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# THE HOSPITAL WORLD

THE OFFICIAL ORGAN OF

## The Canadian Hospital Association

Vol. V.

Toronto, March, 1914

No. 3

### CONTENTS

#### EDITORIALS.

The Teaching Hospital.....	129
A Tribute to Worth.....	131
A Great Advance.....	132
Health Centres.....	135
Medical Inspection of Schools Should be Placed under the Medical Health Department.....	138
A Faint Hope.....	139

#### ORIGINAL CONTRIBUTIONS.

Some Problems in Hospital Train- ing and Teaching. By Miss Charlotte A. Aikens, Detroit, Mich. ....	140
Report of Committee to Outline Standard Course in Hospital Ad- ministration. By Dr. W. L. Bab- cock, Chairman; Dr. Joseph B. Howland, Dr. J. N. E. Brown....	154

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Contents, vide page v.

Index to Advertisers, page 16.





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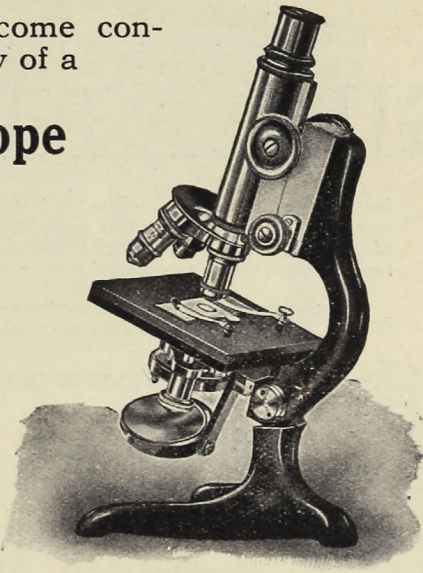
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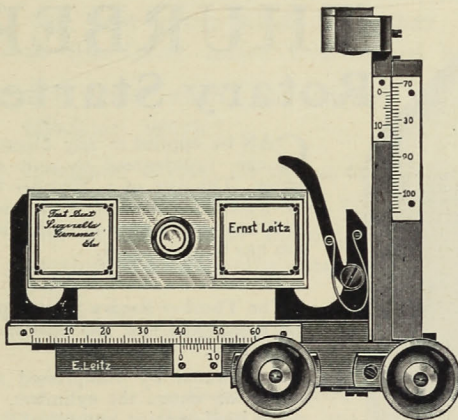
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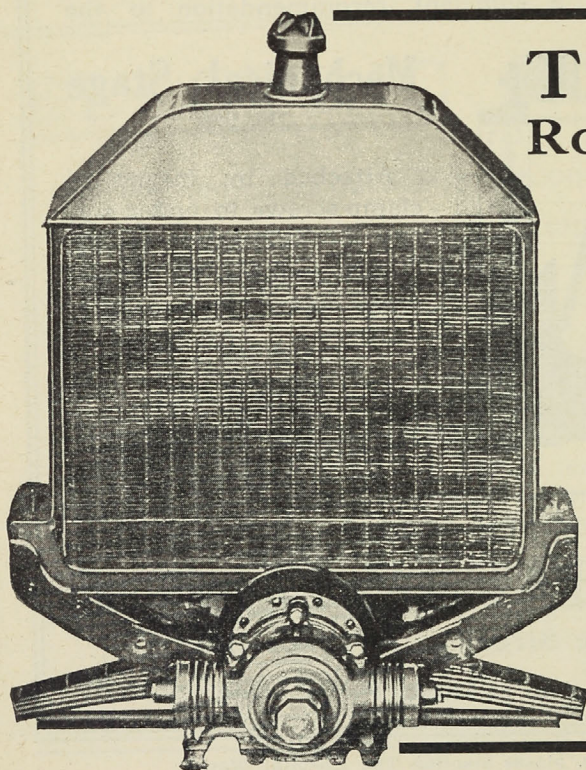
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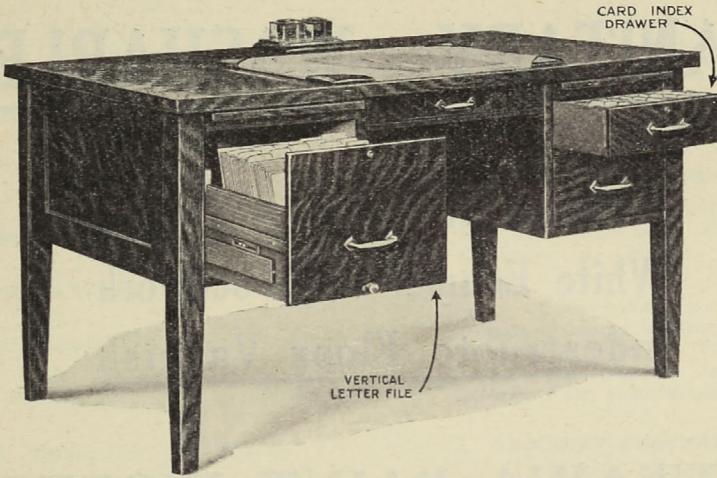
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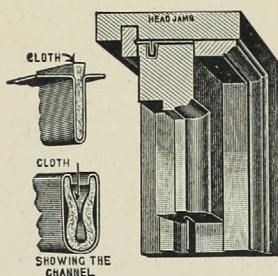
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# Contents

## EDITORIALS.

The Teaching Hospital..... 129

A Tribute to Worth..... 131

A Great Advance..... 132

Health Centres ..... 135

Medical Inspection of Schools  
Should be Placed under the  
Medical Health Department..... 138

A Faint Hope..... 139

## ORIGINAL CONTRIBUTIONS.

Some Problems in Hospital Training and Teaching. By Miss Charlotte A. Aikens, Detroit, Mich. .... 140

Report of Committee to Outline Standard Course in Hospital Administration. By Dr. W. L. Babcock, Chairman; Dr. Joseph B. Howland, Dr. J. N. E. Brown.... 154

## SOCIETY PROCEEDINGS.

American Medical Association.... 161

## HOSPITAL INTELLIGENCE.

Items ..... 166



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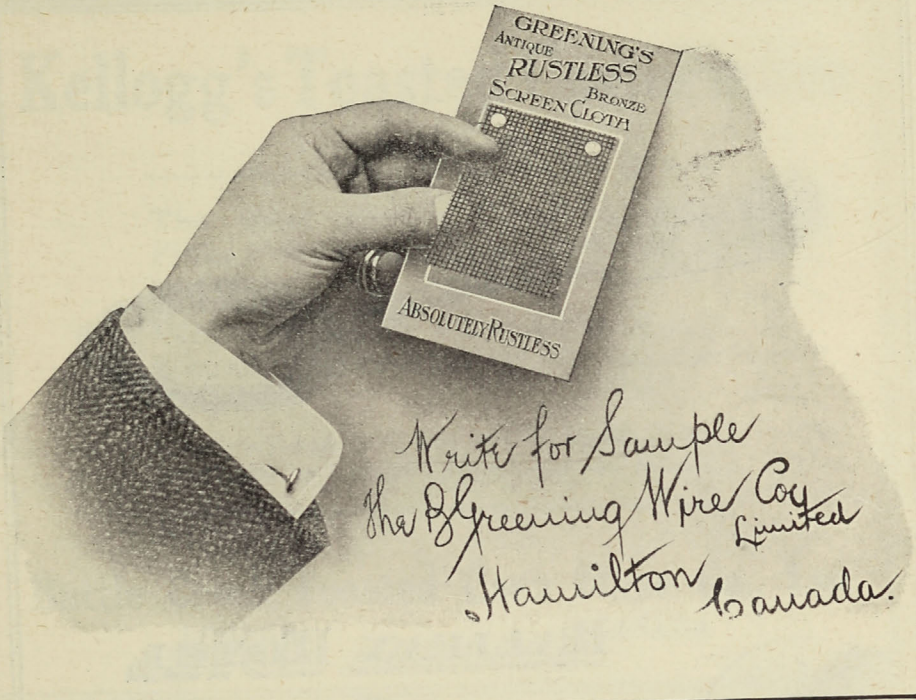
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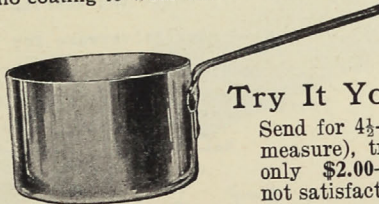
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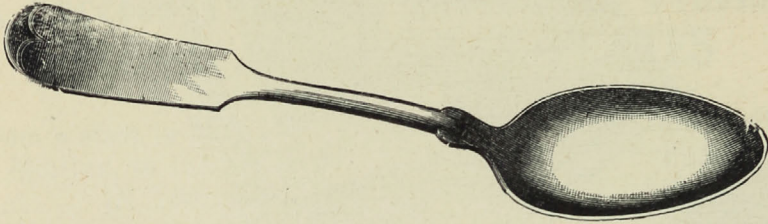
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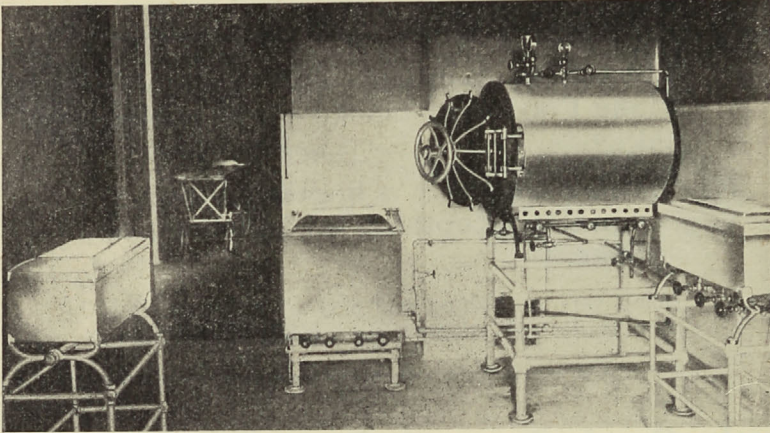
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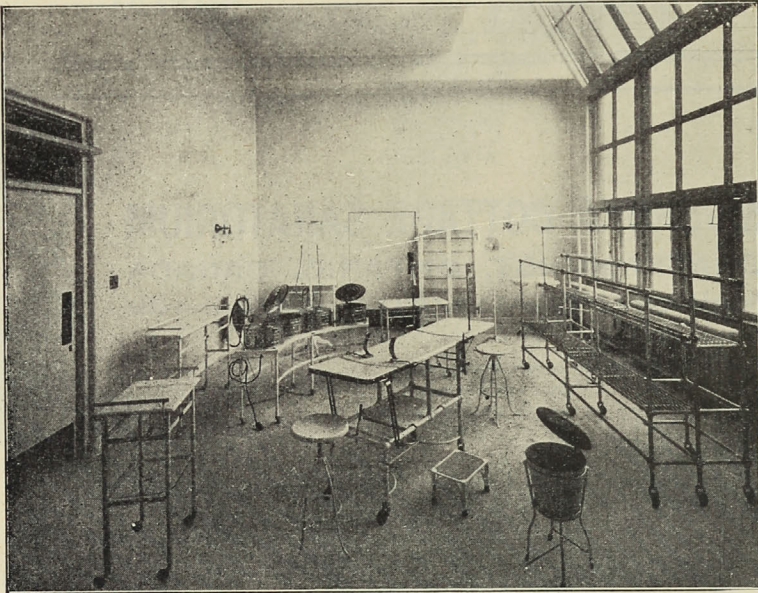
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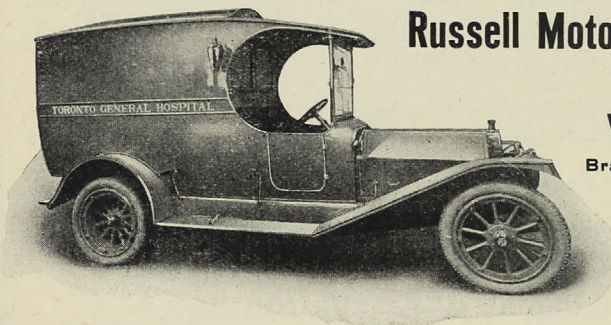
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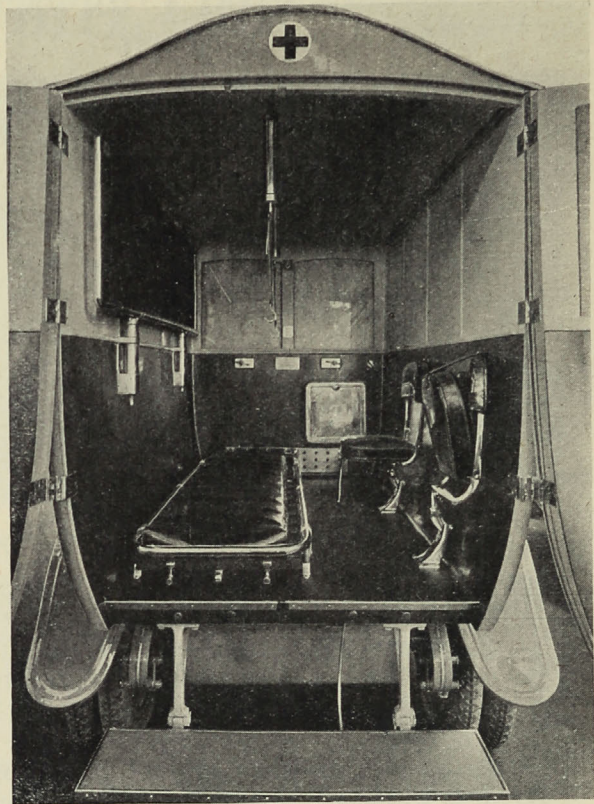
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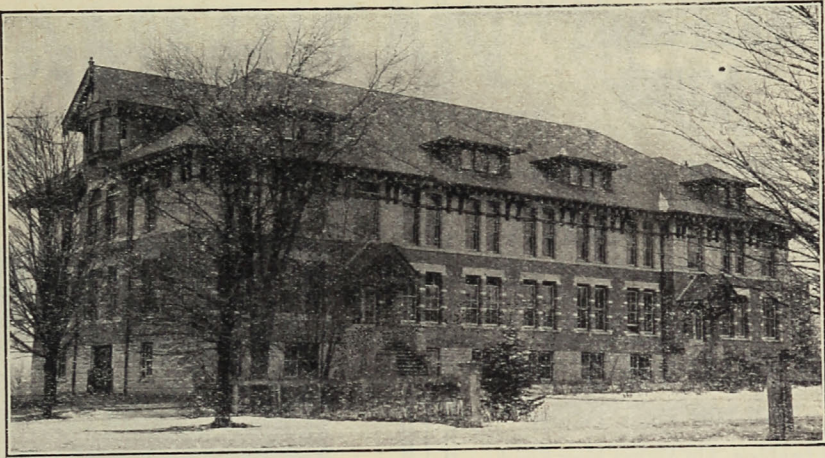
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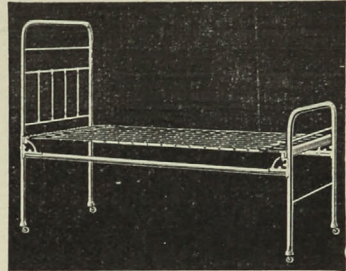
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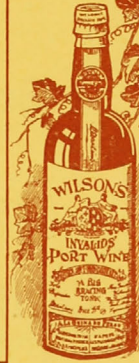
A	Page	G	Page	N	Page
Alaska Feather Co. ....	28	Garlock Packing Co. ...	25	National Sanitarium	
American Enamelled Brick		Gendron Wheel Co. ....	66	Association .....	9
Co. ....	15	Gendron Mfg Co. ....	59	Norris, Thos. A., Co. ....	19
Asbestos Mfg. Co. ....	13	General Accident Assur-		Northern Aluminum Co..	7
		ance Co., Toronto	69	Northern Electric Co. .	31
		General Accident F. & L.		North British Rubber Co.	50
		Co. ....	53		
<b>B</b>		Gillespie Percy Co. ....	54	<b>O</b>	
Babcock & Wilcox ....	71	Gillett Co. ....	2	Office Specialty Co. ....	3
Baker & Co., Walter. ....	5	Globe Co. ....	49	O'Keefe's Brewing Co. ...	76
Barber's Sanitarium, Dr. ....	54	Gowans, Kent & Co., Ltd.	49	Old, R. J. ....	37
Battle Creek Toasted		Gowland	74	Ormsby, Toronto	21
Corn Flake Co. ....	9	Greening Co. ....	7	Ottawa Paint Works ...	4
Bell Filtration Co. ....	46	Grove Park Inn. ....	71	Ottis Fensom Elevator Co.	18
Blake, John H. & Co. . .	55				
Brodeur Co. ....	39	<b>H</b>		<b>P</b>	
Burgess & Co. ....	37	Hamilton Importing Co. .	18	Paragon X-Ray Plates. .	6
Bush & Co, W. J. ....	74	Hartz, The J. F., Co. ....	1	Paripan Paint .....	45
		Heenan & Frowde Co. ...	25	Parke, Davis & Co. ....	30
<b>C</b>		Heron & Co. ....	32	Peacock Chemical Co. ...	73
Canada Wire Co. ....	61	Hillock & Co. ....	17	Pennsylvania Orthopedic	
Canadian Feather &		Horlick's Malted Milk. .	76	Institute .....	19
Mattress Co. ....	22	Hydrox Chemical Co. ...	40	Phipps-Neff Co. ....	58
Canadian Furniture Co. .	48			Platt, Henry Co. ....	49
Canadian Independent		<b>I</b>		Purdy, Mansell, Ltd. ....	62
Telephone Co. ....	26	Ingersoll Packing Co. ...	33	<b>R</b>	
Canadian Morehead Mfg.		Inglis & Son, John. ....	70	Randall-Faichney Co. . .	64
Co. ....	73	Ingram & Bell. ....	24	Reed & Carrick .....	32
Canadian Rotary Co. ...	2	Imperial Varnish Co. ...	28	Revolution Clothes Reel	
Canadian Sunbeam Lamp		International Instrument		Co. ....	53
Co. ....	43	Co. ....	61	Richards Soaps .....	66
Chalfonte Hotel	52	International Varnish Co.	14	Richardson, Wright &	
Chisholm Milling Co. . .	30			Co. ....	14
City Dairy Co. ....	19	<b>J</b>		Roberts & Co., F. G. . .	22
Conduits, Limited .....	20	Jamieson & Co. ....	24	Robertson, Jas., Co. ...	75
Consumers' Gas Co. ....	45	Jefferson Glass Co. ....	63	Robins, Ltd. ....	41
Cosgrave Brewing Co. . .	52			Robinson Cork Co. ....	58
Cowan Co, Ltd. ....	59	<b>K</b>		Russell Motor Car. ....	12
Cramer & Co. ....	66	Keith's Ltd. ....	11	<b>S</b>	
		Kress, Owen & Co. ....	40	Sapho Mfg. Co. ....	66
<b>D</b>		Kuntz Brewery .....	61	Scanlan, Morris .....	10
Dancy, R. C. ....	47			Scholl, Chicago .....	74
Dennis, London .....	31	<b>L</b>		Seaman, Kent & Co. ...	48
Denver Chemical Co. ...	15	Laidlaw Lumber Co. ...	29	Sheldon's Limited .....	42
DeLaval Dairy Co. ....	33	Lambert Phar. Co. ...	Cover	Society Francaise .....	20
Dominion Brewery Co. ...	55	Lever Bros. ....	27	Soss Invisible Hinge ...	55
Dominion Mfg. Co. ....	59	Lister & Co. ....	56	Stevens Companies, The.	68
Dominion Sales Co. ....	44	Lowe Bros. ....	47		
Don Valley Brick Works	67			<b>T</b>	
Drummond & Co. ....	27			Taylor-Forbes Co. ....	72
Duffy Malt Whiskey Co.				The Eberhard & Wood	
.....Cover				Mfg. Co. ....	4
Dunlop Fire Hose. ....	60			Tisdale's Iron Stable Fit-	
Dustbane Mfg. Co. ....	44			tings Co. ....	41
Dyment, Cassells & Co.,				Toronto Electric Light	
.....Cover				Co. ....	Cover
				Toronto Silver Plate Co.	8
<b>E</b>		<b>M</b>		<b>U</b>	
Electro Surgical Instru-		McClary's .....	23	United Brass Co., .....	35
ment Co. ....	59	McKellar Bedding Co. ...	75	United Typewriter Co. ...	54
Elliott, W. A. ....	46	Maplewoods Mills .....	60		
		Marvel Co. ....	56	<b>W</b>	
		May-Oatway Fire Alarm		Warren Mfg. Co. ....	51
		Co. ....	57	Whitney, Boston .....	53
		Meadows & Co. ....	62	Wilson & Co., L. A. ...	17
		Meinecke & Co. ....	cover		
<b>F</b>		Murray-Kay Co. ....	65		
Fearman Co., F. W. ....	61	Muskoka Sanitarium ...	9		
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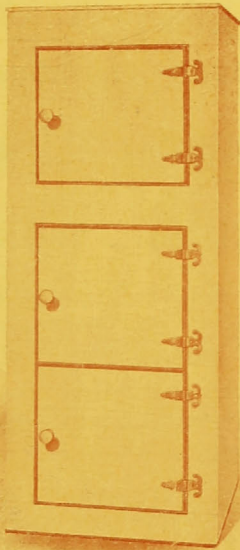
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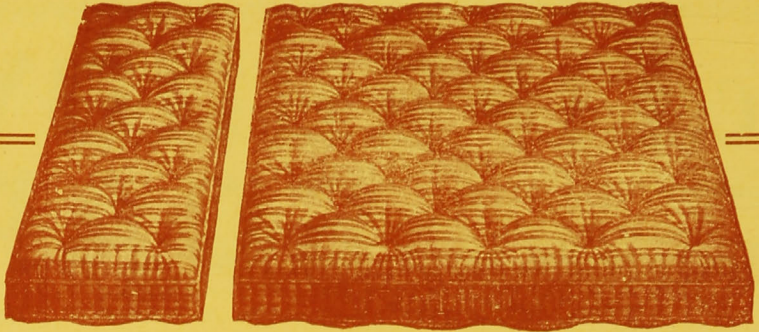
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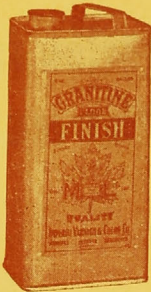
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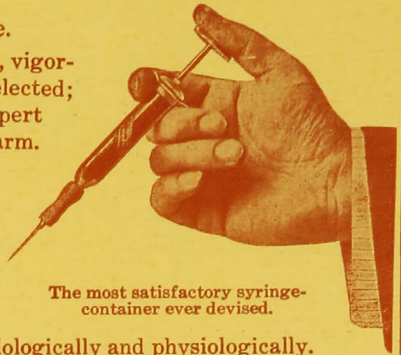
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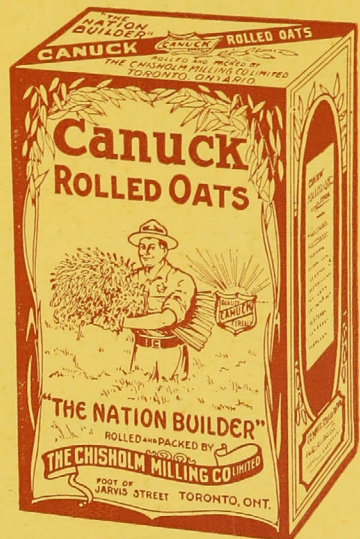
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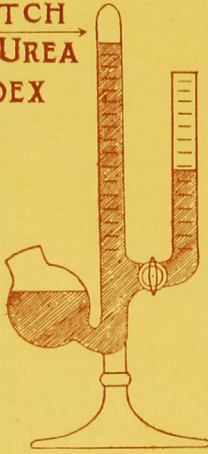
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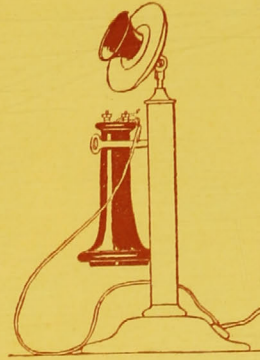


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TORONTO, CANADA

LONDON, ENG.

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Vol. V.

TORONTO, MARCH, 1914

No. 3

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## Editorials

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### THE TEACHING HOSPITAL

---

DURING the conference on medical education held in Cincinnati in mid-January, the new city hospital came in for much admiration and comment.

The installation of Dr. Christian R. Holmes as Dean of the College of Medicine of the University of Cincinnati occurred at the same time, and was

made the occasion of outspoken words of appreciation of that gentleman's labors in connection with the upbuilding of one of the finest hospitals on the continent.

Dr. W. H. Welch, of Baltimore, who was the guest of honor at a banquet held on the closing evening of the conference, paid a great tribute to Dr. Holmes, to whom he gave credit for the new city hospital, which he declared to be "without an equal in the world."

Dr. Welch's words in connection with the relationship of the hospital to the medical school are full of significance.

"The most important part of Johns Hopkins University is the hospital in connection with our medical school. The most important contribution to our present-day medical education is our clinical teachings. Your medical college should by all means take advantage of the great field for clinical teachings offered by your great municipal hospital.

"Patients are better treated in a hospital used for medical teachings than in those which are used purely for humanitarian purposes. The primary purpose of the hospital is the welfare of the state. The teaching hospital is the ideal one. The greatest in the world are the teaching ones.

"The greatest hospitals in the world are of this class. If your municipal hospital is to be a great one—one which will stand out into the world's rank—it must be a great teaching institution. Its functions must not be limited by humanitarian purposes—that is the care of the sick only.

“The heads of the clinics should be men whose main work is in the school. You have here in Cincinnati an unequalled opportunity to build a great medical school. Your great opportunity is the medical clinic, and it should not be overlooked, you have a hospital without equal for educational purposes. The future of medical education is not going to lie with the endowed institution, but with the great public clinical hospital.”

---

#### A TRIBUTE TO WORTH

---

THAT administrative ability in any public direction is appreciated by New York City was instanced in its recent effort to secure Colonel Goethals as supreme head of the city police force. That the effort was not successful did not affect the generally recognized suitability of the man for the place.

A second and more successful selection has been that of Dr. S. S. Goldwater, Superintendent of Mount Sinai Hospital, for the position of Health Commissioner of all New York.

Dr. Goldwater, during the years of his hospital administration has proved himself a first ranker in the profession. He has kept his hospital to the front in all progressive movements, and attacked and solved many of the complex problems peculiar to the varied relationships of these institutions to the outside world.

The New York authorities have been quick to discern the new alliance and blending of service of the

Health Department and the large hospitals. It has also recognized with commendable promptness that the skilled hospital superintendent who administrates his complex domain with a high degree of efficiency, and makes that institution a factor in the solving of larger health problems, has served an apprenticeship in the department of public service that no amount of theoretical study alone can give.

From efficient hospital administration to Commissioner of Public Health is a natural gradation, and New York has been the first to discover the fact.

Dr. Goldwater is a man in the early prime of life, keen, energetic, enthusiastic, and of unusual organizing ability. During the year of his presidency of the American Hospital Association that body made remarkable progress in membership and public recognition.

It will be difficult to fill his place at Mount Sinai, but his appointment to the larger service is a matter of congratulation to New York and to himself, and a tribute to the body of workers which he represents.

---

### A GREAT ADVANCE

---

NOTHING is more indicative of the fresh advances in scientific understanding of mental diseases than the change in medical terminology. From the term "mad-house," still used by old people, to "asylum" and more recently to "hospital"; from "devil-possession" to "lunacy," to "insanity," the terminology has moved on; until now, the latest effort among men-

tal experts is to discard the latter, and substitute the word "maladjustment."

The effort is admirable, inasmuch as the latest terms are explanatory and in line with the modern attitude of science toward mental disease. It will be doubtless a slow process to educate the common people, not only to a use of the terms, but to a realization and acceptance of their meaning. Yet it is undoubtedly upon a campaign of public education in this direction that the medical world is entering.

The recently appointed National Committee of Mental Hygiene, which has yet to make its first annual report, has already gathered much valuable data. It has, in a measure, outlined its field of activities to embrace three departments—first, scientific research; second, public education; and third, organizing and co-relating existing agencies of allied aims.

Naturally, the existing general hospitals are being pressed into service, until such time, at least, as the various communities shall erect municipal mental hospitals. The institution of out-patient departments for mental diseases, and the utilization of the social service work in connection therewith is already begun in the large general hospitals in New York and Massachusetts. The committee look for the extension of this departure to all other similar institutions. Provision for incipient cases in psychopathic wards in general hospitals is urged, and the establishment of a purely psychopathic hospital in each city of over 100,000 population—such hospital to be the centre of practical work in prevention and social service, as

well as for efficient treatment. "Sanitariums for early cases, especially for the psycho-neurosis; hospitals of moderate size in cities with facilities for active treatment of acute cases, and colonies for chronic cases, where patients may be treated in small groups" is a desirable classification of mental institutions urged by the committee.

These suggestions deal with the provisions needed for the possible cure of incipient and developed cases of mental disease; but in its comprehensive survey of conditions, the committee joins other modern movements in making its final aim, prevention, and to this end is working to enlist the co-operation of all modern educational forces. Increasing facilities for instruction in psychiatries for both physicians and allied workers, and encouragement for research work in this field are among the important urgings. This group includes judges, magistrates, wardens and others who deal with delinquents; that they may be able to recognize the symptoms of incipient mental disease, and secure for it the earliest diagnosis and treatment.

Removal of the public mystical attitude toward insanity, and substituting for it the prosaic view taken of ordinary organic disease; bringing all the forces now engaged in fighting unsanitary conditions in the home and individual life, to bear upon it; preventive educative education, education, and still education until the percentage of mental disease becomes an irreducible minimum—this is the great and hopeful programme mapped out by the Committee. Success to it.



## HEALTH CENTRES

---

IN various recent editorials this journal has commented on the inefficiency and waste arising from competing and individualistic methods of hospital conduct, and the need of some measure of consolidation to correct the same. Two years ago, New York City, realizing the large measure of inefficiency in the conduct of its chain of municipal hospitals, appointed a Hospital Investigating Committee with powers "to inquire into and report upon the several lines of activity now conducted by the Department of Health, Bellevue and allied hospitals, and Department of Charity, and to determine efficiency and economy of methods now employed in conducting the same: that it report also recommendations for programme of development for each of these departments, with recommendations on form of organization, methods, and amount of appropriation."

The committee has been steadily and quietly investigating during the past two years, and has recently published the first part of their report on the municipal hospitals and charities.

The findings, confined chiefly to the out-patient department, disclose much wasted effort and inefficient treatment of patients, with the conclusion that reorganization of this department is necessary to obtain satisfactory results.

The recent rapid extension of hospital service into the homes has naturally brought the hospital to the threshold of the Public Health Department. The

plan formulated by the Investigation Committee suggests that the latter body step over the threshold and into the home preventive work that has hitherto been, in a necessarily very limited way, the work of the hospital social service department.

In the rapid evolution of preventive medicine with its many "bureaus" and overlapping agencies, it has been for some time evident that some system of civic administration will have to be established, if any degree of efficiency and economy is to be maintained. This Investigating Committee is developing a plan which provides for the establishment of "health centres" in the thickly populated districts of New York City, where all the several functions now performed by both the bureaus of the Board of Health, and the hospital out-patient departments will be centralized.

The first such "Centre" will be located in or adjacent to, Bellevue Hospital; and here, in one building will be gathered all the different bureaus of the Board of Health, including tuberculosis, child-hygiene and dental clinics, district nurses, inspectors of contagious and other diseases. A pure milk depot will be included, and a force of nurses, and examining doctors and inspectors will be on hand. And from this building will emanate all civic forces for the conservation of health in that especial district.

It is the belief of the Investigating Committee, after close observation, that only a small part of the sick poor—ten per cent.—are treated in the hospitals. The remainder continue in the home, with, what the

committee believe to be, more or less random or inefficient treatment by the rushed doctors of the hospital out-patient departments.

It is, of course, an open question how far the city should go in an attempt to prevent or care for disease. It may yet become a question in how far the municipal authorities may dictate home conditions. But, as the report says:

“The city has taken responsibility for caring for sickness when it reaches a stage needing hospital treatment, and within certain limits for the prevention of contagious diseases. Any theory of social obligation which warrants the city in undertaking the care and prevention of sickness would warrant it going still further if needful.”

If New York or any other city has to assume the responsibility of caring for its sick poor, there should be some means of obtaining fuller knowledge of the conditions which produce sickness; especially in so far as such conditions are controllable.

The health centre to be established in the populous Bellevue Hospital district will be an experiment. It will determine whether preventive and educational health work can be satisfactorily performed by the Health Department. It will centralize the many organizations working toward this end, and will therefore doubtless make largely for economy, both of time and money. It will also do much to relieve the out-patient departments of the hospitals.

**MEDICAL INSPECTION OF SCHOOLS SHOULD  
BE PLACED UNDER THE MEDICAL  
HEALTH DEPARTMENT**

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WE note with satisfaction that the Board of Control are making application to the Ontario Government for the necessary legislation to place the medical inspection of schools in Toronto under the Medical Health Department. We heartily agree in this move, as it is in the right direction. It seems but reasonable that medical inspection should be placed in charge of the Medical Officer of Health. With but few exceptions, authorities agree in this, and we trust that the legislation asked for will be granted, if for no other reason than the almost universal dissatisfaction that is now prevalent with medical inspection as at present carried on in Toronto.

In Great Britain and some other countries, medical inspection of schools is organized under the Medical Health Officer in the town or city or in the county, as the case may be. There is no doubt that this allows of better organization, and as the Medical Officer of Health must in any event take charge of all cases of contagious disease in the schools, it is generally conceded that both time and money are saved by such a plan, such a method frequently preventing overlapping. The Board of Education in Toronto are an elective body, who, of necessity, frequently have to delegate matters of health to the Medical Officer of Health for a report thereon. Sir Geo. Newman, of London, England, than whom there is no one better

able to give an opinion, stated, when in Toronto a short time ago, that there could be no other view taken than that above stated.

The Provincial Health Officers' Association which convened in Toronto a few months ago were also unanimously agreed on this point.

We feel that the medical profession in Toronto are a unit on this subject. and assuredly all poor overburdened taxpayers in this city will welcome any efficient measure that will cut down the ever increasing expense necessitated by all the foolish frills and insignia of the system of medical inspection under present management.

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#### A FAINT HOPE

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DR. HOWARD KELLY, whose religious devotion is known to be as great as is his surgical skill, recently stated that the discovery of radium and its great curative value is prophesied in the Bible. Whereupon a big daily of the irreverent lay press remarks. "It is a great relief to find an eminent surgeon who knows all about the Scriptures. May this attitude spread, is our hope, until the common practice in all the hospitals is 'to open the patient with prayer.' "

# Original Contributions

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## SOME PROBLEMS IN HOSPITAL TRAINING AND TEACHING\*

BY MISS CHARLOTTE A. AIKENS, DETROIT, MICH.

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IN this paper I shall try to bring to your notice several problems relating to hospital training and teaching which seem worthy of discussion and study. I shall not promise to furnish full solutions or panaceas for any of them.

The chief problems which exist in relation to hospital training and teaching may be placed under three main heads—problems growing out of present social conditions, combined with the present state of evolution in the training of nurses; problems caused by difficult people; and problems growing out of special conditions which may differ with each hospital. In any discussion of these problems it is wise to keep the patient and his interests well in the foreground. We cannot properly or intelligently discuss any of these questions and leave the patient out of consideration. Were it not for the patient there would be no need of hospitals, no need of training schools, and very little need of nurses. Neither should we ever lose sight of present social conditions. However high our ideals may be, it seems to be true, that in all the conditions of life we are obliged to stop short of our ideals, and accept the best that can be done under present circumstances. True progress in our work must come by the slow method of evolution, rather than by revolution.

In studying the evolution which has been going on for the last ten years in particular, a close observer cannot fail to note with concern that there is a growing tendency to train our nurses away from service in the common ordinary homes of the people, rather than for such service. Doctors have stated over and over again that it is harder to get nurses for their patients of moderate means in town and country than it was twenty years ago. The public has said the same thing. That fact, for it seems to be a fact, should concern this audience, and any other audience of hospital workers. Several causes contribute to this condition.

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\* Read at the Canadian Hospital Association, Toronto, 1913.

One cause may be illustrated by a booklet which came to my desk a week or so ago. It contained the rules and regulations pertaining to training which were made by a state examining board of nurses. For the last year of training there was quite an imposing list of lectures which nurses were to receive as a preparation for their coming work in the world outside. I noticed on that list there were to be lectures on factory nursing, welfare-work, so called, army and navy nursing, nursing in department stores, Red Cross nursing, lectures on the duties of the nurse to her profession, and several other sorts of duties which she was supposed to have—all of which lecturing is good, within proper limits—but not a reference was made to the practical needs in the line of nursing in the community which immediately surrounded the hospital, and not a word about nursing needs in the average home. The State which issued the booklet is an agricultural State, with no large hospitals, and no large city in it. Is there not a strong tendency to dwell unduly on these newer openings for nurses, which at most can furnish employment for but a small fraction of them, and to overlook, or fail to give proper emphasis to while in training, the pressing needs in the community which lies adjacent to the hospital. Is it pertinent to ask: "What kind of care are the people in the villages, small towns and townships adjacent to your hospitals receiving when they are ill, what kind of nurses seem to be needed most in these places, and are you training nurses who are adapted to and willing to meet those needs?"

Factories are commendable enterprises, if they manufacture something which the world needs, and we can rejoice every time we hear of a factory which has a nurse employed to care for its wounded men. Armies seem to be needed. They furnish employment for a few hundred nurses in America—possibly not that many all the time. Navies and their nursing needs should have a passing mention, but if we wiped out the armies and navies and factories and a lot of other enterprises which employ nurses, we should still have left the most important enterprise of all for which our nurses are required—the American and Canadian homes where our citizens are born, and reared, and trained, to take their places in the world. I wish to make a plea for a closer study of the average Canadian home and its needs,

in sickness, for nurses in training to be given a vision of those needs, and to be better prepared spiritually and technically to meet the practical nursing needs in those homes. There are several ways of doing this. A study of the home conditions in Brant county or Huron county or whatever county your hospital is located in—of the average income of the families, and what happens when they become seriously ill in those homes, ought to be profitable in the last year of training. A whole course on home conditions and home nursing needs, including the conservation of the middle-class Canadian home when the mother of the family is stricken by illness and there are little children to be cared for, ought to be as profitable as lectures on nursing in the navy, even if the subject is rather less romantic. We have seen in recent years the evolution of the school nurse, the factory nurse, the tuberculosis nurse, and the social service nurse of different classes. We are going to see the evolution of a new type of nurse, or of a nurse with a new vision, and with a little different spirit, and the training schools can help mightily in her development. We are going to evolve a nurse who has gotten in the training school a vision of the middle-class home as a field for service, and of her rightful place in that field. She will not try to occupy it all, but she will work in it, if we show her how and help her, if we give her in the training school a vision of the needs and how she can best help meet them.

We all rejoice in the splendid development of hospital social service in the last eight years, but we must remember with regret that, as yet, its benefits are to be had mainly by those who come to free dispensaries or who cannot pay. When we get a little more sense and a little more experience, we are going to evolve a little different type of hospital social service for those who *can pay* a moderate rate for its benefits. Up to this time, social service has seemed to be possible only to the large hospital. Few, if any, of the smaller hospitals without dispensaries have established a social service department. I am convinced that there is yet a vast field of social service practically untouched, which the smaller hospitals without dispensaries and fortunately without great crowds of very poor patients, ought to enter. The training school must sustain a very close relation to this problem. It surely should study it, and it will. The chief field of



social service for the smaller hospital is going to be among middle-class people who cannot pay the highest rates for nursing service, but who can pay enough to make such a department self-supporting. The basic idea of hospital social service is, or seems to be, to study the needs of each individual who presents himself for treatment, to look carefully into his environment, and to try to secure for him the particular thing which he needs, whether it be milk or eggs, eye-glasses or crutches, a change of occupation or a few weeks' rest or something else. We have not yet seriously applied this basic idea to the patient in the middle-class home, but this is going to be one of the developments of the future.

At the present time there is no class of patients so neglected in sickness, none more worthy the consideration of this audience, than is the respectable maternity patient with a limited income, whether in city, town, or country. Municipalities have looked out with compassion on the mothers of the slums and poorer districts and provided means for helping them. The unmarried mother has homes and shelter and skilled care available. The middle-class mother gets along as best she can. Few of these patients can pay over from one to two dollars a day for care during the lying-in period. For this sum they have their choice of two classes of caretakers—the nurse who gets her instruction in a correspondence school, or the nurse who has had no instruction at all, usually the latter. We can berate the correspondence course nurses as much as we like, but until we take hold of this practical need and meet it in a legitimate way, the correspondence nurse is going to increase. The middle-class maternity patient furnishes the chief demand for her, and she has simply entered an unorganized, a neglected and unoccupied field. If we want to get rid of the correspondence nurse or to keep her tribe from increasing we have got to do the work she is doing, do it at moderate rates and do it better. The only thing we need fear is that we shall fail to do this. We have no right to ask the graduate nurse to assume this great responsibility without help. We have in this country no midwifery associations that I know of to depend on to meet this need. I am not sure that we want any. I am sure that the hospitals and the hospital schools can do a great deal to help solve this prob-

lem. I have long felt that if the hospitals would only take hold of this community need, and through a special extension department under the direction of a special committee, and with a practical graduate nurse in charge, who would devote herself to studying how to meet this need, working out the details step by step, we should find it not only more profitable than fighting the correspondence nurses through laws or through the press, but we would find it possible to render a much greater service to the community than by pursuing the methods which are now being used. Here and there in different parts of America are hospitals which are doing this extension work by going into the homes and seeing that the lying-in woman who goes down to the gates of the grave to give another child to the nation has a fair chance of return to vigorous health, and that the new citizen of the state gets proper welcome and a fair start. But unfortunately such work thus far reaches out only to the very poor—it must reach farther and include the respectable but neglected lying-in mother who never applied for charity or for free dispensary service.

Several Cleveland hospitals have joined in a campaign to render the midwife unnecessary by giving better service than she could possibly give to those who would otherwise employ her. Last year through the influence of this effort, 1,178 cases were cared for in homes by the hospitals, cases who would otherwise have had to depend on midwives. The training school of Lakeside Hospital, Cleveland, shared in this splendid work by contributing two supervising nurses and a group of pupil nurses each month for this work. I wish that superintendents of Canadian training schools might consider the opportunity for additional experience and for service to their own community which this form of extension work offers. When you are tempted to send your pupils a couple of hundred miles or more away across the border to secure maternity experience, will you not try to adjust your viewpoint so that you can see the maternity cases that are uncared for nearby, or left to the tender mercies of untrained and uninstructed help in their hour of need. I know all about the prejudice there is about letting pupil nurses receive pay for such service—a prejudice which is not based on sound reasoning nor on common sense. I would not exploit

the pupil nurses for the support of the hospital, but I would urge that they be given this experience in the homes of the common people which they need. I would put every dollar they earned into a training school fund, to pay for proper supervision of this extension service, proper instruction, better equipment for the training school and any other thing which the training school needed. I would see that they got to their classes and were properly taken care of in every way, but if I wanted to train nurses for homes I should try to give them this practical experience in the homes of the common people. I would not have this extension work depend wholly on the service that pupil nurses could give, but would supplement their work by a corps of non-graduate helpers who would work under supervision.

At the present time the services of the skilled graduates whom we have trained are available only to about one-third of the population—to the well-to-do, and the poor. I wonder if it is not time that we went farther and tried to possess the whole land—tried to extend the benefits of the skilled care which our nurses can give to the other two-thirds. Nothing will do as much to increase the supply of pupil nurses as a steadily increasing demand for graduate nurses at fair remuneration. This demand we must help to create. Our duties as superintendents may end when we have handed the diplomas to the graduates, but our duties to them as citizens have then only begun. We cannot forever go on turning out the finished product of our schools, and do nothing to extend the uses of that product, or to create a wider demand for it. We must try to get the far vision as well as the near vision of our responsibilities to those who enter our training schools.

Every now and then someone raises the cry that we are training too many nurses. That at a certain registry there are always nurses idle, and that therefore the production of nurses should be lessened. A Western professor in a medical college has made the statement that fifty per cent. of the nurses we graduate are idle all the time. His remedy for this condition which he says exists is to require every candidate who enters a hospital school to have a high school diploma; to make the nursing course a college course with only enough practical work to

familiarize the student with nursing duties, and to have the bulk of the nursing in all hospitals done by graduates.

Making the statement that fifty per cent. of our graduates are idle all the time is not proving it and he has produced no proof for his statement so far as I know. The fact that at a certain registry a number of nurses are idle proves nothing, except that we need some better methods of distribution. Every minister, every doctor, can tell of dozens of cases which he has worried over within the year, who needed skilled care and couldn't get it. Until the needs in this great field, which includes two-thirds of the population, are much better provided for than they now are, we need not seriously worry over an over-production of nurses. We should, however, get under the burden of better distributing their services, in some way.

We have heard a great deal in recent years about educational standards and educational ideals. We are going to hear more in the future about standards of service, and community needs. Much has been said about lifting or elevating the standards or about not lowering the standards. "Elevate the standards" makes a good battle-cry. It serves the same purpose, on certain occasions, as the waving of a flag at a political meeting, but battle cries may be very confusing, and the person who waves the flag may be notoriously unpatriotic at heart. So it is with this cry, "Elevate the standards." The uninitiated who have not thought very much about the question may easily fall into a delusion, and think that an educational standard and the quality of practical nursing mean one and the same thing, when they mean two entirely different things. It would be easily possible for a given group of people to meet and decide that no one should be eligible to enter a hospital training school who had not received an A.M. or A.B. degree, and to prescribe an elaborate and beautiful curriculum for them. They would have the credit of fixing a very high standard but nothing more. The quality of nursing received by the masses of the people would not have been improved in any particular by such measures. In making our standards let us always keep the sick and their needs and our present social conditions where they belong in any discussion of this question—in the foreground—otherwise we may be lift-

ing up standards with one hand and lowering the grade of care given to the sick with the other hand.

Do not settle down into the belief that high educational standards and good nursing in the hospital or outside of it necessarily go hand in hand. They are often, though not always, radically opposed to each other. The spirit of nursing has a lot to do with its quality, and spirit and character cannot be determined by educational tests. It is easy to find schools which announce a very elaborate curriculum and very high theoretical standards, whose reputation for nursing in the hospital is very poor indeed. One doctor, in discussing this condition with me, remarked that in a certain hospital which had these very high theoretical standards "*two nurses were on duty where six would be busy, if the patients got the care they ought to have.*" His remark shows clearly the danger that exists in losing sight of social conditions and in arbitrary educational standards.

While this paper was being prepared a letter came to me from a physician in a western state who is connected with a small hospital there. He complained bitterly at the burdens laid on their little hospital school by the state examining board of nurses. He had counted up the pages in the numerous textbooks which the nurses were supposed to cram into their craniums and found them to be over 4,000 pages, besides a history of nursing of three volumes. He believed that the nurses could learn all that would be valuable to them in about 1,400 pages, so he said, and he wanted somebody to write something about their difficulty and somebody to do something about the matter that would help his school. I am not prepared to say how many pages a nurse should be forced to study or needs to study in order to become safe and useful nurse. So much depends on what is on the pages. I do say that the remedy for this burdensome condition wherever it exists is in the hands of hospital and training school superintendents and hospital boards. They can simply refuse to allow their nurses to be burdened with studies which are not calculated to make them better able to care for the sick, and insist that those who desire to pursue these extra studies do it after graduation, and not before. I believe we ought to

always hold out a "beyond" to our pupil nurses as an incentive to them to keep up study after they leave our schools.

Probably most of us would like to see all the training schools in Canada at once brought up to the high level of efficiency now attained by the oldest and best schools. Yet we know it can no more be done than can a child of ten attain at will the strength and experience of mature manhood. Hospitals, most of them, start out small, handicapped by lack of money and by lack of experience. Yet even the smallest and most isolated hospital is doing a life-saving work. It is, or it should be, the work of every one of us to assist in this life-saving work, by helping the weaker hospitals and schools in every way possible. The cry that "small hospitals should not have training schools; let them hire graduate nurses or else get off the earth" (this is a quotation from a letter I received a few weeks ago)—this cry is one that Canadians cannot well afford to join in. Canada is too new. Canada needs hospitals and nurses too urgently to adopt that policy. Rather let us help the small struggling hospital to grow and to do good work within certain limitations. Have we any right to expect or demand such a hospital to give the same full course of study and training that is given in this great institution whose hospitality we are now enjoying. They are clearly not in the same class at all, and our efforts to keep all training schools in one class is unfair to both the large magnificently equipped and organized training school and the small struggling school. It is unfair to both of them.

Most of us remember the time when the newly arrived probationer, the first and second and third year nurses, who happened to be off duty, were all turned loose into the same classroom, and a doctor was placed in front of us to give us such crumbs of medical knowledge as he happened to have ready at the moment. Our present system of grouping all training schools in one class—good, bad and indifferent—and giving all the same training tasks, or of putting a stamp of approval on a certain number, and discrediting the others or regarding the remainder as non-existent, is just about as antiquated and just about as sensible as the hit-and-miss system which prevailed in our training schools a score of years ago. I have known of small hospitals of twelve or fifteen beds trying to give a three-

year course in nursing. They could not give a course of more than one year and make it profitable for any nurse. They could have taught the common methods to be used in general bedside nursing in one year, and that is all they should have tried to do, or have been allowed to do. Better do a small thing well than try to do a bigger thing and make a fizzle of it. Better let the very small hospital devote itself to giving a thorough but limited course, and to meeting the home demands for nurses in its own community at moderate rates, than try to force it or encourage it to attempt something which it is not able to do. Just as long as we adhere to the plan of trying to keep all schools on the same level, we cheapen the work of the best schools and lay unnecessary burdens on the small struggling school.

Every conscientious training school superintendent is working constantly at the problem of how to improve the quality of the teaching done in her school. I take it that most of you have to depend for a considerable part of your instruction on the unpaid medical lecturer, who is sometimes a very good teacher and sometimes very poor. It is easily possible for a man to be a brilliant success as a medical practitioner, and a brilliant failure as a teacher of nurses. We are all familiar with the type of lecturer who is habitually late, or so frequently absent that his course of lectures amounts to nothing of practical value in a nurse's education. He rarely came prepared, and was always offering apologies for lack of preparation. We easily recognize the type of lecturer whose doesn't know the difference between a medical lecture and a nursing lecture, who tells a good deal about diseases but little or nothing about how to care for the patient who has the disease. We greet as an old associate the doctor who thought the nurses couldn't know too much about the things in which he happened to be especially interested, and who wearied us by going into details which we knew did not concern us as nurses. These are some of the trials of the volunteer system of instruction. We are all ready, I am sure, to pay our tribute of respect and appreciation to the medical men who have given time and thought and study to the question of how to adapt their teaching methods to nurses, and whose services have helped to improve and strengthen our training school work in a hundred ways. Yet many of us have now

or have had some of the other kind of lecturers to deal with and they constitute a very real problem in some hospitals.

I am convinced that most schools would find the quality of their work vastly improved and their teaching problems simplified by paying at least two outside medical lecturers and keeping them teaching weekly throughout the school year. Such paid instructors are usually chosen from among the younger physicians and are paid from two and a half to three dollars a lecture, which brings the total cost of a paid instructor to around a hundred dollars a year—a small sum, surely, to pay for punctuality, faithfulness and that careful attention to the needs of the training school that is essential for real success. This does not mean that there is not still a place for the volunteer unpaid instructor. In the last half of the training period, when the pupil nurse has acquired a good foundation of practical knowledge suited to her needs, our medical specialists can be used with great benefit. But it will be found that in the training school as elsewhere the most satisfactory service will be had when we pay something for it. It depends a good deal more on the hospital superintendent than on the hospital board whether this improvement is made in the training school. Make the start by asking for one instructor to be paid, to conduct the classes in certain studies throughout the year. After the first year's work it will not be difficult to have an additional instructor for second year nurses, if it seems desirable. Ladies' Hospital Aid Societies can often be induced to assume this expense in the beginning.

How much teaching should the lady superintendent of a hospital be supposed to do? How much can she do and do justice to the teaching, to the hospital and to herself? This is a practical question which every lady superintendent has to meet. I shall not take time to discuss it, but merely submit it as a subject which is well worth thinking about and talking about in meetings of this kind.

One who closely scans the announcements of a large number of schools from year to year cannot fail to notice the increase in the number of nurses who are listed as instructors. Without doubt, the one who has the best opportunity of all to teach is the head nurse who has the daily and nightly supervision of the work of the pupil nurses. Yet the constant changing of head



nurses which goes on in many hospitals, combined with the fact that we have adopted no general and systematic plan of giving them a course of training calculated to better equip them for training and teaching, hinders the best use of the head nurse's opportunity for teaching. The practice of nursing is one thing. The practice of teaching is a different thing, and needs a good deal of study if one is to achieve success. Nurses in general like to refer to the opportunity afforded in Teacher's College, New York, for acquiring preparation for teaching. Yet we all know that out of every hundred graduate nurses who will enter institutional work in the next five years, ninety-nine of them will not have a chance to go to Teacher's College. Let us, therefore, bid God-speed to the one conspicuous exceptional nurse, as she packs her grip and turns her face toward New York. Then let us look around at the ninety and nine who are our probable teachers and head nurses and nurse superintendents of Canadian hospitals, and see what can be done to better prepare them for teaching and training responsibilities. Some time we are going to develop summer schools and ten-day institutes which will help bring to these ninety and nine who "stay by the stuff," who go on with the task of caring for the sick and teaching, some of the opportunities which a college affords for expert instruction in how to teach. I am convinced that such a course can be worked out, and will be worked out when enough hospitals ask for it and promise to support it by sending their head nurses for instruction. But when we make up our minds a great deal can be done right in the hospital to develop capable nurse teachers. In the rest-room of an athletic association visited recently was this significant placard posted:

The very beginning of success is in a nurse *wanting* to be a successful teacher, and wanting it so badly that she will determine to devote some part of each week to studying teaching methods and acquiring proficiency in teaching. Within the past year I have been at work on a series of papers, on **THE MAKING OF A NURSE TEACHER**. I have studied numerous books on teaching with a view to securing practical points which might be utilized in developing hospital teachers, in the place in which nine out of ten of them must be developed—right in the hospital. The more I studied into the question, the more

I became impressed with the possibilities of giving a practical course designed to better equip our head nurses for actual teaching. The papers referred to will be published in serial form—probably in the first half of the coming year, so I will not dwell on the details of this subject at this time.

I would, however, like to direct your special attention to the report presented by Dr. W. L. Babcock at the Boston convention of the American Hospital Association, which outlines quite fully a course for head nurses and lady superintendents and the methods which have been found workable and successful in training for larger administrative positions. At least six hospitals in Canada should be giving courses in hospital administration such as are given in Grace Hospital, Detroit, and Massachusetts General Hospital, Boston. The responsibility for deciding on the quality of administration which present and future Canadian hospitals are to have, depends on this association to a very great extent. We can let it develop hap-hazard—we can let each new hospital go through the old-fashioned expensive method of picking out a nurse superintendent who knows not the A, B, C of hospital administration, and letting her get her experience at the expense of the hospital and learn by her blunders, or we can try to look ahead and make provision for the needs in administrative lines of Canadian hospitals and try to meet them in a business-like way. This responsibility is one that should be undertaken by the large, well-manned, well-located, and well-organized hospital, though that does not mean that some splendid hospital executives have not in the past come from the smaller hospitals. Personality enters largely into success in executive work. But the best executive might have been better still had he had a little training in administration to start with.

In this rather disjointed paper I have tried first to make a plea for some special emphasis to be given while the pupils are in training, to the needs in the line of nursing in the community adjacent to the hospital, and that they be given an opportunity to acquire experience right in the homes of the Canadian people in dealing with home nursing problems, so that good practical home nurses may be sent out of our schools. I have made a plea for some special study to be given to the needs of the respectable

but neglected middle-class maternity patient who is not an object for charity, who now is forced to depend largely on untrained care and assistance in her hour of need. I have made a plea for the small, struggling hospital to be given a chance to develop and meet its town community needs without trying to lay on it the same teaching burdens which are assumed by the large, well-established, well-equipped hospital. Attention has been called to the danger that exists when we try to elevate the educational standards more rapidly than our social conditions will warrant, and to the danger that such measures may easily cause the actual care of the sick to deteriorate. Attempt has been made to emphasize the value of employing one or more paid instructors who would assume responsibility for a good deal of the teaching in the first half of the training course. The question has been raised as to how much a lady superintendent should be expected to teach. Attention has been called to the exceptional opportunities which the head nurse has for teaching, and the suggestion has been made that we try in the hospital to help her to acquire proficiency as a teacher. I have asked for special consideration to be given to the outline for a course in hospital administration submitted at the Boston convention.

None of these are very new questions, but each has its bearing on the care of the sick which is our first duty. These questions cannot be settled in a day, or a year, or a decade, but they are ours to wrestle with till better conditions prevail. Let us keep first things first in all our planning for our hospital schools. Let us not set for ourselves any artificial standards which will hinder us in the great work with which we have been entrusted. Let us constantly study how we may improve and at the same time do justice both to hospital and the hospital school. Let us keep very close to human needs while we work at these problems. Let us remember that the world measures real greatness and real values with the yard-stick of service and practical utility.

## REPORT OF COMMITTEE TO OUTLINE STANDARD COURSE IN HOSPITAL ADMINISTRATION

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DR. W. L. BABCOCK, CHAIRMAN; DR. JOSEPH B. HOWLAND,  
DR. J. N. E. BROWN.

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YOUR committee has prepared its report in two divisions in order to cover the subject of the training of hospital administrators or executives whose future field of work presupposes the larger domain of the large general hospitals; and, secondly, the training of graduate nurses for positions as executives of smaller hospitals and as heads of departments in general hospitals. As this division is made it becomes at once obvious that the method of training candidates under these two headings is quite distinct in subject matter, methods and practical application.

### THE TRAINING OF PHYSICIANS AS HOSPITAL ADMINISTRATORS.

After careful consideration, your committee does not believe that it is practical to establish regular courses for the training of physicians as hospital administrators. Any physician desiring to secure training for the position of administrator or superintendent of a large hospital should first take a position as junior assistant and learn the work from the bottom up. While it is true that only a comparatively small number of hospitals have assistant administrators or assistant superintendents, attention may be directed to the many excellent opportunities of training offered in state hospitals for the insane in the junior staff positions. The insane hospitals of New York and Massachusetts alone require over three hundred physicians to make up their medical staffs. Numerous vacancies occur annually, and in New York State the civil service examinations for the purpose of filling those positions are open to residents of any State. For many reasons the training in State hospitals for the insane provides an excellent foundation for work as general hospital superintendents or administrators; in fact the regular routine, excellent methods, and administrative economies practised in State hospital work furnish the young physician with an unusual outline for administration work in general hospitals.

Several of the larger general hospitals of the East and middle West have from one to four positions as assistant superintendent or junior resident. These hospitals, together with the State hospitals mentioned, offer the only practical opportunities known to your Committee for the adequate training of hospital administrators or executives.

Hospital administration requires broad training, covering, as it does, the executive business of the hospital, as well as a certain medical and social work. It is impractical to teach this work in a limited course.

Liberal salaries should be paid assistants in training so that desirable men may be encouraged to take up the work. The time spent in training first assistants before taking charge of large hospitals should be not less than three years, and preferably longer. The assistant, while attending to the routine duties of his position, should be familiarized with the duties of his senior, and in this manner, where several assistants are employed, each will understudy his immediate senior. It is an economical and social error to place an untrained physician at the head of a large general hospital. A certain number of physicians so placed may learn the business, but at what a sacrifice. The financial and professional interests of such an institution will certainly suffer materially until such time as the executive acquires a comprehensive knowledge of the many-sided requirements of the position.

#### OUTLINE OF PREPARATORY COURSE FOR EXECUTIVES OF HOSPITALS AND HEADS OF DEPARTMENTS.

This course presupposes that the candidate is a graduate or registered nurse and has definitely decided to take up institutional work as a profession. The outline covers a requisite course of training for superintendents of smaller hospitals (100 beds or less), assistant hospital superintendents, superintendents of nurse training schools, night nurse superintendents, operating room supervisors, ward and corridor supervisors and dispensary or out-patient supervisors. A modification of this outline could be used in the practical instruction of women for the position of housekeeper or matron.

The experience of two or three general hospitals that have for several years given a course in hospital economics, administration and institutional nursing, similar to the proposed standard course, has demonstrated that any well-organized hospital of 150 beds or over can give such a course with great advantage to the pupils and material advantage to the hospital.

The heads of departments in any hospital providing this course are greatly benefited by their contact with graduate nurses from other schools. Their interest in their department is stimulated by the practical teaching methods outlined; for example, the matron, the dietitian or the supervisor in whose department the pupil is working, is keenly aroused to the necessity of making every effort to place the practical work of her department on a higher scientific and economical level. Her efforts may be stimulated by suggestions and criticisms from members of the class.

Pupils taking this course of training should act as assistants to the various heads of departments for a limited period of time or in some capacity which carries with it a limited or circumscribed responsibility. After the course is once organized, the amount of time and attention that department heads give to pupils may be greatly minimized, and experience has proven that the teaching does not become an additional burden. It has been demonstrated that the adaptability of pupils in various departments varies to some extent, but that the general average of efficiency is reasonably high, and that few pupils fail to assimilate the training in actual practice. It is not expected that all pupils who take this course will become proficient hospital executives or department heads. A small minority, as in all lines of training, have mistaken their profession and are not adapted to institution work.

The course, as outlined, is essentially a practical one, and pupils should actively participate in the work of all departments of the hospital.

#### QUALIFICATIONS FOR ADMISSION TO THE COURSE.

Applicants should be registered nurses or graduates of hospital training schools which at least maintain the minimum standard adopted by the American Hospital Association in 1909.

They should be graduates of at least two years' standing and between twenty-four and forty years of age. They should be single, in good physical health, and be definitely committed to a future of hospital work. If individuals could be manufactured as wanted and human nature made more pliable, it would be desirable to include in the qualifications for admission to the course a disposition and temperament of adamant texture and resourcefulness. It should also be mentioned that, other qualifications being equal, the woman with a commanding presence, whose stature surmounts five feet five inches, and whose activity gives promise of much potential energy, generally proves the most successful in hospital work. Unfortunately, all of these qualifications are seldom combined in one individual.

Nurses who seriously contemplate making hospital work their vocation should first carefully take an inventory of their mental assets in temperament, tactfulness, adaptability, and their physical assets in stature, physique and endurance. A conscientious survey of these qualifications, which cannot be bought, sold or stolen, will unquestionably avoid future disappointments.

#### LENGTH OF COURSE.

The course as outlined covers a period of six months' practical work, including several didactic lectures. With this outline as a basis, courses of shorter duration in special hospitals could be arranged, notably in psychopathic, obstetric, contagious, tubercular and pediatric work. Special courses in the administration of surgical departments and practical hospital housekeeping could also be arranged to cover a period of two or three months. A special course in "hospital dieties and food service" could be given in a like period.

#### OUTLINE.

##### GENERAL MANAGEMENT.

Responsibilities of superintendent; by-laws, rules and regulations; organization of departments; selection of department heads or supervisors; relation of hospital and its officers to the public; relation to city and county poor departments, associated and private charity organizations; co-operation with other in-

stitutions; attitude of local newspapers; relation of executive to board of trustees, attending medical staff, and auxiliary hospital workers; management of resident staff; appeals to public for financial assistance; nature of general and special bequests and endowments; investment of endowment funds; legal relations of hospital, its officers and employes; preparation of annual reports; preparation of specifications and contracts; general care of grounds and buildings; plans and location of new buildings; ambulance service; fire, elevator, liability and industrial compensation insurance.

#### GENERAL BUSINESS DEPARTMENT.

Classification and training of office clerks; business principles and methods, including hospital bookkeeping; filing of records and reports; hospital statistics; office blanks and records; sources of hospital income; preparation of pay-rolls; cash balances; cost accounting; telephone service; reception of visitors; relation to other departments of hospital; receiving and recording patients' property; credit accounts; collection of old accounts.

#### TRAINING SCHOOL DEPARTMENT.

Methods of teaching; clinical or bedside demonstrations; demonstration room; preliminary course of training and special teaching of probationers; engagement of candidates; ethics of nursing; relation of training school officers and supervisors to pupils, to patients, and to other departments; training school blanks and records; preparation of curriculum; assignment of head nurses and rotation of pupils; organization of night service; keeping of time books and ward and corridor inventories; construction, care and management of nurses' home; economy in the use of supplies; alumnae work.

#### MATRON'S OR HOUSEKEEPING DEPARTMENT.

Management of central and branch linen rooms; sorting, storing and reporting of flat work; checking and issuing linen room supplies; management, duties and obligations of housekeeping employes; stock requisitions for dry goods, crockery and housekeeping supplies; housekeeping time books; pay-rolls,



blanks and records; classification, discipline and housing of employes; waste of food in pantries or dining-rooms and economy in the use of supplies; sale of old rags and other waste; destruction of vermin; inspection of waste and garbage.

#### LAUNDRY DEPARTMENT.

Study and arrangement of laundry machinery; limitation of hand work; marking, sorting, washing, mangling, starching and ironing; soap making; checking and issuing of washed goods; systematic and economical handling of soiled and washed clothing; handling of clothing of nurses and employes.

#### STEWARD'S DEPARTMENT.

Contracts and bids for supplies; purchase of general supplies, provisions, perishable goods, furniture and special equipment; storekeeper's records; requisitions for, and issuing of, supplies; monthly inventories of material, stock, and daily and monthly issue sheets; marketing for fruits and vegetables; per capita allowance of provisions; waste of supplies; economical handling of meats and dairy products; meat cutting; co-operation between steward's department and kitchens.

#### KITCHEN DEPARTMENT.

Kitchen management and division of work; preparation of food; delivery of prepared food from kitchen to pantries and diet kitchen; menus and dietaries; food waste; requisition for supplies; diet kitchen management; pantries and handling of pantry supplies; arrangement of kitchen and pantry equipment; trays and tray service; keeping food warm; night food service.

#### SURGICAL DEPARTMENT.

General management; receipt and issue of supplies; blanks and records; sterilization methods; preparation and care of dressings and sutures; supervision and assistance in operations; preparation for anesthesia; administration and choice of anesthetics; selection and care of instruments; planning, heating, lighting, ventilation and equipment of operating rooms; ward and corridor surgical dressing rooms; operating room economy.

## PHARMACISTS' DEPARTMENT.

Preparation of contracts and requests for bids; purchase and issue of supplies; monthly inventory and other reports; checking of prescription and issue records; storage of supplies; care of rubber goods and special surgical equipment; care of poisons and antidotes; pay requisitions for extras and special preparations; purchase of alcohol in bond.

## WARDS AND CORRIDORS.

Special supervision; practical teaching of supervisors in the training of nurses; general care of patients; care of equipment; requisitions and recording of supplies; relations to resident and attending medical staffs; relation to superintendent, superintendent of nurses and other officers; attitude towards visitors.

## OUT-PATIENT DEPARTMENT.

Planning, equipment and organization; special relations to in-patient department; clinical records and statistics; dental and other special clinics; school and visiting nurse work; relation to social service department.

## RESIDENT STAFF.

Duties of resident physician, of house surgeon, of house physician internes; admitting of patients; treatment of accident and emergency cases; arranging of appointments; classification of patients; handling of attending staff patients; calling of coroner, police, priests and county attorneys; consent of relatives for autopsy; handling of chronic and convalescent cases; isolation of infectious cases and care of dying; care of instruments, splints and apparatus.

## MECHANICAL DEPARTMENT.

Duties of engineer, electrician, master mechanic and assistants; daily inspection of machinery, motors, etc.; heating; lighting; ventilation; refrigeration; purchase of coal and other supplies; water system; sewerage system.

# Society Proceedings

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## AMERICAN MEDICAL ASSOCIATION

### Hospital Section

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(Continued from our November Issue.)

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DR. THOS. HOWELL, Superintendent of the New York Hospital, New York, forwarded a paper on "Factors Influencing Hospital Costs."

The essayist was asked why it was in spite of standardization and uniformity in prices, per capita costs varied so much. What was per capita cost? And what did it exclude? In most instances it did not include interest on investment, as is the case in factories.

In the cheaply run city hospitals the per capita is low—sometimes not over \$1 per diem. In the restricted class of wealthy hospitals, where no expense was spared and the best of everything provided, the cost ran up often to \$3 per day.

The factors influencing per capita cost were: location of the hospital, amount of scientific work done, number of employees and salaries paid, medical school connection, proportion of private-room patients to ward patients, service rendered, including food and attendance.

Per capita cost is higher in large cities than in smaller; in the North than in the South.

The chief factor in the variation of per capita cost was the pay roll. It varies from 28 cents per day to \$1.50. In municipal hospitals it is low, city officials often acting as treasurer, auditor, purchasing agent, etc. But hospitals with a cost of \$1.20 per day for salaries gives a better service than one with a cost of fifty cents. The structure of the hospital affects this item considerably. Hospitals with chronic cases—boarding-houses largely—have a low per capita. Hospitals doing high-class scientific investigation, necessitating paid skilled workers and expensive laboratory equipment, have a high rate, as is the case with teaching hospitals. Also, too, where many private patients are catered to the rate is high. Each hospital has its

own peculiar characters, and an attempt to standardize hospital costs was useless.

Dr. Cleveland Shutt said Governmental differences accounted for the difference between per capita costs in Europe and America: there, influences were permanent; here, fluctuating.

Dr. E. E. Southard, Superintendent of the Psychopathic Hospital, Boston, read a paper on "The Psychopathic Hospital Idea." The essayist said he wished to urge that superintendents of general hospitals look to it either to give their insane patients proper accommodations or to spend time and energy getting their local communities to establish psychopathic hospitals. Excited and delirious patients were not getting proper treatment in general hospitals. The methods employed in hospitals for insane could be introduced—hydrotherapy, special attendance, isolating rooms, and common sense. Until special hospitals for diplomaniacs are created, it would remain the task of general hospitals to take charge of the acute alcoholics of the community.

Seeing that from twenty-five to thirty per cent. of patients admitted during certain months to the Boston Psychopathic Hospital were syphilitics, it was high time that social workers, economists and physicians began to take an interest in that field of mental hygiene which shall seek co-operation with the sex hygiene propagandists.

Social service for psychopaths was as yet scarcely existent in any systematic and well-rounded form. It would soon, however be undertaken.

Whose fault was the present reign of ignorance as to the proper treatment of the acutely insane? Neither the neurologist nor the internist could scarcely be absolved.

The psychopathic hospital was bound to be one of the most concrete sources of enlightenment as to psychopaths, and every society for mental hygiene, for sex hygiene, for the amelioration of alcoholism, for eugenics, should make it part of its business to help start a psychopathic hospital with an out-patient service in every community in which there was any hope of awakening social sense.

Dr. J. A. Hornsby inquired how Dr. Southard would deal with a violent case of surgical delirium.

Dr. Southard, replying, recommended the warm bath or the warm pack, or both. He inquired about how many of such cases Dr. Hornsby had observed.

DR. HORNSBY: Some three a week in a 350-bed hospital.

DR. SOUTHARD: In such an institution I would recommend putting in hydrotherapy. It would not cost a great deal.

DR. HORNSBY: The outlay would not be considered; the cost would be to the patient himself, the danger in transportation to the Hydrotherapy Department and to the other patients.

DR. A. B. AUCKER: The question is not so much one of noise and disturbance to other patients as it is in the danger to the patient himself. It is necessary in many cases to immobilize the injured part, so some restraint or drug seems absolutely necessary. In thirty years I have seen two or three hundred such cases. In certain cases the hydrotherapy cannot be used, nor can the requisite number of attendants be supplied.

Dr. Southard admitted that a pack was somewhat of a restraint; there was, however, no psychologic objection to restraining an unconscious person. In 800 necropsies done in the Boston City Hospital eight per cent. were mental cases—chiefly delirium tremens. He was convinced that many of these delirium cases need not have died had the proper treatment been employed.

Dr. C. H. Shutt believed drugs and restraint were necessary in cases where hydrotherapy proved unavailable—those with abdominal wounds, for instance.

Dr. H. B. Howard considered there was more or less ill-advised restraint—often administered by inexperienced house officers when called to cases in the night. Light and society should be tried before restraint was attempted.

Dr. Southard wished that the State Board would secure a record of these cases from general hospitals.

Dr. Howard said had the State Boards the authority no doubt they would obtain such information.

Dr. Herbert J. Hall read a paper on "Hospital and Asylum Workshops." In opening, he alluded to the work which is being

done for cripples, the blind and the insane in various institutions. His experience had been with nervously exhausted patients, and he had found that among persons of education and taste the ancient handicrafts had appealed to them—work which often could only be done with high efficiency by hand: hand weaving, metal working, leather working, pottery, basket weaving and cement working. Their work had a ready market value. Five handicapped persons last year had made and sold \$5,000 worth of pottery. Last summer a small group of men at the State Farm at Gardner, Mass., produced \$40,000 worth of supplies. Dr. Philip K. Brown, on the Pacific Coast, has established a pottery where convalescent tuberculous girls are paying their own expenses.

A central bureau should be established to conduct extensive experiments. The whole field should be studied and practical shops established where needed. They might be associated with the out-patient departments of general hospitals.

Dr. Gilman Thompson presented a striking paper on "Efficiency in Nursing." In one experiment he had the nurses wear pedometers. One nurse walked  $7\frac{1}{2}$  miles in one day, others made an average of  $5\frac{1}{2}$  miles. One nurse had to walk two miles per day to serve meals, carrying one tray at a time to 26 patients in a ward where the most distant bed was 120 feet from the ward kitchen. The loaded tray weighed fifteen pounds. A truck was procured which held eight trays. Eight patients were served in two minutes. In the old way ten were consumed. The distance travelled was 70 feet, as compared with 240 feet. Upon the introduction of the truck the ward maid exclaimed: "Bless the man that invinted thim thrucks—sure the corns is all gone off me hands since."

Dr. Richard Oldring Beard read a paper on "The Trained Nurse of the Future."

Dr. Beard winds up a very interesting and thoughtful paper by saying:

"Like that of medicine, nursing is no longer a privileged profession. It is a profession of privilege, but it is the

privilege of service. It cannot expect to enjoy the honors and the rewards which always attach to social service unless it accepts the fundamental principle of social serving. Freely it has received; it must freely give. It cannot achieve the solidarity of the social group save on the basis of social service. It cannot continue to command the protection of the police power of the state in safeguarding its own interests unless these interests are at one with the larger interests of the people it serves.

“In common with the profession of medicine, it must take its proper place in the ranks of those social agencies which do not produce, but conserve. It must determine, with the aid of the profession of medicine, whose handmaid and co-worker it is, its own educational fitness for the conservation of the most valuable of human assets, that of human health.”

# Hospital Intelligence

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## Committee on Grading of Nurses

The first meeting of the committee on grading of nurses appointed at the Boston convention was held in Hotel Statler, Buffalo, Jan. 13th and 14th. The members present were Drs. Howell, Mann and Ross, Misses Aikens, Anderson and Barrett. Dr. Renwick Ross presided over the sessions of the committee.

After considering the important question in its various phases, the committee decided to submit the following list of questions bearing on the subject of grading and classification of all who nurse for hire, to the members of the association and others interested, in order to secure an expression of opinion from all parts of the countries represented in the association. Replies are to be sent to Dr. Renwick Ross, Buffalo General Hospital, Buffalo, before April 15th. The committee is making an earnest effort to improve conditions relating to the care of the sick, and this classification is simply a means to that end, Anyone is at liberty to send a reply to the questions, whether a member of the association or not.

1. In your opinion is it possible to meet the nursing needs of the average community in city, town and country, in the United States and Canada, with graduate nurse service alone?

2. If in your opinion only graduate service should be used, will you kindly present an outline of a practical comprehensive programme for supplying graduate service to all classes needing continuous nursing?

3. If more than one grade of nurse is a necessity, will you please state how many grades you consider necessary? How would you classify nurses so as to include in your classification all who nurse for hire?

4. Will you kindly suggest a substitute term for the grade B or "certified nurse," as recommended by the committee on grading of last year, if you consider that some better terms should be used to designate nurses trained in special hospitals or hospitals unable to give a full training. Please state whether or not you are satisfied with the distinctive terms recommended by the committee of last year. Give briefly your reasons if not satisfied.



5. If several grades seem to be necessary, how and where should the several grades be trained?
6. In view of the fact that many tuberculosis hospitals find it impossible to secure sufficient graduate nurses to care for their patients, what measures would you suggest for meeting the nursing needs in such institutions?
7. If training is given in a tuberculosis hospital, how long should the course be and how would you classify those completing such a course?
8. In view of the fact that there is a constant and pressing demand for maternity nurses in homes of moderate means, what measures that are practicable for the average community would you suggest for meeting this need. How classify such nurses?
9. What constructive recommendations would you make with a view to improving on the plans presented by the committee on the grading of nurses in the report submitted to the Association at the Boston convention, a copy of which was mailed to each member.
10. Will you kindly suggest to the committee of this year any feasible plans which occur to you for improving the quality of home nursing now being received by those who cannot afford graduate nurses?

THOMAS HOWELL, M.D.

WILLIAM O. MANN, M.D.

CHARLOTTE A. AIKENS.

IDA M. BARRETT.

EMMA A. ANDERSON.

R. W. BRUCE SMITH.

RENWICK R. ROSS.

Buffalo General Hospital, Buffalo, N.Y.

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### American Hospital Association Meeting, 1914

Dr. Cleveland H. Shutt, Commissioner, City Hospital Department, St. Louis, Mo., will prepare the paper on "Efficiency and Progress" instead of Mr. John Wells, who has resigned the superintendency of the Latter Day Saints Hospital at Salt Lake City.

**CANADIAN**

Hamilton is to have a new city hospital.

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A hospital to cost \$60,000 is planned for Glace Bay, N.S.

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Quebec city is to have a new \$75,000 isolation hospital.

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A new fifty-bed hospital is to be erected at Walkerville, Ont.

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A hospital will be built near St. Catharines for the benefit of the men who are building the new Welland canal.

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A portion of the Nurses' Home of the old Toronto General Hospital is being used as a measles hospital.

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An addition to the hospital for insane at Selkirk is being made by the Manitoba Government, to cost \$65,000.

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A \$42,000 addition is being made to the General Hospital at Regina, Sask.

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A \$35,000 addition is being made to the Children's Memorial Hospital, Montreal.

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Hotel Dieu Hospital, Windsor, Ont., is building a \$25,000 addition.

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The by-law providing that the Vernon Jubilee Hospital should be taken over by the city of Vernon, B.C., was defeated.

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A hospital will be established at Chapleau, Ont., to be known as Chapleau Cottage Hospital.

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A new isolation hospital has been opened at St. Thomas, Ont.

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A sanatorium for consumptives will be established near Mitford, Alta., to be called the Queen Mary Sanatorium.

A tuberculosis hospital is planned for Merritt, N.B.

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Hamilton is building a \$200,000 hospital on the mountain.

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The new Children's Hospital, Hamilton, is about ready for occupancy.

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The private ward building of the new Toronto General was opened early in January.

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The new wing of the Nicholls Hospital, Peterboro, was opened New Year's Day.

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A red brick house in Brantford has been selected for a small-pox hospital, costing \$5,000.

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Dr. W. E. George has been inspecting the suburbs of Cochrane with a view to recommending a hospital site.

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A new \$40,000 addition has been built for St. Joseph's Hospital, Chatham, Ont. It was opened by Bishop Fallon.

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Galt Y. M. C. A. boys sold stamps at Christmas time for the Waterloo County Tuberculosis Hospital.

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Hamilton will be asked to vote on a by-law to provide \$100,000 for the tuberculosis hospital there.

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The Toronto by-laws to provide \$250,000 each for the Riverdale hospital and the Howard Park hospital were both defeated.

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The Sick Children's Hospital, Toronto, secured \$8,927, the cost of treating 25,507 patients during the year ending Sept. 30th, last.

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Canvas chutes have been installed in the Sisters of Providence Hospital at Haileybury. An excellent idea. All hospitals should have some such provision.

Miss G. M. Bennett, for eight years past superintendent of the General Hospital, Brockville, has resigned.

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The city hospital of Rosetown, Sask., was opened in December. It stands on five acres, is municipally owned, and un-denominational in character. Surrounding municipalities are subscribing.

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After a year's experience as Inspector of Private Hospitals and Maternity Homes, Dr. Helen MacMurchy, who has been connected with the Hospitals and Asylums Branch of the Provincial Secretary's Department, reports that the new legislation is working exceptionally well. While there is still a great deal of difficulty in different parts of the Province, largely due to ignorance of the provisions of the Act, it is pointed out that private hospitals, especially in the newer parts of the Province, are doing a great amount of good.

The result in this direction has been, says Dr. MacMurchy, to stimulate a local agitation for more of these institutions where the local organization has not developed sufficiently to warrant a municipal institution.

In the maternity branch of the work a decided improvement has been noticed since these institutions were made amenable to Government inspection, although in a number of places in outlying parts unclean and insanitary methods were detected.

An appeal has been made to the department through the inspector to have medical cabinets distributed through Northern Ontario, stationed at central points with responsible parties. This idea emanates from the Women's Institutes, by whom it is claimed that accidents often happen in parts far removed from the services of a physician, or even where the doctor resides near at hand, his circuit is so wide that he is likely to be distant fifty or a hundred miles when an accident call comes in. The suggestion for a medical cabinet embodies more than the first aid outfit, for in addition to lint and bandages it would also include anaesthetics, morphia, drugs and other chemicals that would enable medical ministrations to be conducted for some days by anyone following proper directions.

A new \$300,000 tuberculosis hospital is being erected near St. John, N.B.

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The opening of the new joint Municipal Hospital at Davidson, N.W.T., took place on February 11th.

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### **St. Frances Hospital**

A new hospital is to be built at Fort Frances, Ont.

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### **Another Hospital**

A new hospital is to be erected at Nakusp, B.C., costing \$12,000.

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### **Vancouver Hospital**

A new nurses' home and a service wing will be added to the Vancouver General Hospital.

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### **Edmonton Hospital Opened**

The new South Side Hospital on the University grounds at Edmonton was opened in January. It accommodates eighty patients, and will be a purely civic hospital.

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### **Hamilton, Ontario, Hospital**

A by-law to raise \$200,000 for hospital buildings was carried January last. Chairman Hospital Board, T. H. Pratt. Architects, Stewart & Witton, H. P. & L. Building. Adv. Architects, Stevens & Lee, 2 College Street, Toronto.

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### **St. Michael's Busy**

St. Michael's Hospital, Toronto, will be enlarged during the coming summer at a cost of \$150,000. This is to include a nurses' home. His Grace Archbishop McNeil is, it is understood, having the plans prepared and when approved of the work will be started at once. The archbishop intends to give Toronto citizens one of the best equipped hospitals in the country.

**Strathroy Hospital**

A new hospital was opened in Strathroy early in February.

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**Strathcona Hospital, Edmonton**

The Strathcona Hospital at Edmonton, Alta., was opened in January. It takes its name from the late Lord Strathcona, who made a gift of \$25,000 to the institution. The total cost of the hospital is \$321,636, and it will accommodate ninety patients. Miss Baird will be in charge.

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**Goderich New Hospital**

The Alexandra Marine and General Hospital will ask the town to submit a by-law to grant \$15,000 for the building and equipment of a new hospital. A fine building on what is known as the Cameron estate has recently been purchased, and, providing the town gives this money, this building will be fitted up as a modern hospital.

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**St. John, N.B.**

Plans for a new public hospital in St. John, which it is said will involve an expenditure of between \$200,000 and \$250,000, were discussed at a conference held in January between a committee of the county council and members of the Board of General Public Hospital Commissioners. The proposed building will have accommodation for 140 patients, and will be complete in every way. It will be provided with a new operating room, with X-ray facilities, and every department will be equipped with all the improvements that advanced science calls for. In connection with the new building there will be a power house, which will be used to light and heat the old building as well as the new.

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**UNITED STATES**

A hospital is recommended for the almshouse, Canton, N.Y.

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A tuberculosis sanatorium is advocated for "Little Warren," near Saratoga, N.Y.

The new hospital in connection with the Gratwick Cancer Laboratory, Buffalo, has been opened.

Canvass is being made to raise \$150,000 for a new hospital at Washington Heights, New York City.

Over 600 persons have subscribed \$31,000 towards the construction of a new hospital at Carlisle, Pa.

A new dispensary of the Hospital for Deformities and Joint Diseases, New York City, is being built.

Jefferson Medical College Hospital, Philadelphia, has opened a new department for diseases of the chest.

The four-story Elizabeth Steel Magee Hospital, Pittsburg, is being erected at Pittsburg, to cost \$600,000.

The Franciscan Sisters of Poughkeepsie, N.Y., are buying sixteen extra acres to enlarge their accommodation.

The new St. Luke's Hospital, Jacksonville, Fla., will not be opened until a plan is completed for financing the institution.

The Missouri and Illinois Baptist societies project a hospital in St. Louis to be known as the Mayfield Memorial Hospital.

New \$60,000 pavilions of the Bowne Memorial Hospital, Poughkeepsie, N.Y., have been opened for the care of consumptives.

Nathan Barnert, formerly mayor of Paterson, N.J., announces his intention of erecting a hospital, to cost \$200,000, for the free care of the sick poor.

One of the pastors in Jersey City writes to the *Journal* complaining of dust on the walls of the wards, and of the refusal to allow a friend of a dying patient to use the hospital phone to reach the relatives.

Efforts are being made to raise \$15,000 for the support of St. Luke's Hospital, Newburgh, N.Y.

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The King's Daughters of Ithaca have undertaken to furnish one of the rooms in the City Hospital.

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The National Emergency Hospital, Chicago, was ordered to be closed by the Health Department. There are others.

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The silver anniversary of the Amsterdam City Hospital was celebrated in November. The principal feature of the occasion was the nurses' graduation exercises.

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Three new buildings have been added to the Rochester General Hospital—the gifts of George Eastman. They consist of an administration building, a private patients' building and a public ward building. Two hundred and fifty patients can now be accommodated.

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The two million Lima State Hospital (Ohio), built for the criminal insane, is said to be much too large and unsuited for the purpose. Experts after examining it, recommend that with some changes it may be used as originally intended. Demented and infirm patients and non-resident insane will be admitted.

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The food at the new Sea View Sanitarium, Staten Island, N.Y., is handled as follows:—

Trolley trucks will be run from the kitchen to the ward pavilions and will also pass between the laboratory, laundry and other buildings, all driven electrically by the aid of an ingenious system of switches. When a nurse on any floor of any of the ward pavilions sends an order to the chef for a special diet for a patient she will wait at the door of an elevator connecting with the subway to the kitchen.

The chef has only to place the food in the elevator, close the door, press a numbered button on a board alongside, and then go back to his other duties. The big chimney and No. 2 buckwheat coal and the subway system will attend to the delivery.



The House of Saint Giles, Brooklyn, for Crippled Children completed at \$100,000.

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Charity Hospital, Cleveland, held a six-day campaign to raise \$250,000 in December.

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A new 25-bed hospital was opened at Powell River, B.C. It was erected by Andrew Henderson.

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The New Britain Hospital (Conn.) received many donations on Thanksgiving Day last—mostly edibles.

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The Washington Heights Hospital of New York city is planning to raise \$150,000 for a new building.

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A county tuberculosis hospital is to be built in Chenango county, N.Y., at Sherburn Falls. Cost, \$100,000.

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A new hospital is proposed for Elizabeth City, N.C. Dr. John Salba is the moving spirit. The capital stock will be \$30,000.

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The Children's Hospital, Los Angeles, had a linen shower on Thanksgiving Day. The new hospital building was moved into at Christmas.

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The new \$1,000,000 City Hospital, Louisville, will open early in the year 1914. The working staff consists of 188, at salaries aggregating \$52,800 per year.

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Five hundred business men, physicians, clergymen, lawyers, actors and artists took part in a \$90,000 whirlwind campaign for the New Rochelle Hospital.

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The Millville, Pa., Hospital managers have announced that more than \$20,000 is now in hand, in addition to the \$10,000 subscribed by Henry A. Dix, a wealthy wrapper manufacturer, and that the proposed structure will be erected in the early spring.

The Insanity Board, reorganized by Governor Foss, is discussing a State-wide probe of asylums. There are thirteen institutions and 13,000 patients. Inquiry at Boston Psychopathic Hospital began early last December. Stories of injuries to patients have not been explained. Too much science is said to exist. Petition is made for opening of the probe at the Westboro Asylum.

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Owing to the overcrowded condition of Vassar Brothers Hospital, and the smaller private hospitals in Poughkeepsie, New York, the physicians and citizens have united in a determination to secure another public hospital which will be managed by the Franciscan Sisters.

The beautiful property has been acquired at Hill Crest, overlooking the Hudson, and preparations for a ten-day campaign to raise \$75,000 or more are now being made, under the direction of Mr. A. F. Hoffsommer of Harrisburg, Pa.

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New York League for Animals is erecting a \$50,000 animal hospital at the corner of Bond and Lafayette streets, New York.—Long Island College Hospital is erecting a \$35,000 addition to its present building.—Rockford, Ill., is erecting a new Swedish-American hospital. Fifty rooms will be available at the start.—Asheville, N.C., is working to raise \$100,000 or more to rebuild the present hospital on the lines of a modern, well-equipped, and fireproof structure.—The decision handed down by a Supreme Court Judge in Rochester, Ill., declares that "A hospital for the treatment of disease, or where surgical operations are performed is not desirable in a residential section, and must necessarily depreciate the value of the property."—Seattle, Washington, is enlarging its tuberculosis sanitarium by erecting an administration building, and one hospital building, at a total cost of \$125,000.—Cambridge, Mass., has purchased a large private estate as a site for a new municipal hospital.—Detroit city fathers are still debating the question of hospital accommodation for the city's sick poor, whether to build a municipal hospital or to give grants to provide further provision in existing hospitals.

Dr. Rupert Norton stirred up the Board of the Cook County Hospital, Chicago, by his charge that the institution was a disgrace. President McCormick asserts that the treatment is being improved daily, gives good service, and is sought by ambitious internes.

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Saturday, November 29th, was Donation Day for the Eastern, L.I., Hospital—vegetables, fruits, groceries, meats, old linen, jellies, etc., etc., poured in. Pastors of all churches on Eastern Long Island were requested to give notice of the affair on the Sunday preceding.

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The House of St. Giles the Cripple, practically the only exclusive orthopedic institution in Brooklyn conducted a short term campaign to raise \$100,000 for a new building, the campaign closing early in December. Despite the difficulties of securing funds for a small institution in a large city, when the campaign closed nearly 3,500 subscriptions had been secured, aggregating \$105,332. Subscriptions secured immediately following the close of the campaign bring this total to nearly \$110,000. The campaign was directed by Mr. A. F. Hoffommer, of Harrisburg, Pa., Dr. Burr Burton Moshier, who is surgeon-in-chief, being chairman of the local campaign committee.

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### Hospital Story

The New Rochelle Hospital, N.Y., closed a twelve-day campaign for \$90,000 on December 17th. There were nearly 6,000 subscribers, and the sum aimed for was over subscribed, the total amount being \$98,275.

There were three neighboring communities that participated in the use of the hospital, from which probably over \$10,000 was contributed. Altogether thirty-five teams of men were organized and thirty-two teams of women. The men met at 6.30 each evening and the women at 1 p.m.; dinner was served in each case, each team of ten having a table of its own.

This fund will provide for the floating debt of \$21,000, and it is proposed to erect a nurses' home and administration building costing about \$40,000; also provide x-ray machine, a new

elevator, improve laundry and install a new heating plant. It is possible that something may be set aside as the beginning of an endowment fund.

Dr. H. J. Parker is president of the hospital. The campaign leaders were W. A. Bowen, of Waterville, Maine, and his associate, Mr. T. W. Davies, of Brooklyn. Mr. Bowen will begin his fourteenth hospital short term campaign at Newark, New Jersey, January 2, for St. Michael's Hospital. Each campaign requires about five weeks for preparatory work and two weeks for the campaign proper, making the period of service and activity about seven to eight weeks.

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### **Hospital for Criminal Insane at Waupun, Wis.**

The new \$200,000 hospital for the criminal insane at Waupun, Wis., which has been in process of construction for the past year, will be ready for occupancy shortly.

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### **Bank Loans Hospital Money**

A county hospital is being erected in Springfield, Mass. Architect Gardner of that town is planning it. It will accommodate 40 patients. The First National Bank offer to loan the commissioners \$50,000 at 4½ per cent. for construction purposes.

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### **Brooklyn Boasts**

During the last four years Brooklyn has expended \$2,484,011 in hospital buildings: Kings County Hospital, \$1,128,178; Coney Island Hospital, \$355,391; Cumberland Street Hospital, \$45,000; Greenpoint Hospital, \$805,442; Bradford Street Hospital, \$150,000.

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### **The City of Brotherly Love**

The *Philadelphia Record* says editorially: It is not uncommon for the physicians in charge of hospitals to refuse admittance to patients who are brought to them in such a condition that survival is unlikely. But shall such persons be left on the sidewalk to die? Shall they be denied all the resources of a hospital for rescuing them from death by an accident? Humanity should be found everywhere, even in a hospital.

### **Manned by Women**

The South London Hospital for Women is being erected in Jersey City, to cost a quarter of a million. It will be manned entirely by women for women.

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### **New \$50,000 Hospital**

A new hospital building is to be erected in Los Angeles for the French Hospital Association. The building committee contemplates a building of reinforced concrete construction to cost about \$50,000.

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### **Hospitals in 27 Counties**

Twenty-seven counties in New York State are either provided with local hospitals within their boundaries or have voted to establish county institutions. There are 19 such local hospitals in actual operation in 15 counties, while 12 additional counties have voted to provide them. The tuberculosis death-rate is decreasing in this state.

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### **Hope Behind**

The *Evening Star*, of Newark, N.J., refers to the Hudson County Hospital thus:

“A new hospital has been talked of for several years, but nothing has been done, and the Board of Freeholders has continued to maintain this shameful plague house, over the portals of which might be written: ‘All ye who enter in leave hope behind.’”

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### **Catholic Hospital**

A new hospital, the St. Francis, is being erected in Charleston, W. Va. The incorporators, their associates and successors, and officers and directors, are to receive no compensation for their services, except a livelihood, and no dividends or division of income shall be made among the members; all income is to be expended on upkeep and improvement of the hospital and furthering the purpose for which it is established.

### Orphan's Hospital

A hospital is being erected at the Montana State Orphans' Home at Twin Bridges, Montana.

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### SOUTH AFRICA

Mr. Polhemus Lyons, chairman of the Cape Hospital Board, Progress Lane, Cape Town, writes to one of our editorial contributors as follows:—

“ We have here seven institutions under one board under a new ordinance which came into effect at the beginning of the year. The Government demands of us a budget at the beginning of the year against which we work our expenses when they have approved of the same, and guarantee to us payment of the deficit when they are satisfied that we have used all reasonable means to collect from the generous public subscriptions, donations, etc.

The Government further give us thirty shillings subsidy for every pound we collect, that is to say \$7.20 for every \$4.80 we collect, which includes all the grants from municipal councils in our district, said grants amounting this year to over \$15,000,000, and the Government gives us pound for pound on all we collect from patient's fees, and on all bequests up to a limit of £500. In this way we are hoping to come through this year without a deficit, but should there be a deficit the municipalities within our hospital district have to bear half the burden while the Government bears the other half, the subsidy in respect to municipal grants could only be valid for such municipal payment prior to October 1st of any year.

“ We obtained \$4,500.00 from a Saturday street collection last week, which is not very bad for a little town at the world's jumping off place.

“ We have an expense account of about \$175,000.00 a year for these institutions, which another year will run into considerably more, as we are adding to our engagements. Just now we are considering a Maternity Home and whether we shall take over the Municipal Infectious Diseases Hospital, both of which are sure to come under our care in the near future.”

## Selected Articles

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### SOME ABNORMALITIES IN BREAST MILK AND THEIR TREATMENT

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BY HUGH H. RIDDLE, M.D., CANTAB.

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A CONSTANT low fat percentage or a decrease in amount in the nursing mother's milk has generally been considered an unanswerable argument in favor of substituting artificial feeding for Nature's own method, *i.e.*, breast feeding.

However convinced the physician may be of the infinite superiority of breast feeding over bottle feeding as a general rule, a sudden cutting off of the supply or a failure of the infant to make a proper weekly gain in weight in practice usually forces him to the conclusion that, under the special circumstances, a change to bottle feeds (to which the requisite amount of additional cream can be readily added) is not only justifiable but absolutely imperative.

Where a gradual decrease in the supply of mother's milk takes place such measures as increasing the fluids in her diet, ordering more rest, etc., sometimes are efficient. Where there is complete cessation of the flow, however, something more radical is needed to stimulate the glandular structures into taking up again their interrupted functional activities.

Where the milk is normal in amount but deficient in fats there are two classic alternatives to resorting to bottle feeding: (1) increasing the nitrogenous elements in the mother's diet while cutting down her exercise, and (2) giving spoonfuls of cow's cream to the infant after or immediately previous to each breast feed.

In actual practice both these alternatives frequently fail to produce the desired effect. The commonest result of the "stuffing" treatment of the mother is a digestive upset, which is frequently the end of all attempts at nursing her baby, while the spoon feeds with cream often lead to undue sickness in the infant, with the appearance of curds and numerous small fat particles in the stools.

Tables I. and II. below give the results of a series of experiments carried out in the past six months at the Queen Char-

lotte's Hospital with a preparation known as Lactagol, which is claimed to act as a direct galactagogue, increasing both the amount of milk and the fat ratio.

To Dr. Arthur Stabb, physician to Queen Charlotte's, I am indebted for the facilities allowed me for observing in the wards a number of his own patients under lactagol and for recourse to his case notes. In the series of observations on out-patients I have to thank Dr. J. B. Banister for his invaluable assistance in carrying out the analyses in the Queen Charlotte's laboratory.

Lactagol is a dry extract of cotton seed containing the active constituents of the seed in a concentrated form. For increasing the amount of milk secreted or raising to the normal a deficient fat ratio it was given in teaspoonful doses in milk three times a day.

The subjects of the first experiment (Table I.) were taken in sequence from the in-patients at Queen Charlotte's, the only common characteristic being a low fat ratio. The analyses were made in the Queen Charlotte's Pathological Laboratories:

TABLE I.

Case No.	Date of 1st Analysis.	Fat p.c.	Time on Lactagol.	Fat p.c. at 2nd Analy.	Fat Increase.
1	4th day	1.8	7 days	2.8	1.0
2	4th "	1.6	7 "	3.0	1.4
3	5th "	1.8	7 "	2.8	1.0
4	5th "	2.4	7 "	3.4	1.0
5	5th "	2.6	7 "	3.6	1.0
6	5th "	2.0	7 "	3.8	1.8
7	5th "	2.2	10 "	2.6	.4
8	5th "	2.2	5 "	3.0	.8
9	5th "	1.9	7 "	3.4	1.5
10	5th "	2.2	7 "	3.0	.8
11	5th "	2.8	7 "	3.6	.8

Carter and Richardson in 94 samples of breast milk examined found an average of 3.07 per cent. of fat in the early months of lactation. The average for these 11 cases after the lactagol is 3.18 per cent.

The second table shows the results when the lactagol was given not at the beginning of the lactation, but at anything



from two to four weeks after the birth of the infant. The mothers here, after samples of their milk were taken for preliminary analysis, were given supplies of lactagol to take at their homes. After the week's supply had been used up they returned to the hospital for the second analysis of the milk:—

TABLE II.

Case No.	Date of 1st Analysis.	Fat p.c.	Time on Lactagol.	Fat p.c. at 2nd Analy.	Fat Increase.
12	21st day	2.8	7 days	2.8	—
13	24th “	3.2	7 “	3.4	.2
14	19th “	2.4	7 “	3.6	1.2
15	28th “	3.6	7 “	3.6	—
16	15th “	2.8	7 “	3.8	1.0
17	18th “	3.6	7 “	4.0	.4
18	10th “	3.0	7 “	3.8	.8
19	14th “	3.2	7 “	3.0	.2
20	14th “	1.8	7 “	3.2	1.4
21	13th “	2.0	7 “	3.6	1.6
22	12th “	2.2	7 “	3.8	1.6

In those cases, such as numbers 13 and 15, in which the fat percentage was about normal (3.2 and 3.6, respectively) at the start of the taking of the lactagol the increase was slight or none at all. On the other hand, those mothers whose milk showed a serious deficiency in fat (as, for example, Nos. 20, 21 and 22) showed a marked rise in the fat ratio after the week's taking. The average fat percentage of the milk of these 11 cases (which were not selected, but were the whole number who could be induced conscientiously to carry out the treatment and to report themselves for analysis) was, at the finish of the week's course of lactagol, something over 3.5, against Carter and Richardson's average of 3.07. In addition to the above series of trials on the twenty-two cases taken in sequence, lactagol was also given in a number of special cases both in private practice and at Queen Charlotte's, in which the milk was either deficient in quantity or patently poor in quality as shown both by analyses and by the failure of the infant properly to gain weight.

Case 1 (private), Mrs. E. S., primipara, æt. 22, twin girls, premature ( $7\frac{1}{2}$  months). Milk secretion began on fourth day. Normal in amount on sixth. On seventh began to lessen. On ninth was unable to get even a half-ounce of milk with breast-pump for analysis. Babies put on bottles plus breast feeds every two hours. On tenth day one ounce milk obtained by breast-pump. Analysis showed 1.4 per cent. of fat. Mother put on lactagol same evening. By next evening (11th day) after four doses of lactagol breasts full and milk oozing. Each infant satisfied with two hour breast feeds from then on till time of writing (6th week). Second analysis on nineteenth day, after ten days of lactagol, showed fat percentage of 3.6.

Case 2 (private), primipara, æt. 26, premature infant, eighth month, mother an alcoholic, wife of an inn-keeper. Milk normal in quality and amount until twenty-first day, when it suddenly ceased. Cessation of milk roughly coincided with the mother's return to her duties behind the bar. Infant immediately put on bottle. As the infant failed to thrive on artificial feeding, the mother on the fourth day after cessation of her milk was put on lactagol. After the third dose the milk reappeared, and, on the third day of taking, the bottles were given up entirely. The infant was breast fed exclusively from then on until the eighth month. The lactagol was taken for periods of two or three weeks with fortnight intermissions from the second to the seventh month.

Case III. (Queen Charlotte's), I.C., æt. 25, primipara. This case instances well the rapid action of lactagol in cases where from the start the milk has been deficient in quantity. The infant had a harelip, utterly preventing suckling. From the start the milk has been drawn off with a breast-pump.

On the fourth day attempts were made by the nurse at two-hour intervals to draw off milk, but not more than three or four drachms could be obtained. On the fifth day, the flow not improving, the patient was placed on lactagol. On the sixth day and from then on until discharge the nurse had no difficulty in drawing off from an ounce and a half to two ounces at each feeding time. A special feature of interest here was that the drying up of the milk, which not infrequently follows when the breast-pump must be continuously used instead of natural suckling, apparently had no effect in curtailing the flow.

Case IV. (Queen Charlotte's), E.F., æt. 36, twins. This woman, a healthy multipara, had had ten children previously. The first six she had had no difficulty in nursing to full nine months. The next four had been each nursed for three weeks or a month, after which bottle feeding had to be resorted to. The twins weighed, respectively, 5 lbs. 12½ ozs. and 6 lbs. 3 ozs. at birth. After the normal loss in weight occurring in the first three days the small quantity of milk observable in the breasts on the fourth day and fifth day suggested the advisability of giving lactagol. The patient was ordered a teaspoonful three times a day. On the seventh day both infants had regained their birth weight, and from thence on kept up a steady gain.

Instead of following the ordinary procedure of alternating breast feeding with bottle feeding, the mother, for the three weeks she was in the hospital, was able to give each infant the breast every two hours without any apparent strain on her own system, and with most beneficial results to the two infants.

Case A. G., æt. 31, primipara. Cesarean section. Here the lactagol was given as a precaution against any scarcity of milk which might result from the shock of the abnormal method of birth, and because of the relatively greater value of what will probably prove to be the mother's only child. An abnormal loss of weight occurring the first three days (8 ozs.) also suggested the use of the lactagol. A mixture of one part cream to three parts water and two or three bottles a day were also given in addition to the breast feeding. The lactagol was begun on the fourth day.

Day.	Weight.		Day.	Weight.	
	lbs.	ozs.		lbs.	ozs.
1.....	7	4	8.....	7	4
2.....	7	1	9.....	7	6
3.....	6	12	10.....	7	7
4.....	6	13	11.....	7	9
5.....	6	15	12.....	7	11
6.....	7	0	13.....	7	12
7.....	7	2	14.....	7	13

On the mother's discharge on the twenty-third day the infant weighed 8 lbs. 10 ozs.

Ethel Pigeon, æt. 34, fourth child. The mother had not been able to nurse any of her previous children on account of lack of milk. After the birth of the present baby there were no signs whatever of milk on the fifth day. Lactagol was given in teaspoonful doses in milk and within twenty-four hours the secretion began, the mother nursing the baby comfortably at the time of discharge from hospital. On examination the breasts were well-rounded and firm, large but not fat, with well-formed nipples, in short the typical healthy breast of the normal nursing mother.—*Medical Press.*

## NATIONAL SANITARIUM ASSOCIATION

### *New College Street Building:*

Contracts are being let for the erection of this building on the corner of College and Ross Streets, Toronto, as the personal gift of Mr. W. J. Gage, founder of the National Sanitarium Association. The gift, which was made last year to the King



NEW COLLEGE STREET BUILDING, NATIONAL SANITARIUM ASSOCIATION.

Edward Memorial Fund, was \$110,000.00. (A recent announcement intimated that Mr. Gage has since made a further gift of \$100,000.00.)

The purpose of last year's gift, as above, was thus expressed: "\$100,000 to be applied in the erection of a Dispensary and Institute Building in Toronto. \$10,000 to be set apart for a scholarship fund for early diagnosis of tuberculosis."

The above buildings and site are expected to cost \$100,000.00, leaving \$10,000.00 for scholarships.

The building will be the headquarters of the National Sanitarium Association, operating the Hospitals for Consumptives at Muskoka, and of the allied institutions on the banks of the Humber, near Weston. While representing the memorial to the late King Edward, for which the fund of one million dollars was secured, it will also represent a complete modern equip-



CHURCH AND RECREATION HALL, NATIONAL SANITARIUM ASSOCIATION,  
MUSKOKA.

ment for fighting tuberculosis. The building will contain the Head Offices of the Association, Board Room for the Trustees, Free Dispensary and Examination Rooms for tuberculous poor, with separate accommodation for the examination of private patients, headquarters of the Physicians-in-Chief and Consulting Physicians of all the Institutions, also headquarters of the Visiting Nurse and Social Service Department, demonstration theatre for students' lectures and clinics, laboratory for research, etc.

*Church and Recreation Hall at Muskoka:*

This seven-day church is to be built with the contribution of \$10,000 made last year by Mr. Chester D. Massey to the King Edward Memorial Fund.

It will be erected on the grounds of the Muskoka Free Hospital for Consumptives and will be a most important feature in the social life of the patients—giving accommodation for Sunday services, for week-day lectures, for moving pictures, for library, reading, writing, and other social features. It has been specially designed to afford an abundance of light and fresh air, and with a view to the comfort, convenience and cheerfulness of the patients—all of which will be of immense help to the patients while they continue to take the cure.

## Book Reviews

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*Elementary Bacteriology and Protozoology: the Microbiological Causes of the Infectious Diseases.* By HERBERT FOX, M.D., Director of the William Pepper Laboratory of Clinical Medicine in the University of Pennsylvania. 12mo, 237 pages, with 67 engravings and 5 colored plates. Price, cloth, \$1.75, net. Philadelphia and New York: Lea & Febiger. 1912.

This work is designed as an elementary text-book of bacteriology and protozoology for nurses and for beginners. Without being technical, it gives a good idea of the nature of micro-organisms, and then discusses with more emphasis the ways in which bacteria pass from one individual to another, how they enter the body and act when once within, and their manner of exit. Such general information concerning the character of the disease process has been included as seemed necessary to clarify the nature of microbe action. Indeed, the subject-matter in many places is but elementary bacteriological pathology. In other words, the author has endeavored to show in the simplest manner how bacteria produce disease.

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*Medical Research and Education.* A compilation by twenty-two of the leading medical men in the United States. The Science Press, New York and Garrison, N.Y., 1913. Edited by J. McKEEN CATTELL.

Dr. Cattell has edited several publications regarding science and education, with the idea of promoting scientific research and educational progress. The first collaborator is Dr. R. M. Pearse, University of Pennsylvania, who takes up the subject of Research in Medicine. This author in his first lecture gives a historical *resumé* of medicine from Hippocrates to 1800, which reads most interestingly. The second lecture is devoted to the development of laboratories for medical science, commencing with those of chemistry, biology and physics, and continuing with those of pathology, the first one of which was established in Wuertzburg in 1855 by Virchow. Many discoveries followed. What changes in the study of medicine succeeded.



Then follows a discourse on Pasteur and the era of bacteriology, and the effect of this study on our knowledge of the causation of disease. The next chapter Pearse devotes to immunology, cancer, protozoology, chemotherapy, physiological chemistry and pharmacology. His last lecture deals with medical research in American universities and discusses their present facilities, needs and opportunities. Pearse also contributes a paper on The Experimental Method: Its Influence on the Teaching of Medicine, and one on Chance and the Prepared Mind. Dr. W. H. Welch makes the next three contributions—The Interdependence of Medicine and Other Sciences of Nature; Medicine and the University; and The Relation of the Hospital to Medical Education and Research. And so on through the volume—such are the subjects written about—by Howell, Mall, Barker, Minot, Cannon, Councilman, Theobald Smith, Stewart, Jackson, Lyon, Herrick, Dodson, Bardeen, Ophüls, Meltzer, Ewing, Keen, Donaldson, Herter, and Bowditch. To every medical man these papers are of great interest, but of especial interest to all professors, lecturers and teachers in medical colleges.

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*Obstetrics for Nurses.* By JOSEPH B. DE LEE, M.D., Professor of Obstetrics in the Northwestern University Medical School, Chicago. New (4th) edition. 12 mo of 508 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$2.50 net.

The nurse will find a fund of information within the pages of this clearly-printed, well-illustrated work.

In his preface to the fourth edition the author remarks that but few changes in the text are necessary, "the fundamentals of obstetric nursing remaining the same from year to year." Careful reading of this newest edition will nevertheless prove profitable and convincing that here Dr. De Lee has the last word.

In the chapter on Infant Feeding, by Dr. F. X. Halls, some changes will be found. That on Cesarean section receives lengthy notice, while the after-care of fistula operations, blood transfusion, and Memberg's method for the control of hemorrhage, are among new subjects.

M. C.

*Anatomy and Physiology.* A Text-Book for Nurses. By JOHN FORSYTH LITTLE, M.D., Assistant Demonstrator of Anatomy, Jefferson Medical College, Philadelphia. Illustrated with 149 engravings and 4 plates. Philadelphia and New York: Lea and Febiger.

This new work presents in a clear and untechnical manner the essentials of anatomy and physiology. Emphasis has been placed on the description of organs and their functions. Questions are added to the end of each chapter, and a good glossary appears at the end of the book. The book is clearly printed and illustrated, and would appear to be an admirable one for nurses in training or for graduate nurses to use in review.

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### PUBLISHERS' DEPARTMENT

#### A Sick Room Beverage

When the Hospital House Physician is looking for an ideal sick-room beverage, let his mind turn to Cowan's Cocoa. This product has but few equals. Why? Because of its high quality and absolute purity. These two points command for it a prominent place in the list of Hospital niceties. Private ward patients will appreciate it. It is made of the best selected cocoa beans scientifically blended, and contains no foreign elements whatever. Hereafter, you might specify Cowan's Cocoa, whenever a nutritious, slightly stimulating sick-room beverage is required.

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#### 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.

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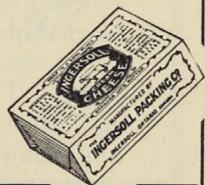
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## Cold Storage, Refrigeration and Ice-Making Requirements in the Hospital

It is peculiar how many hospitals or institutions which are modern, efficient and careful in every other way are still getting along with the insanitary, inefficient and inadequate use of ice for cold storage and other purposes.

Possibly it may be that mechanical refrigeration, being a comparatively new science, is unknown, considered a luxury or too costly, and no ideas on the subject could be more misleading. Mechanical refrigeration is not a luxury, but a necessity. Surely in institutions whose main purpose is to build and conserve health, the food and drink, which are the fundamental bases of restoring and upbuilding energy, cannot be too carefully kept under the most sanitary and perfect conditions, and these conditions cannot be obtained with the use of natural ice, which is probably impure itself, and the dampness and high temperatures obtained by its use serve to breed mould, contamination and hasten decomposition. Contrast this with the low, dry, constant temperature conditions of mechanical refrigeration, and even if it were a luxury, humanity would demand it and pay the price.

There is no doubt that mechanical refrigeration suitably designed to meet the peculiarities of each individual hospital would prove the most paying investment that could be considered, and the plant would actually pay for itself in a few years with the money saved and the economies effected over those now expended on ice.

What more gilt-edge investment could be desired, and when you add to this all the other considerations, such as convenience, control of temperatures, refrigeration wherever required, low cost of operation, absence of all bother handling natural ice, dry air conditions, low temperatures, elimination of waste and increased efficiency throughout all departments, the question becomes a most important one, and one that delay will only result in further loss.

Is your institution still using ice? Are you interested in its progress and equipment? If so, why not investigate the advantages of mechanical refrigeration for your particular needs?

We are at your command and only too pleased to give all information that might be required on this subject, and by way of introduction we would advise that we are the Canadian representatives of the Frick Company, who have been building ice-making and refrigerating machinery for over thirty-five years, and whose apparatus is acknowledged to be the best made. Their reputation and experience on thousands of installations are behind all the contracts we execute, and we would appreciate the opportunity of serving you in any way. A phone or card will do, and you will find the subject most interesting. Keiths Limited, 111 King Street West, Toronto.

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This closet will be found to be absolutely sanitary in every particular.

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### Elevators

Any hospital superintendent who is desirous of equipping his institution with what is the very latest and best adapted for hospitals in the way of elevators, should first consult The Otis Fensom Co., Limited, Toronto. This firm has for many years manufactured nothing else, so that they are in a position to advise along this line. The Otis Elevator is one of the smoothest running and one of the most easily operated elevators installed anywhere, and their prices are consistent with the best of workmanship.

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### The Finest Made

The attention of Hospital authorities is called to the advertisement of the Don Valley Brick Co., Toronto (appearing on Page lxvii of this issue of THE HOSPITAL WORLD). This firm's name is well-nigh a household word among builders and architects, and more so since they supplied, within the past year, several million special brick for the new Toronto General Hospital. This brick has been admired by all. It is a beautiful buff shade, and considerably larger than common brick, giving a very handsome appearance to the building. We take this opportunity of congratulating the manufacturers on their effort to adorn College Street, Toronto. Toronto General Hospital is certainly one of the most imposing-looking Hospitals, from an architectural standpoint, in Canada.

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### 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.

# "Some Abnormalities in Breast Milk and their Treatment."

By HUGH H. RIDDLE, M.D., Cantab.

*Medical Press and Circular, December 10th, 1913.*

IN this article, a reprint of which will be forwarded post free on application to Medical men in Canada, the writer recounts the clinical and analytical history of a series of cases under treatment for deficient lactation at Queen Charlotte's Lying-In Hospitals, London, England, and records some very striking results of the treatment adopted.

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If this were kept up for 20 years it would amount to \$36,800.

20 years is a long time looking forward, but a short time looking back. How many men can look back now and say; "If I had only invested my spare money in safe securities I would be wealthy to-day." A few get rich in a few years by making a lucky strike but more become poor in the same time trying to make a strike.

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### **The Sliding Furniture Shoes have been further Adopted in Montreal General Hospital**

The Onward Manufacturing Company, of Berlin, Ontario, manufacturers of the Onward Sliding Furniture Shoe, have recently received an additional order for shoes from the Montreal General Hospital. This hospital is now almost fully equipped on all their metal beds and furniture with this shoe, which is ideal for adoption in hospitals and similar institutions.

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### **The Athey Cloth-Lined Metal Weather Strip**

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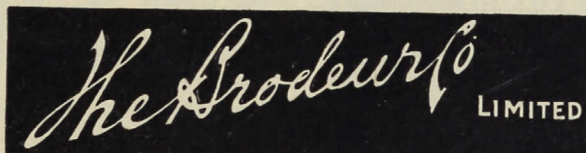
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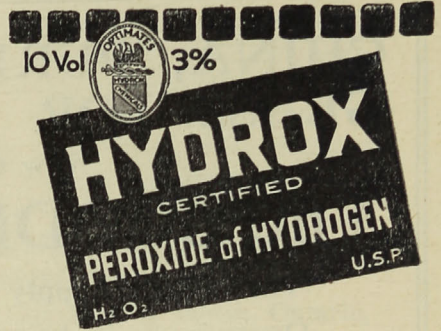
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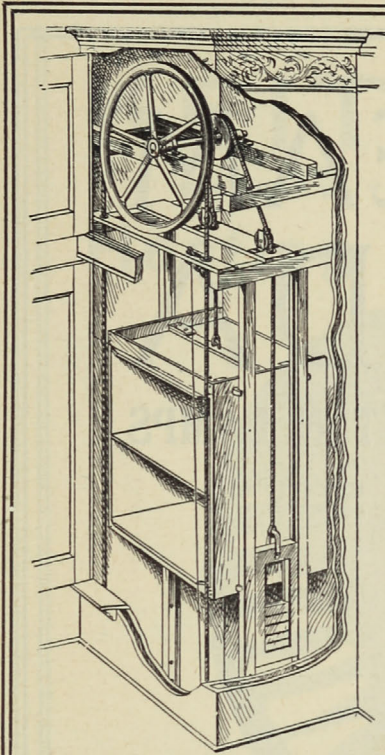
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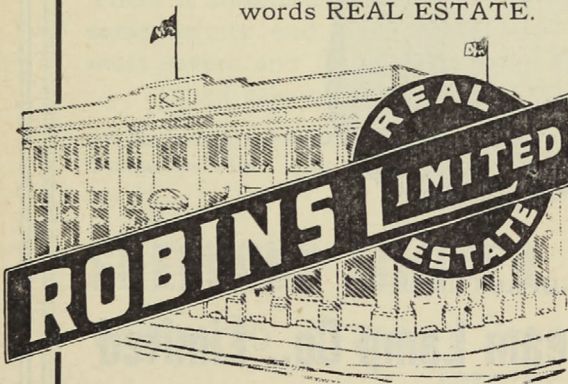
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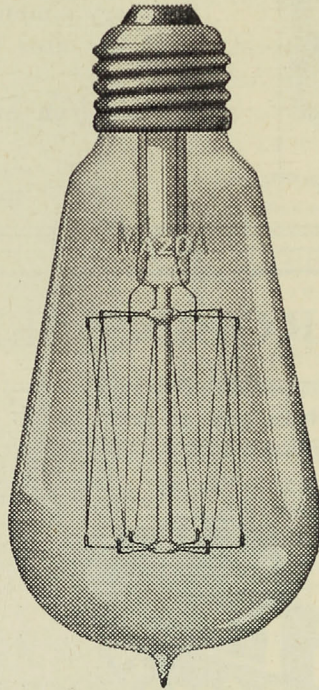
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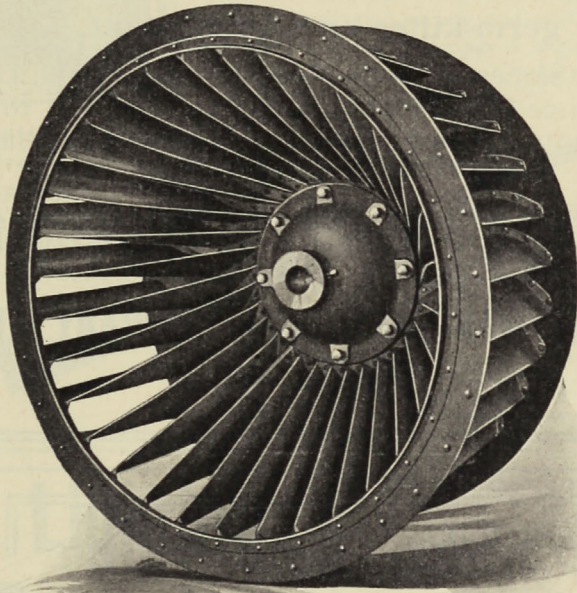
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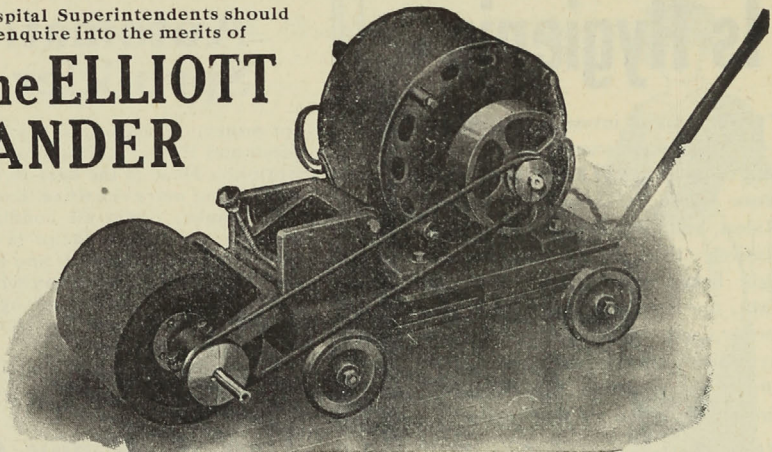
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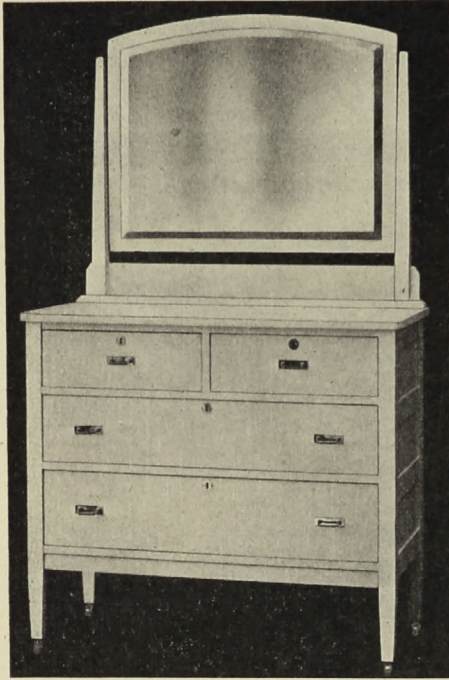
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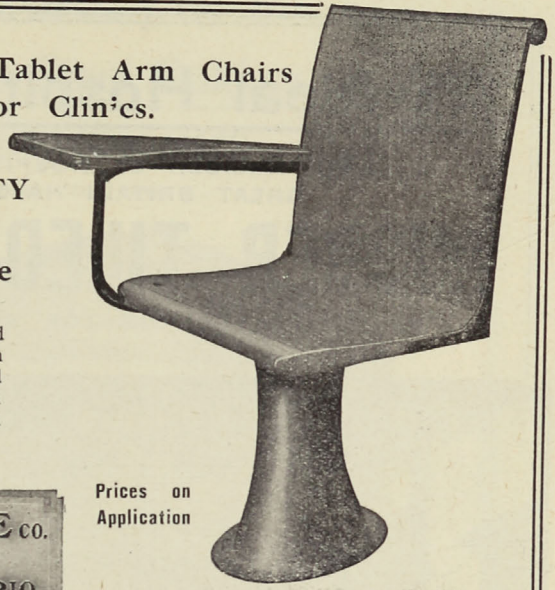
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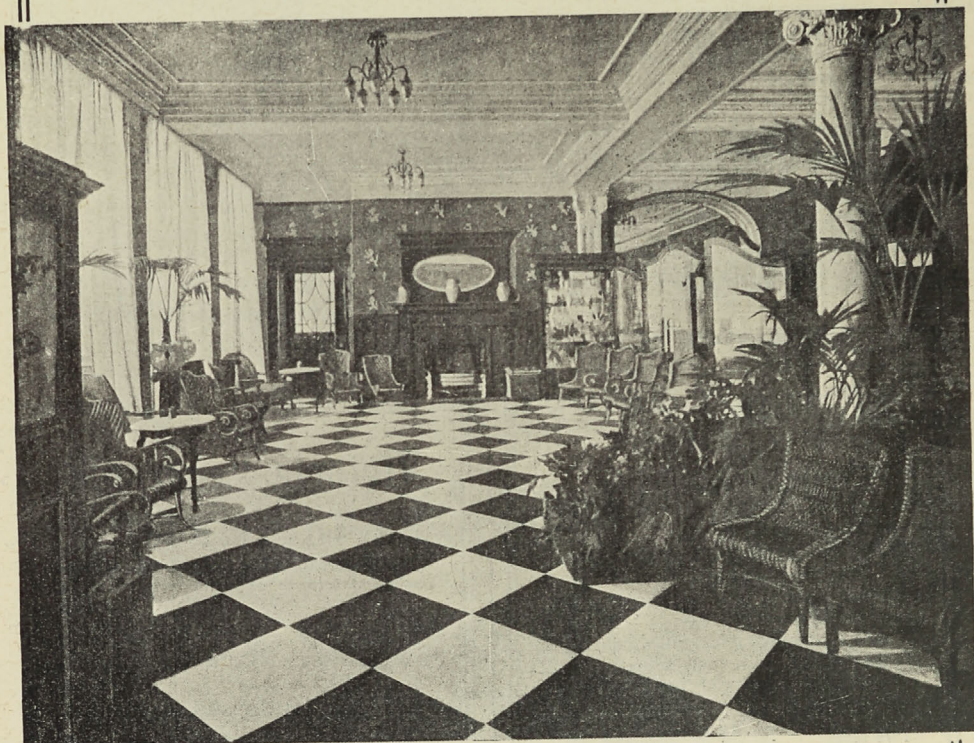
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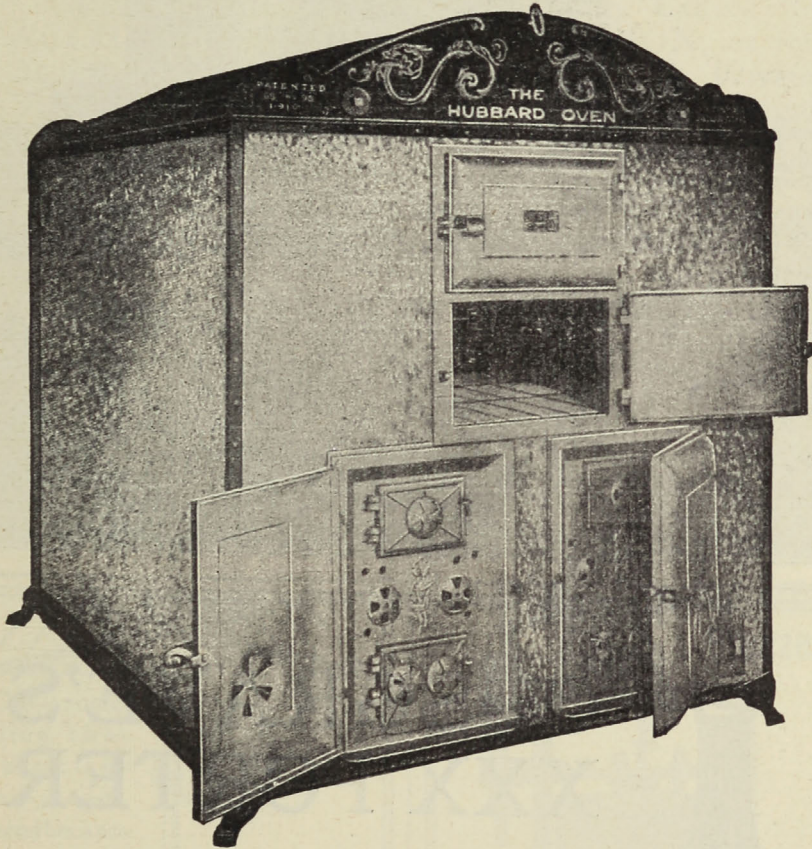
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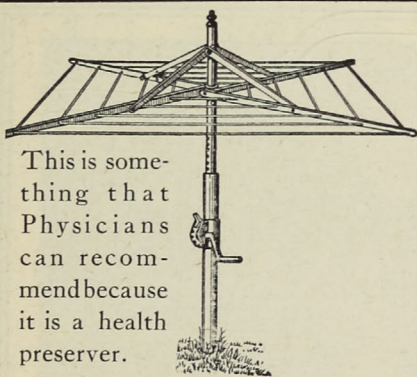
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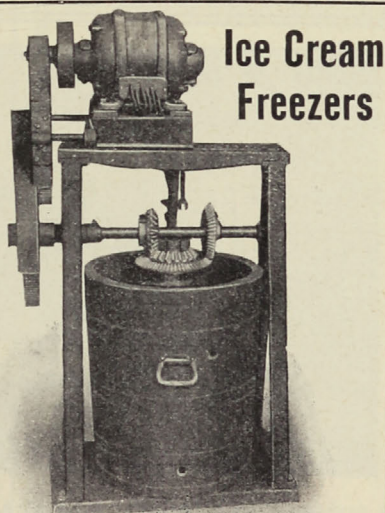
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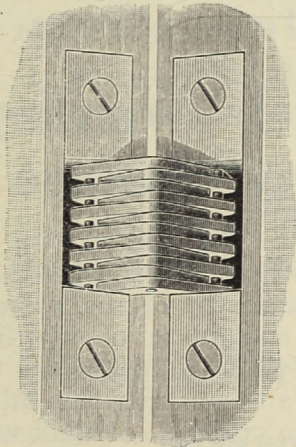


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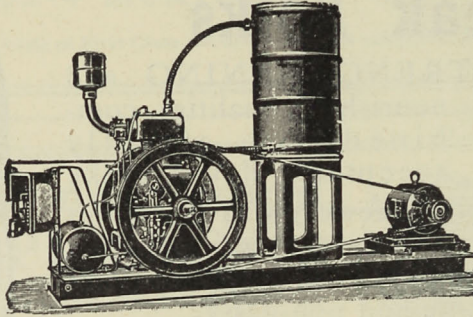
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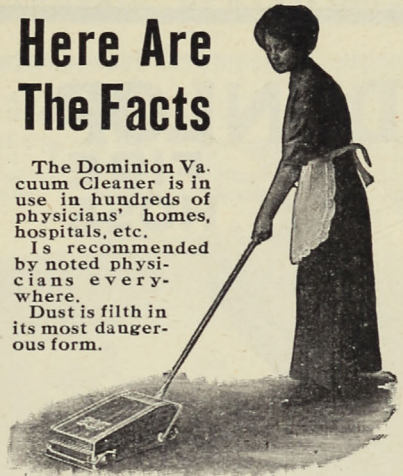
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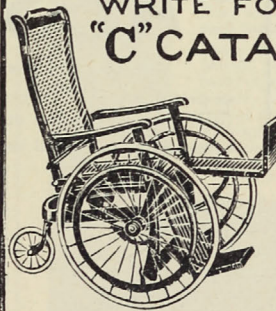
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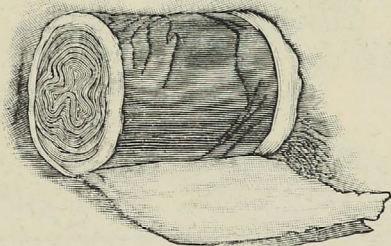
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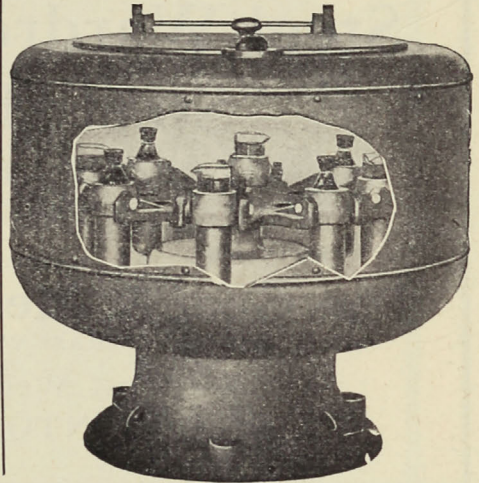
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They will not burn, and they occupy but a small space. They are light and airy, and each has a different lock.

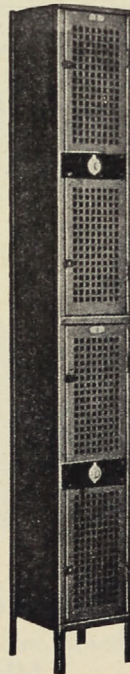
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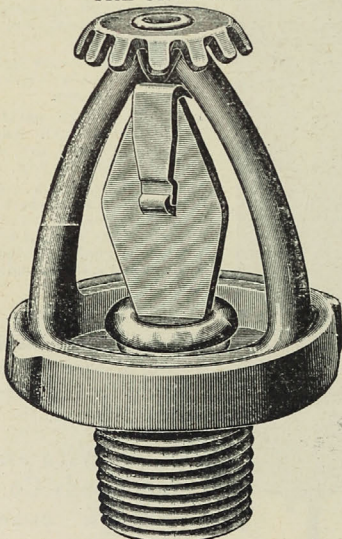
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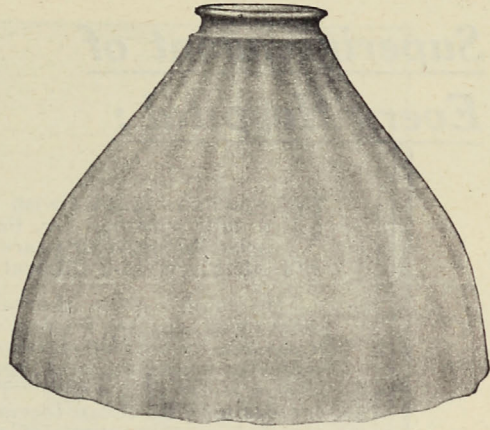
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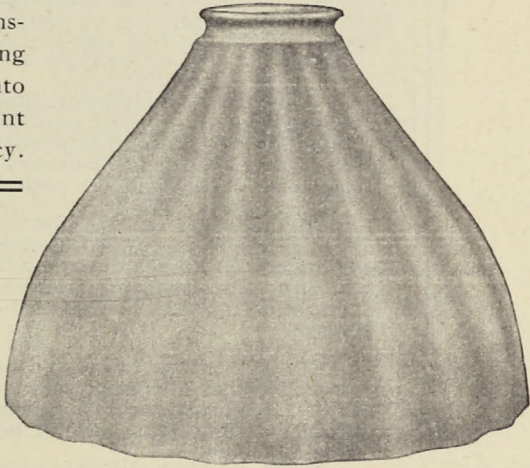


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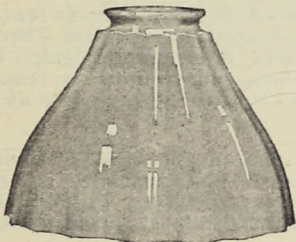
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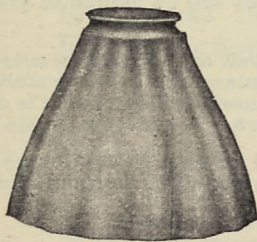
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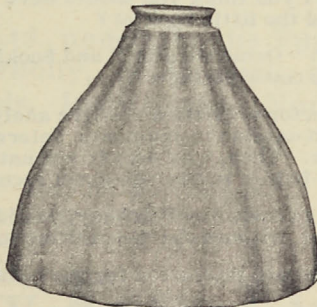
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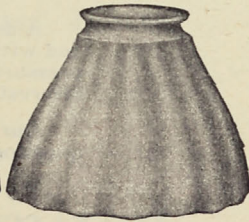
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It should be understood, however, that where thermometers have been properly seasoned and where they have been tested for retreaters, it is possible to make a thermometer that will give a perfect history of the rise and fall of the temperature of your fever patients.

Mr. Faichney has also discovered an easy way to teach first year nurses how to read a magnifying Clinical Thermometer and he has devised a large thermometer which is called a "Demonstrator" that allows an instructor to teach a nurse or a patient how to read a Clinical Thermometer at a glance.

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Both "Demonstrator" and booklet will be mailed to you for 5c to cover postage.

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Our expert, Mr. Faichney, would be glad to answer any questions, without charge, relative to a Clinical Thermometer.

If you are interested further, kindly address

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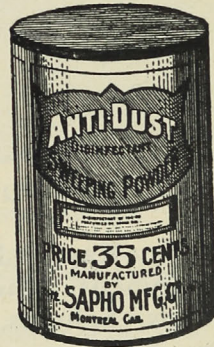
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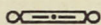
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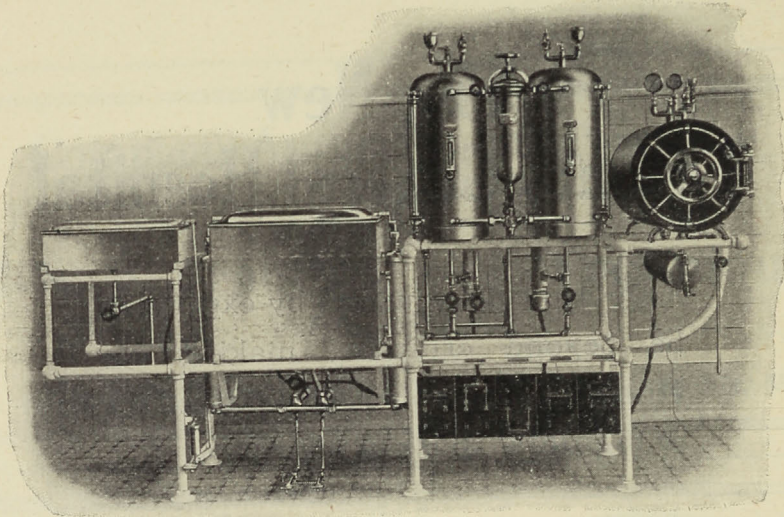


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—Re Claim Policy 7485 R. A. Smith deceased—

We beg to acknowledge with thanks the receipt of your letter with cheque for \$10,000, in settlement of the above claim.

Mrs. Smith desires us to thank you for the prompt payment immediately upon the completion of the claim papers.

Yours truly,

AYLESWORTH, WRIGHT, MOSS & THOMPSON

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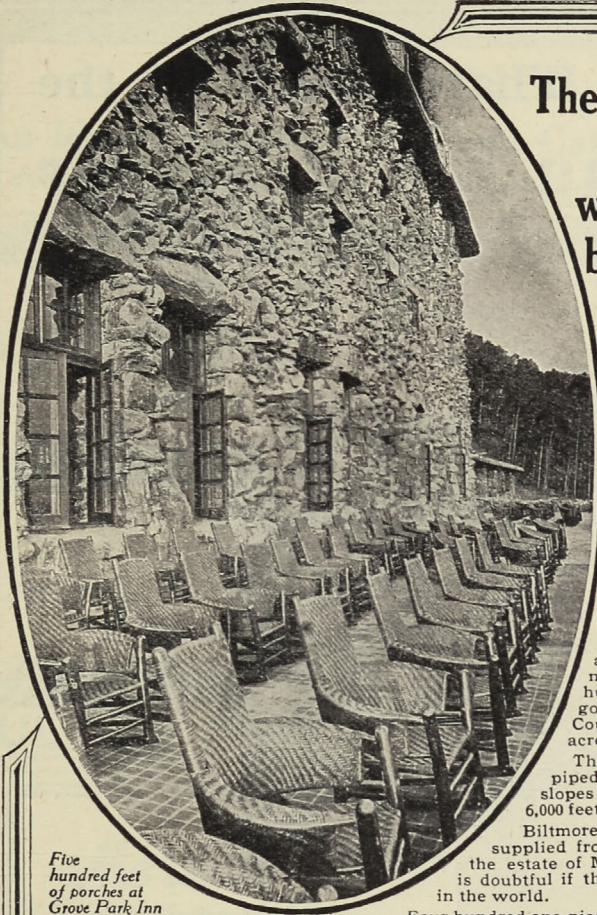
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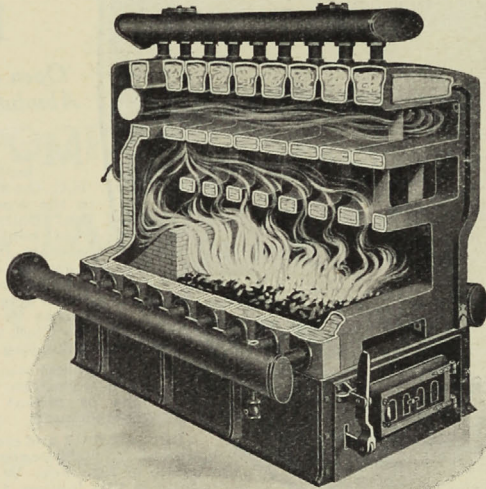
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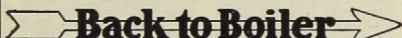
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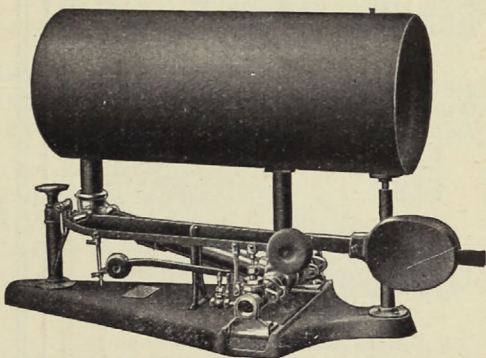
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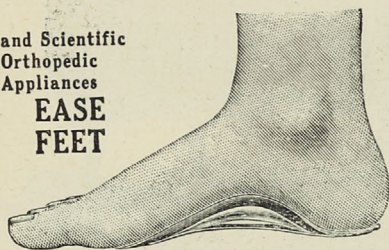
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A scientific appliance that firmly supports the arch of the foot and instantly removes all ligamentous strain by distributing the body's weight equally.

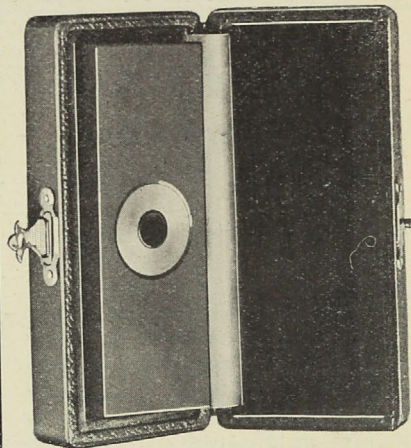
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## Mr. Hospital Superintendent!

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# The Kellaric Mattress

This mattress is particularly well adapted for use by the sick

### BECAUSE:

- A. It is Built on Scientific Principles.
- B. Of its unusual Resiliency.
- C. It does not become Lumpy.

The KELLARIC Mattress is made up of clean, elastic sheets of cotton, built layer after layer to a height of TWO AND A HALF FEET, and afterwards compressed to a thickness of FIVE INCHES.

Every KELLARIC Mattress has a laced opening at the end, proving that the manufacturers are not ashamed of the character or quality of the material used inside.

We also manufacture a special mattress that is IDEAL FOR USE IN HOSPITALS, SANITORIA, ASYLUMS, ETC. It has handles down either side, so that in case of any emergency the patient can at once be lifted from the bed to a place of safety. We would call special attention to this mattress for large institutions.

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*The basis of "Horlick's Malted Milk" is pure, full-cream milk combined with the extracts of malted grain, reduced to powder form.*

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## Duffy's Pure Malt Whiskey

Produced in compliance with the physicians' "Materia Medica" and the druggists' "Pharmacopoeia," it is comparatively free from fusel oil, the aldehydes, tannic acid, and the usual coloring matter, and it is the preferred medicinal whiskey in every institution into which it has been introduced.

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# A Simple, Cheap and Efficient Outfit for the Murphy Drip

Combined with

# A Practical Apparatus for Keeping the Solution Warm

## The Dropping Attachment known as the Meinecke No. 20 Drop Attachment Set (or Proctoclysis Outfit)

In writing us about our No. 20 Drop Attachment Set (which is illustrated on the right in combination with the Meinecke Saline Solution Heater), Dr. J. B. Murphy, Chicago, says:

*"It is an excellent device, and as well adapted to the administration of Proctoclysis as any instrument I have so far seen. At the price you are selling it, it seems to me that it will become very popular."*

The main features of our No. 20 Outfit are the Improved Dropping Attachment and the Attachment for the escape of fecal gases and any return flow.

The Dropping Attachment (which is our No. 2 Drop Attachment Set as illustrated on the left), consists of a specially constructed Glass Nozzle (A) and a Metal Screw Compressor (B). The Glass Nozzle is joined to a Glass Connection Piece (D) by a piece of Rubber Tubing (C) on which the screw compressor is secured. The number of drops per minute can be regulated by screwing down or opening up the Metal Screw Compressor (B).

After the required number of drops have been regulated by the screw compressor, it is unnecessary to touch the screw compressor again; as to shut off, or open up, the flow it is only necessary to shut off or open up the ratchet shut-off which is placed above the screw compressor.

For use with this Outfit we recommend our 2 Qt. Seamless Graduated Irrigator No. 2258. In addition to being fitted with a detachable Metal Spout, this Irrigator is graduated in Grams, Ounces, Pints and Quarts.

## The Heating Apparatus known as the Meinecke Saline Solution Heater (Patent Applied For)

At present the Solution is generally heated before it is put in, or while in, the Irrigator, and then kept warm by various devices. None of these are satisfactory, because the Solution, coming drop by drop, gets cool before it reaches the patient.

With the "Meinecke" Saline Solution Heater (which is shown lying on the bed in the illustration below), it is not necessary to heat the solution before putting it in the Irrigator, and yet the solution will reach the patient at a temperature of between 95 and 105 degrees.

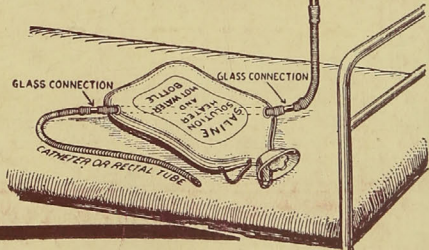
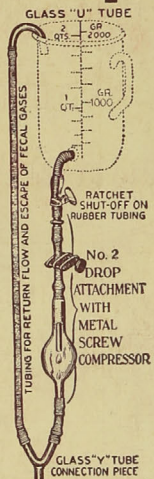
The Heater consists of our regular Metal Hot Water Bottle with a brass tube running diagonally through it. Through this tube a 12-inch length of rubber tubing is drawn, which has a glass connection piece at both ends, and the solution flowing through it comes in contact only with rubber and glass. After the Bottle has been filled with hot water it is placed on the bed and the regular Drop Attachment Tubing is attached to the upper end connection piece, while the rectal tube is attached to the lower end, thus remaining close to the Heater. The Solution, coming drop by drop from the Irrigator, becomes warm as it passes through the Heater and just before it reaches the patient.

By wrapping or covering the Heater, it will retain its heat for many hours, and when the water does begin to get cool it is a simple matter to detach the tubing and re-fill the Heater with hot water. The Rubber Tubing running through the brass tube in the Heater need not be withdrawn when the Bottle is being re-filled.



Enlarged View  
(4 Actual Size)  
No. 2 Drop Attachment Set as used on the No. 20 Outfit.  
A-Glass Drop Nozzle  
B-Screw Compressor  
C-Rubber Tubing  
D-Glass Connection Piece

This No. 2 Outfit can be attached to the Tubing of any Irrigator



## Net Prices to Hospitals Only

- |   |                   |
|---|-------------------|
| No. 20 Outfit, complete with Saline Solution Heater, 2 Qt. Seamless Graduated Irrigator, Tubing, etc., as illustrated on right..... | each, \$7.50      |
| No. 20 Outfit, without Heater, but with Graduated Irrigator, Tubing, etc.....   | each, \$3.00      |
| Saline Solution Heater only.....  | each, \$4.50      |
| No. 2 Drop Attachment Set, (as illustrated on left).....  | per dozen, \$7.20 |

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Doctors and Nurses supplied at 20% above these Prices

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