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The Hospital World

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VOL. IV

JULY TO DECEMBER, 1913

Editors

The Hospital World

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The Hospital World

BUFFALO, U.S.A. TORONTO, CANADA LONDON, ENG.

An International Journal published in the interests of Hospitals, Sanatoria, Asylums, and Public Charitable Institutions throughout America, Great Britain and her Colonies.

Vol. V. TORONTO, JANUARY, 1914 No. 1

Editorials

RETROSPECTIVE

MONTH by month the editorial pages of this journal note, as they occur, advance movements in the several departments of hospital work. But at this season of the year when a measure of retrospection is instinctive, a brief survey of the field and a résumé of recent

hospital movements that make for progress appears timely.

The construction of several large hospitals and the completion of others at costs of from one to three million dollars, evidence the larger philanthropy of private individuals and public coffers in this direction. The Barnes Hospital in St. Louis, the Peter Bent Brigham in Boston, the Montefiore of New York, the Cincinnati, the Toronto General and the San Francisco, are representatives of this class. Besides these must be ranked the many magnificent additions to existing hospitals, instanced in the New Phipps Psychiatric clinic, and the very recent one and a half million dollar bequest to Johns Hopkins, and the many new hospitals in smaller cities costing in the neighborhood of half a million.

Towns that ten years ago would have considered a community hospital neither necessary nor possible, now view it as an essential and an institution to be established, not with cheap economy, like the old-time poor house, but one which will reflect the humanity and progress of the community. To-day the town hospital is the most up-to-date of its public buildings.

It would be interesting to know, if statistics were available, just what amount of capital is invested in those hospitals of the United States and Canada at present under construction or completed within the year. The sum would be a revelation, and full of significance.

A concomitant of the above condition, and another sign of progress, is the increased interest in methods

of administration. This has been evidenced in the past year by the several successful conferences that have been held. There are now three large hospital associations on this side of the water—the American and Canadian Associations and the Hospital Section of the American Medical Association. Each of these is independent of the others, each is allied with the other, and each is a vigorous organization whose annual meetings are well attended, and whose programmes are full of interest. There is also the British Hospitals Association, which is now facing such vital problems as the influence of the Insurance Act on the hospitals, and the introduction into the age-old free hospitals of private and semi-private wards. Twenty years ago it was difficult to sustain one such association, so lax was the interest evinced in hospital affairs, even by the few underpaid, overburdened and poorly qualified workers themselves.

The year has brought a new and admirable hospital journal, *The Modern Hospital,* into the American field to take its place beside the HOSPITAL WORLD and the *Record.* Several medical and nursing journals have recently organized departments devoted to hospital interests. The publishing output is a keen indicator of public interest, and this goes to prove that the hospital industry has a recognized and advancing value in the business world.

Perhaps the greatest advance movement has been the extension of hospital service in the community. This has developed naturally out of the great social service movement, which has swept into churches,

hospitals, colleges and all agencies of reform with a transforming and vitalizing power.

The hospital of to-day, while retaining its primary medical function, has allied two others to this, the preventive and the educational. It "sees people as well as diseases," and is interpreting its larger purpose along lines that reach into and raise the standard of community living. The establishment of health clinics, work for the handicapped, investigation into occupational diseases—these represent some lines of the past year's social work. In the wide field of the allied functions other lines are continually presenting themselves.

But while the general note is one of progress, large problems remain to be solved before the hospital reaches its full measure of efficiency. Perhaps the greatest of these, and one that must be settled at no distant date, is the widely varying conditions under which hospitals are now established and supported. A second is the evident and growing need of some system of hospital standardization. A third is the rapidly increasing necessity for systematized training for hospital administrators—the establishment of a hospital chair in a University Hospital, and the conferring of a degree in connection therewith. The modern hospital is too complex and costly an institution to be placed in untrained hands. With this latter reform would and should follow the adequate remuneration of such administrators.

A HOPEFUL MESSAGE

THE chief message conveyed by Dr. Woods in his book entitled "In Spite of Epilepsy," appears to be one that should be taken to heart by every worker in every hospital—the message of hope.

Dr. Woods is an international authority on epilepsy, and he believes:

> "That in spite of general professional incredulity, many epileptics can be cured; that nearly all may be helped; that frequent seizures may be almost indefinitely averted, and the patient restored to useful occupation, and that even in the most trying and inveterate cases it is better to persevere in hopefulness than to surrender in despair."

But while believing the disease to be in many instances curable, the specialist deals chiefly with the fact that many epileptics have achieved eminence in higher walks of life. Apart from the three historical personages—Mohammed, whom he discusses, Julius Cæsar and Lord Byron—Dr. Wood claims that in his own quarter century of consulting practice he has had among his patients many men high in the service of their country and in professional and business life, none of whom has allowed his malady to stand in his way of advancement in his work.

Apart from its value as the work of a specialist, the book is a lively and interesting study. But the wisdom in it that may be most widely applied in the invalid and medical world, is contained in that last sentence:

"Even in the most trying and inveterate cases it

is better to persevere in hopefulness than to surrender in despair."

The sentiment should be framed and hung in every ward in every hospital, to be interpreted literally and practised continually. Hope is a powerful therapeutic agent, and the entire hospital staff from the admitting clerk to the chief surgeon, from the door boy to the administrator, should be required "to persevere in hopefulness." It is as necessary a mental acquirement as strength is a physical one in the qualifications that make for suitable hospital workers.

OCCUPATIONAL DISEASES

An important forward step has been taken in the Massachusetts General Hospital, in its out-patient department, in the establishment of a system designed to obtain accurate information on occupational diseases. As case histories are set down in most hospitals, the information relative to a patient's occupation is indefinite. In this hospital, the new form history blank sets forth what the man may be doing daily which predisposes him to certain diseases. It is expected in the course of time that the data secured will furnish a basis upon which to take preventive action.

Under the new industrial relationships that are rapidly obtaining, restraining legislation in connection with occupation is already being enacted; also various devices are being tried out to counteract malconditions.

In Cleveland certain out-patients suffering from lead poisoning were sent to the medical health officer who communicated with the employer and caused preventive measures to be adopted. It was found that certain locomotive engineers were disposed to sciatica in the right leg from habitually sitting on the right thigh. When the matter was drawn to the attention of the road it installed cross seats on he engineer's side of the cab.

In an Erie city brass foundry, the writer saw attached to a workingman's bench a shaft through which the fine filings were sucked up by a revolving fan, thus freeing the air from the injurious particles. In a hospital at present under construction the plasterers refused to work where salamanders were used for temporary heating, owing to the ill-effects of the coke fumes. Marble cutters and workers in similar industries which tend to phthisis frequently wear masks over their mouths. The use of white lead in paint and white phosphorus in match making is being prohibited.

In order to do effective preventive work the physical condition of the workman must be known in detail. It must be known also what he actually does, what motions he makes, and what actual muscular strain he undergoes. There must be a record of his exposure to dust, fumes and other agencies which are recognized sources of disease.

Under the new system installed in the above-named hospital it is expected there will be a record of fifty thousand cases in the course of five years.

And from these statistics Dr. Edsall, of the hospital staff, a recognized authority on this subject, believes it will be possible to form sound opinions regarding the causes of occupational disease and the measure of risk which is being run by the workers.

There is sound sense in what this great Boston hospital is doing and suggestions for other hospitals and physicians.

THE LARGER SERVICE

Two large public hospitals, one in the eastern States, one in Canada, have come recently, and within the same month, under public censure for a similar offence—each institution turned away a man who applied for entrance, giving as a reason for so doing that his condition was alcoholic, and therefore he was inadmissible.

The circumstances of each case were much alike. Each patient was taken from the street to the hospital by the police. Each man was refused admission on the same ground, and each died in the police cells within two hours after being returned there.

In one instance the hospital diagnosis was proved incorrect; the case was one of drug poisoning. Whether the other case was alcoholic or not, the point is that he also was refused treatment when in extremis —and died.

The fatal error in diagnosis emphasizes the need of careful and through examination of every appli-

cant for admission—even a midnight emergency brought in by the police. Again, and in relation to both cases, alcoholism is now so generally recognized as a disease, and when taken in excess as a deadly poison, that its victims are as much entitled to treatment as sufferers from any other poison.

Yet, again, it is questionable whether a general hospital, supported by public funds, should turn anyone requiring medical treatment from its doors, no matter what the disease. Large hospitals should have individual probation wards where any such night cases could be placed, and made temporarily comfortable until there is opportunity for thorough diagnoses.

Police stations are primarily for the criminal, but the homeless night applicant is not sent out again to wander the streets, ineligible for admission, because he has not committed a crime. He is given shelter and warmth until morning when some proper disposal of him is made.

Shall a great public philanthropy be less kind than the law?

Apart from the disastrous termination of the cases quoted, the incidents are regrettable inasmuch as they show that our hospitals as a whole are still suffering from a provincialism that prevents them from realizing the larger place that is theirs in service to the community.

Original Contributions

TWO INDISPENSABLE COMBINATIONS IN HOSPITAL WORK

A. S. KAVANAGH, D.D.,
Supt. Methodist Episcopal Hospital, Brooklyn, N.Y.

In my office stands a remarkable teacher, sullen, silent, relentless, like a sentinel clad in armor, as if questioning my right on the premises. I speak of my hospital safe. It contains many things of value, such as contracts, plans, bonds, histories and documents of various kinds; in fact, everything except money; which, as a rule, does not tarry long enough for "safe" keeping.

When a decade or so ago we first became acquainted with our austere friend and learned something of his importance, we determined that the most cordial relations must be established between us with as little delay as possible.

Accordingly, we undertook the task of mastering the talismanic combination by which those iron doors might be induced to swing open. After the necessary instructions, we gently turned the knob forward, then backward, then forward again; then all around, recalling the experience of a well-known New York banker of a generation ago, who spent half an hour trying to open his safe, and was about to give up in despair, when he discovered that he was spelling the combination word, boot, "b-u-t-e." Though that "boot" was a "bute," it could never open his safe; but when, by the aid of his secretary, the proper combination was used, the door swung open as if by magic.

Even with the right combination, I found it no easy task, and more than once should have met with defeat if it had not been for my secretary. In those early days of my superintendency I discovered that there is a rare combination which every superintendent must learn in order to attain any reasonable degree of success.

If I mention a few of the items in this combination, it will not be with the claim that I have mastered them; but rather to indicate the lines of my personal endeavor.

And first of all is that reticent, elusive grace of patience. Oftentimes have I thought of the old rhyme and recited it for my own encouragement:

"Patience is a virtue, try it if you can;
It is seldom in a woman, and never in a man."

I need scarcely say that a nervous, excitable, impatient official would find it extremely difficult to adjust the combination. Here is where some of us fail. Somebody says that "when a lawyer loses his temper he is very apt to lose his case." That undoubtedly is true; but when a superintendent loses his temper his case is lost already. Let us make no mistake, patience is the combination.

And so is exactness. You may be within a hair's breadth of being right when turning the knob, but it won't do. You might as well be a hundred miles away as the hundredth part of an inch.

It is just as well to get that fact indelibly fixed in one's mind. The business world understands this. The book-keeper in the bank or mercantile house knows he must hunt for hours to find a missing nickel. There can be no correct balance until he finds it.

Years ago when I was a boy, I knew a tool maker in New York City who was receiving *four* dollars per day, which was large wages for those days. It fell to his lot to make drills for the oil wells in Pennsylvania. Every drill bore his initials. One day a gentleman from the oil fields arrived in New York, and offered him *ten* dollars a day to superintend the making of drills in a foundry in Pittsburgh. He accepted, and a year later was re-engaged at twice the salary. Why this splendid good fortune? The explanation is this. It was a well-known fact that the drill which bore this man's initials wore out, but never broke.

In the man or woman who is superintending a large or small hospital there must be an exactness which spells thoroughness. A justice and fairness, with employees, patients, doctors and nurses, which will inspire all fair-minded people with confidence in the superintendent as the executive officer

of the institution, and in the institution itself. Laxness, indifference, procrastination, unkept promises, spell failure for the superintendent.

From the very first in my effort to master the combination, I learned that patience and exactness in the ordinary were not enough. To these virtues must be added perseverance. You may have worked out the combination correctly as you supposed only to discover that you have to begin over again. You didn't quite make it, but you cannot afford to stop; you must try again, and yet again. Your patience may have to be reinforced by down-right perseverance; and then you will win.

This, as you know, is true to actual life. Many a battle has been won by just a few more shots; many a picture made perfect by a few more touches, and many a patient has been saved because the doctor, or nurse, or both, refused to surrender. Every efficient superintendent will have unrealized ideals. His motto must be: "I count not myself to have apprehended: but this one thing I do, forgetting those things which are behind, I press toward the mark for the prize." It's a great calamity when any of us feel that the prize is behind us. Perseverance is in the combination, and is the prize-winner.

There are many more things in the combination, but these few characteristics must be found in every superintendent who achieves a respectable degree of success.

Up to this point I have used the word superintendent repeatedly. You may take that word out, if you will, and insert the word physician, or surgeon, or directress of nursing, or the head of any department. There is no success worth while in any department without the mastery of this combination.

And now, turning from this combination which makes individuals efficient, let us examine the combination which will make the hospital in the highest sense successful. And here, as every superintendent will understand, the right combination is realized only by the proper and proportionate recognition and development of each department.

For example: no hospital can be efficient in the highest sense whose business interests are not properly conducted; and this is often more difficult than running a banking institution. In the bank every man is an expert, from the president

down to the policeman at the door. In a hospital you have to deal with a score or two physicians and surgeons whose appointments outside must be kept, and whose duties in the hospital often overlap, because of emergencies which arise in their own practice, or in the work of the hospital.

Then there is a houseful of patients, private and public. They are ill, or they would not be there; and that means nervousness, complaints, unreasonable demands of friends, bills to be collected; some are free, some are partially free, and some pay in full. But, there must be no mistake in the book-keeping. The slightest mistake is unpardonable when nervous patients, or their more nervous friends, are involved.

Then there are nurses, several score. They have come from homes where their independent spirit was never checked; and they, too, involve book-keeping. Books, boards, uniforms, etc., are necessary for each nurse.

Then you have the help: orderlies, porters, maids. Well, in a word, it is not a bank, with experts at every desk; it's a mixed multitude with which you have to deal; and singularly enough many of them feel because it is a charitable institution business methods are almost out of place. This is not always so honestly expressed as it was by one of our women employees when we installed a time clock. She said, "It was all right for a business house, but had no place in a charitable institution." Now, as a matter of fact, there is no place where strict business methods should be more in evidence than in a hospital. There are so many different interests, and so many indifferent people, that a strong organization must be maintained. We are handling the sacred gifts of hundreds, perhaps thousands, of people, living and dead. To carelessly waste a dollar is to prove ourselves unworthy of the trust reposed in us.

In some places a buyer or purchasing agent has a free hand. The doctors, the nursing department, the housekeeper, all press their supposed needs. In some hospitals they occasionally have the privilege of placing their own orders. What a temptation it is for a surgeon to order something new when he visits a well-stocked supply house, and what a temptation for an agent to push his trade by a discriminating distribution of samples among physicians, some of whom seem willing to sell their influence for what, after all, is but a trifle.

I have two rules which protect my hospital against these conditions. First, all orders must be signed by the superintendent. There is no exception. Once or twice a doctor has ordered something he needed in his department, and the bill has been sent to the hospital. I have always returned it. It must be collected from the doctor. Once or twice I have handed the doctor the amount of the bill afterward, but in the first place it was settled by the doctor.

It is our purpose to make clear to the physicians that there is only one person authorized to make purchases for the hospital; but what is more important than that, to teach the commercial houses that orders other than those from the superintendent must not be honored.

The other rule I observe is this: I will never give an order to a salesman who comes to me with a long list of recommendations from my staff, for I have discovered that often, to get rid of him and thus save time, a doctor has given a mild endorsement, which assumed very large proportions in the mind of the agent.

By this method of procedure the equipment of the hospital does not suffer in the slightest degree, for the doctors have a very persistent way of making their wants known.

The American Hospital Association could have rendered no more important service than it did by adopting and recommending a uniform system of accounting which has been adopted by many hospitals throughout the country, and making possible a fairly satisfactory comparison of the work, the income and the expenditures of similar institutions.

History keeping is an exceedingly important matter in a well regulated institution. It has been my privilege to watch the evolution of history keeping for twelve years in my own hospital.

We were proud of our histories, and had reason to be. A physician, not on our own staff, recently writing upon the early treatment of appendicitis by operative procedure, spoke of the exactness of our records of the disease, and its treatment.

In some particulars we cannot claim to surpass those early days, and yet I am sure decided improvement has been made.

A few years ago our hospital was threatened with a lawsuit which drove us to a close study of a certain history. We discovered that it had absolutely no legal value. It was written by an interne from his notes, perhaps after the patient had left the hospital. It was supposed to have been done promptly, but it didn't have the ear-marks of promptness. It was neatly typewritten, and bound in morocco, but as a legal or an exact document, it was not worth its splendid binding.

As soon as we had gotten out of our difficulty, the board of managers voted two things: first, to do away with the custom of typewriting the histories; and, second, to insist that completed histories shall be brought down to the office with the discharged patient, a finished product, to be bound as brought down without any change whatever. Thus the history becomes a document of legal value; and reliable, too, as an exact record of the case from day to day.

But the importance of having the business of the hospital thoroughly organized reaches far beyond the bounds of the hospital. Every doctor, nurse, employee and patient affected will be better equipped for their own business or professional affairs, because of the rules and regulations to which they are subjected.

I shall never forget the simple remark of a poor woman, for whom we had done little or nothing in a medical way, when leaving the hospital she said: "I shall be a different woman because of the regular life I have lived here, and the systematic, orderly arrangement of the work as I have observed it." The business methods of an institution have a far-reaching influence.

The organization of the professional work of the hospital is another element in the successful combination. Here are difficulties of large proportions. The idealists would have one physician-in-chief, and one surgeon-in-chief, and all the others as associates or assistants. This scheme may work well when the chief is a man of such outstanding pre-eminence as to hold undisputed his high position; when his associates are so far below him in the ranks that they would not think of disputing his authority.

But when a staff is composed of strong men of decided in-

dividuality, then the position of chief is often nothing more than an empty honor, or a constant irritant. Strong men will not, with good grace, accept dictation from one no stronger, though possibly older, than themselves.

And yet to all this there may be some striking exceptions. Possibly the college hospital needs this kind of an organization for the unification and supervision of the whole work; but, as a rule, the average surgeon is an independent personality, and will desire to remain such.

Then there is the question of opportunity for young men, and of efficiency for both young and old. It is very seldom one hears of the resignation of an attending physician or surgeon without feeling that there is some sort of trouble in the camp.

In a remarkable address delivered by Dr. Howard Kelly, of Baltimore, a few years ago in Brooklyn, he suggested that he didn't think that the cause of medicine and surgery would suffer if the older men who were serving several hospitals should withdraw from some of them, or should cease their hospital work altogether, and give the younger men a chance.

Without waiting for the older men to develop this altruistic state of mind, and in order to properly encourage it, not a few hospitals have adopted an age limit for their physicians and surgeons.

And I think it is now quite noticeable that boards of trustees are beginning to take a more active interest in the selection of men. Of course there is some danger that the family physician, or personal friend, may receive too much consideration by this method, but the trustees will tell you that there is less danger than in the old way of making appointments, when a few men, perhaps one or two, controlled the matter.

In many places appointments have been of the legacy sort. An attending appoints a favorite as his assistant. He may or may not be the best available. Later, upon the death or resignation of his chief, the name of the assistant is presented to the trustees and strenuously urged because of his long service. It is perfectly clear that this policy has excluded applicants of a superior character who were not close to an inner circle.

It is quite conceivable that a sensible board of trustees, unbiased, unpledged, entirely free from prejudice, like a jury

unfamiliar with technicalities but capable of understanding facts, might succeed in making better appointments than men of long time professional relationships.

Within the past year the hospital of which I am superintendent has adopted a rule that "assistants to attending phycians and surgeons must be selected from those who serve in the dispensary of the hospital, except by special vote of the executive committee."

This rule is a distinct recognition of the services rendered by the dispensary men, whether they belong to our own alumni or that of some other hospital. It puts them in the line of promotion, and is a guarantee to all that ability and service, not pull, will count in appointments.

Then again, no one can read the hospital reports that come to his desk without observing the constant effort to improve the character of hospital work.

In the Massachusetts General Hospital in Boston a new method of organization is being tried, which is exceedingly suggestive. The patients are being classified according to their diseases, and assigned to a physician or surgeon for the time being specializing in their particular difficulty.

For example, to one is assigned all cases, say of heart disease in its various forms. To another rheumatic difficulties. To one surgeon all cases of hernia; to another all cases of appendicitis. Each physician or surgeon is assigned one hundred cases of the particular disease he is treating; and when he has rounded out the allotted number, he is expected to make a written report. Then a different line of cases will be assigned him.

By this method it is thought that each man will become particularly expert in handling a particular disease, and thus the best results shall be secured. The tabulated results of a year or two will be awaited with much interest.

A few months ago my own hospital adopted a plan which as yet is too new to furnish any data. The board of managers authorized the executive committee to expend a sum not to exceed one thousand dollars in any one year, in publishing papers or reports of our attending physicians and surgeons, either as individuals, or in collaboration in the same depart-

ment, such papers, when written by individuals, to be based upon their treatment of fifty patients suffering from the disease considered. When the paper is the joint work of several men in the same department, one hundred patients must form the basis.

If the attendings become interested in this scheme, it will mean closer attention on the part of house staff, nurse and attendings; and last, and best of all, the patient will be the gainer.

Furthermore, it may be added here, a well developed and highly efficient medical and surgical department will have an influence upon the work of other hospitals.

This very week the leading surgeons of Brooklyn meet at my hospital for an evening of discussion and review, as they meet from time to time in the different hospitals.

At the meetings of the medical and surgical societies all important cases are discussed, as also in the medical journals. Thus every physician in the country and every patient of every physician is enriched by the work of any well organized medical or surgical service. And that object every worthy institution must have in mind.

There is another department which must also be considered here; one which is indispensable to the work of the hospital. I refer to the nursing department. I need not say that this is a live wire, and any one who ventures here is in danger of electrocution, but as we have taken some chances before and escaped, we are emboldened to take a few more risks.

There are many angles of vision as we approach this subject, and many interests involved. The women who have made it their life work have a right to be tremendously interested, and perhaps they are not to blame when they consider the man who meddles with their affairs an intruder, which they do except when he happens to agree with them.

It should also cause no surprise that physicians should feel a positive interest in the question, when the relation of the nurse, to them and to their patients, is considered.

The trustees who have invested millions of dollars in the hospital buildings and equipment, and in nurses' homes, and who know the praise and blame accorded the nurse for her

hospital and private work; and who, from practical experience with nurses in their own families know more about these matters than the nurses suppose, think that they, too, have some rights in the premises.

Finally the State claims a right to determine just what instruction a pupil nurse shall receive.

The grievance of physicians and trustees is not that the State assumes these rights, or that it confers with nurse leaders, but that in many places it ignores both trustees and physicians in their deliberations and conclusions.

In our cities the boards of education are composed of men and women who are not technically equipped to teach, but who are supposed to have some sound sense in determining educational matters. The teachers cannot determine either the policy of the education board or the curriculum of the schools.

This principle is acknowledged, too, in nursing matters in New York State, where the board of regents, laymen for the most part, have the final word on all nursing questions. There is a difference, however.

The nurses become the advisers of the regents, while trustees and physicians are excluded. The nurses, while magnifying the importance of the training school as a school, do not wish to be classed with teachers. They prefer to be ranked with physicians. And they claim that as physicians determine the policy and curriculum of medical colleges, subject to the State, nurses should determine the policy and curriculum of training schools.

The doctors, however, will not admit the analogy. They say, while the vocation of the nurse is highly honorable, it cannot rank with their profession, for the physician is an independent workman, while the nurse cannot give so much as a placebo without his permission or order.

The nursing question is immensely embarrassed to-day also, by the outspoken, able and determined opposition of the nursing leaders to the present method of training school organization.

In nearly all hospitals the training school is considered a department. This is not satisfactory to the nurse leaders. It must be divorced and stand alone, independent of the hospital management. To this end the nurse leaders are committed.

Lest you consider this language too strong, or that I am misstating the facts, even in the slightest degree, let me quote from Miss M. Adelaide Nutting.

In her paper on "The Educational Status of Nursing" she says: "The principle of absolute control by the hospital is unsound, and in practice it does re-act unfavorably upon the education and training of nurses."

Again: "The first step toward developing proper schools of nursing lies in separating them from the hospital and its control, and placing them upon an independent basis."

Again: "Whether the freedom of the training school is brought about by means of endowment, or by state or municipal aid, does not matter. The thing to be secured is a separate government for the training school."

Surely no writer could be more frank or explicit; and in this particular she has done well; for now trustees and training school committees who desire to install supervisors and head nurses who will disrupt harmonious arrangements in their hospitals will apply to Miss Nutting for some of her graduates. To anticipate any other result from her class-room work is to underestimate the sincerity, ability and earnestness of the teacher.

The logical outcome of this propaganda can already be discerned in the recognition which is given in official quarters to the training school, instead of to the hospital of which it is a part.

In New York City many of the leading hospitals, observing this fact, have requested the various outside interests to address all communications to the superintendent of the hospital, as the representative of the board of trustees, and not to the head of a department.

And as the usual title of the nurse in charge might be confused with that of the superintendent of the hospital, who is the superintendent of all its departments, several hospitals have changed her title from "Superintendent of Training School" to "Supervisor or Directress of Training School." It seems quite evident that the trustees in Greater New York do not

intend to let nursing matters drift along any further without their attention.

Now let it be frankly admitted that there is much to be said in favor of an independent training school for nurses, and we should hail its coming with great satisfaction, whether founded by city, state, or private endowments, if organized on the same basis as the medical college. Its whole business would be the work of education. It would relieve the hospitals, which were founded primarily for the healing of the sick, from the pressure upon them to make that work secondary and the training of nurses first. And it would give the nurse leaders an institution which they or their friends could manage to suit themselves; and save them from the ungrateful task of forcing endowments given for one purpose to be used for another end.

Trained, as to theory, in such a school, they would come to the Hospital for practical work, as the young internes, who come because they desire the service it offers, and who come with respect for trustees, physicians, and all officers of the institution. In this way an honorable young woman would come to complete her training, which she might accomplish in a year or so.

We are glad to record that, notwithstanding Miss Nutting's antagonism to the present method of training-school organization, yet a sense of justice impels her to acknowledge "that the immediate advantages of the present system do not lie wholly with the hospital, for the student receives, without incurring any expenses for tuition, books, board, lodging, laundry and usually uniforms, such education and training as the hospital is prepared or willing to offer. And this, even when poor in character, and meagre in amount, is always of definite material value to her; enabling her, as a rule, to become self-supporting as soon as she leaves the hospital."

She might have gone further and said what most hospital executives know to be true, that a nurse, for the various articles and provisions enumerated by Miss Nutting, costs the hospital at least $500.00 a year, and that when she leaves the hospital she is able to earn twice, and in many cases three times, as much as when she entered.

There can be no question that, taking the opening and the

closing months of a nurse's course, her cost to the hospital and her increased earning power while in training, she is fully compensated for service rendered.

The nursing question is embarrassed also, and the hospital accordingly, by unnecessary legislation. That some legislation is necessary no fair-minded person will question. That reasonable legislation has already accomplished great good is not a subject for argument.

The nurse leaders point with just pride to the large number of states where registration has been secured. Its achievements need not be recited here, for they are not disputed. But it should be remembered that legislation cannot accomplish everything, and often is wholly unnecessary.

For example: some states have tried by high legal requirements to force up the nursing standards. To quote the tables used by Miss Nutting, in the paper already referred to, six states have, as an entrance requirement, a high-school course, or its equivalent. Those states are North Carolina, Maryland, Indiana, West Virginia, Oklahoma and Delaware.

But what are the facts in the case? How many of them obey the law? Well, the government at Washington called for a report, and you can depend upon it each school made the best showing possible.

We have seen that Maryland, by law, requires a high-school diploma, but only ten out of twenty reporting claim to have complied with the law; while in Connecticut, where there is no law, 11 out of 17 reporting require a high-school diploma.

Or take North Carolina, which, by law, requires a high-school diploma, only 5 out of the 24 schools reporting complied with the law; while in New Hampshire, without any law, 6 out of the 14 reporting require a high-school diploma.

Take New York State, where there has been, perhaps, the greatest expenditure of effort to raise the standards, especially by law, there is a one-year high-school requirement; but every school is free to place its entrance requirement as high as it wishes, and yet only 8 schools out of the 123 reporting require a high-school diploma.

By the side of that put Massachusetts, without an entrance

requirement, where 33 out of the 66 reporting require a high-school diploma.

Or take Pennsylvania, another large state without a requirement by law, yet 37 out of 115 reporting require a high-school diploma.

Now what does all this mean? Why, that the hospitals themselves are more interested than the state, or the State Nursing Association, in raising their own standard. It means, also, that legislation cannot force hospitals to do the impossible.

From the standpoint of efficiency the one year in high-school requirement seems to many to be a complete failure. By so much as this law is enforced, it is seriously injuring the quality of the service being rendered in the hospitals. One year in high school frequently means intellectual or physical incapacity. More than half the girls and boys who leave high school after one year leave for intellectual or physical reasons; but if the girl is physically well, the state is satisfied with her intellectual inferiority. If, however, she is accepted, either with one year or all the years of high school, she must be received quite young. The result is that we are receiving a great many young girls who are altogether too immature to care for patients, and we are rejecting women who are compelled, after leaving the grammar school to go out into the world to support themselves or dependent members of their families. We forget that those years in business matured them, and gave them an experience that one year in high school could never give. The charge that they would lower the social standing of the profession is too unworthy to be mentioned, as well as an insult to hosts of women who are now rendering efficient service as nurses and yet never entered a high school. Under the present one-year rule we have lost largely this class of women, which were at one time available. Education is immensely desirable, but the nursing spirit and maturity more.

If the state should let each hospital settle its own admission requirements for itself, and then classify hospitals accordingly, by this means it would improve, without embarrassing, the nursing of the state.

The attempted legislation at Albany last winter, if successful, would have wrought great injury to the nursing pro-

fession, as well as to the hospitals. The nurse leaders were willing to admit into competition with well-trained nurses a host of women whose training was far below proper standards, all for the sake of having legal limitations placed upon the word "nurse."

They were also anxious to have registration of nurses and hospitals made compulsory, which would greatly embarrass many hospitals and a host of worthy women.

While this law was recommended by the standing committee, it was amended so thoroughly by the Senate that its friends could hardly recognize it. It was finally put out of commission by the Rules Committee. It will probably appear again; and, if in the old form, very likely will receive no better treatment.

There was no time throughout the discussion when the committees, which represented practically all the hospitals and all the medical associations in Greater New York, would not have sat down with the nurses and tried to agree upon a just and equitable bill; for the opposition which the committee presented was not of their liking but of necessity, but those backing the bill would give no quarter; it was all or nothing; and at Albany it was nothing.

As one looks over the nursing field and reads the reports from the nursing conventions, he is firmly convinced that militancy is in the air. The great questions are not the healing of the sick, nor the personal character of the nurse. No, they are substantially these: "How shall we secure more efficient legislation? How can we evolve the training school into an independent organization?"

In the midst of this confusion two great movements stand out in bold relief, which have for their object the welfare of the masses. One of the movements has for its object the highest possible education *of all nurses.*

While in some states the standard has been raised so that applicants must hold a high-school diploma, and other states have a one or two years in high school requirement, thus raising the standard of a few, a committee appointed a year ago by the American Hospital Association, and continued another year,

for further work, is preparing a plan to raise the standard of nursing all along the line.

Following the lead of our public schools, it has proposed three grades: Grade A, for the full-fledged graduate who has met all the requirements of state and hospital.

Grade B, which has had at least one year of theoretical work, and

Grade C, which has had some of the preliminary work of Grade B.

Thus the nurse who had completed Grade C could, if she wished, and had the time, continue the work of Grade B; and the nurse in Grade B, if she found time, and had ambition, might go on with her work, and master Grade A; and graduate.

In my school at this moment is a girl who graduated in the Young Woman's Christian Association course, and having got a taste, wanted more, and has now taken up the regular course with us.

Thus the plan is intended to improve all grades of nurses. It is quite possible that this scheme may be improved. Personally, I should put a premium upon a high-school diploma by granting registration without an examination, save in practical subjects, to all who held such diplomas.

Very much to the same purpose was the report of Miss Mary E. Gladwin, at the sixteenth annual convention of the American Nurses' Association, which was held at Atlantic City last June.

She said that "Registration would never be a success, and would never attain the end desired, until all classes of women who are in any way concerned with the nursing of the sick, are registered; and that we should register, not only the nurse, but the practical and experienced women who are doing nursing."

A little later in the meeting Miss McIsaac said: "Miss Gladwin made one point in her report which I think was not exactly clear to some of the delegates: that was the recommendation about registration of various grades of nurses. As she stated it, it might be interpreted as recommending the same registration for all grades of nurses. I am sure that it is not what she intended to say."

To this Miss Gladwin replied, amplifying and re-emphasizing her previous statement. She said: "We feel very strongly that everyone who has anything to do with the nursing of the sick should be registered, and that they be registered in classes. We feel that there is a place for a woman who calls herself an attendant, a practical, or an experienced nurse; and that she should be helped and protected in every way, and should be supervised. And we feel that the distinction between the nurse and the experienced woman, or the practical nurse who takes care of the sick, can best be made and best be maintained if we register all classes of women."

Now this report of Miss Gladwin is along the same lines as the report which was submitted to the American Hospital Association. There is this difference, however: Miss Gladwin did not attempt to outline an exhaustive plan, but simply emphasized the necessity of recognizing the different grades of nurses.

The American Hospital Association report undertakes to work out a feasible plan.

The other movement to which I referred is that which has for its object to provide nursing care for the sick poor and those in moderate circumstances.

We have all talked about this. In our American Hospital Association we have discussed it; and so have the nurses in their gatherings. All sorts of plans have been suggested. We have overworked what has been called the "book of resolutions," and neglected the "book of acts."

Nurses have been criticised unjustly, it seems to me, because, following the example of the doctors, they don't do more free work. To which a very just reply has been made: that no comparison can be instituted between them at this point. The doctor makes a score of calls, and collects from most of them. He doesn't surrender the entire day to charitable work, which the nurse, in all probability, would have to do, if rendering any free service at all in a family, and of course she cannot afford to do that; and for anyone to insist that she should is being generous with someone else's money, for time is money. The thing that is most open to criticism is the trades-union spirit, by which her price is standardized. The charge of

trades-unionism has been resented with great heat in the past, but its severest criticism and strongest defence have come from the nursing ranks.

No one will question the high standing and authority of the editor of the *American Journal of Nursing*. Here is an excerpt from an editorial in the *Journal* a few years ago. She says: "The rich are provided for in times of illness because they can pay; the poor are provided for because someone pays for them; but the well-to-do mechanic, and the families of small-salaried clerks and professional men must get along with either no nursing at all, except what can be done by members of the family, or be cared for by untrained women."

And again: "So long as the great nursing body leaves the well-to-do middle class unprovided for, we must expect the short-course schools to continue to flourish, and criticism either of the people who organize such school, or the physicians who employ such nurses, or the patients who must be satisfied with such service, is useless and inconsistent. The evil which is at the bottom of this situation is in the fixed, arbitrary, trades-union rate of charge."

She further says in the same article: "While the great nursing body provides service only for the rich who can pay, and the poor who are paid for, we have little claim to call ourselves a profession, for with the profession goes the obligation of service to others first, and money must be a secondary condition."

The sound common sense of this editorial in attacking the trades-union spirit and the standardized salary is commendable, for it would seem that a nurse might take into consideration the condition of patients as well as their circumstances; for some cases are less taxing than others. They often mean a time of convalescence, or of travel and recreation; while others wear a woman down physically, nervously and mentally.

But I am afraid that this editorial does not represent the position of the nurse leaders of to-day, for we find Miss Lavinia L. Dock, at the Atlantic City convention, making this statement:

"As to wages, our conscience is clear. We know that we must not *undersell, that this is treachery to fellow-workers,* and

helps to drag down even remote classes of such. *Be it frankly admitted that this is a fundamental principle of unionism, and a most necessary and indispensable one,* so long as we have our present social system."

Now it is evident from all this that the editor of the *American Journal of Nursing* was right in anticipating the coming trades-union, with trades-union prices, a fact which has been confirmed by Miss Dock.

This evolution of nursing affairs demonstrates clearly that the philanthropists who would help their brothers in distress should no longer depend upon the resolutions of a philanthropic kind voted in a convention of nurses, or in the American Hospital Association, or anywhere else, but should proceed to lay their own plans for the work they desire to do.

That, as I understand it, is what the Thomas Thompson Trust is trying to do. It looks out upon the field, and sees that graduate nurses do not feel that they can afford to cut their price to meet the needs of the great middle class, who in turn cannot afford to hire a graduate nurse at standard prices.

It sees, also, that multitudes do not need the graduate nurses and that for numerous cases the practical nurse is fully qualified. It sees, also, that some need half nurse and half housekeeper; and it undertakes to meet these different conditions.

I could wish that this plan went further, so that it would look after, not only those who could pay for what they receive, but the poor who can pay nothing.

But I must not press this criticism too far, for I claim that if men found a hospital primarily for the care of the sick, it is indelicate, at least, to try to change the purpose of that foundation. So we should not criticise the Thomas Thompson Trust for not going further. They have a well-defined purpose in view, and as they fully realize it, which we earnestly hope they may, they will be a great blessing to multitudes whose burdens and embarrassments will be greatly lightened.

Ladies and gentlemen, hospital work is not a narrow one; it is as broad as the ills of humanity, and as far-reaching as I have indicated this afternoon, and further. Only the perfect combination of interests and departments in the hospital, and extending beyond the doors of the hospital, can make such work in the highest sense successful.

THE RELATION OF HOSPITAL EFFICIENCY TO THE EFFICIENT ORGANIZATION FOR HOME NURSING *

RICHARD M. BRADLEY, ESQ., BOSTON, MASS.

A MARKED feature of our time is the broader and clearer view that we are getting of the facts with which we have to deal in our community life.

As *one* result of this, we are beginning to realize that we must work out a properly adjusted general plan for the handling of the *whole* problem of sickness, whether in or out of our hospitals. In consequence the hospitals are feeling the call that they shall bear a more clearly defined part in this general scheme, partly by doing some of the needed outside work themselves and partly by adjusting their relations to other organizations that have that work in hand.

We are passing the pioneer stage in the problem of handling sickness, when each separate unit had to develop its own individual efficiency, and we are now measuring the efficiency of each unit not alone by its own individual accomplishments, but also by its power of relating its work harmoniously and effectively to the work of other units in the same field. The strong man in the boat must not only be able to put strength into his own oar, but he must also properly adjust that strength to the forces of the other men in the boat. If he does not keep time with the other men his efficiency is at a discount. We are thus coming to test the efficiency of the hospital in part by its ability to help in the co-ordination of all forces for the care of the sick.

We are also beginning to realize that these outside forces, if properly handled and organized, can be made a most important factor in forwarding the hospital's own particular work; and for that end alone the proper organization of these forces is worth the best attention of the hospital head.

It has perhaps been exceptionally hard for those who are giving their life's work to the hospital fully to realize this rela-

* Read at the meeting of the American Hospital Association, Boston, Mass., August 26-29, 1913.

tion of its own work to the general field of related work, or to take hold of the idea that this outside work, scattered as it is, is a proper subject for a studied and comprehensive system of organization.

Everyone who is engaged in effective and absorbing work of his own must sometimes find himself forgetting the great general field of which that work is only a part, and there is double danger of this with the hospital. Hospital work is absorbing, concentrated, and closely organized, while the kindred outside work for the sick has been scattered, unorganized, and consequently as a work hidden from the general view. It is therefore difficult to keep in mind its size and importance.

And yet the magnitude of this outside work, when its scattered units are taken into account, is simply bewildering. A recent estimate puts it as ten to one of institutional work. Recent careful canvasses in New York State, covering a population of 17,000, embracing varieties of locations from the East Side of Manhattan to hill townships of scattered farmhouses in Duchess County, show a ratio of 13.4 per cent. of cases of sickness receiving hospital care as against 86.6 per cent. cared for at home. The ratio of home cases is undoubtedly far larger in the country at large.

We know that there will be upwards of a million and a half cases of mortal illness within a year in the United States and Canada, and most of us expect, when our time comes, to die at home. There will be more than two million confinement cases, and most of us were born at home and expect to have our children born there. When, in addition to births and deaths, we consider the innumerable other cases, part of our daily knowledge, of severe illness needing service outside of the hospitals, we get an added realization of the vastness of this problem of the proper care of sickness in the home.

A few years ago I became impressed not only with the amount of work that must necessarily be done, in dealing with sickness, outside of the hospital proper, and within the homes, but also with the amazing lack of effective organization needed to accomplish that work with any degree of efficiency and economy.

I was not alone in having this impression, for at least one

responsible observer has deliberately declared that the net result up to date of organized and scientific care for the sick has been to leave the average family of moderate means, in case of sickness in the homes, worse off as to assistance in sickness other than medical service, than it was a generation ago. The well-to-do get the benefit of the scientifically trained nurse, and a part of the population have visiting nurses; but the great bulk of the people are, as regards home care, worse off than a generation ago. This is apparently largely due to lack of organization.

Within the hospital we seem to have everything that organization can do in the way of nursing and care; outside of the hospital conditions are reversed. There is one notable exception: namely, the visiting nurse work. This work, however, is largely identified with the poorer classes, and, at best, meets the needs of only a limited portion of the home cases—those in which there is somebody available to give continuous care to home and patient.

I am not able to give you here more than a brief outline of an attempt that has been made to fill these gaps, and to work out a comprehensive system for dealing with sickness in the home.

The work was started in Brattleboro, Vermont, a manufacturing town of some 8,000 people and a centre for a farming district; the bulk of its population was neither very rich nor very poor, but was pervaded with a strong spirit of personal independence. Their financial and domestic conditions were those of at least five-sixths of the people of the United States and Canada, and their problem was the problem of all other communities. Hospital and visiting nurse services were provided, which did well so far as they went, but served likewise to demonstrate conclusively that a large number of the needs in sickness could not be supplied by such means.

The work of developing a more complete system began, and has continued by taking the case of each family where there is sickness, finding out the exact conditions and needs caused by that sickness in the household, and studying to supply the necessary service in the best way at the least cost, whatever those needs might be.

To do this it was necessary to have a headquarters open night

and day, with a capable person always on hand to take the calls, and then to organize forces in accordance with the needs thus developed.

Now *what are* those needs?

Dr. Richard Cabot and his co-workers have shown us that the patient in the hospital ward or dispensary is not an isolated unit nor a one-dimension proposition; and that, in order to be treated successfully, each case must be considered in relation to the patient's individual circumstances, and must be considered in several aspects besides the purely medical or surgical aspect.

It is hardly necessary to say that the housewife and mother of young children, confined to her bed by either illness or childbirth, is equally far from being a one-dimension proposition or an isolated unit, and that precisely the same principles apply to the treatment of her case, and to many other cases of sickness in the home.

Whether the need be for a highly trained nurse or for a good plain cook and children's caretaker, or for both, depends upon the circumstances of the individual case, and not upon any fore-ordained rules. Moreover, there is no question that the cook or caretaker may, under certain circumstances, be a more important therapeutic agent than the most highly trained nurse. It is difficult to cure any woman whose household is going to pieces under her eyes, *and her actual needs and those of her household must be seen, acknowledged and met.*

After work done for a number of years on these lines—work that is still in the experimental stage—the following organization has been evolved:

The headquarters are open day and night to the call of physicians and of families in difficulty through sickness, the usual rules being observed as to relations with physicians in nursing cases.

The working force is as follows:

Under the general superintendent is a visiting nurse doing the usual visiting work, but interchanging and co-ordinating her work with a supervising graduate nurse.

This supervising nurse has under her a salaried body of non-graduate workers, who work under supervision and direction, doing such nursing work as they are directed and instructed to

do by the supervisor, and also such household service as is entailed by the sickness.

In addition to this force there is a directory and employment agency for graduate nurses at one end of the list, and at the other a miscellaneous list of all the people in the town who can go out and help by the hour, day, or week. The association does all of its work on a business basis, doing work, where necessary, for charitable organizations and individuals, but not dispensing charitable aid itself either in remission of charges or in money.

It is intended by thus organizing to have a capable head in touch with all the forces needed in a household when sickness comes, who can use those forces in the most effective way. In using these forces together, we come naturally to deal with the co-ordination of labor in nursing, a thing which, owing to the newness of trained nursing to the world, has hitherto been strangely lacking in this country. We have had competition where we needed co-ordination.

The ordinary confinement case can perhaps best show the advantage of the co-ordination of graduate with non-graduate service.

When the labor begins we call in the supervising nurse, a graduate thoroughly trained in maternity work, and with the experience of dozens of cases in the course of the year. When she has completed caring for the mother and baby during and after the birth, she leaves an assistant in the house, whose business it is to continue the care of the mother and child under this supervisor's directions, and likewise to help with the meals and with the care of the other children. Where the work is very heavy, a third woman may be needed for an hour or two during the first few days. The case is then carried through the succeeding days by means of regular visits by the supervising nurse, who directs the assistant and gives the case such skilled work and observation as the conditions call for.

As before stated, I can here only indicate the general nature of this work, but can give details later to anyone who may be interested.

Whether a local unit in this exact form is adapted to larger towns is a matter for experiment to show. What I am sure of

is that work in the homes can be fully organized along these or similar lines, and that the co-operation, counsel, and assistance of the hospital which trains women for service in the homes is needed in order that the hospital may render to the community full measure of efficient service.

So much for the outside organized work in the homes of the people and the relation of the hospital to it.

Now as to the effect of developing and perfecting this outside organization in making the hospital's own main work, within its own walls, more satisfactory and efficient.

It is in the first place of the greatest importance that the hospital should get the right patients at the right time. As to getting the right patients, you are all aware that you need vastly more money for hospital construction and management than you have or are likely to get, in order to give accommodation and service to those patients for whom the hospital is the only proper place. If then you have at your command another plant that, if properly utilized, can properly serve those who do *not* need to be in the hospital, but are now crowded into the hospitals to the exclusion of cases that do need your especial facilities, it is an economic waste and a failure in the test of efficiency not to endeavor to make effective use of that plant.

The plant that I refer to is, of course, the home, and in the aggregate it is a far greater plant, and has far greater resources of both money and service, than the hospital. It must, however, be used efficiently, and its efficient use has thus a direct bearing on your own effectiveness.

There is another reason why you do not always get the right patient. Without proper organization for the care of the home in emergency, the patient often cannot be spared from the home, or is not spared in time to be helped by the hospital. Here also is an instance of the direct bearing of home care organization on your own effectiveness in doing your own appointed work.

Again, there is no need for me to tell you that timeliness in going to the hospital means much in producing the maximum of benefit from the hospital's services. I need not tell you how greatly this timeliness is facilitated by those outposts in the community, the visiting nurse organizations, for you know it.

What we must not forget is that it is only the edge of a far

larger field that is now touched by these visiting nurses, and that the great bulk of cases in the home is still practically out of touch with the scientifically trained nurse.

This same touch by the skilled graduate nurse of the right kind on the wider field that must be occupied by the organizations giving general service in sickness will necessarily produce the same result; namely, getting hold of more cases that need to go to the hospital, and getting hold of more cases in time.

Next, when we have the patient in the hospital and have done for that patient what the hospital can best do, the output of the hospital often does not represent a completed job. The hospital's output is a man or woman who has just passed through a mortal crisis and is usually physically unfit for the stress of everyday life.

Unless the hospital can content itself in many such cases with the empty name of service, or unless an enormously expensive system of convalescent homes is provided (which, by the way, would by no means relieve the patient's solicitude for the home during absence), we must again have recourse to making efficient use of the home. Otherwise the hospital must either retain the patient too long, to the exclusion of other patients, or must turn the patient out with the certainty that there will be a loss of the whole or a large part of the benefit given by the hospital at so great a cost of skill, service and money.

You cannot get the full efficiency out of your hospitals unless by organizing you get the full efficiency out of your homes.

It is an economic paradox to say that there is no money available to save the spending of far more money. As a business proposition, organized work for the sick in the homes must be made to cover the whole population, if the hospitals are to find room for the cases that should be within their walls, and are properly to dispose of those cases that should not be there.

Outside organization has its bearing upon another field of hospital efficiency; namely, the educational part of its work—the training of women for the care of the sick.

The use of co-ordination of labor by organizations of this kind will afford to the hospitals an opportunity to give a different bent to the minds of those whom they train, and to bring

about a change in the present abnormal and unsatisfactory position of the graduate nurse.

We appear to have something like a hundred thousand women doing nursing for a living in Canada and the United States, of whom perhaps ten thousand are graduates of our hospital training schools. What would we think of a West Point or an Annapolis whose graduates had no working relations with the private soldiers, seamen, corporals, sergeants, and warrant officers of our army and navy? What would we think of a technological institute whose graduates could not build a bridge or a ship except in association with holders of a diploma? It is hardly an exaggeration to say that by our lack of organization in home work we have put most of our graduate nurses into a parallel position.

By organizing we make officers of our trained and educated workers in almost every other line of activity, and thus make their skill and education count to the uttermost. Why do we not do the same for our hospital graduates? *Instead of this,* we are making of most of our graduates a body of women with a position so anomalous that both we and they are puzzled as to what to do about it. The public likewise is suffering from this misdirection, and is finding in the graduates of correspondence schools a measure of relief for which they have looked to us in vain. What we shall call for from the training schools in the development of this outside organized work is a woman who can go into any neighborhood, country or city, and become the friend and helper, guide and counsellor of every faithful, capable worker who is devoting herself to the care of the sick and suffering. Not every nurse is capable of this, but every nurse, when she is getting her training, needs to know that her profession has such ideals for its leaders.

If a well-organized, comprehensive system of outside nursing can be established, using co-ordination of labor and making all-around service to the home the starting point, may there not be a chance of a better adjustment for the graduate nurse, and a wider field for her ability and proper service? I believe this wider field to be possible, because the proper and effective use of the graduate nurse must in the end be determined by the sickness, not by the pocketbook. Organized home nursing in

other countries has produced organized methods of benefit insurance as soon as there is a service to insure for. Organization will doubtless accomplish this with us likewise, not only by reducing the service cost, but by means of insurance, enabling large classes to finance themselves and to get continuous trained nursing when needed, instead of going without or depending upon charity. Social insurance, whether by public or by private enterprise, is a word that we shall hear more of in future years, and there is no escape from the conclusion to which we are coming that reliance on charity to meet sickness and other emergencies of life is not the way out for the classes who are the main support of the country. *We can no more serve the needs of those who support us by charity than we can lift ourselves by our bootstraps.*

Again there is a possibility of simplifying another of your problems. Much thought and trouble are being given to the naming and grading of nurses in accordance with varied courses of training. Important as this may be, how can any diploma given months or years before decide fully the really vital question of how the right woman can be got to the right case? Can this ever be accomplished by the most perfect system of instruction if the products of your educational efforts are turned out with their certificates or diplomas into a weltering chaos to shift for themselves, as they have been for years?

I believe that an able superintendent of a general service office, knowing the individual woman, and understanding the needs of the individual case, can do more than many diplomas to get the right woman on the right case, provided only that she occupies an independent civic position, where she is bound to serve the public to the best of her ability. Likewise, if she has a real touch upon the homes from which the best nursing material comes, she can do much to get you that material which you need for your training schools.

To summarize, if summarizing is possible, with what in itself can be little more than a mere outline:

Better organized service for the sick in the homes of the independent classes is a necessity.

The hospitals can no longer look only to the work within their walls, but must relate their work in a satisfactory manner

with kindred work in the community at large. From them must come help, counsel, and assistance for organizing that outside work.

That work, if organized, will increase by a substantial percentage the efficiency of the hospitals themselves, by helping them get the cases that they should have and to get them in time, and by relieving the hospitals of cases that should be taken home under proper conditions to make room for others in the hospital.

In addition to this, the proper organization of outside work and a better role for the graduate nurse in that outside work, should produce more good material in the training schools, better results from hospital training, and a more satisfactory status in the community for the graduate nurse.

NATIONAL INSURANCE IN GERMANY AND ENGLAND*

BY DONALD J. MACKINTOSH, M.V.O., M.B., LL.D., F.R.S.E., OF GLASGOW, SCOTLAND.

(Continued from October Issue.)

In England, Scotland, and Wales, medical benefit is not administered by the approved societies, but by 238 Insurance Committees, which are semi-public bodies numbering not less than 40 or more than 80, according to the population in their area. Three-fifths of the number are appointed by members of approved societies, one-fifth by the County Council; two members are elected by an association of duly qualified practitioners resident in the county; one to three members, according to the size of the committee, must be duly qualified medical practitioners appointed by the County Council, and the remaining member shall be appointed by the Insurance Commissioners.

These committees issued invitations at the commencement of this year to all the medical practitioners within their areas to join what was known as a panel of doctors. In most places where the panel system exists, payment by capitation prevails. In one or two places, however, payment is made by attendance according to a fixed scale of charges, but this arrangement is not liked by the approved societies, for should the total charges by the doctors exceed the amount available for the medical service for that area they shall be paid a *pro rata* amount; therefore, the doctor who presents the largest bill receives the greater payment, and this is a temptation to a doctor to run up charges unnecessarily.

The experience of one or two of the big societies has been that where the system of payment by attendance prevails they have had very heavy sickness claims. It is not possible at this early date to say whether the charges made against the system of payment by attendance will be borne out, because during the first three months of the operation of medical benefit doctors

* A paper read at the conference held in Boston, Mass., on August 28th, 1913.

have had an enormous amount of clerical work in connection with their patients, and the state of affairs has been somewhat abnormal. The doctors on the panel receive a remuneration under the capitation system of 6/6 per head as capitation fee, 6d. per head for the domiciliary treatment of tuberculous cases, and what is available at the end of the year of what is known as the "floating 6d." This last amount is dependent upon the amount of drugs used. An allowance of 1/6 per head per insured person per annum is available for drugs; this is not paid to chemists by way of capitation, but they are reimbursed up to this amount. So as to induce doctors not to be extravagant in ordering drugs it is provided that the chemists, should their total bills exceed the total number of eighteenpences available, can draw up to a further 6d. per head. If, however, they do not draw the 6d., or only a part, the whole of the 6d., or the balance, is paid to the doctor. In a neighborhood where the doctors are careful they can receive a total capitation fee of 7/6 per person. Special payments are made for mileage in sparsely populated districts.

The panel system is in operation in England, Scotland, and Wales, and seems to be working satisfactorily. In certain places some doctors have an abnormal number of patients, but it is hoped that this will prove to be temporary. The formation of the panel system has brought out that in certain working-class areas there has not been an adequate supply of doctors to give proper medical attendance in the past, on account of the difficulty of receiving payment for services rendered. Now a very promising field is opened up for doctors just leaving the hospitals. There was a sharp and bitter controversy about medical service in England, but the doctors, by the solidarity of their organization, gained a great advance on the terms that were originally offered them. In the original bill, provision was made for a capitation allowance of 6/- per person, out of which had to come 1/6 for drugs, leaving the doctor 4/6. It was argued that doctors had been doing club work in the past at rates varying from as low as 2/6 per person to an average of 4/- to 4/6 a year. The doctors retorted that the old club members were usually picked lives, and that under the present bill they would have a greatly increased amount of work to do. As a result of the doctors' agitation the provisions of the bill were considerably altered. Doctors who

had been doing club work under the control of the friendly societies had no wish to have dealings with the approved societies who would take the place of the friendly societies. This point was conceded, and the dealings were to be with the Insurance Committees.

Free choice of doctor was also granted. Perhaps I should qualify this statement by saying that there is still a controversy raging as to what was promised by free choice of doctor. Some of the doctors say that it meant the insured person could go to any doctor, and if the doctor he wanted to go to was not on the panel he could make his own arrangements and receive a contribution towards the cost of his treatment. Free choice is limited to the doctors on the panel, and as there may be any number up to about 1,000, according to the population of the area, it will be seen that the insured person has a fairly wide choice.

In England the approved societies do not have to bear the whole of the cost of medical benefit. Six shillings and sixpence altogether comes from the approved society, of which the State hands back to the approved society two-ninths in the case of men, one-fourth in the case of women: the rest is found by the Treasury, i.e., from the ordinary finances of the country. The doctors seem content with their remuneration, and probably their yearly income will be found to be about £300, with a general average of £300 to £350 per annum. In certain exceptional circumstances doctors are allowed to dispense their own drugs.

The question of control has not arisen in England, and the question whether it will arise depends upon how the doctors administer the Act. I went into this question at some length before, and showed that in Germany it was the increased cost of medical services which raised this question in an acute form. So far, conditions in England have been abnormal. During the first three or four months of the Act the effects of the controversy were gradually dying down. For about six months before the medical benefit came into operation the doctors had been making remarks about the treatment they had experienced under the Friendly Societies, which were not at all complimentary, and the Friendly Societies were agitating for "whole-time" medical service, but both parties have realized that there is more to be gained by co-operation and better feeling is now prevailing.

Machinery for control is provided by the appointment of local medical committees, and if the Insurance Commissioners are satisfied that such a committee is representative of the duly qualified medical practitioners resident in that area they are then required by the Act to recognize that body and the Insurance Committee has to consult with it on all general questions affecting the administration of medical benefit. A point of difference between the German arrangements and the English arrangements is that under medical benefit in England only treatment within the competence of an ordinary medical practitioner is given, whereas, in Germany, payments are made to specialists. Treatment is not at present given to dependents of insured persons, but power to extend the medical treatment to dependents is an additional benefit which may be given later. The necessity of this extension is being very strongly emphasized at present. Dental treatment is not given, but power is also given to the approved society to pay the whole or any part of the cost. These extensions are known as additional benefits. It is unlikely that any extension will be made before the first valuation, when societies will know their financial position.

Power is given also to the Insurance Committees to allow persons to contract out: that is, to receive treatment from a doctor not on the panel, but, as the matter of contracting out became the subject of keen controversy, it has only been allowed in exceptional cases, such as treatment by herbalists and homeopathists.

Drugs are dispensed by registered pharmacists or by a person who, for three years immediately prior to the passing of the Act, had acted as a dispenser to a duly qualified practitioner or to a public institution. At their meeting the pharmacists expressed themselves satisfied with the terms they had obtained under the Act. Drugs are charged to the Insurance Committee at a special tariff which has been agreed.

In his agreement with the Committee the doctor is required to furnish a person with such certificates as are necessary to enable him to establish his claim for sickness or disablement benefit. The insured person is allowed to choose a doctor; if he does not choose one, then the Committee asisgn him to a certain doctor. Transfer from one doctor to another can be effected

at any time with the consent of both doctors; otherwise, transfers can only be made at the end of the medical year by giving one month's notice.

At the request of her representatives, Ireland was specially excluded from medical benefit and the cost of the benefit was deducted from the contributions payable by the employer and the employed person. This turned out in practice to be a serious drawback, because of the approved societies requiring medical certificates from their members to support their claims, so a supplementary grant was made of £50,000 to enable the panel system to be formed in Ireland, solely for the purpose of signing medical certificates. The doctors receive a capitation fee of 9d. and upwards per person per annum for each person on their list.

On July 15th, 1912, the National Insurance Act (1911) came into operation. The principle of the Act was its compulsory provisions which have been the most striking departure in English legislation. The Act is divided into three parts, the first part dealing with health insurance, the second part with unemployment insurance, and the third part with matters common to both.

The first part embodies and improves upon many features of the German sickness and accident insurance. The principal features of the English National Insurance Act are:

(1) That it applies to practically every person in the United Kingdom employed at a rate of remuneration not exceeding £160 per annum in value.
(2) Its compulsory character.
(3) The absence of expensive collecting machinery.
(4) The flat rate of contributions and of benefits (with certain exceptions which an amending Bill now before the House of Commons proposes to abolish) for all persons entering into insurance within twelve months of the commencement of the Act.
(5) The employer still continues liable for accidents as hitherto, but sickness funds of societies are relieved when compensation is paid by the employer.

Four authorities, known as Insurance Commissioners, have been appointed to administer the Act in England, Scotland, Ireland, and Wales.

Broadly speaking, all persons, whether British subjects or aliens, male or female, married or single, between the ages of 16 and 65, engaged in manual labor under a contract of service, whatever their earnings may be, and all such persons engaged in work other than manual labor whose earnings do not exceed £160, must insure. The actuaries' report estimated the number of employed contributors for the years 1912 to 1913 at 13,890,000. This number has been exceeded by some thousands.

A person engaged in some regular occupation, on the earnings from which he is wholly or mainly dependent, may become a voluntary contributor if he is not entitled to become an employed contributor and his total income does not exceed £160 per annum. The actuaries estimated the number of voluntary contributors for the years 1912 to 1913 at 829,000, but the people have not become accustomed to the compulsory provisions of the Act, and so far the number of voluntary contributors is about 20,000.

Insured persons obtain the full benefit of the Insurance Act by joining approved societies. These are societies approved by the Insurance Commissioners, whose constitutions must be subject to the control of the members, and they must not be run for a monetary profit. Members may transfer from one society to another with the consent of both societies. To enable all persons to join at a flat rate, and to prevent the approved society being penalized by the acceptance of older members, the societies are credited by the Insurance Commissioners with certain sums known as reserve values, the reserve value being the estimated liability which the society would accept, according to the age of the member. These reserve values will be liquidated by a sinking fund of 1 5-9d. out of each sevenpenny contribution paid by a man. As the entry in the first place is only a paper credit on the part of the Commissioners, the approved society receives interest at the rate of 3 per cent. during the process of converting the paper credit into cash. This, as estimated, will take about eighteen years. Societies will then be in possession of accumulated funds if the actuaries' estimate proves to be correct, and they will be able to pay increased benefits.

(*To be concluded in our February number.*)

Society Proceedings

SEVENTH ANNUAL CONFERENCE OF THE CANADIAN HOSPITAL ASSOCIATION

NEW CLINIC HALL, TORONTO GENERAL HOSPITAL.

(Continued)

THE PRESIDENT: We will ask Miss Aikens of Detroit to follow and give us a paper on problems in hospital teaching.

MISS AIKENS: Mr. Chairman, ladies and gentlemen, I might say by way of explanation that this is not the paper that I expected it was going to be when I gave the President the title some three or four weeks ago, but this paper pretty nearly wrote itself, so you will have to take it as it is.

(Reads Paper.)

(Applause.)

THE PRESIDENT: These papers are open for discussion. I hope there will be a free discussion of the papers this morning. Let us not waste time, ladies and gentlemen; if you have anything to say along this line we should be very glad to hear it, unless everything is so plain and distinct that you do not need any discussion, in which case we will pass on to the next.

DR. PARKE: I just want to ask a question. In the lecture which you have spoken of as given by the Medical men to the nurses, is it the difference between a paid instructor and an unpaid instructor, or is it the fact that the older men, whose time is very much tied up, feel they should go before the nurses and give what time they can at the moment; is that not a mistake, instead of giving the services of some of the younger men at the hospital who would have the time?

MISS AIKENS: I think there is quite a point right there. We put the biggest men in our hospital, and yet we may not give a half hour's consideration to the needs of the training school during the year. At the same time I believe we shall get a very much better quality of service, and the school gets a better control over it by paying a man who expects to con-

tinue it throughout the year, and who really will take the pains to arrange his lectures and improve on it from year to year and acquire some efficiency in teaching. I feel the outlay is well worth while in any hospital.

THE PRESIDENT: Any further discussion on this subject?

MR. ROBERTSON: With the expert knowledge that is in this room at present it seems strange that a layman has to get up and try to start the discussion. I am not competent to even give an opinion on nine-tenths of it, but there is just one point in her address that ought to commend itself, and that is about the extension of the work, where people who cannot afford to pay the graduate nurse eighteen or twenty dollars a week must have the opportunity of expert work. Somebody has said that the correspondence schools are filling that. Everybody in this room knows that that is all nonsense, that no correspondence school, or any knowledge she can obtain there, will give her enough instruction to even make up a bed. There are a lot of ladies here who are able to discuss this matter. What do these ladies come to town for, just to listen to the excellent papers prepared and sit like a lot of dummies, or get up and discuss them so their fellow-superintendents may get opinions that will be of value to them. I only wish I had the knowledge; I would stand on my feet for an hour and discuss the matter. It should not come from a layman, but in connection with the work of the Hospital for Sick Children I do know this, and it is in particular reference to the excellent suggestions made by Miss Aikins, our district nurse, who visits forty to forty-five cases every day all over the city, seven miles this way and six or seven miles the other way. Look at the excellent way the Victorian Nurses handle it, and the other Associations where they have trained nurses. So I think that point which Miss Aikins has made is an excellent one, and the people at large should know something of what is going on and not have everything good that is said relegated only to the printed report.

THE PRESIDENT: Any further discussion on this subject?

MISS RODGERS (Niagara Falls): I am very thankful for Miss Aikens' paper being so in favor of the smaller hospitals. We have had a great struggle. Our doctors prefer a third year

nurse to an unpractised nurse. I have been very severely criticized for allowing my nurses to go on the bigger cases; and the small remuneration we get is neither here nor there to the hospital. It merely covers the instruments and linen they take with them.

Miss Sharpe (Woodstock): I represent a hospital which has forty beds, and we have tried to do the work the last winter with a junior nurse, and this junior nurse would go out and help the doctor to assist in any way she could. We did it for several years—we have done it now for three years, and I think it has done a great deal of good. The work of the nurse is to go out in the morning and assist in fixing up the woman and baby for the day and arrange the house, and do anything she can to make things comfortable for the children or whoever may be there. There is another way of looking at it: you never know just what you are going to run into. About two months ago we had a call to a maternity case, and the second day the nurse came back and reported that the baby had a slight rash. Well, it was very hot weather, and the doctor said he did not know that it would mean anything. However, she came back the next day and said the rash was worse. Well, we asked the doctor if he would kindly go and see if there was anything which would cause any trouble, and he went and reported that we had a very bad case of smallpox. Now you can imagine that junior nurses who are mixing up with these cases and who had been about the patients in the hospitals as well, what a mess we were in. The nurse had to be quarantined, the room she was in had to be disinfected and cleaned, and the nurse she was with and the patients she had had to be vaccinated. So in that way we got into a terrible muddle, and we were three weeks at least in a state of very great unrest. However, I think outside of this case we have had great success. The doctors like giving the instructions to the nurses, and under the circumstances I think they learn a great deal, and it seems to me they are a great assistance to the person who is not able to leave her home and go to the hospital and pay so much. We also have several cases where a nurse can go and do a little, and at the same time they do not require hospital attention. Not long ago we had a

patient who was paralyzed. The people were Christian Scientists, and they had not called in a doctor, but every day they expected she would be better. She was better. They sent up to me and asked if I could send some person down to help them in changing. I asked them how long she had been ill—three weeks. I sent two nurses down to the home and asked them all the necessary things. They were very poor for a trained nurse, and from signs it was a very bad case, and they turned the patient over who had not been changed in the linen or anything done for her for three weeks, and you can quite imagine it required a little more than faith to fix her up. I do not know of any of the other hospitals that have had any experience in sending out their pupil nurses. There is another case, sometimes they object to a junior nurse; they say, have you had any experience in doing things? Well, they have to a certain extent, but a junior nurse in her first or second year is not very apt to know anything about a maternity case the first time. They will find fault even if they are not paying anything for the nurse you send. But, on the whole, so far as the work has gone and what we have done, it has been very satisfactory. It has not been a very great strain on us, as I try to keep on hand one nurse who is available for such work, and the nurses like it. I do not think there is any nurse ever objects to going out into the country with the doctor, or into any part of the town where she would be of service. The nurses as a rule usually like that sort of thing, and they can learn a great deal by trying to make the best of what is in the house and use what is put before them. (Applause.)

Miss Miller (Lindsay): We adopted the same plan in Lindsay as Miss Sharpe has spoken about, with the difference that when we send our our third year nurses I keep one nurse ready for calls, and in Lindsay no one suffers. I think that last year we attended about one hundred cases outside, and every woman was cared for.

The President: I am afraid I will have to ask Dr. MacMurchy to give us her address now. After dinner we can take ten or fifteen minutes more about the discussion of this paper.

Mrs. Helen MacMurchy: I have the honor of asking your

attention to the subject of Hospital Service, and to ask Dr. Haywood to open the discussion. I am delighted to see so many ladies and gentlemen present to assist in the discussion of this subject, and to see so many members of the Hospital Association here, the Women's Club, as well as the order Mr. Robertson has so frequently alluded to, and we feel it is an honor to be allowed to discuss matters along with them.

Dr. Haywood: This is a very simple paper, the subject has been so very well gone over.

(Reads Paper.)

(Applause.)

Dr. Helen MacMurchy: Is it your pleasure to discuss these papers one by one, or shall we discuss them as a whole? Those who wish to discuss this paper immediately will please raise their hands (none); those who prefer to discuss it as a whole will please raise their hands. (Carried). The next paper will be presented by Miss Grant, head social worker of the Toronto General Hospital. I have great pleasure in asking Miss Grant to speak on the question of how social service work should be organized. (Applause.)

Miss Grant: I am afraid I am not a very good person to talk about organizing social service.

Dr. Helen MacMurchy: What Miss Grant can do is to do it, and they won't mind.

(Miss Grant reads paper.)

(Applause.)

Dr. Helen MacMurchy: The one on "Physician and Patient" will now be taken up by Dr. G. W. Ross.

Dr. Ross: Ladies and gentlemen, I feel that someone perhaps older than myself, or at least more experienced, should have been asked to discuss this important question of the relationship of physician to the patient, but at least I am interested in the subject of social service, and have a certain conception of the proper relationship between the patient and the physician from the work that Dr. Haywood has so very clearly pointed

out, and Miss Grant, from personal experience, has described. I can hardly speak too highly of Miss Grant's work. I can think of no greater work any individual has been called upon to do, and especially the work Miss Grant has been doing.

(Reads Paper.)

(Applause.)

Thank you very much for your attention.

Dr. Helen MacMurchy: Ladies and gentlemen, one of the professors of the University of Toronto has been kind and generous enough to lay aside a lecture to the students this morning in order to come and speak to you to-day on the subject of "The Training of Social Workers." I have great pleasure in introducing to you Professor Lloyd.

Professor Lloyd: I speak with great diffidence and many apologies, apologies because the notes which I made have been unfortunately left in my office. I am going to speak for a few moments on the training of social workers, which is a question in which I am justified in feeling glad to be called upon to speak by reason of the interest I take in it and the desire I have to see it forwarded. Now, all the excellent papers we have listened to have made it quite clear that the need for trained social workers is of very great importance in a city like Toronto, and I think that it is interesting to note that while the ordinary social worker in my experience, parish worker or volunteer visitor, finds that his work is hindered because it needs medical treatment to supplement it, and it is very interesting to know that the worker of your Out-patient Department and your Social Work Department finds it necessary to supplement the work by the aid of social workers. I think that goes without argument that the two must go hand in hand, and I think there is no place where there is a chance to do the work as in your Social Department. But the question still remains who is to do the work, and what kind of visits are they to be, and what are they to be trained? There is nothing in the world I think more difficult than wise philanthropy. Speaking as I am going to speak, mainly from the academic side, it seems to me that the

theory is infinitely easier than the practice, that putting in practice the simplest principles of charitable relief is a matter of very great difficulty. I think the first point I want to lay down in regard to this matter is that the training must be practical. No school training, no academic training, no lecture work can ever take the place of practical experience, and I am perfectly sure that I shall be supported in that by those who are in close contact with this work. You must learn by experience. But you must learn the difficulties, too. Charitable relief is always the easiest solution where you come in contact with need. That is to say that to give is the easiest, and I think always the least effective mode of treatment, and what a social worker really has to give is to give herself or himself. It is friendly contact and personal human influence that count in social service, and not gifts or relief or help of any other kind. The first rule that one should make, I think, would be never to give money if you could possibly find any other solution, and not to give relief except in the form of a loan if that also can be avoided. The mode of training which I think ought to be adopted must be primarily practical experience in visiting in connection with some organization or institution, but I am here to speak for a moment as to the part which I think might be played by the University in the scheme of social work. I have said already that I do not think that academic training can take the place of practical experience, but I do think the University can do something, I think, if we had at the University which I should call a zoological research laboratory. I should like to see established there a well-equipped room, equipped with literature on all kinds of social problems and civic questions, where all the latest information could be filed and collected, and such a room should be in charge of a competent specialist, who would facilitate the use of that material by any social worker who could go further than that and get direct investigations so that the actual clerical work of the investigations, the statistical side of it, could be directed from such a laboratory. I think if the University of Toronto could direct a work of that character that it would give an opportunity for many who are anxious to obtain a training on the

organized investigation of social facts, a very great opportunity, and I think if it were properly equipped it would produce results that would be of immense service to the city and community. I lay that before you as an idea that I would be very glad to see forwarded. I do not want to see anything inefficient done in that direction. I do not want to see that work half done. If it is to be done, it must be done thoroughly, it must be done so that the results will be dependable. We have a very great deal of social investigation going on in the city. We have very little result from that work, except the experience which has been gained by the Inspectors themselves. In addition to that, I think that it would be possible to supplement by academic lectures, lectures on the structure and history of society, on town life and its problems, on labor legislation, on a hundred and one things that are connected in a way with a social worker's problems, which would give a background to such a training, but I do not know, Dr. MacMurchy, where such a school of social workers is to be established. I think it should be not a purely academic department. I think it should be an independent organization, affiliated, if you will, with the University, and I am sure that those of us who are interested would give the greatest possible support to such a movement, and then I think we might be able to turn into useful channels that great rising tide of desire for social service which so many of the younger men and women of our generation are influenced by, but which to some extent is wasted because they cannot now get just the right opportunities for preparation for such work. (Applause.)

Dr. Helen MacMurchy: Mr. Burnett, one of the social service workers in the Department of the Medical Health Officer in this city, will now address us. We have made very good use of our time. It is now exactly nine minutes to twelve. The discussion will be the most important part of this, if it is possible to say so, and we will proceed to that after Mr. Burnett's paper.

Mr. Burnett: I should like to say at the very beginning that I rather object to placing any particular class apart as social workers. Where I have gone to any community I have looked upon the medical men there as being the chief social

workers, and I believe the whole hospital work should be done in the spirit of social work, but in our hospital work there are often a few things which we do not find. We go around and we hear people saying, "Why don't they do something," and it appears to me that the "They" is the one we call technically the social worker. We cease to look upon the hospital or the medical man as the definitely appointed legislator in the way he used to be looked upon. The hospital is part of the social organization, and we look upon them to diminish the ills of mankind, and, seeing he is part of a social organization, we want him to do also social work, and I want to make a plea this morning that our social work and the social work of the hospital should be looked upon in an even broader way than it is at present.

(Reads Paper.)

I hope the day is coming when we shall be able to say that we so look after the patient when he has left the hospital; but we shall become more vigorous in preventing a greater number of our cases from ever reaching the hospitals at all. The ills of a patient's body are a part of the complex situation due to the ills of the body politic, but still what training a social worker ought to have is largely what we want him to do. Is it to be principally hospital work, or is it to be social work? There has been a great deal of discussion whether he should be principally a nurse or a social worker. I believe he should be principally a social worker, and the doctors and the nurses should do the medical end of it, and I think that primarily the worker should be the social worker. It is a very different problem facing life with the discharged drunkard or the unmarried mother after they have left the hospital than when they are in the hospital. Therefore I think that the first thing we must see to in our social workers is that they have received social workers' training. Now, Professor Lloyd said just now that he was not going to speak to the academic side of things, and I think he would have done well if he had. There is no use day after day finding a job on an elevator for a man. We have got to face the situation in I think a broader and bigger way. If people are suffering

from T. B. in this city to-day there is not much use in chasing around and trying to find a light job for a man. We have got to see if we cannot organize the work for this man in a bigger way than merely in getting a social worker to look for this job. These things should be done in a spirit of co-operation, and to learn that spirit of co-operation and to learn the extent of the various agencies which are at work, I think it would be splendid for the one who has training in business or in a School of Philanthrophy, or both, and we need this training in social work. We need knowledge of the available resources of the local community. We need to know whether a child is destitute, or whether he should be placed in a home. Other things, I suppose, I need not go into, as the details are apparent. The social worker needs executive ability. The worker needs ability to initiate things and not merely to obey orders, and I do not know if that spirit of initiative is especialy encouraged. Our social workers need all the great qualities of leadership. Bands of philanthropists should be trained to do the work, which will never be done adequately or completely by the professional social worker, and I do not know why Professor Lloyd should not send down some of his students to do some of that work. If we could get the theory at the University we could get the practice down here. In concluding, I think we have to understand that it is not merely at the one end when the patient lives out in the world that we have to keep our eyes open; we have got to keep our eyes open upon the patient in the hospital. Whether we should employ little children, whether we should permit women to work at night, whether men should be permitted to continue work in a state of physical exhaustion, whether excessive speed and overwork shall continue, and whether we have not got to give more healthy support than what we are now giving to the public movement for the control of infectious diseases. You know, ladies and gentlemen, all we have done lately to register the T. B. cases, all we have done to fumigate the houses, we cannot be very proud in any tremendous decrease, can we, in the number of T. B. cases that are still applying to physicians.

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Miss Emma A. Anderson, Superintendent New England Baptist Hospital, Boston, Mass.
Miss Ida M. Barrett, Superintendent Union Benevolent Association Hospital, Grand Rapids, Mich.
Dr. R. W. Bruce Smith, Inspector of Hospitals and Charities for Ontario, Toronto, Ont.
Dr. William O. Mann, Superintendent Massachusetts Homeopathic Hospital, Boston, Mass.
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COMMITTEE TO STUDY THE CHARACTER, COST AND VALUE OF DIRECT AND INDIRECT WORK FOR THE PREVENTION OF DISEASES NOW CONDUCTED BY HOSPITALS AND DISPENSARIES, TO ARRANGE IN THE ORDER OF THEIR IMPORTANCE AND PRACTICABILITY SUCCESSIVE STEPS FOR THE EXTENSION OF SUCH WORK, AND TO PREPARE METHODS FOR ITS FINANCIAL SUPPORT AND FOR ITS CORRELATION WITH THE SIMILAR WORK OF OTHER AGENCIES, PUBLIC AND PRIVATE.

Dr. J. A. Hornsby, Tower Building, Chicago, Ill.
Dr. W. L. Babcock, Superintendent Grace Hospital, Detroit, Mich.
Mr. Sidney E. Goldstein, Director Free Synagogue, New York, N.Y.
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Hospital Intelligence

CANADA

The New General Hospital, Toronto

The following article appeared in a recent issue of *The Hospital,* London:—

We have received some interesting details concerning the above hospital from Mr. Conrad W. Thies, Hon. Secretary British Hospitals Associations,* and have much pleasure in publishing the following summary:—

On the occasion of my last visit to Canada in 1909 I was shown over the site of the proposed New General Hospital in Toronto by Dr. Brown, who was at that time the superintendent of the old hospital, but has since removed to Detroit, where he is now superintending the erection of the new General Hospital in that city. It happened that my recent visit, a few days since, was on the day that the new hospital in Toronto was receiving the first instalment of fifty patients, and I observed the careful and expeditious manner in which these sick people were removed to their new quarters. Most of them were carried in the motor ambulances which will form part of the regular equipment of the new hospital. Dr. C. K. Clarke, the present superintendent, accompanied me over the hospital, and kindly furnished me with information respecting the history of the institution.

Genesis of the New Buildings.

For many years past it had been realized by the managers that the old hospital was quite unable adequately to provide for the medical and surgical needs of the increasing population of Toronto and the country around. In 1904 Mr. J. W. Flavelle, who had been elected chairman of the Board of Trustees, at once made his influence felt, and gathered around him several of the most wealthy and influential citizens. At his suggestion a special report was prepared, which strongly recommended the erection of an entirely new hospital upon a fresh site, and pointed out that the demands of modern medical and surgical science could not possibly be properly met by any adaptations or additions to the existing hospital build-

* Mr. Conrad Thies is one of our esteemed collaborators.

ings. Some wealthy citizens at once promised contributions, and a new site of over nine acres adjoining the University was acquired at a cost of some $600,000 (£120,000). A scheme for the new hospital was then formulated, which involved an estimated expenditure of about $3,000,000 (£600,000).

The University of Toronto made a donation sufficient to cover the cost of the land, while grants from the Provincial Government and City Council, together with gifts by various wealthy citizens, promptly provided the necessary funds. Mention must be here made of Mr. Cawthra Mulock, who started the subscription with a donation of $100,000 to defray the cost of the out-patient block. Then Mr. J. C. Eaton generously undertook to build and equip the surgical wing at a cost of about $300,000; while two ladies—the Misses Shields—provided the cost of the casualty and receiving departments, including the equipment and endowment of a complete ambulance service. The citizens were determined that Toronto should possess a hospital worthy of its reputation as "The Queen City" of the Dominion of Canada.

A Comparison with New "King's."

The foundation-stone of the new hospital was laid by Earl Grey, the Governor-General, on April 11, 1911, and the work of building was energetically carried on. The formal opening took place on June 19 last. The entire cost of the new hospital and its equipment was raised before the opening ceremony, an achievement of which any city might well be proud. The hospital now provides accommodation for some 700 patients, 200 nurses, thirty resident medical officers, and 200 male and female servants, together with ample provision for a large number of medical students. It comprises eleven separate buildings, and in many respects it reminded me of the new King's College Hospital at Denmark Hill, which I had visited a few weeks previously. Provision is made for 450 medical and surgical beds; special departments for eye, throat, nose, and ear, 50 beds; and gynaecology, 50 beds; while 150 beds are provided for paying patients.

The main building, which contains the administrative department and medical and surgical wards, is three storeys high and 620 feet in length. The wards are well lighted and venti-

lated, while ample provision is made for heating, which is very essential in this country, where the variations of temperature are so great.

Novelties of Equipment.

I was much impressed by several novel features of the equipment. For instance, every bed is provided with an electric call; upon a button being pressed by any patient a colored electric light appears on an index board at the entrance to the ward, also in the service room and corridor. This light cannot be extinguished until the nurse goes to the patient's bed. I noticed many other useful and ingenious appliances, some of which might very well be employed in British hospitals. The floors of the corridors and wards are of concrete and are covered with thick red linoleum, similar to that used on German battleships. It is claimed for this kind of flooring that it is noiseless, durable, easily kept clean, and pleasing to the eye.

The walls of the wards, corridors, etc., are of cement, coated with Paripan paint, tiled dados being provided for the staircases. The roof-gardens over the wall-blocks are a pleasing feature, and, as elevators run up to these roofs and all the beds are fitted with large rubber-coated castors, the patients can be very easily moved to these roof-gardens.

The electric lighting of the wards and operating theatres is on the indirect principle, and thus a soft diffused light is obtained, and all glare is avoided.

Sidelights on Special Departments.

On the surgical side each ward has its own operating-theatre. The surgical rooms, laboratories, etc., are models, and show a careful study of modern requirements. The equipment of bedsteads, lockers, screens, tables, etc., are of metal and glass, no wood being employed. Ample accommodation is provided for the special departments. The provisions for radiography, pathology, hydrotherapeutics, Swedish exercises, sterilizing rooms, etc., are on a most generous scale. The various buildings are all connected by covered ways. The nurses' home is approached by a beautiful reception-room, and the rooms generally are equal to what is provided in a high-

class modern hotel—ample bathrooms on each floor, with a spacious and handsome dining hall for 200 nurses, library, recreation rooms, and lounge; a spacious garden, with tennis lawns, is also to be provided. Special accommodation is made for medical students and the visiting physicians and surgeons, also a spacious amphitheatre for clinics. The kitchens, storerooms, laundry, and other offices are all on a corresponding scale of completeness. In the power-house are the steam and electrical equipments; the boilers and engines are of 2,000 h.p,. and the electrical turbines develop ample current for all purposes: electricity is here employed in many ways for saving labor that are both novel and ingenious. Time will not permit me to refer in detail to the out-patient and emergency departments. The ambulance department connected therewith has three motor ambulances, which are available night and day.

The buildings are of brick of great hardness and fine finish, relieved with stone ornamentation. The style of architecture is early Georgian. At present the general effect is, I think, rather heavy and severe, but, doubtless, when the grounds are laid out with lawns, trees, shrubberies and gardens, the appearance will be greatly improved.

The New Pay Wards.

The provision which is made for 150 paying patients, as Sir William Osler so forcibly stated in his presidential address at the recent Conference of the British Hospitals Association at Oxford, is an essential part of every general hospital, both in Canada and the United States. This department is entirely separated from the rest of the hospital, and is complete in itself. It is contained in a five-storey building, which is furnished and equipped in the most perfect manner for the comfort of patients who can afford to pay for their treatment. It will be more than self-supporting, and, indeed, it is anticipated that it will prove a substantial source of income. I am assured that it has frequently happened that the well-to-do patients who have been treated in this department have proved generous contributors to the funds for the maintenance of the general work of the hospital.

"Words of Criticism."

Before concluding these remarks, I must venture to add a word or two of criticism. In the first place, as regards the site, I am strongly of opinion that a better position for the new hospital might have been found a little further distant from what will probably in a few years be the centre of the city; for instance, a little to the north of the University there is gently undulating land, which would have been far less costly than the present site, which necessitated the removal of some 200 houses. The front entrance is not sufficiently imposing, and the doorway is certainly too narrow for such a large building. It is surely a mistake that the windows of the wards should be divided into small panes by wooden frames. I can only conclude that this has been done for the sake of architectural effect; but such windows are unsuitable, because the frames only make unnecessary ledges for collection of dust.

Absence of Cross-ventilation.

Strangely enough, the service rooms are provided with plate-glass windows. The lavatories open directly upon the corridors without any cross-ventilation, and this arrangement is common to other modern hospitals that I have visited, both in Canada and the United States; whereas in Great Britain and Europe it is considered absolutely necessary that all lavatories should be placed in sanitary towers which are separated from the main buildings.

Absence of Light.

It is, I think, a very serious defect that several of the corridors and passages leading to the wards, etc., have been so constructed that they are entirely dependent upon artificial lighting for their illumination even upon the brightest days.

Taken altogether, however, this hospital may be regarded as the latest development in Canada of a modern institution for the treatment of the sick; and, I think, well deserves the high eulogium which has been pronounced upon it by Sir William Osler, who recently paid it a long visit and expressed his opinion, "That it was about as perfect as such an institution could be." Certainly its erection and equipment in the short space of just over two years reflects great credit upon the managers, architects, and builders.

NEW HOSPITAL APPLIANCES, PHARMACEUTICAL PREPARATIONS, ETC.

A New Size Package of Platt's Chlorides

An important move has been made by Henry B. Platt, Manufacturer of Platt's Chlorides, the Odorless Disinfectant, by placing upon the market a small size package to retail for twenty-five cents, of this old reliable and well-known disinfectant that has been in general use for over thirty-four years by people of refinement in their homes, and also in hospitals and other institutions.

The subject of household cleanliness and sanitation is now considered of vast importance, and more attention is being given to it by the Health Authorities all over the country. The general public are being advised to use disinfectants as a preventative of sickness, and the careful housewife now uses an efficient article that will safeguard her family.

Platt's Chlorides has been recommended by thousands of physicians in their general practice for many years. It is stronger than Carbolic Acid, safer to use, and being absolutely odorless does not cover one disagreeable odor with another.

The new twenty-five cent bottle will be of a more convenient size to handle, and will enable those housewives who have never used Platt's Chlorides to give it a fair trial at a moderate cost. The regular large size bottle with the yellow wrapper will still be put up to retail for fifty cents.

Advertisements will appear in the Drug and Medical Journals, Newspapers and Magazines so as to create a demand for this new size package.

Fibreware Utensils

A decidedly strong preference is being shown throughout Canada for utensils made of Fibreware, instead of the old wooden bucket variety. This is especially true in hospitals and other places where the most sanitary methods are adopted.

The reason for this preference is readily apparent. The E. B. Eddy Co., of Hull, produce these fibre vessels and have proved them lighter in weight than those of wood, and also much more durable.

Each article is one solid, hardened mass of indurated fibre, shaped and compressed under enormous hydraulic pressure; then baked at extreme heat. They have no hoops to fall off; no seams to crack, and so are the most perfect vessels to be had from a hygienic view-point.

Eddy's Fibreware is made in pails, tubs, wash-basins and similar articles. All dealers can supply them. To use a slogan popularized by the manufacturers, they are "Just as good as Eddy's Matches are."

Pequot Sheets and Pillow Cases

It may be of interest to the purchasing agents of our Hospitals to know that many of the large hotels, institutions and hospitals, both in Canada and the United States, have adopted "Pequot" Sheets and Pillow Cases for their exclusive use.

This selection, in many cases, has been made only after critical competitive tests in which the Pequot goods have demonstrated their superiority to the other makes on the market in strength and wearing qualities.

These goods are likewise noted for their fine finish, which retains its splendid appearance through hard usage and frequent launderings.

The New Ventilation

The *Lancet* of London, in its current issue, contains an article by James Keith, a leading authority on ventilation, describing new methods introduced coincidently with what Mr. Keith calls the "epochmaking" address delivered last year before the British Association by Dr. Leonard Hill, President of the Section of Physiology. Dr. Hill asked the consideration of nothing higher than a stuffy room. He said that the popular mind, supported by all the elementary text-books of hygiene and most standard works, is imbued with the idea that ventilation is a question merely of chemical purity of the air, whereas chemical purity is the last thing to consider and is practically negligible. Dr. Hill asserted in a letter to this newspaper, following his address, that there was continually more oxygen in a closely packed room with all the doors and windows shut than in an equal space of rarefied air in certain celebrated mountain resorts. It is a matter of scientific proof, which Dr. Hill cheerfully submitted. There is danger of bacteria in the crowded room from the exhalations of many lungs, while its heat and the windlessness of the atmosphere are most to be dreaded. Indeed, if the air breathed by the crowd were perfectly pure the room would not, in Dr. Hill's view, be at all well ventilated until it were cooled and set in motion.

The cooling and vigorous circulation of the air we breathe constitute the essential problem of ventilating engineers. The Smithsonian Institution has lately published a study by Dr. Hill, Martin Flack, James McIntosh, R. A. Rowlands, and H. B. Walker, from the physiological laboratory of the London Hospital Medical College, which shows that the chief fault of modern ventilating systems lies in their failure to keep the air moving. Therein is the virtue of open-air schools and of living out of doors, that the air is changed, and acts constantly upon the skin to stimulate the circulation and free the lungs. Mr. Keith's *Lancet* article is illustrated with cuts of mechanical devices lately installed in New York's newest skyscrapers and in the engine-rooms and stokeholds of the newest

ocean liners, which supply thousands of cubic feet of fresh "live" air every hour without discomfort from draught, besides a number of devices for ventilating offices, living rooms, cabins, and sleeping cars. With respect to the new ventilation in factories, Mr. Keith makes this observation of interest to owners:

It may be added that not only does good and healthy ventilation on the lines indicated tend towards increased efficiency, health, and happiness in the workers in crowded and overheated inclosures, but an immense saving per annum may be effected in the wear and tear of running machinery and in lubricants by the reduction of the atmospheric temperature in sultry and often almost "tropical" engine-rooms, etc., to a more natural, normal, and less "vicious" degree; so that all round (as our American cousins might be inclined to say) better or more nearly perfect ventilation is really, after all, a paying proposition.

Incidentally, by this constant change of air, emphasized in the new system, chemical purity is practically attained. But the difference between the new and the old systems is marked, in that the new scheme includes the regulation of temperature to a resquisite moisture and coolness, and the all-important features of rapid displacement. It is an article that should be consulted by the experts in this country and by capitalists and public men who contemplate the installation of ventilating plants.

The Minneapolis Heat Regulator

A thermostat or mechanical thermometer which will automatically raise and lower the drafts of the furnace has been manufactured by the Minneapolis Heat Regulator Co. for the last twenty-eight years, but has just been introduced into Canada.

The thermostat is placed in the living room, or some central part of the house, and is connected by a wire to the motor in the basement. An indicator on the thermostat can be set at any desired temperature, and upon the change of one degree either way, the circuit can be closed and the motor will raise or lower the drafts on the furnace automatically.

The thermostat is also equipped with a time attachment, which enables you to set the indicator at 60 degrees or any other temperature at night. The alarm will automatically and silently move it to 70 degrees at any pre-determined time. You sleep in a cool house, but get up in a warm one.

This attachment can be connected to any kind of furnace, in either a new or an old house, and is guaranteed to keep an even temperature at all times.

A card to Harvey A. Warner, No. 6 Toronto Street, will bring you a very attractive booklet explaining the thermostat fully.

A Dustless Institution

It is a foregone conclusion that such an institution as a hospital or sanitarium should be entirely free from dust. No such thing as successful surgery can be carried on where dust prevails, therefore how important it is that the housekeeper see to the absolute cleanliness of the ward, corridors and operating theatre. This can be accomplished by the use of Dustbane. It is adapted for the sweeping of all kinds of floors, and is at the same time disinfectant in character. In short, it is a sanitary method of eliminating the dust nuisance. Dustbane can be procured from all grocers.

Absorbent Cotton for the Millions

Over seventeen years ago, when little was known about Absorbent Cotton, and when its uses were largely confined to the medical profession, the Maplewood Mills were established in Fall River. At that time their plant was quite unpretentious, but with the popularizing of Absorbent Cotton came a tremendous increase in demand, and the Maplewood Mills had to grow correspondingly until they now are the largest manufacturers of these goods in the world, producing a goodly share of the total quantity of Absorbent Cotton made in America.

This exceptional success has been achieved by sheer merit. All authorities recognize that the " Excelsior " brand produced by these mills fully measures up to the standard required by the U. S. P.

The four grades of Absorbent Cotton produced by the Maplewood Mills are " Excelsior," " Standard," " Sanitary," and " Absorbon," but all of these, from the highest priced to the least expensive are absolutely pure and have excellent absorbent qualities, since all of them are submitted to the same manufacturing process. The difference in quality is occasioned only by the cost of the raw materials; short staple cottons cost less than long staple cottons, though the quality may be identical. Strictly speaking, the matter of staple is not essential, as a wound will heal just as well and as quickly under treatment with short fibre as long fibre Absorbent Cotton. The only difference is the cost, the short fibre Absorbent Cotton allowing a more liberal use without increased expense.

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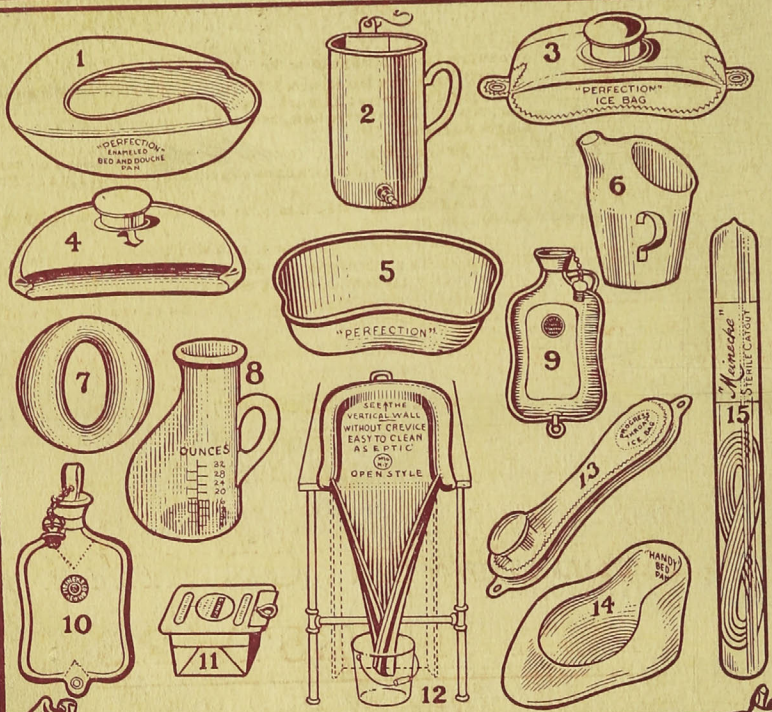

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1—Perfection Bed and Douche Pan.
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4—Army and Navy Ice Bag and Helmet with Unlosable Washer.
5—Perfection Dressing Basin (an improved Pus Basin with high back.)
6—Simplex Feeding Cup.
7—Solid Comfort Invalid Ring.
8—Perfection Male Urinal.
9—Metal Hot Water Bottle.
10—Hospital Beauty Rubber Hot Water Bag with Unlosable Stopper.
11—Simplex Sanitary Paper Sputum Cup.
12—Aseptic Operating Pad (the Pad without a Crevice.
13—Progress Throat Ice Bag with Unlosable Washer.
14—Handy Bed Pan and Female Urinal.
15—Sterile Sutures and Ligatures.

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