find it useful to get some data in writing from the physician both as to the municipality or as to the family or friends to whom you might look for his maintenance. We prepared a form (B) for our hospital. The physician cannot be compelled to sign, and there is no responsibility on him if he does, but as a matter of ordinary courtesy, he will be glad to supply any information at his disposal and will usually sign on the dotted line if requested.

If there is doubt as to which one of two municipalities is liable for the patient's care, it would be better to mail a notice to both. This practice, however, should not be used unless it cannot be avoided. It ought not to be indiscriminately used.

Then (by s.s. 4), unless the clerk within fourteen days after the mailing of the notice by the hospital notifies the

superintendent that the patient is not a resident "he shall be deemed to be a 'resident' of that municipality." The effect of the notice to the municipality is simply to prevent that municipality from subsequently claiming that the indigent person was not a resident. The municipality cannot thereafter disclaim liability and your position is secure.

If you notify more than one municipality and one of these does not record a dispute, you have an established claim against one at least. If, however, both municipalities disclaim liability, then you are "up against" litigation, unless you can arrange a settlement.

Even if you have failed to send residence notice to any municipality and it afterwards turns out that as a fact the patient is a resident of a certain municipality, that municipality, can, nevertheless, be compelled to pay; and, moreover, where you have been misled by the patient or otherwise have concluded wrongly as to the municipality of residence, and you have sent the notice to another municipality you would not be precluded from establishing the true municipality of residence of the patient and recovering from such municipality.

III. As to What is the Municipality of Residence.

When the language or application of any Act is not clear we turn to the Courts for interpretation. I have exhausted all our Ontario reports down to date and the only authority I can find bearing on the point involved in my subject is the Barrie case, *re* Hazel Thomas, previously referred to. This was an action brought in the County Court and taken to the Appellate Division of the Supreme Court of Ontario, over which Court the late Chief Justice Sir William Meredith presided.

In that case the liability was held to rest on the Town of Barrie because of the patient being resident there, in a children's shelter, by order of the police magistrate of another town, who committed her to the care of the Barrie branch of the Children's Aid Society. But by reason of the 1919 Amendment of the Statute the liability would now in such case rest on the County of Simcoe. This Amendment provides, in effect, that where the indigent person is at time of admission an inmate of any institution, maintained by the county, the county shall pay the hospital fees. This case is, nevertheless, still good authority upon the meaning of the word resident and the interpretation of the most important clause of the Act in this regard, viz: Sec. 23, s. s. (1).

We have only been able to locate one other case bearing on the point, and for convenience we shall label it the Vespra case. It was locally a *cause célèbre,* although not found in the reports, and was tried in the County Court of the County of Simcoe. We were fortunate enough to secure a copy of the judgment. Whatever products the County of Simcoe may be noted for in common with other counties of Ontario, it assuredly has a monopoly in the production of authorities on indigent patients.

This will indicate the dearth or almost complete absence of decisions of our courts on the point with which we are dealing; and at the same time perhaps indicate the wisdom of clarifying or improving the present Statute and Regulations.

In all cases of dispute, in this as in other matters, it is first necessary to get at the facts before being able to determine the law that applies.

As to what constitutes "residing" in a municipality that you seek to charge, we quote again from the judgment of the Chief Justice in the Barrie Case:

"What is the meaning of the word 'resides?' I take it that that word, when there is nothing to shew that it is used in a more extensive sense denotes the place where an individual eats, drinks and sleeps or where his family or his servants eat, drink and sleep."

And if the "residing" of the patient has been of a passing or flitting character, like the hired farm-hand, who is here to-day and away to-morrow, and the semi-hobo, there is the colloquial phrase which the Chief Justice uses: "A person who has no home, or other place of residence, resides wherever he happens to hang up his hat at night."

And to quote the Honorable Mr. Justice Riddell:

"For the purpose of this statute it may be considered that the residence is the place where one habitually sleeps."

After getting at the facts in each case, you come to the point of applying the law. The chief enacting section of the Ontario Act would render it only necessary to prove that a man was actually a resident in the municipality on the day or hour of his admission to the hospital.

Section (3) of the Act provides that grants from the Province shall be conditional upon compliance with the Regulations made by the Lieutenant-Governor in Council. Clause 31 of these Regulations contains an interpretation of the word "resident:"

"'Resident' . . . shall mean and include any person who has resided in such municipality continuously for three months

or who not having resided therein continuously for such three months was actually employed therein immediately prior to being admitted to any hospital."

We start with the rule of law that Regulations passed under authority of an Act of the Legislature cannot subvert or controvert the Act itself.

But I have some propositions to propound to you as to the meaning of this three months' clause of the Regulations:

(1st) Does it mean that the three months' residence must run right up to the time of being admitted? His Honor Judge Vance would appear to hold that it does. But the language is by no means wholly clear, and with all deference, we would say that the Judge's view might not be sustained on appeal.

But by the Act itself, residence at the moment of admission determines the matter whether it has continued previously for one day, one month or three months; and, therefore, the three months' continuous residence is not necessary to establish liability against the municipality. From which it follows that the Regulation has no effect, unless it receives some other interpretation.

(2) Does it mean that the three months' residence need not be "immediately prior to being admitted?" that the three months' residence, for example, may have ceased a month before admission?

(3rd) Does it mean the *last* occasion when he resided for three continuous months in *any* municipality prior to admission? If so, it does not say so. If not, then what three months does it mean?

(4th) If the indigent person was not actually employed at the time of admission or had not been continuously resident in one municipality for *any* three-months' period before admission, are we to say that there is no municipality that the hospital can reach? And that, notwithstanding there was one municipality where although not employed, he was actually resident at the time of admission within the meaning of the word "resident" as interpreted by our Judges?

I don't think the Courts would so hold. I believe it would constitute a subversion of the Act itself.

It's a case of the lady or the tiger—or several ladies or several tigers. "You pays your money and you takes your choice."

It is with a purpose that we have propounded these several conundrums. We want to make manifest the need for clarifying the meaning of the present law, and particularly for

making the Regulations consonant or consistent with the Act itself.

The combined effect of the Act and of the Regulations would appear to be about as clear as the waters of the Don in a spring freshet. It would seem, however, if we might hazard a comprehensive interpretation, that you could proceed successfully at least: (1) against the municipality where the patient actually resides at time of admission, which would appear to be included in No. (2) against the municipality where the patient has resided continuously for three months immediately prior to admission. Or (3) where the three months' continuous residence is lacking then against the municipality where the patient was actually employed *immediately prior* to admission.

And if you wanted to be sure of your quarry and there was more than one municipality, each of which fulfilled one of these conditions, you would be wise to proceed against each of them.

IV. Does the Existing Law Call for Amendment?

The municipalities would seem to be even more prejudiced than the hospitals in the unfair working out of the present law under various circumstances. For example, in the Vespra case, the presiding Judge said:

"Notwithstanding the strong feeling I have upon the merits in the matter that Vespra should pay this small claim I realize that the whole question is one of law."

And in dismissing the action against the township, and giving judgment against the hospital, he expressed the hope that it would pay at least half the claim, closing with the words:

"They, (the township) could afford to pay it better than the plaintiff (the hospital) could afford to lose it and the plaintiff did their part."

And, therefore, in any amending legislation to be introduced every consideration must be given to working out a system that will impose the charge upon the municipality that should in fairness bear the burden; or if it should in justice be borne by more than one municipality, a plan that will, if possible, distribute the charge equitably between the several responsible municipalities.

We suggest that your Committee on Legislation do now take the subject actively in hand. They have already the benefit of the answers of the Ontario hospitals, etc. to our ques-

tionnaire, which contain upwards of a dozen expressions on this particular item.

They should decide definitely what they believe to be required: Secure the co-operation of the Department at Queens Park; ask the help of the Law Clerk of the Legislative Assembly, an expert on drafting, and see that any proposed changes in the Act are presented and passed at the next session of the Legislature.

A.

To the governors of the hospital: Admit.....as a patient, and the municipality of.....will be responsible for payment for board and treatment for.....days (or) while in the hospital and for return fare, or, in case of death, for expenses of funeral and interment. Dated at.....

Mayor. *Reeve.*

B.

Ontario..... 192..

To the trustees of the hospital: From such knowledge and information as I have regarding.....a patient admitted to your hospital at my request to-day.....is a resident of the municipality of.....and I verily believe that.....is an indigent, unable to pay for maintenance in your hospital. And I know of no one morally or legally entitled to pay for such maintenance and capable of doing so except..... Remarks:

.....M.D.

Ontario..... 192..

To the clerk of the municipality of.....You are hereby notified that.....who represents.....self as being a resident of the municipality of.....was admitted as a patient to the hospital on.....day the.....day of .....192.. The age of the said.....is stated to be .....years. The said.....has been a resident of your municipality for the past.....years, residing at..... The said.....is an indigent person, and under the provisions of the statute in that behalf made and provided for the municipality of.....is liable to pay to the hospital the charges for the treatment of the said patient at a rate not higher than $1.50 per day and, in case of death, to pay burial expenses. Unless within fourteen days after the mailing of this notice you notify the superintendent of the hospital by registered post that such patient is not a resident of the said municipality.....will be deemed to be a resident of it.

Yours truly,

Superintendent.

Society Proceedings

THE ONTARIO HOSPITAL ASSOCIATION

The meeting of this body in October was an unqualified success.

Mr. Swanson, buyer for the Department of Soldiers' Civil Re-establishment, read a paper on "Co-operative Buying." At regular times stores are reviewed and requisitions sent in to him. These tell the quantity required, amount on hand and monthly consumption, and in plenty of time to secure tenders. On receipt of quotations they are properly scheduled. These sometimes on identical articles vary ten to twenty-five per cent.!

By buying for all the units, the large purchases attract manufacturers; bulk discounts are obtained and discounts for prompt payment secured. Buying in bulk saves from 20 to 40 per cent.! Central purchasing in general throughout the country saves 7 to 47 per cent.; the saving results from buying in quantity and comparative tenders. Co-operative buying depends for its success on the control exercised—all units working through a central office, the governing head of which can lay down the quality of materials to be used, all branches agreeing to abide by the decision. The quality of the articles must be standardized—gauzes, cottons, disinfectants, bandages, etc. The delivered goods must be as per sample submitted. Contracts must be iron-clad. They may be made monthly for meats, bread, butter, eggs, fish, and longer contracts for milk and cream. Invoices are submitted once a month, checked against receipts and passed for payment.

Mr. Parr, of the Toronto General Hospital, followed on the same subject. The first thing is to standardize the main supplies. He found, for example, three sorts of hypodermic needles being used. He arranged to supply one sort only with a saving of 40 per cent. on purchases. As to electric bulbs on contracts for $1,000 quantities a good discount is allowed; larger contracts secure even a better discount. If hospitals would unite on one sort and buy in bulk, a great saving could be made over the present individual system, and buying in comparatively small quantities. The same can be said of gauze, adhesive plaster, chemicals and pharmaceuticals, bed-

ding, food supplies and scores of other items. Mr. Parr drew attention to the manifest advantages of co-operative buying outlined in two articles in the *Modern Hospital* for July, 1923.

Dr. F. W. Routley spoke on "Uniformity of Tariff." He said:

"The reason that the Programme Committee has assigned me the task of introducing this subject is because of a questionnaire sent out from my office to all the hospitals in the province as a result of which the above subject became a live issue. It is my opinion that the hospitals in each community should be competent to care for the patients within the community. That, I am sure, is the first principle upon which we shall all agree. They should have a sufficient number of beds to take care of all the sick in the community as well as the necessary equipment and a well-trained staff. That is a principle which should be laid down by all hospital workers everywhere. If this is done it devolves upon the community to see to it that hospital accommodation is provided for the patients in that particular community. In the past hospitals have been supported by voluntary contribution helped out by efforts on the part of the community and the provision of a government grant. I presume it is because of the nature of the institution and the sympathy that hospitals everywhere have always aroused, that they have so long remained a charge upon the public; I do not wish to minimize the great good to be derived from voluntary effort on the part of the public, but I should like to lay down this principle. They should be fundamentally self-supporting! I will admit that it is not possible to make a per diem budget which will work absolutely, but an attempt should be made to make one that will be as workable as possible. What do we find to be our present state in this regard in the province? The budget should provide for the maintenance of patients in the hospitals and should be in accordance with the hospital's receipts. The average per diem cost for hospitals in Ontario, according to the government returns for 1922, was $3.07 per patient per day. An analysis of the rates of the hospitals in the province during the last year shows that the average public ward rate is $1.56, or $1.51 less than the cost of maintenance, according to the average cost in the province. The rates in public wards run from seventy cents to $2.50 per day. The rates paid by large corporations and the Workmen's Compensation Board averages $1.62 per day or $1.45 less than the average cost of maintenance per patient per day. The average rate for semi-private ward patients is about the same as the average per diem cost, according to government report.

The average rate for private ward patients is much higher than the average cost, according to government report, and I believe that the actual cost in the case of both semi-private and private ward patients is very little more than the average cost of caring for patients in hospital. Outside of overhead charges such as are incurred by any institution, under present hospital conditions, these patients cost the hospital very little more than the ward patients. A summary of the whole question is, first, that the community or the government should be asked to pay what it costs to maintain indigent patients. I do not believe that indigent patients in hospital should be a charge to-day upon voluntary effort, and think that operating charges should be met entirely by the community or by the government. Secondly, I believe that large corporations, and this includes the Workmen's Compensation Board, should be prepared to keep patients in hospital at a rate certainly more than half of what it costs to maintain these patients in the hospital. Thirdly, semi-private patients should get hospital care and all nursing at about 25 per cent. more than the average cost. At the present time in many large hospitals, semi-private patients are not getting all the nursing care they require. Semi-private patients under present conditions are paying from three to ten times as much as is charged against public ward patients, and this is out of all reason. Fourthly, private ward patients should not be asked to pay one more cent for hospital care than it actually costs to care for them. In most hospitals these patients are being asked to pay for the deficit being incurred by public ward patients. As a rule the charge paid by the average man for his sick ones is much more than he earns."

Mr. Geo. A. Reid, Business Manager, National Sanitarium Association, spoke on the subject of "Checking Receipts When the Treasurer is Otherwise Engaged." The essayist says there is difficulty in detecting systematic pilfering, if any assistant to the treasurer is dishonest. He cited two cases: In one, where the official treasurer had to rely on a bookkeeper, the latter became ill. His books up to this time always seemed in order; but his *locum* discovered that in addition to the usual charges for maintenance, going to make up the patients' accounts, other moneys were being paid in from irregular sources which were never recorded and which never got beyond the man's own pocket. Because this man had charge of both debits and credits these items were unknown. In the other instance in using duplicate receipts he inserted a plain piece of paper under the carbon sheet, writing the correct amount on the

patient's form, afterward filling in the duplicate for such an amount as he felt disposed to allow, and pocketing the difference. To remove temptation Mr. Reid advises dividing the responsibility as far as possible, making the bookkeeper a recorder rather than a creator of original charges. Admission and discharge registers should be maintained and one person made responsible for all entries. In other departments from which charge service is given, separate journals should be supplied in which every transaction should be carefully noted by the head of such department. A cash-book should also be kept. Another employee should give receipts from a duplicate receipt-book.

Mr. Reid suggests that all employees handling, or having access to cash, be bonded by some good security company; that efficient auditors be employed; audits made at regular periods and that the bookkeeper furnish weekly statements of outstanding accounts, so that the treasurer is constantly in touch with this department.

Miss Joan Keith, of the Women's College Hospital, Toronto, followed Mr. Reid. At her hospital they expect a deposit on admission, entering amount on reverse side of admission card, which is ruled liked a ledger. A receipt is given, a duplicate being filed. Every morning they check back all receipts received the previous day to make sure the correct amount has been placed to the proper account. Amounts received are then entered in a journal, distributing amounts to the different departments—board, X-ray, pathology, operating room, etc. The totals of these equal total receipts. Totals are carried into the cash book under their own headings, making out the deposit, checking same to see that it corresponds with receipts. They never mix petty cash with hospital receipts.

The paper presented by Dr. Mowbray on "Hospital Standardization" gave a resume of the inspection, formulation and results up to date of the work done along this line, stressing the advantages to the hospital, to the individual patients, to governments, and philanthropic bodies, as well as to medical and nursing schools. He pointed out that in six years the number of hospitals reaching minimum standard had leaped from 12.9 per cent. to 86 per cent. Of the provinces of Canada, Ontario ranked lowest; only 50 per cent. of Ontario hospitals have attained the minimum standard. He closed by suggesting that the newly-formed association take as one of its first problems to ascertain why this province was so low in this respect.

Miss Rowan, of Grace Hospital, Toronto, confined her remarks to standardization of medium-sized hospitals, taking her

own hospital of 124 beds as typical. Speaking on behalf of both medical and surgical staffs as well as the management, she asserted that standardization minimum had been of real benefit to the hospital. She spoke of the difficulty encountered in keeping accurate statistics, but stated how much benefit had been obtained from these, and how gradually the staff monthly conferences had increased in interest thereby. She remarked on the difficulty in securing the co-operation of doctors in cases of securing histories of private ward patients, but said there had been also an improvement in that respect. She spoke a word for the visitors who made the survey, saying that the criticisms had always seemed just and suggestions for improvement practical.

Dr. Groves, medical superintendent of Alexandra Hospital, Fergus, in speaking on the same theme, gave a paper provoking thought, discussion and merriment. While not wholly condemning standardization, he objected to the setting up and imposing of any rigid standard, especially one imposed from without. He suggested that considerable freedom should be permitted each institution to develop according to local needs, and that results thus achieved should be pronounced upon by the local or provincial body. He emphatically stated that the standardization body should be elected by and responsible to the hospitals accepting inspection. Dr. Groves suggested that all hospitals, in order to be eligible for standardization, should be (1) self-supporting; (2) allow the patient to have the choice of his own doctor and nurse to attend him; (3) and should have no public wards.

Miss Jean Gunn gave an illustrated talk on "Training School Records." She pointed out the need for complete records, gave a history of the record system; explained the Bell system and described in detail the plan in vogue in the Toronto General Hospital. She pointed out the advantages of such a system—to the school, to the government, and to the nurse herself. She pointed out the main requirements of such a system—simple though comprehensive; entries must be accurate and made systematically on standard cards. The various cards were shown on a lantern screen—one for containing preliminary training; one for daily record; one for monthly record; a nursing practice card, and a permanent record card, with envelopes.

Mr. Gardner, Toronto General Hospital, discussed the method used in large hospitals to determine the daily output of laundry. He holds that inasmuch as the laundry is not a revenue-producing department, but is a direct overhead expense

which must go on continuously, figures which relate to work done in the laundry can only be used for checking purposes, so that as long as the methods of approximation are sound, it would seem that a record for the number of pieces based on sound averages, which should be determined and checked from time to time by actual count, should give just as much information as is necessary, and does not add any additional expense to the operating cost.

Major Moncrieff took up the question of the liability of municipalities to hospitals for the care of indigent patients. The Major cited the attitude of the law toward indigent persons receiving hospital care, explained what hospitals should do in actual practice, and defined what constitutes an indigent patient. The essayist quotes the law respecting the procedure the hospital shall take, viz:

"The superintendent shall by registered post notify the clerk of the municipality of which such patient represents himself as being a resident that he has been admitted, etc."

The reader of the paper then gave the legal definition of "resident," and pointed out the ambiguity of meaning in the three months' clause of the Act. To clear up the meaning Major Moncrieff recommended that the legislative committee of the Association seek to have the Act amended so that a system will be worked out that will impose the hospital charge for an indigent patient upon the municipality, or municipalities, that should in fairness bear the burden.

Mr. A. C. Galbraith, of the Western Hospital, Toronto, answered the questions, "To What Extent Are Patients Charged for Drugs?" "Are Public Ward Patients Charged Full Value or Partial?"

He says it has been found from long experience that a nominal charge to out-patients covering 75 per cent. of the cost of medicines will be paid when possible. Full cost, or cost plus 10 per cent. charged, results in nothing being collected.

As to in-patients—private, semi-private, semi-public, compensation, public pay, city and county order, and free patients. The last two classes being entirely without ability to pay are not charged. Public pay patients are not charged for specially prescribed medicines if they cannot afford to pay. If they can, they are asked to pay 85 per cent. of the cost of same. These medicines comprise heart stimulants, narcotics, cathartics, expectorants, tonics and sedatives.

Private, semi-private and semi-public patients are charged at cost, except for drugs commonly stocked in the wards.

Cost of medicines means cost of ingredients plus 35 per cent. to cover departmental expenses.

Miss McKee took up the subject of raising money for hospitals deficits. Miss McKee doesn't believe deficits should be permitted; there should be no such word. In her hospital in Brantford the constitution prohibits the incurring of debt. The city makes a yearly appropriation and thus far the hospital has been able to live within the amount appropriated.

The hospital, however, does raise money for constructive work, mainly by the Woman's Hospital Aid, by an annual Tag Day (Rose Day), a rummage sale and from the school children.

Hospitals wishing to meet deficits might inaugurate campaigns, the matter being handled by a local man. If a large amount is wanted a professional campaigner might be secured.

Dr. Herbert Bruce, F.R.C.S., Surgeon-in-Chief at Wellesley Hospital, although not able to be present, sent in his paper on "What do Medical Men Think of the Ten-Hour Day Duty for Private Nurses?" Dr. Bruce approves of the ten-hour days. He says:

"I can see that this might interfere with the work of the hospital in so far as providing relief for the day nurses before the night nurses came on, but think it could be conveniently arranged to take these two hours off early in the afternoon, say from two to four. This should be possible without any interference with the work of the hospital and would give the nurses the opportunity of getting out and enjoying the fresh air and sunshine at the best hour of the day."

The members of the executive for the ensuing year are: Major G. G. Moncrieff, Petrolea; Dr. J. H. Holbrook, of the Mountain Sanitarium, Hamilton; Miss McArthur, of Goderich; Miss Whiting, of Cornwall; Mr. Thomas Pratt, Hamilton; Dr. J. N. E. Brown, Toronto; Mr. Laughlin, London; Mr. J. M. Govan, Provincial Inspector of Hospitals; in addition to the president, Colonel William Gartshore, London; the vice-presidents, Mrs. H. M. Bowman, Women's College Hospital, Toronto, and Dr. Edward Ryan, of Rockwood Hospital, Kingston, and the honorary secretary-treasurer, Dr. F. W. Routley.

THE AMERICAN HOSPITAL ASSOCIATION

This Association held its 26th annual meeting in Buffalo. It met in Buffalo some eighteen years ago. The request was made that all those present on the first night of the meeting—perhaps a 1,000 people—who attended the former meeting in Buffalo should stand up—only some six people stood! Which sober fact may be attributed to deaths, and removals.

The meeting was a grand success, thanks to the efforts of the president and his lieutenants.

Dr. MacEachern holds that the Association should serve as a means of intercommunication and co-operation among the hospitals of the United States and Canada. It should aim to increase the efficiency of all hospitals in the United States and Canada by establishing and maintaining the best possible standards for hospital service. It should stimulate and guide intensive and extensive hospital development in both countries. It should develop on the part of these hospitals a sense of responsibility to the community in respect to education in health and hospital matters. It should keep the people informed concerning hospital problems and in this respect should assist hospitals generally in dealing with all governmental bodies. It should formulate suggestions for additions to or changes in legislation affecting hospitals; and should contribute to the hospital field information and findings for the good of all hospitals.

Dr. MacEachern summed up thus:

1. The Association has had a good year, noticeably characterized by increasing interest, activity and co-operation on the part of the hospital field generally.

2. The Association has important and definite functions to perform in the best interests of the hospitals of the United States and Canada.

3. The ever growing demands for service made on the Association require increased momentum and finances to adequately meet them.

4. The increased momentum and finances to adequately meet the needs of the field can only come through a greatly increased membership—institutional and personal.

5. The increased membership is now being secured through a well organized active general membership campaign carried on throughout the United States and Canada through the co-operation of thirty-two regional campaign committees.

6. The membership campaign should be pushed forward vigorously till all the possible institutional and personal members eligible are secured.

7. It is hoped and expected that the general membership campaign now being carried on will inspire much needed complete organization of the entire hospital field for protection and more progressive development generally, as well as for economic and scientific reasons.

8. The entire hospital field of the United States and Canada should be covered by a complete, closely interrelated organization, consisting of international, state or provincial, and local units, each having its own respective functions.

9. National Hospital Day celebration, through the courtesy of *Hospital Management*, now becomes a valuable activity of the Association, which, under proper direction, will provide a closer and more effective contact with the entire field.

10. The increasing demands of the hospital field for technical and advisory information—administrative, financial, educational, legal and scientific, convinces me that we should add, as required, more technical and advisory personnel to the headquarters staff.

11. Affiliation of state and provincial associations with the American Hospital Association is still in a struggling, embryonic state, but I believe the objects of such affiliation could be more mutually satisfactorily and beneficially accomplished through the addition of a House of Delegates or Representatives to the present organization, as described in the text.

12. The hospital field benefiting from the standpoint of economy and efficiency through the various standards developed by the Association from time to time, looks to the Association to continue to establish such standards, not only in equipment, supplies, organization and procedure, but also in the various services vital to the hospital.

13. The Association can do much to promote better relations and closer contact with all allied organizations in the field, and the federal hospitals of the United States and Canada, as well as hospital interests of foreign countries.

14. There is a great need for the Association establishing and adopting a code of ethics as an antidote to commercialism, unethical publicity, irregular practices and politics in hospitals —all of which in the last analysis affects the patient directly or indirectly, and in this connection I would strongly recommend the adoption of "My Pledge and Creed" (as submitted through the courtesy of *The Modern Hospital*) for universal use throughout the hospital field of the United States and Canada.

15. I believe the time has arrived when the Association should have a definite standard of qualifications for member-

ship which carries with it credentials worthy of recognition and confidence.

16. The urgent and ever increasing need for the training of hospital executives must receive immediate attention and more active co-operation on the part of this Association, as well as the organizing of post-graduate, refreshing or observation short courses for hospital personnel all over the United States and Canada.

The committee on hospital construction, dwelling on the capacity, laid down the principle that if the amount of money available is insufficient to build immediately the hospital that the community needs, an ideal programme should be formulated in the hope that it will be realized step by step. The size of a hospital should be determined by the population, number, character and rate of growth. One must also estimate approximately the number of beds required for public ward patients, semi-private and private; also how many beds should be set aside for medicine, surgery, obstetrics, pediatrics, etc. As to site, the committee recommended proximity to a park, where possible. "Sky, trees, grass and flowers are sources of pleasure, inspiration, mental and bodily health; and are worthy of prominent consideration."

Clinical expansion must be considered. The number of patients to obstetrical wards is increasing very rapidly. How to best handle convalescents must also be worked out. Teaching hospital regime, special study, students' accommodation must be considered. Provision for records and library must not be lost sight of. Points in respecting the planning of operating rooms are worthy of close study—special rooms for eye, ear, nose and throat, orthopedic, etc.; also size of dressing rooms and lockers, rooms for surgical supplies, special anesthetic rooms, etc. The various laboratories must be remembered—pathology, bacteriology, chemistry, etc. Much thought must be given to the planning of the X-ray and physio-therapy departments. Nor must one forget receiving and emergency wards, balconies, out-patient departments, administrative centres, nurses' homes, special dormitories and locker rooms.

The kitchen and food service demand much study; also dining and accessory rooms; the laundry, storage and sterilization of patients' clothes; heating, power and ventilating plants.

Hospitals were urged to hold free cancer clinics in connection with "Cancer Week" in an attempt to control and stamp out ultimately the disease in the course of a report submitted to the Association by Dr. Ernest P. Boas, director of the Montefiore Hospital, New York.

(To be completed in the December issue)

Book Reviews

The Hospital Situation in Greater New York. Report of a Survey of Hospitals in New York City, by the Public Health Committee of the New York Academy of Medicine. Prepared by E. H. Lewinski-Corwin, Ph.D., Executive Sceretary, Public Health Committee, The New York Academy of Medicine. With illustrations. G. P. Putnam's Sons, New York and London (The Knickerbocker Press). 1924.

The importance of this report will strike the reader when he learns that there are 182 hospitals in Gotham, containing 32,000 beds (exclusive of insane). Sixty-eight of the hospitals are proprietary. These hospitals own eighty million of real estate and cost thirty-five million dollars a year to run, 375,000 patients are treated annually. There are 3,200 doctors on the visiting staff and 6,500 nurses engaged. The survey has been made because of the rapid growth of hospital accommodations—a growth unguided by a community policy concerning the need of further services and the better adjustment of existing facilities to the metropolitan requirements. The surveyors have examined critically the hospital services, analyzing the excellencies and deficiencies of organization and management, and have made gentle suggestions for improvements and changes.

We hope to make further reference to this report in later issues.

Manual of Bacteriology and Pathology for Nurses. By Jay G. Roberts, Ph.G., M.D., Oskaloosa, Iowa. Fourth edition, thoroughly revised. Philadelphia and London: The W. B. Saunders Company. Canadian agents: The J. F. Hartz Co., Limited Toronto. 1924. Price, $2.00 net.

That a fourth edition of this book has been called for in twelve years with reprinting almost every year, is certain evidence that it has found a place in the authorized and recommended texts for use in training schools. It is a brief work and the attempt to cover the essentials of bacteriology, pathology and immunity has been very successful. A few slips have been noted, such as placing yellow fever in a group with typhoid and cholera when giving instructions for disinfection and fumigation, paying attention to flies and to the excreta rather than

to protection from mosquitoes, even though elsewhere it is stated that the mosquito is the only source of transmission of yellow fever. The moro and ophthalmo-reaction might well be omitted, as they are no longer recommended by careful clinicians for diagnosis in tuberculosis. On the whole, it appears to cover the ground well and may safely be recommended as a text.

Fundamentals of Chemistry. A Text-book for Nurses and Other Students of Applied Chemistry. By L. Jean Bogert, Ph.D., Research Chemist, Obstetrical Department, Henry Ford Hospital, Detroit. Illustrated. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. 1924. Price, $2.75 net.

Though written as a text-book for nurses and other students of applied chemistry, we cannot but feel that this work covers far more ground than should be expected of any nurse in training. For the nurse who proposes to take advanced work in dietetics or undertake laboratory training, it should afford an excellent basis for the study of chemistry. The book is well planned, carefully written and presents the subject in an interesting form.

Diabetes and Its Treatment by Insulin and Diet, by Orlando H. Petty, M.D., Professor of Diseases of Metabolism in the Graduate School of Medicine, University of Pennsylvania, with an introductory Foreword by John B. Deaver, M.D. Philadelphia: The F. A. Davis Company.

There is no question that a book such as this will be of material assistance in the treatment of diabetes mellitus. As the author points out it is in no way intended as a substitute for the physician, but rather to give a working knowledge of the disease. It is doubtful whether this knowledge is not much better mastered by a short stay in hospital where practical instruction is given, but much useful information may be gained from the book which will be valuable to the patient in meeting every-day problems. The book is, perhaps, somewhat brief and no mention is made of the very important question of the prevention of complications.

THE TRIANGLE CLINICAL THERMOMETER.

It has been felt for some time that a thermometer was required, which could be relied upon in every way and at all times. To make this possible and easy for the doctors and nurses to distinguish such a thermometer from other inferior thermometers, the Scientific Supplies Limited, 204-206 McGill Street, Montreal, through the wholesale trade, are putting their patented "Triangle" Clinical Thermometer on the market according to the advertisement on page xii in this issue.

The special features of this thermometer are that the scale of degrees is made in two colors and with a gripping knob at the end, so as to prevent the thermometer from slipping when the mercury is being shaken down. Further, each Triangle Clinical Thermometer is accompanied by a certificate as to absolute accuracy. This Triangle Thermometer, therefore, should prove a boon to the medical profession.

IDEAL BREAD IN THE FOREFRONT.

The progress of the Ideal Bread Company, Limited, has been one of the striking features of the baking industry. In 1908, a small bakeshop standing on the site of the Ideal Bread Company's present bread factory was taken over by the company. Less than ten years later, the fine six-story building was built, from which streams forth daily the immense number of loaves consumed in the fifty thousand Toronto homes numbered among "Ideal" Bread customers.

Such a rapid advance to a dominant position in the baking industry has been due to a strict adherence to several principles. "Ideal" has ever been in the forefront where improvements in baking were concerned. It was the first in Toronto to instal a travelling oven. It was the first in Canada to use a gas-fired travelling oven. (To-day, five travelling ovens, with a capacity of fifteen thousand loaves an hour, are required to meet the demands of "Ideal" customers). It was the first to eliminate the use of coal or coke in a bakery.

"Service above Self" is the motto which the management believes has played a major part in building the Ideal Bread institution. Strict adherence to such a policy has meant a constant striving to attain the highest degree of perfection in its products. That the Company has succeeded in no small measure, is shown beyond question in the immense clientele it serves daily.

AN OLD FRIEND IN A NEW DRESS.

The dosage of digitalis has always been a problem—for two reasons: physiological and pharmaceutical. And these two are obviously interrelated, for unless a reliably uniform preparation of digitalis is available, how can there be uniformity of dosage, even though there may be agreement as to the

physiologic effect aimed at? The profession seem to be partial to the tincture, unless the case is one which demands hypodermic treatment; and of all the tinctures offered, the best is, undeniably, one that is made from select digitalis leaves, standardized by physiologic test, put up in small packages protected from light and air, and, of course, dated so that the physician can tell at a glance how old it is. The reputation of Parke, Davis & Co. is such that what this house has to say about its Tincture No. 111, Digitalis, will be found worthy of careful consideration. Further particulars, if desired, will no doubt be supplied by the manufacturers.

AN EXPERIMENTAL STUDY OF MULTIPLE SCLEROSIS

The alleged spirochetal origin of disseminated sclerosis was studied by Joseph Collins and Hideyo Noguchi, New York (*Journal A.M.A.*, Dec. 22, 1923), in eight cases. The negative results obtained indicate that the demonstration of *Spirocheta argentinesis* and the experimental reproduction of multiple sclerosis in guinea-pigs and rabbits are difficult.

PAPER SPUTUM CUPS.

It would be wise that Canadian hospitals bear in mind the fact that The Stone and Forsyth Co., Boston, Mass., make a specialty of the manufacture of paper sputum cups, refills and holders, and also pocket flasks. This firm have recently put out a new improved refill which, instead of being paraffined, is double coated, waterproof and guaranteer to stand up for an indefinite period. Messrs. Stone & Forsyth will be glad to furnish samples and quotations at any time, and their prices are right, consistent with quality.

A SEDATIVE OR A TONIC?

Lauder Brunton, in his "Lectures on the Action of Drugs," relates the case of a famous author who came to him for relief from insomnia. Brunton did not dare to give him bromides, or other similar sedatives, because he was in the midst of an important piece of literary work and drugs of this kind would have blunted his mental acuity. The great therapeutist decided that the man's nerves were irritable, not because his work was specially racking, but because the man himself was below par, and that if he could be brought up to normal his irritability would disappear. He, therefore, gave him a nerve tonic, with gratifying results.

Most cases of neurasthenia and so-called "nervous debility" have a physical basis. These patients' physical income is inadequate to the demands of living. They have no reserve, and live from hand to mouth. Hence, their nervous irritability. Too often they are given sedatives and hypnotics

when in truth they need a tonic—that is to say, a true tonic, not merely a whip, but a reconstructant which will supply the body with needed elements and promote nutrition. Thousands of physicians throughout the world have proven the efficacy of Fellows' Compound Syrup of Hypophosphites in conditions of this kind. Brunton's experience illustrates a general therapeutic principle. Fellows' Syrup furnishes an agent for applying the principle.

ICE CREAM A FOOD

Probably the reason for the easy digestibility of the fat and casein content of ice cream as compared with the same substance in the form of milk is that the freezing process prevents the coagulation which usually occurs after milk has been taken into the stomach. The infinitesimal particles remain separated, and are thus easily dissolved by the gastric juices, whereas milk, as we know, may form into lumps, either large or small, and these lumps are difficult of digestion. As is well known, the process of manufacturing ice cream tends to destroy any harmful germs which may be present in the milk, this being true even in the plants that do not use a pasteurizing process. Of course, the pasteurized product is practically free from any harmful bacteria. The consumption of ice cream is in its infancy, for as the public learn—as it gradually will learn—of the exceedingly wholesome properties of ice cream and its comparative low cost when its food value is considered, the consumption of ice cream will increase tremendously.

MONGOLIAN IDIOCY IN BOTH TWINS.

August Strauch, Chicago (*Journal A.M.A.*, Dec. 29, 1923), records two cases of mongolian idiocy in twins, the first born of young, healthy parents. The occurrence of a mongolian idiot with a normal twin has been observed only in double ovum twins, as far as known. Mongolism in both twins has been described only in twins of the same sex. They are probably single ovum twins. Strauch believes that the conception of mongolism being due to an endogenic factor seems to find support in these observations.

JUNKET TABLETS FOR MAKING INVALID DESSERT.

Junket is rich in food value. It contains no gelatine or cornstarch, and requires no baking or boiling. Junket is recommended by physicians, nurses and dietitians, and is ideal for use in the sick-room. Junket tablets make a delicious desert, or a rich, smooth, velvety ice cream, that are most refreshing to any patient. Prepared only by Chr. Hansen's Laboratory, 201 Church Street, Toronto.

When rheumatism grips, the *sustained* heat of Antiphlogistine soothes

AS far as is known to Medical Science there is no *real* cure for Rheumatism. Osler says "hot applications are soothing"—and when Rheumatism grips, especially in joints and muscles, the *self-generated* and *sustained* heat of Antiphlogistine brings blessed relief.

Apply Antiphlogistine hot and thick

—as hot as can be borne comfortably by the patient. Once in position and bound snugly with an outer bandage Antiphlogistine will *produce* and sustain heat upwards to 24 hours.

The scientific reason for this is that the large c. p. Glycerine content in Antiphlogistine, acting with the fluids of the tissues, especially when joint swelling is present, sets up a natural generation of heat.

We do not claim that Antiphlogistine will cure Rheumatism, but it does diminish pain and this is a great relief to the patient.

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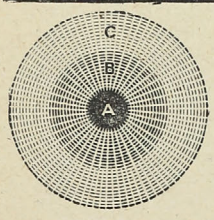
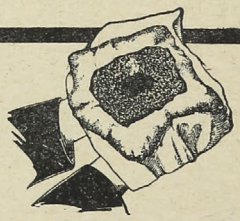


Diagram represents inflamed area. In zone "C" blood is flowing freely through underlying vessels. This forms a current away from the Antiphlogistine, whose liquid contents, therefore, follow the line of least resistance and enter the circulation through the physical process of endosmosis. In zone "A" there is stasis, no current tending to overcome Antiphlogistine's hygroscopic property. The line of least resistance for the liquid exudate is therefore, in the direction of the Antiphlogistine. In obedience to the same law exosmosis is going on in this zone, and the excess of moisture is thus accounted for.



Antiphlogistine poultice after application. Center moist. Periphery virtually dry.

First, a surgical dressing

Then we made Cellucotton into the scientific sanitary pad called Kotex

CELLUCOTTON is the super-absorbent perfected during the world war for use as a surgical dressing.

This quality — super-absorbency — obviously makes Cellucotton the ideal filling for sanitary pads. At last science solved woman's oldest problem in an efficient way.

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Kotex absorbs 16 times its own weight in moisture—instantly. It is 5 times more absorbent than ordinary cotton.

This insures protection, security, under all circumstances, at all times. This means, in turn, peace-of-mind, with consequent poise and self-confidence.

The use of Kotex permits ultra-fastidious daintiness—immaculacy. It promotes physical comfort—is light-weight, cool. It is made odor-proof by a special process. Discarded as easily as tissue.

Kotex is the *sanitary* sanitary pad, made under thoroughly hygienic conditions in a specially equipped, modern plant.

Sold only in sealed packages, so that it reaches the user scrupulously clean, prophylactic.

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