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The Official Organ of the Provincial Hospital Associations

The HOSPITAL MEDICAL and NURSING WORLD

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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.

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Editorial

American Hospital Association

The Atlantic City meeting was a great success. Two Canadians were on the officiary: W. W. Kenny, a vice-president; A. K. Haywood, Montreal, a trustee.

Visitors, in addition to the scientific programme, enjoyed the Board Walk, the golfing, the sea bathing, the roller chairs, and the Country Club. Visits were made to the New Jersey Training-School for the Feeble-Minded and to the hospitals of the convention city and of the City of Brotherly Love, an hour's run away.

There was a fine display of hospital supplies and equipment, the following bodies making exhibits: the American Association of Hospital Social Workers; the American College of Surgeons; the American Heart Association; the American Occupational Therapy Association; the Committee on Dispensary Development of the United Hospital Fund; the Hospital Dietetic Council; the Hospital Library and Service Bureau; and the National Child Welfare Association.

Besides, there was a tremendous commercial exhibit. The Association, whose big activities are made possible through the charges made to exhibitors, has undertaken by resolution to inform purchasers that the executive secretary will undertake to settle or adjust any question of dispute arising out of the purchase of any article from any exhibitor.

The Association had eminent hospital experts present at the meeting whose services were made available by appointment to give information in any department of hospital work to any desirous of adding to their stock of hospital knowledge. In addition, anyone desiring any special information had the opportunity of consulting Dr. Lewinski-Corwin, of the United Hospital Fund of the New York hospitals. Dr. Malcolm MacEachern, representing the American College of Surgeons, was also present to give visitors information relative to the standardization of hospitals. Plans and specifications were also on inspection at the office of the Hospital Library and Service Bureau.

The Committee on General Furnishings and Supplies presented the following summary of their replies to a questionnaire sent to some 426 hospitals:—

	No. of sizes in use	No. of sizes recommended	Percentage of hospitals using sizes recommended	Percentage of hospitals willing to use sizes recommended
Bed pads	63	2	71.6	77.6
Pillow cases	47	2	81.1	71.2
Sheets	50	3	75.0	82.9
Draw sheets	70	1	55.7	70.4
Spreads	54	2	81.1	86.4
Bureau scarfs	49	1	60.8	78.2
Bath towels	42	2	76.6	87.5
Face towels	31	2	78.9	88.3
Hand towels	48	1	58.0	79.0

A letter was sent by this committee to the Department of Commerce, asking that a meeting be held of manufacturers, distributors and consumers of hospital apparatus and equipment, to discuss the question of standardization of hospital equipment. We have not received the report of the results of this conference. One representative suggests that the quality of towels be indicated by their size. Dr. Walsh, executive secretary of the Association suggested that there be appointed a bureau of research. This committee requires more money with which to carry on its important inquiries.

Dr. Karl VanNorman, for the Committee on Scientific Equipment and Work, reported on ethylene gas apparatus, the electrocardiograph, and the equipment for the operating suites of a 100-bed hospital. Ethylene gas is an excellent anæsthetic with little toxic action, is quickly eliminated, induction takes only two minutes, causes little or no excitement; and on account of its high percentage of oxygen the patient remains a good color. Consciousness returns in five or ten minutes and vomiting seldom occurs. It does not affect the kidneys deleteriously. It is especially useful in robust and alcoholic patients, or those suffering from respiratory trouble. Blood pressure is unaffected if there be no cyanosis. It may be used in both major and minor operations, being especially useful in cæsarian section. *But it is explosive.* Hence great care must be exercised to see that there are no gas flames around or thermo-cauteries or static electricity. The greatest danger of combustion obtains when it is mixed with sixty per cent. of oxygen or over.

There are three models of the cardiograph: that for experiments in physiology, that for a doctor's office and that for hospital use. They must be used by a

man who is an expert, should be installed in a location where there is little or no vibration and should be conveniently located with reference to the wards containing patients needing cardiographic examination. Morning is the time preferred for its use. The technician may be able to attend to other work, when this work is finished. Charges for electrocardiograms run from $3.00 to $10.00. Graphs may be filed with the histories of the patients; films in drawer cabinets.

This committee also gave a list of equipment needed for two major and two minor operating rooms in a 100-bed hospital. These rooms would accommodate and be equipped for orthopædic work, operations on the ear, nose and throat. One of the small operating rooms should have light-proof shades on the windows. The comprehensive list of apparatus and equipment may be obtained from the published reports of the Association.

The Committee on County Hospitals considered that special funds should be secured for making a survey of county hospitals. It recommended that such funds should be sought for; and that the final report appear in a separate bulletin. The committee sent out a questionnaire to county hospitals, inquiring, among other things, as to the area and population served; what the hospital and plant was like—its excellencies and defects; facilities for fire protection, water supply, sewage disposal, laboratory work; how administered and supported; character of work done; rules governing admission of patients; receipts and expenditures; organization of medical staff; whether they do social service and dispensary work; training school features; affiliations; with a request for reports, by-laws, etc.

The Committee on Construction gave a list of requisites for a nurses' home—a 500-bed place. Among

topics taken up were site and location; capacity; estimated cost; school features—rooms, laboratories, museums, library, study rooms, etc.; administration and living rooms; accommodation for non-resident nurses, food service, dormitories, special suites; corridors, baths and lavatories, kitchenette service; medical service rooms; linen; domestics; janitors; telephones and signals; general storage; elevator service; heating and ventilation; lighting and fixtures; plumbing; construction and finish.

The legislative committee recommended that two or more members act in each state to watch the legislative activities—state and municipal—and report; that the various state hospitals associations be asked to assist; and that the general secretary be allowed to expend sufficient money to enable the committee to efficiently carry on their inquiries.

The committee on the training of hospital executives felt that the larger hospitals should be organized for teaching purposes and for field work. In this way hospital executives and personnel generally would be able to learn their duties. The following centres have been selected to act as teaching headquarters; Brooklyn, Boston, Cleveland, Chicago, Cincinnati, Detroit, Houston, Los Angeles, Milwaukee, Minneapolis and St. Paul, Montreal, New Orleans, New York, Philadelphia, Pittsburgh, Seattle.

From the nature of the above reports it will be seen how good a thing it is to be a visitor to such meetings.

American or North American

At the very successful annual meeting of the Ontario Hospital Association held in October last the following snappily-worded resolution was sent in by the nursing section:

"That the time has come when the Canadian Medical and Nursing Associations are entirely capable of managing their own affairs, and capable of developing Canadian nursing standards to meet the peculiar needs of our own country rather than be directed in these matters by foreign organizations."

That the resolution passed without protest indicated a fellow feeling by the association as a whole against the present method of directing Canadian hospital and nursing standardization from any by what is felt to be a foreign organization.

A week later the American College of Surgeons meeting in Montreal devoted considerable time to the discussion of hospital standardization in United States and Canada. The standard is the same on both sides of the border; and the fact that between forty and fifty of the hospitals of Ontario have been awarded an A1 grading makes clear that the dissatisfaction evinced by the passage of the above resolution in the Canadian body does not arise from low marking. Ontario hospitals have measured up well.

There is a natural feeling of resentment, however, against the idea of United States standards being imposed upon Canadian institutions. But this is not really the case. The American College of Surgeons includes surgeons of both countries, and that unfortunate adjective "American" is in this instance used in its original application. Perhaps the name "North American" would better apply to the latter institution, and its use would clear the air.

To-day we are trying to think internationally, in health matters above all others; and it is a bigger and prouder achievement to be ranked A1 among continental institutions than to hold the same rank within the limits of Canadian service only.

Let the Ontario organization pass up to the American College of Surgeons a resolution requesting that its name be changed by the addition of the word "North," and the little soreness of misinterpretation will disappear.

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Original Contribution

THE ACHIEVEMENTS AND PROBLEMS OF THE ONTARIO HOSPITALS*

By Fred W. Routley, M.D., Toronto.

A meeting of about fifty trustees of the Ontario hospitals was held in the King Edward Hotel, Toronto, during the evening of the 14th of October, 1926.

A number of subjects of much interest to all the hospitals of the Province were discussed. Among these subjects might be mentioned hospital standardization, the best methods of purchasing hospital supplies, methods of inducing communities to aid hospitals, the need for further financial assistance from the Province and the municipalities towards the maintenance of indigent patients, and other topics.

It was the unanimous opinion of those present that the trustees of the hospitals of Ontario might give careful study to a number of questions of vital interest to these institutions. With this end in view, a committee composed of Dr. John Ferguson, Toronto, Chairman; Mr. A. C. Bonnell, Brantford; Mr. James Gray, London; Mr. Horton, St. Thomas; Col. J. A. V. Preston, Orangeville; Major G. G. Moncrieff, Petrolia; Miss Janet Anderson, Toronto; was appointed to prepare information for trustees and formulate suggestions on which they might act. To the aforementioned committee, the following have been added, namely, Sir Bertram Windle, St. Michaels Hospital; Dr. D. E. Robertson, Civic Hospital, Ottawa; Mr. T. H. Pratt, City Hospital, Hamilton; Mr. R. S. McLaughlin, Oshawa Hospital; and Mr. Galbraith, Toronto Western Hospital. This committee, after careful consideration, respectfully submits the following suggestions:

1. The Hospital Act

This Act should undergo several important amendments to provide for the following conditions:

(a) That the hospitals may receive the government per diem grant for patients on whose account the hospitals are paid from some source, municipal or otherwise, a daily amount of

*Read at The Ontario Hospital Association, Toronto, October 26th.

two dollars ($2.00), the maximum at present being one dollar and fifty cents ($1.50).

(b) That the hospitals receive the full government assistance on indigent patients so long as they are certified as in need of hospital care and treatment. In many cases a longer stay in the hospital than 120 days is necessary.

(c) That one half the municipal and government per diem should be allowed for the care of babies born in the hospitals, whose mothers are in the hospitals as indigent patients. It is well known that the care of the babies costs almost as much as that of the mothers.

(d) That the hospitals should not be called upon to bear the cost of those patients that are called "drifters," who are disowned by the municipalities as having no proper residence anywhere. They should be regarded as wards of the whole Province, or of the municipality in which they become ill.

(e) That it should not be necessary for hospitals in Toronto and Hamilton to first secure a municipal order to enable them to collect the per diem from the municipalities. This is an invidious distinction against two cities which are doing their full share of hospital service for the people.

(f) That the government per diem grant should be paid on Workmen's Compensation Board cases for whose care the hospitals receive $2.50 per day. They are surgical cases and very expensive to treat. For this reason the Workmen's Compensation Board allows $2.50 per day, when the hospitals receive the government grant, and $3.00 per day when they do not. The $2.50 per day from the Workmen's Compensation Board together with the government grant would practically cover the cost of maintenance, as should be the case with regard to municipal patients.

(g) That the hospital will be entitled to the government per diem in the case of patients who lead the hospital to believe that they are able to pay private ward rates, and later submit information to prove that they are indigent.

(h) That the government per diem for indigent patients should be raised from fifty to seventy-five cents. This, with $2.00 from municipalities, would make $2.75 or within thirty-seven cents of the average daily cost of maintenance for all the hospitals of the Province.

(i) That the Amending Act of 1926, No. 176, Section 2, amending Section 23 of Chapter 300, Section 23, should be amended so as to make Section 23 (3) read as follows:

> "Residence" for the purpose of this Section shall mean actual residence or residing or living within the county.

city or separated town just prior to the admission to the hospital.

When one considers the assistance rendered the public hospitals in the other provinces, what is now being sought by the hospitals in Ontario is by no means too much. It should be also borne in mind that the conduct of hospitals in Ontario is very costly, as the general standard of the hospitals is maintained at a very high level.

(1) In New Brunswick the government makes specific grants to fifteen public hospitals. These annual grants vary from $250.00 to $3,800.00. It has been impossible to ascertain what the municipalities pay for the care of patients.

(2) In Nova Scotia the government makes a per diem grant of thirty cents to all local hospitals, whether the patients are indigent or otherwise. There is no fixed municipal grant, as this is arranged in each locality separately. In a number of hospitals the average daily cost is $3.50.

(3) In Quebec Province the government grant is sixty-seven cents per day to hospitals with at least forty beds for poor patients. This works out to about thirty-three per cent. of the total cost in that province. With regard to the municipalities, Section 45 of the Quebec Charities Act states: "It shall be the duty of every municipal council to effectively look after the indigents having their domicile within the limits of the municipality."

(4) In Ontario the government grant is fifty cents per day, the municipal grant $1.50, and the government's contribution is 12.9 per cent. of the total cost.

(5) In Manitoba the government grant is fifty cents a day on all patients, indigent or otherwise, for three months. At the end of three months the grant may be continued from month to month on the recommendation of the health officer of the municipality. The municipal grant is $1.75 per day for indigent patients for a period of three months, subject to extension from month to month on the report of the medical officer of health. These are much more liberal terms than are those in Ontario. The percentage contribution of the Government of Manitoba is about double that of Ontario.

(6) In Saskatchewan the government grant is fifty cents per day for all patients, whether indigent or otherwise. All the hospitals receiving government aid as public hospitals may demand of the municipalities a sum not exceeding $2.50 per day. There is no time restriction on these grants. The government's contribution is a little over twenty per cent. of the total cost.

(7) In Alberta the government pays fifty cents a day for all patients in approved hospitals. It is estimated that the

indigents would call for about one-fifth of the amount paid. The municipalities are responsible for the balance of the maintenance of their indigents up to $200.00 for each patient. The government grant is about twenty per cent. of the total cost of maintenance.

(8) In British Columbia the grant is paid on all patients, and ranges from $1.50 a day to the small hospitals down to forty-five cents a day to the larger hospitals. Each municipality pays seventy cents a day on all patients from within its boundaries. This figures out to about $3.00 a day for the indigents. The government aid is almost twenty-five per cent. of the total expenditures.

With the object of securing these amendments, the trustees of the hospitals, in each electoral riding, should interview the members of the Legislature for their ridings, and lay the facts fairly before them, in order that they may be able to deal intelligently with the question, and approach it with a sympathetic mind. It is too late to leave this educative work until the Legislature is in session.

II. The Duty of the Public

No matter what view people may hold regarding hospitals, it is perfectly clear that hospitals are not called upon to receive and care for at a loss those sick and injured persons who are the proper wards of the public. There are always a certain number of persons who from some cause have no means of securing proper medical or surgical treatment, if such should be required. These persons are dependent upon the charity of others for the required care. When no individual is able or willing to supply this care, they must fall back upon the public for relief from their unfortunate position.

For this purpose the public is naturally divided into two well-defined entities, namely, the province and the municipalities. At the present moment the law provides that hospitals may collect $1.50 per day from municipalities, and still retain the government per diem of fifty cents. These two sums yield a daily revenue of $2.00 per diem. But the latest government report on the Ontario hospitals reveals the fact that the average cost for all hospitals is $3.12 per day. This shows a deficit of $1.12, which must be met in some way, or the hospitals would soon become insolvent. Now, suppose the municipalities contributed $2.00 per day and the Government seventy-five cents, or a total of $2.75, there would still be a deficit of thirty-seven cents per day to be met by the hospitals. These figures make it very clear how imperatively urgent it is that the necessary action be taken by the Legislature.

The revenue contributed by the people belongs to the people. It is only placed in the hands of the Government and the municipalities to be used by the Government and the municipalities as trustees for the people. In no way can it be used to greater advantage than for the purposes of alleviating sickness and suffering and prolonging life. One of the Roman axioms was that, "The health of the people is the supreme law, or supreme duty of all."

III. How This Deficit is Met

So far the governing bodies of the hospitals have been hard pressed to finance the hospitals. They have begged money from those who were willing to give. They hold concerts, and arrange bazaars; and, should all these means fail, have often been forced to make up the shortage out of their pockets. This should not be allowed to continue. The general public should be by statute called upon to do its duty by the poor of each community.

There is another way of meeting, or rather avoiding, deficits; a way that is most regrettable; namely, the impairment of efficiency. It is disastrous to any business when the machinery employed in its conduct is permitted to become run down, or out of date. But when the business deals with human welfare and life, the picture is too sad for words. The demand of the day is efficiency, and this requires money. If money is withheld, efficiency must suffer.

But hospitals have been forced to resort to another expedient that is most unjust. For years there has been in vogue the practice of charging paying patients more than the cost of their hospital care and treatment. The surplus thus obtained is used to cover the loss made by caring for the poor patients. It is entirely wrong to make the sick who can pay, not only pay for their own care and treatment, but also contribute towards the care and treatment of others, while the well public are not called upon to contribute their proper quota towards this laudable work.

IV. What Hospitals Have Done

There is an aspect of this whole subject that has received altogether too scant attention. As the result of the long and faithful efforts of the hospital boards, much of the money that has gone into the sites and buildings has been collected. All this labor and money became a gift to the welfare of the public. But this is not all. These boards have effected arrangements with the medical profession of such a nature that these poor people receive skilled professional attendance free of cost.

This is another great gift to the public, to the persons who require the attendance, and to their families. But there is yet another gift made by the hospitals to the public in the splendid services that so many altruistic men and women have rendered by devoting so much of their time and thought to the management of these institutions, as a pure labor of love.

But in addition to the foregoing, the hospitals have been very important centres of education. The patients that pass through them acquire a certain amount of knowledge of the laws of health. The boards of management become interested in questions of preventive medicine and the care of the sick. The medical men constituting the staffs, and professional attendants, are afforded opportunities of becoming more expert and efficient, and there are created social and professional centres whereby they come to know and respect each other better. Lastly, the nurses, both trained and in training, who are called upon to care for the patients, become a body of intensively educated women, who spread among the people an invaluable amount of knowledge of disease and the care of the sick. No one who has the correct view of citizenship would deny the financial assistance such philanthropic work requires. When, therefore, the hospitals ask the public to contribute more generously to their support they are only asking for mere justice, and for the means whereby they can still better serve the people. The hospitals are non-profit institutions. There are no dividends for any one, and the salaries of officials are never extravagant.

While dealing with the educational work of the hospital, attention should be paid to the extreme importance and value of the clinical teaching given in them to those who are to become the medical practitioners of the future. This important work is in a very special manner prominent in the hospitals which are located in the university cities of Toronto, London and Kingston. But it must not be forgotten that many medical students cannot find interneships in the hospitals of the three cities just named; and, consequently, become resident medical men in other hospitals throughout the Province, where they receive valuable experience and training for their life work. But to do this sort of work in a fitting manner the hospitals must have the most modern equipment, which cannot be procured if the hospitals are in a state of chronic poverty.

V. The Value of Human Life

Very few persons ever give any serious thought to the value of human life; but among those who have given this subject study there is a growing conviction of the vast importance of

the economic effects of sickness on the one hand and that of premature death on the other.

Take for example a young man of twenty-five years of age, who has learned some trade by which he can earn $1,000 a year. Allow that he would be able to follow his occupation to the age of seventy; and also allow that the calculations are made on an interest rate of four per cent. per annum. He meets with an accident or is taken ill, and because of inadequate care he dies. The monetary loss caused by the death is $11,924. This is worthy of the most careful study. Take another example. The hospitals of Ontario can very safely be said to lengthen the average active period of life of all who are treated in them. This would bring a greatly increased revenue to these individuals and those dependent upon them for support. When one recalls to mind the large numbers (155,983) cared for annually in the Ontario hospitals the total value of this improved income would mount up into very large figures. During the past twenty-five years through preventive medicine, the advances made by the medical profession, better housing and food, better factory conditions, more efficiency in hospitals, the average duration of life in Britain, Canada and United States has been lengthened by ten years. This represents an enormous sum of money.

When one turns to the elimination of loss of time by the prevention of sickness, or the reduction of the duration of such sickness as does occur, an equally interesting set of figures present themselves for consideration. In the United States, experts estimate that each adult worker loses one week each year through sickness of a purely preventable character. Allow that each one earns on an average of $25 per week. This on 100,000 adult workers would amount to an annual loss, due to preventable causes, of $2,500,000. But there must be added to this the heavy loss caused by the expense incurred by the sickness.

VI. Affording the Cost

When the Ontario Hospital Association during Legislative Session of 1925 made the request for an increase in the per diem paid by municipalities from $1.50 to $2.00, one influential municipality opposed the increase on the ground that it could not afford the increase. This is a very reactionary position to take. There is no municipality that cannot afford to do justly by its citizens.

But there is another side to this than mere apparent cost. The better idea of efficiency must also be considered. If the municipalities do not pay the cost, or nearly the cost of the maintenance of their poor patients, then the hospitals are forced to become less efficient, because they cannot keep up an

adequate equipment. This means that the sick and injured are denied the means of lessening the duration of the illness, or even of saving life.

While discussing this aspect of the case it should be borne in mind that efficiency does lessen the duration of stay in the hospitals. This saving does much to offset the extra per diem allowance, and this has actually occurred. Every municipality can, therefore, afford the small extra that is required to bring about the efficiency that will, in the least time, and in the best manner, return the invalided citizens back to a useful life again, and changing them from the class of consumers only to that of being revenue producers.

But another reason can be given for the small increase sought. The cost of running hospitals has greatly increased. The great war raised wages and increased the cost of all foodstuffs, supplies, instruments, and scientific equipment. The dollar has now the purchasing power of only fifty cents before the war. There is no indication of any easement in this regard. The hospitals cannot be closed, and modern medicine and surgery are demanding a steadily increasing degree of efficiency. These demands must be met, otherwise, the hospitals of Ontario must fall to the rear and take a secondary place.

To make this matter of increased cost clear, the following figures are submitted from the Ontario hospital reports, giving the daily cost per patient. In 1919, it was $2.55; in 1920, $2.90; in 1922, $3.07; and in 1925, $3.12. With every care in the management of the hospitals, the cost per day for the maintenance of patients is gradually increasing. The per diem of $1.50 is less than in any other province, except Quebec.

A study of the assessment rate and the assessment, and the number of municipal patients in some of the larger municipalities, shows that the increase from $1.50 to $2.00 would mean only an increase of twenty cents per $1,000 of assessment. This would mean only $1.00 to the man who pays taxes on $5,000 of assessment. This is a mere trifle and quite negligible.

Grant that the municipalities paid $2.00 and the government seventy-five cents per day, the total would only be eighty-eight per cent. of the actual cost. The hospitals would still have to finance the remaining twelve per cent. of the cost.

VII. The History of the Grants

A few remarks on the history of the provincial and municipal grants to the hospitals may be interesting. In the first instance the Ontario Legislature made an appropriation of $110,000 to be divided among the hospitals according to the

number of indigent patients each year. As the hospitals increased in number and grew in size, the amount received for each patient naturally became less, until it amounted to only ten or eleven cents per day. In those days the municipality per diem was forty cents. If a hospital received more than forty cents per day for the care of a patient, it could not receive any of the government grant.

In 1904, a deputation from the hospitals in Toronto waited upon the Government, and succeeded in persuading it to grant twenty cents per day and to raise the municipal per diem to seventy cents.

This continued until 1912 when the Ontario Hospital Association which had been formed, induced the Government to amend the Act so as to enable hospitals to collect $1.00 per day from municipalities. The government allowance of twenty cents remained unchanged.

In 1918, the Ontario Hospital Association again pressed for more liberal treatment, and secured from the Government thirty cents per day and from municipalities $1.25.

In 1920, the Association again sought an increase, and was granted fifty cents a day from the Government and $1.50 from municipalities.

The time has now come when the Government should increase its per diem allowance to, say, seventy-five cents, and the municipal allowance should be raised to $2.00. Hospitals should receive half the adult allowance for the care of indigent babies born in hospital. The government per diem allowance, whatever it may be, should be paid on Workmen's Compensation cases. Indeed, this is already admitted as due the hospitals by the Government in these words—"Hospitals receiving government grant from patients are entitled to such grant upon all Workmen's Compensation Board patients even though not in public wards."

A careful study of the government and municipal grants given to public hospitals in aid of the sick poor, reveals the fact that the Province of Ontario is not doing as well by these institutions as are the other provinces.

It should be remembered that the Succession Duties Act was intended to aid hospitals and charities; but as a matter of fact the income so obtained has been otherwise used. All hospitals realize that this tax has made it much more difficult to secure donations and bequests from the wealthy.

VIII. Hospitals Are Not Charities

It should be kept clearly in mind that hospitals are merely the dispensers of the charity, care, treatment, and shelter

patients require. These institutions cannot give out what they have not received.

The several resources of the hospitals are the grants from the Province, the grants from municipalities, the gifts in money and kind from generous people, the payments made by the patients to the hospitals, and the gifts of professional services made by the medical profession. Should all the monetary and material resources fall below the requirements, the deficit must be met by special grants from municipalities, by the trustees making appeals to their acquaintances, and the public, or by the resort to borrowing money, which can only be regarded as a mere temporary expedient. It would be much better for municipalities to pay a larger per diem, and discharge the obligation continuously during the year, than to be faced with large hospital deficits at the end of the year; and it would place the hospitals on a more stable basis of financing their work.

This plain statement of facts proves that hospitals must be conducted on sound business methods. They must have a stable income to meet their liabilities. If they are too severely cramped in the matter of income, efficiency is bound to suffer. It will be a sad day when our hospitals are forced to lag behind, and the work in them be of secondary quality.

IX. Achievements of 1925

Let the year 1925 be taken as an example of the splendid work the hospitals in Ontario are doing. A study of the following figures should convince the most skeptical, and open the way to the good-will and generous support of all.

The hospitals' report for 1925, giving the statistics for the year, reveals the following information:

Number of public hospitals	134
Number of patients on October 1st, 1924	7,043
Number of patients admitted to Sept. 30, 1925	133,781
Number of births during the year	15,159
Number of deaths during the year	7,404
Total number of days' stay in the hospitals	2,750,272
Provincial grant to hospitals for the past year	$720,671
Provincial grant to sanatoria for consumptives	$356,693
Amount received from all sources during the year	$8,817,037
Subscriptions, donations, etc	$827,869
Total expenditures during the year for maintenance	$8,908,801
Expenditures on capital accounts	$4,913,888

These figures show that the total expenditures on maintenance exceeded the total receipts by $91,764, but the hospital made capital expenditures of $4,913,888. Stating the matter

another way, the total expenditures were $13,822,689, and the total receipts were $8,817,037. This gives a grand deficit of $5,005,652, which had to be found by the hospital boards.

The foregoing figures clearly show that the hospital boards had to find the funds to meet the deficit of $91,764 on maintenance, but also to find $4,913,888 for needed improvements, equipment and additional accommodation, or a total of $5,005,652, over and above what the hospitals received from the Government, the municipalities, and the patients. This is equal to 36½ per cent. of the total expenditures, or $1.90½ for every day's stay of patients in the hospitals during the past year. This does seem to be an undue portion of the financial burden to place upon the hospital boards and officials who are giving so much of their time and money freely, for the good of the public. The public should be obligated to assume some of this burden.

But in these statistics are included hospitals that are municipally owned, and no matter what the cost may be, the balance is met out of the city treasury. As an example, take the maintenance of one large hospital of this class. The city contributed towards the maintenance of its poor, the sum of $138,789.57; and the total days' stay of the patients for whom the city paid, was 36,703. This gives a maintenance cost of $3.78. This example very clearly shows the cost to a city municipality of the indigent patients.

Here is ample proof of the need for more liberal treatment by both government and municipalities. Hospitals cannot stand still; and when they can only with difficulty pay their way, there is bound to be an unwise effort at economy, which in the end means they cannot keep abreast of the progress made in the hospital world. Ontario in this matter cannot be allowed to remain stationary, much less go backward.

X. Public and Private Ward Patients

The average cost of $3.12 covers all classes of patients, the public, semi-private, and private ward cases. Much has been said upon the subject that public ward patients cost much less than private ward patients. There is very little in this argument. No matter what the ailment, public ward patients must receive full care and all supplies at the cost of the hospitals. Special nursing, all kinds of dressings, all sorts of medicines, are to them free. In the case of private ward patients, they pay for special nursing, and many of the things that public patients receive free. A very careful cost study in the larger hospitals shows that the public ward patients cost the hospitals as much as do the private ward patients.

The Inspector of Hospitals, in his report for 1924, mentions, "The need for accommodation for the great number of people who cannot afford to pay the rates charged for private patients' rooms, and yet who do not wish to be classed among the indigents." This is a very strong argument in favor of the increase now sought. The hospitals lose so heavily that they are unwillingly compelled to raise the prices for private rooms so high that they become prohibitive to the class of patients referred to in the foregoing comment of the Inspector.

This statement proves that the request of the hospitals is a just one; and that when municipalities are asked to contribute more, that extra contribution is required solely to meet the cost of caring for their own poor patients.

XI. Hospital Accounting

The hospitals have done themselves an injustice in their method of bookkeeping. All moneys received should be accounted for, as these sums are used again in the making of necessary purchases and should go into the cost of maintenance. In the same way, all gifts in materials should be entered at current market prices, and treated as cost of maintenance. Similarly, with interest on endowments when used in the purchase of needed supplies. Interest on borrowed funds, and repairs to buildings should also be entered into the cost column. Then the impairment on goods, clothing, furnishings, apparatus, and buildings should be added to the cost account. Linen and bedding would deteriorate twenty per cent. per year; instruments, apparatus, and furnishings, ten per cent. yearly; frame buildings should be written down five per cent., brick buildings, two per cent., and steel construction buildings, one per cent. yearly.

By such a method as this the actual cost of running each hospital would be shown. The result of such a method of accounting would reveal a per diem cost per patient much higher than that shown in the government returns.

XII. "I Was Sick, and Ye Visited Me."

If any one has any doubt regarding his duty in this matter, let him read the twenty-fifth chapter of St. Matthew, from the thirty-first verse to the end. There one will find the most perfect exposition of duty and from the greatest of all teachers. It might be said that no story has such a world-wide circulation as that of the Good Samaritan recorded in the tenth chapter of St. Luke's Gospel. For a municipality to neglect or refuse to perform its duty to its sick poor is worse than the conduct of the

priest and the Levite who passed by on the other side of the road from the man who had been wounded by robbers, and was left half dead. The Samaritan bound up the man's wounds, first pouring into them oil and wine; and he then set him on his own beast. He then brought him to an inn and gave the host two pence, saying that, if this should not be enough, he would pay the balance when he returned that way.

The municipality must take the place of the Samaritan, the man wounded by the robbers here must represent the sick and injured of each community. The two dollars sought must do the duty of the Samaritan's two pence, care for the patient during illness. And finally, the municipality cannot escape the clear teaching of the Master's parable, namely, that if more is required, that additional sum must be forthcoming.

The 123 general hospitals and the eleven sanatoria for consumptives are steadily educating a great array of good Samaritans. Men and women, boys and girls, doctors and surgeons are daily brought into contact with the sick and the injured, and poverty and need in their most extreme forms. But this is one of humanity's burdens, and it must be borne, met and relieved.

Wherever a hospital is located there develops an atmosphere of philanthropy and altruism. Auxiliary, good cheer and such like societies spring up around the hospitals, having as their objective, to be friends to the friendless, to bring comforts to the suffering, and hope to the despairing. Those who engage in such work are not only brightening the lives of others, but they are enobling their own. "Sow an act and you reap a habit, sow a habit and you reap a character, sow a character and you reap a destiny." In the case of the hospitals the sowing and the reaping is of the highest type. "Verily I say unto you, inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me." That there may be no doubt as to who is a brother, we have a parable of the Good Samaritan and the wounded man given by the Lord himself to the questioning lawyer. *Deum nulla re proprius veneramur quam hominibus salutem dando.*—"In no way can we more fittingly reverence the Deity, than by giving health to mankind."

THE HOSPITAL—A CENTRE OF PREVENTIVE MEDICINE*

In reference to our symposium on "The Hospital as a Centre of Preventive Medicine," I feel that you have received a very

*This symposium was contributed to by Dr. Alan B. Jackson, Miss Marjorie Buck, Miss Harriet T. Meiklejohn, Miss Muriel McKee, and Dr. J. H. Holbrook and read at The Ontario Hospital Association, Toronto, October, 1926

definite picture of the hospital and public health conditions in the three cities from papers which have been contributed to-day. We were very anxious to put a definite picture before you of the actual conditions, but I think you will also agree with me that those who have contributed are victims of that "divine discontent" which is continually striving to improve conditions which they face in the service of humanity.

I think we all agree that the hospitals, while doing a very definite work, are just entering upon their real mission. They have for long been hospitals for the nursing of sick people and for the carrying out of surgical operations, but we are not satisfied with that as their sole purpose. We think it would be far better if the hospital served a broader field in the prevention of disease through the scientific measures which are becoming day by day increasingly useful. By that, I mean methods for the scientific diagnosis of the early conditions. Your chairman to-day painted a picture of the ideal hospital carrying on all the different phases of work, including the clinical and laboratory work, and the work of research, the whole combining to round out a well balanced service for the diagnosis and treatment of disease, and, in listening to him, I felt that he had described better than I could hope to do, the ideal we had in mind.

Now, I first want you to get a clear picture of two types of institutions which we have in the Province of Ontario. After an institution has a total, say of 100 beds, they have sufficient revenue coming in to carry the overhead for a very considerable amount of scientific work, and it would be a disgrace, for instance, if the Toronto General Hospital or the General Hospital in Hamilton did not provide all the facilities for doing the latest scientific work. But you will find in going through the province that the smaller hospitals are unable to undertake the establishment of the different departments which are provided as a matter of course in the larger hospitals.

We have been studying this problem now for a couple of months, but we have not yet arrived at definite conclusions, for every time we have talked the matter over our ideas have grown as we come more fully to realize the possibilities. The smaller hospitals, as we see them, while giving good nursing and surgical care are dissatisfied because they cannot work out the difficult cases to the ultimate diagnosis, because when a start is made in the physical examination they very frequently cannot complete the diagnosis because they have not the necessary scientific equipment.

And in trying to see how these facilities can be attained for the smaller hospitals serving the smaller towns and the rural districts, we have come to the conclusion that it can only be

through the combination of the forces of the Hospital Board and the Public Health Board of that particular unit, and we have also come to the conclusion that areas of activity must be mapped out, and as far as we can see the county should be the unit for these activities.

I was glad that Miss Meiklejohn made a reference to the condition that not only exists in the Niagara Peninsula but throughout the whole Province of Ontario, when she stated that our people flock to the United States clinics because we do not provide an adequate service at our own doors. It is true that such a service is provided in Toronto, and several other centres of the province, but the great majority of the people of rural Ontario, either because they have not the funds, or for other causes, fail to make use of the clinical facilities of these centres, and thus remain at home until overtaken by some surgical condition, while, on the other hand, a great many who do have money go to the United States cities, whether on the first suspicion of trouble requiring clinical investigation, or as advanced cases of disease.

We think this is an opportune time, when the Ontario Hospital Association is proving to be such an active agency in the moulding of public opinion, to present some of the difficulties under which the smaller hospitals are working, and to paint a picture of what we conceive to be a more ideal condition, in the hope that we may have some part in directing the minds of the people toward what we consider to be most necessary changes.

Last year at the meeting of this association you may remember that Dr. R. E. Wodehouse and I gave reports on the work of extension chest clinics which had been developed at the suggestion of the Canadian Tuberculosis Association, and had been carried on as extension work from sanatoria, the clinics being held where possible in hospitals of the smaller towns or cities where regular out-patient clinics had not yet been organized as a feature of their hospital work.

In our reports, we explained the plan of these clinics, the work usually being under the supervision of the local board of health, the examinations being made without charge to the patients. Under this plan no patient would be examined except upon the request of the family physician, or if indigent, at the request of the health officer, the request of the latter practically certifying that the patient was financially unable to pay the cost of consulting a physician.

Following the examination, a medical report was prepared and forwarded to the family physician or to the health officer, and then so far as the chest clinic was concerned, its work was completed for that case, until the patient was again referred by

the physician interested for re-examination or further investigation.

The aim of this work so far as the Canadian Tuberculosis Association was concerned was to stimulate the diagnosis of tuberculosis in the incipient stage when cure was practically certain, and when the menace from contagion was still at a minimum. At first actual cases of tuberculosis were frequently found, but as time went on an increasing percentage of cases were found to be non-tuberculous, and if we are able to judge from present practice it would seem that the physicians who now refer the cases find the clinics of most value in securing an opinion on that great group of cases where symptoms are referable to the chest, rather than to the lungs alone, and therefore, including conditions involving not only the lungs, but also the bronchi, the bronchial glands, and the heart and arterial system, many of which are secondary conditions which make necessary the search for possible primary foci of infection.

In all these conditions the symptoms are very similar to those of incipient tuberculosis, the most common condition complained of being what the patient describes as a run-down condition, or condition of tiring too easily, or as others say, of the nerves being on edge. Associated with this, there is usually some degree of under-nourishment and a history of a gradual loss of weight, and sometimes, though not always, the patient complains of shortness of breath on exertion.

From the standpoint of these clinics, a run-down condition is at once a challenge to the clinician, for it is not fair to the patient to dismiss his case as if a run-down condition were a diagnosis in itself, but rather it becomes necessary to regard the run-down condition as a very early symptom of some physical defect or some commencing infective lesion, and the whole purpose of the clinic is that of endeavoring by means of routine physical examination to detect this incipient lesion at the earliest possible stage of disease, for it stands to reason that if the condition can be definitely diagnosed and the defect corrected at this stage, the patient will very probably be restored to good health without any very definite impairment of efficiency, and oftentimes without even suffering the misfortune of an acute illness.

The thought may suggest itself that this is the field of the family physician, but in answer to this, it is very apparent that the diagnosis of an incipient lesion becomes increasingly difficult, in proportion to the incipiency of that lesion, and the work of the chest clinician is of a fairly technical nature, the value of his findings increasing with the frequency with which he has carried out the same routine examination, while the work

of the family physician is so diversified that it would seem necessary for him, in his capacity as medical advisor, to become fairly familiar with the findings in the whole field of clinical investigation, but to trust to the reports of technicians in all those departments that prove to be too time-consuming to enable the general practitioner to acquire efficiency when combined with the carrying out of his multitudinous routine duties.

As a matter of fact, I am very hopeful that intensive chest work will eventually become a part of the routine work of the general practitioner, but on the other hand am forced to believe that until medical men realize that practically every chronic infection of long standing produces a change in the percussion and auscultation note of the chest which can be detected by careful examination, and until they are able to distinguish between the many factors which can produce impairment of resonance in the chest and can clearly distinguish between impairment due to a healed lesion and impairment due to recent and active trouble while it is still in its incipiency, it would seem that the chest clinician who is devoting practically the whole of his time to this particular work can still be of service to the man in general practice.

The purpose of these chest clinics would seem to be simply to make this intensive training of the chest clinician available for the general practitioner, for it must have become apparent to all who have studied the problem that the science of medicine has advanced so rapidly to-day no one man can master all the details of technique.

It must be apparent, therefore, that no one man can alone supply such a service, but that medicine has advanced to-day to the point where the key-note of medical service is co-operation, and where the key man in such a scheme is the general practitioner. It must be remembered that the last fifty years has proved to be a great transition period in the science of medicine, and that in this process great discoveries from time to time have suddenly come to light, and have been accepted; but for these new discoveries to be made of practical value they must be carried to the people through the medical men who come in direct contact with them, and this latter comes only through the slow and tedious process of education and assimilation, resulting finally in a change of social customs.

This process of socializing medical advances must, therefore, come as a part of the social evolution of our people, and the more we study this great problem, the more convinced are we that in the field of medicine as it is practised, it is necessary to make many radical changes to readjust ourselves to the newer knowledge, for otherwise it cannot be said that the peo-

ple of our towns and villages and of our country cross-roads are sharing in the marvellous advances that have recently been made.

The point of it all is that if the people of any locality desire the advantages of modern medical science, it is necessary for them to co-operate with their physician to the extent of making available for him on a co-operative basis the ordinary facilities for carrying out the common clinical procedures which are fully accepted as of practical value in the diagnosis and treatment of disease.

I have referred especially to the chest clinic, firstly, because this is the technical procedure with which I have had experience; secondly, because in my opinion this should be the first procedure in the investigation of the ordinary case of difficult diagnosis; and thirdly, because all will agree that every new procedure must be started on as simple a basis as possible, and a chest clinic requires only the time of a technician, but even in the chest clinic where the condition is very obscure, confusing possibilities arise and for the purpose of differential diagnosis, it often becomes necessary to refer the case to the X-ray department or to the laboratory department, or to some other special technician.

This brings us, then, to the consideration of the three factors that are concerned in the provision of a medical service to the people, namely, the medical profession, the medical health department, and the hospitals, and this symposium, this morning, has been prepared for the purpose of making it clear that each of the three groups is dissatisfied with the part that it is playing in the rôle of present-day medical service.

This discussion was opened by a man who is interested in all three phases of the work, namely, that of the service which the hospital can supply, that of a general practitioner who has made available for his own people the very best of up-to-date laboratory and X-ray and other clinical equipment, and finally, through a recent appointment, he has taken on the duties of a medical officer of health. In the latter capacity he is far from satisfied to be merely an officer for the control and quarantine of infectious diseases, but is interested in the prevention of all forms of disease, and it is for this reason that he was asked to open the discussion.

The next paper was given by the superintendent of what we believe is the newest county hospital in the Province of Ontario. She has shown you what can be done in hospital organization in a community where only a short time ago it was thought impossible to finance a general hospital, but where the appreciation of the citizens for the service which is being rendered has made

the task of financing a very easy one. Then sometimes a small hospital that is just beginning can be free of the shackles that surround the ordinary institution that has been running for a great many years, where the board feels that they don't need to change their methods. It is a marvellous thing, what the Norfolk County Hospital has accomplished in a very short time, and, with the active support of the people behind it, I think they will go a long way towards working out the ideals we have in mind.

The next paper was given by the superintendent of one of the older hospitals of the province, situated in a city of about 25,000 people, and serving a combined urban and rural community of at least 50,000 people. Until recently this hospital could hardly be said to supply any other service than that of the nursing of the sick, and of the necessary surgical service of the community, and it has certainly not been used by the community to the extent that one would expect. Recently, however, a new spirit of optimism has invaded this institution, and efforts are now being made not only to improve the hospital building, but also, as far as finances will permit, to improve upon the clinical and diagnostic service.

The final paper dealt with another hospital in one of our smaller cities, where a little further advance has been made in the improvement of the clinical and diagnostic facilities of the institution, for here the latest step has been the appointment of a full-time laboratory technician, and a full-time X-ray technician has been employed for the last three or four years. In every case, the superintendents and the governing boards of these hospitals are most anxious to make their hospitals the last word in scientific medical service, but in every case the expansion along this line has been rendered almost impossible through the difficulty of financing new departments, for which there is no equivalent revenue. It would really seem as if the control of hospitals were subject to so little change through all this great era of medical expansion that it was still almost impossible to have the hospitals serve other than as places where patients could be taken to receive nursing care, or for the more spectacular purpose of being operated upon, a fair percentage of the operations probably being avoidable if the patients had had the earlier benefit of adequate clinical facilities.

We feel that the time is already over-due for a great change in the attitude of the people and the government of this province in relation to the hospitals and believe that it is in the interests of the people to provide in every community where the population justifies the expenditure, the clinical facilities that would make it possible for the general practitioner to send his patients

to the hospital as ambulant cases, to be held there for investigation if necessary, and to be sent home if possible with a definite diagnosis, the clearing up of which would very frequently be found to be a simple procedure, but the result of which would often be the prevention of the development of definite life shortening factors.

Perhaps it is unwise to attempt any further working out of a scheme that would make such a plan possible, but it would seem that the main features of such a plan are already suggested.

The only official medical department in every community is the medical health department, and if this department were given the responsibility for the provision of a fuller degree of co-operation with the general practitioners, it would seem to be quite possible for the excellent work that is now being carried out by many health departments to be extended until every community was provided with the necessary laboratory and clinical equipment, and furthermore, this department would have the necessary authority for carrying out the social service work and for authorizing the public expenditure of funds wherever this became necessary, while local departments of health could receive very valuable assistance from the provincial department of health through the expansion of the clinic service that is already a feature of the department's work.

Secondly, the hospital would be the natural place of choice for the establishment of the health centre facilities for that community, and all laboratory and clinical work and all necessary provision of special clinics could be carried on as part of the hospital routine if the necessary co-operation between the public health board and the hospital board were provided.

Thirdly, this plan would make it possible for the general practitioner to receive reports and to gather the clinical data on each individual that he served, very much the same as was done for the soldiers through the service of the Army Medical Corps. As a matter of fact there is no reason why every individual should not have a medical history file which could well commence with the Child Welfare Department, and continue through the school period, to the adult period, when the individual would choose his own family physician, and when a family moved from one locality to another, this medical history might be forwarded to the family physician who was selected in the community to which the patient had moved.

Fourthly, if such a plan were worked out, the state would certainly have to assume a new attitude with regard to assistance rendered to hospitals. Where a hospital has sufficient patients to carry the overhead these facilities come as a matter of course, but in every case referred to to-day the

provision of clinical facilities has been delayed through the difficulty of financing these new procedures, and it would seem that the state would need to subsidize the establishment of these facilities, according to the requirements of hospital standards whenever the total bed capacity was too low to make the plan otherwise feasible.

If the hospital could serve its community in some such capacity as this, the area which the hospital should serve would need to be defined. In most cases the county would probably serve best as the working unit, though whatever is done, the service would need to include rural districts that are receiving the least benefit from the new advance in medicine. Sometimes it would be necessary to combine two or more counties, for as a matter of fact our counties are much smaller than the counties of the United States where plans of a similar nature have already been attempted. Just what would be done in a county such as York or Wentworth, in which a large city is situated, is difficult to say, though here the need is not so urgent as in parts more distant from the larger cities.

I would like, therefore, to bring this symposium to a close by hazarding the statement that because of the great gap between present knowledge and actual practice, no other field offers so great an opportunity for the improvement of the condition of our people as that of the medical service, and if the three agencies of public health departments, the governing boards of hospitals, and the medical profession will but adopt a thorough spirit of co-operation, recognizing the fact that the general practitioner is the key to the situation, and that he must be supplied by the community which he serves with the clinical facilities which have been tried out and proven to be of practical value in the diagnosis and prevention of disease, there would seem to be no reason why this ideal may not soon be attained.

Society Proceedings

THE ALBERTA HOSPITAL ASSOCIATION

The Alberta Association of Registered Nurses and the Alberta Hospital Association met in convention in the city of Calgary, Alberta, on November 23 and 24, 1926.

The following officers were elected for the ensuing year by the Alberta Hospital Association: President, Dr. H. R. Smith, Edmonton; Vice-President, Dr. Washburn, Edmonton; Secretary-Treasurer, Mr. J. A. Montgomery, Edmonton. Executive Committee: Dr. Archer, Lamont; Mr. Barnes, Calgary; Dr. Petitclerc, Edmonton; Mr. Dutton, Lethbridge. Legislative Committee: Mr. Beart, Chairman, Edmonton; Mr. Harris, University of Alberta, Edmonton; Dr. Archer, Lamont Hospital, Lamont.

The following are the officers of the Alberta Association of Registered Nurses: President, Miss B. Guernsey, Royal Alexandra Hospital, Edmonton; First Vice-President, Miss McDonald, General Hospital; Second Vice-President, Miss McPhedran, Central Alberta Sanatorium, Calgary; Secretary-Treasurer and Registrar, Miss Clark, Public Health Department, Parliament Buildings, Edmonton.

It was an extremely busy two days and many phases of both nursing and hospital work were discussed. The convention was fortunate in having present two members of the nursing profession from Eastern Canada, Miss Jean Brown, of Toronto, representing the Red Cross work and formerly president of the Canadian Nurses Association, and Miss Kniseley, head of the Social Service Department of Toronto General Hospital. Miss Brown gave a very interesting history of nursing in Canada. Her message was very helpful, she urged especially the desirability of hospitals avoiding the exploiting of nurses, especially undergraduates. Miss Kniseley outlined very clearly the duties and functions of the Social Service Department operated in connection with the hospital. The members present were very much impressed with the necessity of more work of this kind being established in Alberta and on the last day of the convention a resolution was passed to the effect that this association go on record as being in favor of a system of social service to be operated by the hospitals of this province,

and that as soon as possible some system adaptable to the institutions of this province be prepared and submitted to the various hospitals for their consideration.

The question of the care of indigent patients was also discussed. This is a burning question with all hospitals and as yet no one institution has arrived at a satisfactory solution.

Dr. McGibbon, of the University of Alberta, gave a very carefully prepared paper on "Hospital Administration," stressing the importance of the communities having an interest in the general efficiency and management of hospitals. He also spoke of business methods and their relation to efficiency. It was the consensus of opinion that the work of hospital administration had now become a profession and that provision should be made whereby a thorough course would be available for those who wished to prepare themselves for this work.

"Hospital Accounting" was introduced in a paper by Mr. Harris, of the University Hospital, Edmonton, and following a presentation of this paper a resolution was passed providing for the appointment of a committee to draft a proposed method for promoting uniformity of statistics and accounts having due regard to the system now in use and that the same be forwarded to each hospital in the province for their consideration.

The subject of "Co-operative Buying" was introduced by Dr. H. R. Smith, of the Royal Alexandra Hospital, Edmonton. This was followed by a very interesting discussion and the feeling of many present was that it might be possible to establish a co-operative buying pool that would be able to handle a certain number of standardized articles now in use in hospitals.

A resolution was passed providing for the appointment of a committee to consider the advisability and possibility of standardizing certain supplies used in hospitals with a view to purchasing in bulk the requirements of a number of hospitals, vendor to ship direct to each hospital and collect for same. This matter is to have the most careful consideration of hospitals concerned before any definite steps are taken.

"The Relation of the General Hospital to a Tuberculosis Sanitarium" was dealt with in a paper by Dr. Baker, of the Alberta Central Sanitarium, Robertson, Alberta. He emphasized the need of all general hospitals having a space set aside for the care of tubercular patients and the desirability of all nurses being taught not only the care of tubercular patients, but how to care for themselves when nursing such cases.

There were several other very interesting papers and it was the opinion of those present that the convention was one of the best ever held in the Province of Alberta.

The following resolutions were also passed:

RESOLVED—That the Joint Meeting of the Alberta Association of Registered Nurses and the Alberta Hospital Association deprecates the method taken by the Canadian Medical Association to study the curriculum of the training schools for nurses in Canada as stated in a resolution outlining the functions of the committee. And suggest that this resolution be annulled, and a joint committee composed of representatives of the Canadian Medical Association and the Canadian Nurses Association be appointed to make a study of this question.—Carried.

That the Association believing it to be in the best interest of hospitals of this province wishes to place itself on record as being in favor of the formation of a Canadian Hospitals Association and that a copy of this resolution be forwarded to all provincial hospitals associations in the Dominion.

The next convention will be held in the city of Edmonton in the month of November, 1927.

Book Reviews

The Nursing of Diseases of the Nose, Ear and Throat. By Michael Vlasto, M.B., B.S., F.R.C.S., Assistant Surgeon to the Ear, Nose and Throat Department, West London Hospital. London: Faber & Gwyer, Limited, 24 Russell Square, W.C. 1. 1926. Price, 6s, net.

This book is gotten up in a very practical and simple form. The illustrations are excellent, especially those illustrating the technique of treatment to be carried out by the nurse. The author in his introduction sums up the want of a practical book for nurses in this specialty. The nursing treatment in the diseases of ear, nose and throat is so totally different from that of general medicine and surgery that special instructions should be given. This book, to my mind, seems to fill this want very admirably.

PHILLIPS' MILK OF MAGNESIA

Physicians everywhere have a most kindly and enthusiastic interest in Phillips' Milk of Magnesia. This old reliable, the pace maker in the control of hyperacidity without inflating the stomach, is freely prescribed by leaders among medical men, who have proved its undoubted worth through years of cheerful and helpful experience. Phillips gave the earliest milk of magnesia to the world of relief and the home of Phillips' at Glenbrook is one of the show-spots in Connecticut. The water used is so absolutely pure that it is possible to make and sustain the claim that Phillips' Milk of Magnesia is 100 per cent. effective. The utter lack of carbonates prevents the formation of any gas. Phillips' Milk of Magnesia is essentially antacid and mildly laxative. It is counted as one of the most valuable of the agencies for health that are at the command of the medical fraternity. The slogan of usefulness of Phillips' Milk of Magnesia proclaims its mission as one "to restore the sick to health and keeping well people well."

A COMPARATIVE STUDY OF GENERALIZED AND SPECIALIZED NURSING AND HEALTH SERVICES

The most effective and economical distribution of nursing and allied health services is still a problem in the minds of health officials. In East Harlem, the admonition of the psychologist, "when in doubt, do either or both," was needed and the health district, divided into two equal areas, was organized under both types of administration, generalization and specialization.

In the specialized area, the old familiar story was repeated and the families of the community were visited by maternity nurses, infant nurses, pre-school nurses, by nurses for sickness care, by the tuberculosis nurse, the mental hygiene nurse, and the specially trained nutrition workers. Each time a new service was added to the programme, a different type of field worker was needed to interpret the service in the homes.

In the generalized area, home visiting was developed on the family basis. The first nurse to visit the home might go to care for a sick child or an expectant mother, but when her special task was ended there was no break in the continuity of nursing services. She was the family nurse—the general practitioner—who guided the mother in all phases of nursing and health care as they affected each member of the family group.

The main conclusions of the study—based upon quantitative and qualitative analyses—are overwhelmingly in favor of the generalized nurse from the view-point of efficiency. On the qualitative side, there was no demonstrable difference observed

in nursing techniques under the two types of administration. In other words, the family nurse proved to be capable of carrying out accepted nursing routines in varying services as was the special nurse who was responsible for a single service. On the other hand, the "family nurse," because of her varied contacts in the home, and her unbroken service, i.e., she did not have to transfer sick children, infants, and other members of the family group to other workers, had greater influence in the home and a much better understanding of the health needs of the family as a whole.

This report, says Dr. Haven Emerson in a foreword contributed by him, offers "as nearly conclusive evidence as is humanly possible to obtain under metropolitan conditions. The plan of study was prepared with care, the experience of the "Nursing and Health Demonstration" has been accurately recorded. The conclusions are reasonable and of much importance to the whole army of health workers.

Copies of the report may be secured from, The East Harlem Nursing and Health Demonstration, 354 East 116th Street, New York City. Price, 35 cents.

DIETO-THERAPY IN GASTROINTESTINAL CONDITIONS

A noted gastroenterologist propounds the following interesting syllogism:

Cases of ulcer, colitis, hyperacidity and malnutrition are usually constipated. Coarse foods are harmful to these patients. But low residue foods increase the tendency to constipation. Ergo—low residue food, plus a high-quality intestinal lubricant, solves these nutrition and elimination problems.

The dietetic pendulum has swung too far in the direction of the over-residuized diet in combating constipation, says a leading intestinal specialist. Progressive physicians, he adds, take the dietetic middle ground and instead of prescribing the over-residuized diet, with or without cathartics, they advise either a low or a moderately residuized diet with an intestinal lubricant.

Nujol, the ideal lubricant, is the therapeutic common denominator of all types of constipation. Microscopic examination shows that too high a viscosity fails to permeate hardened scybala; too low a viscosity tends to produce seepage. Exhaustive clinical tests shows the viscosity of Nujol to be physiologically correct and in accord with the opinion of leading medical authorities.

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Only an *all-bran* product could do the work of Kellogg's ALL-BRAN. Doctors know they can rely upon it to accomplish definite results, because it is 100% bran. Results a part-bran product could hardly hope to achieve.

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A SIMPLE demonstration shows the Physician at once why Petrolagar is preferable as an intestinal lubricant.

Mix equal parts of Petrolagar and water in a tube or glass.

In another tube or glass, *try* to mix equal parts of plain mineral oil and water!

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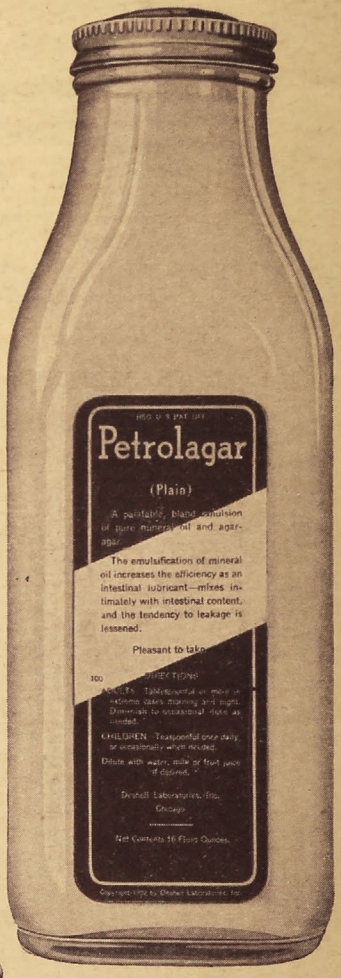
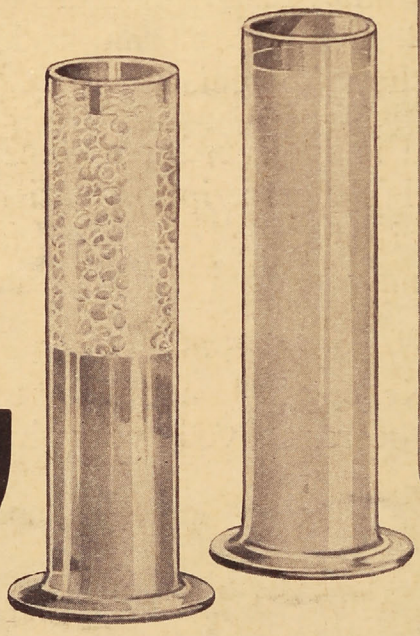
245 Carlaw Ave.
Toronto **Ontario**





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