Vol. XXXI TORONTO, CANADA, JANUARY, 1927 No. 1

The Official Organ of the Provincial Hospital Associations

The HOSPITAL MEDICAL and NURSING WORLD

CONTINUING THE HOSPITAL WORLD

$3.00 PER ANNUM

50¢ PER COPY

Contents.

EDITORIAL

Page

The Ontario Hospital Association 1

ORIGINAL CONTRIBUTION

Correlation Between Hospital Auxiliaries and Social Service Departments, by Miss J. Mabel Kniseley, Director of Social Service Department, Toronto General Hospital..... 5

The Training of Character in Schools of Nursing, by Rev. Sister Camillus, St. John Infirmary, St. John, N.B..... 9

Lessons from the Wentworth County Survey, by Dr. J. H. Holbrook, Hamilton..... 11

SELECTED ARTICLES

CANADIAN HOSPITALS

BOOK REVIEW

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

THE HOSPITAL, MEDICAL AND NURSING WORLD

TORONTO, CANADA

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

VOL. XXXI TORONTO, JANUARY, 1927 No. 1

Editorial

The Ontario Hospital Association

The third annual meeting of this young, vigorous association was a conspicuous success. It was marked by the establishment of both a nursing section and a trustee section.

The programme was one of great interest to all hospital workers, and reflected much credit on Dr. Dobbie, who had most to do with its preparation.

President Moncrieff and Secretary Routley were untiring during the year in performing the duties devolving upon them. They have been in touch throughout the year with all the hospitals of the Province, great and small, studying various hospital problems, and securing much data from all parts of the Dominion respecting hospital matters. Major Moncrieff has visited many of the hospitals, attended executive meetings, interviewed the Government on behalf of the hospitals and in every way shown himself an energetic president. His reward was reappointment for another year. The same with Dr.

Routley. And these men were ably supported in their efforts by a live executive committee and by several of the private members.

The nurses in session recommended the formation of a permanent section for nurse administrators; and the trustees did the same. The nurses took exception to the action of the Canadian Medical Association in deciding on a study of training schools by reference to American medical bodies and ignoring Canadian nursing bodies. This section recommended the use of text-books on nursing for use in Canadian schools which shall be written by Canadian authors. They reported that fifty nursing schools have adopted the standard record form issued by the provincial department. They contend that the teaching of theory should be carried on *pari passu* with the practical teaching.

Exception is taken by the nurses to the doctors investigating nursing conditions, as is being undertaken by the Canadian Medical Association and the Academy of Medicine, Toronto, without consulting the nursing bodies. The nursing leaders seem to think this is wholly their province. Doctors, they maintain, have given little, if any, attention to the development of nursing education.

The nurses think, too, that it is time they cut loose from American standards and set up standards of their own in Canada. The Association, too, passed a resolution in respect of standardization, that a committee of the Ontario Hospital Association draw up a standard for the Province of Ontario, adopting only those features of the standard laid down by the American College of Surgeons as may be applicable to conditions in this province.

The Association feels that the time has come for the Province and the municipalities to increase their

assistance to hospitals. Dr. Ferguson, chairman of the trustees' section, is preparing a strong brief which will have the endorsation of the Association. Public opinion must be formed and legislators must be persuaded that what the hospitals are asking is only reasonable and fair.

One of the outstanding features of the meeting was a symposium on the relation of hospitals to the public health of the community. For this excellent presentation, Dr. Holbrook was responsible. From a perusal of Dr. Holbrook's excellent paper in this issue our readers can see what possibilities lie before hospitals who undertake the sort of community work Dr. Holbrook and his coajutors are undertaking.

All sorts of questions were discussed at the round table conferences, and every one was delighted with the splendid informative address of Professor Lyle Cummins, of Wales, on tuberculosis.

We hope during the next few months to reproduce some of the excellent papers read at the meeting.

The Hospital, Medical, and Nursing World

(Continuing the Hospital World)

Toronto, Canada

The Official Organ of The Provincial Hospital Associations, including The Ontario Hospital Association, The Alberta Hospital Association, The British Columbia Hospital Association, etc.

All communications, correspondence, and matter regarding subscriptions and advertisements to be addressed to "The Hospital, Medical, and Nursing World," Toronto, Canada.

Reprints, including Half-tones, etc., Supplied Authors at Net Cost

Original Contribution

CORRELATION BETWEEN HOSPITAL AUXILIARIES AND SOCIAL SERVICE DEPARTMENTS*

By Miss J. Mabel Kniseley, Director of Social Service Department, Toronto General Hospital

In discussing the means of correlation or co-operation between Hospital Auxiliaries and Social Service Departments, I feel I can make myself more intelligible by presenting some of the differences between general and medical social work, by presenting some of the problems with which the medical social worker has to deal, and also by reviewing the progress of our own department.

General social work gets its material from individuals or families applying for, or needing adjustment of living conditions, due usually to financial difficulties. Hospital, or medical social work finds its material in individuals who apply for medical treatment, either in the public wards or in the out-patients' departments.

General social work is primarily interested in cure and prevention of poverty, destitution, crime, etc. Medical social work has for its foundations a desire to complete the cures begun by physicians, and it interests itself as well in education along lines of prevention of disease.

Hospital social work endeavors to alleviate all the unavoidable "red-tape" of the institution, and to create a better understanding between physician and patient, thus making it possible for the patient to derive more benefit from the treatment prescribed. It also endeavors to interpret the hospital to the community.

The hospital social worker tries to bridge the chasm made by the high-priced specialist taking the place of the family physician. She carries with her a sympathetic understanding of the specialist's point of view, as well as an understanding of social conditions and how those conditions may be improved, to the advantage of both medical science and the under-privileged hospital clientele.

*Read at the meeting of The Ontario United Hospital Aids Association, Oshawa, Ont.

The hospital social worker, too, may do much to keep the machinery of the hospital well lubricated, by assisting in hospital administration, by clinic guidance, by ridding the hospital wards of aged, indigent, and incurable patients, thus keeping the beds free for urgent and acute cases. Let me not, however, be misunderstood to mean that the hospital social worker should be compelled by lack of funds, or shortness of staff, to do routine clerical work. This is a misplaced economy, as the trained and experienced worker should be free to do only that kind of work which cannot be done as efficiently by any other.

The problems with which a medical social worker has to deal range from finding a foster home for an unmarried mother and her babe, to providing vocational training for a young paralytic, who, after long months in bed, is told when the acute condition has passed, that he "may go home." Home! that magic word, the full significance of which we fail to grasp until we find some one less privileged than ourselves who has never known a home. Lucky is the social worker who is located in a centre where social welfare organizations abound, from the well-conducted home-finding agencies to the occupational therapy departments. In the smaller centres where she has personally to superintend and arrange all this follow-up care, she must limit the number of her clientele, in order to do the intensive work necessary in each case.

In the early days of our own social service department the personnel consisted of a ladies' board which took upon itself the responsibility of raising funds for the salaries of full-time workers and for such needy cases as the workers brought to their attention from time to time. They had monthly meetings at the hospital, where a report of the work was given, and ways and means of collecting funds discussed. The head-worker had also the privilege of communicating with members of the board at any time for emergency aid, when a problem requiring expenditure of money was involved. These problems usually necessitated hours of telephoning and interviewing to obtain funds, but the results justified the means.

Members of the board also arranged for the visiting of certain patients who were lonely and more or less friendless, giving them little luxuries so dear to the bed-patient. They also provided a limited amount of clothing for adults and layettes for children, when the necessity arose.

As the work grew and the financial demand became greater both for problems and salaries, collecting of money became a great strain upon the board, and it cast in its lot with the

Federation for Community Service, obligating itself to assist in the yearly drive for funds, in return for being relieved of financial responsibility. This left the board with less of the personal touch with the department, and necessitated a reorganization, whereby interest would be retained. It therefore formed within itself sub-committees to be responsible for certain pieces of work. These sub-committees were as follows: library, sewing, motor service, entertainment, Burnside, occupational therapy, and case conference committees.

The Library Committee has collected approximately 2,000 books, and has financed this work without any drawing on the general funds. This committee has also a corps of workers who give three afternoons a week to the distribution and collection of books throughout the wards of the hospital. These young girls do much, by their friendly contact and bright faces, to cheer the more friendless patients.

The Sewing Committee has arranged itself into groups—one to purchase and cut material, one to allocate garments to different friends, one to collect finished garments and return them to hospital. These garments consist chiefly of layettes, though children's garments are also provided. Thus our cupboards are always full of layettes, though the demand for adult clothing still exceeds the supply. This committee does not finance itself, but draws from the general funds for the purchase of materials wholesale.

The Motor Committee takes the responsibility of paying a taxi service, upon which the department calls when in need of cars to take patients home from hospital. This committee originally consisted of a corps of workers who provided their own cars for this purpose, but it was found to be difficult to keep appointments; and the latter scheme has worked very well.

The Entertainment Committee arranges for entertainment in the out-patients' department auditorium, of all in-patients able to walk or to be taken to the concerts. These concerts consist of singing, playing, reciting, etc., and are provided by artist friends of the committee.

The Burnside Committee provides for a group of young women to attend the pre-natal and post-natal clinics, to assist the worker in charge of entertaining the children who frequently come with the mothers, and to serve refreshments to the patients.

The Occupational Therapy Committee arranges for the annual sale of work done by the patients under the supervision of the occupational therapy worker. This worker is employed

directly by the hospital, but works in close co-operation with the social service department.

The Case Conference Committee is the latest activity of the board, and really functions in a similar capacity to the original board. It consists of a group of about sixteen ladies—former nurses, wives of doctors, lawyers, business men, etc., who meet with the director every second month. They discuss with her problem cases, decide on expenditures of larger sums of money; and sometimes make it possible by their wider contacts to solve a knotty problem that has baffled the combined efforts of all the workers.

Following this explanation of the work of our Auxiliary and sub-committees, I believe it will be of further interest to you to know just how the department itself has developed, and what it really does, or attempts to do.

In its early days only cases specially referred by the doctors and nurses on the wards were dealt with by the social worker, who in the first year of her work handled 180 cases. These cases consisted of those needing relief, convalescent care, employment, special appliances, instruction in hygiene, etc. Today, with our present staff of eleven workers—including two secretaries—we are able to put workers in nine clinics in the out-patients' department, besides having routine interviews with all free ward patients.

Taking charge of a clinic means interviewing patients, consulting doctors, with regard to treatment in order to further impress the patient with the importance of carrying out instructions, interpreting these instructions to the patient, visiting homes to bring back to the doctors reasons for slow progress or lack of improvement, visiting to teach health habits, sending reports to co-operating agencies, etc. In addition to these very necessary pieces of work, the medical social worker can do much by research work to further the cause of both medical and social science. By record keeping and careful follow-up, she can aid the doctor in reaching conclusions with regard to certain treatments; and by careful surveys can help to demonstrate the relation between disease and poverty, heredity and crime, etc., and thus indirectly lend her aid in bringing about certain forms of social legislation.

Not only do problems present themselves in the clinics of the out-patients' department, where patients may come daily for advice and treatment while being allowed to live at home, but a vast number of the problems come to us from the wards where the patient, separated from the family circle, has ample

time to think of those who may be suffering from his absence from home.

Here we find the single man who has no place to convalesce from a serious illness, and has no money. Again we find the patient who has had a serious operation, and needs a surgical appliance to complete the cure, and make him fit for work. Again there is the neurotic who must be re-educated to stand alone, and needs much encouragement, amid frequent failures, to make another attempt. Then, too, there is the problem of rehabilitating the patient who has taken a mis-step and has brought on social disease, or the burden of an infant to care for. Besides all these there is the aged and infirm, not needing hospital care, but greatly needing a place to end his days in some degree of comfort.

In dealing with any of these problems we always work in the closest co-operation with the departments of health, both local and provincial, and we find them our greatest allies in both medical and social work.

Where possible, every hospital serving a non-paying or below-average paying clientele, should have on its staff a full-time social worker, trained in both medical and social work, but where the paid worker cannot be financed, or is not available, the volunteer worker can be of inestimable values, and *no* hospital is complete without her interest and support. She can assist in clinic management, taking patients to and from hospital, and serve in the numerous ways already mentioned.

This branch of hospital work, whether carried on by the paid worker or the volunteer, should never clash with the work of the departments of health. By her keen and untiring interest, she can do much to aid the hospital in becoming a centre of health teaching—a centre of social and moral reform!

THE TRAINING OF CHARACTER IN SCHOOLS OF NURSING*

By Reverend Sister Camillus, of St. John Infirmary, St. John, N.B.

When I was asked to present a paper on the above subject before this conference, I was reluctant to attempt so important and deep a theme. I feel my inability to do justice to a subject which many present know more about and could handle with more precision. However, I shall touch briefly on some of the

*Read at the fourth annual conference of the Maritime Catholic Hospital Association held at Antigonish, N.S., September 1, 2, 3, 1926.

important points, hoping at the same time that my hearers prove indulgent and consider my poor efforts as a starting point for a free and helpful discussion of this vital phase of the nurse's training.

The character of the young woman entering the training school is at least partly, if not wholly, formed, depending, of course, on the age, experience, mental and physical development of the individual. Her character, however, even if fully formed, is still capable of being influenced by the example and spirit of her teachers in the training school and by the atmosphere they create. By the teachers, I mean the superintendent of nurses, the heads of the different departments through which she passes during her training; the attending medical and surgical staff, the senior nurses and, last but not least, the chaplain. A student of this type will also be a great help to the younger nurse who is still in the formative stage and with whose character training we are concerned in this paper.

The young woman who enters the training school fresh from high school, and most of our student nurses belong to this class, has little experience of life and none whatever of hospital life as a student nurse. In her lie dormant, as it were, qualities which, with the right influence and direction, will bud forth and bloom into the choicest flower of our profession, namely one who is all that a student nurse should be and, later on, an ideal graduate nurse. Where these qualities are lacking in the young nurse, the wise and prudent superintendent early recognizes the deficiency and informs the student of her unfitness for the nursing profession. How to instill the fundamental qualities and train character in such an individual, if it is worth the effort, are problems which hospital authorities meet with and find difficult to handle. Personally, I think they cannot be instilled.

The helps that are at the disposal of the nurse in training, as far as development of character is concerned, are many and varied; aside from the great influence of a wise, prudent, firm, but kind superintendent with high ideals who is the nurse's constant companion during training, from her entry to graduation. It is incumbent on the superintendent to instill by work and particularly by example the spirit of her profession; to warn the nurse of the dangers that lurk in the path of the profession and gradually elevate her aims and inspire the best and highest motives in the execution of her work.

Those in charge of the different departments, the head nurses in the wards, the doctors, the graduate nurses with private cases in the hospital exercise an influence for good or ill

on the character of the nurse in training. Then, the regular hours for duty, study, rest and recreation, etc., tend to the formation of good habits; discipline, obedience to rules are helps in acquiring self control and abolishing any laxity of discipline which may have existed in the home life of the student. The maternal instinct of the nurse must be stimulated so that the sympathy, gentleness and tenderness which are essential characteristics of the ideal nurse, may not be blighted while urging the development of the points of character referred to.

The pervading influence and great factor, as I have said, is the instilling of the religious spirit so that it, above all else, permeates the work of the nurse. The maxims of religion as guiding principles are indispensable; the realization that there is nobody without a soul, gives the nurse an opportunity of proving herself an apostle also. The grave responsibilities which occur every day in the life of a nurse, can be borne successfully only by the one who is guided by faith and strengthened by the divine assistance obtained by prayer. This faith can be fostered by yearly retreats, conferences and daily assistance at Holy Mass and frequent reception of the Sacraments.

To my mind the most efficient and commonplace means in this cause, is the good example of the teachers. There is no greater instance in which example speaks louder than words, than in the school of nursing. A negligent supervisor, one careless about the little things, even the seemingly trifling niceties of etiquette, has a tremendous influence for ill on the character of the student.

Encouragement here as elsewhere is a great help. Show the student that you trust her, or explain why you cannot rely on her work, with a view to making her more reliable. Permitting the nurse now and then to assume your responsibility in an urgent circumstance and commending her dexterity, etc., is good.

Many are the aids which might be enumerated and various the methods we might follow, but it is my hope that by exchange of ideas on this, as on other subjects so successfully treated of in former conferences, we come by a better knowledge and newer ideas, so that we give to our profession, nobler women and better nurses.

LESSONS FROM THE WENTWORTH COUNTY SURVEY

Dr. J. H. Holbrook, Hamilton.

The survey carried on in Dundas and West Flamboro was new work for all concerned, and it was only with the completion of the work that we were in a position to express any very de-

finite opinions as to the best method of procedure. In several respects it differed from that of other surveys, these changes being due in great part to local conditions. As an illustration of this point this was made a general survey and it was carried on with the aid of about forty general practitioners of Hamilton and Wentworth County. These men, after completing the general examination, referred the child to the various specialists or consultants including eye, ear, nose and throat consultants, chest consultants and in the case of pre-school children, to children consultants.

Dental consultants were not secured and it is possible that this part of the work was under-estimated in the report, but even at that sufficient gross trouble was found to answer the requirements of the survey.

Finally it was arranged to have a single film of the chest of every child, and this plan succeeded to this extent that of the 1,392 children a few more than 1,000 films were secured.

Under the heading "Lessons of the Survey," we might first make this statement that practically all the work carried on in the examination of the children was in the nature of preventive medicine and was outside the field of the general practitioners, who are almost wholly engaged in the treatment of active disease. We would judge that most parents do not consider it their duty to take their children to their family physician for an examination such as was given in the course of this survey, and that instead of interfering with the work of the general practitioner this survey really extended the field of his activities by showing the parents the importance of consulting their physician about early conditions, and by calling the attention of the physician to the importance of this work.

As proof of the increase of interest of the physicians engaged in the survey in the diagnosing of commencing pathological conditions we would point out that the local medical society arranged for a post-graduate course on the differential diagnosis of chest conditions during the following winter, and we are very sure that any variations in findings owing to the larger number of examiners were more than compensated for by this quickening of interest in the whole field of early diagnosis and preventive medicine.

Another important lesson learned was this, that before attempting to make a diagnosis of active tuberculosis in the early stage of the disease in which it might occur among the children included in the survey we found that it was necessary to take into account every possible source of a non-tuberculosis infection. While the disease of pulmonary tuberculosis in its later stages is

characterized by physical signs which more or less clearly differentiate it from other types of infection, yet in the earlier types of tuberculous infection these differential points become less evident until, in the earliest stages that are possible of diagnosis it becomes very difficult to differentiate between a tuberculous infection and the commoner types of chronic and sub-acute non-tuberculous infection. For this reason we were especially pleased when the survey was over that it had been decided at the outset to make a more general examination rather than merely a special chest examination.

As another lesson I believe all who took part had a higher opinion of the value of the tuberculin intracutaneous test when the survey was completed. To quote from Dr. Elliott's report: "This test is a specific test for the presence of tuberculous infection. A reaction is definite evidence of the presence of such infection, and this may be recent or of old standing. A reaction is not evidence of tuberculous disease. Adult tuberculosis (pulmonary tuberculosis, consumption) may result from these infections demonstrated in childhood. It may also develop from re-infection in after life. What proportion of cases of consumption develop from childhood infection and what proportion are super-added infection in after life, we do not know. 'That childhood infections are prolific breeders of adult tuberculosis cannot be denied.' (Krause.) Periodic health examinations, instruction in general and personal hygiene, and careful living should materially lessen the number of adult cases developing in this group of reactors."

These statements had a much more definite significance for the examiners when the survey was completed.

In routine clinic work had felt, previous to the survey, that the tuberculin test was not very essential in many cases that were referred for examination; but the great majority of the children in the survey were apparently healthy and were therefore in much better physical condition than those that would be referred to a clinic. In trying to come to a conclusion as to the nature of infection in these cases with little or no evidence of disease we came to very highly appreciate the tuberculin test and since that time we use it as a routine in our clinics.

The attitude we have been compelled to take as a result of the survey, is that non-tuberculous, chronic and sub-acute infections in their earliest stages can present practically the same changes as are found in tuberculous infections, and that in the very early cases before making a diagnosis of active tuberculosis we have to rule out all other possible sources of infection before definitely asserting that a child has active tuberculosis.

Summarizing our conclusions with regard to diagnosis of tuberculosis in children, we would say:

(1) That impairment of resonance over any part of the chest may be due to conditions other than tuberculosis.

(2) That broncho-vesicular or still higher pitched breathing may be present apart from tuberculosis.

(3) That rales associated with a sub-acute infection in the chest do not necessarily indicate pulmonary tuberculosis.

(4) That physical signs pointing to enlargement of the mediastinal glands are present in conditions other than pulmonary tuberculosis.

(5) That increased density in the X-ray picture extending to the apices or other increased densities in the lung, are present in conditions other than pulmonary tuberculosis.

(6) That a diagnosis of lymphatic tuberculosis or of minimal pulmonary tuberculosis is only justifiable when all the information necessary for a differential diagnosis is at hand.

This brings us to the matter of the time element in making a diagnosis of tuberculosis, the one measure which it was impossible to make use of in the survey. To illustrate this point, we often found a child who was undernourished and had a slight daily rise of temperature with which was associated a positive tuberculin test. If with this there were slight physical signs of abnormality pointing to the apices, or to the bronchial glands, and there was no evidence of a localized non-tuberculous infection, we would consider the weight of evidence in favor of a slightly active tuberculous process. If, on the other hand, with these conditions we found diseased tonsils, or abscessed teeth with enlarged tonsillar or anterior cervical glands, a positive tuberculin test would not give sufficient evidence on which to base a positive diagnosis of active tuberculosis. In such a case, the test of time is a very important factor, for this would give an opportunity to clear up foci of non-tuberculous infection, by removal of tonsils, adenoids, diseased teeth or other possible sources of temperature; and with the elimination of these factors we would be in a much better position to judge as to whether the positive tuberculin test indicated a chance infection or active disease.

In the matter of the value of X-ray probably the chief lesson learned was that the X-ray is usually more valuable from the standpoint of negative information in children corresponding to the group found in the survey. In the report, we have summed up our impressions as follows:

(1) That while no general rule can be laid down yet there is a tendency for the cases that react positively to tuberculin to

also show increased shadowing in the mediastinal glands and an increase of the linear shadowing in one or more sections of the lung.

(2) That the children who have had measles, pertussis, influenza, pneumonia and bronchitis usually show very definite increased shadowing.

(3) That children giving a history of frequent colds also show increased shadowing.

(4) That defective nasal breathing may be a factor in producing increased mediastinal and linear shadowing and that this condition of defective breathing is often found in children with adenoids and enlarged tonsils, who are mouth breathers.

(5) That it is quite impossible to differentiate between the shadowing associated with these latter conditions and the shadowing due to a very early tuberculous infection, such as might be found in a case with a positive tuberculin reaction, but where no involvement of the parenchyma of the lung can be demonstrated.

We tried to go considerably farther in the matter of reading the X-ray films, in an effort to see whether we could not come to some definite conclusion as to the shadows which begin to develop early in the history of every child, in relation to the positive reactor. In this study, we read the films without having any other information before us, and then made comparative tables of increased X-ray shadowing in relation to positive or negative tuberculin reactions. Our results showed that while forty-four per cent. of the non-reactors showed increased shadowing this percentage was sixty-four in the reactors. Putting these conclusions in a little different form, we would say that the children whose X-ray films show shadowing that might be considered to be increased over the average for a child of that age are about twenty per cent. more liable to give a reaction to tuberculin than those who show average shadowing. This finding, however, is so indefinite, due to the personal equation from the difficulty of any two people agreeing precisely as to what is normal shadowing for any particular age period, that it is of no practical value except to open up a problem for future discussion. This, of course, is of little value in making a positive diagnosis and we agreed with the generally accepted conclusion as summarized by Dr. Hess, that "successive simple respiratory infections could produce increased shadowing, and that in the absence of the definite X-ray stigmata of tuberculosis, such as cavitation, multiple shadows due to conglomerate tubercule, or definite apical lesions; in other words, the evidence of advanced disease, a diagnosis of early pulmonary tuberculosis on the X-ray films

alone, was unwarranted. This conclusion stands out above all others: That the X-ray must be used in conjunction with the other clinical methods, and the findings checked up by careful comparison of all the data in each case."

This survey presented an opportunity to judge between conditions of town children and of rural children. It also gave an opportunity of judging between town children who have had a system of school medical inspection for some years and town children who have had little or no school medical inspection. In the two groups of town children the condition of the children was all in favor of the group who had been under school medical inspection. As none of the rural children had been under school medical inspection the comparison is not altogether fair as between town and rural children. But apart from the difference that this might make, there was also a definite contrast between these two latter groups.

A summary of defects in urban and rural children was prepared which showed that the town children were superior to the country children in the matter of enlarged lymph glands, diseased tonsils, and treatment for children in the same by tonsillectomies; while they were greatly superior in the matter of healthy teeth. In fact, our figures with regard to teeth do not give a fair impression of the great amount of dental disease in county children, for in our summary one small cavity of a town child would be entered as a dental defect while many large cavities for which the only treatment was the extraction of the teeth was also entered as a single defect in rural children. On the other hand the percentage of six-year molars diseased was the same in both groups, which may possibly be explained by concluding that both groups receive very little care of the teeth before they reach the school period. The percentage of adenoid growths was also practically the same in the two groups. The advantage was slightly in favor of the rural children in the matter of nutrition and of defective vision while in the one particular of tuberculin skin tests the percentage was very much in favor of rural children, there being twenty-two per cent. of positive reactors among the latter and thirty-six per cent. among the former.

One striking characteristic with regard to the positive reactors among rural children was that where there were several children in one family they would usually be all positive or all negative to tuberculin and in at least two cases where this was investigated the milk supply had come from tuberculosis cattle.

It was very gratifying to find in the survey no cases of open pulmonary tuberculosis, or acute cervical gland tuberculosis, or

of any other form of gross tuberculous infection.

We are pleased to say that the Provincial Board of Health are planning for a follow-up survey to investigate the cases that were found to have defects in order to find the number of corrections of defects that have been made, as no provision was made in the survey for the correction of defects other than to send a written report to the parent on the condition of each child with the recommendation that this be taken to the family physician. We know of many cases where corrections were made even before the survey had been concluded, but we feel that considerable difficulty would be experienced in convincing the parents, in those sections where no provision for school medical inspection was yet established, to take a serious view of the commencement of these physical defects, and it is to get definite information on this point that the follow up has been planned.

We concluded our report with the following recommendation which might fairly well be taken as a summary of the findings of the survey:

We would recommend, therefore, that children be protected from the milk of tuberculous cattle, and that they be not permitted to associate with patients suffering from tuberculosis. We believe that an occasional chest clinic, perhaps one per year in each school, would make it possible through the discovery of early infections that tuberculosis in a short period of time could almost be eliminated from the rural parts of Ontario.

Selected Articles

SPECIAL CHARGES

By Joseph C. Doane, M.D., Medical Director and Superintendent, Philadelphia General Hospital

There are a number of seemingly valid reasons that warrant a careful study of the subject of special charges, covering unusual or even routine services in the hospitals of the country. In the first place, there is evidenced everywhere in the field an interest in the possibility of some standardization of these charges. On the other hand, there are many who, while favoring such an attempt, feel that the obstacles to complete success are insurmountable.

Before *The Modern Hospital* undertook this inquiry, however, to be doubly certain that in the judgment of hospital men and women such an investigation would be of practical value to them, more than a score of superintendents, of both small and large hospitals, were asked their opinion on this subject. Their views brought out two points:

1. That the subject is undoubtedly of interest, but, at the same time, is troublesome to the majority of executives consulted.

2. That no basis, either as to the amount of charges or as to the services listed as special, now exists in the majority of hospitals in the country.

Being satisfied, therefore, that justification for a review of the subject is not wanting, but with no hope of being able to say the final word on so vexing and inclusive a subject, attention is now invited to a consideration of the arguments that have been advanced, supporting and disfavoring the so-called special charge system.

Most hospitals issue a scale of prices for the use of beds in their private, semi-private and public rooms and wards. These prices do not change at frequent intervals. In addition to this list, there is also published a scale of charges that covers special services. These charges change more often in most hospitals than those to which reference was first made. The charges for these so-called special services vary greatly in different hospitals, hence it is not possible to set down here

any very informative list of these amounts. Moreover, the fees charged private patients do not usually correspond with those exacted from patients occuping public or semi-private beds. In the main, these charges cover the following:

Operating room, delivery room, anæsthetist (sometimes combined with the operating room charge), X-ray, special laboratory work (sometimes all laboratory work except urinalysis, but often including this item), cystoscopy, ambulance, basal metabolism, radium therapy, physiotherapy, expensive drugs (the definition is not always clear—usually the relative expense is the interpretation made), dentistry, electrocardiography, telephone calls, special diets, dressing materials, special nursing and doctors' fees. (The last two are not paid to the hospital.)

Why Flat Rate is Desirable

Now, what are the reasons that favor the substitution of a flat rate for the present multiple system of charges? Briefly, these arguments may be stated as follows:

1. There is a very general dissatisfaction on the part of the patient when he finds that his bill contains many large items of which he had hitherto no knowledge.

2. It is often felt that there is an unusual, or even from the patient's standpoint, an excessive addition of extras to his room bill. Some patients even suspect this addition to be a tax imposed upon them because they occupy private rooms, to be used to meet deficiencies elsewhere.

3. The hospital bookkeeping is greatly simplified by lessening the number of items for which charges are made.

4. Such a system avoids sending extra bills to patients whose discharge took place before tardy departmental heads had notified the accounting department of services performed in their laboratories.

5. When the patient comes to the hospital, he buys the complete service of the hospital to restore him to health as speedily as possible. In other words, the hospital's contract is to restore health, and includes all the hospital services required to do so.

6. A large class of people prefer in the hospital what in the hotel is called the American plan, as contrasted with the European system, because in this scheme their expenses for treatment can be more certainly forecast.

When it is decided by the physician that hospital care is necessary for the patient, the first questions asked by the sick man or his relatives are: "Where can a hospital bed be secured and how much will it cost?" The physician, almost without

exception, replies that he will call up the "X" Hospital and arrange for a room, and that the cost will be about "Y" dollars a week. This cost is invariably the cost of the room alone. Suspicion, or even actual hostility, toward the hospital is engendered when the "Y" dollars a week either on admission (if payment in advance is requested), or at the conclusion of the hospital stay, becomes Y+A+B+C+D dollars.

Nor is it usually possible, or even wise, for the doctor at the time of his patient's inquiry to enumerate or even mention the probability of extra charges. Moreover, the physician at this time is chiefly interested in speedily securing the relief for his patient which the hospital offers, and his mental processes do not easily encompass both the diagnosis of the disease, and an accurate estimation of probable costs for institutional care.

The business office at the hospital then is placed in the disagreeable position of embarrassing the doctor before his client, or of arguing the necessity of the system. In either instance it eventuates that the patient is displeased, and remembers this misunderstanding long after his thankfulness for restored health has been forgotten. This circumstance would appear to be of but trivial importance, were it not for the fact that the hospital must not sacrifice community confidence in any degree, and must avoid even unfounded distrust from any angle.

Bookkeeping is Simplified

In regard to the inadvisability of often changing hospital rates, and the substitution of a rising special charge rate, to meet the increased overhead, but little need be said. The rising cost of drugs, chemicals, apparatus, instruments, and salaries, actually required by special work, should, of course, be covered by a proportionate rise in departmental fees, whether these charges appear separately or are included in the room bill. If bookkeeping simplification would result from a unit charge, consideration should be given to the fact that the number of clerks in the offices of a large institution might be lessened by one or more. But the simplification of work to be performed, or even the avoidance of an expenditure for hospital personnel, does not justify any step that does not react favorably on the patient's welfare and peace of mind.

The next argument advanced is somewhat similar to the first in its effect on the patient. The transmitting of additional bills to patients who have gone home, after they have concluded that the expense of their illness was already sufficient or excessive, is often conductive to misunderstanding as to the motives and methods of the hospital. Nor is it always possible

to draw up these bills earlier. Often the special service is performed but shortly before discharge, and just as often, in the hurry and absorption of scientific research, the sending of statements to the business office is slighted or overlooked. This argument is not one of great weight, but rather of expediency only. To be sure, it is difficult always to secure promptly any sort of a report from departmental heads, but this is a matter for administrative correction.

Hospital Contracts to Restore Health

The next argument advanced in favor of a flat rate appears to be one of great breadth, involving, in truth, the whole subject of community and hospital relationship. Has the hospital a right to accept a patient unless it is ready to provide all the service that is necessary to return the patient to health? Is there any service or facility that the hospital possesses, which can ethically be withheld because the patient is not able to stand the necessary expense therefor? It is argued that a man can recover just as speedily in a ward as in a private room, if equal medical skill is to be found in each location. It is contended that when money is not available to furnish that skill, together with all essential scientific data, then the hospital service to the patient is only partial, and the hospital is not fulfilling its community obligations. There appears to be much meat in this latter argument. Why do patients prefer private rooms? Is it because greater medical attention is to be found there? Usually not. The separation from other patients, as a matter of personal choice, is for the same reason that one prefers a Pullman to a day coach. One reaches his destination in either, but with a little more ease and privacy in the former. Frequently the medical study —especially where ward teaching is in vogue—is as careful and as fruitful of results in the ward as in the private room.

Those who most strongly favor the adoption of a flat rate charge ask this question: "Is it rational for the hospital to sell the service of its rooms and wards, with light and warmth, and then list for sale, in addition thereto, the services of its laboratory, X-ray, and electrocardiograph facilities, when often these services which may be most expert are not available to the patient because of their cost?" Would it not be as reasonable, since the power plant is, perhaps, the most expensive hospital utility, to charge extra for heat and light, and not supply these necessities unless payment is promised by the patient? Would the patient's return to health be more delayed by withholding from him heat and light than it would by not

supplying laboratory or X-ray services? These questions, advanced by the proponents of the flat rate system, are set down here because they are not only thought provoking, but also not without logic. The last argument advanced is one that is more or less individual in its application, and while of minor importance is here set down for the sake of completeness.

Not a few arguments are advanced, favoring the present system. Chief among these are the following:

1. A flat, *per diem* rate is unfair, because the patient who requires but little laboratory or other specialty work must pay for another who needs much more.

2. Patients are willing to pay for what they get, but are unwilling to spend money for what someone else receives.

3. The *per diem* room rate would appear too high, if special charges are contained therein, and an unfair conclusion would be drawn if a hospital with a flat *per diem* rate were compared with another not employing the same system.

4. The cost of special charges varies so much that unless they are listed separately, the unit price of room service would necessarily change often, to the confusion of the hospital clientele, and a consequent misunderstanding as to the reason therefor.

5. This scheme is the most practical and workable one known at present.

Seeming Injustice Noticed

The first objection appears at first glance to be most logical. To require a patient, who is admitted for the treatment of an acute bronchitis, to pay a part of the laboratory, X-ray, or electrocardiographic expense of the patient suffering with Graves' disease, does not seem just. These types of cases have been mentioned because they represent extremes, in so far as a demand for special work is concerned. Nor is any information at hand as to the relative injustice to the average patient, as compared with the extra service received by those patients representing the second type mentioned.

Two questions suggest themselves: Would the law of averages, over a period of time, atone for an undoubted "injustice" to the few on certain occasions? Would the cost of all so-called hospital special services, when prorated among those admitted during the year, be too great a burden for the average patient to carry? It has been suggested that if all revenues, earned by a specialty department, were turned into the hospital treasury, and all salaries and other expenses paid therefrom, it would

simplify in a measure the question now under discussion. Perhaps this would be too Utopian and revolutionary.

It is undoubtedly true that there is inherent in the American citizen two traits: a willingness to pay for what he gets, if he is satisfied that it is worth it, and an unmovable stubbornness toward being required to pay when he believes value has not been received. In hospitals where the flat rate system is in partial vogue, there are a number of expensive extra services for which a charge is made. Laboratory service appears to be the easiest to absorb in the basic room rate. Indeed, in the X-ray, electrocardiographic and some other departments, the physician in charge, being paid a nominal salary by the hospital, derives most of his income from these fees from private patients. Whether the absorption of all the hospital overhead running expenses in a unit *per diem* cost would be generally resented is a matter of conjecture. If such were the established custom, probably no criticism would arise. That there would be an elevation of the *per diem* rate, under the flat rate system, must be granted. Whether this rise in published rates would harm the hospital's patronage is, of course, a question. If such a change were made, no doubt a frank explanation of the change in policy would go far in satisfying the public of the hospital's good intention, at least. A comparison with the rates of other hospitals, not using the same system, would be in a measure similar to the rates of an American plan hotel being compared with an hotel renting only its rooms—a variation in system only.

Three Points Stand Out

In summarizing these arguments, there are three that seem to stand out in importance; the rest, while not unimportant, are minor.

Does the sick man, if accepted by the hospital as a patient, morally, at least, deserve all the curative effort the hospital can command, regardless of cost?

Does the hospital have a moral and ethical right to charge one patient for something another gets?

Is any change in the present system practical even if adjudged fair to the patient?

There can be but one answer to the first question. No hospital in the field deliberately and knowingly, no matter what the cost, withholds anything which it is convinced will benefit its patients. But there are many steps in the study of a patient that do not promise sure help; there are many conjectures and attempts at solution of a knotty diagnosis,

which cost time and effort. These frequently fall into the field of elective procedures from the standpoint of the patient's wishes and ability to pay. Indeed, that there will rightfully remain as special or elective a number of such services seems indisputable.

As to the second question, it does not seem unjust or unbusinesslike, but, perhaps, of too idealistic simplicity, to compute the cost of conducting the whole hospital a day, and then, using this amount as a dividend and the average number of patients cared for as a divisor, thus to arrive at the rate per patient. Also, if the policy of the hospital is to allow the private pavilion to aid in carrying the ward service, from which cost rates cannot be realized, a basic per day or week additional charge could then be computed. This might vary, of course, with the location and the elegance of appointments of the private rooms available.

Five Possible Solutions Offered

Attention is now directed to five possible solutions of this problem:

1. Would it be fair, both to the hospital and to its clientele, to have but one scale of prices, that for the use of room or ward beds, all other charges being absorbed therein?

2. If this is not practical, is it possible to have such an arrangement for certain types of patients, such as medical, surgical, obstetrical, or the so-called specialties, such as eye, nose, throat, and metabolism?

3. If this is impracticable, is it feasible to include the major portion of these charges in a flat rate for general, or even departmental types of illness, and to have a lessened number of services for which special charges are made?

4. Or, is it possible to have for all patients a nominal charge for but one or more of these services, such as laboratory work (the number and types of such services being listed), and the more costly and unusual studies still remaining on the special list?

5. Or, are all these possibilities impracticable, and should the present system continue, or grow, commensurate with the adoption of new steps in the scientific study of disease?

As to the last question, it appears that some alteration in the present system would be workable and not impracticable. The number of items so absorbed, and the rate charged therefor, would depend somewhat on the financial strength, the clientele, the community intelligence, as well as the ingenuity of the hospital itself.

It seems, then, that the weight of evidence points toward the wisdom of some approach toward the flat rate system. This may vary greatly in degree, from only slightly lessening the number of items for which extra charges are made, to the complete absorption of all these in a flat rate.

No attempt has been made to offer any but provisional conclusions on this subject. If this discussion, however, results in a frank expression of opinion from those in the field, it will have served its purpose.—*The Modern Hospital.*

Canadian Hospitals

THE ONTARIO HOSPITAL ASSOCIATION

At the nurses' section of the last meeting of this association it was decided to use text-books in nursing schools which were written by Canadian authors.

Fifty nursing schools have installed the standard record form issued by the provincial department. Schools are finding it hard to secure applicants with the minimum standard of two years at high school. Students are even returning to high school to meet this requirement. There was yet some difficulty in small schools and some special hospitals in securing affiliation in order to round out training. Several hospitals were still affiliating with hospitals in the United States. Miss Munn considers this regrettable.

Discussion was given to the suggestion that all lectures on nursing theory be given during six months. Miss Gunn pointed out the objections: the student-nurse would not be familiar with patients, hospital routine or nursing procedure, so her mind would be filled with unrelated facts—lack of correlation between theory and practice. With theory during the first six months—say in "diet in disease" and obstetrics—practice usually did not follow until the third year. It would be difficult to remember over so long a period. By commencing on theory the students would be unable to know whether nursing appealed to them. The interruption of ward service for class work was over emphasized. Hospitals unwilling to teach nurses should employ graduate nurses. The best method of teaching theory was while the practical work was being done.

In respect to the discussion of graduate nurses in the Hospital World and the *Canadian Medical Journal* of the Canadian Medical Association, the section on nursing regretted the

method by which the study had been launched by the Canadian Medical Association. The nurses' organization would welcome the assistance of the Medical Association in making a study of the question in a professional manner—the investigating committee to operate through the nursing organizations rather than by consulting individual physicians and nurses, many of whom have given little, if any, attention to the development of nursing education.

The following are the purposes for which the special committee of the Canadian Hospital Association was formed: 1, To study and report upon the curricula of training schools for nurses in Canadian hospitals. 2, To determine the process by which the present curricula have been evolved, and the supreme authority in determining these matters. 3, To request the co-operation in this study of other Canadian organizations directly concerned in the education of nurses—pupil or graduate. 4, To request co-operation also from the American Medical Association, the American College of Surgeons, the American Surgical Association, the American Hospital Association and the American Association of Nurses.

The nurses' section reported that it disapproved of the provision in clause 4 because it is of the opinion that the time has come when Canadian medical and nursing associations, superintendents of Canadian hospitals and training schools are capable of managing their own affairs. Further, the time has come when we should develop Canadian nursing standards to meet our peculiar needs, rather than be directed in these affairs by foreign organizations.

In connection with the action of the Canadian Medical Association Miss Dickson, of Weston, stated that the nursing committee in the training school curriculum had invited the president and secretary of the Canadian Medical Association to act on the committee. The president overlooked even answering the letter. She felt that a similar courtesy should have been extended to the nurses of the Association by the Medical Association. Miss Dickson didn't think the medical profession as a whole shared the attitude shown by their Association.

An editorial on the special nurse in the Hospital World was discussed by Miss Carruthers, who pointed out that the special nurse was indispensable to the patient, the doctor and the hospital.

In discussing the desirability of immunizing nurses in training against diphtheria and scarlet fever, Miss Fairley said such procedure was highly desirable. Nurses in training were unusually susceptable to communicable diseases, especially

nurses from rural districts. Their resistance was often lessened by their arduous and confining work. Such inoculations were all particularly necessary in these days when nurses are required to be trained partly in infectious disease hospitals. It is a very serious affliction for a nurse to contract a contagious disease; she is a menace to the rest of the nurses, and her incapacity is a decided loss to the hospital.

Miss McKee discussed replacement of ward equipment. Condemned articles should be replaced immediately. In small hospitals such action should be taken by the superintendent; in large hospitals by a condemning officer. The worn or broken article, if beyond salvaging, should be sold or destroyed.

Miss Ritchie spoke on her method of handling special diets. A pupil nurse trained in dietetics was responsible for the clear broths and special deserts. These were added to the trays and inspected by the nurse in charge.

In a discussion on the relation and power of the superintendent to help, nurses in training, and medical staff, it was decided that the superintendent was responsible for all three.

The following are the clauses in the Nurse Administrators Section of the Association:

1. *Name*—The section shall be known as the "Nurse Administrators Section" of the Ontario Hospital Association.

2. *Objects*—The objects of the section shall be (a) to study and report upon problems of internal administration of hospital; (b) to study and report upon matters pertaining to training school administration and nurse education.

3. *Officers*—The officers of the section shall be a chairman, vice-chairman and a secretary; these officers shall be elected by the members of the section.

4. *Membership*—All nurses who are members of the Ontario Hospital Association may become members of the section upon request for enrolment.

5. *Meetings*—(a) Meetings of the Section may be held at the discretion of the chairmen of the section or upon the call of the president of the Association. (b) The secretary of the section shall send to the president and secretary of the Association a copy of the minutes of all meetings of the section.

Financing of the Section:

The section shall be financed by the Association in the same manner as a standing committee of the Association is financed.

Limitations:

The section may not act upon any resolution affecting the Association as a whole until such resolution has been endorsed

by the Board of Directors of the Association or by the Association in general meeting.

Amendments:

These by-laws may be amended at any time providing that thirty days' notice of proposed changes be mailed to the members of the section and that such changes are sanctioned by the Board of Directors.

WESTERN GRADUATES HOLD ANNUAL REUNION

From the first graduating class in 1898 down to the present, members of the alumnæ of the Western Hospital Training School for Nurses, Toronto, assembled on October 22nd for the largely-attended reunion in the new Edith Cavell Memorial Nurses' residence. Dr. Augusta Stowe-Gullen, president of the Women's Board, one of the prime movers in securing the home, was made the recipient of a portrait of herself, to be hung in the new residence. Other guests of honor were several former superintendents of the Training School, including Mrs. Shaw, of Montreal: Mrs. W. A. Skeans, Miss Muriel McKee; the present superintendent, Miss Ellis, and assistant, Miss McAfee. There were three of the 1898 graduates present, Mrs. J. McConnell, Mrs. J. Chubb and Mrs. Annie York. The president of the alumnæ, Miss Gertrude Wiggins, was in charge of the ceremonies.

After assembling in the spacious lounge, where many happy recollections were recalled, the guests were invited to sit down at flower-decked tables in the large dining-room. Mrs. York, one of the first class, was asked to say grace.

Among the graduates present were two nurses who served overseas and were awarded the Royal Red Cross, Miss Misner and Miss Drysdale. Miss Wiggins conducted the roll-call for the different years, which proved a merry feature of the programme.

The graduates of 1925, the first class to inaugurate their own student government, and the largest class in the history of the training school, responded with their school yell:

"We are the class of 2T5;
Thought we were mighty lucky
To get out 'f here alive;
Had enough, had enough,
Still going strong,
A few years more ain't very long."

Messages of regret were read from two former superintendents, Mrs. J. C. Keddie and Miss Scott, who extended warm congratulations on the opening of the new home. From Miss Teresse Ashland, Fort Washington, came another letter of congratulation.

The presentation to Dr. Gullen was made by Miss Mary Corley, who expressed the alumnæ's deep appreciation of her efforts to promote the welfare of the nurses. In replying, Dr. Gullen reviewed some of the early days in the nursing and medical professions for women. Doctors and nurses must co-operate to the fullest extent, she pointed out, and women doctors and women nurses should preserve a finer *esprit de corps*. Nurses had necessarily to cultivate a broad outlook on life, and she urged the women of the profession to be very loyal to each other and in that way to advance the universal welfare of the race.

Miss Ellis spoke of her pleasure in being able to participate in the reunion. Mrs. Shaw of Montreal, Mrs. W. A. Skeans, Miss Muriel McKee and Miss Eleanor Johnston, superintendent of the Orillia Hospital, were among the speakers. A vote of thanks to the president of the Alumnæ, Miss Wiggins, for her planning of the interesting reunion, was extended by Mrs. Henders.

There were about one hundred and fifty graduates present for the event, a number attending from out-of-town. Among those present were: Miss Riddell, Mrs. McLean, Mrs. Baillie, Mrs. Huston, Mrs. Bell, Mrs. Valentine, Miss Anderson, Miss Cooper, Miss Agnew, Miss Low, Mrs. O. R. Thompson, Belleville; Mrs. S. Buck, Port Rowan; Mrs. Gilroy, Mrs. Armstrong, Miss Tuckett, Miss McWilliams, Miss Sinclair, Miss Sharpe, Miss Sparrow, Miss B. Stacey, Mrs. McKee, Heathcote; Miss Kneeshaw, Mrs. Duff, Mrs. Wright, Clarksburg; Miss Boggs, Miss Urquhart, Miss Poret, Miss Hicks, Mrs. Rowantree, Mrs. Wettlaufer, Miss Cooney, Miss Battrick, Midland; Mrs. Lane, Port Elgin; Miss Caesar, Mrs. Spence, Mrs. A. E. Wilson, Miss Ella McLean, Miss Bond, Miss Annan, Mrs. Dunbar, Miss Turton, Mrs. L. Fortier, Mrs. J. Wood, Miss Creighton, Miss Lucas, Mrs. Scythes, Miss B. Smith, Miss McWilliams.

ANNUAL MEETING TORONTO HOSPITAL FOR INCURABLES—ADDITION IS NECESSARY

A fine new building adjacent to the Hospital for Incurables, Toronto, reminded those who attended the fifty-second annual meeting of the Hospital Board of Management held October

27th that soon another up-to-date nurses' home will be added to Toronto's splendid institutional residences. Lieut.-Col. Noel Marshall, in the course of his brief presidential address, explained that the opening of this new building was not far distant and that friends of the work might have the privilege of furnishing some of its rooms, thereby perpetuating the memory of relatives and helping to reduce the expenses of the residence. One room, he explained, might be fitted up at the comparatively small cost of $135.

The addition of the Nurses' Home, accommodating 150, will make possible larger quarters for cancer cases in the hospital, and Dr. Edmund King, in presenting the medical report, stressed the necessity for adequate provision for the ever-increasing number afflicted with this disease. Twenty per cent. of the fifty-eight patients admitted during the past year had been victims of cancer, he stated, and more deaths were due to it than to any other malady.

Applicants for admission to the hospital during the past year, Dr. King said, had numbered 147, these patients ranging in age from 17 to 94. Fifty-nine had been admitted, and at present the inmates totalled 215. Of those accepted in the last twelve months 18 were over 70 years of age, 9 over 80, and 1 was 87.

In all reports submitted yesterday reference was made to the passing of the late Mrs. Grant Macdonald and the late Ambrose Kent, two devoted friends of the institution. For twenty-eight years Mrs. Macdonald served as a directress of the hospital, and the Grant Macdonald Training School for Nurses is a living monument to her work and influence. For twenty-two years Ambrose Kent was the wise and kindly President of the Board of Managers, and during his thirty-two years' connection with the hospitals he also acted as a Vice-President and as a Secretary-Treasurer. The death of "Collie" Ross, whose attention to the inmates had been unremitting, was also mentioned with sincere regret.

A satisfactory financial statement showed receipts of $193,660, and expenditures of $182,773.

Tributes of appreciation were paid to Miss Cooke, the hospital superintendent, and to all her staff, and also to Miss Mortimer Clark for her services on the Board of Management.

Rev. Dr. Pidgeon and Archdeacon Ingles offered the opening and closing prayers; the Rev. Father Minnehan spoke briefly. Others taking part in the programme were: John Macdonald, John Firstbrook, and Br. Band.

The Board of Managers for the ensuing year is composed of: Miss Mortimer Clark, Mrs. Ambrose Kent, Mrs. J. P. Balfour, Mrs. A. M. Cowan, Mrs. William Davidson, Mrs. S. L. Fountain, Lady Hearst, Mrs. Stewart Houston, Mrs. H. H. Love, Miss Grant Macdonald, Miss Effie Michie, Mrs. Hugh MacMath, Miss J. M. McGee, Mrs. William Sparks, Lieut.-Col. Noel Marshall, John Macdonald, John Firstbrook, W. A. Baird, Rev. Canon Bryan, S. B. Gundy, Dr. W. H. Harris, Venerable Archdeacon Ingles, W. G. Kent, Dr. Edmund E. King, E. J. Lennox, R. Millichamp, Rev. Basil Thompson, his Worship the Mayor.

SERVICES OF NURSES LAUDED BY SURGEONS

A joint conference of hospital, medical, and nursing professions featured the afternoon session of the convention of the American College of Surgeons at Montreal on October 25th.

The conference took the form of a symposium of addresses on subjects relating to three branches of service represented in the conference. Dr. A. K. Haywood, of Montreal, Superintendent of the Montreal General Hospital, presided.

Dr. W. W. Chapman, of McGill University, President-elect of the American College of Surgeons, opened the symposium with an adress on "Nursing as a Service Profession."

He could not speak too highly of the service done by the nursing profession. It demands great exactness in mind and body from the nurses, but the recompense is adequate, he said, not so much materially as morally and spiritually, the consciousness that comes of work well done.

"Yet surely," he said, "the laborer is worthy of his hire." Undoubtedly the $5 a day paid the nurse, while adequate, perhaps, for daily needs, is not adequate to provide for sickness and old age, and it seems that it should be a matter of national, and certainly municipal, interest that provision should be made to care for nurses in old age and sickness.

Dr. J. L. Austin, of Kingston, Professor of Clinical Surgery of Queen's University, contributed further discussion to this subject, as well as not a little humor, particularly in his comments on the matter of discipline, which, he declared, in London hospitals was equalled only by that of the "Guards."

It is not simple to give people what they want at the price they can afford, said Miss Laura R. Logan, R.N., of Chicago, Dean of Illinois School for Nurses, the first speaker to outline the women's point of view. Her subject was "A Standardization Programme for Schools of Nursing."

The simplest method of giving the public what they need is the adoption of a minimum service of nursing as instituted in the hospitals by the American College of Surgeons, she advised.

UNTIMELY DEATH TAKES NURSE GRACE WASHINGTON

The death occurred on September 27th, of Grace Washington in her twenty-ninth year, at the residence of her grandmother at Oakwood. She had been ailing for about five years, but her death came as an unexpected blow to the members of her family who reside at 16 Simpson Avenue, Toronto. She was born in Oakwood, but came to reside in Toronto with her parents a number of years ago. She took courses in nursing in Toronto and Chicago, and graduated at the Western Hospital in January, 1921, and later took charge of Dr. Sharp's electrical treatment rooms on Bloor Street.

Book Review

The new *Fisher Catalogue* is a publication of over 600 pages, devoted entirely to laboratory equipment. It was compiled strictly from the laboratory view-point and consequently is an invaluable reference to the technician. The old style of equipment has all been eliminated and only the modern apparatus, as approved by the various scientific organizations, is now featured. A whole section of the catalogue is devoted to clinical diagnostic apparatus alone. The catalogue is the most complete book ever issued and on account of its size is a very costly publication. Hospitals and pathological laboratories can obtain a copy free of charge by writing direct to the Fisher Scientific Co., Limited, 206 McGill Street, Montreal.

CUTTING OUT THE DEAD-WOOD

Some laymen cannot understand why medicine is casting aside cherished theories every year and adopting methods which are based on new principles.

It was not so many years ago that there were still persons who stoutly declared that the earth was round. For centuries, the learned world held to the belief that a fish in water could not weigh anything. It was only when some daring soul insisted on putting a pail of water on the scales, balancing it, and then putting a lively trout into it, and weighing fish and pail of water, that the time-honored theory of the weightless fish was abandoned —but years of argument followed before it gave up the ghost.

There is nothing harder to get rid of in this world than precedent and tradition. To this day it would be impossible to persuade any tailor not to put buttons on the sleeve of a man's coat. Centuries ago, such buttons were put there to prevent soldiers from making an unconventional use of their coat sleeves as hankerchiefs. They are certainly not ornamental—but custom decrees we must have them.

For a decade after coaches for railways came into use, they always had a socket for whips in the front, although the iron horse did not need the lash. This is only one example of the firm grip of custom in every branch of business and trade.

As a matter of fact, the medical profession has rid itself of more useless precedents and ideas than has any calling. It was long a stickler, for instance, in following the practice of blood letting. The most distinguished physicians wrote long treatises on phlebotomy and even prescribed the times of the month in which it should be practised. When, however, investigation demonstrated that blood letting was not based on sound physiological principles, the doctors discarded it. They were soon turned away from a custom which had the traditions of thousands of years behind it. Within a few years the majority of the profession had adopted means of relieving congestion which did not entail the loss of a single drop of the fluid which is the life. Then the mineral poultice, Antiphlogistine, as soon as its merits were known, took the place of the unsightly and often unclean messes of organic substances.

Taken all in all, the medical profession leads the world in its readiness to throw useless theories and established practices into the limbo of forgotten things.

INSURANCE COMPANIES' STOCKS ATTAIN NEW HIGH PEAKS

Unprecedented demand for insurance stocks has been the occasion of very marked appreciation, especially among the older companies. It is of special significance that this demand appears to come almost entirely from old and shrewd investors. One reason for this, and probably the greatest one, is that this high-class form of investment has been comparatively little known to the average investor. The stock records of the aver-

age, old insurance company must resemble, to a large degree, a family record, the shares passing on from generation to generation. Occasionally, however, through the winding up of estates and otherwise, fairly large blocks of the more desirable companies' stocks find their way to the market. It would appear, judging by the past wonderful records of most of these companies, to be a wise move to buy such shares for future appreciation, whenever available. To our minds, at least, this appears to be an investment which compares very favorably with government and municipal bonds and debentures, bank and trust companies' stocks, etc. The writer commends this article particularly to the attention of men of the medical profession. Recently, in my capacity as executor of the estate of a certain doctor, I was surprised and shocked by the worthlessness of most of his investments. I have since found that this case was only typical insofar as the medical profession is concerned. This is probably due to the fact that the average physician is so busy with his patients he has no time to study the merits or demerits of different forms of investment. The writer himself must plead guilty to past ignorance regarding insurance stocks, and the facts shown to him recently have surely been a revelation, showing as they do a situation of stability and profits almost unbelievable. The facts are, however, incontrovertible.

THE NURSERY NAME NECKLACE

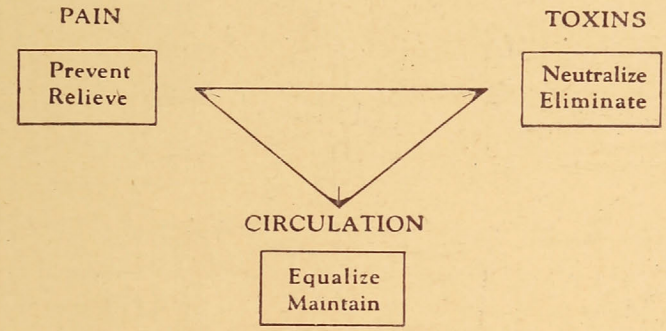
Six years ago an obstetrician in the Brooklyn Hospital, Brooklyn, New York, conceived the idea of identifying hospital babies with a bead necklace, that not only embodied all the essentials of infallible identification, but accomplished it in a most pleasing and refined manner. This method has developed to such an extent that the majority of hospitals having maternity departments in the United States and Canada use what is known as the Nursery Name Necklace method of baby identification. Attractive blue beads are strung on a silk enamelled cord along with white beads which are flat, and each plainly lettered in black, spelling the mother's surname. The complete necklace is sealed with a lead bead and does not leave the child's neck until the baby is ready to take the necklace home as a souvenir.

As a convenient and lasting identification this method is regarded by doctors and nurses as one hundred per cent. dependable.

A few of the hospitals in Canada using the Nursery Name Necklace method of baby identification, are: Edmonton General Hospital, Edmonton, Alta.; St. Boniface Hospital, St. Boniface, Man.; Winnipeg General Hospital, Winnipeg, Man.; Toronto General Hospital, Toronto, Ont.; Jeffery Hales Hospital, Quebec, Que.; Victoria Hospital, London, Ont.; Holy Cross Hospital, Calgary, Alta.; St. Catharines General Hospital, St. Catharines, Ont., and others.

The Nursery Name Necklace is patented and manufactured by J. A. Deknatel & Son, Inc., 222nd St. and 96th Ave., Queens Village, Long Island, New York.

THE TRIAD OF TREATMENT IN PNEUMONIA



Authorities assert that the symptomic treatment of Lobar Pneumonia calls for applied heat for the pain and congestion, to ease cardiac activity, augment superficial circulation with resultant contraction of deep blood vessels, and to promote neutralization and elimination of toxins.

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