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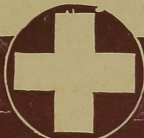

THE HOSPITAL WORLD

(Incorporating The Journal of Preventive Medicine and Sociology)

THE OFFICIAL ORGAN
OF
THE CANADIAN HOSPITAL ASSOCIATION

Vol. VII (XVIII) Toronto, May, 1915 No. 5

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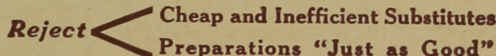

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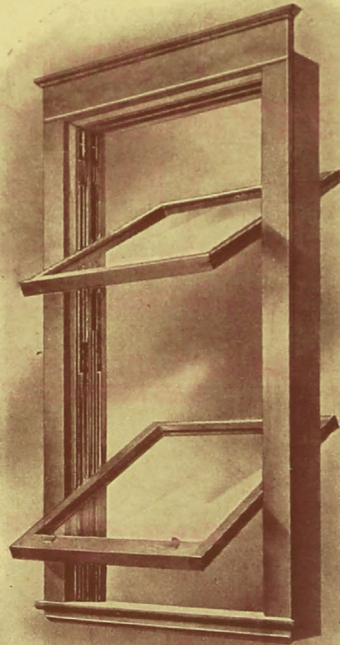

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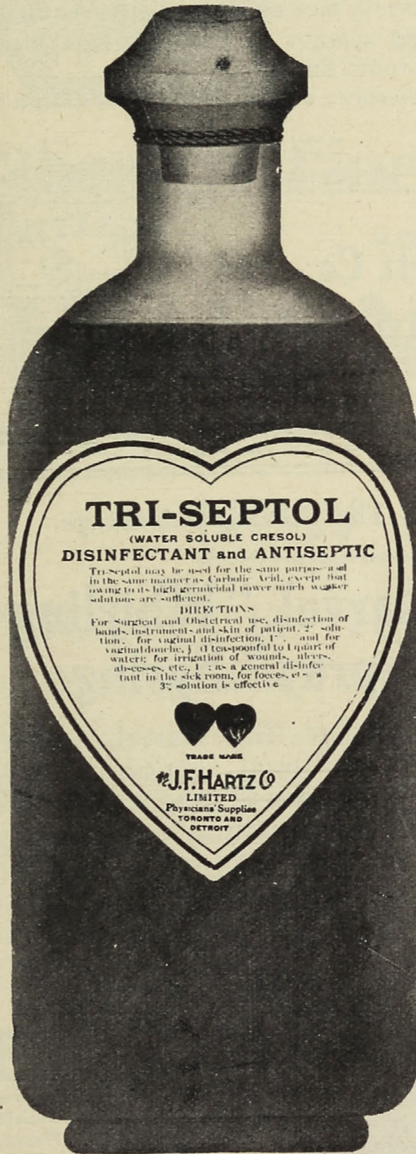

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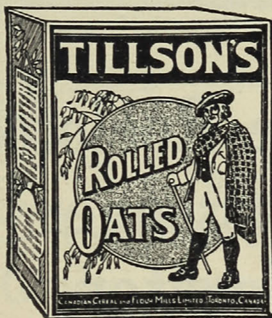

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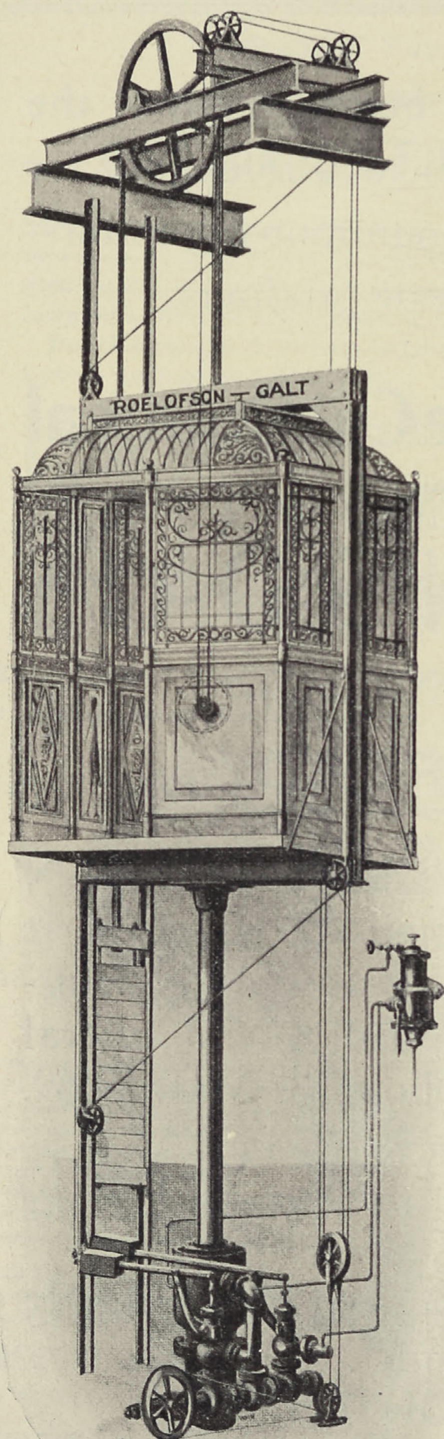

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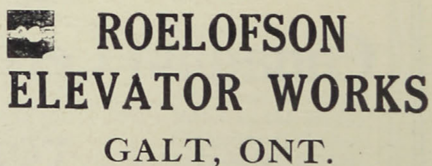

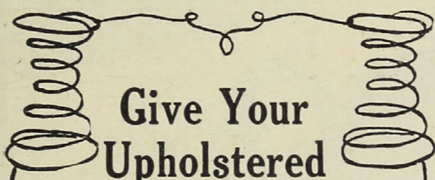

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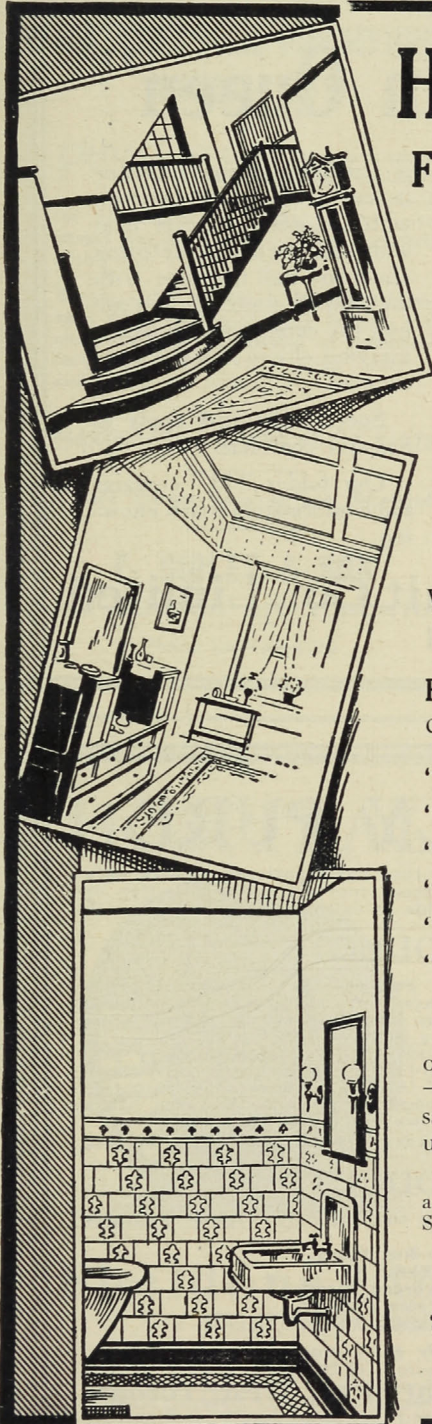

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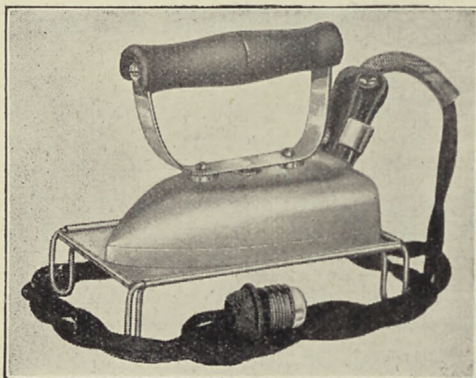

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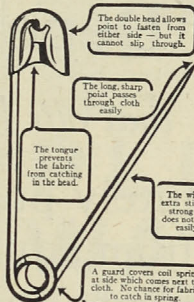

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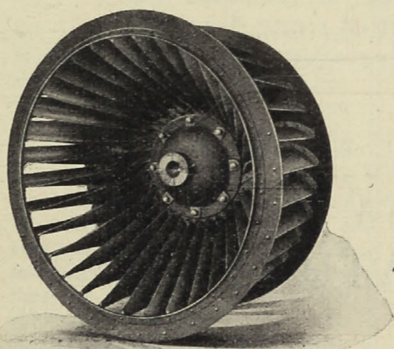

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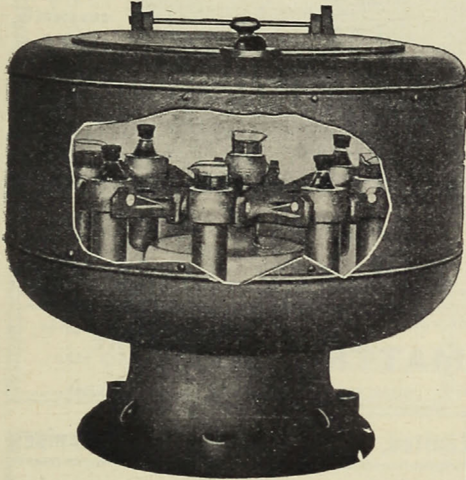

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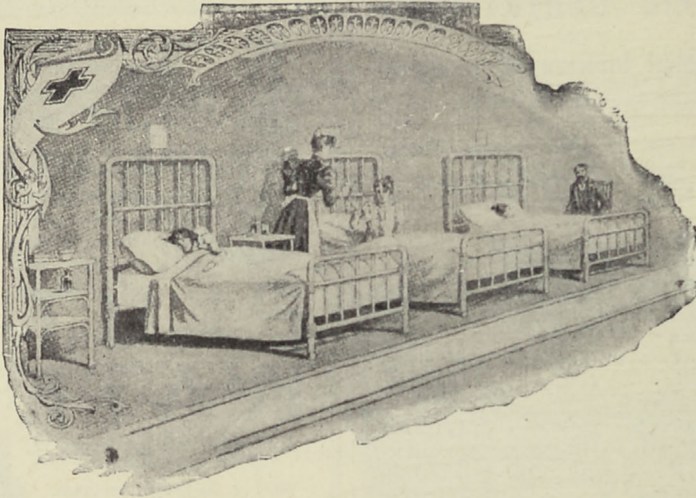

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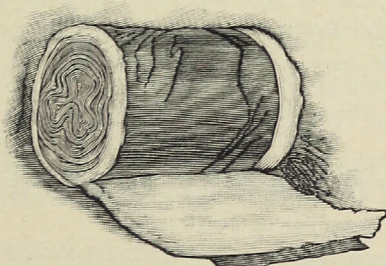

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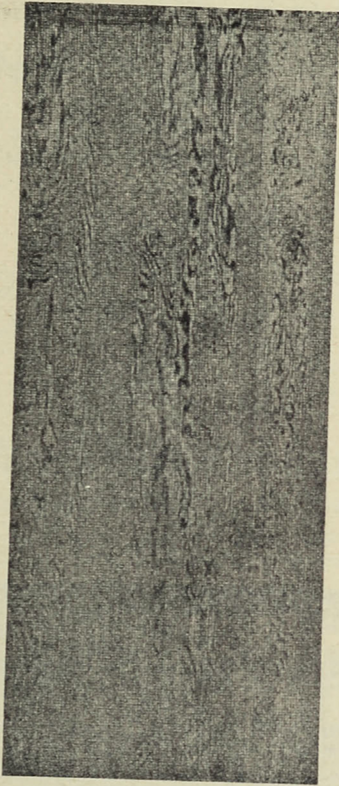

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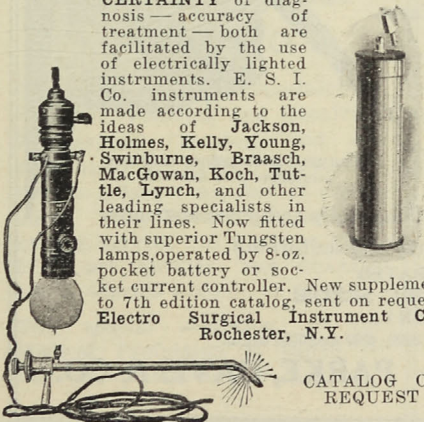

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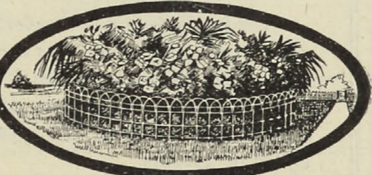

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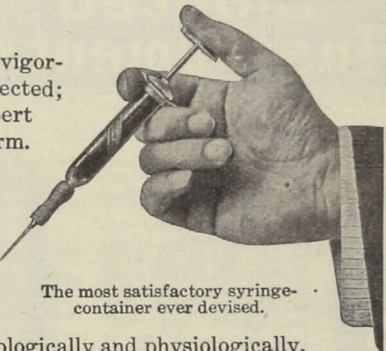

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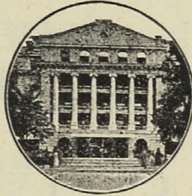

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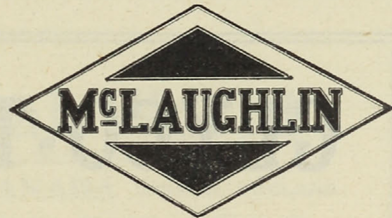

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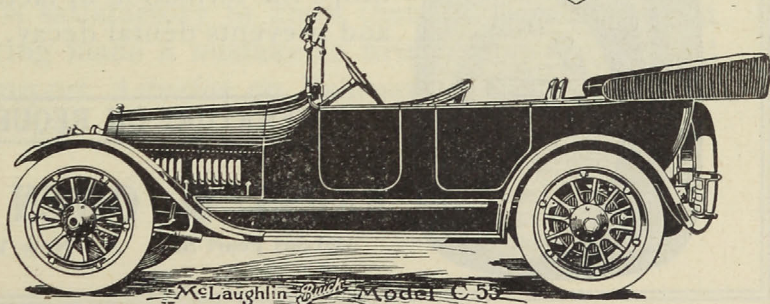

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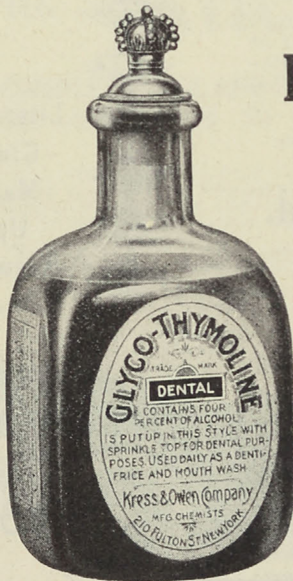

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All Communications, Correspondence and Matter regarding Subscriptions and Advertisements TO BE ADDRESSED TO THE HOSPITAL WORLD, 145 COLLEGE ST., TORONTO, ONT. Reprints Supplied Authors at Net Cost.

Vol. VII. TORONTO, MAY, 1915 No. 5

Editorials

HOSPITAL FLAGS

It is satisfactory to know that the Germans admit having made a mistake in firing upon the hospital transport *Asturias* on February 1st. The *London*

Times recently published a statement from the German embassy as follows:

> The Government is sorry to admit that the *Asturias* was attacked on February 1, at 5 p.m. Looming up in the twilight, carrying the lights prescribed for ordinary steamers, the *Asturias* was taken for a transport carrying troops. The distinctive marks showing the character of the ship not being illuminated, they were only recognized after a shot had been fired. Fortunately the torpedo failed to explode, and the moment the ship was recognized as a hospital ship every attempt at further attack was immediately given up.

The *Hospital,* in commenting on the above, notes a communication recently sent out by the Home Secretary concerning the correct flags to be used by the civil hospitals in event of a bombardment. It states that civil hospitals, as well as churches and museums, should be marked by a black and white sign—a stiff rectangular panel, divided diagonally into two pointed triangular portions, the upper part being black and the lower white. The Red Cross flag, it is pointed out, may be used only by hospitals which are exclusively under naval or military control, or in cases where special authority has been granted by the Army Council.

"It would be interesting to know," says the *Hospital,* "to what extent, if any, the building displaying it would be protected from bombardment or attack. In view of the facts already known about bombardments during the early months of the war, we fear that there is not much chance that any sign will serve much protective purpose, or that care

would be taken to avoid shelling the building on which it is used. The aspect of the matter in international law is as follows:

"Under Article 27 of the annex to the Hague Convention of 1907 it is provided that such buildings as those enumerated above are to be spared as much as possible during bombardments, provided that they are not at the time being used for military purposes. Such buildings, it is also stated, should be clearly indicated by distinctive and visible signs which have been notified beforehand to the enemy. The panel above mentioned is then described, and it is pointed out that the Red Cross may be used only by hospitals exclusively under military or naval control."

It is to be hoped that English institutions will have no experience of the practical value or otherwise of the black and white panel.

HOSPITAL WAR WORK

Preventive medicine is showing its hand in the practical absence thus far of epidemics among the allied armies. The military hospitals are dealing very severely with the insect conveyors of typhus fever by insistent sterilization and cleanliness. The bath arrangements for the men who come from their turn of trench service are one of the most important and insistent of the field hospital adjuncts; and the "bath corps" of muddy, weary soldiers, are put through a cleansing that as one soldier writes, "scalds

and cleanses every bit of our skins, as well as the rags we wear." The present sorry conditions in Serbia at least serve to redouble the efforts of the hospital corps of the Allies in the prevention of this dread disease, which is purely one of dirt.

Protective inoculation against typhoid is keeping this disease down to a minimum. Hospital, or dry gangrene, from which so many of the trench soldiers have suffered during the past winter months, and which is caused by failure of blood circulation in the feet, has been largely abated by soaking the boots in hot oil, greasing the feet and unlacing the boots at intervals while in the trenches.

Only two infections, gas gangrene and tetanus, are still giving serious trouble. These diseases, it has been proved, are derived from the soil that is being fought over. The hospitals are combating tetanus by injections of antitetanus serum. Protective doses are being given to the wounded among the Allies as soon as the hospital forces can administer it; and where the disease develops, the serum is used in quantities. The total number of cases of tetanus is not large, but the death rate is high, and the hospital authorities are not yet ready to pronounce on the efficacy of the remedy.

No preventive remedy has yet been found for gas gangrene, which is quite distinct from the hospital type. The former is due to the presence of spore-bearing organisms found in the soil. The infection occurs chiefly in wounds which contain soil or fragments of muddy clothing forced into them by the

guns. So far the hospitals use various antiseptic treatment and peroxide, but neither of these is highly effective.

A feature of the present war is the large and very prominent share in it born by the medical and hospital authorities. Never before has there been so complete a realization of the part these bear in the conflict. The appreciation of hospital values is shown by the importance given to this branch of the struggle.

To prevent decimation of the army by disease and to restore the wounded, the services of men highest in medical ranking are enlisted. The laboratory and the sanitary expert are on the alert. Men of the ranking of Sir Almroth Wright, Harvey Cushing, Sir William Osler and many more are using their knowledge to the utmost, while efficient hospital workers, both men and women, are carrying out their orders.

Much that is of transcendent value to the hospital world will accrue from experiences gained in this conflict, not alone in the departments of surgery and medicine, but in swift and effective hospital expedients called forth by terrible emergencies. Whatever else of good may arise from this great conflict, the hospital world will at least be sorrowfully enriched.

THE ADMINISTRATOR ABROAD

NOTHING helps a hospital administrator more than making periodical visits of inspection to other hospitals either at home or abroad; and it is a wise Board that makes it possible for its superintendent and department heads to do this.

Although something may be learned from the smallest hospital, the heads of large institutions naturally elect to visit hospitals of similar size; since, in such instance, the same problems must be met and solved.

In making such visits it is well to know beforehand not only what one wants to see, but also just where it may be seen. Each of the large hospitals excels in some special department of management, has solved some troublesome problem, and a strict schedule of times and institutions to be visited, with a note of what the visiting administrator desires most to see, means a marked saving of time to both sides.

In visiting European and British hospitals letters of introduction greatly facilitate matters—as these secure personal attention which would otherwise be lacking. Otherwise in Continental hospitals the Pfoertner at the lodge or gate house directs you to the main office, where, after handing in your card with an expression of your desire to make a general inspection of the institution, you are given a guide who will take you over a regular route. After the round is finished this officer usually offers you a hand-

book of the institution which you purchase, and this constitutes the "tip"—accepted without loss of dignity to the officer.

But if you carry letters of introduction to some special medical department head, that official takes much pains to show you in detail the interesting features of his own wards and laboratories. He will also introduce you to the heads of other services, if you so desire, who will accord an equally cordial reception.

Of course, it facilitates matters considerably if the visitor speaks the language of the country however haltingly. It means a considerable increase in the interest shown and the warmth of his reception.

In Great Britain, where there is no language bar, the visiting hospital man is able to place himself at once in touch with the hospital authorities. But, here also, a letter of introduction means much, since the English officials stand more on the order of their office than does the American, unless the former has previously experienced the kindly hospitality of American institutions.

The difficulty .confronts the American visitor whether to ask for the medical director, the matron, or the Secretary—since these three officials are largely independent and on comparatively equal standing in many English hospitals. The secretary is usually the head, though the other two do not rank much below him. It is best to decide in advance just which department you would like to inspect, leaving the others for any overtime.

A suggestion might be made here that in visiting the English hospitals, some attention should be paid to niceties of dress, since the silk hat and morning coat are still correct form for the profession in England.

In the United States and Canada, as is well known, these formalities are not observed. The visitor has only to enter an institution, announce his standing and wishes, and he is welcomed and taken through every department that he wishes to inspect. It is wise, however, to arrange a date and hour in advance if he wishes to make a careful study of the entire institution, also to formulate in his own mind a definite idea of what he wishes to inspect or learn. If it is possible to read up the history of the hospital previous to the visit, its activities and medical notabilities—this also aids in appreciating the hospital output and atmosphere.

It would possibly be more instructive to the visiting expert if he were shown mistakes in construction, equipment or even management, in addition to the successes—things to avoid, as well as things to emulate. But it is naturally difficult to discover these except through the trained eye of the visiting administrator.

While most large hospitals have a guide for the ordinary lay visitor, not a few administrators make a point of personally accompanying visiting superintendents through the institution, a courtesy which

should be promptly acknowledged at the close of the tour or by letter after leaving.

Always take a note book on such visits; otherwise many valuable details observed at the moment are forgotten. Many visiting experts have trained perceptive faculties and memories which enable them to see and remember much. But the note book is an invaluable reminder even for these.

Original Contributions

A VISIT TO THE MAYO CLINIC

By John N. E. Brown, M.D.,
Medical Superintendent, Henry Ford Hospital, Detroit, Mich.

The last meeting of the American Hospital Association was held in St. Paul, within a three hours' run of Rochester, Minnesota. The writer, who was at the meeting, was thus afforded a convenient opportunity of visiting the celebrated Mayo Clinic.

The evening before my visit, I met Dr. "Charlie"—as he is known by his intimate friends—at the St. Paul Hotel, the meeting place of the association, where he was to read a paper on the "Relation of the Hospital to Medical Education." He had motored over with his family from Rochester, a hundred miles away. His home is on a farm a few miles out of town, and is modelled after the plan of the Sans Souci Palace and gardens, of Frederick the Great at Potsdam.

Dr. Charles is a man upward of fifty, rather stout of build, quiet in demeanor, possessed of a sympathetic voice—low-pitched—and kindly brown eyes; a man of pleasant address. After a few words, he informed me I would be welcome at the clinic on the following day, when he would be on the lookout for me.

After a trip over the beautiful driveways which connect the twin cities on the banks of the Mississippi, and a visit to the Minnehaha Falls, we left St. Paul and travelled southward by train through magnificent stretches of undulating country. Wonderful banks of cloud islands, edges gilded by the setting sun, seemed hundreds of miles distant. Here and there on the ample farms were beautiful woodlands sheltering pleasant and comfortable homes. The air was dry, cool and stimulating.

I mention these facts regarding the environment of Rochester, because I believe these broad vistas, fertile farms, quiet, prosperous homes, glorious skies and bracing air have had some influence in the production of the men who have made the "Clinic in the Cornfields" the most famous surgical centre in the world.

Another potent influence which doubtless had much to do with the formation of the characters of these surgeons was that of heredity. The father was a doctor in Rochester for many years—one of the Minnesota pioneers. He must have been a man possessed of character and vision, desiring that his sons should receive a grade of medical training that had been denied him.

Arriving at our hotel, I observed that the guests were doctors with their wives, friends and relatives of patients, prospective patients, and convalescent patients.

One of the smaller dining-rooms of the hotel is set aside for the use of the bachelor members of the clinical staff. The men are from the leading medical colleges in America. They have been specially trained in the particular branches to which they have devoted themselves, and are spending three or four years here to increase their efficiency, and in so doing do much to increase the efficiency of the clinic. "The young man for the new problem" is one of the epigrams of Dr. William Mayo, the executive head of the clinic.

Among the assistants I met during my brief visit to the clinic were men trained at the Johns Hopkins, the University of Pennsylvania, the Universities of Toronto and McGill, in Canada, the North-western University, and other noted medical teaching centres.

The work of the medical corps of some seventy men is carried on mainly in two places. The St. Mary's Hospital, managed by the Catholic Sisters, is where the major operations are performed. It is ideally located on the outskirts of the town. Miles of smiling fields slope and dip until they meet the horizon in the distance. The other work-place is the clinic or diagnosis building. It is of the block type of construction.

Waiting patients, convalescent patients, requiring after-observation and after-treatment, fill several hotel-sanitariums and scores of boarding-houses of various degrees of quality throughout the town. They include people from all parts of the continent. One patient was from Candle, Alaska, and another was from Porto Rico, West Indies.

The visiting doctors were from districts as widely scattered —from New England, from Los Angeles, three or four representatives from Canada, east and west, and from Texas.

The patient may be required, like the sick at the pool of Bethesda, to wait his turn for operation, which, unless his case is acute, may be deferred for several days, owing to the busyness of the operator to whom he is assigned, and to a possible ante-operation preparatory regime.

It is manifestly impossible that all the patients should see one of the famous brothers; but where special request is made to see one of them an effort is made to grant the request.

Some 10,000 operations per year are performed here—2,000 operations for goitre alone. These figures give an idea of the magnitude of the work done.

But it is not the quantity of the work done alone that impresses one. The quality is also noteworthy.

The method of the examination of a patient is somewhat as follows:—

The patient is brought to the clinic by his local doctor or by a relative. He is suffering, let us suppose, from some more or less obscure disease of the stomach, which may have been diagnosed by the home physician, and operative relief is sought; or, the trouble may be obscure and a diagnosis is wanted, as well as relief.

A general inquiry is made into the patient's condition, physical and financial (he is charged according to his ability to pay), is referred to one department after another, each in charge of a specialist—referred as long as any new light is needed to clear up the diagnosis.

Thus is carried out the famous Oslerian dictum—"the first step in the treatment of any case is to make a diagnosis."

The patient with the stomach " trouble " has the contents of this organ analyzed at the laboratory by men thoroughly versed in physiological chemistry.

While at the clinic I learned from visiting medical men and from a member of the staff that the clinic had come in for a considerable degree of adverse criticism. It is stated that there is a degree of jealousy in certain regions against the clinic. The surgeons in a nearby city find it a strong competitor; and I am told, some of them, in order to get and hold patients from that section of the country split fees with the local physicians who bring them cases.

I was interested in hearing that the local physicians and surgeons in Rochester itself are busy men, and appear not to suffer from the presence of the clinic.

The clinic is very much talked about by everyone who attends it, whether he be patient or doctor. The result is that, if the patient does badly and dies, as occasionally happens, there is a dearth of patients, from the part of the continent from which he came, for some time. On the other hand, if the case does well, the reputation of the clinic is enhanced and the clinical material from that part of the country is increased.

To give an instance of the latter case:—

During my stay of two or three hours in the ear, nose and throat clinic, a bewhiskered farmer—I took him to be—about 56 years of age, came in to report. A few days before he had come from his distant home to the clinic, complaining that he had been for fourteen years a sufferer from tic douloureux.

The doctor in charge had injected alcohol into the region of the tri-facial nerve. The effect was almost magical. The man who for many years had scarcely been able to open his mouth and had been obliged to live almost entirely on warm milk, gently sipped, who dared not try cold water for fear of the excruciating paroxysms, was now able to take refreshing drinks of cold water. His face was lit up with smiles, and his enthusiasm was good to behold.

He was beginning to enjoy life again after a long drawn out period of torture; and his pleasure was not dulled by the conservative statement of the doctor that he must remain under

observation for a few days longer, in order to see whether or not the painful seizures would return, nor by the prediction that sometime he might again be a sufferer from the terrible affliction. These cases often do not recur for years; frequently remain permanently cured. The expression of gratitude on the part of the patient and the straightforward and modest attitude of the doctor recalled to my mind the maxim of Dr. Paré, "I tended him; God healed him."

The most of the return cases in this clinic are the common ones of running ears, diseased tonsils, cancer of the eyelids, deafness due to various causes, and sinus disease.

In purulent discharges from the middle ear good results appeared to be obtained largely by first cleansing the canal, followed by the introduction of about one half dram of saturated solution of boracic acid in alcohol.

Cases of lupus and superficial carcinomata were treated by radium, with good results.

All minor operations on patients able to walk about are done in the clinic building, such as, speaking generally, may be done under local anesthesia. Following these operations or treatments, the patients retire to their hotels or boarding-houses.

Reverting to the clinic for the treatment of the special sense organs, the work is carried on in four rooms en suite. The two end rooms are about twelve feet long by nine in width, the nine feet intervening being divided in two by a partition parallel to the outside wall. One of the rooms thus made—next the outside windows—constitutes a third small examining room; whilst the inner room next the waiting corridor (about the same size) forms a passage way between the two rooms. This is used for cautery treatments, and for giving such treatments as require insufflations of compressed air. Beside the air valve is a sputum sink. On a small table beside the cautery stands a bowl containing alcohol, into which the tips of the sprays are dipped to disinfect them.

The other three rooms are simply furnished—a small three-shelf wall cabinet about 2 ft. x 2 ft. x 5 in., which contains a few special instruments; a small three-tier shelf stand for dressings; a small table with a 2 ft. x 2 ft. top and an under shelf.

On the top of the table stand five or six two-ounce bottles—alcohol; 10 per cent. cocaine solution; 1-1,000 adrenalin; 1 per cent. novocaine, etc.

On the other side of the second story of the clinic building is the X-ray department. Here several men are employed—all leaders in their field. In one suite of rooms the thorax work is done, in another the kidney and pyelographic, in another the colonic, and in another the stomach.

The writer spent an hour or so with Dr. Carman, in the suite devoted to the examination of the stomach. With Dr. Carman were associated two assistants. The patients were brought from the dressing-room, through an ante-room about 8 ft. x 10 ft.—used for making plates when necessary—into an inner room of about the same size, where fluoroscope examinations were made.

An attendant brought the patient; also a brief general history of the case.

The patient's stomach had been emptied by fasting or lavage.

One of the assistants asked a number of routine questions, the answers to which were instantaneously noted on a special stomach form—questions relating to the pain, its duration; its character; vomiting, etc. This took about one minute. The patient was then made to stand on a low platform between the tube and the screen, in front of the seated examiner.

A second assistant placed in the right hand of the patient a pint bowlful of an emulsion of barium sulphide, which was drunk. The current was turned on for a few moments, then off for a few moments. The spectators could see the shadow of the ingested material entering the stomach as a blackened shadow. The folds of the viscus and the movements could be easily observed.

As soon as these were noted by the examiner the assistant handed the patient another drink of the same sort—a solution of bismuth in combination with starch or potato—with words of encouragement.

As this added portion was ingested the stomach was seen to distend—the wrinkles and folds flatten out. A few interrupted series of sparks flashed out while the roentgenologist moved the fluoroscope screen from side to side, up and down, and at various

angles. Having secured all the views wished for, the patient was courteously dismissed.

I was pleased for the patients' sakes, in the dozen who were examined, to note no serious pathological abnormality, cancer, ulcer, hour-glass contraction, gastroptosis, etc., though the workers, I fancied, were a shade disappointed at the end of the hour to find that nothing of great positive value had been discovered in the series. The negative evidence, of course, is of much value to the surgical chiefs, as learning what the trouble is not, they are, by exclusion, so much nearer arriving at the diagnosis.

It appears that ulcers situated near the lesser curvature of the stomach posteriorly cannot be successfully shadowed. In other parts of the stomach they often show on the plate as round black spots about the size of a small bean. During an operation I noticed one of the brothers recognize one of the posterior ulcers by touch. It had not been revealed by the X-ray.

Leaving the clinic we will proceed to St. Mary's Hospital.

On the top floor of the east end of a great four-storied block building is a suite of operating room and annexes. In six of these the chief surgeons operate continuously from 8 a.m. until 1 or 2 p.m., or even later, depending on the number of cases.

Herewith is a schedule of the operations noted for one day.

Room I.

Exophthalmic goitre, thyroidectomy.
Left ovarian cyst, subtotal abdominal hysterectomy.
Gall-bladder and duodenum, partial pyloric obstruction.
Explore stomach. Ulcer.
Nephrectomy, right kidney for pyonephrosis.

Room II.

Subtotal hysterectomy.
Pyloric obstruction.
Dilate and curette. Appendix and examine pelvis.
Right nephrectomy.
Kraske, carcinoma rectum.

Room III.

Total abdominal hysterectomy.
Gall-stones.
Appendix and examine gall-bladder.
Epithelioma, larynx.

Room IV.

Adenoma of thyroid.
Resection mass, right thyroid region.
Cyst, right neck.

Room V.

Exophthalmic goitre. Ligation.
Explore gall-bladder and stomach.
Repair cervix and perineum.
Tonsils and adenoids.

Room VI.

Adenoma of thyroid.
Right hydrocele. Left omentocele.
Tonsils and adenoids.
Inflammation gland, left neck.

The Mayo brothers and one assistant do general surgery; one assistant does bone surgery, another brain surgery, and the sixth corrects deformities.

Between operating rooms I and II there is a sterilizing room. A second sterilizing room serves the remaining three, if I remember well.

The dressings are sterilized in bundles instead of in drums. The sterilizers are some 30 in. in length and about 24 in. in diameter. The usual water, instrument and utensil sterilizers are also in evidence.

The wash-up for surgeons and nurses is in the operating room, water from the regular hot and cold water taps being used. Dr. William Mayo informed me that as the water supply to the hospital was sterile, and all of that passing through the hot

water tap had been boiled, they have no compunction about washing up or cleansing their gloved hands during an operation in this water. The tap is manipulated by the means of a foot valve, and ejects a copious stream. On the mouths of the taps are tied layers of gauze.

The operating rooms are some 16 ft. x 18 ft. There is an observation stand in each, capable of accommodating a dozen onlookers. Over the operating table in room No. I is a large mirror suspended from the ceiling, which affords a good view of the operation.

The instruments and dressings are spread on a rather spacious table conveniently located. These tables are covered with sterile sheets, as is also the wall behind them to a height of some thirty inches.

The more frequently used instruments are placed on a table attached directly to the operating table—just over the patient's knees. Beyond this, between the patient's lower legs, is a basin for the soiled sponges and used instruments. The two types of operating tables used were: (1) A German, on the single, heavy pedestal, revolving and adjustable as to height, adapted also to various positions, built by the Kny-Scheerer Co.; and (2) the Minnesota White Line table, manufactured by The Scanlan Morris Co.

The patients are disrobed in a small room near at hand, and brought through the corridor—among many doctors, quite often —into the operating room, where they meet the operator, climb on the table and go off quietly.

I asked Dr. Charles Mayo if this procedure of giving the anesthetic directly in the operating room met with his approval. He said that it did. He said that he liked to be present in the operating room to meet his patients when they arrived. Where they had seen him at the preliminary examination they liked to have him present while the anesthetic was being administered. It gave the patients confidence. I did not notice any shrinking or diffidence on the part of the patients.

The surgeons do not use any other anoci association methods, as far as I observed, except the psychical as above exemplified.

"Dr. Crile is a great surgeon," said one of the staff to me, "but not because of anoci association."

For years nurses have given the ether, and, I believe, with good results. It is claimed that women perform this duty better than men. They are not tempted, as doctors are, to watch the operator. It is a natural process—maternal—to be put to sleep by a woman. The point is of psychological significance.

The ether is administered through an ordinary inhaler covered by many layers of gauze. When the under layers are well soaked several thicknesses are superimposed, which keep the fumes from escaping into the air. The upper layers are opened when fresh anesthetic is given or more air is needed.

The patients are strapped down to the table by the wrists and ankles. While I did notice the patients move a little I did not observe that the operators were bothered with abdominal straining.

On no occasion during my two days' stay did I notice any of the surgeons exhibit the slightest interest in what the anesthetist was doing. I noticed that the patients in Dr. Wm. Mayo's room were not deeply under. I asked one of the anesthetists as to this. She told me Dr. Mayo preferred that the patients be kept near the waking margin rather than deeply under.

The anesthetist appeared to me to pay no attention to the pulse, pupils, or conjunctival reflexes. The respiration seemed to be the main thing loked for and listened to.

It is quite an amusing and edifying experience to be present during Dr. Wm. Mayo's operations, particularly if the doctor is in a reminiscent, didactic, homiletic or story-telling mood.

The greater number of operative movements with him are like those of the skilled musician, automatically playing a well-remembered selection on a piano; the muscles and lower brain centres do the work in hand, while the upper brain is reflecting, remembering apt incidents, salient points in the character of friends. These are reproduced with dry humor, sarcasm or homely touch.

The senior brother loves to take a crack at the ultra laboratory refinements and the over emphasis often laid upon them

(to quote hm) "characteristic of a well-known medical school—too well known to be mentioned."

These superfine points Dr. William Mayo refers to as the pennies and nickels of diagnosis; and are, he declares, often made much of, while the ten-dollar bills are overlooked.

One forenoon, while operating on a case of gall-stones, he opened a monologue in this vein:—

" You know," said he, " some of our bright young men will spend hours investigating a case of this sort and find a long list of signs and symptoms, and perhaps overlook the two great diagnostic points in the case, the mass under the liver and the colic. I know one of these young men, a graduate of an A1 college, with a good training here. After looking around for a place to settle, he came to me to say that he believed he would go out to a certain locality. ' There's only old Dr. Smith there,' said he, ' an old fogey. He's twenty years behind the time; he can't do a blood count, a stomach analysis, or any of these new stunts. I believe that is the place to start.'

" The young man went to the place, and I learned that his pride was very much hurt on one occasion.

"After making a very careful examination he found a number of diagnostic pennies and nickels, but was uncertain what the real trouble was. The family, getting anxious, called in old Dr. Smith, who, after a few moments, made a positive diagnosis on a couple of ten-dollar bill diagnostic points, much to the dismay of the young man. Dr. Smith was trained to look for big things upon which the diagnosis of most diseases can be made.

" You know," Dr. Mayo went on, " there are everyday diseases and Sunday diseases. Give me the man who can make a diagnosis of an everyday disease. We sometimes find a man who can make a Sunday or holiday diagnosis, but who is an utter failure on the everyday diagnosis.

" Now, take the subject of occult blood, for instance. We hear a great deal about occult blood. ' Occult blood '—you know what ' occult ' means. You remember, years ago, when we were younger, occasionally Hermann, Keller, and other magicians used to come to town. You have seen them." As he said this,

Dr. Mayo's twinkling grey eyes were turned inquiringly upward under his heavy eyebrows to the visiting doctors ranged on the observation stand.

"The town people all turned out. One of the stunts the magician did was this:—

"He asked someone to lend him a top hat. Well, about the only fellow in the town who owned a top hat was the sheriff. (You know the sheriff is always a good fellow, he has to be a good fellow, a popular fellow, or he wouldn't be sheriff. And he wears a top hat.)

"Well, everybody looked at the sheriff, and they called out to him to lend his hat. So the sheriff, getting red in the face, handed up the hat.

"The magician took the hat, covered it with a cornucopia, and gave it a shake. He then put in his hand and pulled out a big bouquet of flowers. He put in his hand again and hauled out a rabbit. He then withdrew to the rear of the platform, stumbled and fell upon the hat, apparently accidentally, crushing it flat. Everybody laughed. The magician looked horrified at the damage he had done to the hat. But with a few magic movements he restored it to the sheriff as good as new.

"That is doing the occult; that is what occult means. So whenever I hear about occult blood, I think of Keller and the sheriff's hat.

"Our own laboratory diagnostician triumphantly reports that in a stomach analysis he has discovered 'occult blood.' Now, what does that mean? Well, it doesn't mean much to me. What definite information does it give? Little or none. This blood may come from an ulcer, or a carcinoma; it may result from the use of the toothbrush—you have heard those fellows cleaning their teeth in the morning in the sleeping car, which operation sounds like an old woman scrubbing the front steps. Well, those fellows will have 'occult blood.' It may also result from eating meat; and from other sources. You can't count upon it. It is one of the diagnostic pennies."

This straining after the comparatively unimportant was emphasized over and over again by the chief as he handled the intestines, dissected and stitched.

"Ochsner," exclaimed he, looking up again, "tells a good story, as he alone can tell it with all the frills. I cannot attempt to reproduce it as he tells it. It was in regard to a preacher who came to take charge of a church in a certain village. Now there belonged to this church a horse trader. The preacher needed a horse, and, naturally, turned to the horse trader to procure one for him.

"So he asked the horse trader if he would sell him a horse. A great struggle took place in the horse trader's mind. It is delightful to hear Ochsner describe the agony of the man—torn with conflicting emotions—his desire not to cheat the preacher—to overcome his long-acquired habit of over-reaching, and, on the other hand, to make something on the deal. He did not want to lose his status in the church, neither did he want to lose his reputation as a horse trader. The horse dealer asked for a day's grace. The interval was one in which there was a great battle in the man's conscience. The following day the minister returned and inquired if he had picked out a horse. The trader replied that he had, and set the price. 'But,' said he, 'he has one or two faults I ought to tell you about.'

"'What's the matter with him?' queried the parson.

"'Well,' the trader replied rather hesitatingly, 'if he gets loose you can't catch him.' The preacher thought for a moment. 'Oh! that's all right,' he said, 'I am going to keep him in the stable, when I am not driving him. He'll never be loose. I'll take him.'

"So the preacher took the horse, hitched up, and drove off. But before he got many yards away, the horse trader, conscience-smitten, ran after him to tell the truth; and in a state of great agitation he blurted out, 'When you do catch him, he ain't worth a darn.'

"That's the way with some of these diagnostic findings," concluded Dr. Mayo, with a smile, "when you do get 'em they ain't worth a darn."

Society Proceedings

AMERICAN HOSPITAL ASSOCIATION—SMALL HOSPITAL SECTION

(*Concluded from April issue.*)

MISS McCALMONT: Mr. Chairman, this, of course, is the biggest problem, I believe, in hospital management. There is a great deal to be said on both sides, but I have yet to see a hospital that is satisfactorily managing a central diet kitchen. It is almost impossible to get the food to the patients properly hot or properly cold. Undoubtedly the trays are served more attractively and sent up in many ways in better condition when served from a central diet kitchen under the supervision of a dietitian or a nurse who is specially detailed; but it is most difficult to get it to the patient in a satisfactory condition, because when it is sent out it is sent on the assumption that the patient is ready to eat it. In many instances the patient is not ready; the patient is being visited by the doctor or some form of treatment may be going on, or something which will interfere with the patient getting the tray at the time she is supposed to get it. In the Stanford Hospital in San Francisco we are trying a new experiment. We are having the separate diet kitchens on each floor. The food is to be cooked in a central or special diet kitchen. It is to be sent in bulk to the smaller diet kitchens, but the nurses who are in training in the diet kitchen are to go to the smaller diet kitchens and serve that food, which does away with the very logical objection that special nurses come into the smaller diet kitchens and, of course, the first one there takes their choice of everything for their patient; the special nurses will not be allowed in the kitchens, but the nurses who are in training will serve the trays and the special nurses will be notified that the trays are ready and taken in to the patients only when the patients are ready for them. Of course that is an experiment, but it seems to me it is a very logical solution of the food problem.

The Chairman: Miss McCalmont, may I ask how large a hospital that is?

Miss McCalmont: Well, the new hospital is to be 200 beds. They already have a hospital of about 180 beds. Of course this problem for the smaller hospital is comparatively simple, but the larger hospitals find difficulty.

A Lady: Mr. President, I wish to say in our hospital we have 120 beds and for the past three or four years we have carried out this plan exactly that the lady has just mentioned and we find it extremely successful

Miss Burns: As far as the special nurses are concerned, I have the same plan also. They are not allowed to go into the diet kitchen at all. We have the diet kitchen door cut in two and a shelf there; they remain outside and their trays are passed out to them. But in our hospital the private patients are allowed to order special diet and the special nurse has to send in her requisition for what she wants. She gets it served on her tray and taken charge of by the dietitian, but they are never allowed in the diet kitchen. I have anywhere from 20 to 30 special nurses.

Dr. Morritt: I have been fortunate or unfortunate in having experience with both methods. As has been said, both methods have their advantages. With the central diet kitchen away from the floors, you have the advantage that no odor of cooking gets into your rooms. You also remove all the noise and rattle of washing dishes and preparing meals. With proper containers, electric heaters, etc., you can, by care and watchfulness, get your tray to the bedside hot or cold as the case may be. I had charge of a hospital for some years that did that and it worked satisfactorily. Now I have charge of a hospital where each floor has its own diet kitchen, and the rooms in the immediate proximity to the diet kitchen are not occupied unless the hospital is crowded. Nobody wants them because of the noise, especially in the summer time when you have to keep your doors open. There is noise of the preparation and cleansing of dishes, etc., afterwards, and the odor of cooked food sometimes before the meal is served, so the patients get an inkling of what is coming, which is always an undesirable thing. My chief objection to the diet kitchen on the floor is that it is noisy in the extreme

and the patients in the rooms adjoining know exactly what is going on. The advantage, of course, is that ordinarily you can get your tray to the bedside in better condition than you can bring it from a central diet kitchen.

The Chairman: As was stated by Miss McCalmont, this is one of the important problems in nearly all hospitals and it is very valuable to learn from the experience of others. Now, we haven't arrived at any answer to the question. I think the central serving room and individual rooms are both in vogue to about the same extent. Let us have some positive statement in favor of or against one or the other.

Miss Webster: Mr. Chairman, I have tried both. I think the most satisfactory way is to have a diet kitchen on each floor. It does have the objection that Dr. Morritt speaks of, but it is the only way in my experience to get the food to the patient in the proper condition.

The Chairman: Score one for the individual diet kitchen.

Dr. Packard: Mr. Chairman, I have a positive statement to make, because I have passed through the experience. A year ago, we built an addition to our hospital. Before the addition to the hospital we had serving kitchens on each floor. At that time we took under advisement having a central serving kitchen, In our new building we planned and put in a central service kitchen and made the original diet kitchen on the floor in the old building into private rooms. We tried that for about a year, and now we are going to tear out our private rooms and put our service kitchens back on the floors. It is true that the kitchens on the floor make considerable noise, especially with the dish washing but we are going to have the dish washing carried on in the main kitchen the same as before; send all the dishes to the main kitchen to be washed, and the trays set up and sent back on the dummy elevator to the kitchen, our chief difficulty being that we are unable to serve the trays, hot or cold, that we want to, and serve them in the fashion that they should be served.

Mr. Stevens: If I may inject one suggestion to the hospital people, just to overcome that very thing which the doctor spoke of. If we make our serving kitchens outside of the ward, outside of the rooms, so that we get two doors, we will say, let

those open from a cross-corridor, and not directly onto the corridor where the rooms are, so as to get no patient within a very close range of our serving kitchen. That minimizes the noise. In that way we can build our serving kitchen at each ward unit, and in that way overcome the difficulty which has been spoken of, and so make it possible to serve direct.

MISS ANDERSON: I think Superintendents here will be interested in the system which you might ask Miss Thrasher to tell you about.

THE CHAIRMAN: We would be very pleased to hear from Miss Thrasher.

MISS THRASHER: Our condition at the Robert Bent Brigham Hospital is not completed. We are a very new hospital, and while we have individual diet kitchens, I am not sure that we shall not make some arrangement to change it after we have worked on it for awhile. We are still working on our problem.

MISS THOMAS: I think there is more waste in the separate floor service room than there is in the general serving room in the hospitals.

THE CHAIRMAN: Now, of course, this problem is not alike in two places. For instance, with the Peter Bent Brigham Hospital I know they have a great deal of territory to cover, being a hospital on the pavilion plan. It would be almost impossible to have a central service room. It would have to be a kitchen for each ward unit. Are there any others who would like to speak, so that we may make some converts, one way or the other?

MISS REED (Monongahela): In April we moved into a new building with the serving rooms on each floor. Prior to that, in the old building, we had a central service room. Now, with practically the same serving force we are serving from the central room. We find it a very great advantage, having separate serving rooms on the different floors, with only a very slight increase in waste. Possibly a slight increase, but very slight. And there is simply no comparison in the shape in which we can get the trays to the patient. We feel that the separate serving room from each floor is far and away ahead of the central serving room as we had it.

The Chairman: May I ask how large a hospital you have?

Miss Reed: At present we have a sixty-bed hospital. Our old building was forty-five beds.

The Chairman: And how many floors?

Miss Reed: We have two floors with patients, with the kitchens on the first floor, connected with the serving rooms by a waiter going up and down and in that way handling the food in bulk to the serving rooms, and from there serving.

Question 6. Have hospitals the right to fix the rate which nurses specialing private patients in the hospitals shall charge?

Miss Metcalfe: Personally, the experience I have had is that the price charged for graduate nurses is such as the average rate in the city or town where they are nursuing. But I do not believe the hospital has the right to fix the charge. In the hospital where I am now, we know perfectly well what the nurse is going to charge, and so state the case to the patient. That is usually paid directly to the nurse. I would like to hear what the experience is in other places.

Miss Webster: I think the superintendents should have supervision of the charging. I have had some experience along this line, of nurses overcharging; for instance, charging ten dollars for a day in a hospital where they have all assistance that they require, by pupil nurses. I think the charges should be uniform, and patients should be protected.

The Chairman: I may say, in the cities up in this part of the country, that is governed by the Nurses' Register, which is more or less of a labor organization, I might say labor union of the nurses. They get together and fix the rate and we accept it as the going rate, and we would not stand for nurses charging any more; nor would we like to see them charge any less. I presume that is the custom elsewhere. The only question that comes up is where nurses serve for less than a week, because the registry rate is usually so much per week, and in some places they fix it so much per day, as well.

Question 7. Comparative merits of coal, gas and electricity for cooking and heating.

DR. PACKARD: Offhand, I should say that coal has its disadvantages, as it has advantages. Among its disadvantages, I should say first that it was dirty; second, that it requires a great deal of work to build a coal fire, keep it going, and keep an even heat. It is almost impossible to keep an even heat with a coal fire; and, third, that you cannot turn out the fire as soon as you are through with it. Those are three disadvantages, I believe, to coal heat.

On the other hand, if you are going to have a steady fire in a range during the day, it probably would be more economical than the other heat.

I cannot see that gas has any disadvantages as a means of cooking. It is easy to start, you can maintain an even heat, and you can turn it out when you get through, and you aren't burning up any fuel unless you are using it. In regard to electricity, I don't know. The only thing that occurred to me was this, that if you happened to be in the midst of a family dinner and the electric current should give out, you probably would be glad that you had either gas or coal. That would be one objection that I would have to electricity, the possibility of the loss of the current, the loss of the heat in that way. I also believe that electricity, as a matter of cooking, would probably be rather expensive, though I could not give any relative figures regarding the expense of coal and gas and electric heating. On the whole, I should say that gas furnished the most advantages, inasmuch as it is clean, there is no dirt connected with it, it can readily be started, you can regulate the heat to any point or degree you want it, and as soon as you are through cooking, you can turn the gas off.

THE CHAIRMAN: The question is open for discussion. Let's have some more opinions, if not experiences.

MISS BARRETT: Mr. Chairman, the hospital with which I am connected, in Grand Rapids, has had coal stoves, and we have taken them all out and are now using gas. We find it is not any more expensive. We are building a new hospital; we are going to use gas in that.

DR. MORRITT: I would like to add this, that at one time I looked into the matter of cooking with electricity. Of course, I was in a place where electricity could be gotten very cheaply;

and I found there was not an electric stove on the market that would take a large roast of meat. I wrote one of the large electric companies and they said they were not quite ready to put one on the market yet. They all could furnish the apparatus for small family cooking, but not for a large place.

THE CHAIRMAN: I think that is the situation, they cannot furnish an electric stove big enough for a hospital.

DR. POTTS: I would like to know the price that the lady has to pay for gas, where she is cooking with it.

THE CHAIRMAN: Miss Barrett, will you give us the rate of your gas?

MISS BARRETT: I don't believe I can give you the exact rate, but we have a special rate in Grand Rapids.

THE CHAIRMAN: It is under a dollar a thousand feet there, is it?

MISS BARRETT: I think so, something about that.

DR. MATHERS (Winnipeg): I would like to relate our experience in cooking with electricity in our new municipal hospital in Winnipeg. This is a hospital for contagious diseases, a 200-bed hospital. Winnipeg is situated perhaps fortunately. That city has within the last three years established their own power plant seventy miles from Winnipeg. They carry the current seventy miles into the city, and supply current for heating purposes at the rate of one cent per kilowatt hour; that is, for the first fifty hours' continuous load, after 500 continuous hours, that is, in the month, it drops to eight-tenths of a cent. Our hospital which, as I say, is a municipal hospital, is supplied in the main kitchen with an electric range, built by the General Electric Company, a counterpart of the ranges which are used in the U.S. battleships, except in this regard, that we had to have it built especially for our hospital, because they did not build one of exactly the size we wanted. The range itself cost $1,700, something more than it would have cost if we could have used the standard range. Each of the diet kitchens is supplied with a small electric range, with two hot plates and an oven. I might say also we have the building piped for gas, so if the current fails at any time, we are ready. There is an arrangement there, also, between the electric railway company and the city, which are to a certain extent competitors, that if

one plant fails the other takes up the work. So we are comparatively safe.

Now, some time ago we undertook an investigation of the work that this range was doing. We took the number of full meals that we cooked in that range during one week, and we had a meter attached to the range so that we could ascertain the amount of current consumed. Working it out, we found that we are cooking full meals (I mean full meals for the help and those patients who are on full diet) for less than one-third of a cent each.

Now, as I say, we are perhaps more fortunately situated than most hospitals. In the matter of cooks, we averaged about a cook a day for the first two weeks. These were all female cooks, and they gave up at the end of the first day, generally. At last we managed to get a chef who apparently has mastered the thing completely, we have absolutely no trouble with it. The ovens are built in such a way that the current may be turned off and you can use them between one and two hours after the current is off. The diet kitchen ranges are very useful. They can be turned off when not being used. They are clean. The only disadvantage is that a careless nurse or ward maid may perhaps spill some liquid over the plates and destroy them, which costs us $1.50 to renew. I just mention this to show that electric cooking is still a possibility.

Dr. Potts: Mr. Chairman, I would like to know something about steam cooking?

The Chairman: Well, let's hear of steam cooking. Do you have some experience yourself to give us?

Dr. Potts: No, sir.

The Chairman: You wanted to learn something about it?

Dr. Potts: Yes, sir.

The Chairman: We have heard of the principal merits of cooking by coal, gas and electricity. This gentleman wants to know something about the merits of cooking by steam.

Dr. Morritt: You mean by that, steam as displacing coal and gas entirely?

THE CHAIRMAN: It couldn't do either. I presume we have to have steam to operate the hospital. I don't think this question comprehends the use of either gas or electricity for the production of steam. I suppose steam is used for the cooking of vegetables, cereals and puddings, and perhaps cooking meat. I don't know of anyone making griddle cakes by steam, or frying eggs.

MISS SMITH: Mr. Chairman, we have in our kitchen a steam jacketed kettle, whereby we roast our meats and cook our soups, and we cook all our vegetables in the steam cooker. Of course, we cannot fry.

THE CHAIRMAN: You cannot get a dry heat?

MISS SMITH: We roast our meats.

THE CHAIRMAN: But it doesn't scorch them.

MISS SMITH: No, it roasts them beautifully.

THE CHAIRMAN: Yes, that is quite general, I think, roasting meats, cooking soups and cereals and vegetables by high pressure steam.

MISS ANDERSON: On this question of fuel I would like to know if any one here has found a fireless cooker that is large enough to be of any use as an auxiliary in the cooking of food. It has always seemed to me if one could be found large enough, we could find a great deal of use for it.

THE CHAIRMAN: That is a pertinent question, the fireless cooker is for hospital use. Has anyone any experience?

MISS RITCHIE: Mr. Chairman, we have a very good Caloric, sufficient for our use. We have only a 30-bed hospital. Our cereals, some meats, and most vegetables are cooked in the Caloric. We have a nest which lends itself very well to small quantities for special diet. Our cereals are all cooked in that way, in sufficient quantity for our numbers. There are two sinks, and each operated with two heated stones. We find it sufficient, but I have never seen a large enough one for a larger number.

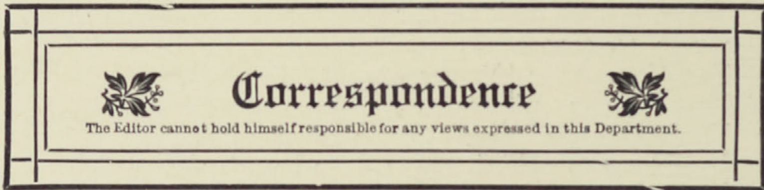
THE CHAIRMAN: With the individual diet kitchens or serving rooms, I presume it could be used. I would like to be enlightened upon the baking in hospitals, and how extensively coal, electricity or gas is used for that purpose, because of the fact that I am just contemplating installing a bakery, and want

to know which to adopt, the coal or gas oven. Will someone please tell us about their experience in baking, and what means of heat they use.

MISS BARRETT: We do all of our baking with gas. Of course, we only have a 75-bed hospital now.

THE CHAIRMAN: Do you find it more economical to do your own baking, than to buy your bread?

MISS BARRETT: Well, we like it better.



THE WELLESLEY HOSPITAL

THE following letter recently reached us from the Directors of The Wellesley Hospital, Limited, and should be noted:

"An erroneous idea seems to prevail amongst the laity that Wellesley Hospital is too expensive for people with moderate means, and we should therefore be greatly obliged if you would be good enough to correct the misconception if you have an opportunity of doing so. The mistake may be partially due to the fact that the reception rooms are furnished on a more lavish scale than is customary in the ordinary hospital.

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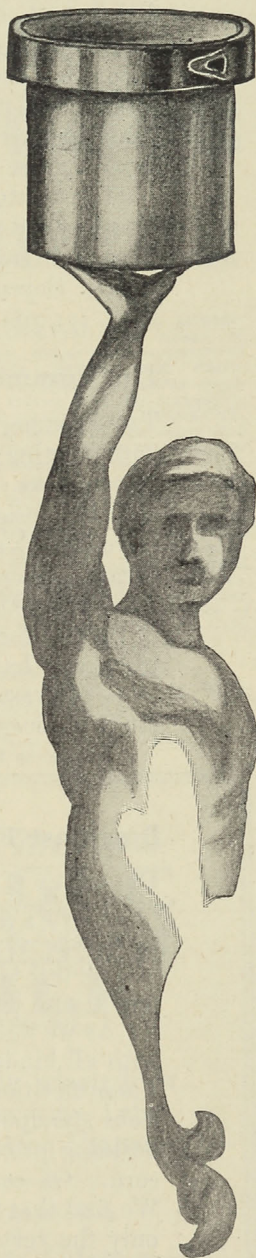
If there is a building that should have as nearly as possible a perfect system of lighting, it is a hospital or sanatorium. How often it occurs that a surgeon, in operating after dark, is confused by the unsatisfactory lighting in the operating theatre, and medical practitioners know well of most distressing cases of eyestrain due to defective illumination. The James Devonshire, Limited, 166 Bay Street, Toronto, are Canadian agents for the Alexalite System of Lighting, which is ideal for use where the human eyesight is to be preserved from not only fatigue, but permanent injury as well, and also where everything should be distinguished in its true relationship as in an operating room. This can be only done by removing all spots of light from the normal range of vision, thus effectually screening the eye from the actual source of light. This is accomplished by the Alexalite system, which illuminates the object seen with an even intensity of light at all points, causing a feeling of restfulness and preventing any struggle on the part of the human eye to avoid a glare. As is well known, the best daylight is on a bright day with the sun obscured by a cloud, showing the value of indirect light. This is afforded only by the Alexalite system. It is for these reasons that hospital authorities and physicians should investigate this system first.

Dr. H. A. Boyce Resigns as Superintendent of Kingston General Hospital

Dr. H. A. Boyce, who for seven years has so acceptably filled the position of Medical Superintendent of Kingston General Hospital, has tendered his resignation. The Board of Governors met on April 6th to consider the matter and all present were quite unanimous in expressing their deep regret at the prospect of parting with the Medical Superintendent, who for seven years rendered such efficient service and during which time the hospital has made very satisfactory progress and has become probably the best equipped institution of the kind in Canada outside of Montreal and Toronto. It was hoped that some arrangement would be made with Dr. Boyce to remain a little longer than the time specified, as the governors felt that the few weeks still left in April would be hardly sufficient in which to secure a successor.

A strong and hearty resolution was drafted and placed on the minutes setting forth the very valuable and efficient service rendered by Dr. Boyce during his term of office. It was felt

* Publisher's Department.



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that he had shown not only much skill in his duties required as Medical Superintendent but that the business end of the institution had been handled in a way that showed the doctor to be possessed of more than ordinary executive ability, and the wish was heartily expressed that he would have a very successful and happy career as a medical practitioner.

The matter of his successor was left with the Committee of Management to confer with the Medical Staff and take such steps as are necessary.

Dr. Boyce is relieved from office on May 1st.

The Summer School of Management

The Summer School of Management, third year, will be held at 256 Meeting Street, Providence, R.I. This will be held for three weeks, beginning August 1st, 1915. This course is especially designed for professors of Engineering, Economics, Psychology, and Business Administration, but is also open to surgeons who are occupying positions of management in connection with recognized hospitals.

Mr. Gilbreth is consulting engineer for the New York Hospital, and has for two years been actively engaged in the problems of waste elimination, hospital management, and motion study in surgery.

There is no charge whatever in connection with the Course.

Breakfast Foods

Recently Tillson's Oats, which has been on the market for some time, has been brought to our notice. It deserves the patronage of the Medical Profession, being undoubtedly the best Rolled Oats on the market. These oats would be especially useful and beneficial in your institution.

As we well know, the market has been flooded for some years with all kinds of fads which the public is deceived into buying. These fictitious foods have absolutely no value from the nutritious standpoint. We also know that for heat producing, tissue building properties, Oats take the lead, then follow wheat and corn. Of course, like all other grains, Oats vary in quality. We find that Canadian Cereal & Flour Mills, Ltd., Toronto, use only the very best Western Oats.

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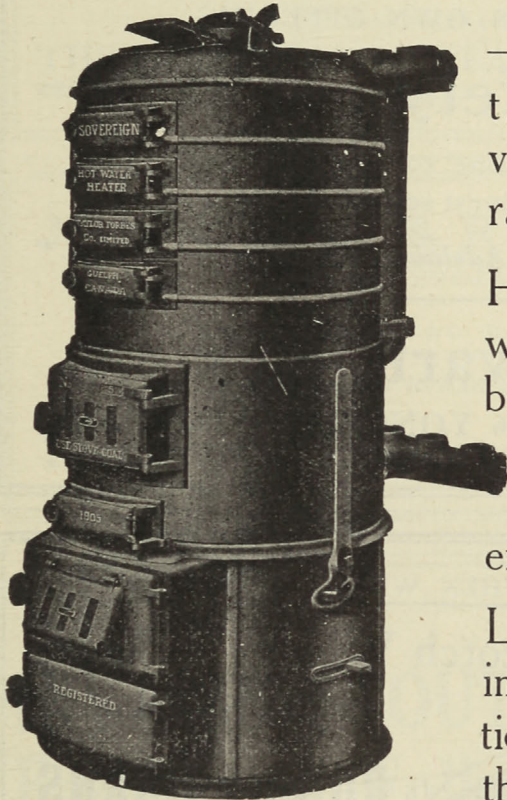

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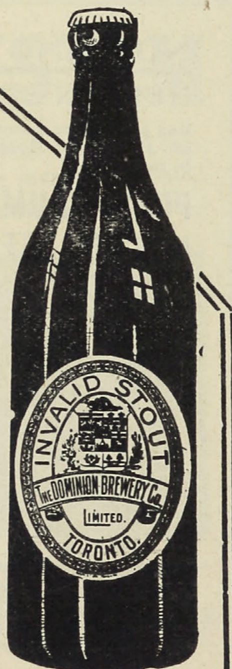

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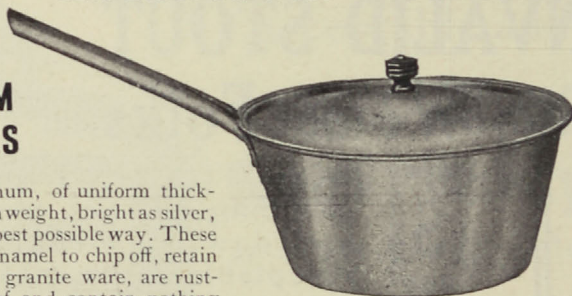

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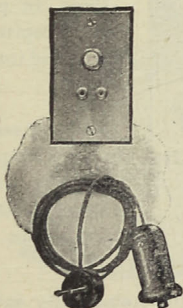

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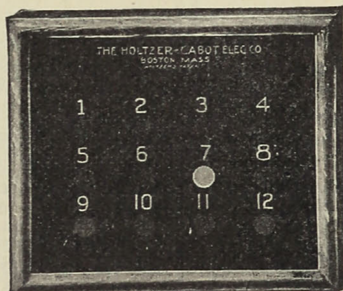

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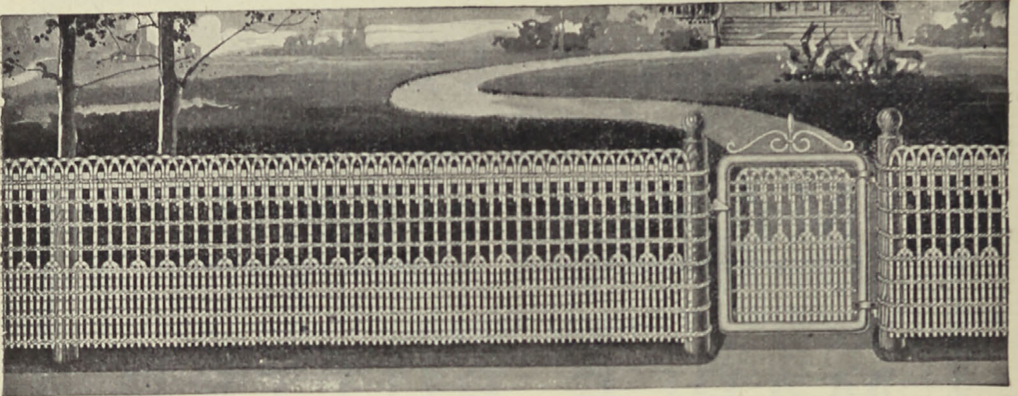

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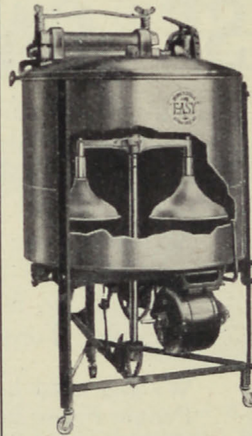

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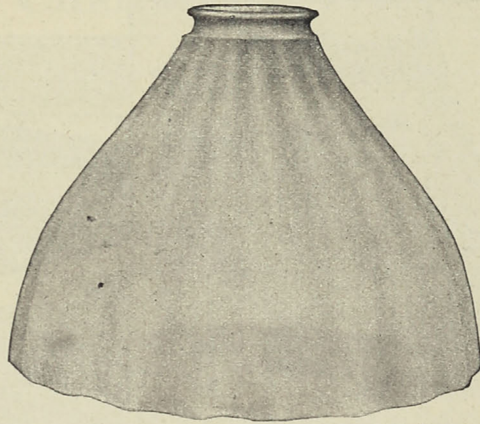

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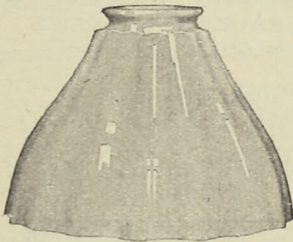

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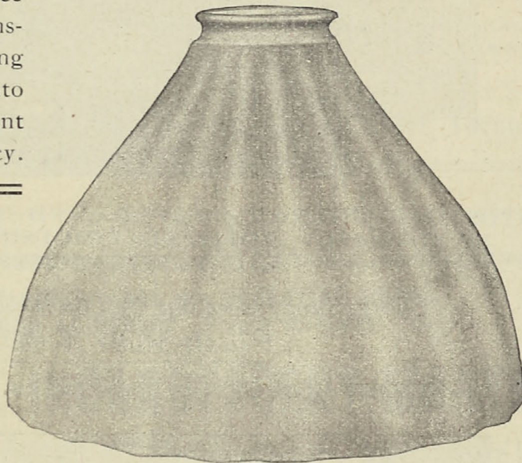

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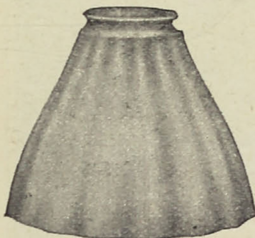

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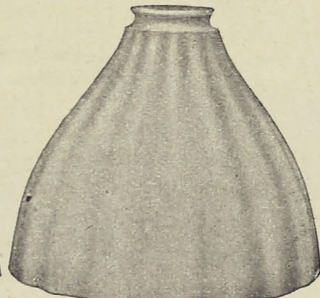

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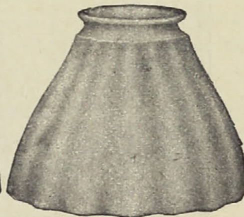

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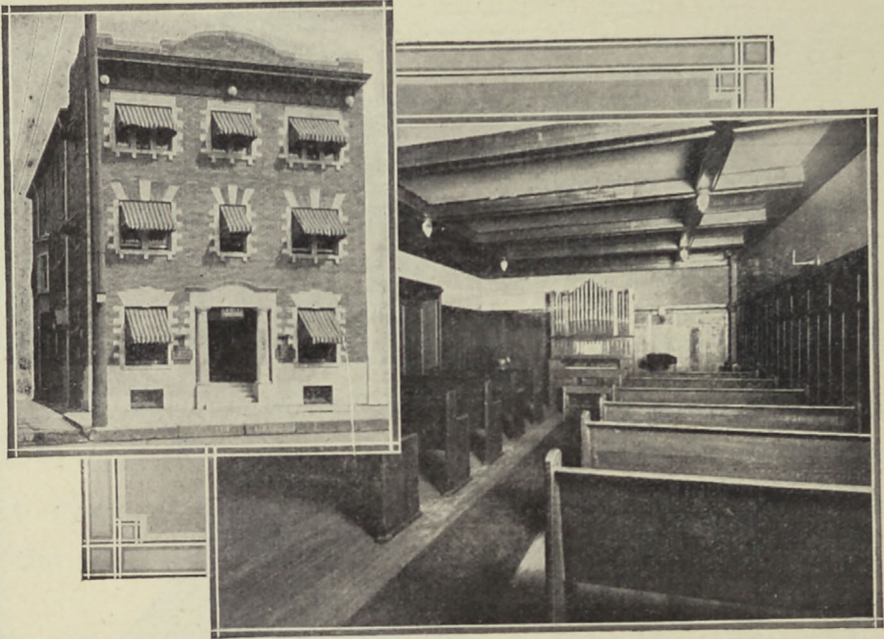

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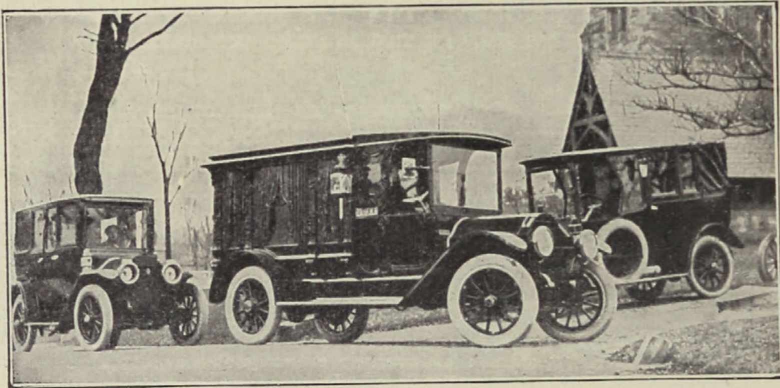

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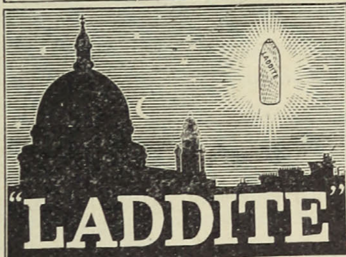

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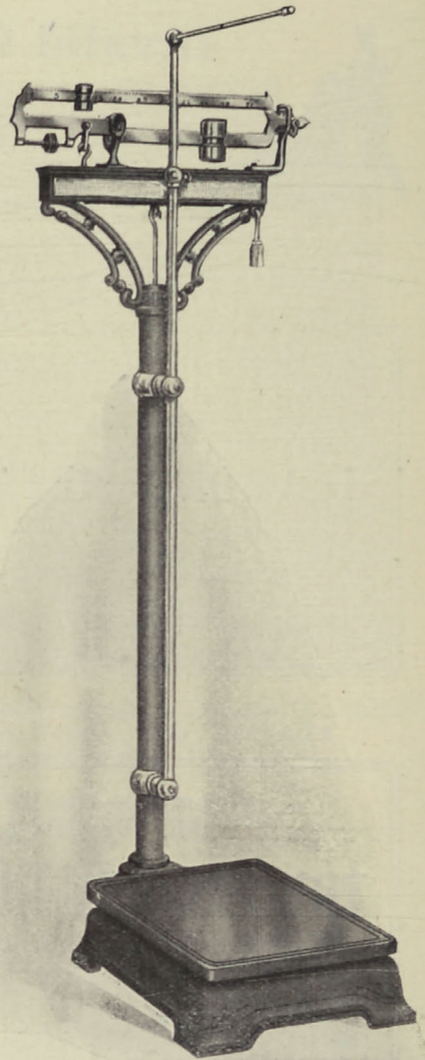

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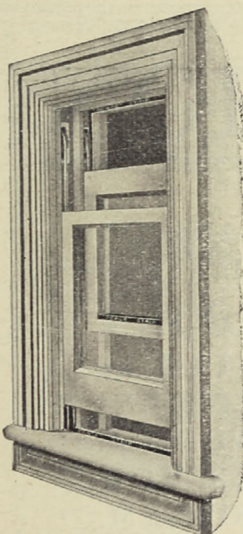

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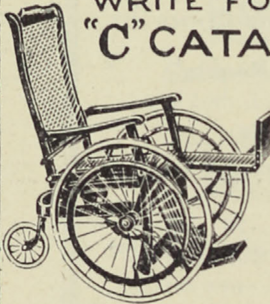

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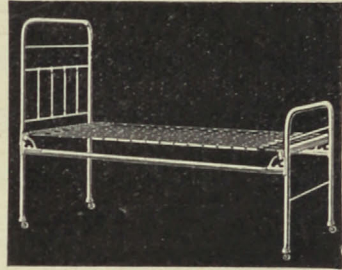

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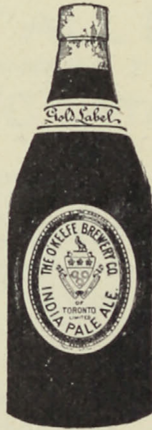

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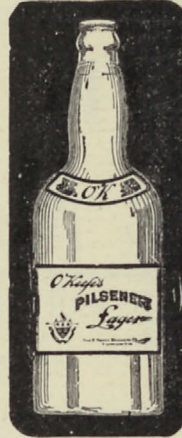

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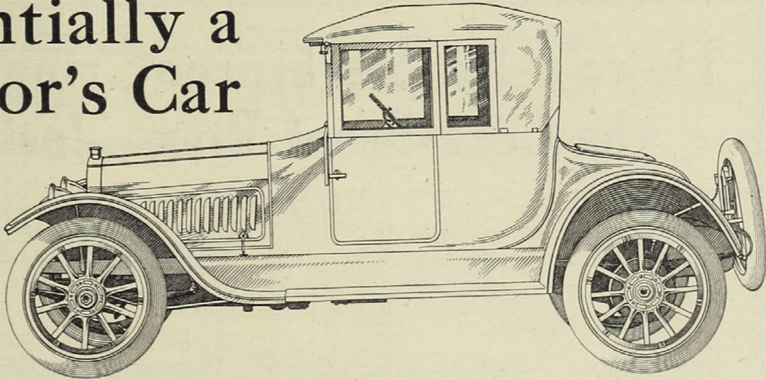

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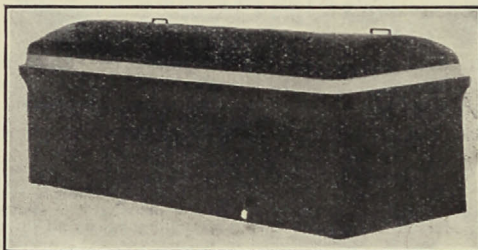

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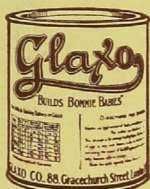

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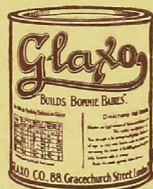

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