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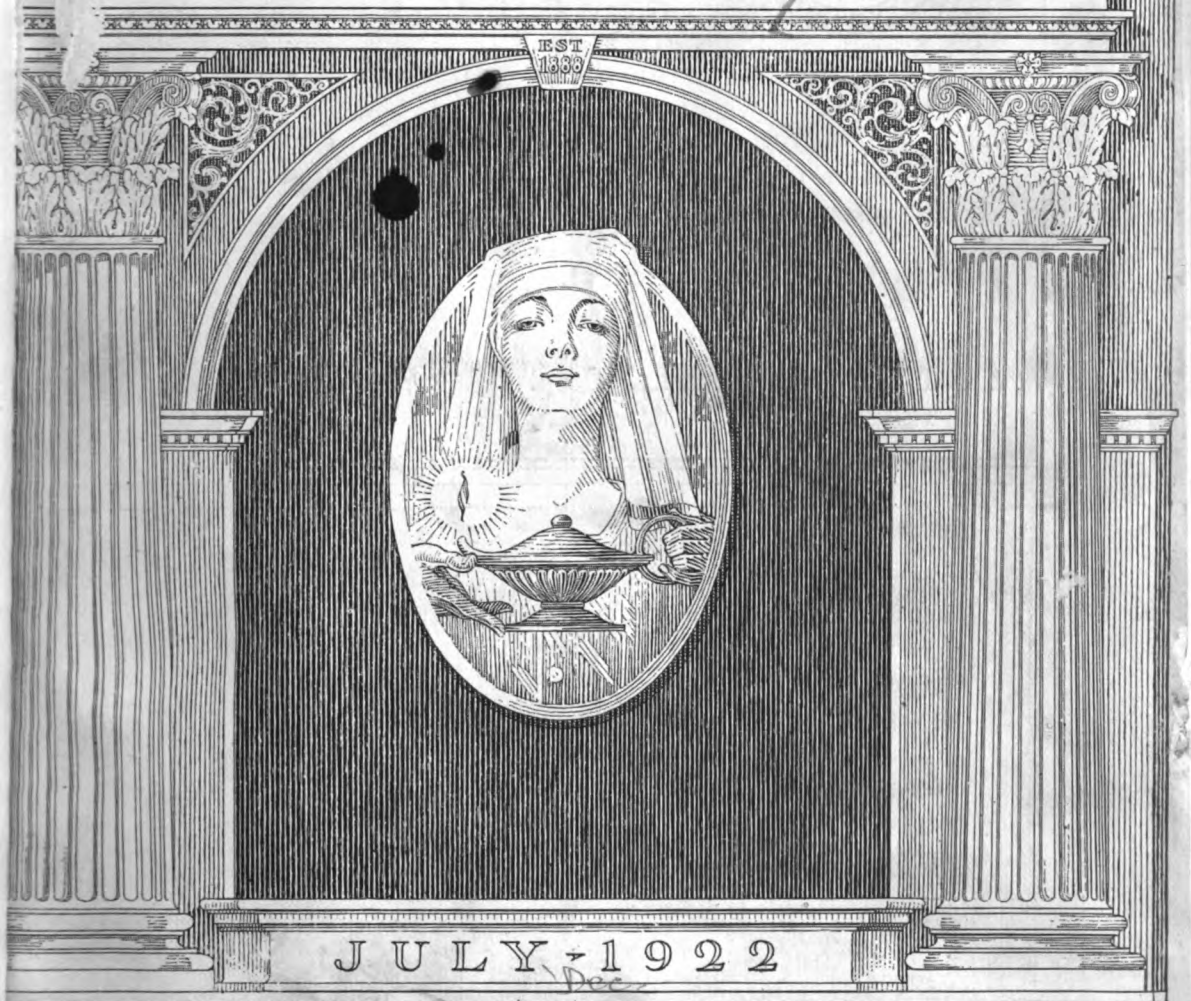
# THE TRAINED NURSE AND HOSPITAL REVIEW




JULY 1922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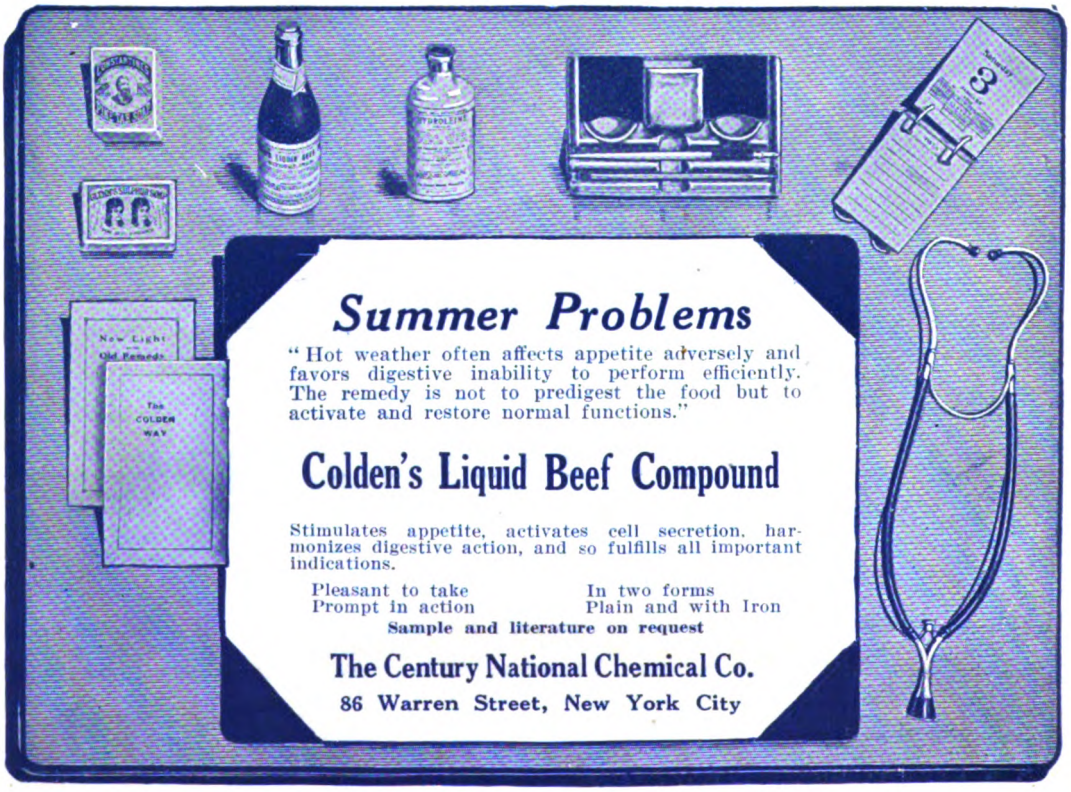


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Vol. LXIX JULY No. 1

# The Trained Nurse and Hospital Review

**A Monthly Magazine Devoted to Trained Nursing in Private Practice, in Hospitals, Institutions, and Public Health Service**

*Editor,* CHARLOTTE A. AIKENS
*Managing Editor,* META R. PENNOCK
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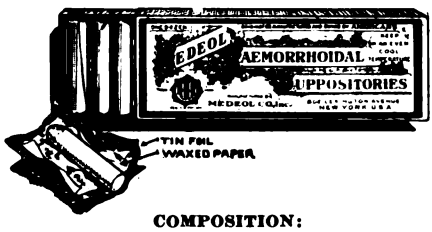


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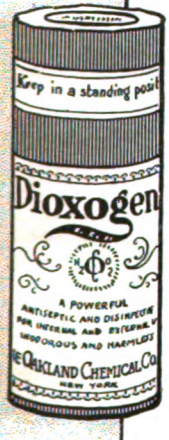

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Herewith is a photograph of Page 95, Vol. 11, "Diseases of Women," as edited by H Marion-Sims, M D, and in Dr Sims' own words, is recorded the high esteem in which he held *Hayden's Viburnum Compound* and the "great service" rendered in treating

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DYSMENORRHŒA. 95

It has been long known that rest is most efficacious in relieving dysmenorrhœa. Some patients habitually go to bed during the menstrual process, finding so much relief from the position. There is nothing therefore new in the recommendation to rest at this time, but experience has shown that the positional treatment above described carries the effect still further. The treatment is particularly valuable in the case of young single women who are suffering from dysmenorrhœa not of such severe character as to render internal treatment imperatively necessary. And indeed I have in several cases employed positional treatment with great success where no examination at all had been made, but where the symptoms and general history conclusively showed that the patients were suffering from commencing uterine flexion.

Positional treatment is also very valuable as an adjunct in cases where internal mechanical apparatus are in use.

*Palliative Measures.*—Rest, the horizontal position, postural treatment, as above described, are all of first-rate importance. The warm hip-bath, temperature 100° or even higher, is to be recommended. Copious vaginal injections of hot water are sometimes found very serviceable. Ether, compound spirit of sulphuric ether, camphor, and henbane are ordinary and very useful remedies. Gin and water is a common domestic remedy. Poultices with laudanum sprinkled over them, hypodermic injections of morphia, turpentine stupes, are other remedies occasionally employed. Suppositories containing opium or morphia are very effective, but the use of opium is not advisable unless under strict medical orders. Chloral and bromide of potassium are good remedies. Guaiacum (Dewees), black hellebore (Meigs), have been strongly recommended. Colchicum, cannabis indica, and in fact every sedative and anti-spasmodic in the pharmacopœia, have been employed for the relief of the pain with more or less success.

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# The Trained Nurse and Hospital Review

ESTABLISHED 1888

Vol. LXIX NEW YORK, JULY, 1922 No. 1

# IS THERE EVIDENCE FOR THE THERAPEUTIC USE OF MUSIC?

ESTHER L. GATEWOOD, PH.D.

Edison Music Research, New York City, New York

*Invention has brought the stimulating outside world within hospital walls. A screen version of "Penrod" sports across the ceilings of convalescent wards; the vibrant tones of Homer and Caruso or the cheery voice of Lauder are reproduced by the phonograph; radio now transmits monologues and music to eager listeners.*

*To what scientific uses are we putting these new factors? Miss Gatewood answers for the field of music.*

WHEN Eurydice was in Hades, Orpheus invaded that region, played on his magic lyre, and the heart of Pluto was softened. Eurydice escaped, the wheel of Ixion stopped, the vultures ceased to torment Tityos, and the thirst of Tantulus was quenched. Many old Arabian legends tell the same story of how some gifted musician played upon the emotions of the king of his country and miracles were performed.

Historical stories from both the Orient and Occident relate incidents not unlike those which we find in ancient legend. The Scotch king led his men to war to the stirring notes of the bagpipe. The Russian oarsmen were stimulated by the Volga River Song. The American Indian called his men together by means of the tom-tom.

Old and numerous as are these stories about the effects of music and the use of music in practical situations of one sort or another, very little real historical material of authentic source can be found. We are interested, today, in the practical uses to which music can be put in industrial, economic, and social situations.

Pinel and Esquirol, almost a century ago (1824-1825) first introduced music in the Salpetriere. They provided musicians who were to play, at their direction, different types of music and they reported encouraging results. A Dutch physician a few years later tried music with chronic cases and with convalescents, and he, like the earlier experimenters, found it useful.

In London thirty years ago (1891) the Guild of St. Cecelia was founded. This organization provided musicians for various hospitals, and the reports of their work assert that music "quiets the nerves and soothes pain." One case of melancholia is cited in which the patient had not talked in nearly two weeks. After listening to the music awhile, she began to converse and showed marked improvement from then on. Florence Nightingale put her approval upon the Guild of St. Cecelia. Some years later a similar Guild of St.

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# IS THERE EVIDENCE FOR THE THERAPEUTIC USE OF MUSIC?

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*Invention has brought the stimulating outside world within hospital walls. A screen version of "Penrod" sports across the ceilings of convalescent wards; the vibrant tones of Homer and Caruso or the cheery voice of Lauder are reproduced by the phonograph; radio now transmits monologues and music to eager listeners.*

*To what scientific uses are we putting these new factors? Miss Gatewood answers for the field of music.*

WHEN Eurydice was in Hades, Orpheus invaded that region, played on his magic lyre, and the heart of Pluto was softened. Eurydice escaped, the wheel of Ixion stopped, the vultures ceased to torment Tityos, and the thirst of Tantulus was quenched. Many old Arabian legends tell the same story of how some gifted musician played upon the emotions of the king of his country and miracles were performed.

Historical stories from both the Orient and Occident relate incidents not unlike those which we find in ancient legend. The Scotch king led his men to war to the stirring notes of the bagpipe. The Russian oarsmen were stimulated by the Volga River Song. The American Indian called his men together by means of the tom-tom.

Old and numerous as are these stories about the effects of music and the use of music in practical situations of one sort or another, very little real historical material of authentic source can be found. We are interested, today, in the practical uses to which music can be put in industrial, economic, and social situations.

Pinel and Esquirol, almost a century ago (1824-1825) first introduced music in the Salpetriere. They provided musicians who were to play, at their direction, different types of music and they reported encouraging results. A Dutch physician a few years later tried music with chronic cases and with convalescents, and he, like the earlier experimenters, found it useful.

In London thirty years ago (1891) the Guild of St. Cecelia was founded. This organization provided musicians for various hospitals, and the reports of their work assert that music "quiets the nerves and soothes pain." One case of melancholia is cited in which the patient had not talked in nearly two weeks. After listening to the music awhile, she began to converse and showed marked improvement from then on. Florence Nightingale put her approval upon the Guild of St. Cecelia. Some years later a similar Guild of St.

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Cecelia was organized in New York City, but soon died from lack of financial support. In 1900 the Academy of Sciences, at Paris, reported that "respiration and circulation are increased by lively tunes."

In America, as early as 1878, music was used on Blackwell's Island. The reports show that the physicians in charge were pleased with the results, although their statements were indefinite. They asserted that the right sort of music quieted the pulse. At Ward's Island in 1900 music was introduced, and here it was reported that it was best suited to melancholia cases. This agreed with the report of Pinel and Esquirol many years before.

The Irish physician, Dr. Drapes, states that "nothing cheers patients like music; removes depression, assuages grief, quiets excitement; rarely, if ever, does it produce the slightest ill effects." In 1903 Tarchanoff reported the effects of different kinds of music on ergograph records. This is one of the few objective, measured experiments. He noted that different kinds of music gave different results. He adds: "It (i. e., music) exercises a genuine and considerable influence over the functions of the body. It is a good antidote to the pernicious habit of introspection and self-analysis."

The normal and the abnormal patient are not so unlike as we usually think. In the every-day life of the average individual there are times when he is more or less melancholic, or when, on the other hand, his gaiety becomes excessive, and yet we do not accuse him of being other than normal. Similarly the well and the ill are not wholly unlike. Many forms of hysteria and psychiatrical conditions, as well as physical derangements, are but exaggerated or extreme cases of conditions which frequently occur in lesser form. Hence many of the results which one derives from experimenting with normal individuals are applicable in cases of illness or neurotic conditions.

The last few years have seen a revival of interest in this field of experimentation which, as is apparent to any one who undertakes to review the literature, has only been touched upon here and there by an occasional experimenter. Recent experimental work outside the medical field, shows results which are interesting from the standpoint of the physician and the nurse.

In studying the psychology of music, we mean nothing more than an objective, experimental analysis of the effect which a given kind of music may have on a variety of listeners, or upon listeners under a variety of determined conditions. There is nothing strange or mysterious about such effects. They belong to the layman as well as to the experienced listener. The difficulty arises, however, both in making the conditions objective and in properly analyzing the results.

### Analyzing the Effects of Music

We have definite evidence of the positive effects of music. Certain fundamental causes result uniformly in a corresponding effect. For example, music with marked rhythm has as its physiological result a feeling of movement which may be one of two sorts, (1) kinæsthetic, in which the movement actually takes place in the body of the listener, or in which there is a desire for movement, but the actual movement is inhibited; or (2) in terms of imagery, that is, the movement is related to the music itself. This physiological reaction reveals itself in simple terms as happiness, gayety, or joyousness. Music with slow, well-defined melody, particularly if combined with a pleasing tone quality or timber, produces a feeling of rest and a serious attitude. This is more often the effect of stringed quartets, instrumental solos, or stringed orchestral numbers.

The marked degree of constancy with which the results from music are obtained is sufficient basis to predict that after adequate study music may be used to decided

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advantage. One set of musical selections when played by means of a phonograph to a group of fifty listeners on two different occasions produced the same effect each time. This experiment was repeated with another group of listeners with the same result.

The consistency of effect was equally marked. Study of a group of ten selections shows that the selection with the lowest degree of consistency gave to 45 per cent of the hearers the same effect each time it was heard, and that many of the selections show a very much higher per cent, 80 to 90.

Another study which is even more interesting from the standpoint of its therapeutic use is an analysis of the relation between the listener's mood and the kind of music for which he expresses a desire, between his existing mood and the effect which definite kinds of music have. The many different varieties of feeling or mood may all be classified under three types. Some writers have referred to these as active, neutral, and passive. The terms, active and passive, are, however, misleading, as one could not accurately define any effect as passive. That would mean nothing more than neutral. Hence, we have adopted the terms, dynamic, neutral, and enervating (or quieting). One might criticize the use of the term, dynamic, as one may similarly say that any effect is dynamic, but its meaning is decidedly clearer.

If we conceive of the physical energy of the body rising and falling as a katabolic and anabolic process, then dynamic would mean that the music tends to arouse a feeling or a fact of more physical expenditure of energy, a surplus within the body, acting upon things outside the body. Enervating, or quieting, would, then, be the opposite, a lessening of the feeling of energy, a lack of response. The energy within the body is less than that from the outside. There is no feeling of desire to act upon something without. This may go so far as to result in a feeling of depression, or opposition from external forces. Neutral will need no explanation. The testing of dynamic types of music upon the dementia praecox patient or of enervating types upon the patient with manic tendencies may in time produce measurable therapeutic results.

### Music and Mood

An analysis of the desires of people and the relation of these desires to the existing mood is worth studying. In normal life most people want music in keeping with their present mood or humor. Also in normal life energizing and stimulating music is most often desired.

It is a different problem, however, to determine the kind of music which should be given to the listener under given conditions. It seems evident that the existing mood of the listener is a minor factor. A comparison was made of the effect of each record on those who characterized themselves as active and those who characterized themselves as passive. The results for the two groups were the same, with a single exception. This does not mean that differences in the listener's temperament, his experience, his familiarity with various kinds of music, et cetera, are not vital factors. It does mean, however, that the music has some dominant quality which awakens in the listener a characteristic response. The physiological increase or decrease of energy is directly dependent upon the music and is but little influenced, except in quantity, by the already existing mood of the listener. Analysis of the effect of certain music upon people whose records state that at one of the two hearings their existing mood was active and at the other passive, showed that the effect on the individual was the same, regardless of his existing mood, and regardless of the kind of music for which he expressed a desire. He recorded the same effect on both occasions. This point is particularly

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significant here. *It means that the music selected should be in keeping with the effect desired.*

Individual differences, due to the existing humor, are not so marked as most of us have thought. In addition to that, the effect on a given individual is constant on different occasions. Only twenty-one out of 140 instances showed a different dynamic effect at two hearings. These facts are explicable doubtless in physical terms, although we have not as yet sufficient experimental evidence in this direction.

The reports from the use of music at Ward's Island say that "after musical treatments patients were less disturbed through the night, and the results show that the curative effect was at least prolonged for some time." The literature on dreams deals extensively with the pleasant and unpleasant. They have separate causes and interpretation. Any stimulus which in waking life gives a pleasant effect rarely appears other than pleasant in one's dreams. Similarly any stimulus which is unpleasant is waking life does not produce pleasant dreams. It is important, therefore, to make the last waking hours as pleasant as possible.

The secret of much of the improvement which nurses are able to bring about in patients is very simple, and yet one which is difficult to accomplish. By various means the patient's mind is kept off his physical condition. Just as hiccoughs and toothache may disappear if the patient's mind is distracted to something else, so the body may improve when the patient's mind is taken from his suffering and pain. And the substituted stimulus may actually prove beneficial.

The intelligent use of music must be based not only upon a familiarity with the fact that music does have an effect upon the listener, but a knowledge of the *how* and the *why*. The sensory effect is the most fundamental and the one which must ultimately lead to the most accurate physiological results. The imaginative, associational and emotional factors must, however, be taken into account. We have entirely too few records of the use of music in various illnesses.

We have, however, definite evidence of the effect of music upon normal individuals —that the effects are uniform among a large per cent of the people, and that the effects are consistent from time to time. More than that, the effect is not dependent upon the existing humor or condition of the listener at the time. Doubtless there are individual exceptions—many of them —but there is sufficient evidence to warrant and to encourage the extensive use of music in a variety of circumstances.

Some object that physiological results are the only safe and scientific ones. They are by far the most reliable; but medical science has not yet definite physiological support for a great many successful procedures. This is no reason for rejecting them. Observations of the results produced by music are important and they may become invaluable if carried on systematically and reported. The work needs organization and a systematic comparison of the results derived by different experimenters. No one is in a better position to make such a study than the nurse. She watches the patient hour after hour, and understands his wants even before they are expressed.

Careful observation and report of the effects derived from this rather simple sort of experimentation can give most valuable results and much useful information. It is important that the few who are giving rather careful but individual study to the problem and its possibilities report their experience and findings. Organization of the work and a systematic comparison of the results will prove both interesting and beneficial. We have had music since the world began, but only recently have we begun to get results from its use.

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# THE NURSE WHO SERVES IN THE OPERATING ROOM—II

## NEWER PHASES OF SURGICAL TECHNIQUE

MARY CECILE MCNELLIS, R. N.*
Wichita, Kansas

### PREPARING FOR THE OPERATION
(*Continued.*)

WHILE the assistant is preparing the abdomen the surgical nurse puts on the surgeon's gown and gloves, putting on left glove first, holding it thumb toward him, cuff well open and glove steady until his hand is settled in it. She hands him a sterile towel in which to fold his hands. When the assistant is ready the field is again surrounded with dry sterile towels placed over the preparation towels. The sterile sheets and lap sponge are placed in position, one end of the lap sheet being thrown over the screen or a separate cover slipped over it. The instrument tray is put in position, a towel and sterile basin for discarded instruments placed between the feet of the patient, sponges one, two and three placed in the sponge basin which stands on the instrument tray, and the operation is started. It is now considered poor technique to place wet sponges on the instrument tray or the lap sheet.

Our present technique demands that instruments once used be discarded and not used again, being placed in the basin between the feet of the patient. The knife with which the skin incision is made, the hemostat and scissors used around the stump of the appendix or in opening an intestine are immediately discarded and all hemostats and needles as soon as released are placed in this basin. If for any reason it becomes necessary to reuse a needle, the surgical nurse picks it up with the forceps she keeps near the basin for this purpose, wipes it off with an alcohol sponge and rethreads it. Needle forceps once used must be wiped off with an alcohol dressing before being placed on another suture. The surgical nurse will see that the sponge basin is supplied with at least two warm sponges at all times during the operation. She will bring her sutures to the operating table quickly when called for keeping them well stretched out, not dragging, twisting or wrapping them around her gloves. She will turn her back on the operating table as little as possible, but watch the steps of the operation and try to anticipate the wants of the surgeon. She will give out her sponges in rotation, keeping her sponge count so that she can report on it at any time. She will keep the operating field clean by surrounding it with dry towels as necessary, and will do so as routine before closing. The surgical nurse will refrain as much as possible from handling material with her gloved hands and will retrieve needle holders or needles with a hemostat.

### THE SPONGE AND NEEDLE COUNT

The sponge and needle count are now called for. She will report them quickly and clearly. Nearly all surgeons now use seven and eight-inch instruments. If anything shorter than this is used these must be counted before operation and accounted for before the abdomen is closed. Her duties end with the passing to the assistant of the sterile dressings and abdominal pad.

Without exception the most distressing thing that can happen in the operating room is a mix up on the sponge count. Several methods exist for keeping track of sponges during an operation. Some operating rooms are still equipped with the old sponge racks

*Surgical assistant to Dr. A. D. Updegraff, surgeon to Wesley and Wichita hospitals, Wichita, Kansas.

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containing sharp hooks on which the sponges are hung in view of the surgical nurse. This is an unsatisfactory method, as there is no reliable way to sterilize this apparatus and the sharp hooks constitute an ever present menace to the hands of all concerned. As there are no numbers above the hooks, this is also a confusing method for a student just learning to scrub. The gauze sponge folded about like a small handkerchief is not only obsolete but will sooner or later cause serious trouble. Some surgeons use the continuous sponge five yards long, one end of which is sewn to the bottom of the sack which contains the sponge. Individual sponges should be at least eighteen inches long, made with eight folds of gauze. To one edge of the sponge a tape six inches long is sewn; the other end of this tape is tied securely in the ring of a brass sponge tag on which is stamped a number. Aluminum tags will not show in a roentgenogram and should not be used. Sponges are put up by one nurse who checks them over twice before sterilization. On counting her sponges before placing them in her sponge basin the surgical nurse looks at every number on the tags, making sure that the numbers have not been duplicated and that none are missing. The surgical nurse places no more than one dozen at a time in her sponge basin and gives them out in rotation, one, two, three, etc., up to twelve. On the wall of our operating room directly opposite the surgical nurse and the assistant hangs a blackboard. The numbers from one to twelve are placed on this as many times as are necessary. As the sponges are thrown into the floor basin the unsterile nurse will mark them off on the board by drawing a line through that number. If number three of the first dozen remains in the abdomen during the operation, then number three in the first row of figures remains uncrossed until it has been removed. In counting sponges the unsterile nurse will pick them up out of the floor basin, look at the number, cross it off on the board and place the sponge in another pan. When the first dozen is in this pan she spreads a towel between it and the second dozen, so that should a recheck be necessary it can be done quickly and without confusion. The surgical nurse should keep her sponge count up all through the operation. Needles are placed in the instrument pan and are easily counted.

The assistant dresses the wound. Should it devolve upon the surgical nurse, she should remove dirty sponges or linen from the vicinity of the wound with a hemostat, clean the stitches with a sponge dipped in alcohol or ether. She pats but does not rub the stitches, going down the line of incision and never coming back over it with the same sponge. She must not clean the abdomen in the neighborhood of the incision before cleaning the stitches. The wound must be left clean and dry. Gauze is placed under the sharp ends of the silkworms, and the sterile dressing and pad applied. In clean cases instead of using the pad many are now employing a permanent dressing consisting of one width of adhesive wide enough to cover the abdomen from the umbilicus to the pubis extending to the midline on the sides. This acts as a splint for the several abdominal muscles and prevents the patient from investigating the wound.

Our routine proceeding requires that all patients are dried, mentholatum rubbed into the chest and well down over the lungs and a warm chest pad and gown put on before they are taken from the operating room.

If the surgical nurse is "scrubbing" for a clinic or a large string of operations, she will not handle the needle forceps after they have been used the first time, but will bring the threaded suture to the assistant, who places it in the needle holder. At the close of the operation her sterile table must be clean and dry. It will only be necessary then for her to change gloves and proceed with the second operation. In many hospitals it is not deemed necessary to change gloves if this technique is maintained.

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# CARRYING THE HOSPITAL TO THE CRIPPLED CHILD

## THE NEW CRUSADE OF THE MYSTIC SHRINE

FORREST ADAIR
Secretary of the Board of Trustees, Shriners' Hospital for Crippled Children, Atlanta, Ga.

*THE hundreds of children paralyzed by poliomyelitis, other hundreds of children handicapped by orthopedic deformities—as evidenced by the publicity attending the visit of Dr. Adolf Lorenz—the thousands of young men unfit for Army service because of orthopedic defects which might have been remedied in childhood, and other thousands of soldiers maimed by shells—all testify to the need for orthopedic emphasis.*

*Mr. Adair estimates that at least 400,000 children in the United States and a proportionate number in Canada could be benefited by orthopedic surgery. The wonderfully planned hospital at Atlanta, Georgia, gives this free service to the children of the South. "In the course of a few years," predicts the secretary, "Shriners will have at least twenty to twenty-five of these little orthopedic work shops in North America." The development of the movement is the crusade of the twentieth century.—Editor.*

DURING the past decade people have turned more and more to the aid of the unfortunate ones. Large endowments have been made and immense sums contributed toward charitable and philanthropic institutions, and the creation of great foundations. This tendency indicates that the world is getting better or at least is becoming more kindly disposed toward the afflicted and unfortunate.

Hospitals, sanatoriums and homes have been founded for the tuberculous, and for the blind, but one class of the handicapped has, in a measure, been omitted—the crippled children. Indeed there were homes in plenty. Note the use of the word "homes," places where cripples were carried, fed, clothed, and given some little education, but where no successful effort was made to correct their deformities and return them to their parents healed.

Perhaps this was because of the prevalent idea that a child born with club feet, or stricken with infantile paralysis or tuberculous spine, or any other condition that today comes within the scope of the skilled orthopedist, was a hopeless incurable cripple. Even parents accepted such afflictions as a curse to be borne until a kind Providence removed the child. Naturally children so hampered through no fault of their own developed a warped mental attitude toward the world—a feeling of utter hopelessness.

During the past decade, the development in orthopedic surgery and its complement, physiotherapy, has progressed by leaps and bounds. The work of Jones and his coworkers in England, France and America is one of the brilliant contributions of the late War. But as yet the application of this greater science is inadequately broadcasted.

Nearly seven years ago the Scottish Rite Masons of Atlanta, Georgia, opened two modest little cottages of twenty beds as the Scottish Rite Hospital for Crippled Children. Dr. Michael Hoke of Atlanta, a man with great skill in the profession of orthopedic surgery and endowed, above all, with a heart of gold, agreed to give his services free to this little hospital. The results obtained were pronounced by those connected with the hospital as little short of miraculous.

In order to provide greater facilities, the money was quickly raised to erect a new hospital provided with administration quarters, operating rooms and all necessary apparatus and appliances on the second floor, and on either side a wing one story in height with ramps leading out to the ground so that the children can be rolled out into God's sunshine—not only the chil-

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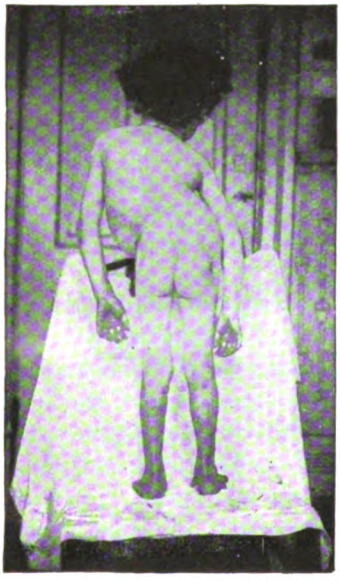
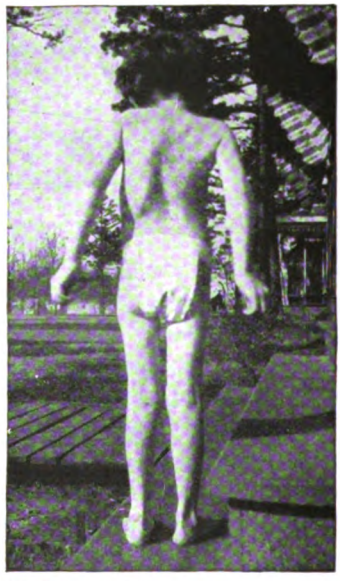
dren in wheel chairs but even those who are confined in their beds.

The little hospital then began to attract attention. John H. Atwood of Kansas City visited the hospital and wrote of it as the "Miracle House." The daughter of Frank C. Higgins, the great Masonic writer, had been stricken with infantile paralysis in New York City during the devastating epidemic of 1916. After spending four and a half years in different crippled homes in the East, she was admitted to the Scottish Rite Hospital. After five months of treatment she was able to walk. Higgins wrote of the hospital in the *New Age* dubbing it the "Temple of Babies' Smiles."

At about this time, Noble W. Freeland Kendrick, Past potentate of LuLu Temple, Philadelphia, became the head of the great Order of the Mystic Shrine. As he had had some experience with homes for crippled children, his heart naturally went out to these children. To this order of about 500,000 members, Kendrick introduced a resolution to tax each member two dollars per annum—a fund of $1,000,000 a year. The resolution called for the erection of a large central hospital—possibly at St. Louis—to be used for the correction of children's deformities.





EVELYN KINNEBREW, Stevens, Ga.
Spinal Curvature That Shoved Many Internal Organs from Natural Positions. Discharged at the End of 5½ Months with Only Slight Curvature That Will Disappear.

The Shriners elected a Board of Trustees who were intrusted with the carrying out of the spirit of the resolution. Last September, this board met in Atlanta and while there visited the Scottish Rite Hospital for Crippled Children. Needless to say, they were simply overcome by the wonderful work being done in restoring crippled children to their normal condition.* It was immediately decided that rather than put $2,000,000 in a large, central hospital, which would be inacessible except within a radius of 300 miles, they would divide this fund and build several hospitals. As one of our surgeons very aptly expressed it—"The board decided

* The "before and after" pictures in the Hospital Bulletin show the versatile character of the work and the wonderful results achieved.

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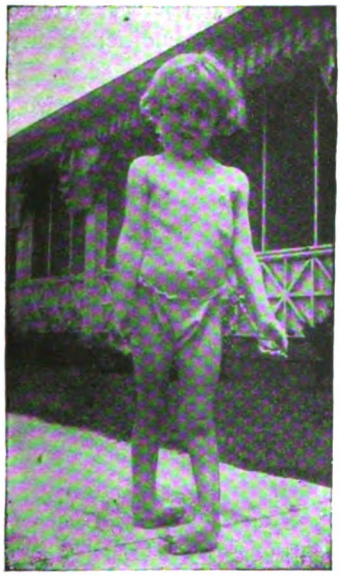
that rather than send the child to the hospital we will 'carry the hospital to the child.'"

Since the hospital in Atlanta can be duplicated for about $250,000, the fund will be sufficient for the erection of eight hospitals along these lines. The trustees immediately decided to build five hospitals in the following places: St. Louis, Mo.; San Francisco, Cal.; Montreal, Canada; Shreveport, La.; and the twin cities of Minnesota—Minneapolis and St. Paul. As soon as those are completed five more will be erected—one to be located in New England, one in Pennsylvania, one in Virginia, one in the Rocky Mountains, and one in Portland, Oregon.

From my seven years of association with the Scottish Rite Hospital in Atlanta, I can see and appreciate the intense interest which trained nurses will take in these institutions. I have already seen how many such nurses, with the love of children in their hearts, are beginning to specialize in orthopedic work. I also realize the fact that without underestimating the value of the skillful work that is done by the surgeon, equally important is the work of the superintendent, assistant superintendent and perhaps, especially, of the physical therapist. We have had numerous cases here in Atlanta where the skeleton needed no surgery, but where the children have been vastly improved, in some instances practically restored to normal, by the little lady who knows how to induce the muscles paralyzed by that dreaded disease —polymyositis—to refunction.

But to return to my story of the new hospitals. An advisory board of orthopedic surgeons was elected. These men will attend all meetings, assist the board of trustees in advisory ways and in the actual operation of the hospitals.

Our idea is to take children, without regard to race, creed or fraternal affiliations, and treat and care for them absolutely without any expense to them. The interest of the Shriners in this work is growing more and more active and I confidently predict that within the next five or six years, there will be one of these hospitals within the reach of every poor crippled child in the United States.



AGNES SHUMAKE, Atlanta, Ga.
A Bad Case of Club Feet—Complete Cure in Five Months

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# THE USES OF PHYSIOTHERAPY

## WITH EXAMPLES OF ITS PRACTICAL APPLICATION

MARY MCMILLAN

Formerly Supervisor of Reconstruction Aides, United States Army Medical Corps.
Cambridge, Massachusetts

IN 1918 the U. S. Army Medical Corps by its establishment of a "physiotherapy" section of the Reconstruction Department coined a new word. This word —a contraction and combination of the two words physical therapeutics—means the scientific application of physical methods of therapeutics.

The results achieved in the War Department, at the various Army hospitals and camps throughout the country and in France have won recognition for this branch of medical science. In fact, the subject of physiotherapy is one that is engaging the attention of physicians with ever increasing interest all over the country at the present time. If this form of treatment be indicated the medical profession realizes that it should not be given in a haphazard way, but with intelligent understanding of the subject, in prescribed dosage, and with skilled hands.

The various procedures of manipulation and massage, medical or remedial gymnastics, electrotherapy and hydrotherapy are by no means new forms of therapeutics. The first two divisions have been used for remedial purposes for centuries. Manipulation of muscle and joint and remedial exercises were used in the practice of medicine by the Chinese 3,000 years before Christ.

### THE NECESSITY FOR THOROUGH TRAINING

It is unfortunate for the coming profession of physiotherapy that so many people now engaged in this type of work have had so little fundamental training in it. The study of manipulation, therapeutic or remedial exercise, electrotherapy and hydrotherapy is a vast one. In order that the patient may receive expert treatment in this field, as in others, it is necessary that the operator be versed: (1) in the principles which govern muscle and joint control; (2) in the physiology of exercise and the science of movement; (3) in the laws of electrophysics, in the different effects upon the body tissues of the various electrical modalities; and (4) in a knowledge of the systemic reaction from the use of hot and cold water in the various remedial applications that are now devised. Radiant heat and light treatments are included in hydrotherapeutics while the ultra violet rays, chromotherapy and *x*-ray treatments are included in electrotherapy. Since a study of anatomy, physiology, symptomatology and pathological conditions as well as the foregoing subjects cannot possibly be acquired in a one hundred or two hundred hour course of study, courses of sufficient length and prescribed content should precede any independent work.[1]

And this is only the beginning. The combination of the various branches of physiotherapy is a matter that requires much careful and intelligent consideration. Too often a person practicing physiotherapy does not use the best combination for the specific case in hand. An overdose of one form is quite frequently given while another form is entirely overlooked. The physiotherapist who is thoroughly conversant with each branch that comprises the subject as a whole, is more likely to accomplish favorable results and establish a confidence in her profession.

To gain a definite idea of the varied application of physiotherapy let us consider

[1] The Harvard Medical School, Boston, Mass., plans to give an important post-graduate course in physiotherapy this summer (July 5 August 15). Other well-planned courses are available at reliable hospitals and medical colleges.

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its use for one or two medical and surgical types of cases which the trained nurse is continually being called upon to nurse. In each case we shall follow the outline of physiotherapeutic treatment indicated as an aid in the speedy recovery of the patient. A person suffering from an acute attack of sciatica must be treated skillfully. Usually this calls for complete rest, the application of heat, and the relaxation of the affected limb. The earlier physiotherapeutic treatment is commenced after the acute inflammation has subsided the better.

### Physiotherapy for Sciatica

Let us consider the general condition present. Any acute inflammation is followed by atrophy from two causes: (1) the degeneration in the tissue which results from any form of acute inflammation; and (2) the atrophy of disuse in the affected and in surrounding parts. If the part is not restored it is reasonable to expect that at some future date the patient is going to suffer. Repair goes on continually in the body tissues. If a part is allowed to get much below normal it often does not improve sufficiently without outside assistance. By allowing any part of the body to remain below normal we leave a part of the citadel unprotected. A recurrence of the trouble is very often the result of lowered resistance in certain parts. It is most important, therefore, that the after care of any form of acute inflammation receive the building up treatment it requires in order to prevent a recurrence of the trouble which may lead to a chronic condition. Physiotherapy in the sub-acute stage will often prevent the condition from becoming chronic.

### Effective Electrical Treatment

Whether the positive or negative pole be used over the sacral plexus in the treatment of sciatica depends entirely upon whether any pain still exists. If pain exists, the treatment should be of a sedative nature and may be applied in the following manner. The foot of the affected limb is placed in a foot tub half filled with water, the temperature of which should be 95 to 100 degrees F. The negative pole is clipped to the metal tub while the positive electrode, after having been well soaked in a solution of salt (one teaspoonful to a pint), is placed directly over the sacral plexus. If the foot tub is not metal it is better to let the foot rest in the water on the negative pole which is placed at the bottom of the tub; the positive pole, well soaked in a sodium chloride solution, is also placed over the sacral plexus. Between fifteen and twenty milliamperes of direct or galvanic current are used and the treatment lasts about twenty minutes. If no pain exists in the thigh, merely a numb feeling or stiffness, then electrical treatment of a stimulating nature is indicated. Exactly the same procedure is used as described above, except that the negative pole, which is stimulating in its effect, is placed over the sacral plexus. The positive pole is, of course, sedative in its action.[2]

### Testing Polarity

The easiest way of testing polarity is by dropping both electrical terminals in water. Since the negative pole attracts hydrogen to itself, small bubbles of hydrogen appear around the metal tip of the negative pole very shortly after it reaches the water. The immersed metal tip of the positive pole remains unchanged.

Following the electrical treatment the patient should lie down with the hip and knee joints slightly flexed in order that the muscles may be relaxed. The dorsal and

[2] For the use of medical electricity, if small inexpensive apparatus is desired, the following machines answer the purpose very well: 1. The Victor galvanic controller with meter, made by the Victor X Ray Corporation, Chicago, Illinois. This machine costs about $50. 2. The Wappler galvano-faradic machine is very satisfactory, since it may be used for administering either the galvanic or faradic current. The price is around $100. 3. The "Telatherm Junior" is designed to convey current of high potentiality. This machine costs about $150. The McIntosh Battery & Optical Company, Chicago, Illinois, will send special literature with clinical data free to any person who is interested in medical electricity.

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plantar surfaces of the foot are stroked from the toes to the heel; pétrissage of the plantar muscles is then followed by stroking and kneading of the muscles of the leg and thigh. Final stroking of the foot, leg and thigh is followed by vibrations along the course of the sciatic nerve from the sciatic notch—that point where the nerve issues from the pelvis—to the terminal branches in the foot. Passive movements through every arc of motion of which the joint is capable are given after manipulation of the muscles. The phalangeal, ankle, knee and hip joints are exercised, great care being taken that all movements are given slowly and evenly, especially in the hip joint.

Sciatic nerve stretching follows when all fear of recurrence of the inflammation is over. For this stretching the patient lies in the supine position, the knee is kept extended. The operator fully flexes the leg and thigh with the limb in the vertical position, the foot is dorsiflexed by the operator. This gives the final stretch to the sciatic nerve. If a spastic contraction of the hamstrings occurs, straight leg raising may help to overcome this spasticity.

### Treating Foot Strain

Let us take another type of case. A patient suffering from general debility and foot strain needs not only a general massage daily to overcome the evils of the prescribed rest, but also special exercises to strengthen the weakened muscles plus a daily graded schedule of exercises which will tend toward a shorter convalescence and a more normal recovery.

It is not at all uncommon to find that a person suffering from general debility complains of crippling pains in the soles of the feet and in the calf muscles. An alternate hot and cold foot bath in water at a temperature ranging from about 100 degrees to 60 degrees F. is most helpful preceding manipulation of the plantar, anterior tibial and calf muscles. The contrast bath causes a contraction and expansion of the small blood-vessels in the lower extremity. Sir Robert Jones calls this "gymnastics for the arterioles." A weakened longitudinal arch indicates that the short flexors of the toes and the invertors and dorsiflexors of the foot have lost their normal tonicity. Relaxation of these groups of muscles causes the ankle joint to be strained slightly inwards and sometimes there is also a shortening of the tendo Achilles.

After the contrast bath, which should last for about ten minutes, each muscle group should be effleuraged and kneaded; the manipulation of the muscles is finished with firm strokings from below the ankle to above the knee joint. The whole limb should be supported horizontally during the treatment and the three groups of thigh muscles should also be effleuraged and kneaded.

(*To be continued*)

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## TYPHOID FEVER

The amount of typhoid fever in a community is recognized as one of the best indexes of its healthfulness. So also the mortality rate from this cause is a very important sanitary index.

The steadily decreasing mortality rate from typhoid fever, from 13.3 per 100,000 population in 1916 to 7 in 1920, is therefore most gratifying. In 1920 of the states in the registration area Massachusetts and Wisconsin share the honor of having the lowest rate (2.5), while the highest (22.4) appears for South Carolina. Of the eleven states showing rates by color, the lowest rate for the white population was 3.6 and the lowest for the colored was 4.6, both for New York State, while the highest rate for the white population was 19.1 for Kentucky and that for the colored was 30.2 for the same state.

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# TALKS BY A PSYCHOLOGIST

## THE MECHANISM OF SUBLIMATION—HOW TO USE SUGGESTION

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THE worm-like, fuzzy caterpillar metamorphoses into the golden winged butterfly. The crude, crumbly ore is forged into the strong thing of iron. All Nature is characterized by this transformation of common, weak, menial things into that which is beautiful and stable. In this the mental activities, also, run true to form. Our ordinary repressions are beautified through sublimation.

In sublimation the energy which might be permitted to run wild when tendencies to actions are repressed is put to some use which is usually of social value, or at least of much more value to the individual than projection or compensation. Through sublimation the crasser sensual tendencies find expression in paintings, sculptures, and love sonnets. A properly sublimated outbreak of anger finds no outlet for its usual manifestation, but perhaps becomes righteous indignation. It does not become projected by thinking the other person hates one or compensated by manifesting intense affection for the person who in reality is hated.

### SUBLIMATION

Sublimation is of very frequent occurrence. The love tendencies of the spinster are sublimated in her attentions to the proverbial household pets or in a more spiritual sublimation through the care of children of others. The childish tendency to inflict pain may be sublimated as the zealous devotion of the surgeon to his chosen calling.

The tendencies to action are not repressed in sublimation. They are simply drawn off in other and more useful channels. A knowledge of this mechanism is of much importance for the nurse. The nervous patient who tears the hem of the sheet in her fidgeting may have her actions repressed by applying mitts. But then, as is now clear, the repressed tendencies will find outlet in a converted form, very likely an antagonism to the hospital. The same patient could have this nervous tendency sublimated, as I have frequently seen it done, by having the same bed patient who persisted in destroying sheets fold paper napkins by the hour. To be sure not all of the napkins were accurately folded, but the tendencies to action were utilized in a useful form and the nervous energy disappeared much more rapidly than would have been the case if it had been repressed.

It should always be the aim of the nurse to sublimate rather than to repress any undesirable tendencies in action and thought, both in herself and in her patients.

One effective manner in which action may be directed is through the use of suggestion. Now, as we have said before, human beings are essentially organisms which react to their environment. A schoolmaster sits upon a tack; he is promptly stimulated to rise. His first reaction after seeing the point is to jump; his next reaction will probably be to single out the boy who is absorbed in deepest study, the boy who apparently evidences profound interest in his lessons.

It is the aim of applied psychology to be able to predict what people will do under certain conditions and to control their response so that they will act as we would like to have them. And under actions we must include thought for this, too, is a method of reacting to the outer world as well as the world of ideas. It is easy to predict what some responses will be. Strok-

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ing the bottom of the foot lightly will bring about the simple type of response known as the Babinski reflex. In a normal person a light tap on the tendon below the knee cap brings about a jerking of the foot. Such simple bits of behavior as these can be readily and accurately predicted. Controlling them is a more precarious matter.

Although these reactions are valuable to the diagnostician, in our everyday dealings with patients and friends these simple reflex responses are not of much importance. We are usually more interested in the complicated responses of ordinary life, mundane as it may seem. We want to know how to control the behavior of others so that they will do certain things intentionally. We desire to get them to act voluntarily.

Suppose the nurse, or the physician, wishes to obtain or modify certain responses of the patient. Perhaps the patient refuses to submit to a needed examination or operation. Needless and groundless fears may exist which need to be modified into interest and anticipation. A certain attitude toward life may be needed to forestall the pernicious effects of "hospitalization." The most effective way to get others to do as we want or to think as we want is the big problem.

Each human being has countless thousands of learned and unlearned actions which it is possible for him to perform. These are waiting in readiness for the time when they will be needed. All that is necessary is that they be brought into action by the proper stimulus. Practically everyone can throw a ball with more or less skill. All that is needed to have them do it is to supply the proper stimulus. There is the rub! What is the proper stimulus? You might throw the ball to another and he might respond by tossing it back to you. Or you might hand him the ball, saying, "Throw this as far as you can." Or you might vary the procedure by saying: "Throw that ball at once or I shall make you go without your supper." You might get the response you wanted, or you might get bowled over.

*(Courtesy of the American Red Cross.)*

An artistic example of unspoken suggestion.

Any old stimulus is not sufficient to bring forth the response that is desired; not all are equally effective. Sometimes a gesture is more effective than a spoken command. Some spoken commands are more effective than others.

The child patterns most of its actions upon *imitation;* he does what he observes his elders doing. If they swear he swears; if they stutter he learns to stutter. If they

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throw a ball over-hand rather than underhand he does likewise. The parents can thus control the behavior of their children to some extent by doing what they want the child to do. It is the old adage that example is better than precept. And it has good psychological justification. The depressed patient, the homesick youth, is not made happier and more comfortable by weeping on the shoulders of others. Some one who thought imitation was limited to smiling said a smile is contagious. Frowns and bad tempers are probably just as contagious. All visible actions are contagious and may result in imitative activities on the part of the observer.

The application of imitative control over action is obviously limited. But it must not by any means be undervalued. Habit is little but imitating our own actions; imitation of our own actions is thus seen to be quite as important for the control of our own behavior as it is for the control of the responses of others. But when we are trying to encourage a patient to have some ulcerated teeth extracted, we cannot very conveniently have ours pulled by way of example. It therefore becomes necessary to look for other ways of getting the reins of the other fellow in our hands.

One way in which this might be accomplished would be through the aid of hypnotism. We might hypnotize our patients. Then they would do to the letter everything which we asked them to do. A regular hospital heaven here on earth! It would only be necessary to tell the giggly, silly, talkative patient to be serious and, lo! it would be done. Minor operations could be performed, as, indeed, they have frequently been done, without any anæsthetic but hypnotism. Just tell the hypnotized patient that there will be no pain and he will feel none. Would it not be the millenium if all this could be brought about? Perhaps it cannot be realized in as desirable form as we have just pictured. But there is no gainsaying the point that the principle of hypnotism gives us a clew which will give us great aid if we follow it up.

The key to the understanding of hypnotism is *suggestibility*. We all react to suggestion. In the hypnotized person it is exaggerated for the time being. So here we have another master key for unlocking the secrets of the control of behavior. We cannot hypnotize our patients or our contrary friends. But we can use suggestibility.

What is meant by suggestibility, anyhow? We hear people say that as they passed the shop window and saw a display of clothing the thought was suggested that they need some new clothes. Or sometimes one hears it said that black clothing suggests sorrow. In the language of psychology these are examples of *the association of ideas*. This is not suggestion. In suggestion a stimulus to action, either visible or in thought, is accepted and acted upon unconsciously. The stimulus is accepted uncritically; the action is carried out automatically without stopping to think just why it is being done. Almost all inner opposition is overcome and the stimulus to act is carried out in a reflex-like manner. This is suggestion.

Suggestion is capable of controlling the actions of individuals under usual conditions as well as when in the hypnotic state. Certain tricks, however, facilitate and increase the degree of suggestibility. Their use is very important; accordingly we will take them up in some little detail.

One of the first things to be used in producing successful suggestibility in normal individuals in their waking condition, is *monotony*. Better results in suggesting actions and forms of response in general can be obtained off the wards. The loud ticking of a clock in regular rhythm, the ominous silence—these conditions contribute to the state of mind that makes for effective suggestion. The public speaker

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uses long pauses just before he utters the sentences which he wants to produce action. The physician and nurse can also use these pauses that make seconds seem like minutes. It is not *how much* is said that leads to effective action through suggestion; it is *what* is said that counts. Saying too much may "spill the beans." Pauses not only heighten the receptiveness for suggestions to action but they give one time for anticipating the next step. The pause gives one an opportunity to apply the general principles which we are giving.

Closely pressing monotony for first place is the *limitation of movement*. This is one factor that adds to the suggestibility of the crowd or the mob. Large groups of human beings are much more suggestible than any of the individual members of the group would be away from the group. The fact that in the crowd the voluntary movements are limited due to the jamming and crowding aids in this increased suggestibility. While the patient is lying perfectly quiet is the most advantageous time for suggesting definite action. The débutante waits until Dad is comfortably relaxed before she broaches a new gown; she does not mention the subject while they are on the golf course. The physician and nurse can do likewise; see that the patient, through some pretense or other, is relaxed and motionless. Rest has its own therapeutic value—and it is an advance in strategy.

Now, that the stage is all set for the highest degree of normal suggestibility, what are you going to say and how are you going to say it? In many instances this is *the* question. Lack of time and favorable circumstances may make it impossible to minimize the patient's movements and produce monotony through a faked reading of the pulse as the suggestions are being deliberately given the patient. In many instances it is through the mediumship of language alone that suggestion is accomplished.

A hypnotized person can be told to do a thing directly, as a command. But obviously that cannot be done with persons in the normal waking state. To command them directly to go to the operating room is likely to bring out all the opposition which may exist. To tell the patient directly to stop brooding will more than likely intensify the mental attitude. In normal

An example of contra-suggestion in extreme form. A catatonic patient was directed to put his hands in his pocket, look straight ahead, and keep his chair on the floor. The picture shows what he did.

suggestibility the best results are obtained when the actions or thoughts are brought up *indirectly*. When desired responses are suggested in a rather unostentatious way, as if they had almost been thought of by the subject himself, then they are more likely to be acted upon.

Through flattery you can often *produce the effect of having the response originate within the mind of the patient*. "You have *good* judgment, you are intelligent, and of course you want to have the window open," will forestall objections. The contrary-

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minded person is rather taken off his feet through the use of *indirect suggestions* such as these. The spoken formula, which often brings almost magical results, can of course be varied. But it must be kept *indirect* if results are to be obtained. "You are getting stronger now, your cheeks are rosier each day. You will probably be walking in a day or so." "My, but you are looking better! Aren't you? (And rushing on before the patient can think or reply.) I know you want more on your tray to-night."

There are other little tricks in giving successful suggestions besides *always* using these indirect fomulas. During a stay in the patient's room while the morning's work is being done the actions that are desired can be mentioned, indirectly of course, several times. There is a cumulative value attached to this *repetition* of the indirect suggestions. Do not repeat the same suggestions several times one right after another. *Space them.* Tell a story to distract the patient's attention. Then turn back to suggest the responses that are being cultivated in the patient. And always leave, as a parting shot, an indirect suggestion. The *last impression* has great suggestive value in producing desired responses. In the above paragraph you will notice that the response was brought in at the last of the little speech. It should always be so.

### Precautions

These precautions should be noted. It is the easiest thing in the world to think one is giving an indirect suggestion when it is really a suggestion of the opposite response. Saying, "You are not going to be afraid" really suggests being afraid. "Do not think sad thoughts" suggests that they be thought. "Eventually, why not now" has been a rather expensive advertising slogan, since it suggests to the prospective purchaser that he keep putting it off a little longer. It should always be the aim to give out the suggestion *indirectly*, and to present the idea in as *unequivocal* manner as possible. Negative phrases must be avoided. Make the suggestion appear spontaneous, indirect, but at the same time avoid all possibility of having suggested the opposite response.

Regardless of one's best efforts to avoid giving a suggestion which would produce actions that are not desired, it sometimes happens that people do just the opposite. Small boys are noted for doing just the contrary of what they are told to do. Some people who are full grown have the same reputation. These people are called *contra-suggestible*. They act exactly opposite to any suggestion; they never agree upon any point brought up; are always ready to argue the opposite. In its extreme forms contra-suggestion is found in the *negativism* of patients with certain kinds of mental disorder. Certain catatonic patients if told to stand up, sit down; if told to be quiet, talk; if told to eat, promptly stop eating. These are the rare cases, however. For every person who is strongly contra-suggestible there are a hundred who are readily suggestible. These hundred may be moved to plain stubbornness if suggestion is not correctly used. But by following the principles which we have laid down for successful suggestion the actions of others can be brought more securely under our control.

### The Manner of the Nurse

There is no royal road to success in applying suggestion. It means simply the conscientious and persistent application of the teachings of applied psychology. The manner of the nurse is extremely important. Diffidence or fear at once register their impression. Quiet, unostentatious assurance is perhaps the word picture for the golden mean. Those most successful with difficult mental patients have a purposeful, unhurried manner and a quiet, even voice accompanied by a real quality of interest in the patient. Success means practice, lots of it, perhaps. Careful thinking will be necessary until the art has been firmly acquired.

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# ÉCOLE FLORENCE NIGHTINGALE

## THE NURSES' MEMORIAL BUILDING

The international spirit of service which characterizes the nursing profession was once more expressed on May 12, 1922, in the dedication of the Florence Nightingale School—a training school built for *French* students by *American* nurses and bearing the name of the *English* pioneer.

Over twenty years ago, Dr. Anna Hamilton assumed the directorship of the school of nursing at Bordeaux. During her practice work at Marseilles and Montpellier she had been convinced of the need for skilled, educated nurses. The training school methods of Florence Nightingale were at once adopted at Bordeaux—the first real nurses' training school established on French soil.

During the intervening years, this school has attracted the finest minds of France and its competent graduates are now serving in the hospitals and visiting nurses' services throughout the country. But the fullest development of the school has been hampered, in a measure, by the lack of a suitable school building and of the best teaching equipment.

At the close of the late war, which brought American, English and French nurses into helpful relationships, an American nurse conceived the idea of erecting a nursing school at Bordeaux as a lasting memorial to the nurses who sacrificed their lives in the service. Acting on this suggestion a fund of 800,000 francs was quietly contributed through the three national nursing organizations. The plans for the building were first passed upon by representatives of the contributors in this country, and then reviewed by Miss Clara D. Noyes, president of the American Nurses' Association, and Dr. Hamilton in Paris. With a view to safeguarding the future educational standards of the school, a section was incorporated in the charter whereby a duly appointed American representative will sit as a member of the hospital board, and an advisory committee, also appointed by the three national organizations, will aid in shaping future policies. Finally the ground was broken at "Bagatelle" in the quiet suburb of Talence. The site, a sixteen-acre estate with its quaint manor house, charming garden, and extensive orchards, had been given to the school by Mlle. Elizabeth Bosc during her lifetime.

The building incorporates the most modern features of training school construction, including individual rooms (designated by the names of flowers instead of the stereotyped numbers) with running water in each, and ample baths and showers on each floor; a well-lighted assembly, a lecture hall, a demonstrating room, and a

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model diet kitchen. One very attractive feature is the technical and fiction library with homelike furnishings—the gift of the Alumnae Association of the Presbyterian Hospital Training School, New York, in memory of Amabel Scharf Roberts. Over the front and rear entrances of the school are the words "American Nurses' Memorial." In addition a large bronze tablet in the main hall conveys the motives of service which inspired the nurses whose lives were sacrificed and in whose honor the memorial is erected.

An exterior view of the Florence Nightingale Training School

As the one hundred and second anniversary of the birth of Florence Nightingale drew near, Miss Noyes received a graciously worded invitation to attend the dedication service. The invitation from the hospital president, M. Henri Crouse, included "any who might be interested in the ceremony."

On May 12, the newly completed building was dedicated before an understanding audience of physicians, philanthropists, nurses and public-spirited men and women. Representatives of six nations stood with bared heads in tribute to the American nurses who had died in the preservation of France. Unfortunately, the press of work prevented Miss Noyes from representing the three American nurses' associations in person, but her simple and inspiring message of fellowship was delivered in clear true tones by Miss Mary Beard.*

"It is fitting that this memorial to the American nurses who died in line of duty during the World War should be dedicated on the anniversary of the birth of Florence Nightingale, who has been truly called the patron saint of modern nursing.

"To her was not given the martyr's crown in the same sense in which these 281

* As a member of the subcommittee and the European director of the American Red Cross nursing service, Miss Hay had been asked to deliver the dedicatory address. On May 12 she was unable to be present and her place was graciously taken by Miss Beard, of Boston.

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devoted nurses have received it. Death's angel did not wait upon her at the close of those nightmare days and ghastly nights in the barrack hospitals of the Crimea. Instead an undermined constitution and shattered health were the sacrifices exacted.

"The skill, the trained intelligence, the highly specialized services which equipped the American nurses in fullest measure for the tasks they performed for the wounded were but the modern harvest from the seed planted in the dim days of yesterday by the Lady of the Lamp. How many thousands of precious patriotic lives were won back from the shadows of death by their ministrations—who can tell?

"May the future of this republic and of the world never again know such holocausts of battle lust and carnage as made necessary the sacrifices which this building commemorates. But may the science, skill and devotion carried out from these walls by the young women of France bring about a new dispensation in which battles will be fought not against men but against disease and ignorance; and conquests will be recorded not in blood and ruined hearths but in healthy, happy childhood and safeguarded homes.

"Nursing in the past has been associated in the public mind only with the relief of pain and the softening of death's last hours; nursing in the future will be directed toward the prevention of disease, the grounding of the human race in habits of health and well-being, and the launching of every young life under the best influences that medical science and wholesome environment can bestow.

"This beautiful building does not represent the largess of a great and prosperous nation. It is a testimonial to the loving remembrance of thousands of American nurses expressed in spontaneous gifts of such small sums as could be spared from their modest earnings. Many of them have never known in their own student days the luxury and advantages which have been incorporated in this memorial building for there are still many schools of nursing in America lacking in such appointments. But by means of their contributions they desired not only to honor the memory of their dead sisters but to afford to the

Miss Helen Scott Hay, who, as a member of the subcommittee, has aided in the satisfactory completion of the Memorial Building.

student nurses of France the privileges that they themselves had been denied.

"To you, the pupils of the Florence Nightingale School and to all its graduates, of the past and future, these nurses in America send their felicitations. Especially to the pupils who now stand at the threshold of their careers do they commend the best and holiest traditions of our common profession. To you they hand the torch first lighted at the lamp of Florence Nightingale, praying that grace be given you to keep it ever held aloft—an immortal flame upon this altar consecrated to the memory of those who have passed but whose will it was that you should carry on."

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# ARE INDUSTRIAL NURSES UNETHICAL?

## THE OPINIONS OF PHYSICIANS, EMPLOYERS, INSURANCE COMPANIES AND NURSES

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FOR some time a storm of protest has been raging in certain sections of the country against the industrial nurse. Curiously enough, this protest emanates not from the firms which employ her, nor from the employees for whom she cares, but from her co-workers, the industrial physicians.

Now, there is seldom so much smoke without some fire. In order to get at the facts in the case, a questionnaire of ten questions was prepared and sent to seventy-five industrial physicians, seventy-five industrial nurses, and seventy-five managers of industrial plants. To the insurance companies, of which only a few are handling group insurance, eleven questionnaires were sent.

### GATHERING EVIDENCE

This survey was undertaken in an absolutely impartial spirit. If the industrial nurses were at fault in as many instances as a casual reading of the New England newspapers would lead one to believe, then there would be urgent need of reform. In order to decide whether this need existed, evidence was required, and to whom should one apply for evidence except to those making the charge? Since some industrial physicians were the complainants in the case, it was but natural that their grievances be ascertained, and, if possible, the underlying causes thereof discovered.

However, in fairness to the nurse, she should be heard in her own defense, and since she is merely an employee in a factory, and subject to the orders of the owner, his point of view is also important. Lastly, since nearly all plants carry industrial insurance the attitude of the companies granting such insurance is a matter of interest.

The response was surprising and indicated a deep interest in the subject. Of the 75 industrial physicians written to, replies were received from 34. From the nurses, 38 replies were received; from the insurance companies, three replies were received. The poorest response of all came from the employers, from whom only six replies were received. This was probably due to a misunderstanding. The letter which accompanied the questionnaire stated that names of firms or individuals would in no case be used. Had we mentioned that it would be sufficient to sign the letter, "manager," "doctor," or "industrial nurse," and mail it in a plain envelope, this further precaution would have rendered identification of the writer impossible, in case the author of the questionnaire were disposed to disregard her promise and use names. Perhaps many of the firms felt there was a catch somewhere and that their answers might be used against them later, possibly to their detriment.

Some of the plant officials even went so far as to demand to see the nurse's questionnaire after she had answered it, and some forbade their nurses to answer at all. The fact that so few answers were received from employers is most regrettable, because it is very desirable to know the attitude of the business man toward health conservation. As employers, they are in a position to prescribe the nurse's duties. If they wish her to act as employment manager, or personnel worker, or in any other capacity, she must either accept their requirements or resign.

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It is entirely up to the firm whether or not a doctor or a nurse shall be employed, or whether the nurse is considered sufficient for all purposes. Employers strongly resent coercion of any kind, and rightly or wrongly feel that the effort to compel them to employ a physician smacks unpleasantly of the much talked of "doctor trust." This feeling is, of course, unjustified by the facts, but it is their feeling, nevertheless, and only re-education of the employer will change this attitude.

It is extremely gratifying to note the spirit of cooperation which exists between the industrial physicians and nurses in New York, New Jersey and some of the Western States. Indeed, if it were not for the signatures on the questionnaires it would be impossible in some cases to determine by which group the answers were made. The replies submitted by the nurses show a very definite understanding of their duties and a clear appreciation of their professional limitations. The answers of the industrial physicians evince an absence of friction, a flattering appreciation of the nurse's ability, and a spirit of cordial cooperation. The replies, in fact, have convinced us of what we had suspected from the first, namely, that the vast majority of nurses and doctors are strictly ethical, and that they cooperate toward the accomplishment of the same ideal: preservation of health, alleviation of suffering, and the spreading of public health education.

It is evident that the shrieks we have been hearing from a restricted area of the country arise from a disgruntled minority, who have such little regard for the dignity of their calling as to permit the following to appear in a daily newspaper under date of April 3, 1922:

. . . . Thousands of dollars are lost to the practicing physicians in —— —— today, due to this industrial nursing system and the industrial hospitals that are in existence today. If the patients desiring the care of their family physicians today, who are misguided by expert industrial advice, would follow the dictates of rights by law, it is reasonably sure that less worry would be experienced by the average medical practitioner when the monthly bills come due at the first of the month.

The above is a verbatim excerpt from a rather long article. Nothing in our knowledge of the medical profession, and nothing in the answers received from industrial physicians, leads us to accept the foregoing as representative.

In all cases where an industrial nurse is charged with treating cases, performing operations, or otherwise exceeding her professional limitations, we feel that justice demands that it be definitely established: First, that she is a graduate, registered nurse; second, the hospital from which she graduated; and third, whether she acted under the standing orders of a duly licensed physician. If the above charges are well founded and a duly registered, graduate nurse has been guilty of the unethical conduct charged, then a full statement of the case, substantiated by the necessary evidence, should be prepared and presented to the state board of regents or similar body. The nurse should, of course, be given an opportunity to be heard in her own defense and if the charges are proved, her license to practice nursing in that state should be revoked. In cases where the offense is not sufficiently serious to warrant such drastic punishment, she should be suspended for some stated period of time. In every case the state nursing association should be notified of the action of the board. In this way all nurses will be apprised of the circumstances and it will tend to make them more cautious about subjecting themselves to similar unpleasant consequences.

If, on the other hand, she is merely an untrained person assuming to be a nurse, it is as unfair to saddle the registered trained nurse with her indiscretion as it would be to charge the malpractice of a charlatan against the medical profession.

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A summary of the answers to the questionnaire follows. To obviate any question of possible bias in the compilation, the answers were tabulated strictly in accordance with the way in which they were made: affirmative, negative, amplified, etc., and later classified according to the group by which they were made. They, therefore, reflect as far as is possible, the sentiment of the individual making them.

## THE QUESTIONNAIRE

1. *What do you think should be the duties of an industrial nurse? Should every first aid case be referred to a physician?*

*Doctors.*—Sixteen said that the nurse should give first aid, one that she should have standing orders to guide her in her first aid work. Fourteen said that first aid should be given only under direct supervision of a physician. Seventeen said the nurse's work should also include routine dispensary work, while 5 qualified this by saying that this also should be only under a doctor's orders. Eleven mentioned welfare work as a desirable part of the nurse's service, while only 8 included public health education.

In reply to the second part of this question, 6 doctors stated that whether *every* case be referred to a physician or not depended (1) upon the nature of the injury, and (2) upon the intelligence of the nurse. Twenty-nine stated that such a reference was unnecessary, 3 stated that the nurse should refer the patient to the doctor if more than one dressing was required.

*Nurses.*—The duties of the industrial nurse were enumerated as follows: Twenty-seven listed first aid, 25 listed dispensary work; 25 included welfare work, while 22 included public health education and 7 stated that the nurse's work depended on the circumstances. In reply to part two, 33 answered in the negative and 3 said that the case should be referred if necessary.

The *employers* answered part one as follows: the decision depends upon the case, 1; first aid should be given, 5; the nurse's work should include routine dispensary work, 4, and welfare work, 1; public health work, 1. In answer to part two, 3 considered that the question depended on the circumstances of the case. One considered that first aid should be given, and 2 advised against this.

*Insurance companies.*—The insurance companies gave the duties of the industrial nurse as follows: First aid, 3; routine dispensary work, 2; public health education, 3. To the second part of the question, 1 answered in the affirmative, and 2 answered that such reference was not necessary.

2. *How long should a nurse be permitted to treat a case without consulting a physician?*

*Doctors.*—Ten stated that the length of treatment would depend on the case, and qualified this as in question 1. Thirteen stated that first aid only should be given. Seven stated that nurses should never give even first aid, except under the doctor's supervision.

*Nurses.*—Twelve said that this depends upon the circumstances; 5 answered *never.* Seventeen stated that first aid only should be given; 3 said indefinitely, and 1 qualified this by saying "under doctor's orders." One stated from 1 day to 1 week.

*Employers.*—Three said it would depend upon circumstances, and 2 answered, "yes."

*Insurance companies.*—One stated that the nurse should give first aid, 1 that the question depended upon the circumstances of the case and 1 that the nurse should never be permitted to treat a case.

3. *In case of an apparently simple injury or infection, where patient refuses to go to a doctor, what should the nurse do?*

*Doctors.*—One stated that it depended upon the case. Nine advised giving first aid, 11 advised refusal of treatment by the nurse, 7 advised referring patient to doctor, 6 advised reporting refusal to insurance company. One advised nurse to recommend dismissal of employee, and 1 did not answer the question.

*Nurses.*—Twenty-five advised giving first aid, 11 advised refusing to treat. Sixteen advised referring case to the manager; 7 believed that written refusal should be obtained from the patient before first aid should be given. One answer was indefinite.

*Employers.*—Five advised reporting case to the management; 1 stated that nurse should refuse to treat, and 1 said that nurse should give first aid.

*Insurance companies.*—Two stated that nurse should give first aid, and 1 that she should refuse to treat patient.

4. *In cases where no physician is employed by the plant, should insurance company's doctor leave standing routine orders as guide for nurse?*

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*Doctors.*—One stated that this would depend upon the case; 18 answered yes, while 3 qualified this by saying that standing orders should be given only in case the doctor visited the plant every day. Ten replied in the negative; 2 said standing orders were unnecessary for first aid.

*Nurses.*—Two stated that it depends on the circumstances; 32 said yes; 2 said no; 1 said, "no nurse should work in plant which did not employ a doctor." One said she did not know.

*Employers.*—Six answered this question in the affirmative, and 1 stated that the nurse should give only first aid.

*Insurance companies.*—Two replied in the affirmative, 1 that such orders were not necessary.

5. *Is a nurse justified in prescribing treatment for colds, sorethroat, constipation, headache, indigestion, dysmenorrhea?*

*Doctors.*—Fourteen answered yes; 5, "Yes under doctor's orders"; 1, "Yes, there should be standing orders for this." Thirteen answered no.

*Nurses.*—One stated that this depends upon the circumstances. Nineteen answered yes, one qualifying her answer by saying "under doctor's orders." Nine answered no; 4, "under standing orders"; 5 answered, yes, as included in first aid.

*Employers.*—Two answered yes; 2, yes, with doctor's approval. Two answered yes, as first aid.

*Insurance companies.*—Two said no, 1, yes.

6. *Where employer requires nurse to discharge above function (by reason of refusing to employ a phyiscian), does he or the nurse become legally liable if injury or death of employee result?*

*Doctors.*—Thirteen felt that the employer would be liable, 9 that the nurse would be, while 3 felt that liability would fall upon both. Seven stated that in their opinion it was a question of law, and 2 stated that they did not know.

*Nurses.*—One said it depended upon the circumstances. Four thought the nurse would be liable, 20 that the employer would, and 6 that the liability would be shared by both. Five advised refusal to treat without doctor's direction; 3 did not know.

*Employers.*—One thought that the employer would be liable, 1 that the nurse would be, 1 that both would be liable. Three believed that it would be a legal question.

*Insurance companies.*—One said the nurse would be liable; 1 did not know; 1 said it would be a legal question.

7. *Should the nurse be used for other than medical purposes, i. e., employment manager, personnel worker, etc?*

*Should not all her spare time be devoted to health education and welfare work among employees?*

*Doctors.*—Twenty-two stated it depended upon circumstances. Eight stated that such extra professional employment of nurses was permissible. Sixteen objected to her being so employed. Nineteen felt that her spare time should be used for public health education while 3 thought this unnecessary.

*Nurses.*—Eight said this depends on circumstances; 8 said yes; 20, no. To the second part of this question, 15 answered yes and 9 answered no. Thirteen felt that all extra time should be devoted to welfare work.

*Employers.*—Three answered yes to the first part of the question and 3, no. To the second part of the question, 6 answered yes.

*Insurance companies.*—To the first part of the question, 3 answered yes, and to the second part, 3 also answered yes.

8. *Should the employment of other than graduate, registered nurses in charge of health work in plants be permitted?*

*Doctors.*—Two said it depended upon circumstances; 1 failed to answer. Three approved of such employment, and 3 approved if she should be supervised by a doctor. Twenty-five objected to employment of any but graduate nurses.

*Nurses.*—Three said it depended on circumstances. One answered yes; 34 answered no.

*Employers.*—One replied that it depended on circumstances. One answered yes; 1 answered yes if a doctor was employed. Four answered no.

*Insurance companies.*—All 3 approved of such employment.

Two other aspects were touched upon in the questionnaire:

9. *How much of the knowledge possessed by the nurse of the physical, medical or mental defects of employees, should be at the disposal of the employer?*

10. *To what extent, if any, should a nurse be called upon to testify in a compensation case?*

The answer to these points and the interpretative discussion of the data as a whole will appear in the August issue.

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# HOW MODERN MEDICINE REVAMPS THE HOSPITAL PROBLEM*

WILLARD C. STONER, M.D.
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THE advances in scientific medicine and their rational application during the last twenty years have been of such a nature as to demand hospitalization for complete realization in medical practice. Under most circumstances, home conditions will not permit of improvised hospital facilities and since it is impossible to bring hospital facilities to the home, it has become more and more necessary to hospitalize in order that we may apply in diagnosis and therapy that which modern medicine affords. Unless it is unavoidable, the well-trained surgeon no longer performs surgical operations in the home; the well-trained internist no longer attempts to diagnose obscure conditions in the home, much less manage them. The well-trained obstetrician no longer delivers the expectant mother in the home, as such a course too often is at the expense of both the mother and child.

## THE HOSPITAL AS A WORKSHOP

The hospital is being recognized as a workshop where there are facilities that represent the last word in scientific medicine and workers who represent the best in training and skill that modern medicine affords. The public is coming to realize that a hospital is a community problem, that it must have community support and must serve everyone, the poor, the rich and the great middle class on whom a great hardship has come by reason of the tremendous cost of medical treatment, if it is not afforded them by an institution at a cost which shall not make it prohibitive. The public is coming to realize that hospital practice by the medical profession shall not be abused; that the hospital shall not exist for a few select physicians of a community, but shall be accessible to all well-trained medical men.

It is obviously unfair to the young man who has thoroughly trained himself in modern medicine and satisfactorily met all the prescribed standards of qualification to expect him to practice that type of medicine which he has been trained to practice, without hospital facilities. A certain per cent of illnesses do not require hospital care; this is especially true of acute conditions where the diagnosis is obvious and definite and where the course of the disease is likewise definite. Under such circumstances, good care can well be improvised at home and the well-trained physician who does home work suffers no handicap other than that of time in carrying into the home that necessary medical attention.

We had it well demonstrated in the Army Service that a large per cent of acute illnesses require no particular medical attention other than good care, satisfactory elimination and a proper diet. Nature is a good doctor and has more specifics for the cure of disease than she is generally credited with.

We must come to look on a hospital as a complete workshop; not a place to hospitalize bed-ridden patients alone, but as a workshop for diagnosing and advising treatment in ambulatory cases, as is being done in our free clinics and part-pay clinics.

The growth of co-operative schemes of work, such as the co-operative clinics now being developed all over the country, demonstrates the advantages of utilizing this complete workshop where the obscure, acute, sub-acute or chronically ill may go for diagnosis and treatment. Obviously

* Abstracted from a paper read before the National Methodist Hospital and Home Association, Chicago, Ill., February, 1922.

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this affords the advantage of acquiring a thorough examination and diagnosis in an individual case with a single fee, which is supposed not to be prohibitive to the individual. These co-operative clinics have their advantages and disadvantages. The outstanding advantage is completeness of work without necessitating the charge of a prohibitive fee and the outstanding disadvantage is the lack of personal interest in the patient and the failure in some cases properly to evaluate findings. Obviously, these clinics do a certain amount of unnecessary work in order that necessary work be not overlooked. The complexity of modern medicine demands this sort of practice, and the co-operative clinic is here to stay, but it can never represent the whole of medical practice and, if it did, it would be detrimental, robbing a large per cent of medical men of individual initiative and resolving medicine into machine methods.

### Co-operative Clinics

If we accept the premise that the hospital represents a complete workshop for the hospitalization of cases, and that there is a great advantage in having such a workshop in order that we apply modern scientific medicine, then we must accept the conclusion that the hospital must furnish the other portion of the workshop, namely, the thoroughly equipped diagnostic clinic where means are afforded for a proper diagnosis of all diseases. Why shall we not look to the hospital as the complete workshop where all cases difficult of diagnosis shall go and be investigated at a cost prohibitive to no one, where all worthy practitioners of medicine may take their cases for diagnosis and for suggestions as to proper therapy? Life and health should not be made prohibitive to any one and medical practice should see to it that both are within the reach of all in so far as scientific medicine affords real aid. Many of the co-operative clinics compete with the whole profession; that is, they not only take cases for diagnosis, but also for treatment. I believe that this departure will tend to lower the standard of medical practice, as it will take from the worthy man in general practice his best clientage and not afford him hospital facilities.

Hospital practice is a great incentive to do good work. Standardization of hospital practice, such as is being done by the American College of Surgeons, is tending to elevate the standard of medicine generally. Fads, quackery and sectarianism will thrive less when the public generally are educated as to the value and limitations of modern medicine. The facts of modern medicine rationally applied will bring a proper respect for medicine, greatly alleviate human suffering, prevent disease and eliminate a great waste. The hospital must ever be the important means of making these facts accessible to the public.

### Need of Rural Hospitals

The establishment of hospital facilities in the rural communities must be the rational solution of medical practice in these districts. The physician's investment in the modern training in medicine is too great to make rural practice inviting to-day. Better conditions must be the solution. Good roads and our present means of transportation make the establishment of hospitals in the larger towns in rural communities practical. It will be less and less necessary for the acutely ill to be taken to the larger centers for diagnosis and treatment, which is often at the expense of the well being of the patient.

### Responsibility Toward the Nurse

The hospital must have a larger responsibility in the education of nurses who shall enter the fields of preventive medicine and public health nursing. The hospital must emphasize more and more the importance of regular complete examinations for the purpose of detecting the development of diseases that are insidious in onset. It must afford health clinics where the facts of

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medicine may be obtainable to every one. The story of disease would be quite a different one if diagnosis were always made early and the proper therapy applied. The hospital must furnish the same workshop that the industrial world furnishes for the man-made machine—the automobile motor. May we not think it reasonable to have inspections of the human machine in the same way? Modern medicine affords a means of diagnosing early. Disease diagnosed late generally represents either indifference on the part of the patient or a failure to properly apply the means that modern medicine affords, or perhaps both.

### Organization and Correlation of Hospital Service

The satisfactory work of a hospital depends in part upon proper organization and correlation of the administrative, professional, nursing and social service functions of the hospital. It is well to have the professional service divided into the two great groups, viz., medicine and surgery, with a director of each division. Each department under the medical or surgical division should have a departmental chief who should be directly responsible to the division director.

In our hospital the medical council is made up as follows: Superintendent of the hospital, the director of medicine, the director of surgery, and a fourth member who shall be selected by the department heads, not including general medicine and general surgery, and shall serve for a period of one year. The medical council shall determine or initiate all matters of policy and standards of professional efficiency, which shall be subject to the approval of the board of trustees. Upon invitation a representative of the professional services chosen by the medical council shall meet with the executive committee of the board of trustees.

The medical council meets weekly to consider all matters that have to do with the professional services of the hospital. The professional services of the out-patient department are organized in the same manner as professional services in the hospital. All visitants to the hospital have professional responsibility in the out-patient department.

Reports of the work of the out-patient department, the house staff and the nursing service, are made to the medical council weekly.

The medical staff meets monthly, or oftener, for the purpose of holding clinics and discussing matters of professional efficiency.

The social service department determines the social status of every patient applying to our out-patient department for professional service. The medical clinic department determines all diagnoses and classifies cases accordingly. The social service department keeps a follow-up system and, where failure to report at a stated time, a card or letter is mailed, or, if necessary, a home call is made.

The out-patient department in our hospital is open from 8:30 A. M. to 10 A. M. which gives the members of the medical staff the advantage of completing their hospital work early in the day and does not necessitate their return to the hospital for an afternoon clinic.

Work in the medical and children's clinic is done by appointment which enhances the appreciation and co-operation of the patient. Time is thereby controlled and loose, hurried-up, incomplete work is not done.

In conclusion, let me emphasize the great need of amplifying hospital facilities everywhere—that the hospital must be made a complete workshop accessible to all reputed physicians; that it must represent all that modern medicine affords in preventive medicine, diagnostic medicine, curative medicine and social service; that it must be an institution of learning where nurses, physicians and social workers shall be trained in every phase of scientific medicine; that it must render service to every one at a cost that shall never be prohibitive.

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# The Zone of Agreement

Most of us like to think that we are agreeable and have the ability to make friends.

When we come to think about it, the individual who gets along in the world best, is the one who is pleasant, tactful, and yet sincere, the one who does not arouse antagonism by being continually on the opposite side of a question. The zone of agreement is a most important territory, where many of us should learn to dwell more continuously. As it is, some people go through life tilting with windmills, people, and ideas as a matter of principle.

Those who are always on the opposite side of a question, never win converts to their own ideas or ideals—unless, indeed, they are chronic objectors like themselves. Even then there is sure to be warfare within the ranks in a short time.

The art of agreeing with people is called by various names—*tact, diplomacy, magnetism, charm,* and *cleverness.* Naturally we are inclined to think the people who agree with us are far-sighted and brilliant, for this very agreement is a compliment to our own perspicacity.

The art of agreeing with people is not necessarily thinking as they do; it is the more subtle act of getting them to think our way. That is why the scientific salesman never argues with his prospect. He knows that he will kill the sale when he begins a polite wrangle. A wise theologian never argues with another whom he would persuade to accept the religious tenets offered. He knows that as soon as he becomes a combatant, all chance of agreement is ended. And the physician or nurse who wishes to influence a patient, should avoid carefully that unfortunate attitude of mind which expresses itself in continual disagreement.

If we expect to get along in the world, we must cultivate the habit of finding a common ground where we can be in harmony with everyone whom we may meet. It matters not how wide apart socially or intellectually two individuals may be—there *is* a ZONE OF AGREEMENT which *can* be found if only it is sought. From that point of unity, a departure may be made, and the other person gradually led to accept in part, at least, what is offered. Some people sell goods, and some sell ideas. We are all salesmen!

Resistance is aroused by opposition and argument. A commercial salesman steers clear of arousing what is known in the business world as sales-resistance. Much more intelligence is displayed by remaining with the prospect in the ZONE OF AGREEMENT. Other people are much like ourselves. They may seem otherwise, but underneath they react in much the same way as we react to interest, kindness, scorn, a domineering attitude or indifference. When we find that people listen respectfully to what we have to say, and are inclined to accept our ideas courteously, we are off our guard at once and anxious to show ourselves equally generous.

Those whom we address may disagree with much which we have said, but if they possess trained minds, broad sympathies, and a comprehensive understanding of life, they, too, will select the facts, ideas, or principles which appeal to them as acceptable. It is the savage and barbarous nation which is always quarreling. We smile at that early court rule which forbade a man to strike his wife when attending a royal function, when it is now considered ill-mannered to show anger, excitement, or tense feeling in public. Even a platform speaker must be restrained, and show hatred of evil rather than of persons.

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# In the Land of Ideals

When people begin to oppose everything and everybody, it is a sign of old age or hardening of the *mental arteries,* regardless of the number of years one has lived. The skillful person who wishes to influence others, is tactful for the simple reason that he is subtle enough to locate the point upon which both can agree.

Paul, coming upon the heathen worshipers at Mars Hill, might have berated them soundly when he read the sign which they had raised for all to read—TO THE UNKNOWN GOD. But he was too wise for that, and in place of starting in to find fault or to show his own superiority, he took a pleasanter and more sensible course—a course much more likely to succeed.

He said in substance: " I see that you are a religious people, reaching out for that which is fine and lofty. TO THE UNKNOWN GOD you have raised an altar and *it is this very God* about whom I have come to tell you, in order that you may worship Him in spirit and in truth."

No crowd could stand against that psychology. He raised no argument, for he remained within the ZONE OF AGREEMENT. If he had started in to bully-rag them, in all probability he would have been stoned, and then he would have had no chance to deliver his message.

There are people all about you. And unless you elect to live a hermit's life, you will mingle with people as long as you live. Nurses *must* mingle with families, members of organizations and communities to function with the best results. It is especially important for you to get along well with folks. Discord is extravagant. It wastes nerve force, influence, time, and opportunity, and you can dwell within the ZONE OF AGREEMENT if you will only take the trouble to do so. It will not be necessary for you to be silent when you should speak; or to speak when you should be silent. Citizenship in the ZONE OF AGREEMENT merely calls for you to understand your brother and sister—man.

A certain individual who was very anxious that his friend and neighbor should see certain important principles as he saw them felt that the outcome warranted subtlety and patience. The man with the ideas to sell avoided argument. He gave his friend books and magazines to read; he lived happily what he wished to teach; and once in a while he dropped an earnest sentence, made a flat statement of fact, or planted a seed-thought in parting.

The friend, who was a clever professional man, had a very good idea of what the first man was trying to do. He decided to stop this sort of thing, and one day he deliberately began a somewhat combative argument. The first one listened gravely. The contention offered was too absurd. He made no remark, but with tears in his eyes and a smile on his lips, he pressed the hand of his companion, then turned and walked away.

Two days later, the friend who had tried to argue sought that one who had steadfastly remained within the ZONE OF AGREEMENT, and said, simply:

" You have won. I can't oppose you any longer for you always agree with me and you never argue. There is nothing for me to come back at you with! The other day I behaved badly and I know it. Your very silence told me that you *agreed with me in that*—but it left me ashamed."

We do not like to be snubbed, or patronized or opposed; rather do we enjoy people who are able to agree with us in the right way, and then who are capable of leading us up on the Mountain — up on the Mountain where we glimpse the splendid vision which has gladdened them.

A DWELLER IN THE ZONE.

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# A STORY OF THE PROMISED LAND

## NURSING IN PALESTINE

R. GOLDGAR, R. N.

New York City, New York

THE first sight of Palestine is very disappointing. The impression gained when walking through the streets is that cleanliness in the Holy Land is hundreds of leagues away from godliness. Dirty streets, dingy shops—one on the heel of another—natives lounging in dirty cafes, food sadly exposed to layers of flies! One is amazed at the conspicuously diseased eyes of all. I asked myself secretly, "Is this the Holy Land?"

It was in the summer of 1914 that the writer responded to a call for service in Palestine. The engagement almost became a reality when war was declared. At a much later date when medical aid was again being organized for this region my service in the United States Army prevented me from going.

Fate, however, finds a way. In 1919, after I was released from Army Service and at a time when I was uncertain as to just what to undertake, this rare opportunity was again offered to me.

A few weeks later a group of five—three nurses, including myself, a dentist and a surgeon, —were on our way to Palestine. Since traveling facilities were still on a war time schedule, especially in the Orient, our route was devious. After drifting for seven weeks through England, France, Italy, even touching the shores of Greece, we reached Jaffa early in December.

The Medical Unit which I joined was organized during the war by the Hadassah section of the Zionists' Commission and sent to Palestine with a corps of doctors and nurses. Its clinic and hospital service extends throughout the whole country except in the more comfortable colonies where the communities prefer to maintain their own doctor.

The work at Jaffa was under the direction of an American physician. My courage revived when we were shown the clinic—a fine little building with waiting rooms and examination rooms for medical and surgical treatment. A very busy eye department and the pharmacy were just then in charge of an American nurse.

Three days later I was assigned to supervise a small thirty-bed hospital situated in the colony of Tel-Aviv (Hill of Spring), a nearby suburb

A Representative Street Scene in Jerusalem

and the residential section of the Hebrews of Jaffa. This colony presents a more pleasing appearance; it has comfortable homes built mostly on the European plan, some paved streets and fairly sufficient water-supply. One can hear the children practice their music. Here is located the well-known Jaffa Grammar and High School, graduates of which are being admitted to European universities.

The hospital was located in a two-story private home at the extreme end of the colony with upper and lower porches facing the glorious Mediteranean. The lower floor was devoted to the medical cases of children; the upper floor had just been opened for the surgical cases of adults and was fairly well equipped. In addition to nursing care and assisting in a busy operating room a few afternoons in the week, the supervision of the hospital included acting as dietitian, housekeeper, admission clerk, bookkeeper, etc.

The nursing staff consisted only of practical workers—girls who had picked up some nursing knowledge during the war, when every woman was engaged in caring for the sick soldiers. They were very willing but had no idea of time,

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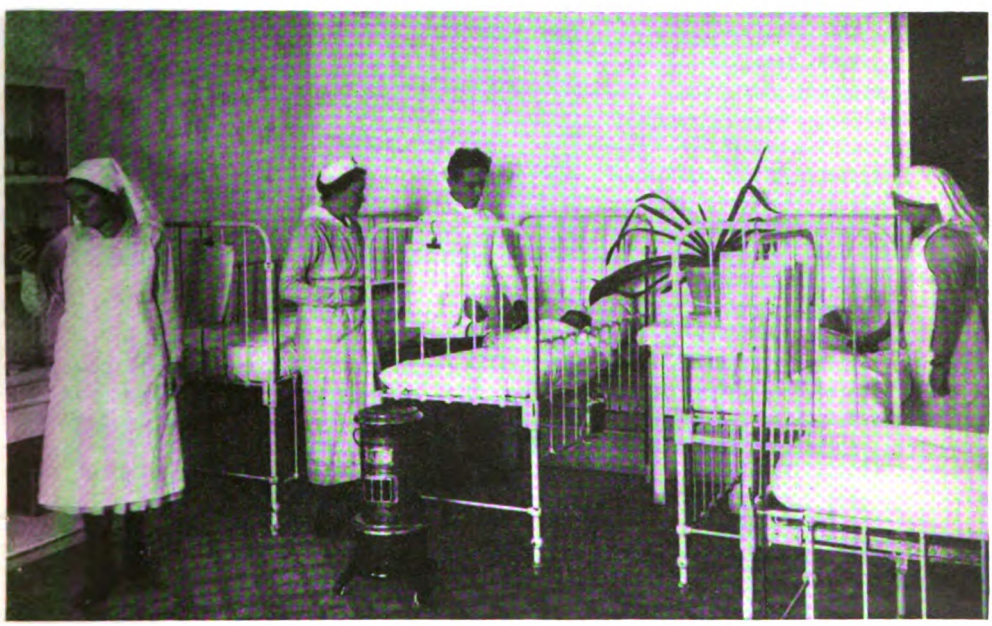
order or system and could not understand the why and wherefore of doing things at a certain time and in a certain way every day. Some, however, were very good workers. One, for instance, was thoroughly capable of taking charge of the surgical cleanliness of the operating room, of packing and sterilizing supplies and of assisting in all eye operations. Weekly demonstrations helped to make the girls more efficient and soon improved the entire appearance of the hospital. This was the busiest institution imaginable for its size. Among the children, we had mostly intestinal and malaria cases with a sprinkling of surgical cases; among the adults we had surgical cases only. The character of operations varied from tonsillectomies to operation for fibroid tumors, occasional goitre, also all sorts of gynecological disorders, hernias and abscesses. The latter I always felt were due to the great lack of public bathing facilities.

The work was intensive. Seldom did I reach my room before nine P. M., and often I was called during the night from the hotel where I lived when anyone was seriously ill or for an occasional emergency obstetrical case. The work was trying, due to the peculiar temperament of the people and other conditions. However, the joy of the service in spite of its hardships was full compensation, and interesting incidents punctuated the days.

One morning a Bedouin patient was admitted. After the nurse had spent some time in inducing her to take a tub-bath, she handed out two bags filled with all sorts of ancient coins which would have delighted the eye of a coin collector. When, upon being discharged, the money was handed to her, she could not remember anything about it and looked at it in astonishment. The natives do not trust their money to any bank but keep it hidden in holes dug near their hut or carry it around with them.

Another morning I heard an unusual commotion in the children's division. A woman had brought in a badly burned child and my laundress was wringing her hands and screaming as though the child were hers. Later I found that the woman who had brought that baby was the third wife of the laundress' husband. It is customary for Mohammedans to have more than two wives. Both women loved and fondled that child and I was never quite certain as to who was the actual mother of it. Part of the burn was obstinate in healing. The doctor tried to explain to the woman that he would have to perform a simple skin grafting operation. She objected and quickly took the baby home and just as quickly brought it back the next morning, saying that her husband refused to have a sick child at home. The skin-grafting was performed and the child was taken home well.

To send patients home was often another problem, especially with those who lived in the



A Room in the Children's Division at Jaffa Hospital

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more distant colonies. We had no definite address, sometimes no wagon or train was available on a particular day and it was often a matter of waiting until some one would visit the patient. With Bedouins it was still more difficult, as they often live in tents in the wilderness. One day a Bedouin patient gave a wild yell. Upon being asked what she wanted she said she was calling to her daughter. I do not know whether she heard the familiar trot of the donkey or her daughter's voice, but her daughter appeared a few minutes later.

The following summer I was transferred to the Jerusalem Hospital, the headquarters of the Medical Unit. The hospital, which contains about one hundred and twenty beds, has a splendidly organized laboratory and clinics. Here the organization has also established a training school for fifty pupil nurses, the only one in Palestine. The nurses' home was until recently in charge of an American nurse. The pupils are intelligent; many are graduates from high schools. They have a psychology of their own, speak Hebrew and Arabic fluently; many also speak French, Russian, and are just now showing an interest in English. Their work on the wards is supervised by American head-nurses. Owing, perhaps, to the tropical climate, they are not very energetic but all are very enthusiastic about nursing, very idealistic and most of them make splendid nurses.

The doctors are very much interested in this training school and the pupils are given a splendid course of studies, all lectures being delivered in Hebrew. In fact, in some branches, they have exceptional opportunities for practice in diseases characteristic of the Orient—such as trachoma, skin diseases, and malaria which is treated by giving large doses of quinine, subcutaneously. The pupils have three hours off duty daily for studies. The training covers three years and the authorities are planning to send the two best nurses to the United States for a course in public health work at Teachers' College.

This training-school, like every other school just beginning, has had its problems, its rough and hard stumbling blocks. Its existence is due to Miss Henrietta Szold, who, while not a nurse herself, has devoted years of her life in tireless effort toward creating American nursing service for Palestine. In a letter dated January 22, 1922, a friend of mine has written:

"I suppose by this time you have heard all about the graduation; it took place in Renaissance Hall on December 7. It was a most thrilling moment for all those who have ever had anything to do with the school and hospital. Miss Szold looked splendid; happiness was in her face. The twenty-two nurses all dressed in white were inspiring to look upon. The diplomas in Hebrew were distributed by Lady Beatrice Samuel. We all feel very glad to see so many trained nurses in the country; all graduates were given positions in the hospitals of the organization."

A Group of Workers Who Were Active in the Influenza Campaign of 1920

Supervising the influenza work during the epidemic of the winter of 1920 gave me quite a bit of satisfaction. The disease lasted a few weeks and was severe in form, but not fatal. It was noticed that the pupil-nurses, who are frequently ill from malaria, were not taken ill with influenza while on this duty.

Acting as night-supervisor was another source of interest. In addition to the obstetrical department, the children's ward was another busy section, requiring two night nurses. Here malaria, intestinal and pneumonia cases were prevalent.

### The Heroism of the East

Coming on duty one evening, my attention was drawn toward a very sick Arabic man, who gave the following story. He was traveling on his donkey from the Dead Sea toward Jerusalem when he was attacked by Bedouins who demanded that he give up his donkey. When the man refused, the Bedouins shot at him injuring his leg. I do not know how he managed to escape, but he arrived at the hospital with a piece of board tied to the injured limb, having ridden in that manner almost an entire day. His leg was so badly infected that he could not be saved. The poor man had preserved his donkey and paid for it with his own life.

(*To be Continued*)

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# Department of Public Welfare

## THE SCHICK TEST AND TOXIN-ANTITOXIN

The following abstract from the *Monthly Bulletin* (New York) summarizes the opinions of Dr. William H. Park regarding the usefulness of the Schick test and toxin-antitoxin injections:

### General Technique

Three injections of 1 c.c. each, of a suitable toxin-antitoxin mixture spaced one to two weeks apart, will cause about 85 percent of susceptible children or adults to develop sufficient antitoxin to give the negative Schick reaction and produce protection against diphtheria. The development of immunity is slow. An amount of antitoxin sufficient to prevent the positive Schick reaction does not develop for from one to six months after receiving the injections. The duration of immunity in at least 90 percent of the children is for more than six years and probably for the remainder of life.

### The Ideal Mixture

The toxin-antitoxin mixture should be slightly underneutralized. The exact degree of neutralization has not been determined. A dose that causes paralysis, but not immediate death in young guinea pigs, is effective and absolutely safe for infants and young children. Toxin-antitoxin should not be given within two weeks of an injection of antitoxin, otherwise the toxin is slightly overneutralized and the resulting development of antitoxin is lessened.

Mixtures made from old stabilized toxin and antitoxin are fairly stable and can be used for a period of one year. Even such preparations are at their best when first sent out as mixtures slowly tend to become first neutralized and then slightly antitoxic. This change lessens the immunizing power. The toxin-antitoxin should be kept cool and in a dark place; it is best to use the mixtures within three months of their final preparation.

A toxin-antitoxin mixture of stabilized materials which is safe when it leaves the laboratory, cannot become more toxic on being kept. No serious effects have ever resulted from the injections given to the New York children since we began our work seven years ago.

### The Value of the Schick Test

The Schick test is an extremely reliable means of separating those individuals who have antitoxic immunity from those who have none. Although a simple test, it must be carried out with extreme care and the toxin present must be neither 25 percent more nor less than the desired amount. It is extremely important to choose glass of suitable chemical composition for the containers in which the toxin is to be placed.

The Schick test is usually omitted in children under three years of age. This is for two reasons: First, that two-thirds of these children require the toxin-antitoxin injections anyway; second, we are not certain whether those that do give the negative reaction are immune because of an unusual persistence of the antitoxin given them by their mothers, or because of the active development of antitoxin in their own bodies.

### Use in the Schools

In practical school work, the first Schick test is frequently omitted in children up to the age of six because it is easier to inject the children at once rather than to delay for the test. At this age the percentage of children requiring immunization is still high and the annoyance from the injections slight. The omission of the preliminary Schick test facilitates the introduction of the immunizing injections in the schools. Above the age of six years, the preliminary Schick test should be made whenever practicable.

No child should be pronounced immune from diphtheria because of having received three immunizing injections of toxin-antoxin. A negative Schick test is absolutely necessary before one can properly make such a statement or issue a certificate.

The use of the control protein test made with the heated toxin is advisable at all ages when a careful separation of the pseudo negative reaction from the combined positive is important. Like the Schick test it is frequently omitted because of local conditions. The older the child the more likely it is to be immune and to give a confusing protein reaction. In children under five years, the protein reaction seldom confuses the picture if the Schick tests are read on the

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fourth day; between five and seven years, the control does not help greatly in more than 10 percent. In older children and adults, the control protein test not only helps us to decide more correctly as to many doubtful reactions but it also indicates with some probability those individuals who are apt to have the marked local and constitutional reactions from the injections.

TOXIN-ANTITOXIN INJECTIONS

The toxin-antitoxin injections are inadvisable before the age of six months. During this time most of the infants retain the antitoxin received from their mothers. Up to the age of three months, immunizing injections are usually ineffective as the infant tissues do not respond well during this period to the toxin-antitoxin to produce antitoxin. Under usual conditions it is probably safe to wait until the infant is nine months or a year old and then to give the injections at the first suitable occasion. During the first three years there is almost no annoyance from the injections. As the child grows older, the danger from diphtheria gradually lessens and the percentage of those developing local and constitutional reactions slowly increases. When adult life is reached, the danger of infection is almost negligible except under unusual conditions, such as those to which a nurse or a physician may be exposed.

There appears to be no difference in the degree of immunity between those individuals who have developed antitoxin from natural causes and those who did so because of the stimulus of the toxin-antitoxin injections.

The only plausible explanation of so-called natural immunity in those who have never contracted diphtheria is that the immunity is due to the stimulus of diphtheria bacilli which have been acquired by the persons as carriers without developing the disease. This explanation seems inadequate to explain many of the known facts such as the presence of antitoxin in the majority of horses and its tendency to appear at a definite age in the children in different families.

POINTS ABOUT IMMUNITY

The immunizing of school children in acting to prevent their contracting diphtheria also lessens the exposure to infection of the younger children of pre-school age in their families.

It is important to realize that we have in our bodies as a protection against diphtheria not only antitoxin, but bactericidal antibodies for the diphtheria bacilli themselves. Antitoxic immunity is more stable. Recovery from the disease diphtheria is usually due to the development of protective substances other than antitoxin. The latter usually develops some weeks later. Recognizing this fact, we realize why those who have no antitoxin immunity do not necessarily contract diphtheria when exposed to it. There is no way of determining the immunity not due to antitoxin. It is certainly more fluctuating and less reliable than antitoxic immunity.

## Detecting and Reporting Ear Discharges After Contagious Diseases

In discussing the treatment of ear infections in contagious diseases at the December meeting of the Rhode Island Ophthalmological and Otological Society, Dr. John J. Gilbert emphasized the great importance of detecting this condition subsequent to the exanthemata of childhood. As public health and school nurses are in a position to detect aural discharge and urge immediate medical attention to insure early treatment, the following points will serve to emphasize the importance of this service.

In scarlet fever and measles, the progress of destruction of ear tissue is very rapid, and when the fulminating mastoid signs develop, operation is fortunately done promptly. These cases leave the hospital with dry ears and fare far better than those that drag along with mild discharge.

In general practice, after the acute stage has passed, the discharge is allowed to continue because it is inoffensive and is considered harmless by those who are uninformed. This supposition is not borne out by the experience of otologists. *All ears that continue to discharge after four weeks, without other visible signs of mastoid involvement, need conservative operative treatment regardless of the infection, but this should be particularly early and prompt in ear discharges of contagious origin.*

In the long discharging ears of adults, a careful history shows, in most cases, that the original ear infection began during one of the exanthemata of childhood. The neglected cases show extensive destruction of drum membrane and ossicles. When polypi

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and cholesteatome are present, in addition, the ear becomes a very dangerous one, and besides the loss of hearing that results, a radical mastoid operation with its dangers, difficulties and disadvantages is often necessary to save life. Someone has likened discharging ears to a gasoline tank constantly exposed to a flame, in that it is unknown when the flare up will come. This is especially true when irrigations and swimming are indulged in. Cases of meningitis, brain abscess, facial paralysis, or sinus thrombosis, resulting from discharging ears and requiring serious operations, may be rare in one physician's practice, but in a large ear clinic they are common.

Do not forget that ears which continue to discharge for weeks and weeks after the normal time of healing are a source of infection in spreading these diseases. Accordingly, these patients must be kept isolated for a long time when other factors of the disease have already cleared up. This does not seem to hold true in measles, in which disease the discharging ear or nose has not been proved to transmit infection, except in the first few days of the disease, but it is particularly true in scarlet fever and diphtheria.

### Conclusions

Many suppurating chronic ears of adult life originate during the contagious diseases of childhood, and cause as much serious trouble in later life as any of the sequelae.

In many cases of middle ear disease in the exanthemata, the destruction and damage does not result in the first few days, but takes place slowly from a neglected discharge that persists because infection continues unrelieved in the adenoid and tonsils, or mastoid antrum and cells.

The simple mastoid operation in these children is not a formidable procedure, and the public should be taught that it is a measure required to save hearing as well as life. It should be termed "post-aural incision" instead of "mastoid" to allay the public fear in case of children.

Most of the infection is located in the adenoid and tonsils (not in sinuses) and these should be removed routinely, after infection with contagious disease has passed, if not during the disease.

## How to Give Health Talks to Mothers

In giving health talks to groups of mothers, causes can be dealt with apart from cure, and simple hygienic rules taught. The stimulus of mind on mind in the little circle of mothers increases interest, and therefore deepens impression. The health visitor can deal outspokenly with common mistakes without the risk of giving offence.

Therefore, no matter what the difficulties, use your resource and sagacity to ensure that no mother attends a centre without going away possessed of one clear fact of hygiene. There are a few simple rules of success in giving health talks:

### The Elements of Success

(*a*) Adapt yourself to the class of mothers you are talking to. Know their practical difficulties and show that you understand their everyday trials. Be sympathetic, but encourage them to aim higher.

(*b*) With uneducated women be very definite and decided; they are not intellectually able to appreciate a nice scientific balancing of facts and theories.

(*c*) You should be able to show that you practise what you preach.

(*d*) Never speak from full notes. Have, if you must, a rough outline of headings of your subject, but trust very much to the inspiration of the moment, and the sudden opportunity. Encourage questions and even interruptions.

### Logical Presentation

Your talk should be divided into three parts, of which the first or introduction should take half the entire time you have allowed yourself.

1. *Introduction.*—Begin with any little story or occurrence or matter of topical interest. Be as vivid as you can. Arrest their attention, get every mother listening. Then link on the moral of what you have been saying to the teaching you intend to give and continue with:—

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2. *The Actual Teaching.*—The mistake of the beginner is to plunge straight into her subject and cram too much in, hurling facts at her audience like bullets out of a machine-gun. Concentrate on two or three facts. In the case of the tired, uneducated mother even one will be enough. Do not be afraid of repeating yourself. Say the same thing over and over again in different words.

3. *Conclusion.*—Sum up your teaching in one or two striking sentences, then drive it home to your audience, with, perhaps, praise and encouragement, or perhaps blame and encouragement to do better.

Always finish by announcing what you will talk about next time.

In a ten-minute talk the introduction should occupy five minutes; the teaching, three minutes; and the conclusion two minutes. Arrange your course of talks as far as possible on seasonable subjects, such as summer diarrhœa and bronchitis, common colds, and so on. Spread cause, treatment, and prevention over three separate talks.

### Community Problems

In another type of talk you can enlist the active co-operation of the mothers. Start by telling a story of some wrong condition which you may have found on district for instance, and ask the mothers' opinion as to the cause or as to the treatment or prevention, according to which of these aspects you intend to deal with. You will get many strange suggestions, no doubt. Deal sympathetically with each; if you reject one or the other, give a clear, brief reason; try to draw out from them the right answer to the question. Then elaborate and explain. Then drive your teaching home. Finish up as before by stating what will be discussed next time.

You will find that you will need a thoroughly sound knowledge of physiology, especially if you are going to address the more intelligent type of audience and wish to encourage questions.—*The Nursing Times* (England).

## Do You Want a Health Clown?

The National Tuberculosis Association is making fall bookings for "Humpty Dumpty," the Health Clown who has performed before audiences of children from coast to coast. He gives two performances a day to children in the grade schools, presenting a health message in a very effective manner. Charges are $25 a day and expenses for less than one week, $125 and expenses by the week, and $450 plus expenses by the month.

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## The Message to Parents

The Parents' Association of Horace Mann School, New York City, has published a valuable little pamphlet covering the daily routine of the school child from rising to bedtime. It is accompanied by height and weight tables, by suggestions concerned with mental hygiene and co-operation with the school, and by a brief bibliography. The pamphlet, a well-studied and effective piece of educational publicity, should be widely circulated among parents of school children.

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## The Cause of Epidemic Jaundice

Accidental infection of a young woman bacteriologist from a rat which she was examining in search of the germ of epidemic jaundice has furnished the first direct evidence that microbes harbored by these rodents can induce that disease in human beings, according to a report recently submitted to Dr. Hermann M. Biggs, State Commissioner of Health, by Dr. Augustus B. Wadsworth, Director of the Division of Laboratories and Research. A microbe believed to be the inciting agent of epidemic jaundice has been found in both human beings and in rats in Japan and in France, and later in wild rats captured in New York City.

Dr. Noguchi of the Rockefeller Institute was the first scientist to find the jaundice organism in rats in this country some years ago.

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# The Hospital Council

## HOW THEY DID IT AT BRIDGEPORT

*A Story of Hospital Reorganization*

THE situation which confronted the Bridgeport Hospital in June, 1921, was duplicated in many other excellent institutions throughout the United States. The hospital was far below its quota in pupil nurses. The nurses in training were, as a consequence, greatly overworked, and the hospital was fast accumulating a huge deficit, due to the necessity for hiring graduate nurses.

The physical fatigue of the nurses and their mental discouragement at prodding with tired minds through the necessary pages of study had released a poisonous gas which spread over Connecticut. Its chemical formula read something like this: "Don't ever take up nursing, but if you do, don't take the three-year course at the Bridgeport Hospital." The accumulating hospital debt made it unwise to spend money for labor-saving equipment or the needed interior decoration of the hospital. The deplored lack of service due to the nurse shortage, and the uninteresting surroundings made the patients dissatisfied; in time this condition would have diminished the number of patients, and led to a less efficient distribution of overhead expense. The whole vicious chain of less nurses, linked with less service, linked with less funds was being lengthened daily.

Obviously, the connection had to be broken. The first move meant a reorganization throughout the whole institution, so that the training school could carry out its educational function unhampered by abnormal pressure from hospital work. Dr. Bresnahan, the superintendent, called in Miss Katherine G. Kimmich of Teachers' College to aid him in this reorganization.

A careful analysis of each piece of work previously performed by the pupil nurses led to the classification of these movements under two heads:

(1) Acts intrinsically related to the *medical care* of the patient;

(2) Acts unrelated to the *medical care* of the patient.

Under the new plan, as formerly, the pupil nurses learn to carry out the work included under both classifications. Sufficient practice is arranged to assure accurate and speedy accomplishment. However, after these acts have been mastered those classified under division (2) are routinely performed by ward helpers and ward maids.*

Although this division of work must be arranged to fit the individual needs of each hospital, the analysis of a few hospital operations will show where the line of cleavage might be drawn. Take a dinner tray, for example. Obviously, the setting of the tray, the distribution of the bread and water, and the helping of the food portions are not, in themselves, skilled medical acts and may be performed (under supervision) by ward maids who have been drilled in care and cleanliness. The tempting arrangement of the food, however, and the adjustment of the contents of the tray to the patient's dietetic needs must be finally checked up by the nurse who makes the contact with the patient. She also makes a survey of the tray when the patient has finished his meal, and then passes it to the

* All the hospital employees—pupil nurses, office help, ward maids, ward helpers, orderlies, etc., wear distinguishing uniforms.

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helper to be returned to the diet kitchen. The cleansing and drying of the tray and dishes and the scrubbing of the diet kitchen tables and floors are again left to the ward maids.

Or take the movements of the nurse on the ward or in the private room—carrying linen to and from closets, counting supplies, making beds in which patients are not confined, sanitary cleansing of bed frames, cleaning windows and floor, bringing water and towels with which the nurse bathes the patient—these are acts which may be performed by ward helpers, as well as the thousand and one small attentions such as adjusting lights and curtains, and getting the proverbial glass of water. The helper is also ready to support the ambulant patient to the toilet, or wheel a chair to the shady side of the porch.

The elimination of unnecessary steps is further accomplished by careful management. The practice on the maternity ward will bring out this point. After the trays have been removed following the midday meal, the bedpans are taken from the sterilizers, stacked on carriers available for the purpose and distributed to all the patients on the ward at once. (Careful screening of each patient is, of course, arranged for.) Later the pans are collected on the carriers, wheeled out and prepared for the sterilizers. After the ward is ventilated, the patients are ready for an undisturbed rest before the visiting hour.

Here, as in all well-organized hospitals, the hypodermic trays, the surgical trays for special dressings, etc., are kept set up for instant use. An additional saving of time is accomplished in the preparation of the maternity packets. The hospital handles about 70 maternity cases per month. Complete supplies for a normal delivery (instruments, of course, excepted), including Kelly pad, sterile gauze, sponges, gauze pads and rubber sheeting, are kept wrapped in sanitary packages ready for instant use.

As routine operations, the making and sorting of surgical dressings are eliminated from the duties of the nurses by the employment of a reliable woman for this work. The gauze is cut by an electrically operated cutter. Pupil nurses spend only sufficient time in this department to insure speed and accuracy.

Other short cuts in operation are worth noting. Each diet kitchen is equipped with a fireless cooker for holding cracked ice. The ice is prepared at a central point, the cookers filled, and then distributed to the individual diet kitchens. In this form it is ready to use in cooling water or in packs or bags. The separate kitchens are also equipped with gas toasters, accommodating just the number of slices which can be watched by one operator. Simple friction lighters attached by chains to the gas stoves eliminate fire hazard and lost motion. All toilets are equipped with special attachments which release a stream of antiseptic deodorizer as required.

Having eliminated unnecessary repetition in all the hospital work classified as nursing, it was estimated that the curriculum could be thoroughly covered in two years and four months. The time on day duty was reduced to eight hours with one-half day off on Sunday, and the time on night duty reduced to ten hours. More time was left for study and class work. The training school was then ready to bid for pupils on honest terms. The first task was to eradicate the poisonous gas with its damaging formula. Connecticut parents had to be taught that nursing undertaken under proper conditions was a promising career for their daughters, and that the Bridgeport school was an excellent place in which to study for the nursing profession.

Newspaper write-ups and a splendid, well-motivated movie carried this message to thousands of parents. The film showed the attractive life at the nurses' home, the

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interesting human phases of the hospital work, and the opportunities for nurses after graduation.

By October, 1921, the school was filled with splendid pupils, carefully selected. The breaking of the vicious chain had been accomplished, and a promising waiting list insured the future. The nurses' home, which the movie had truthfully pictured, was alive with ambitious nurses. Off hours found them gathered for study on the porches on the warm days, or grouped around the grate fire in the fall evenings. At meal time bevies of new faces appeared around the smooth, white tablecloths.

By January, 1922, the improvement in the hospital atmosphere was marked. The private rooms and wards were filled with satisfied patients; along the corridors tripped satisfied nurses, and the ward maids and ward helpers were well located in their own comfortable quarters.

An added impression of prosperity was conveyed by the rapidly changing interior. The dingy brown walls were being toned to a warm gray. About four feet from the baseboard the monotonous stretch of wall was broken by a conservative dash of color —a wallpaper border coated with shellac to permit cleaning. A lighter shade of gray was being used above, finished by another border at the ceiling. The chairs, beds and other furniture, formerly a nondescript collection, were being harmonized by several coats of a good cream paint. Crisp curtains at the windows completed this impression of livableness. The children's playroom gave another human touch, with its diminutive chairs and play table silhouetted against the birds and beasts from Noah's ark. This transformation, fully completed by June, 1922, has been brought about at small outlay by utilizing the odd times of the hospital workmen to revamp the standing equipment.

One other change in the arrangement of the school has been introduced to promote efficiency. To save time in transit and make the classes an integral part of the hospital work, the recitation rooms have been moved from the nurses' home to an accessible wing of the main building. This change permits excursions to the wards or laboratories for demonstrations, or the easy removal of apparatus to the recitation rooms.

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# CONVENTION HIGH LIGHTS

## Occupational Therapy Association Joins Hospital Conference

The conference of the American Hospital Association will be broadened this year by the addition of the Annual Convention of the American Occupational Therapy Association. This work is developing rapidly as evidenced by the appearance of the society's quarterly publication and the increased interest in this type of therapy as applied to hospital work. It is fitting, therefore, that the Association join the American Hospital Association conference so that superintendents and occupational therapy directors may discuss their mutual problems and study the best crafts adapted to this work.

## The Convention Program

The practice of electiing presidents two years in advance will show excellent results in the program which President O'Hanlon has well in hand. This year a trustees section will cover those important questions in finance administration, and organization which come within the scope of supervisory management. The following valuable committee reports will be submitted at the forthcoming convention:

1. Report of the Special Committee on Hospital Floors. By F. E. Chapman, *Chairman.*
2. Report of the Special Committee on Gauze Renovation and Standard Dressings. By Dr. A. B. Denison, *Chairman.*
3. Second Report of the Special Committee on Forms and Records. By Dr. A. C. Bachmeyer, *Chairman.*
4. Report of the Special Committee of the Relations between Hospitals, Cities and States. By John E. Ransom, *Chairman.*

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5. Report of the Special Committee on the Training for Hospital Social Service Workers. By Michael M. Davis, Jr., *Chairman.*
6. Report of the Standing Committee on Out-Patient Work. By John E. Ransom, *Chairman.*
7. Report of the Standing Legislative Committee. By Dr. Christopher G. Parnall, *Chairman.*

## Committee on Dressings

Appointments have been announced of the members of the special committee on gauze renovation and standardized dressing which was discussed by Mr. Chapman at the last convention. The following members have been assigned to the analysis of this important hospital service: Dr. A. B. Denison, *Chairman;* Asst. Director, Lakeside Hospital, Cleveland, Ohio, Miss Claribelle Wheeler; Supt. of Nurses, Mt. Sinai Hospital, Cleveland, Ohio, Sister Cornelia and Sister Patricia; St. Vincent's Charity Hospital, Cleveland, Ohio, Sister Amadeus and Sister Agnes Therese; St. John's Hospital, Cleveland, Ohio; Mr. Guy J. Clark, Purchasing Agent, Cleveland Hospital Council, Cleveland, Ohio.

## Educational Function of the Exhibits

As previously announced, the exposition will be of special scientific importance this year due to the educational analyses of all exhibits and the reports of these analyses on the floor of the convention. The personnel of the committees making these reports is a guarantee of their helpful nature.

BUILDING — CONSTRUCTION, EQUIPMENT AND MAINTENANCE

Dr. S. S. Goldwater, *Chairman,* Director, Mt. Sinai Hospital, New York, N. Y.

Dr. John M. Peters, Supt. Rhode Island Hospital, Providence, R. I.

Dr. W. E. Woodbury, Director Hahnemann Hospital, New York, N. Y.

Mr. F. E. Chapman, Supt. Mt. Sinai Hospital, Cleveland, Ohio.

Dr. Christopher G. Parnall, Supt. University Hospital, Ann Arbor, Mich.

Mr. Pliny O. Clark, Supt. Presbyterian Hospital, Denver, Colo.

Dr. R. G. Brodrick, Director of Hospitals, Alameda County Hospital, San Leandro, Calif.

GENERAL FURNISHINGS AND SUPPLIES

Dr. H. W. Hershey, *Chairman,* Supt. New Haven Hospital, New Haven, Conn.

Dr. Louis H. Burlingham, Supt. Barnes Hospital, St. Louis, Mo.

Dr. K. H. Van Norman, Supt. Charles T. Miller Hospital, St. Paul, Minn.

CLINICAL AND SCIENTIFIC EQUIPMENT AND SUPPLIES

Dr. A. B. Denison, *Chairman,* Asst. Director Lakeside Hospital, Cleveland, Ohio.

Dr. A. K. Haywood, Supt. General Hospital, Montreal, Canada.

Dr. John D. Spellman, Supt. Touro Infirmary, New Orleans, La.

FOODS AND EQUIPMENT FOR FOOD SERVICE

Dr. C. W. Munger, *Chairman,* Supt. Blodgett Memorial Hospital, Grand Rapids, Mich.

Dr. F. R. Nuzum, Medical Director, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

Miss Alice Thatcher, Supt. Christ Hospital, Cincinnati, Ohio.

Miss Rena S. Eckman, Household Director, University of Michigan Hospital, Ann Arbor, Mich.

Dr. E. T. Olsen, Supt. Englewood Hospital, Chicago, Ill.

Dr. C. S. Woods, Medical Supt., M. E. Hospital, Indianapolis, Ind.

LAUNDRY EQUIPMENT AND SUPPLIES

Dr. W. P. Morrill, *Chairman,* Supt. Shreveport Charity Hospital, Shreveport, La.

Dr. George F. Stevens, Supt. Winnipeg General Hospital, Winnipeg, Manitoba.

Dr. R. L. Henry, Supt. City Hospital, St. Louis, Mo.

## Special Group and Committee Meetings

On September 22-24, prior to the formal convention opening, special group and committee meetings will be held at Atlantic City to cover points which cannot be considered in the rush hours of the general convention meetings. Chairmen of committees and committee members will receive special notification of these meetings at a future date.

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# Gleanings

## Conditions Governing the Secretion of Human Milk

To add to the meager literature on normal lactation, Dr. Frank Howard Richardson* has collated new data on this physiological process under the three periods—establishment, middle period and retrogression, or weaning. These data were obtained from a very comprehensive questionnaire submitted to a representative group of nursing mothers.

1. There occurs quite frequently, following the first inrush of milk that marks the beginning of lactation, a marked diminution in the amount of milk secreted. This is frequently so alarming in degree as to lead both mother and physician to believe that lactation is about to cease permanently. This probably constitutes the most frequent cause of premature weaning. Complementary feeding will tide over this danger point.

2. There is a definite and well-recognized "coming in" of the milk, which occurs several times during each day of the whole period of lactation, and which may occur several times during an individual nursing period. (This is not to be confused with the initial filling of the breast, two or more days post partum.)

3. The appetite and thirst of a nursing woman are increased *pari passu* with the demands made upon her milk by her nursing baby. Hence, "forcing fluids" are quite unnecessary.

4. If reasonably long feeding intervals are observed (three hours, or longer), it is impossible to overfeed a healthy nursing child. It is, on the contrary, quite frequently that a baby is *under*fed. The application of this point is quite obvious.

5. The nine months or less during which a mother is nursing her child are, almost without exception, a period of marked "tiredness," amounting in many cases to a serious exhaustion.

6. Almost the sole answer given to the question concerning factors noted as diminishing amount of milk secreted is, tiredness, exhaustion, lack of sleep, etc. The remedy for this cause is embraced in the avoidance of the condition mentioned in (5).

7. At some time or other during lactation most women have some trouble with nipples, breasts, or both. As the surgeon rarely allows the pediatrist more than twenty-four hours' grace before stopping breast feeding, and as reestablishment is almost never permitted in such cases, prevention is the practical point to be emphasized here.

8. Amount of milk secreted is almost always greatest at the first feeding in the morning and least at the last feeding at night.

9. The far cry between what mothers describe as a "good nursing" and a "bad" one is conditioned far more upon the difference in the amount (and perhaps in the character) of the milk secreted by the breast at that particular time than it is upon any factor concerned with the baby.

10. Only less universally noted than the above (9) is the fact that a tired, nervous, fussy state in the mother usually means an unsatisfactory nursing by the child.

If some or all of these points may be considered as definitely demonstrated, they may be of much help in the maintenance of breast feeding.

* From an address delivered before the American Medical Association, June, 1921.

## How to Apply Mustard

The popular rule, "put the plaster where you feel the pain," is generally wrong; for where we irritate a spot on the skin we not only have a response from the parts which lie beneath, but the whole bulk of blood in the body sets toward that point with the steady trend of an ocean current. This fact should always be remembered in applying counter-irritation.

A typical instance of the necessity for, and the method of using the mustard leaf, is seen in treating inflammation about the throat—tonsilitis (the follicular form or true quinsy) and pharyngitis, whether diphtheritic, syphilitic, or simple inflammatory. In the intense coloring of the mucous membrane, the deep red of the outer

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skin, the heat, the swelling of the tissues within and around the throat, we have a striking picture of the blood and lymph gathering from all parts of the body, and in dangerous quantity; for the tissues cannot support so much new material.

Mustard should be regarded as acting upon the blood mass as a whole, therefore, whenever blood has gathered in too great a quantity in any part, draw to some innocent lower skin surface.

In drawing from the head and chest, the skin of the legs and abdomen is preferable, especially that of the epigastrium, located as it is directly over the solar plexus.

Blood drawn from the head and chest down into the arms easily reacts to the old spot, therefore, the skin of the arms is used only for temporary work. In fact, mustard seems rarely indicated above the diaphragm.

In an urgent case, as chill, hemorrhage, or convulsions, use the skin of the arms, legs and abdomen; in the moderate and chronic cases it is sufficient to alternate from the legs on one day to the abdomen on the next, and so alternate from day to day.

### How to Make a Plaster

Black mustard seed is the only kind fit to use, and every particle of dirt, leaf or foreign substance left in the seed as it is ground is a hindrance to the action of the sinapism.

All these should be removed, else the plaster will not act as promptly, and they will be susceptible to moist air and mold. In a word, they should be as perfect as the art of pharmacy can make them.

If not thoroughly soaked the leaf will soon dry and cease to act. It should be kept in water fully two minutes, after which it will remain active even upon a fevered skin. In derivative work, the mustard side of the leaf should be placed directly against the skin with no intervening cloth. With some exquisitely sensitive patients, however, a thin linen protection, which must be thoroughly wet, may be used at first, but the skin soon grows used to the process, when the covering should be discontinued.

### How to Apply Plasters

The time which a leaf should be kept in place varies from ten to thirty minutes. It should never be left long enough to cause blistering, which is liable to occur after thirty minutes. On some sensitive skins an application of ten or even five minutes will produce a bright red patch which will remain for days. That patch is the indication of success. The spot will burn for some minutes after the removal of the plaster. This is just what is desired; and the patient should be cautioned against using vaseline or any other soothing preparation unless the pain is unendurable.

During a prolonged mustard course the skin will thicken and scale off. This is of no real consequence, though often the cause of anxiety to the patient.

When the applications are stopped the skin resumes its normal state.

In congestive headaches from whatever cause, including exposure to the sun, in concussion of the brain, in the unconsciousness of a brain congestion or hemorrhage, mustard leaves are our first thought, and they have well served us. In the last two conditions they are superior to ice or cold coil, for mustard causes no shock and does not paralyze the absorptive power as cold is liable to do.

### Application in Special Conditions

In pneumonia and pleurisy, where the internal pain is intense and the power to transfer it to a distant spot is limited, the plaster should be applied directly over the pain. But plasters should also be used, and for a long time, on the legs and abdomen to limit the whole amount of blood going toward the chest.

In whooping cough, mustard has double

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value. An artificial red spot on the stomach will lessen the spasmodic cough, and counteract the effect of the persistent coughing which throws blood toward the head.

In nausea, vomiting, dyspepsia, and seasickness, mustard applied directly over the stomach will draw blood and power to it and relieve the symptoms. A severe case of arsenical poisoning was made very comfortable in this way.

In these cases we do not use mustard on the legs unless the feet are cold. In the initial chill of cholera morbus, of malaria, of typhlitis, in the collapse of cholera, in dysentery, colliquative diarrhea; in fact, wherever we have a cold surface, mustard should be used plentifully on the arms, legs and abdomen, and kept in place from twenty to thirty minutes. It will greatly assist in the warming reaction.

Cystitis and stranguary are sometimes much relieved by a mustard leaf over the bladder, with others on the leg. Suppressed menses are brought on and painful flowing relieved by reddening the leg. Here the hot mustard foot bath is commonly and successfully used, though the leaves are just as active in the former case and even more active in the latter.

In the eruptive fevers when the brain is in danger, especially in measles and scarlatina, also in smallpox and chickenpox, the mustard plaster will help to prevent many a cerebral complication. The same is true in typhoid (where mustard should never be applied to the abdomen — always to the legs), in bilious and gastric fevers.—A. H. and F. Laidlaw in *Medical Standard.*

## Hiccough

This difficulty may be induced by eating too rapidly or swallowing food in too large masses, or by drinking carbonated waters, or the generation of gas in the stomach. It may also result from the reflex irritation originating in disease of the gall-bladder or in the pelvic viscera.

Hiccough is also often due to an accumulation of irritating liquids in the stomach. Washing out the stomach, drinking copiously of hot water, and care to avoid the errors in eating which induce the trouble, are the measures necessary to secure relief.—*Good Health.*

## Taking Vitamins in Foods

Our subconscious minds are so "educated" by well-worded advertising that we often overlook the facts. Experimental science indicates that the healthy individual needs proper proportions of vitamins A, B and C to complement the necessary food intake. But science has *not* indicated the necessity for the use of commercial vitamin products under normal conditions.

On the contrary, it is believed that the use of proprietary products may disturb the normal intestinal flora and hence induce digestive irregularities. How much more thrifty and natural, therefore, is the addition of a pint of milk (containing sufficient vitamin A and B for the daily ration of a normal adult) and an orange or some tomato juice (containing sufficient vitamin C) to the daily diet. Milk and oranges or tomatoes supply real nutritive food and have a beneficial influence upon the intestinal bacteria.—M. E. Jaffa in *The Pacific Coast Nursing Journal.*

## Smallpox

Deaths from smallpox have been very few in recent years. Since the beginning of its annual compilations in 1900 the highest rate from this cause in the death registration area of the United States was 6.6 per 100,000 population in 1902, while in 1903 it was 4.2 and in 1904 2.1, since which time the rate for the registration area has never reached 1 per 100,000 population. Much higher rates in certain states and cities, however, clearly show that *the danger of smallpox in an unvaccinated population* must not be lost sight of. The high rate (9.2) in 1920 in Louisiana is a warning.

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## Autotransfusion in Abdominal Hemorrhage

Auto-transfusion is indicated in active hemorrhage in the abdomen of such gravity as to jeopardize the life of the patient if no other means are at hand to supply the blood. Contamination of the blood in any manner, either by the nature of the injury or in the preparation of the blood, contraindicates its use. Extra-uterine pregnancy would seem to be the ideal indication for auto-transfusion and has been the most frequent condition in which it has been used. In rupture of the liver, spleen, gunshot wound of the mesentery, the volume of hemorrhage, the call for speed and the delay in obtaining a donor, justifies the use of auto-transfusion.

We have proceeded in the following manner: As soon as the abdomen is opened, having previously sterilized all parts of the aspirating outfit which come in contact with the blood, and 50 c.c. of 2½% of sterile citrate of soda solution having been placed in the receptacle, the nozzle of the aspirator is introduced into the peritoneal cavity and the blood removed.

For this purpose we have found that the Balfour aspirator was ideal, permitting a thorough and quick method of obtaining it and we do not agree with the statement that the aspirator traumatizes the blood more than the slower ladle method. The motor or hydraulic aspirator certainly accomplishes the same result in less time, with less injury to the viscera and more completely than can be done in any other way.

If more than a pint is obtained, a second 50 c.c. of sodium citrate is added to the container. An excess of citrate does not appear to be harmful. The source of the hemorrhage is found and receives appropriate surgical treatment. If a ruptured intestine is found or any gross contamination of the blood is seen, the blood cannot be used. The citrated blood is then poured through gauze into the infusion outfit and introduced into a vein of the arm by an assistant without interrupting the operation. We have used from 500 to 700 c.c. of blood, believing that a larger quantity is not without danger of embarrassing the heart. We have obtained more than 1000 c.c. of blood from the abdomen and have been almost reluctant to discard the excess over 750 c.c. It may be possible, although we have never done so, to refrigerate the blood from the abdomen and keep it in reserve for the particular patient from whom it was removed, or for any other suitable case. It has always appeared a needless waste to see 500 to 1000 c.c. of blood removed from the abdomen and emptied into a bucket of soiled sponges.

CHARLES S. WHITE, M.D., F.A.C.S. in *Southern Medicine and Surgery.*

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## Treating Simple Ills

Tincture of benzoin compound or spirits of camphor give good results in treating fever blisters, but if you want to know the best remedy here it is: Just put four or five drops of tincture of iodine in half an ounce of spirits of camphor.

### INSECT STINGS

Of insect stings those of wasps and bees are the most common. Ammonia water is usually used for such cases, but the best results are obtained by using a preparation of one dram of carbolic acid crystals dissolved by a little heat, and mixed with one dram of water and four drams of glycerin; see that the sting has been removed, then put two or three drops of the preparation on a piece of cotton and bind upon the place.

### CORNS AND CALLUS

One way to obtain relief from corns is to pare the corn off as close as possible without drawing the blood, using a sterile blade, then put a piece of adhesive plaster on the spot. The plaster can be replaced as often as desired, but should be worn continuously for some time.

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# The Editor's Letter-box

The Editor Is Not Responsible for the Views of Contributors. All Letters Must Be Accompanied By the Name and Address of the Writer

## A VALUABLE SUGGESTION

An English nurse gives the following helpful suggestion in *Nursing Times.*

"I am nursing a case of cerebral hemorrhage in a private house, having only gas-fires and no supply of constant hot water.

"I have placed the patient upon a circular air-cushion and placed under the cushion a photographic tray, large enough to clear the hole in the center of the cushion and so placed that the edges of the tray are well protected by the rubber. I put a folded napkin over the vulva and direct it down into the tray, well under the buttocks. The urine which is unconsciously passed drains into the tray, and the napkin can be easily changed as soon as soiled. This saves endless discomfort to the patient, as her back is kept perfectly dry, and to the nurse it saves the constant changing, washing and drying of innumerable sheets. The gaps made under the patient's back by the air-cushion should be filled in with pillows. A pillow is also required under the knees, if this is done the position is rendered quite comfortable."

## A QUESTION OF ETHICS

DEAR EDITOR:

What is the proper attitude of one graduate nurse toward another? The following incident covering a point in professional ethics has left me puzzled.

Not long ago I was called in to nurse a young expectant mother, who, unfortunately, had to submit to a hurried operation for appendectomy. Naturally, all of us were greatly concerned over the patient who was in intense pain part of the time, unless under the influence of narcotics.

The patient's sister (Miss Blank I will call her), a graduate nurse from a Virginia training school, was nursing a patient located directly across the hall from her sister's room and spent a greater part of her time in my patient's room ordering me about. In her anxiety, I suppose, she even administered the treatments, reported the patient's condition to the doctor, took his orders and did the charting. Twice, after I had taken the pulse, temperature and respiration, I found Miss Blank repeating the operation and comparing her results with my report.

The time which Miss Blank spent in looking after her sister could not be used in nursing her own patient. The floor nurses, therefore, waited upon her.

I well understood that Miss Blank was very concerned over her sister's condition and for this reason I tried to overlook the situation as much as possible. Finally, however, I mentioned my difficulty to the superintendent who advised me to leave the case.

Does this seem a fair solution? I am not of a quarrelsome disposition. In my last four years of private nursing (I graduated from the General Private Hospital, Chicago, Illinois, in 1918), I have never had a misunderstanding with any of my patients. In the few instances in which friction did arise it was with the relatives. The patient I was nursing was, I am sure, quite pleased with my work and seemed to like me personally.

I consider the incident finished and shall forget it. I would like to know, however, if any move on my part might be construed as unethical? Will other nurses please be frank in their criticism? I certainly tried to keep my place as well as possible. OHIO.

## EVALUATING STATISTICS

DEAR EDITOR:

Nurses can and do give very important service in the reporting of diseases and unsanitary districts. This information when tabulated *en masse* is a valuable index to health conditions.

But nurses must be exceptionally careful in their evaluation of statistics. As a case in point—Several of my nurses who had attended a lecture brought to my attention this startling conclusion: *that midwifery service produced better results than the service of skilled obstetricians.*

If this were actually true we might all deplore the progress of science. As verified, however, the facts quoted were these: A noted specialist in Buffalo, who was very partial to the procedure of version, reported a mortality in a

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series of cases which was six times as great as that reported through the midwife service in Newark.

In drawing the sweeping conclusion, therefore, these nurses had failed to evaluate several important facts which entered into the situation.

(1) This obstetrician interfered with nature in the first stage without permitting a natural delivery—a practice by no means followed by all skilled obstetricians.

(2) The compilation of the statistics might have made comparison erroneous. The physician's records, for example, which were doubtless very exhaustively kept, gave a fairer picture of the end results than would the compilation of the birth reports of the midwives.

(3) Again, the specialist's clientele were doubtless women from aristocratic, wealthy families whose sedentary habits, overcorseting, and overeating would predispose them to irregularities at delivery. The midwives' patients, on the other hand, were foreigners of the peasant class, whose active habits, simple diet and greater pelvimetric dimensions would naturally tend to lessen the mortality at birth.

Evaluate facts carefully before drawing conclusions!

F. D., New Jersey.

## THE PRACTICAL NURSE

DEAR EDITOR:

I am a practical nurse with nine years of experience. If I nursed only the "minor ills," as they were termed by the Iowa nurse in the June issue, I would find little thrill in my work. As a rule such cases require little more than the accurate recording of temperature, pulse and respiration and the giving of a bath. It is in nursing cases in which life hangs in the balance where the real joy of my work comes in—when I get a case of diphtheria, scarlet fever, meningitis, pneumonia or a very complicated confinement case out in the rural district.

The Iowa practical nurse lays down quite a large program, but I do not think it is comprehensive enough. She failed to mention that a nurse must have a good grounding in anatomy and physiology.

Then just what was she considering under general nursing? A nurse must know, for example, the symptoms of shock and collapse and of post-partum hemorrhage and what she must do before the doctor arrives.

Under points of general technique I would include the following: The irrigation of the bladder; the making of urine analysis if necessary; the application of artificial respiration; how to put on bandages, not "any old way" but in a professional manner; how to give first aid; how to prepare a patient for examination or operation, including the different positions in which the patient may be placed; how to make solutions and their use; how to make sponges, packs, tampoons, drains, etc.; the names of surgical instruments and a general knowledge of their use so that the nurse can hand these to the surgeon as needed; above all she must have a thorough grounding in asepsis.

As to therapeutic measures—she must know how to give cold and hot packs; how to apply mustard plasters; how to give turpentine stupes, etc., also she would profit by a knowledge of simple massage.

With the requirements which the other nurse has mentioned and the points I have added, I think the practical nurse should be able to nurse most cases.

ANOTHER IOWA PRACTICAL NURSE.

## Book Reviews

SURGICAL OPERATIONS. A Practical Guide to Instruments and Appliances. By W. Ibbotson, M.R.C.S., F.R.C.P. The Scientific Press, Ltd., 28 Southampton Street, London, W. C. 5 shillings.

The book begins with an introductory portion dealing very thoroughly with the operating theatre and its appliances, then hints on personal cleanliness, and directions for the sterilization of instruments, ligatures and sutures—all matters of the greatest importance for the success of an operation. In Section I, the general instruments required for most operations are carefully detailed, the articles necessary for the use of the anæsthetist, and also the special ones which may be necessary.

In Section II are given the detailed lists of instruments required for each operation, beginning with the operations on the scalp, the head and the neck. Section III., with those for Thoracic Surgery; IV., the Abdomen; V., Spinal Column and Nerves; and so on throughout the whole range of surgery, including those for gynæcology and ophthalmology.

Part II. is made up of illustrations of instruments and appliances, alphabetically arranged.

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# In the Nursing World

Articles in this department, whether bearing signature or not, are contributed and do not necessarily represent the ideas or policy of this magazine.

## TRAIL BLAZERS, NOT TRADERS!

Fully 250 nurses gathered at the Nineteenth Annual Meeting of the Massachusetts State Nurses' Association held in the Central Library Building, Boston, Mass., applauded the slogan of Mrs. Esther M. Mellory when she said: "We are not traders; we are trail blazers." Mrs. Mellory gave the first address to the private duty section, which was presided over by Miss Minnie S. Hollingsworth. Her speech solicited the active cooperation of all alumnae associations in trying to solve the many problems which face the graduate nurse. She urged frank discussion at meetings, with the elimination of "sidewalk debates" and "stairway clinics."

Her talk was followed by an interesting discussion of nursing conditions in Maine by Miss Jane Prevost. As manager of the Portland Registry, Miss Prevost gave a comprehensive outline of the difficulties there, where twenty-four hour days are the rule, where the variation in salaries for graduate nurses is marked and where physicians in some cases show insufficient discrimination in the selection of untrained nurses for difficult cases. Her comment, "A good nurse is not born but made after hard study and diligent work," brought another moment of applause.

In sketching the future of the private duty nurse Miss Mary V. O'Reilly's outlines were not reassuring. She urged the necessity for strict regulation of partially trained attendants, while evaluating fully the difficulty which families of moderate means were having in their efforts to employ the private nurse in their homes. The combination of conditions, she thought, might mean the permanent withdrawal of the private duty nurse to other satisfying fields. She advanced as a tentative suggestion the possibility of a voluntary reduction in rate scale in advance of the decline in the cost of living as a means of insuring more steady employment to nurses in this group. Other five-minute discussions covered:

(1) The best way to manage a directory.

(2) The adoption of a standard graduate uniform.

(3) Individual Dues for the Private Duty Section?

(4) The best method of providing hourly nursing.

(5) Which should stand first in the duties of the private duty nurse—nursing in private homes or specializing in the hospital?

(6) What does the nurse owe to doctor and patient?

(7) What does a nurse learn as a patient?

In the afternoon Dr. C. Macfie Campbell, of the Boston Psychopathic Hospital, delivered a valuable address on "The Importance of Psychiatric Experience for the General Nurse." The Public Health Section was presided over by Miss Zepha M. Gardner, the Industrial Nurse Section by Miss Evelyn Collidge, the School Nurse Section by Miss Helen McCaffrey (covering city problems) and Miss Emily Poulin (covering the rural aspects).

Mr. Robert Kelse, general secretary of the Boston Council Social Agencies, gave a very helpful talk on "The Public Health Nurse as an Exponent of Constructive Social Work."

The evening session, presided over by Miss Carrie M. Hall, president of the Massachusetts State Nurses' Association, was addressed by Dr. Richard Olding Beard, of the University of Minnesota, who covered in his clear analytical way "Problems in Nursing Education."

The report of the points developed at the second day's session covering the program of the State League of Nursing Education will appear in the August issue.

## VERMONT NURSES MEET AT BELLOWS FALLS

The annual meeting of the Vermont State Nurses' Association met on May 23-24 at Bellows Falls, Vermont. On Tuesday afternoon, after reports were submitted, short papers were delivered on public health, private duty questions and points covering educational problems.

The evening session was addressed by Mrs. H. A. Slayton, president of the Vermont Federation of Women's Clubs, and Miss Alice Shepard Gilman, president of the New York State Nurses' Association. Miss Gilman stressed the point that hospitals which lacked a nursing quota

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were, in most cases, not giving students a real education. As corollaries she demonstrated that lack of adequate clinical facilities (as furnished by hospitals with less than a daily average of 30 bed patients), long hours, too many purely household duties, and other drawbacks would naturally lead to a nurse shortage.

The closing session of the Vermont State Nurses' Association was held on May 24 at the Mary Fletcher Hospital, with about 30 from the Alumnae Association of the Proctor, Fanny Allen, and Mary Fletcher schools present. Mrs. Lucy Lazell, of Brattleboro, gave a very interesting paper on "The Value and Relationship of the American Nurses' Association to the State Association."

The following officers were elected by ballot for the year 1922-23: President, Miss Elizabeth Van Patten, Burlington; vice-president, Miss Anastacia Corey, Burlington; secretary, Mrs. Rose Lawler, Springfield; treasurer, Miss Katherine Kingsley, Burlington; directors, Mrs. Bassett, Rutland; Mrs. Giddings, Proctor; chairman of private duty, Miss Elsie Pease, Mary Fletcher Hospital; vice-chairman, Mabel Dodge, Proctor; secretary, Lida Collins, Mary Fletcher Hospital.

## 400 Nurses Attend Michigan Convention

The eighteenth annual meeting of the Michigan State Nurses' Association was held in Muskegon, Michigan, May 23-26, 1922. About 400 nurses were present.

The first day was given over to committee reports, elections and visits to hospitals. The president's address, delivered by Miss Anna Schill, superintendent of Hurley Hospital, Flint, Michigan, touched upon the necessity of giving nurses training which would aid them in nursing drug addicts, the advisability of having state board examinations given in the nurse's own hospital and other pertinent points.

At 5:30 a Red Cross dinner was arranged under the direction of Miss Elba L. Morse, secretary of the association and field director of the Red Cross Nursing Service for Michigan, which was followed by a constructive address—"What Is Our Goal?"—by Miss Minnie Ahrens, director of the Central Division.

On Wednesday morning addresses were delivered by Miss Lola G. Yerkes, of the Merrill Palmer Nursery School, and Miss Mary M. Roberts, co-editor of the *American Journal of Nursing*, followed by an interesting round table for private duty nurses.

The afternoon session, held at the Country Club, included an address on thrift by Miss A. Filge, and a discussion of private duty organiation by Miss Minnie Hollingsworth, secretary of the Private Duty Section of the A. N. A.

The evening meeting, presided over by Miss Schill, included special addresses on "Centralization of Training Schools," by Miss Mary M. Roberts, and "Standards and Methods for School Work for School Nurses," by Miss Anne L. Stanley, supervisor of school nurses, Department of Public Instruction, Harrisburg, Pa.

On Thursday morning Miss Stella M. Hughes, of the Kalamazoo State Hospital, gave an address on "Psychiatric Social Work," which was followed by round tables on Industrial Nursing, Catherine Edwards, R. N., Solvay Process Co., Detroit; Tuberculosis Nursing, Esther Nash, R. N., Grand Rapids; School Nursing, Abbie Keyes, R. N., Owosso; Child Hygiene, Eleanore Hines, R. N., Wyandotte; County Problems, Edith Stoll, R. N., Ann Arbor.

A health play given by the Muskegon school children, under the direction of Miss Mae Wooley, completed the morning session.

The afternoon session, presided over by Miss Harriet Leek, was addressed by Mr. A. L. Stoneman, state supervisor of Michigan Children's Aid Society, on "The Social Worker and the Public Health Nurse." Stella Booth demonstrated the "Mary Gay Theatre."

The evening session, also presided over by Miss Schill, was addressed by Dr. Richard Bolt, director of the American Child Hygiene Association. Health films were shown at the close of the meeting.

## Public Health Service

By executive order, effective May 1, 1922, all veterans' hospitals with the personnel of these hospitals were transferred to the Veterans' Bureau from the U. S. Public Health Service.

The original twenty-three (23) U. S. Marine hospitals, with the addition of Hospital No. 70, Hudson St., N. Y.; Ellis Island No. 43, N. Y.; Tanners Creek No. 82, Norfolk, Va., and the Leprosarium at Carrville, La., remain under the jurisdiction of the U. S. Public Health Service.

This division expects to develop work which will be of interest to nurses and announcements regarding the service will be sent at a later date.

The assignments and transfers during the month have been as follows: Assigned—Margaret Farley, U. S. Marine No. 14, New Orleans, La.; Alberta Trerrian, U. S. Marine No. 14, New

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Orleans, La.; Vida Butts, U. S. Marine No. 14, New Orleans, La.; Mary Hawthorne, U. S. Marine No. 15, Pittsburgh, Pa.; Mary Walsh, U. S. Marine No. 16, Portland, Me.; Addie Alexander, U. S. Marine No. 21, Stapleton, N. Y.; Emma Miller, U. S. Marine No. 21, Stapleton, N. Y.; John Roland, U. S. Marine No. 43, Ellis Island, N. Y.; Isabelle MacDonald, U. S. Marine No. 70, Hudson St., N. Y.; Ellis Squires, U. S. Marine No. 82, Tanners Creek, Va. Reinstated—Ethel Cameron, U. S. Marine No. 21, Stapleton, N. Y. Transferred—Imogene Sullivan, U. S. Marine No. 15, Pittsburgh, Pa., from U. S. Marine No. 14, New Orleans, La.; Christine MacIvor, U. S. Marine No. 19, from U. S. Marine No. 15.

LUCY MINNIGERODE,
Superintendent of Nurses.

## Y. W. C. A. CONFERENCES

Nurses of the staff of Grace and Harper hospitals were hostesses at the second annual Nurses' Training Council of the Y. W. C. A., held in Detroit, June 3 and 4. The first session of the convention, which was state-wide, was held at Couzens' Hall, the new nurses' home at Harper Hospital.

Miss Marguerite Stuart, national student secretary of the Y. W. C. A., and Mrs. C. R. Wilson, president of the local association, were the principal speakers at the afternoon session. At the banquet in the Y. W. C. A. building, Saturday evening, the subject of conventions and conferences was the theme of general discussion. Miss Lois Cone, Harper Hospital; Miss Magna Tillotson, instructor, University Training School, Ann Arbor; Miss Mary Skeoch, Harper Hospital; Miss Margaret Newton, Homeopathic Hospital, Ann Arbor; Miss Margarite Stuart, Miss Stella Dueringer and Miss Fern Awry spoke after the banquet.

Delegates then went to the Helen Joy Vacation Home at Grosse Ile, as guests of Grace Hospital nurses. After a sunrise service Sunday morning a general discussion on association work and the church followed. Nurses from the University Training School and Homeopathic Hospital, Ann Arbor, were guests of Detroit Nurses.

The following conferences will be attended by many nurses:

Southern Student I, Blue Ridge, N. C., June 2-12; Southern Student II, Montreal, N. C., June 2-12; Eastern Student, Silver Bay, N. Y., June 25-July 3; Northeastern Student, Poland, Me., June 20-30; East Central Student, Eagles Mere, Pa., June 20-30; Central Student, College Camp, Wis., Aug. 18-28; Rocky Mountain Student, Estes Park, Colo., Aug. 15-25; Pacific Coast Student, Asilomar, Cal., Aug. 1-11; Northwestern Student, Seabeck, Wash., Aug. 28-Sept. 7.

For information apply to Miss Mabel Everett, 600 Lexington Avenue, or Student Department, 600 Lexington Avenue, New York.

## INTERNATIONAL CONGRESS OF NURSES

The International Council of Nurses met in Copenhagen, May 23, 1922, for the first time since its session in San Francisco in 1915. Representatives of Belgium, China, Italy, Norway and South Africa (represented by Miss J. C. Child) were admitted, bringing the total of member countries to fourteen.

Miss Nelson, acting for Miss Helen Scott Hay, the American delegate, proposed that the next Congress be held in America in 1924, but the meeting decided upon Finland, and set the date for 1925.

Baroness Sophie Mannerheim, sister of the Finnish General Mannerheim, was elected President of the next Congress.

## BELLEVUE TRAINING SCHOOL FOUNDED FIFTY YEARS

On May 11, 1872, the New York Visiting Aid Committee established the Bellevue Training School for Nurses. On May 11, 1922, a dinner was held in the Hotel Biltmore to honor its founder, Miss Louisa Lee Schuyler.

Miss Schuyler wished the Nurses' School to be modeled on the one Florence Nightingale had opened at St. Thomas' Hospital in London, and to that end one of the doctors at Bellevue, Dr. W. Gill Wylie, went to England to study the school. When he returned with full data from Miss Nightingale, the school was opened.

Dr. Wylie was present at the dinner. So were other charter members of the association, among them Miss Schuyler's sister, Miss Georgina Schuyler, and Mrs. William B. Rice, who has not only worked through fifty years of the association with Miss Schuyler, but also through the Civil War, when both were on the U. S. Sanitary Commission.

Speakers at the dinner reviewed the half century of achievement in public health and charities of the association. Among them were Isaac Adler, president of the Tuberculosis Asso-

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ciation of Rochester and Monroe County; Homer Folks, secretary, and George F. Canfield, president of the State Charities Aid Association.

## INSTITUTE FOR ILLINOIS NURSES

On June 12-15, 1922, an important institute for the chief nurses of the State Department of Public Welfare was held at the Chicago State Hospital. The following program was covered:

MONDAY, JUNE 12TH.

Introductory Address, Charles F. Read, M. D., State Alienist; The Essentials of Well Balanced Curriculum, May Kennedy, B. S., R. N., Superintendent, School Psychiatric Nursing; The Psychology of the Adolescent Girl, Stella Vincent, Ph. D., Chicago Normal School; Recreations for the Adolescent Girl, Emily J. Duncan, Y. W. C. A., Secretary for Young Women, with a discussion by Anne Gutherie, General Secretary, Y. W. C. A.

WEDNESDAY, JUNE 14TH.

Some requirements in Teaching Student Nurses, May Kennedy, B. S., R. N., Superintendent School of Psychiatric Nursing; Teaching Home Economics, Jennie Snow, Ph. D., Supervisor Household Arts, Chicago Public Schools; Hospital Administration, Mary G. Wheeler, R. N., Superintendent, Illinois Training School for Nurses; Teaching Practical Nursing with Demonstrations, Hattie J. Robinson, R. N., Instructor in Preliminary Practical Nursing, Illinois Training School for Nurses; The Place of Psychiatric Clinics in Nursing Education, David E. Rotman, M. D., Physician, Chicago State Hospital.

THURSDAY, JUNE 15th.

The Training of State Hospital Nurses & Attendants, Charles F. Read, M. D., State Alienist with a discussion by Orpha Koger, Shirley Bostrand, Rose Bigler, Katherine Brown, Cora M. Robinson and Myrtle Leanord; Occupational Therapy in State Hospitals, H. Douglas Singer, M. D., formerly State Alienist; Teaching Occupational Therapy to Student Nurses, Anna Tompkins, Chief Occupational Therapist, Chicago State Hospital with discussion and demonstrations by Georgia Spainhauer, Instructor, Occupational Therapy, Scholl of Psychiatric Nursing; Teaching Psychiatric Nursing, May Kennedy, B. S., R. N., Superintendent, School of Phychiatric Nursing.

## INSTITUTE FOR PENNSYLVANIA NURSES

Seventy-five nurses of the Pennsylvania State Department of Health have been released from their routine work to attend an institute given by the Pennsylvania School for Social Service in affiliation with the University of Pennsylvania. The subjects covered from May 29 to July 8 include:

Public Health Nursing—Miss Harriet Frost.

Public Hygiene and Sanitation—Dr. Alexander C. Abbott.

Child Health—Dr. Howard C. Carpenter and Dr. Walter S. Cornell.

School Hygiene—Dr. Walter S. Cornell and Miss Anna L. Stanley.

Community Problems—Miss Katherine Tucker and Miss Anne Flanders.

Family Social Problems—Miss Virginia Robinson and Mr. Karl de Schweinitz.

Nutrition—Miss Anna L. De Planter.

Methods of Teaching—Miss Harriet Frost and Miss Virginia Robinson.

Tuberculosis—Dr. H. R. M. Landis and Miss Fannie Eshelman.

## PUBLIC HEALTH COURSE FOR COLORED NURSES

Twelve graduate negro nurses have been enrolled in the Public Health Postgraduate School of Nursing for negro registered nurses opened early in April at the Flint Goodridge Hospital under the auspices of city and state health authorities and health agencies.

The school is the first of its kind though negro nurses are admitted to the School of Civics and Philanthropy where Louise Ross and Viola Domminick, now working in New Orleans public schools, were sent by the Red Cross three years ago.

The school was organized April 1 at the suggestion of Miss Ross, Junior Red Cross nurse in charge of nutritional work at the Thomy Lafon School.

During the course, which is two months in length, the very best authorities will lecture on the subjects related to public health work.

Field work is given by the City Board of Health in work among negro tubercular patients; by the Metropolitan Life Insurance Company under its visiting nurse service; by the Child Welfare Association, which has several negro nurses; and by the State Board of Health, through its rural nurses. Charity Hospital is giving ward visiting through its Social Service Department.

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# GRADUATIONS

## Alabama

On April 22, the Frasier Hospital, Dothan, Ala., graduated three nurses; Willie Mae, Mattie Lou Kirkland and Bessie Cain. Hillman Hospital, Birmingham, graduated the following nurses on May 25: Grace Glenn, Inez Wesson and Eula Stewart. On May 29, five nurses graduated from Norwood Hospital, Birmingham: Mrs. Myrtle Holcombe, Miss Louise Rogers, Miss Mabel Reeves, Miss Rilla Fowler and Miss Esther Fowler.

## California

On May 12, fourteen nurses graduated from the Angeles Hospital, Los Angeles. Ten were graduated from the Clara Barton Hospital and twenty-one from the Los Angeles County Hospital. On May 17 forty-four nurses graduated from the University of California and fourteen from the St. Francis Hospital, San Francisco, Cal.

## Colorado

On April 17 twelve nurses graduated from St. Anthony's Training School, Denver., Colo. Twenty-five young women graduated from the Children's County, Park Avenue and St. Luke's hospitals on May 12. On June 6 twenty-five nurses were graduated from the St. Joseph's Hospital Training School, Denver. On the same date, four nurses graduated from the Beth-el Hospital, Colorado Springs.

## Connecticut

On May 3, eleven nurses graduated from the Joseph Lawrence Training School, New London. Twenty-four nurses graduated from the Connecticut Training School for Nurses of New Haven Hospital on May 24. Two days later, sixteen nurses graduated from the Bridgeport Hospital Training School. Eight nurses graduated from the Waterbury Hospital Training School on May 31. On June 1, four nurses graduated from the Connecticut Hospital, Middletown. On the following day, Greenwich Hospital, Greenwich, graduated six nurses.

Backus Hospital, Norwich, graduated eight nurses on June 6. On the same day, the Middlesex Hospital Training School, Middletown, graduated eight more. On the 7th, Danbury Hospital graduated nine nurses, and Grace Hospital School of Nursing, New Haven, graduated sixteen, while on the following day, thirteen nurses graduated from the St. Vincent's Training School in Bridgeport.

## Delaware

Delaware Hospital Training School, Wilmington, on May 23 graduated four nurses.

## Florida

On May 30, eleven nurses graduated from the Gordon Memorial Hospital, Tampa.

## Georgia

On May 18, thirteen nurses graduated from the University Hospital Training School, Augusta.

Five nurses graduated from the Oglethorpe Sanitarium Training School on May 24. On June 2, thirteen more nurses were graduated from the Macon Hospital Training School.

## Indiana

On May 3, fifteen nurses graduated from the Lutheran Hospital, Ft. Wayne. Eight graduated from the Epworth Hospital on May 19, South Bend. On May 31, four were graduated from St. Joseph's Training School, South Bend, and in Terre Haute, on the same day the Union Hospital graduated five more.

## Illinois

Four nurses of the Galesburg Cottage Hospital, Galesburg, graduated on May 2. May 18, five were graduated from Rockland Hospital. They were followed on May 19 by three more from the Pekin Hospital, Peoria. On May 23 a class of seven nurses graduated from the Decatur and Macon County Hospital, and on May 26, commencement exercises were held for nine nurses from the Proctor Hospital, Peoria.

## Iowa

On April 12, St. Joseph's Hospital graduated twelve nurses of Sioux City. At the New Samaritan Hospital, also Sioux City, eight received diplomas on May 17. St. Vincent's Hospital graduated seven nurses on June 1.

## Kansas

On May 17, seven nurses were graduated from St. Francis' Hospital, at Topeka, followed on May 23, from the Wichita Hospital, Wichita, by eleven more young women. Christ Hospital, at Topeka, graduated twelve on June 5.

## Kentucky

On May 11, thirteen nurses graduated from the City Hospital, Louisville.

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# *Doctor:*

## Do your patients ever think of this:

## It's not what they *eat* but what they *assimilate* that counts

As every physician knows, digestion of food is essential in order to benefit by its nutritive qualities. Moreover, if in digestion food ferments or undergoes putrid decomposition it may be an actual menace to health.

This is one reason why it is of advantage to have all cereal foods thoroughly baked. Baking not only partially digests cereal foods, thereby developing the particular flavor, but it establishes the physical condition that avoids fermentation and promotes digestion, so that the food is properly assimilated by the system to yield strength and energy.

Grape-Nuts, the delicious cereal food made from whole wheat flour and malted barley, is probably the longest baked of all cereal foods. It is kept for twenty hours in ovens heated to just the proper temperature to develop the best condition of the cereal for digestion.

Grape-Nuts contains valuable mineral salts required for nerve, tooth and bone structure. It is a good all-round food that helps children to grow sturdy and healthy, and there is nothing better for adults.

For breakfast or lunch the delight and appetite-satisfaction in a dish of Grape-Nuts with milk or cream is known practically throughout the civilized world.

You and your patients can get Grape-Nuts anywhere and everywhere; in the most exclusive hotels and clubs; on dining cars; in modest lunch rooms; and at the largest and the smallest grocery stores.

Samples of Grape-Nuts, with full information, for personal or clinical trial will be sent upon request to any physician who has not received them.

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Battle Creek, Michigan, U.S.A.




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### Louisiana

On April 16, five nurses were graduated from T. E. Schumpert Memorial School, Shreveport.

### Maine

On May 1, five nurses were graduated from the Waldo County Hospital, Belfast.

### Maryland

On May 3, eight were graduated from the Church Home and Infirmary in Baltimore. On May 13, five nurses were graduated from the City Hospital in Frederick. From the Maryland Tuberculosis Sanitarium seven were graduated on May 24, followed on May 25 by a large class of sixty-nine from the Johns Hopkins' Hospital, Baltimore. At Hagerstown, on June 6, six students were graduated.

### Massachusetts

From Boston the following schools graduated nurses, June 1, the School of Public Nursing and the Inst. District Nursing Association, thirty-two; May 16, twenty-two from the New England Deaconess Association. May 25, seventeen from the Children's Hospital, and on May 26, twenty-nine, from the Boston City Hospital. From the Waltham Hospital, Waltham, eighteen were graduated on June 2. On April 19, ten nurses received diplomas from the Framingham Hospital. On April 13, five were graduated from the Goddard Hospital in Brockton. Five nurses from the Moore Hospital, on April 14, in Brockton also. On May 11, fourteen young women from the Lynn Hospital, in Lynn, were graduated. Six nurses from the Milford Hospital, Milford, on May 25. Six from the Beverly Hospital, Beverly, on May 12. On May 31, seven received diplomas from the Hillcrest Hospital, Pittsfield. From Lawrence General Hospital, Lawrence, twelve graduated May 4. May 11, nineteen were graduated from Springfield Hospital, Springfield. From the Lowell General Hospital seven were graduated on May 31. On June 5, eight young women were graduated from the Salem Hospital. June 22, the Waltham Hospital, Waltham, graduated sixteen. June 7, thirteen graduated from the Truesdale Hospital, Fall River.

### Michigan

On May 9, in Detroit, the following were graduated: from Grace Hospital, thirty-two; Harper Hospital, thirty-nine; Providence Hospital, fifteen; St. Mary's Hospital, thirteen; Woman's Hospital, eight; Children's Hospital, nine; Samaritan Hospital, one. From the University Hospital, Ann Arbor, thirty-five were graduated in June, with six more nurses from the Homeopathic Hospital. Six nurses from the Harley Hospital, in Flint, on June 6. They are: Josephine De Viney James, Lillian Margaret Lelle, Sylvia Alberta Drager, Flossie P. McGeachy, Gertrude Ann Jaerling, Janet Gilmour Goodspeed. On June 7, from the Battle Creek Sanitarium, the following forty-four senior nurses were graduated:

Callie B. Allen, Bertha M. Bagwell, Sarah Esther Browne, Berenice Aledah Barber, Tilda Borjene Colby, Helen Claire Canfield, Mary Elizabeth Crane, Juanita Cudaback, Anna C. Dingwall, F. Hazel J. Dennis, Agnes Evans, Biddie Faulkner, Kate Louise Gregory, Mildred Elizabeth Hoge, Gertrude C. Hill, Etta Irene Houser, Doris Hamilton, Margaret B. Johnson, Henriette Fern Kloetzer, Nellie Edith Kiser, Dora Mae McBride, Mary May McKenney, Edna Blanche Maphis, Ruth Miller, Emilie F. Muscat, Katherine Mundell, Grace M. Nestle, Rose Nelson, Harriette Mandana Oberdorf, Auburn Lucille Ray, Lois E. Robb, Bessie Lee Ruffner, Edna E. Schmidt, Linnie Mathilda Smith, Sylvia Marie Sawvell, Lydia Stauffer, Fern G. Stevens, Helen Vung-Kyoen Su, Ethel Sophia Swakko, Gertrude A. Towsley, Verle A. Wilson, Mabel Winnifred Smith, Elsie Davis, Alice Lamb.

### Minnesota

From Duluth, on May 9, St. Luke's Hospital graduated seven nurses; St. Mary's Hospital, on May 12, twenty-one. From St. Luke's Hospital, St. Paul, nineteen were graduated on the 12th, and fifteen nurses of St. John's Hospital, May 25. In Minneapolis thirty-one nurses from the Swedish Hospital on May 25; on June 9, seventeen from the Northwestern Hospital; on May 26, twenty-eight from the Minneapolis General Hospital.

### Missouri

On April 18, five were graduated from the City Hospital. May 22, eleven nurses graduated from St. John's Hospital. From the Noye's Hospital, St. Joseph, on May 25, six were graduated, and on that day the Trinity Lutheran Hospital, of Kansas City, graduated nine nurses. The Ensworth Hospital, of St. Joseph, graduated eleven nurses.

### Montana

The Butte Deaconess Hospital, of Butte, graduated two nurses in early May.

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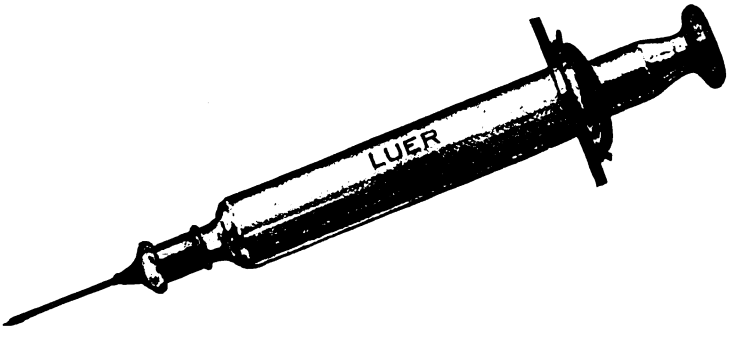
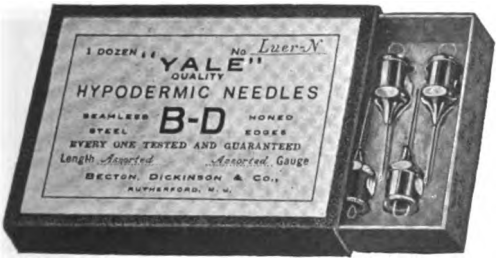



## YALE Needles

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### Nebraska

In Omaha, on May 25, eighteen nurses were graduated from the Methodist Hospital. The Walter Scott Training School of the Presbyterian Hospital graduated five nurses on the 31st. From the Paxton Memorial Hospital, fourteen nurses. June 8, the Lord Lista Hospital graduated eighteen. The University of Nebraska Hospital graduated thirteen on June 5. From Lincoln, on May 25, from the Orthopedic Hospital, three were graduated, with eight nurses, from the Lincoln Sanitarium on June 1.

### New Jersey

On April 19, six nurses graduated from Christ Hospital, Jersey City. On April 20, two nurses from St. Peter's General Hospital, New Brunswick. On May 2, the Orange Memorial Hospital of Newark, graduated twelve. St. Francis' Hospital of Trenton, had eleven on May 3.

All Saints' Hospital, Morristown, on May 11, graduated the following: M. Foran, A. Geary, M. Conners, S. Dawson, F. Burns, K. Swain, K. McCormick. May 12, Bridgetown Hospital, Bridgetown, gave diplomas to three. Cooper Hospital, at Camden, graduated eight on May 19. The Mountainside Hospital of Montclair, had sixteen on May 18. St. Barnabas Hospital of Newark, with six on May 20. St. Joseph's Hospital of Paterson, four nurses on May 24. City Hospital, Newark, with ten on May 25. Jersey City Hospital, Jersey City, fourteen on May 31. May 16, Elizabeth General Hospital, Elizabeth, five: Lillian G. Yeser, Marjorie M. Farber, Ruth A. Callahan, Margaret D. Kelley, Sue E. Lofgren.

In June, on the 1st, West Jersey Hospital, Camden, two; Memorial Hospital, Morristown, six. On the 6, Barnett Memorial Hospital, Paterson, five. The 7th, Englewood Hospital, Englewood, with six. Perth Amboy City Hospital, Perth Amboy, with two. On June 9, McKinley Hospital, Trenton, three. Bayonne Hospital, Bayonne, eight. June 15, the Muhlenberg Hospital, Plainfield, the following (seven): Adele C. Kroohs, Mabel Cregar, Carrie B. Heckendohn, Ellen Isabella Varley, Helen M. Baird, Ella M. Jensen, Lillian V. Pettengill.

### New York

In Albany, on May 16, Albany Hospital, twenty-nine; May 31, Homeopathic Hospital, seven. In Auburn, May 23, Mercy Hospital, eight. On April 28, in Brooklyn Swedish Hospital, five; St. Catherine's Hospital, fourteen; May 3, Brooklyn Hospital, twenty; May 11, St. Mary's, fourteen, May 16. On June 1, Lebanon Hospital graduated seventeen. In Buffalo, May 11, Buffalo Hospital, Sisters of Charity, the following seventeen: Florence B. Karpowicz, Helen T. Brown, Anna Powell, Jane E. Mazurowska, S. Irene Boughter, Sophia S. Swiencicka, Hazel C. Hanson, Gertrude J. Moynihan, Helen M. O'Shaughnessy, Catherine Doyle, Teresa Q. Collins, Marian T. Tully, Marguerite Michels, M. Frances Williams, Monica R. Dolan, Julia McCarthy, Charlotte M. Campbell. Flushing Hospital, Flushing, June 8, five. Ithaca City Hospital, Ithaca, May 12, five. W. C. A. Hospital, Jamestown, graduated six on June 1. From the Mary Immaculate Hospital, Jamaica, L. I., on May 16, six. The Nassau Hospital, May 25, five. In Poughkeepsie, St. Francis' Hospital, May 21, six, and at Vassar Hospital, on June 7, thirteen. A. Barton Hepburn Hospital, Ogdensburg, May 30, thirteen. In Rochester, on May 18, Homeopathic Hospital, nineteen; General Hospital, twenty-one; Highland Hospital, fifteen; Park Avenue Clinical Hospital, two. In Syracuse, April 26, Syracuse Memorial Hospital, eighteen; Crouse-Irving Hospital, May 31, forty. Schenectady, Schenectady Hospital Association, May 22, sixteen. Troy, May 24, Samaritan Hospital, eleven; Watertown, St. Joachim's Hospital, ten. Yonkers, Cochran Training School, April 27, eleven.

### North Carolina

On May 19, six were graduated from the Rex Hospital, Raleigh. On May 29, four from the Good Samaritan, Charlotte.

### Ohio

On May 10, five nurses were graduated from the City Hospital, Lima. Mercy Hospital School for Nurses, Hamilton, Ohio, held its Commencement Exercises on May 17. The faculty of the hospital feel that they were fortunate in securing the speakers of the evening. Mr. R. M. Hughes, president of the Miami University, Oxford, Ohio, and Reverend M. F. Griffin, Youngstown, Ohio, gave the addresses. Diplomas and medals presented by Dr. Mark Millikin, president of the executive staff of the hospital. Ten nurses were graduated: Misses M. Tappel, E. Murphy, G. Cruse, Mrs. G. Morgan, L. Goldberg, Nano Paul, O. Smith, L. Frechtling, I. McMahon, G. Conlon.

Lists of graduations will be continued in August issue.

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# KELLOGG'S BRAN

*cooked and krumbled*

***is high in food values as well as a natural regulator***

Bran has been used with such satisfying results by leading physicians all over the country that it is becoming a standard remedy. Nurses will find that convalescent, bed-ridden and old-age cases, in particular, respond quickly to this wonderful natural bowel regulator. Aside from its regulatory feature, bran is extremely high in food value, carrying as much as 8.41 per cent mineral salts.

Attention of nurses is directed to Kellogg's Bran, cooked and krumbled, because, unlike common brans, Kellogg's is not only palatable—it is delicious! Kellogg's Bran is cooked, then krumbled. Its nut-like flavor wins the most fastidious appetite eaten as a cereal, sprinkled over other cereals or used in a hundred different ways in baking and cooking.

Try some Kellogg's Bran muffins or raisin bread, cookies, macaroons, etc. (Recipes on every package.) Prove to yourself the value of this great natural regulator and health-maker. Your physician will indorse Kellogg's Bran for constipation. All grocers sell Kellogg's Bran. Insist upon Kellogg's—your patient will appreciate it.

***Kellogg's***
**BAKED BRAN CUSTARD**

1 cup Kellogg's Bran
2½ cups hot milk
½ cup sugar
¼ teaspoon salt
½ teaspoon vanilla
3 slightly beaten eggs

Mix all together and bake in a buttered dish until custard is firm. The yolks of three eggs may be used in pudding, and the whites used for a meringue to be browned slightly on top.

**Kellogg's** *Look for this signature W. K. Kellogg*

**the original BRAN** - *cooked and krumbled*


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## PENNSYLVANIA

### Rittersville

The meeting of the Graduate Nurses' Association of District No. 2, was held yesterday at the Homeopathic State Hospital and with more than 100 members of the organization in attendance the session proved a most interesting one from every standpoint.

Upon the arrival of the nurses they were taken on a tour of inspection of the institution, with a dual purpose in view. The first object was to show the nurses to see just how a modern hospital for the mentally ill is conducted and the secondary thought was to overcome the existing aversion to the mentally ill.

After the business had been concluded, a scientific program was given when Dr. Henry I. Klopp, superintendent of the institution, addressed the nurses on the subject of "The Recognition of Early Symptoms and the importance of a Nurse's Knowledge of the Mentally Sick."

The next meeting of District No. 2 will be held at St. Luke's hospital, Bethlehem, Saturday, September 16th.

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## RHODE ISLAND NURSES MEET AT PROVIDENCE

The Rhode Island State Nurses' Association held an interesting session in the Providence Medical Library on June 8. Interesting talks were given by Miss Nelle Selby, superintendent of the Memorial Hospital, who spoke on the Central School of Nursing; Miss Gladys Holman, industrial nurse at Ostby & Barton Co., whose subject was "The Perkins Institute, for the Blind"; Miss Belle Avery, nurse at the Women's College in Brown University, who discussed the "Resident Nurse in College"; Miss Irene Graham, a private nurse, who took for her topic, "Private Duty Nursing"; Miss Margaret Carberry of the Veterans' Bureau, who told of this organization's work, and Miss Alice Hall, a district nurse, who told about "Babies' Clinics."

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## VERMONT

The regular meeting of the Randolph Sanatorium Alumnae Association was held with Mrs. Grace P. Rye, Tuesday, May 2. The business meeting was followed by a social hour with refreshments. Five members were present. Nina Burridae, Secretary.

### The City of Service

Two main highways lead to the City of Service. One winding through the green cool country is known as May; the other bordered by bowers of roses is called June.

And whom can you see on these main highways? Lines and lines of children scuttling out of our grammar schools to crawl into niches in industry; lines and lines of boys and girls striding out of our high schools to find their place in the shops and offices; other lines and lines of men and women hurrying out of our colleges to command a position in the world's scheme of things. But if you will watch closely, you will observe another group wending a purposeful way from the doors of our hospitals direct to the City of Service. These are trained nurses—at least 10,000 strong!

From our lookout we counted 293 crisp caps enter on the April road; 2,255 passed on the May highway; and only half a glance has shown 759 nurses on that broad walk called June; 3,307 fully trained nurses have passed by our narrow window; many others, we know, have entered the streets of the city. And on and on they come. Sometimes it seems as if their very numbers alone would crowd disease from the earth.

Something of this hopeful outlook was phrased by Miss Margaret Slattery when she addressed fifty-five graduates of the General, Homeopathic, and Highland Hospitals in Rochester: "My only regret is that I will not be here in fifty years to see the wonderful transformation. If the nurses of that day find their work in the United States too tame, they can carry their skill abroad where one nurse now serves 400,000 people, and ignorance and squalor are unconquered."

Nurses graduated and graduating can bring about this transformation. Of all the graduates poured into the world at this season, nurses are best prepared to hold an uninterrupted way to the City of Service. Its streets are many and broad. Enter.

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| Wonderlift Service | for all women, 9 models | $6.50 to $13.00 |
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## PERSONALS

Miss S. Rose Beard, for the past three years affiliated with the Bridgeport Hospital, has been appointed superintendent of a new hospital which was opened at Glen Cove, New York, on June 1.

First Lieutenant Florence A. Blanchfield, instructor of the Letterman General Hospital, San Francisco, has been transferred to service in the Phillipines. Nine other nurses, temporarily stationed at the Letterman General Hospital, have also sailed for service there: First Lieutenant Frances M. Steele, from the Fitzimmons' General Hospital, Denver; First Lieutenant Anne Williamson, from Walter Reed Hospital, Washington; First Lieutenant Ida Ethel German, Fitzsimmons' General Hospital, and Second Lieutenants Mary E. Armstrong, Mary E. Cardwell, Anna Claypoole, Florence I. Lee, Agnes A. Resch and Alvine L. Schmidt.

Miss Celia Brian, superintendent of Danville General Hospital, Danville, Va., has resigned to take up work in the north.

Mrs. Brown-Lewers who has served in the office of Dr. L. P. McCalla, Boise, Idaho, for the last four years has accepted the superintendency of a new hospital about ready to open in Fresno, Cal. Mrs. Brown-Lewers' very varied experience in the nursing field including her dietetic work in New York State, her work at Cornell University, supplemented by postgraduate work in surgery, anesthesia, and X ray,makes her peculiarly fitted to develop this model hospital.

Mrs. Alice C. Cleland has again taken up her work as superintendent of the Cooley Dickinson Hospital and Training School for Nurses, Northampton, Mass., after a four months' leave of absence spent in Cleveland, at the Lakeside, Mount Sinai and Cleveland Maternity hospitals, and in Chicago visiting the hospitals and training schools of that city.

Miss Catherine Conrick has become superintendent of the Framingham Hospital, Framingham, Mass., to succeed Miss Josephine Mulvehill who has resigned to become superintendent of The City Hospital of Indianapolis, Indiana.

Mrs. Mary A. Hickey, has been appointed superintendent of nurses of the United States Veterans' Bureau with headquarters at Washington, D. C.

Miss Anna E. Laughlin, superintendent of the Bryn Mawr Hospital, Bryn Mawr, Pennsylvania, has been appointed superintendent of the Waynesboro Hospital, Waynesboro, Pa. A graduate of Junita College and of the Jefferson College Hospital and Training School for Nurses, Miss Laughlin acted as director of nurses at the latter institution prior to her affiliation with the Bryn Mawr Hospital in 1915.

Miss Mary Maloney, affiliated with the Summer Street branch of the Worcester State Hospital, who sustained a very severe spinal injury early in May, is happily recovering, although the accident may incapacitate her for nursing service for many months.

Miss Dorothy F. Williams, a graduate of the St. Mary's Hospital, London, England, is planning to open an Obstetric Home in Glens Falls, New York.

Miss Eugenia D. Ayers, superintendent of the Elizabeth General Hospital, Elizabeth, N. J., has resigned from the hospital to enjoy a much needed rest. For nearly ten years Miss Ayres has been developing and enlarging the work of the hospital until its natural growth has necessitated the building of a new $600,000 building, and an addition to the Nurses' Home. A graduate of the Rhode Island Hospital of Providence, Rhode Island, Miss Ayres held executive positions in the Manhattan Eye and Ear, Worcester City and Patterson General hospitals before assuming her present position at Elizabeth.

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## Marriages

Miss Bertha R. Henry, graduate of the Allentown Hospital, Allentown, Pa., in the class of 1913, to Charles W. Morrison on May 23.

Miss Anna F. Goos, of Bangor, Maine, to A. Boyd Fisher of Fairfield, Maine, on May 29.

Miss Mary Ann Zogart, of Helena, Montana, to Thomas T. Hawthorne, also of Helena, at St. Helena Rectory, on June 1, 1922. Mrs. Hawthorne, a graduate of St. John's Hospital, Helena, served overseas during the late war, and later as industrial nurse with the American Smelting and Refining Company, East Helena, before her appointment as county nurse.

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## Deaths

Miss Katherine F. Tobin at St. Vincent's Hospital, Worcester, Mass., on May 23.

Mrs. Grace T. Shadman, superintendent of the Bellows Falls Hospital, Bellows Falls, Vt., at the home of her sister in Brookline, Mass., as the result of serious burns caused by the explosion of an alcohol stove. Mrs. Shadman had endeared herself to all those who knew her through the kindly spirit with which she managed her efficient institution.

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COMPLETE oral hygiene as practised by nurses and other attendants is not only recognized as good administration, but is a necessary precautionary measure adopted by medical directors, superintendents and superintendents of nurses in the safeguarding of patients.

Interest in sanitary, healthy mouths of hospital personnel grows steadily. The subject will receive even more attention in the future.

Colgate's Ribbon Dental Cream does all that a dentifrice can do in cleansing the teeth and maintaining oral hygiene.

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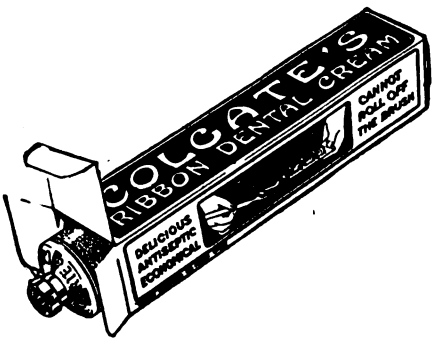




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### The Therapeutic Use of Music

To relieve the monotony in certain types of factory work, careful employers have introduced music in the workrooms. The innovation usually results in a speeding up of production without any measurable difference in the accuracy of the work produced. Here we are dealing with supposedly normal individuals and the results are reckoned in dollars and cents.

When we apply music in the sickroom, however, we are undertaking a new and delicate adjustment. The results will be measured in the improvement or retrogression of the patient's condition. It is especially important, therefore, that music be applied in a scientific manner, and that the observed results be recorded in terms which may be useful to future investigation. Miss Gatewood's article in this issue outlines how such observations may be carried out.

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### Visions

Lying on my bed in that dreamy state which is neither sleeping nor waking, I thought I was in the company of the Recording Angel, who writes in his book the story of the strivings of humanity.

"Tell me," I pleaded, "something of what is written in your book."

"Mortal," he replied, not without some sternness, "the records I have here may not be lightly revealed. But stay; I think I recognize you. Do you not live in a large hospital?"

I bowed my head in token of assent.

"Then," said the Angel, "I am permitted to give you some insight into what is written. You see the casual work, the touch that might be gentler; you hear the thoughtless word that unintentionally inflicts a wound; you notice the act of kindness omitted amid the stress of work, or through shyness or fear. These things are true and are faithfully recorded here. But you do *not* see—and I may not reveal to you in detail—the secret loneliness, the inward self-accusation, the longings after the attainment of the highest that go with them. These also are written here. Do you not also hear, amid the bitter criticism wrung from pain, the kindly word that makes a hard day easier, the extra steps taken to relieve another's burden? Do you not notice the sorrow or disappointment bravely borne, the duty done with a smile that hides an aching heart? *These* are the more excellent, and therefore the truest, things."

I tried to speak, to tell him that I, who lived amid it all, could not believe this. But with uplifted hand he went on: "Your power of vision is limited; you cannot see clearly, but believe in the best; seek for it, and assuredly you will call it forth!"

. . . . . .

The Angel vanished; the daylight was streaming into my room; a new day had dawned.—*Nursing Mirror.*

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### The Questionnaire

During the last three months many of our readers have been asked to fill in a questionnaire covering the contents of certain issues. The answers have teemed with valuable, constructive suggestions.

Since it has been impossible to acknowledge the receipt of some three thousand questionnaires personally, we take this opportunity of expressing our sincere appreciation of the genuine and helpful co-operation we have received. Often, after reading a thoughtfully marked blank with, perhaps, an additional word of comment, we have felt as if we have just come from a personal chat with the writer.

Before the year ends, the questionnaire will be in the hands of every reader, and long before that time many of the valuable suggestions will be woven into the texture of the magazine.

We wish THE TRAINED NURSE to fill the needs of its readers. The comments and suggestions which we have received will aid us in making a bigger, better periodical.

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# The Price You Pay

## For dingy film on teeth

Let us show you by a ten-day test how combating film in this new way beautifies the teeth.

Now your teeth are coated with a viscous film. You can feel it with your tongue. It clings to teeth, enters crevices and stays. It forms the basis of fixed cloudy coats.

### Keeps teeth dingy

Film absorbs stains, making the teeth look dingy. Film is the basis of tartar. It holds food substance which ferments and forms acids. It holds the acids in contact with the teeth to cause decay.

Millions of germs breed in it. They, with tartar, are the chief cause of pyorrhea. Thus most tooth troubles are now traced to film. And, despite the tooth brush, they have constantly increased.

### Attack it daily

Careful people have this film removed twice yearly by their dentists. But the need is for a daily film combatant.

Now dental science, after long research, has found two ways to fight film. Able authorities have proved their efficiency. A new-type tooth paste has been perfected to comply with modern requirements. The name is Pepsodent. These two film combatants are embodied in it, to fight the film twice daily.

### Two other effects

Pepsodent also multiplies the starch digestant in saliva. That is there to digest starch deposits which otherwise may cling and form acids.

It multiplies the alkalinity of the saliva. That is Nature's neutralizer for acids which cause decay.

### Millions employ it

Millions of people now use Pepsodent, largely by dental advice. The results are seen everywhere — in glistening teeth.

Once see its effects and you will adopt it too. You will always want the whiter, cleaner, safer teeth you see. Make this test and watch the changes that it brings. Cut out the coupon now.

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**Pepsodent**
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## HELPING THE LAYMAN TO UNDERSTAND

The world would hardly wag these days if discussions on the nursing question did not fill our newspaper columns. We think we have explained the question fully when a voice is raised in Texas, in North Dakota or in New York City and we begin the tale all over again.

This condition will obtain until the general public—every man, woman and child—understands the whole question. Miss Mabelle S. Welsh, executive secretary of the Eastern Council of Nursing Education, has again come forward with her clear, concise statement of the situation. Let us get these ideas firmly fixed in our minds so that we can pass them on to others:

Has nursing lost its lure?

It is most gratifying to be able to report that interest in nursing, far from being dead, is evidenced by increased enrolment in schools of nursing the country over.

This is clearly shown in the experience of Bellevue Hospital the past year. From September, 1921, to April, 1922, there have been 141 students admitted to the school, only two less than during 1918, when nation-wide propaganda for war service brought an unprecedented number of students into all schools of nursing. Last year Bellevue admitted forty-five student nurses, the year before only thirty-seven. Bellevue can admit no more students until September because of lack or further housing facilities.

What has happened at Bellevue is true in our better schools everywhere. The year following the war was marked by a great falling off in the enrolment of all schools, one factor possibly being that wartime propaganda had been successful in enlisting all girls who were inclined toward nursing and old enough to enter the schools.

Facts prove that interest in nursing is keen, and that the profession is rapidly increasing in numbers. The advance sheets of the 1920 United States census show an increase in the number of graduate nurses that will amount to not less than 75 per cent., and seem to show an increase of 100 per cent.

A profession that has gained 100 per cent. in a single decade can scarcely be said to be suffering from a shortage.

Confusion exists in the minds of those who see some institutions obviously in need of workers and try to place the responsibility upon the system of nursing education.

All institutions caring for the sick are not suitable for the maintenance of schools of nursing. We must not confuse an economic problem with an educational project.

It is true that the modern system of nursing education has been a tremendous asset to hospitals, and that the student body has carried 80 per cent. of the burden of the care of the sick in the hospitals. Some of this burden must be removed from the back of the student nurse, so that she may be free, during her period of training, to gain experience in all branches of nursing work and to receive the instruction which shall make her an intelligent and efficient worker in her chosen field.

Our conclusions after some years of experience and a careful study of the supply and demand in the nursing field are that:

1. There is a marked, intelligent, growing interest in nursing shown by young women.
2. Prospective students of nursing show by their searching questions that they are no longer choosing schools without consideration of the opportunities offered.
3. High standards do not deter. On the contrary, the schools known to have the highest standards are the first choice of many girls who have had no educational opportunity, but who have heard that these are the "best schools."
4. The length of the time of training does not affect the enrolment of a given school, provided the time is well invested educationally.
5. The care of the sick in public and private institutions cannot be given entirely by student nurses. Paid workers, graduate nurses and attendants must supplement the work of the student nurse.
6. We have a community problem in the cost of the care of the sick not to be camouflaged by an alleged lack of interest in a profession that has gained 100 per cent. in ten years.

An encouraging sign of help from another source is evidenced in this bulletin issued by the New York State Federation of Women's Clubs:

"Club women, encourage your young friends and daughters to prepare themselves for nursing, because:

"1. It is a woman's profession which offers opportunities to educated, socially minded young women.

"2. It is a profession which educates for life. Every normal girl looks forward to a home and her own children. A nurse-mother is equipped with an invaluable education for her profession of home making and motherhood.

"3. The public health nurse and nurse citizen becomes familiar with all the problems of poverty and ignorance as well as those of disease and has an enviable background of knowledge for civic work.

"4. When the nurse's training is finished she can begin her work at once and does not have to face competition with men. As long as health lasts she has an assured income."

---

## HOSPITAL SOCIAL SERVICE AIDED

The Russell Sage Foundation has made a grant for one year of $3,000 to the American Association of Hospital Social Workers with the understanding that the additional $3,000 estimated to be needed to carry the work of the Association would be raised by the Association. The grant was made on the appeal of the Executive Committee to enable the Association to employ the necessary salaried personnel to carry out the program as adopted at the Annual Meeting held in Milwaukee, January, 1921.

---

## ONE HUNDRED TRAINED ATTENDANTS GRADUATE

On May 31, seventy trained attendants completed the nine months' course conducted by the Department of Public Welfare, New York City. This course, as explained by Miss Agnes S. Ward in the January issue is given to women who are disqualified because of insufficient education, age or other reasons from taking the regular course.

A similar departure has been undertaken in Boston, where thirty-three attendants completed a thirteen months' course at the Training School for Attendants of the Household Nursing Association on May 10.

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# "With this Treatment I Seldom Write a Death Certificate *FOR* INFANTILE DIARRHEA"

***THE BRITISH MEDICAL JOURNAL SAYS:***

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**—Extract From Doctor's Letter.**

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**To each half-pint of rice or barley water add one-quarter teaspoonful of Virol. Give one or two ounces of this mixture every two hours. In cases of great prostration add 10 to 15 minims of brandy. When the evacuations indicate that the infection is at an end, sterilized milk can be cautiously added to the Virolised rice or barley water, the milk being substituted for the rice or barley water, dram for dram, until Virolised milk is the sole article of diet. As the child improves the Virol can be gradually increased.**

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## FLORIDA

District No. 4 of the Florida State Nurses' Association held an interesting meeting in Lakeland, Florida. Six hospital superintendents and the state president, Miss Lillian Hollohan, were present as well as local nurses. A committee was appointed by the president to formulate plans for a public entertainment to raise money for the nurses' relief fund.

After the regular business meeting, a pleasant and profitable round table discussion was held, mostly on problems which confront a hospital superintendent. The next meeting will be held at Clearwater.

## MASSACHUSETTS

### Fall River

The annual meeting of the Bristol County Branch of the Massachusetts State Nurses' Association was held in Fall River, May 12, at the Truesdale Hospital.

Addresses were delivered by Miss Alice Shepherd and Miss Sally Johnson. The following officers were elected: President, Mrs. Frederick B. Albert of the Union hospital, Fall River; first vice-president, Miss Ursula Noyes, of the Morton hospital, Taunton; second vice-president, Miss Marion E. Seaver of St. Luke's hospital, this city; secretary-treasurer, Mrs. Anna E. Duffy, of the Union hospital, Fall River; directors, Miss Stella Evans of the Truesdale hospital, Fall River; Miss Rosella Wells of the Union hospital, Fall River; Miss Florence Thistlethwaite of the City hospital, Fall River; Miss Edith Meates of St. Luke's hospital, this city; Miss Jane McAdam of the Moreton hospital, Taunton, and Mrs. Averill, superintendent of the State hospital of Taunton.

On June 16, a new East Wing was opened by the Free Hospital for Women, Brookline, Mass. This important addition will greatly increase the hospital's facilities.

## NEW YORK

### Buffalo

The following officers were elected at the annual meeting of District No. 1 of the New York State Nurses' Association held at Buffalo, New York, May 17: President, Miss Anna L. Hansen; First vice president, Miss Anna Hooley; second vice president, Miss Tessa Klein; secretary, Miss Laura F. Lewis; treasurer, Miss Margaret Daley; directors, Miss Ella F. Sinsebox, Miss Ruth G. Hall and Miss Rose Nagle.

Miss Alice Shepherd Gilman spoke on "Different Propositions Governing the Nursing Problem."

## THE BATH PROBLEM IN ARMENIA

A bath every day is not considered an unreasonable luxury in American hospitals. In Near East Relief orphanages in Armenia, where they have an over-supply of orphans and a shortage of bathtubs, very careful planning is required in order to provide everyone with a bath a week. Of course even this is more than Armenian youngsters are used to, but it is absolutely necessary to keep down scabbies and favus, to which years of mal-nutrition make them especially liable.

Given 5,000 little girls, 40 shower-baths, hot water needed in the laundry from 8 a. m. to 5 p. m.—how to get clean almost 1,000 a day, "that's the question" as it presents itself to the Kazachi Post orphanage in Alexandropol. The answer is—American system and early rising. It is a quarter of a mile from the orphanage bath-house, and the mercury in winter often creeps down to 15 below, but rain or shine, snow or storm, five o'clock in the morning sees bathing begin. In lively companies of forty at a time these wee girls rush through the process: first, shed their clothes, which are taken out to the laundry; then, plunge under the showers, ingeniously improvised by home-grown talent, with such devices as sprayers made out of condensed milk cans; and last, dash to the outfitting room, where, with all speed, they get themselves into fresh costumes, all done up in bundles and laid out ready for them. Then back to the orphanage for food, and work in the schools or industrial shops.

This bath factory turns out 150 clean orphans an hour, and is on the job every day. Without American care these youngsters, now strong and healthy, would be miserably existing in caves and dens, suffering from all sorts of skin and other diseases, and with never a bath among them from one year's end to the next.

## DEVELOPMENTS IN BRAZIL

Mrs. Ethel Parsons, a nurse in the employ of the International Health Board of the Rockefeller Foundation, who went to Brazil last August, is now organizing a public health nursing service there and developing training courses for public health nurses, as director of a bureau of nursing in the National Department of Health. All the nursing activities are to be under her general supervision.

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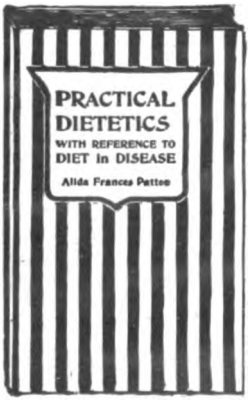


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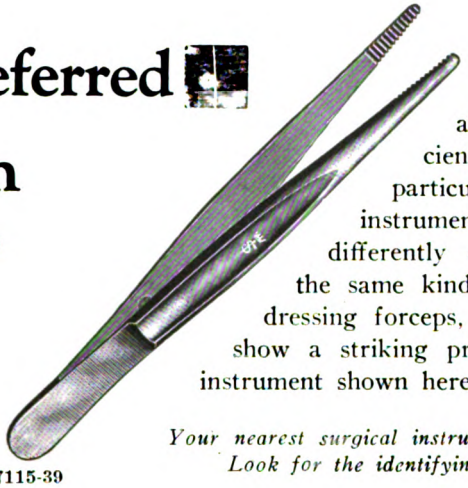

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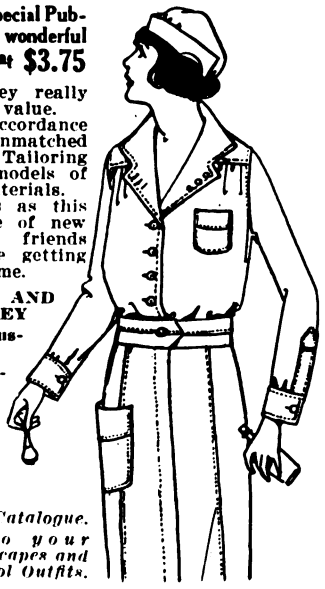

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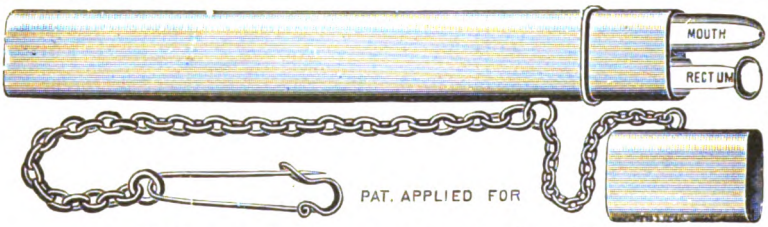


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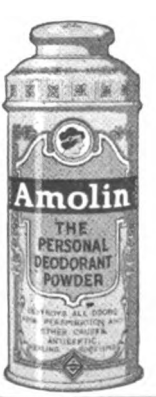


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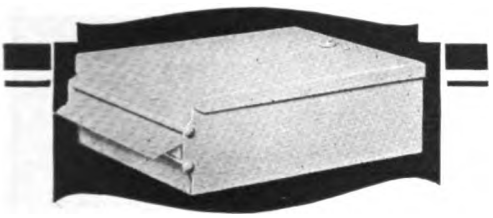

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Vol. LXIX AUGUST No. 2

# The Trained Nurse and Hospital Review

**A Monthly Magazine Devoted to Trained Nursing in Private Practice, in Hospitals, Institutions, and Public Health Service**

*Editor,* CHARLOTTE A. AIKENS
*Managing Editor,* META R. PENNOCK
*Advertising Director,* CAROLINE DEXTER

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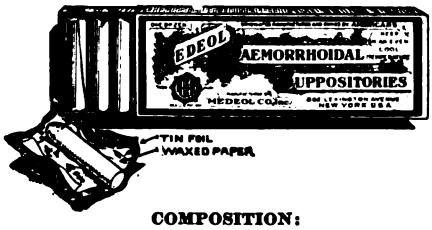


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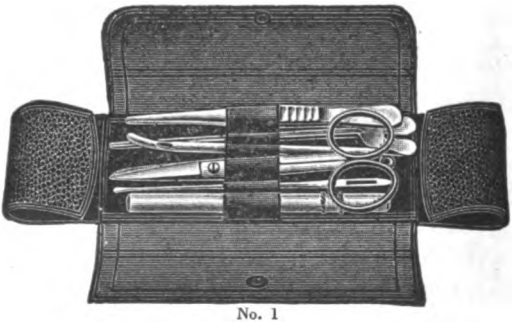

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# The Trained Nurse and Hospital Review

ESTABLISHED 1888

Vol. LXIX NEW YORK, AUGUST, 1922 No. 2

# WHAT THE TUBERCULOSIS NURSE SHOULD KNOW AND DO

F. W. WITTICH, M. D.

Physician in Charge, Tuberculosis Dispensary, University of Minnesota

THE nature of tuberculosis, its prevalence, its infectiousness for children, its tendency toward chronicity and its many other characteristics, makes this disease stand in the foreground as a disease of the masses. Unlike other infectious diseases, preconceived opinions of it are practically worthless. It requires special knowledge and experience in those serving to combat it. The manifestations of the disease are so varied among different races and the people of different climates and are so greatly influenced by environment that one cannot lend oneself to any phase of the subject without a knowledge of its fundamentals.

## THE BASIS FOR EFFICIENT WORK

It is inconceivable for any nurse to undertake such a study without having had at least two years or more of general training. In fact, its real place is in the form of a post-graduate course in a well-equipped and well-organized sanatorium, a post-graduate school of tuberculosis or in a well-coordinated dispensary where the tuberculosis dispensary forms a special division of the out-patient department preferably of a medical school. Special lectures in tuberculosis should be available from teachers trained in various branches of the work. A course given by public health workers of local reputation, unless well organized and correlated, does little more than confuse.

The tendency to standardize one's own theories is very great. This leads, of course, to the exclusion of uniformity and wholehearted cooperation. The student must appreciate this and be broad enough to sift the grain from the chaff to see the finished picture as a whole if she is going to be useful in studying details. *To be specific, one must have an idea of the present day knowledge of the pathology of tuberculosis, the influence of primary infection upon subsequent infection, the universality of infection and its relation to manifest disease.*

What are the cardinal and secondary symptoms of clinical tuberculosis requiring treatment, and the non-specific factors which were probably responsible for its actuation? The history of tuberculosis is so interwoven with that of medicine that one cannot study the latter without knowing the former. When men ceased to roam the plains and congregated in communities consumption was one of the first marks of a stricken man and the disease tuberculosis increased as civilization progressed. This tuberculization became more universal down through the ages until man began to study its nature. He ground lenses that

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he might pierce the invisible world and see its effects upon the tissues and he fashioned instruments whereby he might detect the disease early. He studied the factors influencing its progress or retrogression. Rational treatment was the result.

### Growth in Tuberculosis Work

Strange as it may seem, the sanatorium came into existence long before the dispensary, and the dispensary long before the visiting nurse. Take this country, for example. The first institution devoted exclusively to the treatment of the tuberculous poor was established in Boston in 1857. Eighteen years later we find the first private sanatorium for its treatment at Asheville, N. C. In 1884, the year made famous in medical circles by Koch's announcement of the discovery of the tubercle bacillus, Edward Livingston Trudeau founded the world-renowned institution at Saranac Lake for the care of tuberculous patients who were poor or of moderate means. So late as 1898 the Massachusetts State Legislature opened the first state sanatorium. To New York City belongs the distinction of having started the idea of voluntary registration of cases, the first municipal dispensary and the first auxiliary or social service organization associated with a tuberculosis dispensary.

### An Educational Fight

The first really organized attempt at education of the masses was made in 1904 when the National Association was organized at Baltimore. Since that time more than a thousand tuberculosis associations have been formed, about six hundred sanatoriums have been established, more than five hundred dispensaries are now in operation and about three thousand open air schools are caring for students. As the specialization grew and prophylaxis was emphasized the children's preventoria came into existence. And during the past year Minnesota made a small beginning in a new field by establishing a training school for early tuberculous patients where they may receive instruction along the lines most needed while awaiting their admission to sanatoria. The sanatorium can only reach the minority for years to come in spite of an intense active campaign; the dispensary, as a clearing house, attempts to sort the manifestly diseased and the suspects from the strong; and the dispensary nurses and the visiting nurses must constitute the fountain head for all this material as well as the pool into which the arrested cases are again dumped for post-institutional care.

### The Need for Trained Workers

Can you as a nurse accept responsibilities of such grave character and handle them adequately without a special knowledge of all these things? If the solving of the problem lies in education of the people by personal contact, is your sphere of influence going to be worth while unless you appreciate this fact as well as exercise the rôle of that indefinable characteristic which may be acquired but is more often inherited, personality. I know of no field with more unlimited possibilities of achievement bounded only by your qualifications than the noble pursuit of sorting the sick from the strong, teaching the latter the A B C's of prevention, starting the stricken on the right road to recovery and showing them how to become useful citizens on their return to health. The outlines for such work you can get in special lectures and books; the details in actual practical work in the sanatorium, the dispensary and the home.

### An Opportunity!

The successful tuberculosis nurse must possess a very special degree of intelligence and tact; she must be firm, cheerful and have fair health. And above all she must understand psychology in the broader sense on the one hand and the minutiæ of practical details on the other even to the "Klondiking" of a patient's bed.

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# A STORY OF THE PROMISED LAND

## NURSING IN PALESTINE

(*Continued*)

R. GOLDGAR, R. N.

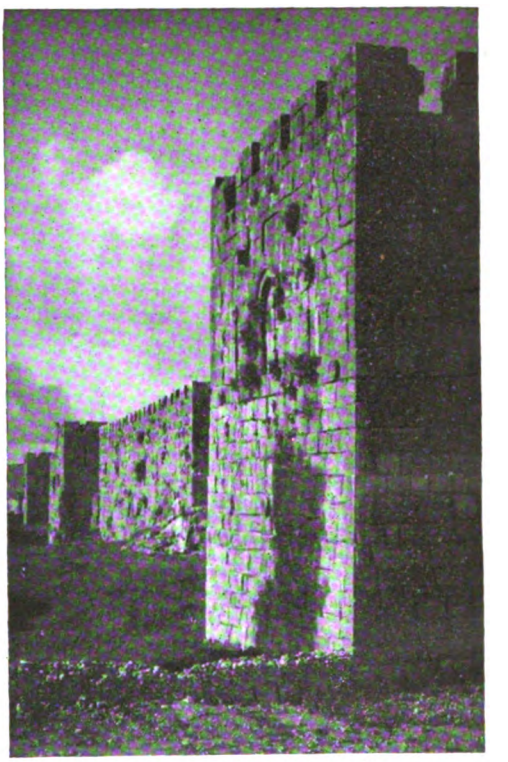
New York City, New York

THE work in Jerusalem gave me leisure to roam about the city. Since the British occupation the three official languages of the country are English, Hebrew and Arabic. Movie films are explained in all three; important legal sessions are conducted in both Arabic and Hebrew; and to a certain scholarly gentleman has been left the difficult task of naming and re-naming the streets of Jerusalem in English, Hebrew and Arabic.

As head nurse of the surgical ward here it was always amazing to me to see a Yeomanite patient in one bed; a Bucharian in another; an Ashkinazi in a third; and an Arabic woman in a fourth. At one time in a room of four male patients one was an English Hebrew; the next a Russian Hebrew; the third a Mufti; the fourth a young French missionary student. The American surgical treatment is so well known to the Arabic population that aside from all nationalities of Hebrews we had Arabic patients of all grades and classes, from the savage Bedouin to the most aristocratic type. They came from everywhere—from Nazareth, from Bethlehem, from the distant Jordan Valley and the region of the Dead Sea, and even from Damascus, Syria, for this organization strictly observes its principle of non-sectarian service.

The city of Jerusalem is divided into the old and the new. The old city is surrounded by a massive stone wall dating back to the fifteenth century. It stands there as if in defiance of the ravages of all the ancient wars fought for the possession of the Holy City. A lover of rough climbing may take a walk on the top of the wall to gain an unobstructed view of the inner and outer city. The inner city presents an appearance of having been built in layers. Evidently after a devastating war a new city was built on the former ruins. Tall palm trees and vegetable gardens grow on what seems to be the roofs of former homes.

The wall has several gates leading into the old city. On entering the main or Jaffa Gate, the stranger's interest is held by the variety of nationalities and costumes seen. Here is the savage Bedouin, the Syrian and Egyptian Arab



The Eastern Wall of Jerusalem

in civilized clothes and high red cap, and Monks representing various sects in their respective garb; the Yeomanite, Bucharian, Ashkinazi and Sephardic Hebrew; the Turkish woman in her native garb with veiled face, and occasionally a Turkish woman in a modern tailored suit, but with face still veiled so that only her eyes are visible; the tall, pretty Bethlehem woman who is recognized by her distinct headgear, consisting of a white cloth falling from the top of a cone, the lower part of which is fastened in some mysterious way to her head. One also meets English officers and ladies, tourists with their guides, and once in a while a group of American white-capped navy boys on shore leave. All are passing in endless procession through the dirty, lane-like mysterious streets, some with arched roofs, others lined with closely crowded, dingy shops.

In this mystic old city also centers much re-religious interest—synagogues and the Church of the Holy Sepulchre. The Mosque of Omar occupies the very spot where the Holy Temple once stood. The Hebrew wailing wall, which is a part of the wall surrounding the Temple area, is built in three distinct sections distinguished by the grade and size of the massive stone blocks as the Hebrew, Roman and Arabic divisions. Here Hebrews of the Yeomanite, Ash-

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kinazi and Bucharian types come, particularly on the Sabbath Day, to lament with genuine grief the loss of that wonderful Holy Temple, just as they have done during all the centuries since its destruction.

Leaving the old city is like going from a cellar into sunshine. The outer city with a few large buildings appears very modern. It has the American, Greek, Bucharian and Yeomanite districts, and, before the war, a beautiful German colony. Further from the center are the grammar schools, trade and lace making schools and plain but well kept orphan homes.

The Mount of Olives was another favorite roaming place of mine. A hike to its top reveals it bare of olive trees. Quaint Jerusalem lies below. Looking to the East as far as the eye can travel, over rolling hills and depressions, are the barren Moab Mountains and the silent Dead Sea. As you linger to see the sunset or the wonderful Palestinian moonlight you receive a permanent impression of the spiritual tranquillity which pervades the region.

One entire day off duty gave me an opportunity for a most interesting outing. The party left Jerusalem which has an altitude of over 2,500 feet and traveled toward the Jordan Valley where within three hours we found ourselves 2,500 feet below the level of the Mediterranean. The intervening region is bare of any sign of life; not even a tiny grass blade is visible. We rode through stretches of sandy hills which were shaped in twists, huge pointed heaps, or deep folds. The desolateness of the region fills the traveler with horror at the thought of being lost in that barren waste. Finally we reached the deserted village of Jericho, had lunch on the banks of the Jordan River and a dip in the Dead Sea—expecting at any moment to be transformed into lumps of salt—and so completed a thrilling day. The return trip without lamps for the machine was the final touch. Traveling through Palestine is always an adventure. A trip which I took through the Galilean colonies on my visit to a friend who was in charge of an orphanage in the Northern Mountains is representative.

I left Jerusalem on Thursday at six A. M., arriving in Haifa at seven P. M. At six A. M. on the following morning I boarded a train for Zamaka, a railroad station on the shore of the Sea of Galilee. A little boat awaits this train. As I stepped aboard, the wild crowd with bundles, boxes and supplies tipped it to one side. I felt rather shaky and doubtful of ever reaching the other side. After sailing on the Sea of Galilee for one and a half hours the boat reached the very ancient city of Tiberias.

When I arrived there at Friday noon I was given the cheerful news that the wagon for Safed had left in the morning and none would be available until Monday. I was determined to reach my friend that same day. On making further inquiries I learned of a Post Caravan about to leave for Safed.

"Are there any more women going?" I asked.

"A few," the tricky manager answered.

Shortly I found myself riding on the back of a mule, my blanket roll and suitcase sewn in two rough sacks and tied to either side of the animal. We were following a string of camels and a couple of donkeys which carried mail and freight and I was the only woman among several natives. The Caravan does not take the main road but trails through woods, over brooks, down valleys and over mountain tops. My first fear soon passed and I became elated over this novel manner of traveling. As I became absorbed in watching the animals pick their path over the many stones, my mule suddenly decided to throw me off his back. Nothing to do but to climb up again feeling mighty thankful it did not happen while crossing a brook, and continue this twentieth century method of traveling! For some nine hours we ambled on. Finally, drenched to the skin from rain, I reached my friend's settlement. A royal welcome awaited me—a warm dinner, flowers on the table, a charcoal fire glimmering in the low Arabic copper stove, and the lighted Friday night candles emanating a spirit of Sabbath through that little room in the inaccessible mountain city.

One day while at Safed I accompanied one of the doctors on his rounds. This ancient city nestled among the mountains was at one time an important seat of Rabbinical scholars. Its centre lies at the base of tiers and tiers of steps. So the doctor and I walked down, down through lanes, then on down more steps until we landed in a two-room basement home where the light was poor and an odor of dampness permeated the air. In one corner on a couch and sunken in feather beds was a young woman. Her hollow, flushed cheeked, sunken eyes and cough told the story. Our next journey through more narrow lanes and up some rickety steps behind a house brought us to a dark garret room where we found a very old woman in bed. After bestowing a shower of blessings upon the doctor she informed him that her rheumatism was better that day.

"Yes," she said, "my daughter who lives in Syria is imploring me to make my home with her, but I could never leave Palestine."

The next patient was another old woman on a feather mattress which rested on a broad board

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supported at upper and lower ends by boxes. Her very old and orthodox husband was dividing his attention between reading the Talmud and caring for his invalid wife. I looked upon the doctor as a marvel in finding his way into these unlivable homes. His genuine interest and goodness were just created for these people. As I returned to the "upper level" of the city I visualized the change which will take place when some organization awakens to the need for organized visiting nursing* and tuberculosis sanatoriums in these forgotten regions.

On the Road to the Dead Sea
(Note the peculiar formation of the sandy hills)

Even now parts of Palestine are assuming a more modern aspect. Roads are being built and train facilities are being improved. Public automobiles are running between Jerusalem and Jaffa and from Jerusalem through Haifa and Nazareth to Tiberias. The British Government has very elaborate plans for rebuilding the country on the most modern sanitary lines in order to make it habitable. Electricity is to be drawn from the Jordan; a seaport is being built at Haifa; swamps are being drained in some sections.

This impetus of physical progress is paralleled by a mental awakening, a yearning for greater opportunities. Labor is demanding higher remuneration, school teachers are saving their meagre earnings to study the latest school methods in Europe and bring the acquired knowledge back to their native land, and the agriculturist is sending his son or brother to study modern agriculture so that scientific methods of cultivation may be brought into Palestine.

"Is Palestine interesting?" I have been asked again and again. Who can point out any other corner of the world where every acre of ground and every hill top is famous because of the history which that country gave to the world? It is perhaps largely these historical associations which endear the country to those who have lived there, and create a desire to return to it.

The country has been sadly neglected during the Turkish rule. No effort toward sanitation is evident; nor can it boast of large industries. Malaria still reigns supreme. The natural beauties lie in the mountains and valleys, the orange groves developed by years of hard toil, the picturesque Arabic villages. Haifa has Mt. Carmel rising from and extending along the Mediterranean Coast for many miles. Tiberias (which is 650 feet below sea level) is unlivable in the summer, but a paradise during the rainy season when it is considered the winter resort of the country. The city also boasts of the historical hot sulphur baths in natural springs which are supposed to cure every imaginable ailment. On winter mornings one meets a constant procession going to and from these baths.

Lunching beside the Jordan River

The main products of the country are oranges, grapes and almonds. There is no rain for seven or eight months in the year, yet each summer

* Even in Jerusalem child mortality is high and I regret to say that a child hygiene department is still lacking. A group of well-meaning lay women do baby welfare and prenatal work to the extent of their ability, but it cannot be compared with a child welfare department organized with well-trained field workers to instruct and give demonstrations.

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month brings its fruit and vegetables. One agriculturist, whose farm at Migdal (Tower) is on the banks of the Sea of Galilee and plentifully supplied with water, told me that he had experimented in the raising of grape fruit and had found that it would grow in great abundance. He did not continue to produce it fearing that no market would be available. Another fruit-grower in the large and prosperous colony of Petach-Tikva (Gate of Hope) pointed out to me an orange tree which bore the leaves of the previous season's fruit, the fruit of the season just gone and the blossoms for the next season's crop, all on one tree. This is the character of the Palestinian climate and soil.

Spending a day in the wine colony of Rishon-Le-Zion (First in Zion) and traversing its extensive wine cellar is another revelation. Before the war these wines had a large market in France, England, and the United States. The industry is just beginning to thrive again. There are still vast stretches of undeveloped land—land which is waiting and pleading for some skillful hands to come and make it productive.

Unfortunately, political conditions are tense. The Arabic population is strongly resenting Hebrew immigration. The mere suspicion of such a movement has stirred them to think in the wrong direction. If they could be brought to understand that Hebrew immigration would bring them progress in industry, in culture and in a thousand avenues of self development, they would cease their brutal massacres and bend their energies toward peaceful relationship. Then the "Promised Land" would be realized.

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# ETHICS IN THE EVERY-DAY LIFE OF THE STUDENT NURSE—VI

*"Neither a borrower nor a lender be"*

CHARLOTTE A. AIKENS

THE nurse's duties to the patient, to the institution and to its officers, are, as a rule, quite thoroughly emphasized. Her duty to herself and to her school associates—especially to the members of her own class—is very often buried in the press of work and study.

On the whole, few groups of young women students are surrounded by more safeguards than are hospital students. Most of them are housed in comfortable buildings with provision for adequate social and religious life and wholesome recreation. Their physical, mental and spiritual progress is usually under the supervision of sympathetic women who have traveled the road before and are eager to smooth out the difficulties.

Faulty social growth, therefore, rests in a great measure with the individual nurse. If she fails to observe a proper respect for the rights and property of others who share her room or building, ill-feeling and inconvenience are the result. Each day some nurse wears a deeper track in the road to unsocial habits by thoughtlessly borrowing or actually appropriating another nurse's belongings. The nurse who has acquired this habit of temporarily adopting another's wearing apparel, advertises to all her deficient home training. Or perhaps, despite her mother's wise guidance, she lacks that innate sense of honor which would aid her in appreciating the rights of her associates. To illustrate:

A student nurse in an Eastern city set forth on a week-end holiday with friends in a city seventy miles away. As the weather looked unsettled, she appropriated an umbrella of a nurse on duty and wended her serene way. On returning, she left the ill-fated umbrella in the city seventy miles distant. Days later when the owner of the umbrella returned drenched to the skin after a trip down-

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town, the story came out. Of course, the borrower was very sorry; she hoped the friends would visit her soon and return it. *But she made no effort to replace the missing umbrella.*

Another example: As a student nurse came off night duty and prepared for a jaunt, she helped herself to a new pair of silk stockings belonging to her roommate, wore them into holes, *then returned them to the owner in that condition.*

Still another! An undergraduate borrowed a thermos bottle from her classmate across the hall. While using it, the bottle rolled off the table. The inner tube was cracked. *Yet subsequently she made no offer to replace it.* And so on to the *nth* power.

Many students who take the property of others without permission would be horrified if their actions were labelled "plain stealing." The difference is only in intention. The owner loses her property just the same, and, in the case of the friendly borrower, she cannot seek redress in the courts, even though she knows the guilty party. Is this a fair way to foster genuine friendship?

### Businesslike Financing

Quite as embarrassing to the lender as this pernicious habit of unsanctioned borrowing of clothing, is the actual borrowing of money. This practice may lead to foolish spending—unnecessary purchases are often made "just because I had the change"—and the creditor is seldom repaid. Borrowing money to meet legitimate needs while getting an education is never a disgrace. So necessary has this become that thousands of college students make straightforward business arrangements along these lines every year. As a consequence special loan funds are available for this purpose. A vast difference exists, however, between such dignified financial arrangements based on promissory notes and the promiscuous borrowing from classmates. Few acts, in fact, create a greater strain in friendly relationships than this habit of borrowing in driblets. As the good old wiseacre advises:

> Neither a borrower nor a lender be,
> For loan oft loses both itself and friend
> And borrowing dulls the edge of husbandry.

The nurse who needs funds to tide her over a period should make her needs known to the superintendent or principal and ask her advice about the problem. If the need is legitimate, a way can usually be found to secure the needed funds without embarrassing the nurse who needs the money or her friends.

Many nurses who would hesitate to commandeer the wearing apparel of their friends without permission, have less hesitation about stealing their associates' time or needed sleep. What is the difference? The right to rest, sleep or study belongs to the student nurse in off-duty hours. Yet we often rob our neighbor of needed sleep by promiscuous nocturnal visiting. Though door notices warn, "Do not knock," or "Sleeping to get over a headache, please don't disturb," we often waltz right in with no real reason for the intrusion, simply a restless disposition which seeks an opportunity to relate some trivial happening.

Although borrowers of clothing, money and time are nuisances in any school, they are particularly obnoxious in purposeful schools of nursing. A nurse in whom such unsocial habits are deeply ingrained, chafes at all restrictions; her tongue runs away with her judgment. Quite unintentionally she becomes a menace to the comfort and well-being of her associates. The application of the Golden Rule in the school of nursing would mean the abolishment of these anti-social habits. It can be done. Try it!

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# ARE INDUSTRIAL NURSES UNETHICAL?

## THE OPINIONS OF PHYSICIANS, EMPLOYERS, INSURANCE COMPANIES AND NURSES

CHRISTINE R. KEFAUVER, R. N.
Acting Supervisor of Industrial Hygiene, Department of Health, New York City, New York

### THE QUESTIONNAIRE
(*Continued*)

9. *How much of the knowledge possessed by the nurse of the physical, medical or mental defects of employees, should be at the disposal of the employer?*

*Doctors.*—One said it depended on circumstances. Eleven felt that all such information should be at the disposal of the firm; 6, that none of it should be; 2, that facts only should be given to employer. Eleven held that only sufficient information to protect others should be given. Three answers were indefinite.

*Nurses.*—Three said it depended on circumstances. Seven said all information should be at disposal of employer, 5 that none should be. Twenty thought that sufficient information to protect others should be given; 2, that employer should have information "as to facts and records only." One answer was indefinite.

*Employers.*—Two said that all information should be given employer; 1 that none should be. Three stated that facts sufficient to protect others should be given.

*Insurance companies.*—Three answered that all such information should be given employer.

10. *To what extent, if any, should a nurse be called upon to testify in a compensation case?*

*Doctors.*—Six approved of her testifying and did not qualify this approval as to the extent of her testimony. Twenty-one approved of having her testifying to actual facts of which she had knowledge, and to the authenticity and accuracy of records introduced. Seven disapproved of her testifying at all.

*Nurses.*—Six said "all"; 8 answered, none. Nineteen thought she should testify as to facts and records only. Six replied that they did not know.

*Employers.*—Two replied that it depended on circumstances; 3 said she should testify as a witness, and 1 that she should testify as to facts only.

*Insurance companies.*—One replied that he did not know, and 2 answered yes.

### DISCUSSION OF THE QUESTIONNAIRE

As one reviews the answers to a questionnaire such as the foregoing, it becomes evident that the conclusions to be based thereon must be accepted with reservations. It is impossible to frame questions that will be short, comprehensive, concrete enough to defy misinterpretation, and free from any indication of bias in favor of a special angle of the investigation, or particular parties to the controversy.

All four parties to the investigation practically agreed that the nurse should give first aid, that she should do routine dispensary work, and a fair number sensed the importance of public health education among the employees, though this seemed to be more evident to the nurses than to members of the other groups.

As to how long she should be allowed to "treat" the case without consulting a physician, that depends upon the reader's interpretation of the word "treat." Suppose a workman comes to the nurse in a big plant with a splinter in his finger which has a scarcely visible accumulation of pus. Is she to bother a busy doctor, who has many other more important things to do, or is she to do under more hygienic conditions what the man's wife would do for him if he were at home? Should she not sterilize a needle, remove the splinter with it and then paint the spot with iodine?

Suppose the workman is engaged in the handling of irritating chemicals, which, if they penetrate the pricked skin, will increase the irritation. To avoid this she covers the finger with a bandage. She may change the bandage for a clean one the next day, or even two days, until she is sure it

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is entirely well. Technically, she is "treating" the case, yet there are few doctors who would not approve of her doing this.

As to those employees who refuse to go to a doctor, the majority of all those questioned agreed that first aid should be given by the nurse and further aid refused. This seems the logical thing to do, but the further suggestion, which also had many supporters among all four groups, was that the stubborn employee be reported to the management and dealt with by it.

Question Four seems to have been misunderstood by most of the doctors. This question presupposes in the first place that no doctor is employed in the plant; whether one *should* or should not be has nothing to do with the case, they are *not*. On the other hand, the insurance company's doctor visits the plant at stated intervals. For the nurse's protection, should he not leave certain standing orders? In all hospitals there are certain routine or standing orders. For instance, upon admission the patient's pulse and temperature are taken, a bath given. In many hospitals, calomel and salts are also part of this routine treatment. All patients, within certain prescribed temperature limits, are given this initial treatment upon admission. Should not "standing orders" applicable to industrial conditions be in force in a plant?

Constipation is a condition which exists among industrial workers—they are always "dosing" with one patent medicine or another. This tendency can be corrected to a great extent by education of the worker by the nurse and doctor, where the latter has the time, in the matter of proper diet, drinking plenty of water, exercise, etc. But where this is still not adequate, the doctor should suggest such cathartics to be given as in his opinion are most effective in providing immediate relief, and least apt to inculcate the habit of depending upon medication.

This subject was brought up in Question Five, which of all others seemed to create the most discussion and seemed to best lend itself to misinterpretation. "Is a nurse justified in *prescribing* treatment, etc.?" It would have been much better had the question read, "Is the nurse justified in *giving first aid* for, etc.?"

A young girl employed in a plant suffers with the usual discomfort at the menstrual period. She will not consult the plant physician, nor would he wish to be bothered by so ordinary a thing. If the nurse gives such an employee a dose of viburnum and a hot water bottle and tells her to lie down in the rest room for a while, such treatment usually affords relief, but in the strict sense of the word she "prescribes" in so doing. Similarly, if a workman comes to work with a cold, in the sneezing and nose-running stage, and the nurse advises him upon his return home at night to take a cathartic, a hot bath and a hot drink and go to bed, and if he is not better in the morning to remain in bed and send for his family physician, she is "prescribing." Yet there are few physicians who would not approve of her action. Without this timely advice from the nurse, the employee might continue to come to work until a very serious condition developed under the misapprehension that so "slight" a thing as a "cold" was unimportant.

Of course, no intelligent nurse would set herself up to prescribe for, or to treat, an employee who appeared to be really ill.

The seventh question appeared to us to be important. In many plants it is the custom to use the nurse as employment manager, and the hiring and discharging of employees thus comes within her jurisdiction. It is humanly impossible for her to disregard her knowledge of an employee's physical condition when the question of dispensing with his services comes up. This knowledge, gained through her confidential professional relations with the

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employee, influences her to his detriment in deciding his case. This is unfair to the employee, to the nurse, and to the cause of public health generally, because it influences the employee to refrain from going to the nurse for advice even when he is greatly in need of it, and she is thus prevented from seeing him and advising the necessity of his consulting the plant or his family physician until it is too late.

The cause of public health generally is injured because the workers come to look upon all health measures as a ruse of the employer to "get something on them" which will militate against them later on. As far as it is possible to do so, the nurse should maintain her professional and confidential relationship with the employees. If her employer cannot see the importance of her inaugurating public health education in the plant, then she should start by educating *him,* and, if she is the right sort, she will succeed.

Dr. Lee K. Frankel of the Metropolitan Life Insurance Company, at a dinner of the Industrial Nurses' Association of New York was asked by a nurse present what he would advise doing in a plant where the nurse was considered as a minor employee, relatively unimportant. He replied that if a nurse found herself in such a position she must be unfit for the job, or she would not be so considered. This is unpleasantly frank, but perfectly true.

The objection of practically all of the members of all four groups to the employment of other than graduate nurses was most gratifying; the best is none too good for our millions of industrial workers. There is no more reason why they should have inferior, imperfectly trained medical service than why any other portion of the community should be similarly discriminated against.

The answers to the ninth question showed the appreciation felt by all groups of the confidential nature of the information possessed by the nurse and the doctor of the employee's personal affairs. All agreed that the employee's fellow workmen were entitled to protection and to that extent, physical conditions tending to jeopardize their health or safety should be reported, but only sufficiently to attain this result, and injury of the employee avoided as far as possible.

The tenth question is really a legal one, which differs in the various states. It would appear to be the consensus of opinion that the nurse may be called as a witness to testify as to facts within her knowledge, but in no case to qualify as an expert where the physical condition of the patient, the accuracy of the diagnosis or the correctness of treatment given is the matter under discussion. This is distinctly the province of the physician and the nurse's training is not such as to qualify her to give competent testimony. On the other hand, she should testify, if required, as to accuracy and authenticity of records and charts introduced and such other matter as properly comes within her knowledge.

This question is of interest because a case was reported from the West where an industrial employee became paralyzed and claimed that his condition was due to an injury to his spine sustained in the course of his occupation. The physician in the case denied this and said that the condition was due to disease which had no connection with the man's occupation. The nurse was subsequently called.

Damages were allowed (it was stated in the newspaper report) on the strength of the nurse's testimony. If the facts were as stated, she clearly exceeded her authority and was entirely unjustified in the course she took. Perhaps, on the other hand, the facts the nurse gave regarding date of injury in the plant, etc., brought up conditions for consideration which had not been known to the physician previous to her testimony.

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# THE USE OF ANTITOXINS

## THEIR MECHANISM IN THE TREATMENT OF DISEASE

ROBERT A. KILDUFFE, A.M., M.D.

Director of Laboratories, Pittsburgh Hospital, Pittsburgh; Director of Laboratories, McKeesport Hospital, and Serologist, Providence Hospital

WHILE in these days of modern medicine the use of antitoxins in the treatment of disease is so general as to be almost commonplace, their discovery and elaboration as therapeutic agents forms one of the most interesting chapters of modern medical history.

### HOW ANTITOXIN WAS DISCOVERED

The discovery of antitoxins arose directly from the persistent and assiduous study of the various problems grouped under the heading of immunity, and their practical utilization in the treatment of disease is due largely to the work of Behring, Kitasato, and Weinicke. These observers, while studying the problems of immunity in the endeavor to elucidate the factors responsible for resistance to various infections, noted that in animals experimentally infected with diphtheria and tetanus, though the animals grew progressively more and more resistant to the disease, living and virulent organisms could be demonstrated at the site of infection. Elaboration of these studies in 1890 showed that the blood serum of such animals, though absolutely free from any bactericidal property, could protect non-immune animals from diphtheria and tetanus infections. From the analysis of these observations, evidencing that the resistance to the infection was independent of any ability to destroy the bacteria in question, arose the discovery of antitoxins and the demonstration of their therapeutic utilization in the treatment of these two infections.

(Courtesy Chicago Health Bulletin)

### WHAT ARE ANTITOXINS?

Antitoxins, then, are antibodies which are present in the blood and which are capable of directly and specifically neutralizing the toxins responsible for their production.

Their production is explained according to the side-chain theory of Ehrlich as follows: In this theory the ability of the body cells to enter into combination with and utilize various substances is represented in graphic form by a purely imaginary outbudding to which the name receptor or side-chain is given. A toxin introduced into the body enters into combination with a side-chain of the cell by a union probably of chemical nature. If destruction of the cell does not occur, but only of the side-chain, then the cell is stimulated by the injury to repair the damage done. This repair is accomplished by the generation of new side-chains having a special affinity for the toxin which caused their production. In accordance with what is known as Weigert's over-production theory, which is an attempt to express the pro-

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Their production is explained according to the side-chain theory of Ehrlich as follows: In this theory the ability of the body cells to enter into combination with and utilize various substances is represented in graphic form by a purely imaginary outbudding to which the name receptor or side-chain is given. A toxin introduced into the body enters into combination with a side-chain of the cell by a union probably of chemical nature. If destruction of the cell does not occur, but only of the side-chain, then the cell is stimulated by the injury to repair the damage done. This repair is accomplished by the generation of new side-chains having a special affinity for the toxin which caused their production. In accordance with what is known as Weigert's over-production theory, which is an attempt to express the pro-

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digality of nature in her efforts at repair, a far greater number of such side-chains are produced than are actually needed to replace that which was destroyed. Since all that are thus produced cannot be attached to the cell, the excess are cast aside in the circulation, where they remain free. Each of these excess side-chains is a receptor capable of uniting with and neutralizing a toxin and so rendering it harmless, so that the term antitoxin, as loosely used, means simply a blood serum which contains a large number of free receptors capable of neutralizing a specific toxin.

### Commercial Production of Antitoxins

While many efforts have been made to determine the exact nature of antitoxic serums, none have met with success because of our inability to secure the antitoxins free from serum and serum constituents. The proof that the antitoxins are precipitated with the globulins of the serum and the further demonstration (by Gibson and Banzhof) that that portion of the globulin precipitate which is soluble in saturated salt solution also contains the major portion of the antitoxins opened the way for the preparation of concentrated antitoxins largely free from the non-antitoxic portions of the serum.

Antitoxins are striking examples of the law of specificity between antigen and antibody, diphtheria antitoxin, for example, neutralizing only diphtheria toxin.

It is obvious from what has been said that an antitoxin arises directly from the stimulus following the introduction of a toxin and is therefore to be looked for in amounts directly proportionate to the amount and virulence of the toxin produced by the infecting organism. Naturally, therefore, they have given the best results in those infections in which the etiologic organism produces a virulent and soluble toxin, notably diphtheria and tetanus.

The serums commercially utilized in the production of antitoxins are, of course, of animal origin, generally obtained from the horse because this animal not only reacts vigorously to the injection of diphtheria and tetanus toxins, but also because it can withstand the withdrawal of large amounts of blood.

The first step in the manufacture of antitoxin is the preparation of the toxin for injection. This is secured by growing pure culture of the organism, B. diphtheriæ, for example, in a special boullion medium. After incubation for from seven to ten days, during which time the toxin produced goes into solution in the boullion, the culture is examined microscopically and culturally to determine its purity, i.e., that it contains only diphtheria bacilli. The organisms are then killed by the addition of carbolic acid, the dead bacilli filtered off and the clear fluid remaining constitutes the toxin for injection.

The horses, after a preliminary isolation period to rule out infectious diseases, and after a thorough examination for tuberculosis, anthrax, glanders, and other diseases, are then given a subcutaneous injection of a sufficient amount of toxin to produce a reaction, generally calculated according to the weight of the horse. When this has subsided a second subcutaneous injection is given of slightly larger amount and this procedure is repeated until the animal withstands many times the usual fatal dose. At this time a trial bleeding is made and the antitoxic strength of the serum tested. When a sufficient potency is obtained the animal is bled from the jugular vein under aseptic precautions and the serum thus obtained constitutes the antitoxin, which is then further purified by the precipitation and solution of the globulin fraction of the serum in salt solution. Preservation is attained by the addition of small amounts of carbolic acid and sterility assured by culture and animal inoculation.

(*To be continued.*)

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# CHILDREN OF THE NIGHT OWL

## THE STORY OF THE DIAMOND

AGNES JAMES, R. N.

Cincinnati, Ohio

THERE ought to be a special Providence to take care of night nurses; tradition delegates one to the protection of drunken men and little children, also a "sweet little cherub sits up aloft and looks out for the life of poor Jack," and you've got to convince me that any of the aforementioned are more deserving than night nurses, or indeed any who turn night into day to get a living.

Say what you like, everything is more fearsome at 2 A. M. than 2 P. M. As one sneaks along the corridors a delirious patient can give you goose flesh all over, to say nothing of deaths! And yet you are supposed to meet everything that comes up with the same judgment and poise as in the day time.

Anyhow, it wasn't as a day nurse that Florence Nightingale was immortalized. No, Sir! Snooping around at night like the rest of us and with only a snuffy old lamp too. I'll bet she was scared stiff! Miss Silvain, who was our night superintendent until Romance robbed us, was the only person I ever knew who could make allowances for what she called the "nocturnal viewpoint"; she treated us half decently when we fell down on "poise." She called night nurses "the Children of the Night Owl" and she was the "Owl Mother" and we belonged to the "Ancient Order of Prowlers," and she expected a very high code of honor among us.

You would never have guessed that Miss Silvain was like that to look at her, and, of course, we never gave her away. She wasn't young, thirty at least, tall, rather pale and very dignified. In the kids' ward she behaved differently, and betrayed symptoms not apparent elsewhere. I wouldn't for worlds have let her know that I saw her sit down beside little Tommy Lang's bedside and read "Serpent Gulch" to herself for a good half hour, when she thought I was still at night lunch. I was thrilled to death! Dr. Matheson didn't see me either and he watched her for several minutes before she heard him. He's so bashful I don't know which of them was most confused, but the next minute, instead of talking to Tommy Lang, they were giggling over "Serpent Gulch." Dr. Matheson took it to read in bed, and I expect that was the beginning of the end of the "Owl Mother." Well, if you could find anyone good and nice enough for her it was Dr. Matheson, though I used to think him old. One of the day supervisors said Miss Silvain was about the same age. To settle it we got an interne to investigate. We found out that Dr. Matheson's age was forty-one, but, of course, we couldn't ask Miss Silvain, only nothing but envy could make her less than ten years younger.

Miss Silvain had a night off every week and when a graduate could not be spared to relieve, Miss Sparks would put a junior on my floor to help me, and let me keep house for the night. She said it was good practice in the senior year as it developed our sense of responsibility, which we would need as soon as we got out. I rather enjoyed it, for one night at a time, but when Miss Silvain got her Christmas leave and I was told I would have to relieve all three nights, I wasn't quite so keen. Knowing how many of the "Prowlers" were

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juniors and spending their first Christmas away from home, it was characteristic of her to wait till Christmas night was over, all the patients possible discharged and the house lighted before she left. I reached my third night without anything worse than twins and a new D. T. and I was feeling on the home stretch when one of those cases came along which to me seem like the great seventh wave in the ocean of human records that comprise a hospital.

And yet she was only a poor old woman, not so dirty as neglected and wretchedly ill.

"Twelve hours on the road," said the driver of the ambulance in which she was conveyed. He was a kindly sort of man, but his conveyance was freezingly cold, one of those decorative festooned effects in pale gray. The little old woman lived way out in the country and on Christmas eve had fallen and sustained a bad fracture. The local doctor had done his best but she had insisted on being brought to the city. She wasn't going to "die like a dog," she said; she had "things to do." That she was pretty nearly through "doing things" was very apparent, but we sent for Dr. Matheson and prepared to make her as comfortable as we could

There was a man with her who was so strangely resentful at being put out of the room that I felt interested. It was not solicitude of the ordinary sort, and I took a good look at him. He was fairly young, sleek and well groomed for a rustic, yet I did not like him.

"Is she your grandmother?" I asked bluntly.

"She is my wife's grandmother," he said with dignity.

All the same I put him out when we undressed the old soul. She was tractable enough, but slightly irrational at times, and called me "Laurette." Then she came to herself and asked wistfully if Laurette would be long, because she had something to tell her. I said I hoped not, but couldn't she tell me and I'd tell Laurette. She shook her head.

"No, that wouldn't do. Sam would get it out of you."

I gathered from a few scattered words that "Sam" had married "Laurette," her only grandchild. Subsequently he had been so unkind to her that she had left him. Sam had "stuck around," sponging what he could "get off" the old woman, and now he was out for the pickings. Her eagerness to see her granddaughter was pitiful. Do what we could, however, to stimulate her, we knew we were playing a losing game. The sight of Dr. Matheson seemed to help her a lot, especially the quiet way he dismissed "Sam" while he made his examination. She wasn't fooled by his non-committal manner, and when he got through she asked to speak to him alone. So we left them.

When we were summoned again, both Miss Spinney and I remarked how grave Dr. Matheson looked. He said briefly that the patient had preferred a dying request which was somewhat unusual, so he had put it in writing and wished us to witness it. He handed us his fountain pen and though the paper was spread out on the bedside table we neither of us saw a word of what was on it. That it was Dr. Matheson's affair was enough for us. The poor old soul died with only the two of us beside her, the sight evidently being distasteful to Sam. Laurette did not arrive till too late.

I went down with the body to the morgue and, to my amazement, Dr. Matheson emerged from the shadows.

"Take the body to the post mortem room," he said to Wilkins, then he turned to me.

"This responsibility is mine, Miss Freer; you know nothing of it."

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When Laurette came I had my hands full; a poor little wisp of a thing. Sam was as sweet as pie to her, but she was obviously scared to death of him. The entrance of Dr. Matheson relieved the tension; he seemed so kind and interested that Laurette was comforted. I think Sam would have enjoyed killing him for the self-confidence his influence aroused in the girl and the subtle instinct of defence which gradually replaced her attitude of fear. She arranged the necessary details bravely, ignoring Sam's assistance and remaining unmoved at his solicitude. She was like some sensitive instrument which has been tortured by discord till the strings refuse to vibrate. Never again would she respond to his touch, clothe it as he might in propiation.

Tired as I was, the sight of them walking together to meet the reddening dawn struck me with dramatic incongruity.

"Poor child. A future with that man would be more night than sunrise," I said to Dr. Matheson.

"He will leave her," he said briefly, "because he believes she is penniless. She thinks it too," he said. "Only I, in all the world, know that that child is beyond want." Something in his voice held me breathless. He put his fingers in his vest pocket and took from it a single unset diamond which even I knew to be of great value.

Then he told me the tale the old woman had related to him about Laurette's marriage and flight, and Sam's attempt to find her savings; how her desire to outwit him led her to indulge in a life-long craving to own one jewel of great price. In a shabby little bag around her neck she carried it, the consciousness of its presence warming body and soul. Its possession consoled her loneliness and strengthened her secret scorn of her son-in-law's transparent attachment. Then came the accident, and the delay in finding Laurette. With distrust for all the world, she clung to her wealth and her life. During all that ghastly journey in the ambulance she hid the little bag from Sam; then terrorized by her failing strength she spent what she had working under the covers with her claw-like fingers till she wrested the jewel from its frail mount (it was set in a lavalliere) and held it naked in her hand. Fearing sleep, she grew panicky and put it in her mouth, and you can guess the rest. Oddly enough, she accepted the mishap as a solution, and with childlike faith in all she had heard of surgical skill she fell asleep.

Dr. Matheson said that when she told him she had swallowed a diamond he felt convinced that she was out of her mind, and only acted because he had given his word. The balance of his promise bound him to silence, till Sam, convinced of her poverty, should break the legal tie that held him to Laurette.

Since that morning when I look at diamonds I know that some of them were created not simply to adorn those who are replete with luxury, but to concentrate in the smallest possible space and time enough light and color to warm and amplify a starved life.

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## LOSING THE TRAIL

It ain't far from right to wrong—th' trail ain't hard to lose,
There's times I'd almost give my horse to know which way to choose.
There's places where there ain't no guides t' keep you on th' track,
Wrong's sometimes white as driven snow, an' right looks awful black!
I don't set up to be no judge of right an' wrong in men,
I've lost th' trail sometimes myself—I may get lost again,
An' when I see a chap who looks as though he'd gone astray
I want to shove my hand in his an' help him find th' way. *Selected.*

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# THE USES OF PHYSIOTHERAPY—II

## ITS PRACTICAL APPLICATION

MARY MCMILLAN*
Brookline, Mass.

### TREATING FOOT STRAIN
(*Continued*)

KNEADING the larger groups of muscles is given with the whole palmar surface of the hand but for the small relaxed anterior tibial group it is better to use fingers and thumb pétrissage. The passive, resistive and active exercises should all aim to over-correct the relaxed condition of the plantar muscles, the dorsiflexors and the invertors of the foot.

If the trouble is entirely due to muscle weakness, contrast baths, manipulation of the muscles and active exercises usually render a cure; but if there is much inflammation of the tarsus, hot packs over the foot and ankle are utilized and absolute rest is imposed until the inflammation has disappeared. The active exercises in this stage are preceded by passive and resistive exercises and the patient bears no body weight on the feet during the treatment. These passive exercises of plantar flexion, dorsiflexion and inversion prepare the way for a series of light, graded, active exercises. The patient should then be taught to stand and walk on the outer border of the feet. The toes should be kept in plantar flexion during all the exercises since the tendency is to curl the toes upward. Pivoting the feet on the heels until the toes come together, when the patient stands with the feet well apart, is a good exercise, also standing on a small towel and puckering it up with the toes. In this case the feet are again placed well apart and the toes of each foot are brought close together always keeping the heels firmly fixed on the floor.

Picking up marbles with the toes is an excellent exercise. A relay marble race in children's clinical foot work is not only of great value but the competitive spirit it evokes is also very helpful. Sometimes if adults are suffering from the second stage of flat foot a small soft pad, of elliptical shape, no larger than a fifty cent piece, is placed on the inner side of the heel and either bandaged or kept in position by several strips of adhesive tape about one inch wide and from ten to fifteen inches long. The pad is placed directly over the sustentaculum tali and the first strip of tape, 15 inches long, is passed from above the external malleolus under the heel covering the pad and is pulled tightly over the sole and the internal malleolus so that the foot is inverted and adducted. The second strip of tape, 10 inches long, is placed transversely to the first and four or five strips each way are fixed in the order of the first two. The pad and bandage provide only a temporary support and should be discontinued as soon as the muscles are stronger. The patient should be instructed to wear the straight inner line shoe with a military heel. No radical change of shoe should be urged until the foot can adjust itself to the change. After the patient has been taught the first lessons of overcorrection the corrective shoe may be gradually "broken in" until it can be worn all the time in comfort. Any tendency to toe-out should be brought to the patient's attention and a straight line walk encouraged. A toe-in exercise is helpful to overcorrect the outward tendency and so bring the patient more into a straight position walk.

In order that the general musculature of the body be raised, a short series of exercises should be given twice daily. It is well to instruct the patient in diaphragmatic breathing—from ten to forty good breaths

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should be taken daily. Breathing out of doors or by an open window is preferable. Diaphragmatic breathing not only expands the chest cavity which brings about better aeration and improved oxygenation of the blood, but the rhythmic movement of the diaphragm causes an internal massage of the viscera in the abdominal and thoracic cavities.

The following list comprises the fundamental activities from which more complicated and coordinated exercises are derived. Head bending backward, arm bendings and stretchings, head circumduction, knee bending, knee bending and stretching, knee bending with heel raising, trunk bending and circumduction. The patient should take these exercises in the standing position; he should be instructed to assume good posture and be encouraged to practice it. The head should be carried erect with the chin held in, the shoulders should be drawn back and down, the abdomen held in and the body weight should fall on the balls of the feet. Exercise periods should last from ten to fifteen minutes and should be given once or twice daily. The previous exercise training of the patient should guide the operator both as to the grading and length of the prescribed exercise periods.

The daily active exercises are gradually substituted for the daily general massage and passive movement. If the patient suffers from constipation, deep abdominal manipulation and leg and trunk raising as the patient rests in the supine position is excellent until the patient is able to take regular walks. Golf or any kind of outdoor activity which will not overtire the patient should be encouraged.

From these medical types of cases let us turn to the surgical patient and see how physiotherapy will be of service in the more speedy restoration of health. First, let us take a case of femoral or inguinal hernia after operation. Whether the incision be over the femoral ring or the inguinal canal the exercise treatment is the same. The hernia has caused a dilatation of the muscle sheath. In an inguinal hernia there is frequently a stretching apart of the muscle and tendon. If the cause of hernia is a lowered tone of the abdominal muscles it stands to reason that after the operation the tonicity of the abdominal muscles will be still lower.

### Inguinal Hernia

In order to strengthen these muscles and so prevent a recurrence of the trouble, light abdominal exercises should be commenced as early as the surgeon permits them. Diaphragmatic breathing can even be started before the incision is healed, although for fear of breaking open the incision active exercises should not be started until the incision is completely closed. Diaphragmatic breathing will draw up the abdominal viscera thus relieving the pressure of the organs on the anterior muscle wall. The first lesson, after deep breathing, should bring about the voluntary contraction of the abdominal muscles. For the purpose of maintaining a constant pressure over the abdominal rings a truss is worn during exercise. Throughout these exercises the patient is instructed constantly to keep the abdominal muscles well contracted. The patient stands with the hands placed on the hips and the body is bent from the hips. This may be followed by an exercise in which the patient drops the head well forward so that the cervical spine is completely flexed, next the dorsal and lumbar spines are bent so that the spinal column is flexed upon itself. Too much emphasis cannot be laid upon the point that the patient must keep his own abdominal muscles contracted throughout. Raising the level of the arms to behind the neck and lastly to the upward stretch position makes a more difficult exercise because it elevates the center of gravity. Another good exercise for convalescing herniotomy patients is to have them assume the prone

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lying position the head and shoulders being well raised. In a left-sided hernia the right hand should be placed behind the neck, and the trunk twisted to the right. Compression either by the fingers or a truss is maintained throughout the exercise over the inguinal canal and the femoral ring. Each of these points need special protection.

In right sided hernia, the opposite neck position and trunk twisting is indicated. If a hernia were present on one side and a tendency only on the other side, then compression should be maintained over the abdominal rings on both sides and the trunk should be turned to each side alternately, the hands being placed on the hips during the exercise.

As our next case we will take a patient convalescing from an appendectomy. It is well to have the patient start with deep breathing as early as possible. This is a perfectly natural movement and if it is encouraged early after the operation many of the adhesions which so frequently follow any abdominal operation may be prevented. You remember the old idea of keeping a lobar pneumonia patient perfectly still! Now, how many patients are saved because the doctor leaves instructions for the nurse to roll the patient from side to side every hour or so in order to prevent the lung tissue from becoming adherent. After an appendectomy the incision should be entirely healed before active exercises are commenced. With the patient lying in the supine position, first one leg and then the other should be slowly raised and lowered. At first this should be done with the knee fully extended. The muscular action is more marked in the abdominal muscles if the legs are kept wide apart during the exercise in the straight leg raising. Another excellent exercise to strengthen abdominal muscles is to have the patient sit on a stool or bench; the operator holds down the feet of the patient while he reclines backward. If the arms are moved forward during the movement it is easier for the patient to maintain balance. To increase the difficulty of this exercise the arms may be raised by placing the hand behind the neck; an even more difficult position would involve raising the arms to the upward stretch position.

### The Opportunities for Physiotherapists

The only way to have an all round understanding of physiotherapy is to study each branch of the work separately. After this thorough grounding much practical and clinical experience are necessary before the operator becomes a competent physiotherapist.

We hear the call for physiotherapists from all over the country. Hospitals that have not already a physiotherapy department are seeking to organize one. Physiotherapy clinics controlled by industrial accident commissions are being started in many of the states. Firms that employ thousands of workers are finding that physiotherapy is a sound commercial investment and are installing well-equipped departments in their own hospitals. Institutions and large department houses that engage quantities of women are utilizing physiotherapy. The work in such cases is directed especially to keeping the employees in sound physical condition. This form of prophylaxis which provides treatment of early symptoms is frequently responsible for the saving of much suffering to the patient and the elimination of economic loss to the employer. This widespread use of physiotherapy means a broadening field for trained physiotherapists and a nurse who is capable of handling industrial cases from a physiotherapeutic standpoint has excellent opportunities for work both with state commissions and with large private hospitals and industries. Just think over the types of cases which call for early physiotherapy—sprains, dislocations, fractures, fibrosis of joints, muscle and joint injuries,

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arthritis, flat-foot, anterior-metatarsalgia, enteroptosis, occupational neurosis, weakness of the back muscles and various orthopedic conditions. Truly physiotherapy is in its infancy and those who grow with it will be repaid in actual accomplishment.

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# NATURE STUDY FOR CONVALESCENTS

## OCCUPYING THE TEDIOUS HOURS

CHRISTINA GRACE RANKIN

FOR the patient convalescing after a serious fracture, or any other condition requiring a long period of hospital confinement, occupation therapy has done much to reestablish the proper muscle function and relieve the tedium of waiting. But for the patient who is undergoing a prolonged convalescence at home, no well-organized system has been devised to promote the spirit of contentment—an important adjunct to physical reconstruction. The nurse with energy usually prefers to work hard and lose sleep with a critically ill patient rather than face weeks of comparative idleness with a patient undergoing a long, tedious convalescence. As a nurse's real purpose, however, is completely to restore the patient to health, she must know how to utilize these tedious hours for his upbuilding.

Reading for an hour a day helps to while away the time, if the nurse can read well. But more diversion is needed in order that the patient will find less time to pity himself, or brood over his misfortunes. For this purpose nature study is one of the best side interests, and spring, summer and autumn furnish excellent material for observation. Of course, the patient's condition precludes intensive study, but any new facts observed from the windows or on the lawns may be utilized as starting points.

Even a superficial form of bird-study may lead the patient into an entirely new world. From a porch or garden patients can watch the nesting habits of birds; they can observe for themselves whether a bird serves mankind as a constant insect destroyer, or whether he is rather an economic loss, because of his depredations.

Careful experiments and statistics compiled by Government experts indicate that some birds prove invaluable to us "by keeping within proper limits the various forms of insects which are injurious to crops and animals. They prey upon rats, mice and other enemies

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of growing crops, devour weed-seeds and in various ways act to destroy plant-eating insects and as scavengers in disposing of animal matter which would otherwise decompose and poison air and water."

The gardener of the small patch in the city knows that the results of his toil are measured by the character of his bird neighbors. Even a lettuce patch may be made valueless through the early morning energy of a family of sparrows. In eating the tender green leaves they can rob the family table very effectively. Farmers who have cherry orchards have no love for the robin, and flocks of black-birds are responsible for poor corn and grain crops.

Orioles, meadow larks, blue-jays, black-birds, cow-birds, bob-o-links, robins, wood-peckers, thrushes, wrens, all have their distinctive habits of feeding. To the city bred man and woman all these bird habits are decidedly worth studying. Others to whom these facts seem like A, B, C will find genuine delight in reading more extensively of the "doings" of these friends and amplifying these readings by personal observation.

The varying habits of bird migration are exceptionally interesting. Bird specialists know that climate and food supply are not the only conditions which induce birds to move from one region to another. A fixed routine exists in the bird mind and these winged neighbors will not stay in a region where their habits are greatly interrupted. Some prefer the crevices of city buildings; others the wing stretch in open fields.

The impulse to migrate carries out a natural law which provides for the dispersal of birds over the world during the season when their services are most required in maintaining the balance of nature. As conditions change, the species of birds which migrate into a region will also change. Hence unless alien conditions disturb this helpful distribution the birds would always be available to perform their special functions in nature's economy. The ruby-throated humming birds, they tell me, arrive at their summer home early in May, the males preceding the females by a week or two. Through June they are occupied with nesting and rearing their young. Early in July the males return to the South. The females and their young birds remain in their summer home through August and sometimes into September, before they begin their southward flight. Indeed the migration of birds tells, within a few days, the exact time of the year. Inclemency of weather, which diminishes the available food, has little influence in any year, although it tends to redistribute the visitors on their arrival.

Children can often while away hours trying to identify and imitate bird calls. The correct imitation of bird notes can be acquired by anyone who learns the scientific control of the vocal chords. Entertainers known as "bird men" are in great demand, and an invalid who cared to utilize his enforced idleness in learning to imitate bird notes, and in tying that knowledge to a discussion of their habits might be glad to find an economic market for his knowledge after his recovery. Nest building is another interesting branch of this subject which should appeal especially to men of a mechanical turn of mind.

The varieties of wood-peckers, song sparrows, wrens, owls, thrushes, etc., are unlimited, and many seasons could be spent in just learning to know the birds. With the aid of a field glass, a bird can be brought close to the patient, so that its distinctive points in form and plumage can be noted.

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And birds are only one small branch of nature lore! What lessons in prophylaxis could be taught through observing under a microscope the dirt laden legs of the fly, or the germ-bearing "sting" of the mosquito! Then the dissection of flowers; their classification under the numerous genera; the therapeutic uses of *Aconitum napellus, Garcinia Hanburii, Lobelia inflata,* etc., provide other fields of study. Men are especially interested in tree growth, variations in bark, pulp, texture, etc., since they are eager to correlate this knowledge with the lumber and wood industries with which they are familiar.

The nurse who encourages the patient to seek out the "why" of many common things in nature does much to divert her patient's mind into happy channels.

What makes the colors in the sky at sunset? Why does a dog turn around before he lies down? Such simple questions often baffle the most intelligent patient and set him to searching for the answers.

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## Positive Health!

Any complete program of constructive health must include:

*First,* Educating doctors to practice preventive rather than remedial medicine.

*Second,* Annual physical examinations for everyone, young and old.

The great danger from the infectious diseases of childhood are in their after effects. Scarlet fever is likely to leave weakened heart and weakened kidneys. Many sufferers from Bright's disease owe their disease to a childhood attack of scarlet fever, and any one who has ever suffered from scarlet fever is particularly liable to degenerative affections of the heart and kidneys.

Measles, diphtheria and whooping cough all seriously weaken the human machine and give the degenerative diseases a chance to begin their development. The common degenerative diseases include heart disease, diabetes, Bright's disease, probably cancer and various diseases of the kidneys, stomach and other special organs.

Many degenerative diseases can be traced to bad personal hygiene, to wrong diet, wrong habits of exercise, wrong mental habits, etc. Practically all of them can be arrested by correcting the wrong habits, *if detected in time.* It is because of this fact that annual physical examinations are so important.

*Third,* Eradication of communicable diseases.

Any community can be completely rid of any contagious disease if it is willing to pay the price. Most communities, however, are as unwilling to pay to be rid of disease as Hamel was to pay for being rid of its rats, and all too many of our children follow the Pied Piper of disease into an unknown country because the price asked for getting rid of germs seems too high.

The common contagious diseases are pneumonia, influenza, tuberculosis, syphilis, gonorrhea, diphtheria, scarlet fever, measles, whooping cough, chicken pox, infantile diarrhea, dysentery, infantile paralysis, colds, grippe, mumps, erysipelas, tonsilitis, streptococcic sore throat, and various eye and skin affections. Formerly smallpox, bubonic plague, typhoid fever, malaria, typhus fever and yellow fever would have been included in this list; but these diseases are no longer common in civilized countries.

*Fourth,* A thorough education of the public as to the things that make for positive health—in exercise, clothing, recreation, good habits of personal hygiene, diet, etc.

*Fifth,* Education of the public as to the individual health responsibilities of each member of the community.

*Sixth,* The prevention of the reproduction of the unfit.

Recently the University of Oregon made a state-wide survey of mental defectives. They found that more than 75,000 men, women and children, out of a population of 783,000, are dependent, delinquent or feeble-minded. This 75,000 are unable to work, and are a constant drain on the finances, health and morality of the state.

Inasmuch as Oregon is one of our newer states and the present population is removed from the sturdy pioneer by but one or two generations, it seems reasonable to suppose that conditions in older states would be much worse. Such figures are appalling, and should waken us to the necessity for action.—Grace S. Wightman, M. D., in *Bulletin* (Chicago).

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Delegates grouped before McMahon Hall, Catholic University, Washington, D. C.

# THE CATHOLIC HOSPITAL CONVENTION

FULLY five hundred workers from hospitals of the United States and Canada met at the Catholic University, Washington, D. C., on June 20 for the Seventh Annual Convention of the Catholic Hospital Association.

The Tuesday afternoon session, constituting a symposium on hospital organization, was opened by the presidential address of Rev. Charles B. Moulinier, S. J., Marquette University, Milwaukee, Wisconsin. Due to the delay in starting, Father Moulinier condensed his carefully prepared speech into a few forceful conclusions which emphasized the three-fold character of the hospital association as a religious, ethical and scientific body. The purpose of the convention, he said, was to realize personal and institutional weakness and receive a new viewpoint and new strength in the achievement of fundamental principles.

The first paper on "The Organization of the Hospital as a Whole" was read by Father Ahearn for Sister Amadeus of St. Johns Hospital, Cleveland. As components in the unified hospital Sister Amadeus named (1) the chief executive, a woman competent to deal with the business aspects of the institution; (2) the medical staff, men of high ethical and professional standards with a spirit of paternal charity evidenced between senior and junior members; (3) the executive board composed of five active staff members, competent to judge the skill and ethics of the physicians practicing in the hospital; (4) an advisory board of seven successful business men with well-balanced judgment to insure the backing of the community; (5) the Sisters; (6) the nurses; and (7) the other administrative personnel. In stressing the influence of the Sisters in the hospital, Sister Amadeus showed that the force of example, the acts of service, and the soul cleansing influence which resulted from the patient's opportunity to talk things over, were professional accomplishments which could not be listed on bulletin boards. She advised that all Sisters holding executive positions of a scientific character be registered nurses. In conclusion, she urged the pursuance of a middle course in hospital operation, realizing that over-organization tends to subordinate the needs of the patients to the execution of meaningless routine, whereas under-organization again tends to sacrifice the welfare of the patient through slack methods of administration.

"The Scientific Organization of the Hospital" was very carefully outlined by Sister

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Cephas, Mercy Hospital, Cedar Rapids, Iowa.

As an adjunct to the scientific care, she showed that surroundings create a favorable mental attitude. The patient should receive a real welcome and realize that his welfare is of the first consideration. With this idea in mind, financial arrangements should be made in a pleasant tactful manner. When the patient is settled in his room, the Sister in charge of the floor should call upon him and see that all his wants are supplied. The nurse in attendance must show by word and action her full confidence in the attending physician. Finally, as the patient leaves the hospital, he should receive a personal word of farewell. A card should subsequently be sent to inquire regarding the patient's recovery.

Sister Cephas was especially emphatic in stressing the importance of carefully kept records. She urged (1) that a complete history of the patient be taken within twenty-four hours after entrance. (In the smaller hospitals a graduate nurse trained to take case records can be of great assistance to the busy physician.) The complete record, as compiled after careful questioning and acute observation plus a thorough physical examination and careful progress notes, etc., is necessary to ensure the best care of the patient, and to protect the hospital from damage suits.

In discussing "The Economic Organization of the Hospital," Sister Innocent of Mercy Hospital, Pittsburgh, gave the audience the benefit of her wide experience in conducting a 600-bed hospital. She advised the use of a system of accounting which would allocate the proportion of receipts and expenditures equitably among the various departments. At Mercy Hospital these accounts are checked carefully to show that each department is not only self-supporting but that it provides for a dividend of from 10 to 20 per cent. on the amount invested to allow for depreciation or permit future construction. To prevent misunderstanding regarding charges, the patient is advised on admittance of the cost of special service. As a usual practice patients are asked to pay one week in advance on entrance and are billed weekly thereafter. The budget system is used at Mercy Hospital, where the complete amount is based upon the records of operating costs during a previous period. A margin of 10 per cent. is allowed for incidentals. For the keeping of these records Sister Innocent uses the latest bookkeeping and filing devices available, making it a rule to employ a few competent high-salaried employes rather than many less competent. In purchasing she advises studying the market and buying in large quantities. In this way one large buying problem may be handled at a time and the expense distributed over the yearly period. Mercy Hospital has a central receiving department for all supplies. Requisitions are made for distribution in any department. Throughout the hospital the work is allocated under the guidance of the employment manager so that highly-paid executives do not handle unimportant details. The present hospital building has been planned with great care to secure the minimum number of movements for the execution of any required act. Labor saving devices, such as the new system of stoking, the proper routing of work, the use of standardized electrical fixtures and parts, etc., are points, she said, which further economic administration.

The final paper covering "The Administrative Organization of the Hospital," by Sister M. Regina of Mercy Hospital, Wilkes-Barre, Pa., showed the important function of the hospital as the health educator of the community. She suggested that the medical staff be denied representation on the administration board since this might lead to the advancement of the interests of certain physicians over their colleagues. She also advised that the chief executive be unhampered by any specific work so that she is free to superintend the institution as a whole. One sentence of her speech, which brought an understanding smile from the audience, contained a plea for less subservience to rules. In discussing staff appointments she advised that newcomers receive a preliminary appointment for one year. At the Mercy Hospital the consensus of opinion of the existing staff is used as a guide for future appointments since Sister Regina feels that the hospital's reputation and success are dependent upon the permanent staff. She urged the admission of younger men to the staff in order that they may profit by the criticism of the older members and themselves be prepared to assume the senior positions in later life. As a last point Sister Regina urged that sisters be educated for the position of superintendent of nurses in religious hospitals to secure unified results in administrative management.

In the last address of the afternoon, Dr. Charles O. Giese of the Glockner Sanatorium, Colorado Springs, Colorado, emphasized the need for more sanatoria or departments of

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institutions devoted to the care of tuberculosis patients. The last census, he said, showed a total of 307,256 general hospital beds in Catholic hospitals throughout the country—about 50 per cent. of the total number available. The same census showed only 1,200 Catholic beds available for tuberculosis patients, or about 3 per cent.

Wednesday was given over to group conferences and consultations at the bureaus of information. As the idea is developed, these bureaus will provide an excellent opportunity for individuals to take up practical problems with experts.

The Wednesday evening meeting of nurses and physicians proved exceptionally interesting. In an illustrated lecture on "The Birth Process," Dr. John F. Moran of the Georgetown University School of Medicine, gave a lifelike demonstration of the underlying principles of childbirth, using his hands to show the passage of the fetus through the pelvis. Subsequently Dr. John Foote gave a talk on "The Nursing Care of the Child as Shown in Art and Archeology."

Dr. B. F. McGrath, director of surgical laboratories, Marquette University School of Medicine, Milwaukee, opened the Thursday morning session by presenting a carefully planned diagram to show the relation of medical activities to the realization of the hospital's functions.

Rev. C. B. Moulinier, S. J., also of Marquette, touched the keynote of hospital service when he showed that deviations in the biological laws of creation resulted in disease and that hospitals were the laboratories in which God restored perfect function. As the creature of the Creator each patient has a right to the best service available. The force of science is constantly expanding; the hospital must dominate that important force and utilize it to the perfection of the individual within the scope outlined by medical ethics.

Although specialization in hospital work demands a concentration of energy in this field, Dr. John M. Cooper, D. D., of the Catholic University of America, urged in his address on "Extra Hospital Activities" that executives become actively interested in solving the health problems of the community. As he pointed out, unclean milk, infected water, and poor food are questions in community control which have a direct bearing upon the incidence of disease. To do preventive work the hospitals must enter politics and control these conditions. Lead poisoning, malnutrition, poor housing, lack of playgrounds are due to improper government control, insufficient wages, and lack of sanitary ordinances; again hospital executives must enter the legislative field to right these conditions. Activity, Dr. Cooper emphasized, must be stimulated (1) by having the best health periodicals accessible, (2) by cultivating an intelligent, informed interest in city and national health movements, and (3) by securing active representation on city health committees.

"Hospital Administration" was discussed by Sister Beniti of the Holy Cross Hospital, Salt Lake City. She advised that the executive head of all Catholic hospitals be vested in a Sister Superior who knows every detail of the hospital activity and who bears the united burden of the whole hospital staff. Because of her onus of responsibility, she should be consulted by her aides and no change in procedure effected without her knowledge. In conclusion she advised that the executive secure the helpful cooperation of all her associates by giving them active, constructive support; their viewpoint must be understood if defects are to be eliminated.

Dr. F. D. Jennings of St. Catherine's Hospital, Brooklyn, in the absence of Dr. G. P. Muller of Misericordia, Philadelphia, gave an extemporaneous address upon the administrative aspects of physiotherapy. As he pointed out, many hospitals carry the industrial accident patient only to the stage of bone knitting. They are not prepared to accelerate improvement by the application of physiotherapy as specified under many state compensation acts. "From the commercial side alone a department of physiotherapy is good business; it is also real Christianity."

Touching upon his assigned subject of "Staff Meetings and Case Records," Dr. Jennings said that staff meetings should not be primarily clinical nor should they consist of set papers; they should serve as a staff mirror through which results are viewed impersonally. "A hospital without records is like a property without a deed," Dr. Jennings continued, "but the important thing is the scientific honesty of the man behind the record."

In a talk on "Research, Education and the Library," Dr. John T. Bottomley, of Carney Hospital, Boston, stressed the paramount value of research as perfected through the combination of analytical minds, sufficient personnel, adequate funds and versatile clinical material—alive and dead.

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Dr. Bottomley urged that staff physicians accept their responsibility as educators. "We have too many budding specialists—sign-post doctors," he continued. By rotating internships, the establishment of laboratory centers in outlying districts, and the extension of hospital consultation privileges, Dr. Bottomley believes that more physicians can achieve well-rounded, well-grounded educations. On the subject of nursing education his criticism was drastic. In this field Dr. Bottomley says that the present tendency is to overeducate nurses. He is opposed to such a course though he stresses the need for adequate education of all nurses, and the desirability of specialization for some.

"Every hospital should have a working library," he advised, "supplemented, as funds permit, by current monographs and the older source books which portray the heritage of medicine and act as a stabilizing influence."

In discussing "The Patient's Entrance," Dr. Raymond P. Sullivan of St. Vincent's Hospital, New York, urged prompt, simple and sympathetic care at entrance. He pointed out that ambulance service, for the prestige of the hospital, should be rendered by experienced men. He showed that placement must be carefully considered by the admitting officer (preferably a physician) to prevent infection, and secure proper surroundings for difficult surgical work.

Admission records, he felt, should be filed in triplicate: one copy to be sent to the wards (with written physical examination) to insure proper classification; (2) one copy sent to bookkeeper; and (3) one copy filed for reference.

Dr. Charles H. Nielson, professor of medicine at the St. Louis School of Medicine, and Dr. H. W. Loeb, dean, in discussing "The Hospital as a Diagnostic and Therapeutic Center," advised that physicians be alert in checking the work of technicians and especially careful in evaluating findings.

Dr. A. C. Gillis, professor of neurology and clinical psychiatry, University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, brought out the psychological aspects of healing. As he pointed out, the materialism of the Nineteenth Century has overstressed the physical factors in disease. Man has been treated as a glorified machine. "Remember, your patients have minds!" Christian Science, he showed, actually heals because in that case the mind ceases to retard gains. He advised that general hospitals be utilized for the treatment of psychoneurotic patients.

In an address on dietetics, Mrs. Agnes O'Dey, chief dietitian of Johns Hopkins Hospital, emphasized the value of that therapeutic branch by mentioning that one in every six cases at that institution receives special dietetic care. She urged that the dietitian be permitted to handle the food problem of the whole hospital and that her full capabilities be utilized by permitting her to study the per capita costs through participation in the buying.

In discussing "Nursing," Miss Lucy Minnegerode of the U. S. Public Health Service, urged that hospitals avoid the exploitation of pupil nurses, (1) by employing graduate nurses in sufficient numbers to allow time for education, (2) by ruling against special duty, community nursing, and service which do not serve to educate the nurse.

In discussing "The Scientific Basis for Post-Mortem Examinations," Dr. C. A. Gordon, of St. Catherine's Hospital, Brooklyn, pointed out that those hospitals which fail to avail themselves of the clinical facilities furnished at autopsies will soon fall behind in the hospital race. Johns Hopkins, for example, performs autopsies on 62 per cent. of its cases, Royal Victoria 67 per cent. and the Mayo Clinic 95 per cent. "Vital Statistics, which form the basis for future efficient treatment, must be based on facts, yet our most concrete proofs of the success and failure of science are buried in the ground." The demands of scientific research can be furthered by (1) routine request for autopsy; (2) the education of executives, physicians, internes and the public; (3) the performance of autopsies by an experienced pathologist and the keeping of accurate records of all findings.

In the last paper on "Medical Social Service," Miss Elizabeth Cosgrove of the Mercy Hospital, Pittsburgh, brought home to the audience the real function of hospital social service and the co-operation demanded of executives, physicians and nurses to secure results.

The following officers were re-elected: Honorary president, Most Reverend Sebastian G. Messmer, Milwaukee; president, Rev. Charles M. Moulinier, Milwaukee; active vice-president, Rev. P. J. Mahan, Chicago; secretary-treasurer, Dr. B. F. McGrath, Milwaukee; executive board, Dr. Louis D. Moorehead, Chicago; Sister Rose Alexius, Cincinnati; Mother M. Madeleine, Minneapolis.

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Miss Clara D. Noyes, retiring president of The American Nurses' Association

# A RECORD OF ACHIEVEMENT

*(Monday Evening Session)*

TO catch the enthusiasm and constructive thought* of a composite group of over 4,000 nurses and condense it into a few short pages is like dropping a bottle in the ocean and expecting to capture the fascinating surge of the sea. The huge auditorium of the Seattle First Presbyterian Church was filled to the doors at the formal opening session on June 26, and during the welcoming speech of the Mayor, Dr. J. E. Brown, white capped ushers were distributing dozens more in stray corners.

The simple, direct address with which Miss Clara D. Noyes opened the meeting is characteristic of her efficient management of the American Nurses' Association during a critical period of nursing history. The extraordinary nursing shortage obtaining during the war, the further emotional stress caused by a country unnerved and the subsequent criticism received at the hands of individuals in the medical profession, created a condition which de-

* In reporting the main points of the meetings, an effort will be made to record ideas rather than names, connections and exact titles of papers. This we know is not the way to popularity—since all of us (the writer perhaps most) are pleased at seeing our names in type; it is, however, the writer's own claim to intellectual integrity.

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manded masterful handling. Despite Miss Noyes' modest account of her part in the growth of the organization, the results achieved bespeak the broad judgment of the governing executive and her unfailing effort in marshaling funds to accomplish the results desired.

Actual advances include the passing of legislation to provide rank for Army nurses, the erection (in cooperation with the National League of Nursing Education and National Organization for Public Health Nursing) of the Florence Nightingale Memorial in France, the successful launching of a publicity campaign (which was subsequently handled through the League) to present the subject of nursing education before the public in its true light, and the establishment of a center for information and growth at National Headquarters, 370 Seventh Avenue, New York.

An indication of the nursing achievements in Europe through American influence is evidenced in Miss Noyes' announcement of the formation of a European League of Nursing Education at the convention held in Prague.

In sketching the lines of future development she said: "Those attributes of service and sacrifice which we have inherited from the cloister must not induce us to hide our light under a bushel. The future work of the nurse will mean the broadcasting of health information everywhere." The Red Cross rural nursing service has undertaken the demonstration of health in the more inaccessible localities and the condition of this work indicate that the missioners of the future must be given the best possible education in order that they may embrace their broadening opportunities.

### Educational Gains

As president of the National League of Nursing Education, Miss Anne C. Jammé gave a comprehensive report of the progress in the educational field during 1921-1922. Her first point stressed the renewed effort which must be put forth to bring nursing schools up to the standard set by other educational systems. As an aid she urged the necessity for a full time secretary at National Headquarters, able to interpret the ideals of the League, and prepared to keep superintendents of nurses, pupils, executives and the public in touch with nursing developments. This center should be a court of appeal to which the public, the student. the teacher, the administrator, the trustee and director of hospital boards could come for timely advice and for a concrete and clear expression of the best and latest thought on nursing education and administration of schools of nursing.

Miss Elizabeth G. Fox, president of the youngest nursing organization which celebrates its tenth anniversary this year, spoke of the rapid growth in the field of public health, a service begun to meet the individual needs and now being so swiftly developed that the ideals of good workmanship cannot always keep pace with the demand. In her survey of the field, she expressed the need of added economic machinery by which nursing service could be brought within the reach of the families of moderate means and the immediate desirability of extending the service to include the adequate nursing of contagious diseases, pediatric cases, orthopedic adjustments, etc., through the agency of one well-trained family health worker. Her second point advocated the extension of the teaching of home hygiene and care of the sick so that a more helpful environment would be created and the incidence of disease minimized.

### Do Health Nurses Teach?

Her third point was well taken: "Conceiving the function of nurses as that of health teachers, do we really know how to teach?" Do public health nurses possess that workable knowledge of psychology and pedagogy which would enable them to present these health messages to children and grown people in the most effective manner? Do public health nurses understand the mental and emotional aspects of their work? Do they utilize the principles of mental hygiene?

Finally, as public health nurses are brought under the administration of politics, are nurses prepared to carry public spirited backers with them so that they can surmount the political handicaps and increase and broaden the scope of their work? "Certain it is," concluded Miss Fox, "that the need for more public health workers is conspicuous; the lack of sufficient numbers of fully trained workers is equally conspicuous."

In closing, Miss Noyes stressed the basic point in all successful co-operative organizations: "Let me urge on each one here the necessity for full and free participation in the affairs of the convention. We extend the warmest and most cordial welcome to all, but most especially to the younger delegates upon whose shoulders we older workers must eventually place the burden of administration."

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# THE OBJECTIVE OF THE NURSE IN A DEMOCRACY

## DEVELOPING THE HEALTHY INDIVIDUAL

*(Monday Evening Session)*

THOSE listeners who appreciate the sincerity of Miss Goodrich's life purpose and the indomitable will power which she has put forth in achieving it, considered her text a personal message: "Men should fix their minds upon the idea of purpose and give that idea precedence over every subsidiary activity." An unconscious silence fell upon the audience as she directed her penetrating voice to the very top of the gallery. The following gives only the substance of her speech:

### The Application of Research

Though the nursing profession stands within the doors of our great universities, as evidenced by the conferring of the degree of master of arts upon M. Adelaide Nutting at Yale University, the application of science in the field of nursing is but in its infancy. In America, today, we have only one trained nurse for every seven hundred in population, an entirely inadequate ratio when we realize that untold uses for nursing service are yet to be uncovered.

Society is far from its goal of developing the perfect man. The present wastage of human life in cities and rural districts shows that we must have more workers is the preventive field. We preserve art in our large museums, we develop art in our schools of sculpture and design, but what lasting progress are we making in the perfection of the art of living. It was Florence Nightingale who said: "Why is the carving of stone greater than the making of a perfect human body?" "In Chicago on my way to the coast," Miss Goodrich continued, "I was mentally depressed at my failure to accomplish an important undertaking. I went up into the museum to regain my poise. In one of the rooms I saw a boy whose limbs were deformed, but whose face was fine as those who have overcome suffering. At once I felt that the expression of a beautiful mind had been crushed with the physical handicap. There were many others like him in the world."

May not the true incidence of art be expressed in the words of Ruskin: "Art is the result of mind developed through successive generations?" The same thought was in the mind of Tolstoi when he argued that real art was unattained unless expressed in the simple perfection of life. Today, despite the scientific knowledge at our command, energy which might be utilized for great purposes is constantly being dissipated by disease. Science has already conquered the fear of the tropics. With these gains behind him man can no longer close his eyes to the physical handicaps of his fellows.

In the old world, the reaches of civilization are marked by cathedral steeples. Are smoke stacks alone to measure the progress of the new? Should these outposts of vision not be the towers of our universities?

However, if we have access to these storehouses of contemplative knowledge, intellectual integrity demands the utilization of facts in eliminating suffering. We have enough knowledge today to wipe disease from the earth if we would but apply it. Education, after all, is a sacred trust. Those who have been sitting at the feet of knowledge are obligated to pass their information on to those who are out of hearing. We have no intellectual right to absorb the vision and not disseminate it.

### A Great Cause as Leader

The great objective of the nurse is to produce the day when each newcomer on this planet will enter the garden of youth, experience a healthy and productive manhood or womanhood and pass through a serene and happy old age. And each nurse must have access to these universities of knowledge in order that she may possess the scientific equipment which produces sure results.

The work cannot be done by leaders, it must be done by every public health nurse (and all nurses are public health nurses) who goes out into this field of service. As H. G. Wells puts it: "Man has forgotten his personal interest and become man thinking for the whole race." A great cause is the greatest leader possible and only as cooperation succeeds competition and each worker becomes part of the mosaic pattern of the whole can we bring about the ideal state when "all men *shall be* born free and equal."

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Miss Elizabeth G. Fox, president of the N. O. P. H. N., who read the greeting of the chairman—Prof. C.-E. A. Winslow

Miss Annie W. Goodrich, assistant professor of nursing and health at Teachers' College, who read the Rockefeller report.

Prof. Richard Olding Beard of the University of Minnesota, who commented upon the report from the collegiate viewpoint.

# THE REPORT OF THE COMMITTEE ON NURSING EDUCATION

THOUGH the report on nursing education seems coldly analytical when reduced to type, the facts marshalled before the three nursing organizations on June 28 bristled with interest and vitality. As Miss Goodrich touched a live phrase here and there in the nineteen-page document, visible currents of understanding surged over the sea of faces. Speaker and audience appreciated the truth of the survey almost too acutely.

Though many in the large group of nurses had received an education in the best nursing schools of the country, as many had eked out a meager curriculum by painstaking post-graduate study. Though many were administrators in large, well-organized schools, as many more were mustering every effort to provide adequate education with limited funds and facilities. Though many were thinking, especially, in terms of present need—patients with inadequate hospital care, preventable deaths during childbirth, stunted childhood—a need so great that the combination of all available nursing forces cannot meet it; as many with greater vision, perhaps, were conceiving a future—a future so guarded by

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adequately trained health workers in sufficient numbers that only cooperative community agencies or sick insurance benefits need be added to make health financially accessible to all.

As the facts crowded each other for attention each listener waited to have his limited, individual opinion amplified by the comprehensive national survey. To make the *ideal* of universal nursing service a workable *reality*—this was the proposition which challenged the foremost health educators and administrators of the country.

How was this representative committee† brought into being? Over three years ago Miss M. Adelaide Nutting, R.N., professor of nursing and health, Teachers' College, approached the Rockefeller Foundation to secure endowment for the Johns Hopkins School of Nursing. During the interview the whole subject of the education of public health nurses was pried into. The conference resulted in the appointment in January, 1919, of a special committee to conduct a study on "the proper training of the public health nurse." In February, 1920, the scope of the inquiry was broadened to include "a study of general nursing education with a view to developing a program for further study and for recommendation of further procedure."

As secretary of the committee, Miss Josephine Goldmark, best known in the economic world through her basic report concerning the relation of fatigue to industrial efficiency, was placed in charge of the investigation. Under her direction the opinions of the health educators of the country were carefully collated; in addition, surveys were made, through scientific sampling, of representative conditions in schools of nursing and public health and private duty nursing.

But to turn to the actual report*:

### The Role of the Nurse in Public Health

The major health problems of the present day, such as the control of infant mortality and tuberculosis, can be solved only through personal hygiene,—an alteration in the daily habits of the individual,—and through the establishment of new contacts with the public, —contacts which shall permit the application of the resources of medical science at a stage in disease when they can produce a maximum effect. Such changes in the daily habits of the people and in their relation to their medical advisors, can be accomplished by but one means,—education. We have sought during the past twenty years for a missionary to carry the message of health into each individual home; and in America we have found this messenger of health in the public health nurse. In order to meet generally accepted standards we should have approximately 50,000 public health nurses to serve the population of the United States,—as against 11,000 now in the field. All public health authorities will probably agree that the need for nurses is the largest outstanding problem before the health administrator of the present day.

There are at present two distinct types of public health nursing practise in the United States,—that in which the nurse confines herself to the teaching of hygiene, and that in which such instructive work is combined with the actual care of the sick. A third type of visiting nursing in which bedside care is given with no educational service, may be observed in individual instances.

The introduction of the instructive but non-

† This committee was composed of Dr. C.-E. A. Winslow, professor of public health, Yale Medical School, Chairman; Miss Mary Beard, director of the Visiting Nurse Association of Boston; Dr. Herman M. Biggs, Commissioner of Health of New York State; Miss S. Lillian Clayton, superintendent of nurses, Philadelphia General Hospital; Dr. Lewis A. Conner, of New York; Dr. David L. Edsall, dean of the Harvard Medical School; Dr. Livingston Farrand, formerly head of the American Red Cross and now president of Cornell University; Miss Annie W. Goodrich, director of nurses of Henry Street Settlement and assistant professor of nursing and health in Teachers' College; Dr. L. Emmett Holt, New York City; Miss Julia C. Lathrop, formerly chief of the United States Children's Bureau; Mrs. John Lowman, Cleveland; Miss M. Adelaide Nutting, professor of nursing and health in Teachers' College; Dr. C. G. Parnall, director of the University Hospital, University of Michigan; Dr. Thomas W. Salmon, medical adviser of the National Committee for Mental Hygiene; Dr. Winford H. Smith, superintendent of Johns Hopkins Hospital; Dr. E. G. Stillman, New York; Miss Lillian D. Wald, head of Henry Street Settlement; Dr. William H. Welch, director of the School of Hygiene and Public Health, Johns Hopkins University, and Miss Helen Wood, superintendent of nurses, Washington University, St. Louis.

* The condensed report occupying nineteen closely typewritten pages is obviously too extended for complete reprinting. We give here points of special interest. The full text of Miss Goldmark's material will soon be available in book form.

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nursing field worker creates at once a duplication of effort, since there must be a nurse from some other agency employed in the same district to give bedside care. In the second place the field worker who attempts health education without giving nursing care is by that very fact cut off from the contact which gives the instructive bedside nurse her most important psychological asset. The nurse who approaches a family where sickness exists, and renders direct technical service in mitigating the burden of that sickness, has an overwhelming advantage, then and thereafter, in teaching the lessons of hygiene.

With an adequate number of nurses per unit of population, we believe that the combined service of teaching and nursing will yield the largest results. Nurses employed by State Health Departments and others whose work is largely stimulative and supervisory in nature may not, of course, be in position to render direct bedside care.

There are other messengers who may be sent into the field to fulfill other functions. The task of the trained social worker, for example, is to diagnosticate and repair maladjustments in social relationships, a correlated but quite distinct vocational field. Even public health agencies may employ other field workers of an allied type, such as clinic messengers. It is obvious, however, that where health instruction is combined with bedside care the fully trained nurse is the only possible type of health educator; and *such a combination represents the one type of service which it is feasible to supply in rural districts.* Even purely instructive work, if conducted on the generalized district plan, calls for an ability to detect the early signs of contagious disease, to discern symptoms which suggest tuberculosis, to give counsel as to infant care or the feeding of older children, which can scarcely be attained without a wide training.

That an improvement in quality, as well as an increase in the number of public health nurses is fundamental to the complete success of the public health movement, is a point on which we find all competent authorities to be substantially agreed. Miss Goldmark's report of an intensive study of the daily work of 164 public health nurses,* representing 47 different organizations, gives glimpses of women whose constructive service and compelling personal inspiration seem to touch the highest possibilities of social achievement. Such a nurse establishes herself in the confidence of her community, so that she becomes its trusted advisor and best friend, caring for the sick, securing medical aid, counselling as to hygiene, resolving difficulties of a hundred sorts with the touch of a practised hand.

Nearly half of the nurses observed in our survey were classed as definitely successful in their work and less than one-fourth as definitely unsuccessful,—a showing perhaps better than would be made by a random sampling of most professions. Yet it remains true that either from a lack of knowledge of preventive measures or of teaching methods, from failure to effect contact with physicians or with social agencies, a substantial proportion of public health nurses do fail to realize the possibilities of their profession. Administrative policies, overloading and inadequate supervision, are sometimes at the root of the trouble; yet it is obvious that *such a calling as public health nursing demands in the first place a high degree of natural capacity and in the second place a sound and a broad education.*

### Essential Qualifications of the Public Health Nurse

*Conclusion 1. That, since constructive health work and health teaching in families is best done by persons:*

*(a) capable of giving general health instruction, as distinguished from instruction in any one specialty; and*

*(b) capable of rendering bedside care at need, the agent responsible for such constructive health work and health teaching in families should have completed the nurses' training. There will, of course, be need for the employment, in addition to the public health nurse, of other types of experts such as nutrition workers, occupational therapists, and the like.*

*That as soon as may be practicable all agencies, public or private, employing public health nurses, should require as a prerequisite for employment the basic hospital training, followed by a post-graduate course, including both class work and field work, in public health nursing.*

### The Need for High Grade Nurses in Hospital Supervision and Nursing Education

The development, both of public health nursing and of administrative hospital nursing, involves and demands a corresponding development in nursing education which constitutes another inviting field for women.

The defective preparation and qualifications

* The field investigations in public health nursing were made by Miss Janet R. Geister and Mrs. B. A. Haasis of the National Organization of Public Health Nursing.

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of many instructors in schools of nursing, in both theoretical and practical branches, is very marked. Yet in the training school the instructor is often called upon to teach six or eight different subjects, far more than would be demanded even of the teacher in a country high school. (It should be noted, however, that the appointment of full-time instructors is a very recent development, and has marked a signal educational advance.)

With the development of nursing education which we visualize in the future, and particularly with the growth of University Schools of Nursing, the field for well-qualified teachers of nursing should prove an increasingly attractive one.

### The Problem of Nursing the Sick

When we pass to the urgent and fundamental problem of providing nursing care for the sick of the community, we find far less unanimity of sentiment, in regard either to the quantitative or the qualitative adequacy of nursing service under existing conditions. The census reports show an increase in trained registered nurses, male and female, from 82,327 in 1910 to 149,128 in 1920, a truly phenomenal increase of 83 per cent. This 1920 figure gives us a ratio of one trained nurse to 700 persons for the country as a whole. The reason why many persons who need nursing care in hospitals and in the homes fail to receive it is to be sought in economic factors, and in the overdistribution of trained nurses in large centers and underdistribution in rural districts, rather than in a shortage of nurses.

In regard to the quality of the nursing service available at the present day we find private physicians frequently expressing the view that for ordinary nursing, even the graduate of the existing training school is "overtrained," that the service which she renders is too costly, and that a woman with a very brief training in bedside routine would be as satisfactory, or perhaps more satisfactory, than the average registered nurse. As a result of this feeling there have been persistent and vigorous efforts in certain quarters to break down the standards of nursing education which have been laboriously built up during the past twenty years.

Nurses, physicians, hospital authorities and legislators, in erecting these safeguards, have been inspired by a just sense of the vital dangers to life which may result from the unskilled nursing of a critical case and of the grave responsibility incurred by both the medical and the nursing professions when such malpractice occurs. We would therefore record our conviction in regard to this point as:

*Conclusion 3. That for the care of persons suffering from serious and acute disease the safety of the patient, and the responsibility of the medical and nursing professions, demand the maintenance of the standards of educational attainment now generally accepted by the best sentiment of both professions and embodied in the legislation of the more progressive states and that any attempt to lower these standards would be fraught with real danger to the public.*

### The Subsidiary Type of Service

For the care of mild and chronic illness and convalescence it may well be that a different type of capacity and training may be necessary.

It seems clear to the Committee, however, that, if two types of nursing service are desirable, the distinction should be drawn, not on economic grounds, but according to the type of illness involved. We are even somewhat doubtful as to the possibility of attaining very substantial economies by the introduction of a subsidiary type of private duty nurse. Our survey of the situation does not indicate that the income of the private duty nurse is at present generally an exorbitant one, when we take into account the amount of unemployment, —amounting in a typical group* of 118 nurses to a week each month during the busy winter season. If this factor be allowed for, the margin between the average annual income of the private duty nurse and that of the domestic servant is not so great as to permit of the existence of an intermediate grade on a salary level very much below that of the present registered nurse. *The solution of the economic problem which confronts the family of low income must probably be sought along the lines of cost distribution through some form of community organization, or along the lines of group insurance such as that being experimentally tested in New York City.*

In our own study we have secured careful estimates from 118 graduate nurses which indicate that during a period of three months, one quarter of their time was spent on cases which could have been cared for by an attendant of the partially trained type. A somewhat similar estimate was obtained from 48 practising physicians, 21 believing that trained nurses were un-

* The investigations in the private duty field were conducted by Mrs. J. David Thompson, Mrs. Parsons and Miss Adda Eldredge. Additional investigations were made by Miss Carolyn E. Gray.

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necessarily employed for less than a quarter of their cases, 17 placing the figure between half and three-quarters and 10 at over three-quarters.

In considering the problem of subsidiary nursing service it must be remembered that we are dealing with no new development. Of the 300,000 male and female nurses in the United States in 1920, slightly more than half were of grades below the standard of the graduate nurse. The "practical nurse," the "trained attendant," is an existing fact; and in the opinion of a large group of the medical profession who utilize her services she fills a real place in the complex problem of caring for the sick.

If we include with the trained and registered nurses (149,128) the student nurses in hospitals (54,953) and to these add the number of attendants and practical nurses (151,996) as constituting the entire body of persons occupied in caring for the sick we have altogether one nurse, trained or untrained, to every 294 well persons. This would seem to give an adequate supply if numbers alone are considered, provided a proper distribution could be secured.

On the other hand the dangers in the existence of a loosely defined and unregulated group of partially trained workers, in the same field as a more highly educated type, constitute a real and a serious complication. The nursing profession has discharged a fundamental duty to the public in stimulating the development of registration laws which define and delimit the practise of that profession, and protect the community against fraud and exploitation by those who collect fees and assume responsibilities to which their qualifications do not entitle them. In addition to the registration of the trained nurse it is essential that the lower grade of nursing service should also be defined and registered; and the states of New York, Missouri,* California, Michigan, and Maryland have taken definite steps in enacting legislation toward this end. We are inclined to believe that the term "nursing aide" or "nursing attendant" best meets the need for clear differentiation, while providing the subsidiary worker with a suitable name.

With two distinct grades of service available, the individual physician would be responsible for the choice of a trained nurse or a nursing attendant or nursing aide in a given instance. The public can only be safeguarded in these matters by state legislation providing for licensing of nursing registries and requiring explicit statement as to the license qualifications of each nurse or nursing aide furnished. We would therefore recommend as

*Conclusion 4. That steps should be taken through state legislation for the definition and licensure of a subsidiary grade of nursing service, the subsidiary type of worker to serve under practising physicians in the care of mild and chronic illness, and convalescence, and possibly to assist under the direction of the trained nurse in certain phases of hospital and visiting nursing.*

### Educational Provision for the Subsidiary Type of Nursing Service

Existing facilities for the training of the subsidiary worker are today of the most limited type. It is obvious that courses in home nursing of a few weeks' duration, such as those conducted under the auspices of the American Red Cross, while most useful in disseminating the sort of knowledge which all girls and women should possess, in no way suffice as preparation for the practise of a profession. When they are advertised as adequate for this latter end, such courses may do far more harm than good, as evidenced by the fact that "graduates" of such courses, after forty-eight hours of training, have practised as qualified nurses and received $5 a day for their services.

Courses for the training of nursing aides offered by the Household Nursing Association of Boston and by local Young Women's Christian Associations in various parts of the country and those stimulated by the Bureau for the Home Care of the Sick under the Thomas Thompson Trust are on a wholly different basis. The number of graduates from such courses is, however, small and their control after graduation, loose and unsatisfactory.

The field for the training of nursing aides would seem to be an ample one. The special hospital not served by affiliation with a school of nursing, and the small general hospital whose facilities are inadequate for the maintenance of a nursing school of standard grade might be considered as training grounds. In the large general hospital whose opportunities are not fully utilized by student nurses there is no valid objection to the training of the subsidiary group, provided that it is con-

* The Missouri act is unusually effective in providing that "no person shall practice as a nurse for hire or engage in the care of the sick as an attendant for hire unless licensed by the Board as hereinafter provided."

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ducted in separate and distinct wards so that the sacrifice of the interests of either of the two groups of pupils may be avoided. The requirement for entrance should be a Grammar School course or its equivalent and the period of training approximately eight or nine months. Suggestions of great value in regard to the safeguarding of such a course for "trained attendants" will be found in a recent report issued by the Board of Regents of the University of the State of New York.

It is essential in providing for this new type of education that hospital patients should be protected from malpractice and students from exploitation by an adequate graduate nursing service for the care of acute illness and for supervision of the students.

### The Hospital Training School

So far as the trained nurse is concerned, whether she is to function in private duty, in public health or in institutional service, it is clear that her basic professional education must be acquired in the hospital training school.

An extensive survey of the vast field of hospital training schools (there are over 1,800 such schools in the United States) was obviously beyond the possible resources of our Committee. It was therefore decided to select a small group of schools, of reasonably typical character, for intensive study. Twenty-three such schools were finally chosen, representing large and small, public and private, general and special hospitals, in various sections of the United States. Each school was studied in detail by two types of investigators, one a practical expert in nursing education and the other an experienced educator from outside the nursing field. By this means we aimed, on the one hand to secure competent criticism of nursing procedures, and on the other a broad viewpoint of general, educational standards.*

The training of the nurse involves a certain basic knowledge of the fundamental chemical and biological sciences, theoretical instruction in the principles of nursing, and, above all, supervised practical training in actual nursing procedures. In all three phases of this work Miss Goldmark's report reveals conspicuous successes and equally conspicuous failures; and the remarkable thing is that successes and failures so often appear side by side in the same institution.

Thus, we may find in a training school with a good ward service that the fundamental science courses fail because of wholly inadequate laboratory equipment. In another school, the theoretical instructor may show a hopeless lack of teaching ability (as in the case of class presentation which consisted in the dictation of questions and answers from a pre-historic note-book); or she may be so handicapped by other duties as to leave no time for the proper conduct of her classes. Lectures by physicians may be informative and inspiring in one department of a hospital, irregular in delivery, careless and dull in content in another. Ward assignments are in many cases largely dictated by the need for hospital service rather than by the educational requirements of the students. Of the 23 schools surveyed by us one made no adequate provision for obstetrical service, while five gave no training in pediatrics, seven no experience in communicable disease and eighteen none in mental disease. In view of the difficulties in making affiliations in some of these subjects, notably in communicable and mental disease, some of these omissions are scarcely to be wondered at.

The supervision of work on the wards was in certain instances notably inadequate. In only a few brilliantly exceptional cases was the ward work purposefully correlated with theoretical instruction. The lack of an intelligently planned progressive training was obvious in a large number of the hospitals studied, first-year students often being found in positions of responsibility for which they were wholly unprepared, while seniors in another ward were repeating an educationally idle and profitless routine. Most striking of all was the factor of time wasted in procedures, essential to the conduct of the hospital, but of no education value to the student concerned. Hours and days spent in performing the work of a ward maid, in putting away linen, in sterilizing apparatus, in mending rubber gloves, in running errands, long after any important technique involved had become second nature, accounted in one typical hospital where this problem was specially studied for a clear wastage of between one-fourth and one-fifth of the student's working day.

Our selected group of hospitals shows a median day of 8.5 hours on ward duty alone, exclusive of all classroom instruction. Irregular and excessive and unproductive night duty is the rule rather than the exception. Crowded

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and unattractive living conditions tend, in certain hospitals, to impair the morale of the student body and an atmosphere of autocratic discipline frequently prevents the development of a psychological atmosphere favorable to effective co-operative effort.

The following statement is, we believe, thoroughly justified by such facts as we have been able to obtain:

*Conclusion 5. That, while training schools for nurses have made remarkable progress, and while the best schools of today in many respects reach a high level of educational attainment, the average hospital training school is not organized on such a basis as to conform to the standards accepted in other educational fields; that the instruction in such schools is frequently casual and uncorrelated; that the educational needs and the health and strength of students are frequently sacrificed to practical hospital exigencies; that such shortcomings are primarily due to the lack of independent endowments for nursing education, that existing educational facilities are, on the whole, in the majority of schools inadequate for the preparation of the high grade of nurses required for the care of serious illness, and for service in the fields of public health nursing and nursing education, and that one of the chief reasons for the lack of sufficient recruits, of a high type, to meet such needs lies precisely in the fact that the average hospital training school does not offer a sufficiently attractive avenue of entrance to this field.*

### The Improvement of the Hospital Training School

Miss Goldmark's study has not stopped short with a revelation of the defects which are commonly found in the conduct of nursing education. It makes clear that only the co-ordination and standardization of the best existing practise is necessary in order to place nursing education on the plane where it belongs.

In the first place we believe that a training school which aims to educate nurses capable of caring for acute disease or of going on into public health nursing or supervisory and teaching positions must require for entrance the completion of a high school course or its equivalent.

The course should begin with a preliminary term of four months' training in the basic sciences and in elementary nursing procedures with appropriate ward practise but without regular service, as outlined in Miss Goldmark's report. (The necessary teaching personnel and laboratory equipment for the former may in many instances be secured by the smaller hospitals through the establishment of a central training course or by co-operation with high schools, normal schools or junior colleges.)

There should then follow a period of twenty-four months (including two months for vacation) devoted to a carefully graded and progressive course in the theory and practise of nursing, with lectures and ward practise so correlated as to facilitate intelligent case study and with the elimination of routine duties of no educational value. Hospital and dispensary services in medicine, surgery, pediatrics, obstetrics, communicable diseases and mental diseases should be provided through appropriate affiliation. Teachers and equipment should be of such a grade as would be acceptable in a reputable college or normal school.

We regard it as fundamental that the working day for the student nurse, including ward work and classroom periods, should not exceed eight hours. The working week should not exceed 48 hours and preferably 44 hours.

By such an organization of the course of study, and particularly by the elimination of unrewarding routine service, we are convinced that the period of training may be safely shortened from the present standard of three years to twenty-eight months.

Two fundamentals are essential to the success of a training school planned on the suggested lines. (1) It must be directed by a board or a committee, organized more or less independently for the primary purposes of education. The interests of hospital management and of educational policy must necessarily at times conflict and unless the educational viewpoint is competently represented the training school will infallibly suffer in the end. (2) Adequate funds should be available for the educational expenses of the school itself, and for the replacement of student nurses by graduate nurses and hospital help in the execution of routine duties of a non-educational character.

A satisfactory relationship between school and hospital demands careful cost-accounting and a clear analysis of the money value of services rendered by the school to pupil and hospital, by the pupil to the hospital, and by the hospital to the pupil and the school. The following conclusion seems to us justified:

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*training school committee, organized primarily for educational purposes, it is possible, with completion of a high school course or its equivalent as a prerequisite, to reduce the fundamental period of hospital training to twenty-eight months and at the same time, by eliminating unessential, non-educational routine, and adopting the principles laid down in Miss Goldmark's report to organize the course along intensive and co-ordinated lines with such modifications as may be necessary for practical application; and that courses of this standard would be reasonably certain to attract students of high quality in increasing numbers.*

### Post-Graduate Nursing Education

The course of twenty-eight months discussed above would furnish the complete education for a student desiring to practice as a bedside nurse in private duty or in hospitals and other institutions; and its completion should entitle her to the Diploma in Nursing and to state registration. For the nurse who desires to specialize along either of the more advanced lines of public health nursing, or hospital supervision and nursing education, a further period of post-graduate training is obviously desirable.

### The University School of Nursing

As long ago as 1899 Teachers College in Columbia University admitted properly qualified nurses to its Junior Class, thus giving two years of college credit for three years of nursing training. Since 1916, no less than thirteen different colleges and universities have provided combined courses, through which students may acquire both a nurse's training and a college degree.

The combined course in such a school, for example, involves two years of ordinary college work, including besides work of a liberal nature certain of the fundamental sciences basic in nursing education. Then follow two years of intensive training in the hospital and, finally, a fifth year of post-graduate education in one of the higher specialties of nursing, public health, institutional supervision or nursing education. At the close of training, the student receives a diploma in nursing and the bachelor's degree in nursing or in science.

A definite affiliation with one or more hospitals must in any case be established, along the line of these agreements now in force between medical schools and hospitals. The school supplies student nursing, service and assumes a definite responsibility for a larger or smaller share of ward supervision and perhaps of graduate service. The hospital, on the other hand, provides maintenance for the nursing staff and conforms to the standards held by the University to be essential for the realization of its educational ideals.

The numerical proportion of the nursing profession to be contributed by the University School will perhaps always be a relatively small. One of the greatest, if not the greatest of the reasons for the imperfections in the present training of private duty nurses is that great numbers of schools have developed without any coincident development of adequate numbers of persons properly trained to guide the pupils during their course. Unless well taught they cannot be well trained. The University School of Nursing should be the keystone of the entire arch. It will not only train leaders and develop and standardize procedures for all other schools, it will, by its permeating influence, give inspiration and balance to the movement as a whole and gradually but steadily improve the efficiency of every institution for the training of nurses of whatever type.

### The Financial Problem

It is clear, however, that the attainment of these ends requires financial support at all points along the line. The training of nursing aides will cost money; the training of nurses will cost more money; the university school will require endowment. The hospital, in its operation of the training school, has for generations been trying to make bricks without straw. It is time that the hospital should be relieved from the dilemma of exploiting student nurses on the one hand, or of diverting funds given for the care of the sick on the other, by the provision of endowment specifically devoted to the purpose of education.

If the community needs and desires the service of competent nurses for the care of the sick and the prosecution of the campaign of public health, it must pay for their education, as it pays for every other conceivable kind of education—either through taxes or through voluntary contribution or through the generosity of its great philanthropic foundations.

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The Detroiters? No, you will see them in 1924. The rooters from St. Paul—A cheer for Good Losers!

# PRANKS AND PRUNES

LEST the convention reports present the spirit of modern nursing only in its intellectual garb, we hasten to slip in this page of singing fests, eating orgies and what nots as a balance.

Bidding for the 1924 convention early became the chief indoor sport. The lustiest contestants were St. Paul and Detroit. Both factions adopted the methods of experienced campaigners.

St. Paul began her publicity as the trains passed through the twin cities. Souvenir flour bags were distributed to nurses en route and placards and flowers trimmed the dining cars. Detroit showed her voice at the first large convention meeting by concentrating in the gallery and singing her "Yoo-hoo" invitation at the direction of Miss Morse's megaphone. As the days went by and St. Paul members donned their white tasseled red caps the contest became exciting. Pauses in meetings, doorways and recessionals were punctuated with cheers and songs of the chief competitors. Even in the most solemn conclave one would catch a glimpse of the green and red sign saying: "Eventually Minnesota—why not in 1924."

The Detroiters were equally persistent. On one afternoon the delegates found a Detroit Ford blocking the church entrance and Detroit rooters blocked the vestibule with their "Yoo-hoo." To be sure Boston had been bidding with her blue and gold badges and her engraved invitations, but then Boston is too intellectual to compete with the lungs of the West. Washington, D. C., was another dignified competitor and the final vote which she received without any campaigning, was indicative of her possibilities.

On the day of voting, Boston presented a solid phalanx from the choir loft of 133, St. Paul mustered 163, Washington, D. C., 33, and Detroit gathered unto herself 230. At the last moment the far West threw its support to Detroit and the 1924 convention was decided upon.

Perhaps Detroit won because so many nurses were handicapped by their Thursday luncheons—seven "feasting reunions" were held on that day. Wednesday and Friday were quite as taxing, however, since twenty-two groups—state and alumnae associations. Army nurses and specialized nurses held luncheons or dinners on these days.

These meetings often meant the reunions of nurses who had not met since graduation or since their long full service "overseas."

When you realize that these activities were sandwiched between relaxation in community singing, receptions at the Ranier Club, boat rides, an American Legion dance and a thousand plans for sightseeing, a correct estimate is given of the social leanings of the nursing profession.

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# THE GOAL OF NURSING EDUCATION

## ACCOMPLISHING THE IDEAL

*(Wednesday Afternoon Session)*

THIS meeting, which was presided over by Miss Annie W. Goodrich, handled the subject of nursing education from the viewpoint of the lay public.

Miss Carol L. Martin, executive secretary of the Central Council of Nursing Education, summarized the successful publicity work which had been carried out during the past two years.

In a paper by Miss Carolyn E. Gray on "The Ideals of the Nursing Profession for Schools of Nursing" (read by Miss Adda Eldredge), the unfortunate isolation of nursing schools was emphasized. Miss Gray urged that endowments and public funds be made available to secure adequate educational facilities for nursing education.

As Miss Noyes emphasized in her concise talk, until recent years the public has failed to look upon nursing as an educational field.

"The significance of a college degree," said Miss Noyes, "is readily understood by the intelligent public, but people have not as yet become accustomed to thinking in terms of nursing education. Consequently, there is a lack of respect on the part of the public for the work of our nurse training schools.

"A great part of our work therefore has been directed not only to recruiting for the profession, but to the study of the various schools of nursing and the training they offer, in the hope that we may finally bring the public to insist upon proper nurse education and to contribute adequately to its support."

### The Function of Research

In introducing Dr. Richard Olding Beard, champion of university schools of nursing, Miss Goodrich took the opportunity to emphasize the contributions of university training by quoting Field of Toronto: "Research workers are the constructors of the world. The results of their work are effective after they are dead."

Dr. Beard showed most clearly that public support could only come as a corollary to public understanding. Education in nursing, as in all professions, gives the individual an opportunity for self-expression. Dr. Welch of Johns Hopkins is the authority for the statement that a nurse cannot be overeducated.

"We hear frequent complaints even from medical men of the over-educated nurse," said Dr. Beard. "Did you ever hear of an over-educated physician? Yet, had she all the education of the most finely trained doctor the equally well-trained nurse could not be too educated, too wise or too good.

"In fact," he continued, "the faults of the nursing profession today are due to the lack of breadth, the half-developed mind, the unemancipated souls of the under-educated women to be found in its ranks."

### Opportunity Great

"The gates of opportunity have been flung wide to the nurse in recent days," he said, "by time, occasion and the new stirring of public consciousness in regard to health needs. The great war wakened the American people to our physical deterioration. We needed the iron test of human quality and we got it. We saw fitness pitted against force and the result of our observations has operated in a multiplication of health activities in which the nurse stands forth as major agent."

In building up nursing we must not pull down the hospital, Dr. Beard commented. But nursing education must be considered for its own sake. The university school with practice work in the major hospitals presents the field for complete, thorough education. In the hospital school (unless extended specialization is possible through affiliation) the three-year course is too long. Two years and four months give the student sufficient education if needless repetition is eliminated. Through centralization and affiliation with universities all schools could be brought up to an adequate collegiate standard. If the unfit schools are unable to obtain pupils (and that is the natural consequence) let them be starved out.

"Aspirants to the nursing profession have learned the imperative need of professional preparation for a career in which service is the motto and to which fitness is the open sesame. My faith in you not only as nurses, but as women, is so great that I believe you will no longer submit to the pseudo training of the subnurse.

"The educational future of your profession is in your own hands and will be determined not by doctors, hospitals or schools, but by your own great nursing organizations."

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Miss Anna C. Jammé (California), retiring president of the National League of Nursing Education

Miss Laura R. Logan, principal of nurses at the University of Cincinnati, and the newly elected president of the League

# POINTS ON NURSING EDUCATION

THE teaching and school administrative problems discussed at the meetings of the League offered countless new viewpoints.

The first attack upon the present inadequate curriculum came from Miss Holmes of Minnesota when she discussed the need for special theoretical and practical training in tuberculosis nursing. Though her address was given before the special public health section on tuberculosis her remarks were applicable to the educational field.

### Curriculum Additions

Answers received from a comprehensive questionnaire which she had sent to state boards indicated that few schools in the whole country gave any specialized practical work in this subject despite the fact that 400 individuals die each day of tuberculosis. She urged that principals of nursing schools supply this deficiency in the education of their pupils by securing a few months' affiliation with up-to-date sanitariums. Private duty and public health nurses were urged to supplement their own inadequate preparation by taking special practical work at sanitariums or clinics during slack seasons.

The usual curriculum was again scored, in sessions chairmaned by Miss Elnora Thomson and Miss Alma C. Haupt, for the lack of emphasis upon psychiatric training and the mental aspects involved in bedside nursing and the larger field of public health.

### Administrative Problems

In the paper prepared by Miss Elizabeth Burgess, Department of Education, Albany, on "The Problems in Classifying Nursing Schools," it was shown how difficult were the questions involved in estimating the educational value of a school.

The paper by Miss Ada Belle McCleery on "What Nursing Education Costs," outlined a very careful study which she had made in the Evanston Hospital (126 beds) to allot the distribution of costs to the various services and arrive at an estimate of the exact cost of education. Such a survey must record, (1) details as to the exact cost for food, room, linen, etc., needed per pupil nurse; (2) details as to cost of teachers' salaries or an estimate of the equivalent of gratis lectures; (3) details as to the cost of the teaching equipment. These totals must be evaluated with the replacement cost for nursing service if supplied by graduate specials. The result will show the educational costs.

Miss Sally Johnson gave the experience of the Massachusetts General Hospital in the

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training and use of attendants to supplement the work of graduate and pupil nurses. She expressed the opinion that the experiment had been partially successful but would have to be verified by further trials.

One of the most active sessions of the convention evolved around the subject of "Faculty Conferences" as presented at a round table conducted by Miss Margaret Dunlop, president of the Pennsylvania State Nurses' Association.

### Faculty Conferences

The discussion was brought to a head by the paper of Elizabeth F. Miller of Philadelphia. She outlined the type of subjects which could be threshed out at such meetings. As the discussion developed it was evident that the previous methods of administration which at times made the supervisor of nurses an administrative and disciplinary autocrat in her domain was fast giving place to cooperative work. As an exponent of the newer spirit, Miss Alice Gilman, superintendent of Troy Hospital, Troy, New York, gave many clear talks on the working out of the plan in her hospital. In Troy conferences are held with pupils, head nurses and administrative heads present. In this way the faults in administration are shown up. Cause and result are brought together. Miss Gilman also has conferences of chief administrators only to talk over the interworking of departments. In head nurse conferences, the administrative ideas of head nurses are developed and utilized. Miss Gilman considers the position of the head nurse in its educational light—an opportunity for developing initiative—and her conferences aim to make the head nurse a factor in the teaching force as a step in her own future development. Head nurses must be trained for administrative and teaching positions by their growth in developing hospital work.

Miss Allison conceived the conference as a mechanism for pooling professional resources and experience to be used in realizing the common interest.

Some superintendents used actual mistakes made in the wards to illustrate faulty coordination. Others felt that the individuals so criticised would become supersensitive and fail to react in a cooperative manner.

Many superintendents had conferences of instructors and head nurses to check up the correlation of work. In this instance demonstrations are given to heads of wards so that they can check up the practice of the student.

Conferences of pupil nurses tend to bring out points upon which individual students need help.

Conferences with physicians acting as instructors as extensions of ward clinics will also insure that the body of knowledge which the student is assimilating will be tied up with its application in the care of the patient.

Miss Mary C. Wheeler, superintendent of the Illinois Training School, Chicago, who was re-elected to the League directorate.

Miss Mary C. Wheeler, superintendent of the Illinois Training School, Chicago, spoke of the mechanical aids to successful conferences. She advised that conferences be held at stated times as announced in advance. As conducted at the Illinois Hospital, conferences of different groups of personnel meet separately. One group comprises the superintendent of the nurses' home, the night supervisor and the day supervisor. Another group, comprising the ward supervisors, is held bimonthly in two groups. Other conferences are held with dietetians, head of operating room, etc., and heads of theoretical department to bring up theoretical questions before the supervisors and heads of nurses. Such conferences produce dignity and tone on the ward since the instructors know that the

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technique taught will be backed by head nurses. Miss Wheeler also advised that written record be made of all points covered for future reference. This is especially essential in providing that the demonstrations presented to the head nurses coincide with the technique given the pupils.

The superintendent of nurses also meets with the medical staff, a privilege which is likewise extended to a representative of the graduate school.

Student nurse conferences are held separately, usually at the nurses' home, where points are discussed which may be referred by the student government committee. Two members of the Alumnae Association of this hospital represent the school on the hospital board. This privilege was granted after the association had contributed substantially to the building of the nurses' home.

### Conferences in Public's Health

Miss O'Hara, superintendent of public health nurses in Pennsylvania, gave this clear point on the use of conferences in the health field: "I make it a rule to thresh out and give a solution of every problem discussed. Never leave a subject in a 'do-the-best-you-can' state. Find the answer at the meeting or send it by mail." When the Pennsylvania conferences were first instituted, groups were brought together at seven different points. By the time the seventh conference was held the point of view differed greatly from the first. Now all field directors meet at one conference, the subjects for discussion are announced in advance and all carry away the same impression.

Miss McLaughlin (U. S. Navy) felt that sensitiveness among individuals in conference would be obviated if justice were the basis of all criticism. The possession of knowledge brings with it the obligation to pass it on. Staff meetings provide excellent opportunities for the interchange of ideas.

When the topics for conference were being talked over it was evident that many superintendents began with a discussion of concrete points and used these facts to develop sane principles of administration.

The time of holding conferences ranged from 9 A. M. to evening meetings encroaching upon the off-time of executives and students, depending upon conditions in the individual hospitals.

### Student Government

Under the chairmanship of Miss Mary A. Deaver a comprehensive paper was read showing the value of student government, as developed at Christ Hospital, Cincinnati, in bringing out initiative, correlating extra-curriculum activities, establishing voluntary discipline, and in helping students to appreciate and utilize the elements of social or cooperative control.

Miss Ethel Johns, of Vancouver, B. C., addressing a special session on administration of schools of nursing, described the division of labor in force at the Vancouver General Hospital since last November. Here the supervision of instruction is handled by one executive and the administration of nursing service by another. Two distinct functions are therefore being carried out by two heads. It is believed that this system insures a more consecutive education for the nurse without disturbing the real function of the hospital in nursing patients.

"The challenge of the Rockfeller report is no greater than the call of human need," continued Miss Johns. We stand in a transitional period when the service of the hospital and the education of the nurse must both be maintained. The educational program must be kept before the attention of the training school committee at all times. "It is a wise move," Miss Johns advised, "to put the kickers on the board where they can see actual conditions." The ideal board should consist of a public-spirited citizen, the superintendent of nurses and a member of the board. With this committee, the purpose of the school can then be accomplished.

We are now groping toward a possible solution of the problem. The future will bring the liberation which the younger nurses seek with impatience. "After me cometh a builder. Tell him, I, too, have known."*

### New Officers

Miss Laura Logan, of Cincinnati, was elected president of the National League of Nursing Education. Other officers include: First vice-president, Carrie M. Hall, Boston, Mass.; second vice-president, Amy M. Hilliard, Troy, N. Y.; secretary, Martha M. Russell, Boulder, Colo.; treasurer, Bena M. Henderson, Chicago, Ill. Directors for two years: Anna C. Jamme, San Francisco, Annie W. Goodrich, New York, Mary C. Wheeler, Chicago, Elnora Thomson, Portland, Ore.

* A further report of the League sessions will cover points for instructors.

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# THE CHILD AND PUBLIC HEALTH

## THE GROWTH OF THE NORMAL CHILD

*(Tuesday Afternoon Session)*

THE address of Dr. William Palmer Lucas on "The Normal Development of the Child," the most purely instructive talk delivered at the convention, opened the Tuesday afternoon joint session, which was presided over by Miss Elizabeth Fox, president of the National Organization of Public Health Nursing.

With the skill of the physicist and psychologist rolled into one Dr. Lucas traced the normal development of the child in the formative years when the senses are so active in acquiring information and the nervous system so pliant in registration.

Conceiving the child as born with hereditary traits, reflex nerve actions (as the reaction of the pupil to light), automatic nerve actions (as the heart beat), instincts and innate abilities, Dr. Lucas showed that unlearned tendencies are inhibited, modified or developed by the stimuli furnished from outside.

In directing energy in a productive way the teacher and the school nurse have the opportunity to convert this inheritance into channels of right thinking, right living and wholesome habit formation. Conceiving the whole nervous organism of the child as a group of neurons acting in a chain at each stimulation, the wise educator finds it necessary to give this action outlet in a channel which produces pleasure. This mechanism is at the root of all wise direction. The don'ts of life, its inhibitions, thwart the natural nerve action and result in the unsocial expression of displeasure, or abnormal conversion.

To manage the child of six or under, reactions must be produced by the crude stimulations of light, color, etc., and the proper action must receive immediate reward to produce the feeling of satisfaction.

Emotions in children must be controlled, not suppressed. Anger in very young children must be drawn off by outside diversion; as the child grows older this emotion can gradually be brought under his own inner control.

Known reactions of childhood are more pliant at certain ages. Between one and three imitation predominates, and during these years the nurse's own movements, actions and habits mark definite health lessons upon the consciousness of the child. Between the ages of three and seven imagination holds sway. Sometimes the child cannot distinguish between the images of memory (fact) and those of imagination. To develop the child's power of discrimination he should practice telling "real" and "make-believe" stories.

### Child Psychology

We must not from our adult pedestal judge the child's mind or his reasoning by adult standards. Fear may be aroused by sense impressions that are negative to the discriminating adult. As psychologists have shown, the growth of the individual parallels the history of the race and those primitive superstitions and fears which are found among less civilized peoples find their prototype in the normal child.

Since the mind of the child is extremely sensitive to concrete imagery, dramatization may be used to bring home important health lessons. This may prove harmful, however, if it produces overstimulation.

In this plastic inheritance of the child

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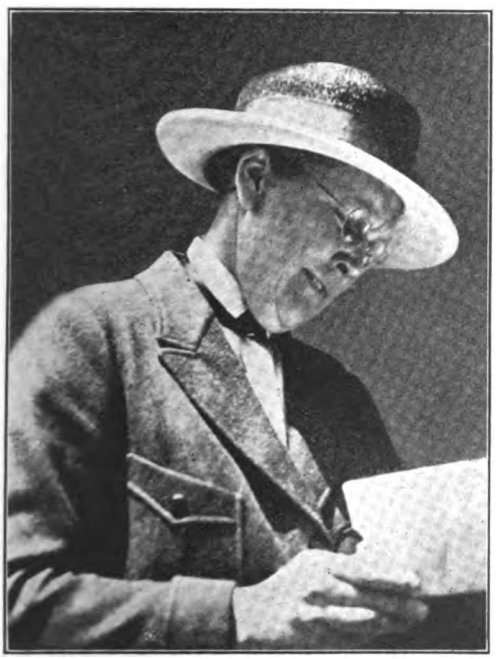
the sensory motor stimuli produce a more permanent result than the sensory imaginative—our reason for the use of drill. Just as memory is most acute between 10 and 12, this plasticity of the motor impulses is greatest from 30 months to



Dr. Carolyn Hedger, nutrition specialist at the Elizabeth McCormick Foundation, Chicago

nine years—the period during which good health habits must be formed.

In conclusion, Dr. Lucas summarized the bearing of psychology upon health teaching in the following laws on habit formation:

1. Reward good impulses immediately to secure repetition.

2. Since first impressions produce the strongest permanent record, exercise care in having the correct impression appear first in point of time.

3. Never permit exceptions to occur.

4. Follow each health lesson with a motor impulse to strengthen the habit you wish to inculcate.

# POSITIVE HEALTH!

## STANDARDS FOR EFFICIENCY, REPRODUCTION AND MENTAL GROWTH

As a sample of positive health Dr. Carolyn Hedger, nutrition specialist at the Elizabeth McCormick Foundation, Chicago, did not need labelling. Every movement she made, every spontaneous chuckle she drew from her responsive audience were indicative of her physical exuberance and mental vigor. "We must leave germs behind and build positive health," she challenged, as she turned her whole health battery upon nurses and nursing conditions—"positive health—that efficiency and balance which makes work and play worthwhile."

### The Economic Aspect

Poor health is an economic waste—years of profitable work and hard cash have been lost to the profession in the past because of negative health conditions. To be fit and to remain fit a nurse must possess this positive asset.

Moreover, as a salesman of health, a public health nurse must be able to give parents a positive conception of her wares.

The height-weight relationship is only a talking start. Positive health should embrace a regimen of life which permits normal body chemistry and produces the normal human being.

"Take nursing schools, for example," continued Dr. Hedger. "From a purely commercial standpoint positive health pays." Over-taxing the system of the nurse by night duty, weakening her by improper food—is this a sample of a democratic institution? The "I-can-bear-it" attitude must be replaced by positive health. Often, monotonous diets and meals lacking the known food essential are served to student nurses. They

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need foods containing vitamin C to give them hearty appetites. Good food in the hospital schools will aid in recruiting nurses and in inducing them to complete their training.

### The Reproductive Life

Above all, Dr. Hedger pointed out, women must maintain a standard for reproductive life. While they have been "making good" intellectually (and the action of certain universities has shown that women are outstripping their brothers), they have lost sight of their big job. "We must conserve our nurses for parenthood if they are fit for it. Of all women, the nurse is most admirably prepared for this work, and yet I am sorry to say (and Dr. Hedger was in earnest) that the women of my class in thirteen years have produced exactly seven-tenths of a child apiece. If we wish to put into America the ideals of freedom and justice (the heritage of the Norse) we must maintain our ratio with the fertile races of the Mediterranean."

### Sufficient Sleep

We should plan the regimen of the pupil nurse that she may experience normal, painless menstruation. We must make a woman first then educate her. It is not the material stored in the attic but the solid foundation that makes the enduring structure. The nurse must have the foundation of right living to "put her ideas across."

Regular and sufficient sleep are necessary for this proper foundation. Edison may steam away on his four hours per day but he is as deaf as a post. "Others have to maintain standards of nervous control toward all the distracting outside world of sound while he thinks undisturbed in his citadel," commented Dr. Hedger dryly.

At this point in her speech she introduced the seventh inning by a quick demonstration on posture. The whole audience relaxed and then straightened at the following commands:

1. Stand with weight resting on the balls of your feet.
2. Loosen the muscles at the shoulders.
3. Pull up your breast bone (boss it). [Now do you feel the pole at your back?]
4. Pull in your chin.

### The Importance of Posture

Dr. Hedger considers improper posture at the root of many cases of debility. She mentioned that roentgenograms indicate that the viscera of certain nervous patients have prolapsed. As children imitate the nurse in every conscious action, her posture must give them perfect poise.

Finally, the nurse must strive for a standard of reserve vigor. Too many workers are living on the ragged edge of endurance. The phrase "pulled through," which closes each day in Mark Twain's "Diary of Adam," is too near the truth under our present living conditions. The nurse must call upon this reserve "to do something for her government," Dr. Hedger continued.

### The Mental Life

In the last analysis the nurse must have enough vitality left after the day's physical work to grow a soul. Life is the fulfillment of the highest possibilities of the individual—the appreciation of art, music. The nurse must pursue an avocation—some interest outside of her work, something to utilize her hands.

"I have taken up music at the age of 52," Dr. Hedger added with a wry smile. "Avocations may be begun at any age."

"As nurses, we touch and are responsible for the ends of the earth. Only by proper living and proper eating can we bring this positive health to our world."

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# THE PROGRAM OF THE RED CROSS

## REPORTS FROM THE ARMY, NAVY, PUBLIC HEALTH AND VETERANS' BUREAU

(*Friday Evening Session*)

AS the reserve of the army,* Navy and the United States Public Health Service with a membership of 39,000 nurses, as the motive force behind 6,000 health workers in the United States and abroad, and as the amalgamating organization for 5,000 nurses engaged in Federal service, the Red Cross is very closely allied to the American Nurses' Association. It was fitting, therefore, that the final joint session of the convention be devoted to this national and international service.

A bit of the overseas spirit crept into the gathering as "Over There," "Tipperary," "Ki-ki-ki-katy" and other tunes, made sacred by firelight and silent memories, filled the church.

In her opening speech Miss Noyes kept her audience on foreign soil by tracing the growth of European nursing education under the stimulus of the Red Cross. Concrete gains, she pointed out, were evidenced in the public health course in London and the new two-year courses for nurses at Warsaw (through the generosity of Miss Hughes), at Prague, Posen, Constantinople, etc. The teachers in these schools have now organized a European League of Nursing Education. Twenty nurses, Miss Noyes reported, have already graduated in Poland. During the past two years thirteen nurses have been supported in schools; others have been maintained by scholarships. In the field of public health the Red Cross has given substantial administrative and monetary service. At the signing of the Armistice, eight nurses were engaged in this work; at present over 1,200 workers are in the field.

Miss Elizabeth Fox, director of the public health service of the American Red Cross, then gave the audience a true picture of the rural nursing service by reading breezy excerpts from the letters of field workers.

A concrete report of the scope of the home nursing courses was given by

Miss Olive A. Chapman, director of the Southwestern Division of The American Red Cross Nursing Service, and retiring secretary of the National Organization of Public Health Nursing.

Miss Grace Harrington, assistant director, Pacific Coast Division. During 1920, the course of fifteen lectures * was given to 117,890 young women and mothers. In the following year

* The 505 graduates of the Army School of Nursing are planning to join the American Nurses' Association in a body.

* Miss Delano's book is used as a text.

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65,610 individuals attended the course. The lectures, Miss Harrington explained, are received with special enthusiasm by rural mothers. The whole program of home and public health nursing has been emphasized to the lay public by the movie film of Mrs. Helpless.

The next report by Miss Lucy Minnegerode traced the work of the U. S. Public Health Service in caring for disabled soldiers from March, 1919 (when only 500 nurses were necessary for the work), until the nursing was delegated to the Veterans' Bureau in May, 1922. In the near future the Public Health Service plans to specialize in research work. At the conclusion of her address Miss Minnegerode read a communication from Mrs. Hickey, superintendent of nurses of the Veterans' Bureau, in which the continued support of the Red Cross was solicited for the work of the organization.

### Compensation

The following ruling covering the terms of compensation for Army and Navy nurses serving in the World War is of special importance:

"Any member of the armed forces who enlisted from April 6th, 1917, to February 9th, 1922, may file a claim for compensation within five years from the date of his or her discharge from the service. After February 9th, 1922, no claim can be filed against the Veterans' Bureau for compensation on account of disability or death in the service for any member of the armed forces who may have enlisted after that date who has not secured a certificate of injury prior to August 9th, 1922, unless there is evidence on file to show that claimant had a disability occurring within one year of separation from the service."

A communication from Major Julia Stimson, superintendent of nurses, Army Nurse Corps, followed. This report detailed the administrative and monetary gains which have resulted from the passing of the Army Bill. A letter from Mrs. Lena S. Higbee, superintendent of nurses, U. S. Navy Nurse Corps, gave the biennial report of the corps. It was urged that nurses lend their support in putting through a bill which would give Navy nurses rank. The meeting closed with Miss Minnegerode's report on the Delano Memorial.

Miss Lucy Minnegerode, superintendent of nurses, United States Public Health Service. Miss Minnegerode is chairman of the Delano Memorial Fund Committee.

## PROMOTING INDUSTRIAL HEALTH

The American Institute of Safety has again emphasized the breadth of its constructive publicity work by the appointment of Dr. C.-E. A. Winslow, of Yale University, as health supervisor.

Dr. Winslow's pre-eminence as a health teacher is well recognized by nurses who have known his guidance in the development of public health nursing and his most recent service as chairman of the Committee on Nursing Education. Professor Winslow's interest in industrial hygiene dates from the pioneer course in that subject which he gave at the Massachusetts Institute of Technology in 1908. Since then he has devoted a large part of his time to teaching and to research in this field.

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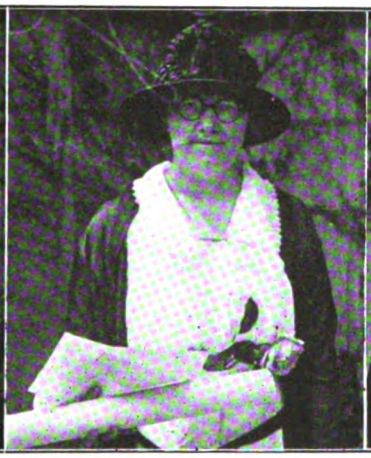
Miss Harriet L. Leete, field director of the American Child Hygiene Association, and newly elected vice-president of the National Organization for Public Health Nursing



Miss Ann Doyle, supervising nurse, Division of Venereal Diseases, U. S. Public Health Service, a newly elected director of the National Organization for Public Health Nursing

Miss Jane B. Allen, Oregon state director of the Bureau of Public Health Nursing, also a newly elected director of the N. O. P. H. N.

# POINTS FOR HEALTH WORKERS

IN stressing the inroads of tuberculosis, Dr. David A. Stewart, superintendent of Ninette Sanitarium, Manitoba, pointed out the constant menace of tuberculosis in these words: "War observes armistice, truce, cessation; tuberculosis never halts." One cause of tuberculosis is the germ (as found in bovine tuberculosis from cattle and the soil, and the excretions of tuberculosis patients), but the greatest cause of the incidence of tuberculosis is found in poor husbandry—poor housing, poor food, lack of sleep, overwork and all the other debilitating influences which result in health bankruptcy—the open portal.

The cure is found not in chasing climate, not in gulping medicines, but in a mode of life. The nurse and physician must teach the patient how to build up resistive power by proper rest for body and mind plus properly correlated exercise.

## Tuberculosis Nursing

The first practical point discussed at the special tuberculosis section of the National Organization of Public Health Nursing, covered the routine which is being worked out in Los Angeles for the examination, treatment and follow-up work of tuberculous patients as outlined by Miss Agnes G. Talcott.

Miss Holmes, of Minnesota, urged that nurses in training receive practical experience in bedside and convalescent tuberculosis nursing and that all public health workers receive practical specialized training in bedside, clinic and follow-up work in order that they may produce results. She advised that practical questions in tuberculosis nursing be introduced on state board examinations so that training schools will be compelled to give real nursing experience in this subject. She showed, by quoting available statistics, that nurses undertaking this work were not in personal danger of infection. In conclusion, she urged that tuberculosis standards be kept high so that the best nurses will be drawn to this work.

Miss Anna M. Drake gave a review of the points applicable to the field of nursing which were developed at the National Tuberculosis Association Convention, May 4-6, 1922. From the administrative standpoint she discussed the organization of county demonstration clinics which may be accomplished in about a week's time. Thorough publicity must be secured by advance notices. The physicians' cooperation will aid in ferreting out cases needing a home survey; the school nurse can also round up cases for examination. Hospital superintendents will usually supply student nurses in exchange for the clinical knowledge which the pupils can receive when carrying out such work. Follow-up work through organized channels must be supple-

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mented by careful re-examination at intervals.

The general diagnostic clinic, which is a necessary correlation to the work of the nurse, must take complete case histories as a basis for work. Its success will depend upon the presence of a social bureau and the utilization of community resources.

Of course, the framer of any program must have a full conception of the ends to be accomplished. Usually the program is worked out territorially to fit in with the existing health schemes of the community. The work must be demonstrated by a nurse. For intensive work a nurse who has specialized in tuberculosis work is preferable; at least the nurse must have the public health aspect toward her work. In Rochester the work is carried out by general nurses, who have received a short course in special tuberculosis work. For clinic and sanitarium work longer and more thorough special courses are necessary.

In the intensive work the physician uses every diagnostic means available. When the diagnosis has been established, the patient should be told his real condition and given minute directions for treatment. Physicians then cooperate with nurses in constant oversight.

The functions of the nurse were outlined as follows: (1) Locating the patient; (2) taking the history and supplementing this knowledge with a survey of home conditions; (3) utilizing all the health and social resources of the community and the family to secure favorable environment and treatment; (4) following up all work with great care.

### Venereal Disease Control

Under the chairmanship of Miss Ann Doyle of the United States Public Health Service, the work of the nurse in venereal disease control was very carefully considered. Assistant Surgeon General C. C. Pierce emphasized the present alarming situation of the prevalence of gonorrhea and syphilis by citing the figures which compulsory Army enlistment had revealed. He outlined the details of the government campaign now in motion to assume supervisory control.

An address by David Robinson, assistant director of educational work in the division, gave the "Legal Measures Necessary and in Force in the Prevention of Venereal Disease." As prostitution represents a very potent force in the spread of venereal disease, he first discussed the laws governing commercialized vice. As social workers have learned to their sorrow, the scope of enforcement of the laws of prostitution depends upon the force of public opinion. Property laws of abatement, fines and forfeitures imposed upon drivers of automobiles engaged in white slave traffic, dance hall, hotel, rooming-house and amusement park regulations now exist on the statute books. The nurse must be the active agency in the home and in the community to create the force of public opinion which will make the prosecuting attorney utilize the laws available.

Control and prevention will be accomplished through the state law requiring examination of both parties before marriage, which, if it does not prevent in all cases the marriage of infected parties, does tend to secure treatment; through laws requiring the examination of food handlers, nurse maids, barbers; through the law now enforced in 45 states requiring the treatment of the eyes of all children at birth to prevent blindness; through laws forbidding the sale of quack nostrums; through laws requiring the report by the physician of the name (or the number, until the patient refuses treatment though not cured) of all patients infected with venereal disease; through the law, now existing, which requires a report on all patients so infected which move from one state to another, etc.

The uniform quality of the specifics now in use is assured through their preparation by the U. S. Public Health Service under conditions requiring most rigid inspection.

As Dr. William F. Snow pointed out, the Committee of Mental Hygiene is cooperating with all agencies to spread the gospel throughout the country. To be effectual, information must be disseminated to the *individual* and treatment instituted for the *individual*. Here is the field of the public health nurse.

Before the nurse entered the field of tuberculosis nursing, the good work of the physician was unproductive because the patient was not constantly guided in carrying out the treatment. Again the nurse must be called upon to handle the venereal situation from underneath by creating a force of public opinion through educators, through the clergy and through parents to secure informed action in the protection of marriage and the childrn ensuing from it.

Dr. Snow pointd out that men who could not be appealed to through fear of any consequence brought upon themselves were fair enough to believe in the conservation of natural

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resources and the right of succeeding generations to a square deal.

*When nurses equip themselves with the necessary technical knowledge,* they can carry this message into every home. Results will then be accomplished.

Public Health workers had another opportunity to look at health problems through Dr. Snow's eyes when he discussed "The Workers in the Field of Public Health and Their Relation to Each Other." Dr. Snow possesses that far-seeing impersonal viewpoint which looks upon the physician, the nurse, the dentist, the pharmacist, the teacher, the nutrition worker, the statistician, and the social worker in terms of "getting the job done quickly and well."

### The Interrelation of Public Health Workers

The nurse—and any other public health worker—does the public and herself an injustice, he said, when she attempts work for which she has not the requisite basic training. The nurse who assumes the functions of the social worker without having a knowledge of case work and of social adjustments is as false to her creed of getting the job done quickly as she would be in the assumption of any other basic work without adequate knowledge. On the other hand, since the work of the nurse touches the fields of sociology, nutrition and psychology, she must have a real understanding of the scope of each field to appreciate her limitations and be ready to call in these specialists. Discussion developed the viewpoint that adjustment must come in the future. Perhaps we may develop a super nurse who will have basic training in several of these allied health fields. For the present the gaps must be filled by specialized workers. This means careful cooperation in getting the job done.

Miss Amelia Feary of Tacoma stressed the value of a social service exchange in preventing the duplication of investigation work on cases. In Tacoma this organization (which is not connected with any acting agency) receives each day, on cards prepared for the purpose, the names of individuals or families who are being served by any organization in the city. Church workers, health workers, relief organizations all cooperate. As soon as the name of the individual or family is reported, the reporting agency is advised of any other agency or agencies interested in the individual or the family. The exchange follows up this information by a telephone call to see if the contact has been made. In small centers all records may wisely be kept at a central point. The exchange is financed by the general budget.

The discussion indicated that the community chest idea might lead to a pooling of social resources with decided benefit. It opens the possibility, through the common board of financial managers, of subsequent conferences on other related problems. Buffalo now has a central purchasing agency for all those benefited by the community chest. One disadvantage may be experienced: under the old scheme contributors became boosters for the special social service agencies they were backing; under the new scheme it may be necessary to develop some other means of stimulating interest and gaining personal support.

### Fighting Reactionists

A few side issues, discussed at this meeting are worth recording: (1) In commenting upon the milk campaign in schools Dr. Snow brought out the point that the use of milk in the schools (except for children whose parents were unable to supply it at home) was rather a means of emphasizing the need of regular and sufficient diet to children and parents than an actual necessity. Nurses must beware of overemphasis in any type of teaching lest the child acquire a distorted view of the whole nutrition problem.

(2) The nurse must fight the reactionist as represented by the teacher who ignores the findings of modern psychology, the physician who refuses to cooperate in bringing about social betterment, etc.

### Industrial Nursing

As Dr. Legee pointed out, in addressing industrial nurses, the present financial depression must not be permitted to lower the standard of health work in industry through the use of limited equipment or the employment of inadequately trained personnel.

The function of the nurse was defined as the personal health teacher in factory, clinic and home with special emphasis upon the preventive aspects of the work.

Two important points were brought out in discussion: (1) The importance of keeping complete industrial records in standard form and with standard nomenclature so that essential facts may be available for industrial statistics; (2) the need for demarcating the scope of the nurse's work under standing orders or first aid directions in those plants which do not employ a physician on full time.

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**Communicable Disease Technique**

Since this report cannot cover every point touched upon at the convention,† we have chosen the practical demonstration of the technique of the visiting nurse in the care of communicable diseases as a finale.

As carefully outlined by Miss Cecilie Evans of the Western Reserve University of Cleveland, the work of the visiting nurses in that city has proved that communicable diseases can be handled through district nursing without spreading infection if the nurse exercises due care in her technique. The very fact that the case has been diagnosed is a greater surety, since in visiting work the nurse often handles communicable cases before diagnosis is known —witness the cases of smallpox which a nurse may come upon in the ordinary line of duty. This possibility should show the nurse that *she must never relax her technique in any case handled.*

To make the technique of the visiting nurse effective, it must be reduced to the simplest terms which will produce sure results. The simple procedures used in Cleveland, as Miss Evans pointed out, have been demonstrated before a board of physicians and received their unqualified approval. The slogan of Miss Laura M. Grant of the Cleveland City Hospital should be the basis of work: "In surgery you take nothing unclean to the patient; in contagion you take nothing unclean from the patient."

Assistant Surgeon General Cobb is the coiner of the statement that preventive medicine is applied Christianity. The visiting nurse can express her gospel, Miss Evans pointed out, by holding kitchen classes with busy mothers and giving them the facts to guard their families against the contagious diseases which may attack the neighborhood.

With the caution that the nurse secure the correct location of the patient from the reporting physician, Miss Evans then dramatized a visit to a diphtheria case. On entering the sickroom she selects a wooden chair in the corner of the room away from the patient upon which to place her hat; her coat when folded with lining in is placed on the same chair. Her visiting nurse bag she places in the room at some distance from the patient. Her soap and paper towel are kept near the top of the bag.*

Her wrist watch is taken from her arm and placed in the uniform pocket; sleeves are fastened well above the elbows. The nurse then washes her hands and arms thoroughly, preferably in the bathroom. If the house lacks one, in the sink. She then takes the paper bag from her grip. For diphtheria cultures, this bag contains paper towels which are first spread on the table and upon which are placed the culture media (must be kept cool), the tongue depressor, swabs, another paper towel used to cover the hair (optional), pins, a large towel which is pinned on as an apron, a small square of paper which is adjusted with an elastic as a mask, and the envelop in which the culture is sent to the board of health with the accompanying identification card.

Before the nurse puts on her mask she establishes friendly relationship with the patient who must be placed in a good light to facilitate the work of the nurse. If the patient is a child it may be necessary to have the mother hold it firmly. This is most easily accomplished by having the child stand with its back to the mother with hands held by the mother and feet held between her thighs.

In taking the nose culture, Miss Evans explained, the swab must be passed straight back to avoid contaminating the swab with any other infection in the nasal passage. The nurse impregnates the swabs from the nose and throat in the same culture media, being careful not to break the surface by churning or stirring. The right-handed nurse holds the culture media tube between the thumb and first finger of the left hand with the plug for the tube so held between the second and third fingers that the portion which will be replaced in the interior of the tube does not come into contact with fingers or other substance. The nurse can remember to hold the tube by the upper or lower end, place it to one side on a paper towel and handle it by the other portion (after her hands have been cleansed) when putting it in the envelope.

If the patient coughs during the taking of one culture the nurse must wash her hands before taking the next.

When the cultures are taken the nurse places towels, tongue depressor, mask, extra swabs, etc. in the bag from which they were taken (without touching its exterior) then washes her hands. Subsequently she takes the culture tube by its untouched end, places it in the envelope and seals it. Her next duty is

† Reports of the sessions on school, rural and visiting nursing will appear in subsequent issues.

* Cleveland physicians have decided that brushes are not advisable. Ivory soap is generally used.

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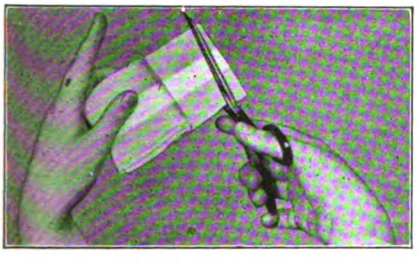
# J & J
# BAND-AID

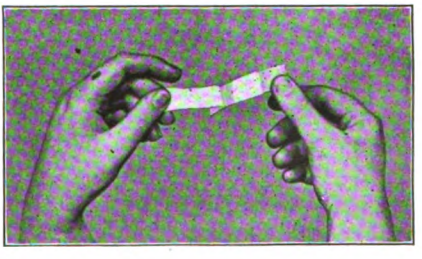
(A combination of gauze pad and "ZO" adhesive plaster)

## FOR BANDAGING CUTS

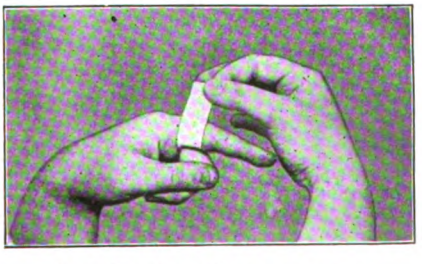
### Easily Applied—Have You Tried It?



Cut off piece you need



Remove protective covering



Apply to the wound

You can get **BAND-AID** from your druggist. Each piece is 3"x18"

*A sample will be sent on request.*

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to burn the refuse bag *herself,* don hat and coat and proceed to the next case.

In scarlet fever cases, Miss Evans explained, the bag used contains a long-sleeved gown of unbleached muslin which covers the nurse from head to foot, and plenty of newspapers. The usual washing of the hands may be supplemented by washing with 70% alcohol. The details of the code of handling the patient's dishes and bedclothes are explained to the mother by demonstration. The nurse, herself, goes to the kitchen, gets a pan which the mother is told to set aside for this purpose, puts the dishes (taken directly from the patient) in it, covers them with cold water, sets the pan on the fire and shows the mother (by waiting until the water boils, if necessary) that she must boil them thoroughly *before* she touches them to wash them. The same demonstration is carried out with the wash boiler, underclothes and bed linen.

After the nurse has finished caring for the patient she takes off her gown, folding it with infected side in, places it on paper and (after washing her hands) wraps it in paper. If the nurse arrives in time she can show the mother how to cover the top of blankets or spreads with the sheet.

Comforters, blankets and pillows are disinfected by sunshine and air. In Cleveland the nurse's thermometer is carried in soap or alchohol or cleansed after it is used with a cotton pledget and alchohol or with soap.

In Cleveland fumigation is not used after quarantine is lifted but furniture is sunned and walls, furniture, floor and windows are washed with green soap.

In handling cases of pneumonia each case must be considered as a separate infection since one type may be imposed upon another type or upon cases of influenza.

Good practice demands that nurses and physicians be examined at least once a week to detect carriers.

## NEW OFFICERS OF THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

The final Saturday sessions of the convention were devoted to the announcement of the results of the election and the reading of resolutions.

Miss Elizabeth G. Fox, Washington, D. C., was elected to succeed herself as president of the National Organization for Public Health Nursing. Other officers elected are:

First vice-president, Miss Janet Giester; second vice-president, Miss Harriet Leete, Washington, D. C. Nurse member directors, to serve two years: Jane Allen, Ella P. Crandall, Anna Drake and Anne H. Strong; to serve four years: Ann Doyle, Cecelia Evans, Elnora Thomson and Katherine Tucker.

Sustaining member directors to serve two years: Mrs. John Blodgett, Mrs. Chester C. Bolton, Miss Mabel Choate and Mrs. Robert G. Dieck; to serve four years: Miss Julia George, Mrs. William Henry Lee, Miss Gertrude Peabody and Mr. A. M. White.

Nominating committee for 1924: Mary L. Cole, Margaret Stack and Helena Stewart.

## NEW A. N. A. OFFICERS

Miss Adda Eldredge, newly elected president of the American Nurses' Association

Miss Adda Eldredge, of Madison, Wis., was elected president of the American Nurses' Association. Other newly-elected officers include: First vice-president, Miss Elnora Thomson, Portland, Ore.; second vice-president, Mrs. C. V. Twiss of New York; secretary, Miss Agnes G. Deans, St. Louis, Mo.; treasurer, Miss V. Lota Lorimer, Cleveland, O.; directors, Sarah E. Sly, Birmingham, Mich., Clara D. Noyes, Washington, D. C., and Katherine de Witt, Rochester, N. Y.

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# *"There is No Art to Read the Mind's Construction in the Face."* —Shakespeare

FOR the same reason it is quite impossible to gauge the potentialities for harm in a few cups of coffee.

Sometimes they do—and sometimes they don't—manifest their full capacity for serious forms of physiological mischief.

A patient doesn't know—and perhaps a doctor cannot tell—except by testing the matter clinically—whether it's coffee, or something else, that is causing tachycardia, nervous irritability, insomnia, indigestion or headaches.

There's one way to find out, however—stop the coffee for a week, and have him drink Instant Postum instead.

Postum is an absolutely pure cereal beverage. It is scientifically prepared in a modern, sanitary plant, and serves every purpose of a hot meal-time drink.

With thousands of people, Postum is as satisfying in flavor as the average coffee—undoubtedly one of the reasons for its increasing popularity.

Doctor, why not suggest Instant Postum to your next neurasthenic, and see if it does not help your general sedative and reconstructive treatment?

***Samples of Instant Postum*** for individual and clinical test will be sent to any physician who will write for them on his office stationery.

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# PROBLEMS IN PRIVATE DUTY

### Public Health Teachers

WHEN the private duty section met under the chairmanship of Miss M. Frances Ott, the director of the Seattle Community chorus was present. In a few moments the huge auditorium almost lost its roof with exuberance. That element of community singing which takes the individual out of himself and makes him a part of group thought and energy had produced such satisfactory returns that Miss Noyes hesitated to break into this overflow of spirits with her opening address. She seized the demonstration to interpret the newer, freer attitude which characterizes the development of all professions today. She tempered her viewpoint, however, with the caution that thinking in terms of nursing must always mean a higher, worthier standard than is demanded in commercial endeavors since each nurse must remain to all a personal example of the highest ideals of service.

On this basis, Miss Noyes urged that each private duty nurse consider her contact with patient and family as a concentrated bit of public health nursing—a wonderful opportunity to be a health teacher. No nurse who does hourly nursing, no nurse who makes occasional contacts in the home, at the clinic, or from the lecture platform has as great opportunities to teach true hygiene and right living as the private duty nurse. For this reason, the private duty nurse must be especially conscientious in collecting accurate health knowledge and equally conscientious in imparting it to patient and family in forceful terms.

Mrs. Jane Prevost's* paper on "Nursing Conditions in Maine" brought out the need of cooperation between graduates of different schools. As she pointed out, the recognition of the profession as a whole demands a subordination of the so-called "pride-of-school" after registration. Registered nurses from large and small hospitals must get together and serve the community "as a unit."

Such service requires a definite standard of work, definite rate charges in zoned localities and the placement of registered nurses, nongraduates and practical nurses under conditions and at rates which will insure adequate service to the community and equitable compensation for nurses.

### Cooperating to Serve the Public

In this connection Mrs. Prevost considered that part of the present difficulty was due to inadequate legislative control of all those nursing for hire. With compulsory registration physicians and the public would be appraised of the degree of skill which could be expected from registered nurses, nongraduates and nursing aides and work and compensation would be distributed accordingly. Mrs. Prevost feels that standard rates are necessary to prevent physicians from spoiling a nurse on a special case by advising additional compensation. In the future that nurse is apt to feel that she may continue to expect the higher rate and the trouble begins.

The good private duty nurse, as Mrs. Prevost appreciates, is developed only after adequate training and subsequent experience and she should receive real compensation for the service she is competent to render.

### Educators in Venereal Disease

The next address by Ann Doyle, of the United States Public Health Service, covered "The Obligation of the Private Duty Nurse as an Educator in Venereal Diseases." Miss Doyle stressed the interdependence of physician and nurse in putting over the program of preventive medicine. In its execution the nurse has been led up to that thin line which separates the functions of the physician and nurse. Under these new conditions the private duty nurse has a great responsibility in protecting the public against the spread of venereal disease. Miss Doyle cited the following hypothetical cases to indicate the scope of the nurse:

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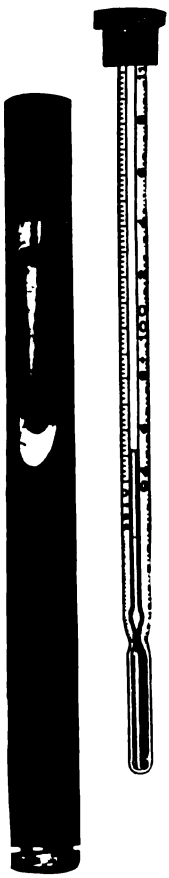

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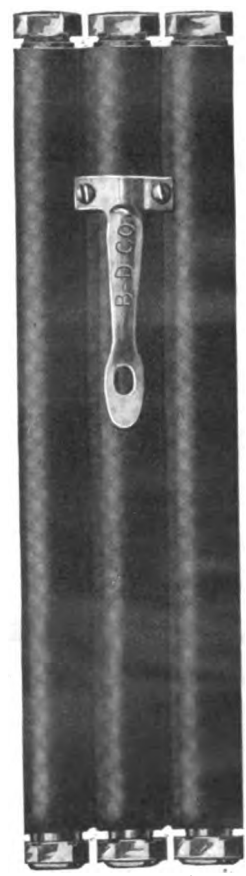


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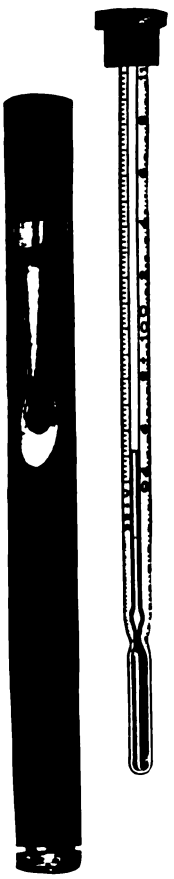

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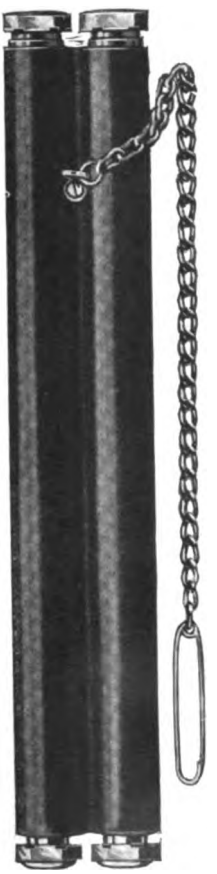

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Case I.—Imagine a nurse called upon an obstetrical case where the child is born with symptoms that strongly indicate syphilitic infection. What is the duty of the nurse if the physician in charge refuses to explain the situation to the family and does not advise proper prophylactic measures? The nurse is in duty bound to assume that health service for the protection of other members of the family, and to insure the proper care of the child.

Case II.—Imagine a nurse serving upon a case with a new physician in attendance. If she possesses knowledge of the previous mental or physical condition of the patient when she was handling the case under the direction of a previous physician—knowledge which she believes would aid the present physician in applying his full knowledge to the treatment of the patient—should she refer physician No. 2 to physician No. 1, or give the facts to the attending physician herself. Assistant Surgeon General Pierce believes that the nurse is in duty bound to reveal her information to the attending physician.

Case III.—If the nurse is managing the case of a father with symptoms that indicate syphilis, and familial syphilis is suspected, what is the duty of the nurse? She should endeavor to have the physician make a family survey with a view to detecting any communicable condition and bringing about the application of prophylactic measures.

The difficulty in initiating social action under certain circumstances makes it advisable that the nurse have recourse to a final court of appeal through the state or national public health organizations.

In going into this field the nurse must not confuse the moral and social issues. The patient is often infected innocently and the nurse must use infinite care in avoiding the infliction of social or industrial handicap upon the patient or his family through the divulgence of suspected or known conditions. The private duty nurse can function in the control of venereal disease as follows:

I.—Acquaint herself with the symptoms, mode of infection and treatment of syphilis and gonorrhea so that she may be prepared to discuss the condition with physicians or patients from the scientific standpoint and be prepared to pass on the directions of the physician as to hygienic and prophylactic measures.

II.—Learn the state laws governing the condition. (Copies of state laws may be secured by application to the Surgeon General.)

III.—Be conversant with the agencies of social hygiene.

IV.—Associate with and consult the *best* physicians in the community.

V.—Seek action on any known condition through medical channels if possible.

VI—Consider it a duty to divulge no information other than that which the safety of the patient or the public demands.

## Local Directories

The question of local directories was again discussed in the third paper by Miss Grace M. Cook, registrar, Indianapolis, Indiana.*

As organized in Indianapolis (and many other centers) the two nursing registries are under the direction of the district board though directly governed by a board of managers selected from the nurses comprising the private duty group in that vicinity.

As credentials the Indianapolis registries require a letter from a member in good standing in the district and the record of the nurse issued by the superintendent of her nursing school. Miss Cook believes that many of the commercial registries do not make a thorough survey of the nurse's records or make an attempt to send the properly equipped nurse to fill the requirements of the case. Miss Cook conceives the Central Registry as the headquarters for private duty nurses.

Here they should be notified of all lectures, of nurses' meetings and here helpful periodicals as well as the best books may be recommended.

The last paper of the private duty section on "Means of Counteracting the Prevailing Tendency to Commercialism" was read by Miss Minnie S. Hollingsworth in the absence of the author, Miss Annette Fisk, Waltham, Mass. Miss Fisk pointed out that we are experiencing in nursing today the same evolution which has overtaken religion. In our emphasis upon nursing technique we are losing the spirit of the work. Though the necessity of routine service is more evident in our present system of diagnosis, we must not overlook the healing adjustment of mind and soul. It is not enough to mend body tissue; the nurse must surround her patient with an atmosphere of sympathetic cheerfulness to secure results.

The present stress upon efficiency in hospital work—the strict observance of visiting hours under all conditions which at times results in the sacrifice of individual care to time routine—tends to lessen the personal emphasis in the minds of pupil nurses. These surroundings, Miss Fisk believes, leave their mark upon the mind and heart of the nurse and are, perhaps, responsible for the soulless, commercial spirit which characterizes the work of a few registered nurses.

When the meeting was thrown open for discussion the following live points were touched upon: (1) Miss Waterman, editor of the *Pacific Coast Nursing Journal*, urged that adequate public recognition of the different character of nursing furnished by registered nurses and nursing aides be brought about by compulsory state registration of all those nursing for hire (national registration if possible) and a real standardization of all

* Read by Miss McCastline.

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# KELLOGG'S BRAN

*cooked and krumbled*

## *is becoming a standard remedy*

Bran is steadily gaining in nation-wide importance as a natural relief from constipation! Physicians prescribe bran because it gives permanent results when the patient eats it regularly. Two tablespoonfuls a day will correct mild cases, but for chronic constipation or in old-age or bed-ridden cases, as much as two tablespoonfuls with each meal will be found effective.

Unlike ordinary bran, Kellogg's is really delicious. First, it is cooked, then slightly flavored and krumbled. The result is a highly palatable food that will appeal to the most fastidious taste.

Kellogg's Bran ranks high in food value; with milk, it is practically a complete diet. Its mineral salts content is 8.41 per cent.

Serve your patients Kellogg's Bran in numerous ways. It is most appetizing sprinkled over other hot or cold cereals, or eaten as a cereal. Recipes on each package suggest the many delightful bakery batches that can be made with bran. All grocers sell Kellogg's—be certain to get it!

*Kellogg's*
**BRAN MACAROONS**

1 cup flour
1 cup Kellogg's Bran
1 tablespoon butter or butter substitute
1 tablespoon sugar
¾ cup milk
2 teaspoons baking powder
1 egg
Pinch salt

Cream butter and sugar. Add milk, and egg well beaten; then the dry ingredients. Stir well together. Drop from a spoon on a buttered tin. Bake in oven about 10 minutes.

This will make three dozen.

**Kellogg's** *Look for this signature W. K. Kellogg*

**the original BRAN - *cooked and krumbled***

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schools of nursing. (2) Nurses were urged to use the appellation "trained registered nurse." The use of the term "graduate nurse" in the last census returns almost resulted in the classification of skilled nurses under the nomenclature adopted for the less completely trained group. (3) Private duty nurses were urged to make a greater effort in keeping abreast of each new scientific advance in the profession through lectures at hospitals, at Alumnae meetings, etc., and superintendents of nurses were urged to be more conscientious in informing the registered nurses of their locality of lectures and sources of information. The private duty nurses were scored heavily for their lack of interest as evidenced by their reluctance to attend lectures, etc.

At the successful round table of private duty nurses held Wednesday morning, the following stimulating papers were read: "Hourly Nursing," by Gertrude Leedy, Huntington, Indiana; "Lest We Forget," Mary Farley, Concord, N. H.; "A Word to Private Duty Nurses," Winnifred Boston, Cedar Rapids, Iowa. The sane philosophy passed on through these papers may be judged from a few quotations: "Enlarge your interests; go out into the world and make real friendships so that you can bring back a cheerful philosophy to your patients." "Eliminate non-essentials." "Profession means service. Be a human being first then be a nurse." "A nurse must never feel bored with life. We take out only that which we put in. The personal happiness which results from giving health is worth more than any other thing in life."

Nurses who are not in private duty work and outsiders who are prone to criticise this group for the tendency to specialize in certain directions, should make the effort to understand the nurses' point of view. The consensus of opinion showed that private duty nurses registered for certain types of cases because they found they could handle these cases most successfully. After all, we are what our experience has made us and the nurse who has been handling obstetric patients continuously is as little prepared to take a difficult case of mental adjustment as is the specialized hospital manager to instruct in biology. This question is easily adjusted, however, if nurse and registrar work together.

From the point of view of the registry the public receives better service under these conditions: (1) The nurse should report to the registry only when she is ready to go on a new case. Subsequently she must be prompt in answering calls. (2) The nurse should work *with* the registrar. If she endeavors to work with certain physicians only, the registrar finds her force in a non-mobile state and although plenty of nurses may be free, these nurses cannot be distributed to the advantage of the public service. In this connection it was pointed out that rural nurses might find more satisfying opportunities if they would enter their names on the town registers in the district and receive assignments by telephone.

One other paper delivered at the convention applied especially to the field of the private duty nurse. We use the word "especially" advisedly because almost every session of the convention, except those devoted exclusively to administration, brought out points that could be applied in this field. This brief address by Miss Elsie A. Kampf, Glockner Sanitarium, Clear Springs, Colorado, was read at the Wednesday afternoon session devoted to tuberculosis nursing under the chairmanship of Miss Anna M. Drake, Iowa. She stressed the obligation of the private duty nurse to wage an intensive health campaign in every home to which she is called. As the previous addresses at this session demonstrated, tubercle bacilli find permanent lodging only with those individuals whose systems are run down. Since the natural resistive power of each individual is lessened by lack of proper sanitation and cleanliness, fatigue, improper food, etc., the private duty nurse can be the protector of every family, teaching her health message tactfully but with force. In those instances where she is nursing a tuberculosis patient she can teach him the safeguards which he must use to protect his wife, his children and other members of the family from becoming infected.

The nurse should ever be on the lookout for possible sources of infection. She should be assured that the family's milk is obtained under conditions which insure proper testing, etc.

Finally, the nurse should be on the lookout for incipient cases as evidenced by fatigue, continual complaint of being "just run down," "always tired," having "no appetite," and by the presence of frequent colds.

The private duty nurse who is armed with invincible hopefulness will inspire it in her patient and secure results in curing tuberculosis.

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Minneapolis—21 Eighth Street, South
Missoula—Missoula Merc. Co.
Newark—897 Broad St. (opp. City Hall)
New Orleans—109 Baronne St. (Room 200)
New York—22 W. 39th Street
Omaha—1708 Howard Street
Peoria—Lehman Bldg. (Room 203)
Philadelphia—1300 Walnut Street
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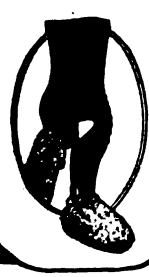

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# Editorially Speaking

### Avoiding Violent Reactions

One unobtrusive sentence tucked away in the conclusion of the Report of the Committee on Nursing Education bears careful analysis:

> Progress must be made gradually, of course, building up for the future, step by step, upon the basis of existing facilities.

When a report of such dynamic importance is presented to four or forty thousand individuals it produces four or forty thousand distinct reactions. The mention of the inadequate nursing education in some of the inspected schools, for example, produced a slight stiffening of the backbone. Why? For as many reasons as there were individual listeners. Perhaps some accepted this statement as an arraignment of their own professional fitness; others recalled, perhaps, a "superior" attitude assumed by graduates of certain schools; still others visualized their struggles to bring up small schools in the face of great financial handicaps.

The statement that "the numerical proportion of the nursing profession to be contributed by University schools will always remain relatively small" brought another stiffening of spines. Why? Many realized that for the present, at least, funds would not be available to graduate 10,000 women from University schools of nursing each year. However, having experienced the value and inspiration derived from University work, they felt baffled and disappointed that actual accomplishment fell short of the visualized ideal.

Another section in the conference felt aggrieved not at the wording of the report, but at the expressed reactions of individuals. They resented, perhaps, the implication that the issuance of the report would mean the cessation of the poor schools. In this instance, again, they were coloring generalities with personal paint. Had they analyzed only a step further they would have realized that such statements carried no animosity toward the smaller hospitals. The almost superhuman difficulties experienced in giving patients adequate care, giving nurses. Many nurses could not help realizing, however, the greater service which the carefully trained nurse could render, and again they experienced that deep disappointment which comes to us all when we fall short of the ideal. Still other rural visible bank account are well known to nurses real education and keeping a public health nurses who had learned to appreciate the sincere efforts of "practical nurses" resented the "off-with-his-head" attitude, as Alice would have expressed it. In their own minds, they candidly acknowledged the limitations set by inexperience and incomplete nursing education, but they realized also that these 150,000 undergraduate and practical nurses were conscientiously meeting a need which, because of economic conditions and numerical shortage of workers, graduate nurses were, as yet, unprepared to fill.

Why do we consider these points? This report will result in action. We wish that action to be directed along the most helpful lines. Therefore, to analyze and utilize these findings to the full we must put aside all narrowing personal reactions and strike out into the field of ultimate good.

The plot of a famous play* produced

* Hauptmann, G.: "The Weavers."

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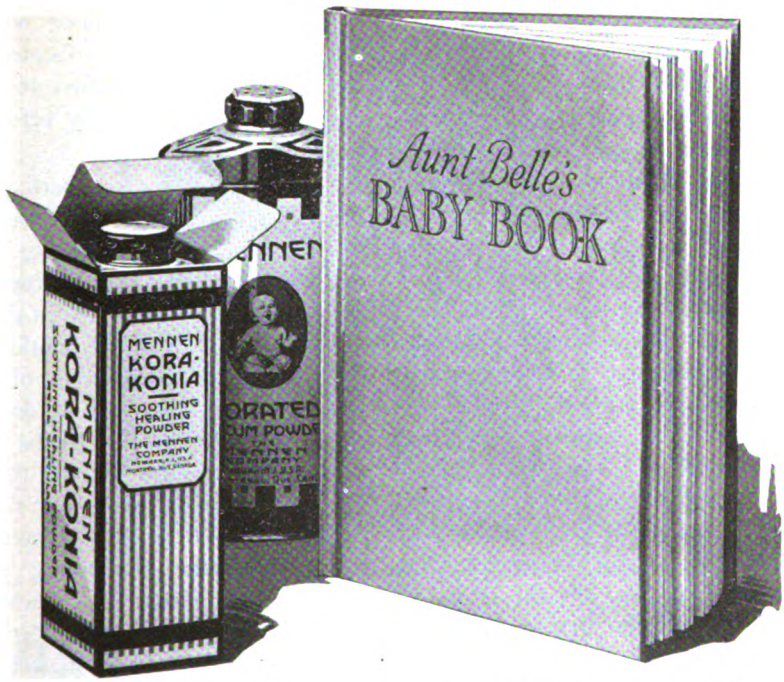


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on the New York stage some years ago crystallizes two interacting currents of thought. These philosophies of life are so closely bound to the present problem that we are tempted to visualize them. The play is laid in one of the smaller hamlets of East Prussia. In the dank, hovel-like cottages, the older generation of weavers is fashioning fustian. Like serfs, imprisoned by their work, they weave, weave all the long day and far into the night. Always their backs are bent over the patterns, so that they see little of the world around them. They possess, however, a beautiful, Christ-like spirit of patience and accept this barren monotony of life as the will of God who rules their lives. Such an attitude is quite acceptable to the overseers who throw them scant food for the fruits of their labor, but market that labor in the capitals at high prices. The rugged mode of living, the hard work and little sleep are accepted without question because these faithful peasants cannot conceive of change.

Then comes the urge of the newer generation. Young men returning from the wars abroad have seen the clean, light houses in the West. They know of wholesome recreation in the sunshine, of leisure to delve into the storehouses of knowledge. They have sensed the difference in free individual development—perfect bodies through which the liberated soul may function. What do they do? Cannon and shell rip the countryside; death and disaster tear down the old without building up the new. Tottering grandfathers bow to the inevitable and all those old and valuable traditions of simplicity, craftsmanship, and humble trust in God are swept to the discard.

Why this analogy? The younger generation has already sensed the faults in the system of nursing education. Passive reaction is evidenced in a lack of probationers. We do not wish to experience that wild rush of demonstration which will bare the poor hospitals of nurses and leave them stranded with the sick and dying under their roofs. How can this be avoided? By reform within the hospitals.

Some institutions are, perhaps, permanently disqualified as educational schools for nurses or nursing aides. As our work in public health progresses, we hope to see a marked rise in the number of health and nutrition workers, and a marked fall in the number of hospitals, of bedside nurses, and of doctors who care only for the sick. In the meantime, many hospitals now "under the ban" as teaching centers can be reorganized to give efficient, helpful training. We must show the consuming public its financial obligation to educate nurses and see that complete understanding is demonstrated in educational funds.

Many old and valuable traditions exist in the smaller educational units—individual oversight, perfection of detail and a beautiful spirit of faith and intimate neighborliness; these must not be thrown into the discard. Rather must we do all in our power to retain and build up that which is intrinsically good. Reform, however, must be brought about while action is yet controlled from within.

---

### The Power of the Concrete

*Why not use the Delano Memorial to endow beds for ill nurses, to establish scholarships, to augment the relief fund, or, indeed, to do anything but erect a monument? . . . Many of us cannot find it within us to contribute to the construction of a useless monument when other things are so much needed.*

These two abstracts index the content of a few letters which we have recently received. Let us consider for a moment the reasons why this form of memorial

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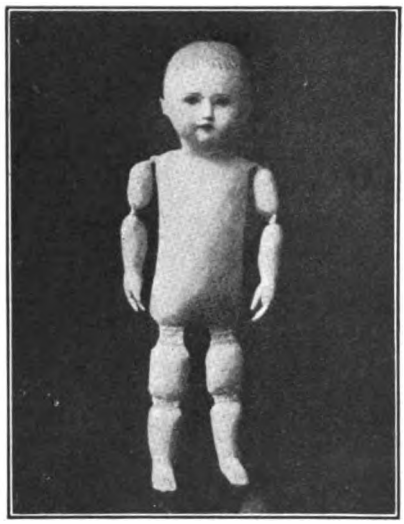

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has been thought of. With the question settled in our minds, we will then be heartily in favor of the final disposition of the fund which is fast accumulating.*

The Jane Delano memorial will commemorate "the last full measure of devotion" which an American nurse was permitted to give during the cataclysm of the ages. But it will commemorate a far greater event in history—it will mark the outposts of a new civilization when war is replaced by peace, and disease by health through the teaching of the public health nurse.

Many nurses feel that in adding to the relief fund or endowing beds their contributions would become gifts to themselves. They want future generations, as they pass by the Red Cross Building once a day, once a year, or perhaps once a life time to experience that feeling of reverence with which they look upon the sacrifices of the Great War.

Could a few beds set aside for ill nurses in scattered parts of the country bring this feeling home to every man and woman in the United States? Could a few scholarships offered to aspiring students carry this message from coast to coast? Could a few more health nurses, added to our civilian army of thousands, adequately express the bigness of this conception of service?

Perhaps, after all, these abstract expressions of altruism appeal to that small corner in our beings dedicated to intellect. The Rhodes scholarship, the Nobel prize have not remolded our lives. Yet many of us have conceived a new purpose after looking at that rugged bronze of Lincoln seated upon the park bench in prosaic Newark, New Jersey! What would be our inspiration at seeing a well-loved American Red Cross nurse silhouetted in white marble against the Washington green?

All nurses own dyeing vats in which their ideas are colored. Usually, the individual solution is composed of many elements—inheritance, environment, education—and the color of the mass is constantly modified by new ideas and new experiences. Now imagine all these dye solutions—indigo, fuchsin, Congo Red, aniline orange and malachite green—poured into one huge receptacle. The new solution takes on an entirely different color, and the quantity of liquid so pooled permits the dyeing of huge ideas which could not be dipped in individual solutions.

The ideas of individuals and the resources of the three nursing organizations were pooled at the Seattle convention. We have used the new solution to dye twenty-six pages of the current issue* of THE TRAINED NURSE so that nurses throughout the country may utililize it to recolor their own thoughts.

Progress, after all, is built upon mass accomplishment. A new idea germinates simultaneously in Norway, England and South America because the minds of the three inventors have been raised to the same productive level. The wonders of modern aseptic surgery are the last stones in the pyramid shaped by Paré in the use of the ligature, Von Leeuwenhoek in the perfection of the microscope, Koch in the isolation of bacteria, Lister in the appliction of aseptic princiciples, Carrell in their further adaption, Florence Nightingale in the development of the trained nurse and Morton in the use of anesthesia.

In the same way, the future of nursing must be built upon past accomplishments and present gains. The contribution of each builder will be more constructive if placed upon the present structure with a conception of the finished building in mind.

* Miss Lucy Minnegerode, chairman of the Delano Memorial Fund, reported total contributions of $15,884. After her report was received Miss Dunlop pledged $425 for Pennsylvania, and New York gave $2,300 more.

* To accommodate this added material, *Gleanings* and *In the Nursing World* have been curtailed in this number. As a further warm weather concession we have included a few stories for summer reading.

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# In the Nursing World

**Articles in this department, whether bearing signature or not, are contributed and do not necessarily represent the ideas or policy of this magazine.**

## PERSONALS

Miss Edith M. Safford, superintendent of the maternity ward at the House of Mercy, Pittsfield, Mass., has resigned to take the superintendency of the Coolidge Memorial Hospital, West Pittsfield. Miss Safford graduated from the Bishop School for Nurses in 1904. The staff of physicians and nurses tendered a farewell reception to Miss Safford on April 28.

Miss Margaret Rogers, under whose efficient superintendency the Jewish Hospital of St. Louis has reached its outstanding position during the past ten years, resigned in late May to take an extended European trip, now indefinitely postponed. At a farewell gathering the medical staff presented her with an elaborate diamond and platinum pin, the members of the Alumnae Association gave her their pin and the board of directors tendered a check for one thousand dollars to back the following appreciative resolution: "It is with sincere regret that the Directors of the Jewish Hospital yield to the request of Miss Rogers and accept her resignation as superintendent. Her many years of loyal and faithful service are greatly appreciated and the results accomplished stand and will continue to stand as evidence of her intelligent and excellent work."

Mrs. G. W. Fuller has been appointed superintendent of St. Luke's Hospital, Fargo, North Dakota, to succeed Dr. A. O. Fonkalsrud, who resigned in June. Mrs. Fuller is a graduate of St. Luke's Hospital, in St. Paul, Minn.

Miss Caroline Wellwood, superintendent of the Woman's Hospital, Chengtu, West China, is home on furlough with headquarters at Wingham, Ontario, Canada. Before leaving China she had begun the translation into Chinese of Miss Aikens' book—"Studies in Ethics for Nurses." The publication of the whole book in the language which will aid Chinese nurses has been deferred for various reasons, but the first section of the book is now available in pamphlet form.

The Alumnæ Association of Grace Hospital, Detroit, has undertaken the raising of $2,000 to endow, in perpetuity, a scholarship for a pupil nurse in the training school of the Williams and Porter Hospitals in Tehchow Shantung, China, of which Miss Myra L. Sawyer is principal.

## DEATHS

Sister Clotilda, who served as a nurse on the battlefields of the Civil War, at the St. Vincent's Home, Albany, New York. Sister Clotilda, who attained the age of eighty-four, in her long life exemplified the crystal virtues for which the Sisters of Charity, instituted by St. Vincent de Paul, are ever distinguished. She was born in Scotland, her parents coming to this country during her childhood. She joined the community of Sisters of Charity at Emmitsburg, Md., when but eighteen years old. Her lovable qualities always endeared her to children, and she remains a hallowed memory to Civil War veterans.

Miss Annie E. O'Brien, graduate of the Philadelphia Hospital, Class of 1896, and a member of the Spanish American War Nurses, died in January, following an illness of about eight months. Miss O'Brien, a true optimist, endowed with a bright, sunny disposition, was much loved by all who knew her. She served at Fort Myer, Va., in 1898, and in 1899 was sent to Santiago, Cuba. While nursing yellow fever at the General Hospital there she contracted the disease and was later transferred to the Yellow Fever Hospital (Las Animas), Havana, Cuba, serving most faithfully those stricken with this dread disease. She remained at this hospital when it was taken over by the Cubans and at the time of her death had been chief nurse there for more than twenty years. The Cuban nurses as a mark of their love for her had placed on her casket a silver plate with the words "Rest in Peace" in Spanish.

Miss Emma L. Park, a graduate of the Homeopathic Hospital, Brooklyn, N. Y. (1892), and a member of the Spanish American War Nurses, died in Brooklyn on May 20, and was buried with military honors in Arlington National Cemetery on May 22. At the funeral the Spanish American War Nurses were represented by Mrs. Harry Epps and Mrs. James S. Ruby. Miss Park, of a quiet, unassuming nature, was dearly loved by her patients and co-workers.

Miss Euphan Washington, a graduate of the Old Dominion Training School, Richmond, Va., and a member of the Spanish American War Nurses, died in February. She had been in poor health for some years. She was buried in Ware Church Cemetery, Gloucester Co., Va. During the Spanish American war she served at Fernandina, Jacksonville, and at the Presidio.

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# The Strain of Summer

with its variations in temperature, exhaustion of mind and body resistance to the effects of heat, loss of sleep, excessive perspiration and physical or mental exertion, handicaps the nurse and should be combatted by all helpful means.

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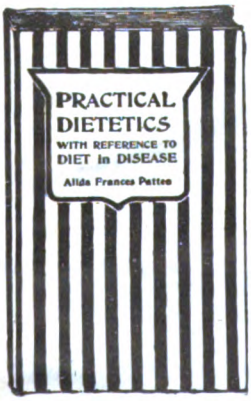


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A hospital mattress receives the hardest kind of wear and misuse. However, it will remain clean and sweet if shielded by a Quilted Protector. The mattress so protected becomes more comfortable to the patient.

Excelsior Quilted Protectors are made of bleached muslin on both sides, quilted with pure white cotton batting. These Protectors can be frequently washed without losing their fluffy texture and pure whiteness. Made in sizes to fit all mattresses.

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ADHERENCE to some pet theory of baby feeding may blind a physician to its fallacies, or bias his viewpoint so that they are overlooked.

Physicians who insist upon the home modification of cow's milk sometimes fail to consider the inability of the average mother to follow properly a complicated formula. They overlook the probability that the purest milk may sour in hot weather, become tainted by other food in a refrigerator, or be contaminated through carelessness.

You can eliminate these dangers for your patients by prescribing a food of protected purity which is easily prepared by the most inexperienced mother and which can be kept pure under the most trying conditions.

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While not offered as a specific, extended experience has shown that the following prescription is one of the most effective the physician can employ for the relief of the symptoms of hay fever:

℞ Adrenalin Chlor. m. XV
Pond's Extract dr. I to II
Aquae destil. q. s. ad. oz. I
*M et Sig.* Use as a spray every hour or two.

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**Hay Fever**

**TEN LESSONS IN CHEMISTRY FOR NURSES**
**By Minnie Goodnow, R. N.**
**Superintendent of Nurses, Children's Hospital, Washington, D. C.**
**PRICE FIFTY CENTS**
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# Classified Advertisements

THIS DEPARTMENT IS DEVOTED EXCLUSIVELY TO HEALTH BOARDS, INSTITUTIONS, AND OTHERS WISHING SERVICES OF NURSES, AND FOR NURSES DESIRING POSITIONS

The rate for advertisements for hospitals, training schools, health boards, etc., is five cents per word with a minimum charge of $3.00. To nurses advertising for positions, the charge will be $2.00 for fifty words or less. No display. Addresses are included in the count.

## Courses of Instruction

STATE OF ILLINOIS, Department of Public Welfare.—The Illinois State Training School of Psychiatric Nursing offers a six months' post-graduate course of lectures and practical instruction in the care of mental and nervous cases to registered nurses from accredited schools. The course includes psychiatry, with clinics, psychology, hydrotherapy, occupational therapy and amusements. The field work is performed in wards reserved for the pupils of the school, and accommodation is provided in the home set apart for the training school. A certificate is granted upon the successful completion of the course. Allowance, $35.00. For further information apply to Superintendent of Training School of Psychiatric Nursing, Chicago State Hospital, 64th and Irving Park Boulevard, Chicago, Ill.

THE CHICAGO LYING-IN HOSPITAL OFfers a four months' post-graduate course in obstetric nursing to graduates of accredited training schools connected with general hospitals, giving not less than two years' training. The course comprises practical and didactic work in the hospital and practical work in the out department connected with it. On the satisfactory completion of the service a certificate is given the nurse. Board, room and laundry are furnished and an allowance of $10 per month to cover incidental expense. Affiliations with accredited training schools are desired as follows: A four months' course to be given to pupils of accredited training schools associated with general hospitals. Only pupils who have completed their surgical training can be accepted. Pupil nurses receive board, room and laundry and an allowance of $5 per month. Address Chicago Lying-In Hospital, 426 East 51st Street, Chicago, Ill.

INSTRUCTION IN MASSAGE AND SWEDISH movement treatment by A. C. Hallbeck, qualified by Royal Swedish Board of Medicine. Chief of Massage Clinic, St. Luke's Hospital, and Hospital for Ruptured and Crippled; Licensed by the City of New York, 181 W. 87th Street, New York. Telephone, Schuyler 8358. Students have the advantage of assisting extensively in clinical work. 18,778 free treatments to 1,495 hospital patients during the last fiscal year.

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NEW YORK EYE AND EAR INFIRMARY, 218 Second Avenue, New York City, offers a six months' Post-Graduate Course for Nurses. The course comprises practical instruction and demonstrations, lectures by the attending surgeons, and special course of lectures in the laboratory by the Curator, also a definite time on Wards, Clinics and Eye and Ear Operating Rooms. Thirty dollars ($30.00) per month will be paid, together with board, lodging and laundry. For detailed information, address Superintendent of Nurses.

NEW YORK SCHOOL OF MEDICAL GYMNASTICS and Massage offers a practical and theoretical course in Swedish movements, massage, special course in electricity, etc. Training at leading New York hospitals. Diploma. Patients secured. For further information apply Carl S. Hall, Director, New York School of Medical Gymnastics and Massage, Sydenham Building, 616 Madison Avenue. 'Phone 1349 and 1470 Plaza.

POST-GRADUATE TRAINING SCHOOL FOR Nurses, Manhattan Eye, Ear and Throat Hospital, 210 East 64th Street, New York City, offers a course in special diseases and operating room training of the eye, ear and throat. The course will be both theoretical and practical. Instruction will be given by means of lectures, demonstrations, teaching at the bedside and in the regular performance of duties. The new residence for nurses, which has been occupied since January, 1913, provides separate rooms and excellent facilities for the comfort of the nurses. A registry is maintained for our graduates at the Hospital, and a limited number of graduates who complete the course of instruction may obtain permanent institutional positions. Graduate nurses from recognized schools will be admitted for a term of three months in the Eye Department, three months in the Ear and Throat Department, or the combined course consisting of six months. Remuneration thirty dollars ($30.00) per month and uniform, board and laundry free. For further information apply to Superintendent of Nurses, 210 East 64th Street, New York City.

SLOANE HOSPITAL FOR WOMEN, COLUMBIA University, 447 West 59th Street, New York City. Affiliation may be made by accredited training schools for a three months' course in Obstetrics. Post-Graduate Course. A four months' Post-Graduate Course in Obstetrics and Gynecology is offered to a limited number of graduate nurses of registered training schools. An allowance of $15.00 a month and maintenance is made. For further information address A. Isabelle Byrne, R.N., Superintendent.



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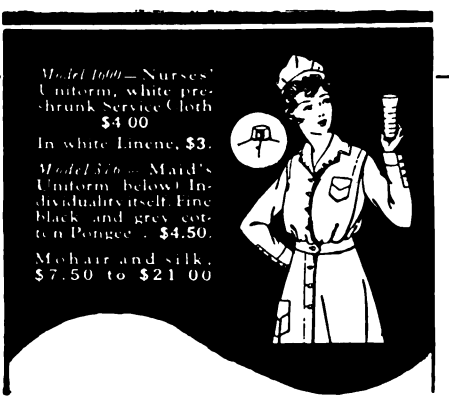


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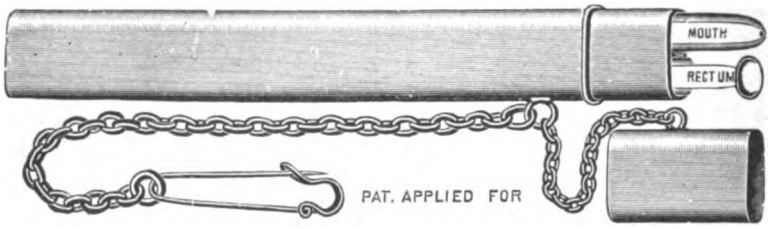


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Theoretical instruction by Attending Staff and Resident Instructor.
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Nurse Helpers employed on all Wards.
Full particulars on request.
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PEDIATRICS—THE CHILDREN'S HOSPITAL of Philadelphia offers a four months' Post-Graduate course in pediatrics to properly qualified nurses who desire special training in preventive and in curative work with children. A theoretical course correlates with the practical work on the wards, and is repeated for each group. For detailed information address Superintendent, The Children's Hospital of Philadelphia, 18th and Bainbridge Streets, Philadelphia.

THE SCHOOL OF MASSAGE, ELECTRICITY AND ALLIED BRANCHES OF THE PHILADELPHIA ORTHOPEDIC HOSPITAL AND INFIRMARY FOR NERVOUS DISEASES, PHILADELPHIA, PA., offers an eight months' thorough course in MASSAGE, ELECTRO-, MECHANO-, HYDRO- and THERMO-THERAPY. Modern equipment. Unequalled opportunity for clinical and bedside work. Circular on request.

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GRADUATE NURSES AND DIETITIANS wanted. Many excellent paying hospital positions now open in almost every State in the United States. Supt. of Nurses, Asst. Supt., Surgical, General Duty, Night Supervisor, Anesthetists, Industrial, Public Health, School Nurses, Dietitians. Write for free book now—today. It tells all about the work this organization is doing for nurses and dietitians everywhere. Aznoe's Central Registry for Nurses, 30 North Michigan Avenue, Chicago, Ill.

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## Classified Advertisments

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## Success in Nursing Depends on the Feet

Because of its exacting physical demands, success in nursing more than any other profession depends on the condition of the feet. Healthy feet mean a happy, healthy, vigorous attitude toward life, which is conducive to success.

Coward Nurses' Shoes were designed especially to promote healthy feet. Their pliant flexible leathers relieve strain on foot muscles. Their soles are noiseless and resilient. The heels, fitted with rubber "silencers," come in three heights to accommodate individual arch differences.

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**$5.50**
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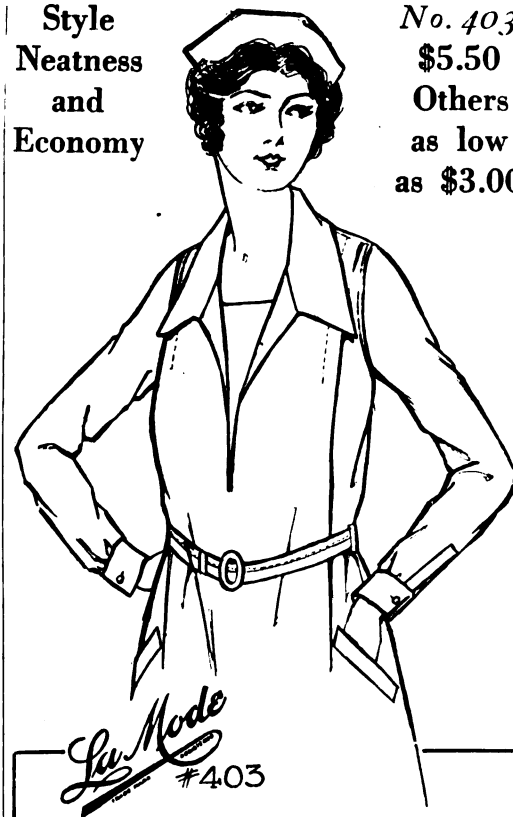


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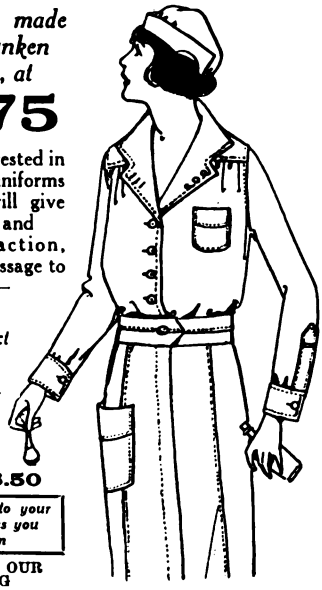
*Buy Your Uniforms Direct From Us.*



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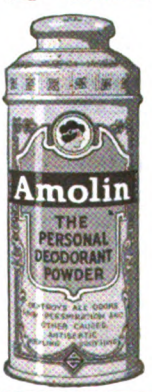


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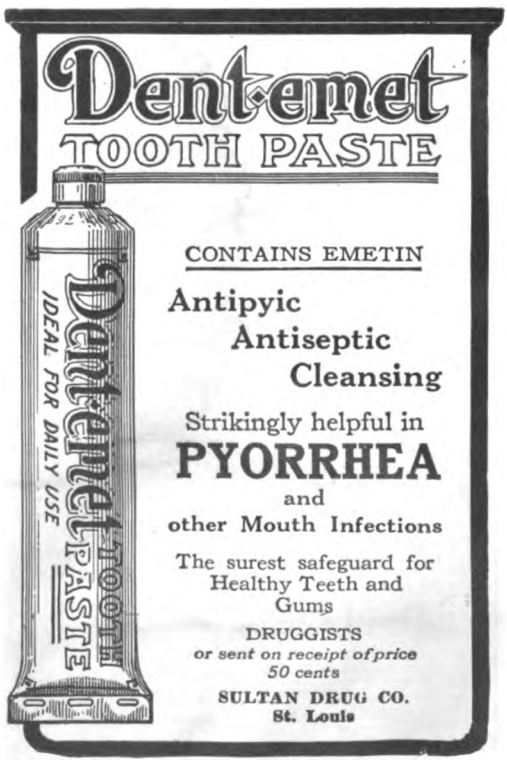
***Insist Upon It***

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*Sample and literature on request*

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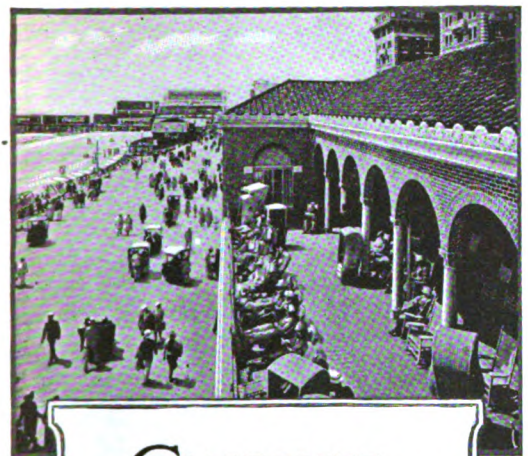

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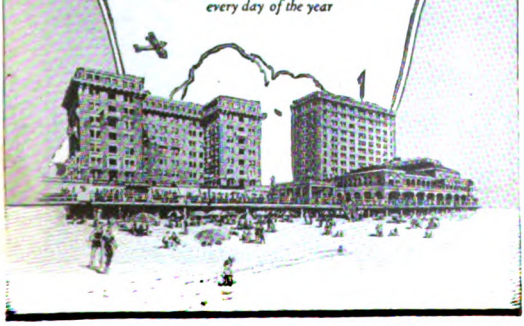

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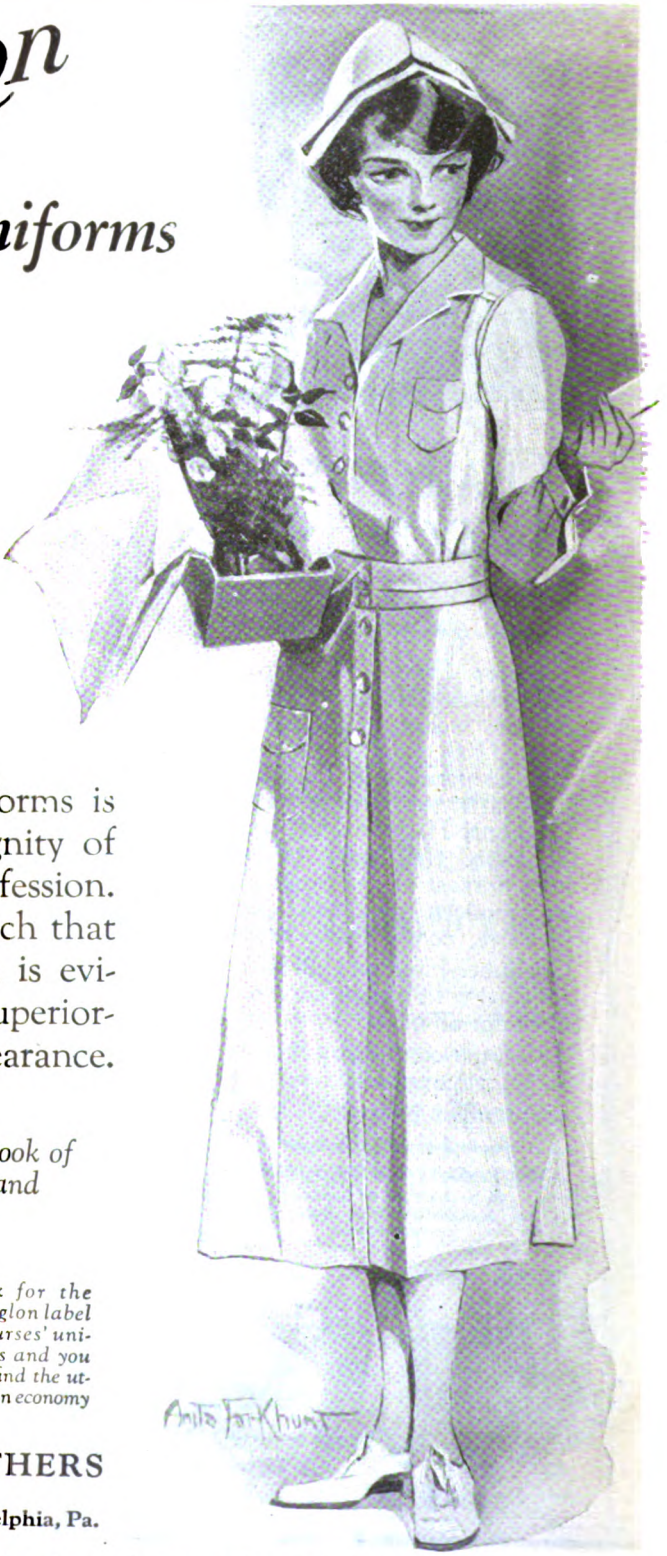

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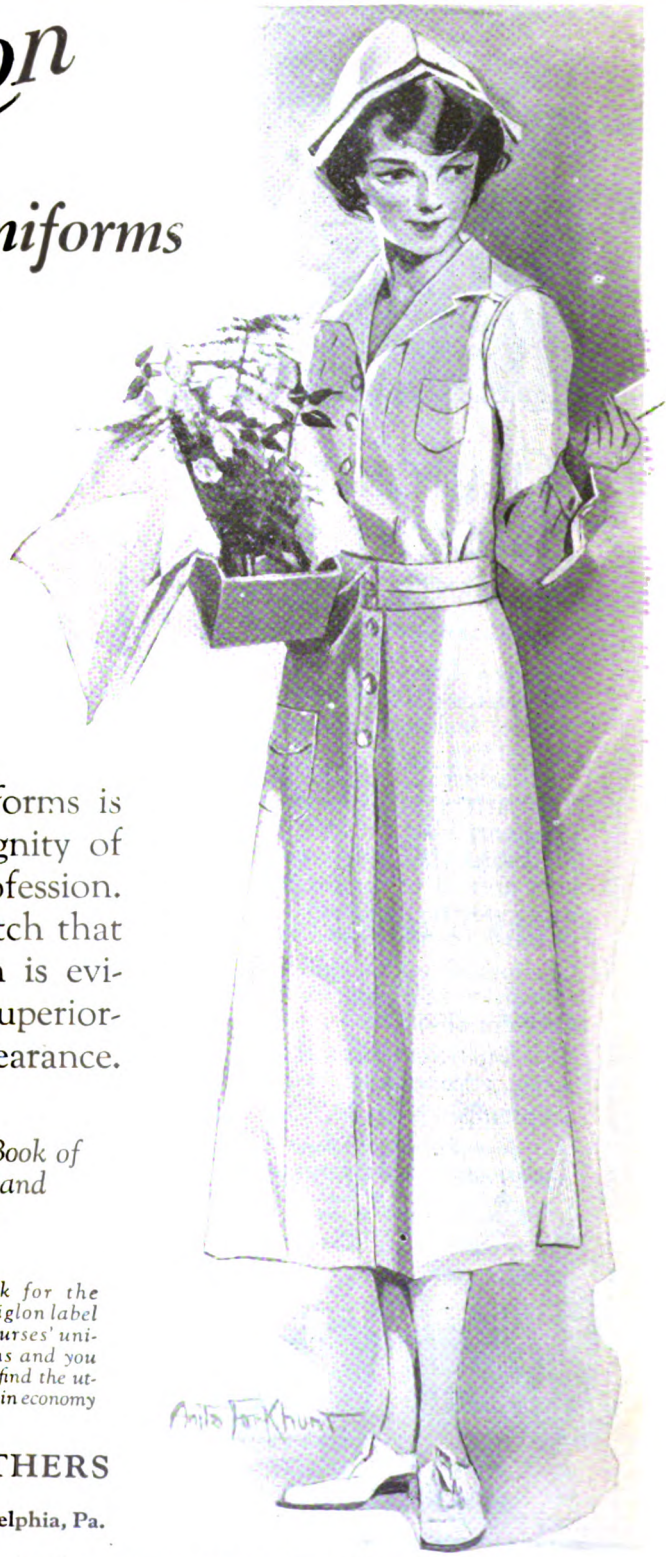

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**Vol. LXIX SEPTEMBER No. 3**

# The Trained Nurse and Hospital Review

**A Monthly Magazine Devoted to Trained Nursing in Private Practice, in Hospitals, Institutions, and Public Health Service**

*Editor,* CHARLOTTE A. AIKENS
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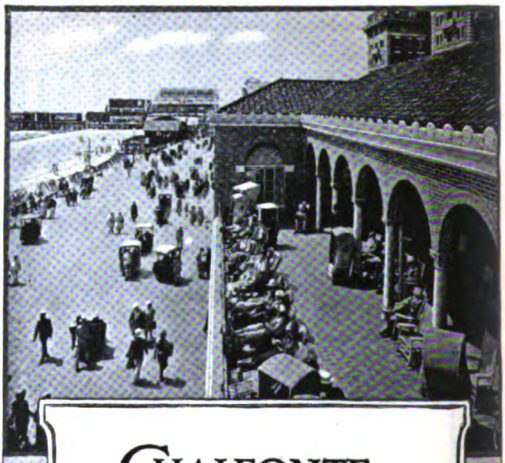

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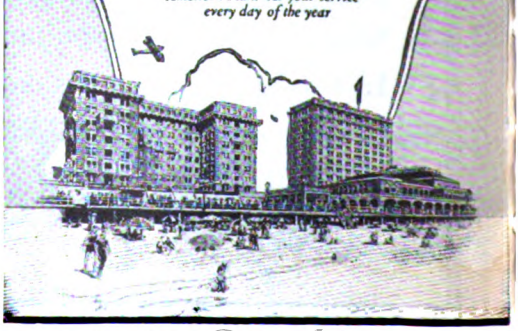




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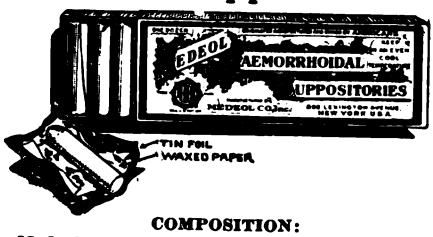


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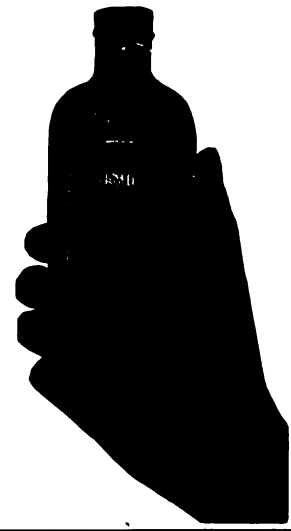

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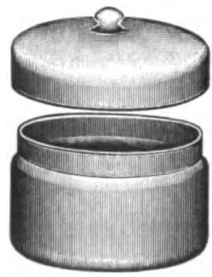

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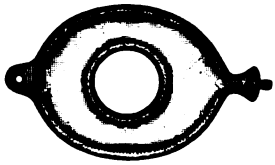

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# The Trained Nurse and Hospital Review

ESTABLISHED 1888

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## THE PURPOSE OF ORGANIZATION†

### FRANK SPEECH WITH SUPERVISORS

ANNA M. SCHILL, R.N.*
Hurley Hospital, Flint, Michigan

WE have arrived at a time when the value of an organization is measured in terms of service rendered, and by the success with which it promotes such service. It is pertinent, therefore, to ask what functions the community expects or should expect the nursing profession to perform.

The wise builder looks well to the foundation. The grander the edifice the more stable must be the underpinning. If a structure should prove topheavy, it is the height of wisdom to level it and rebuild. So with our nurses' organizations. We have gone forward with leaps and bounds, for our profession is a new one and the paths of the world are ours. We are like children in a field of wild flowers, running here and there, ever reaching for the more beautiful ones, and crushing equally beautiful ones beneath our feet. Because of our haste, perhaps, a few of us have lost our bearings and are being called to account. We are juggling with mighty facts. Our work has been legally declared professional; but this must not prevent us from drawing heavily upon the practical side of things in many points. Who can say what body will dictate our policy a decade hence, if we continue annually to turn thousands of young, impressionable, highly educated women into the community without restraining and guiding them in their performance of the duties which they owe to the profession and to the public? That our association is entitled to the loyalty, membership and support of this ever-increasing body of recruits need not be reemphasized. That our present methods of enlisting them are entirely inadequate to the task is equally well acknowledged. Our structure has grown topheavy; the foundation needs attention.

We have, too recently to forget it, passed through a siege which taxed the ingenuity of our leaders to supply registered nurses for the demands of war and epidemic and our long-fought for Registered Nurse Law was waived in order to fill our ranks. *We were not ready.*

National Prohibition is here, and we are warned by those who know that there may be a deluge of drug fiend cases upon our hands to care for and to cure. But

† Abstracted from an address delivered before the Michigan State Nurses' Association at the Eighteenth Annual Convention, Muskegon, Michigan, May 23-26, 1922.

* President, Michigan State Nurses' Association.

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we do not know how to nurse such unfortunates; we do not like such work *We are not ready.*

Where now lies the fault? In conditions? No. In our failure, as instructors of pupil nurses, to anticipate conditions? There are, in the first place, moral obligations peculiar to the graduate nurse which should be so strongly impressed upon her while there is yet opportunity that in case of emergency she sees her obligation and fulfills it uninstructed.

If our training does not cover drug cases or other equally unfortunate types, then we have not produced a thoroughly rounded nurse. Let us take steps to include this point in our days of study. Surgery is important, and by nature confined to the hospital, but medical work is waiting for the trained hand in every part of our country, praying for the day when it shall be given its proper place in consideration and administration. Public health work is certain and continuous, therefore let it supplement our curriculum, that every graduate may play her part wherever her lot be cast.

The splendid endeavors of our organization leaders are continually handicapped by the indifference of the graduate nurse to the cause—herein lies the danger. The chain is only as strong as its weakest link, and it behooves us to locate the weakened link and take the proper measures to strengthen or replace it. This weakness—this indifference—is not manifested until the day the nurse graduates. It is perfectly natural, under present circumstances, that she should accept her freedom along with her diploma and go forth utterly regardless of any further tie except that which her pleasure dictates.

We are like Mohammed, waiting for the mountain to come to us, and our folly will result in worse fashion than his, for that mountain was probably immovable, while ours is decidedly not so. Not only will the graduate nurse not *seek* admission to our ranks, but very strenuous efforts will have to be made to reach her at all.

We do not say to the child in the home, "There is the school, you really ought to go." How many children would attend school? If Uncle Sam had said, "I need you boys, I can do it if you volunteer, but suit yourselves," where would we be today?

So it should be with our organization work. We cannot afford to be indifferent to the nurse at any stage; the proper method is to prepare our student nurse for her future place in our great nurses' organizations. Meet her upon graduation with plans so ambitious, so appealing as to demand her full interest and support. Show her that future policies will depend upon her *positive* action. Women who first feared "muck-raking politics" have at last realized that it is their duty to make it clean; women who fear organization must cease to be negative and learn to make that organization accomplish results which will benefit the community.

The nursing education of today must include the study of the graduate's future relation to society, aside from the mere wage earning. She must know her duty and be prepared to assume it. This important phase of her education cannot be accomplished at any other time or by any other agency.

In this connection I would like to offer a suggestion. If the R. N. means anything at all, every graduate nurse must have it. In some cases this is a heavy financial burden to the new graduate. Could we not offer, through proper legislation, to the student about to complete her training and the nurse just graduated a State Board Examination held in or near the hospital from which she graduates? Writing examination papers on home ground would eliminate

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excessive nervousness and so result in better grades; this custom would also reduce the expenditure of energy and funds on travelling. Suitable proctorship would stabilize this innovation and secure true results.

As the graduate steps from her hospital to her Alumnæ and is launched upon her professional career the Alumnæ becomes the next link in our chain which must secure attention if our organization is to continue to expand and to extend its influence. Through the Alumnæ we must continue to bring to the students that body of knowledge which will develop the further workings of the profession. The Alumnæ is the link between the hospital school of nursing and the profession, and remember! our organization is not complete until we have enrolled every graduate into her Alumnæ and through this affiliation into the district, state and national organizations.

---

# TALKS BY A PSYCHOLOGIST

## INSTINCTS AND THE PATIENT

DONALD A. LAIRD
Instructor in Psychology, University of Iowa

AS one sizes up his fellow creatures he is impressed with two opposed observations. First he recognizes certain common structures and functions which are possessed by all mankind. All human beings, barring accidents, possess a certain number of limbs, certain osseous characters, a stomach, a lung or two, and several yards of intestines. It is these morphological and physiological characteristics common to groups of living organisms which aid the naturalist in classifying animals into families and species.

But Dame Nature is typically feminine —she goes by contraries. So all members of the same species, as in the case of Man, have individual differences which mark them off from the rest of the group. The typical man may be about five feet ten inches tall; but some grow to be eight feet tall and some stop at the three foot mark. All sizes and conditions of men exist between these limits. Some have their internal organs arranged in reverse order.

Though these observations are commonplace they serve to bring out the point that there are two groups of factors to be dealt with in studying organisms—(1) those fundamental factors common to all members of the group; (2) those variegated factors which may pass, for the present, as individual differences. Every day of the nurse's experience serves to reinforce this physical conception. It is also necessary, however, for the nurse to make this same distinction in the matter of psychological characteristics. Here she finds it quite easy to notice individual differences but she neglects to analyze the common factors behind all behavior.

### REACTION PATTERNS

In this paper we will take up the common psychological factors only. Just as one finds the physical arrangement of the living organism modeled after a certain pattern, so certain features of the mental life function after a common pattern from one generation to the next. These resemblances are due to the reaction patterns resulting in certain neurone combinations within the nervous system.

The simplest of these reaction patterns

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are those termed the reflexes. These are organized solely within the spinal cord and brain stem. As examples of this type of reaction we have the "knee jerk" or the reflex dilation of the pupil of the eye under differing intensities of illumination. This reflex behavior is beyond voluntary control; the action may even take place without the actor's knowledge. The "knee jerk" and the pupillary reflex invariably take place when the proper stimulation is applied; they are altered only in diseased conditions. In the case of the pupillary reflex, the reaction occurs year after year without the reactor being aware of it.

### Instincts

At a somewhat higher level are evidenced other common reaction patterns which are handed down from generation to generation as are eye color and the human digestive tract. Although these complex reactions involve a greater amount of the musculature and organs than do the simple reflexes, this does not mean that they are characterized by diffuse action. They furnish, however, the tendencies to action which guide the most complex actions of the living human being. These are the instincts.

The instincts are unlearned; they come to the individual spontaneously and without any coaching; except in intensity, they vary but little from person to person. As the great sources which prompt certain responses, the instincts give one insight into the most serviceable means of controlling the behavior of others in a natural and effective manner.

There is nothing at all mysterious about the working of the instincts. Indeed there is nothing mysterious or miraculous about many expressions of mental life. Cause and effect. In the case of the instincts, for example, man and all other animals receive as a part of their equipment with which to start life some definitely arranged muscles, bones, glands, and nervous structures among other things—excluding Nature's provisions for maiden aunts and family Fords. The arrangement of the muscular osseous and nervous cells predetermines many of the activities of the organism. We have already seen how the simple reflexes are determined in this manner. The instincts, too, are formed about these inherited patterns. But they involve a larger portion of the organism and are usually under voluntary control. Such is the case in the flight of the bird. Nests have been robbed by experimenters and the wings of the fledglings have been tied before they have had an opportunity to imitate their elders in flying. Later when their wings were released the young birds without any previous training or observation, spontaneously began to fly. What else could they do with their wings? Muscles and bones were arranged for flying; nervous connections were installed for the same purpose. So they flew—they could not have successfully used their wings for any other purpose if they had tried.

### Unlearned Tendencies

As the bones, glands, and nervous system of man are hooked together, numerous unlearned tendencies to act exist in the highest of the animal kingdom. Perhaps the first manifestation of these tendencies is in the sucking of the newborn babe when placed to the breast. From that moment on the taking of nutrition becomes one of the essential acts in the life of the human being. Here is a fairly complicated action, performed without any coaching on the part of the parents, usually under voluntary control, and common to the race. As such it is an instinctive act, based upon an instinct. These illustrations should clarify your conception of the characteristic qualities of instincts.

Before proceeding further it may be

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well to differentiate between instinctive and habitual actions. The instincts are tenacious inclinations to action which are unlearned and common to the race. Habits are methods of action which consciously or unconsciously have been systematized by the organism of the individual and are not common to the race.

*(Courtesy American Red Cross)*

THE GREATEST MOTHER IN THE WORLD appeals to the instinct of parenthood. This slogan has probably brought the Red Cross closer to the hearts of the people than any of its humanitarian works.

Eating has an instinctive basis; taking food three times a day and holding the little finger at a delicate angle when manipulating a teacup are habitual actions. Habits, therefore, soon come to veneer the surface of the instincts and alter their appearance. But the instincts are still there urging the organism on to action; it is only their outward manifestations that have been changed. The formation of habits is not by any means limited to the consumption of tobacco, alcohol and food, although these may be the most pleasant habits depending upon the point of view. A certain individual may have habitual modes of putting on his clothes; he must sit on the bed to put on the shoes, it would be impossible to put them on while sitting on the floor. In the same way certain speech habits and even certain habits of thought are formed.

### Applying Psychology

The instincts are the remnants of the past behavior history of the race; the habits are the remnants of the past behavior history of the individual.

As we have said before, the cardinal aim in an applied science is to predict and control individual behavior. In the first of these articles it was stated that the past behavior history offers the key. The meaning of that statement is now becoming clear.

In facilitating control the use of instincts presents certain advantages over the use of habits. In the first place the instincts are common to all mankind, while the various habits of thoughts and conduct vary from individual to individual. Also one can be relatively certain of the instincts, while it takes a long period of study to ascertain the past personal history. In addition, instinctive action* is quick and is commonly performed without reasoning. Then, too, instinctive drives or motives are back of practically every conscious act. They are the springs back of human behavior.

Accordingly, we review the chief instincts found in man and suggest some

* Instinctive action takes more time than reflex action, but much less time than reasoned action.

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practical ways in which they may be appealed to in controlling the behavior of others.

It is customary to classify the instincts into three groups—those centering around the preservation of the individual, those centering around the preservation of the race, and those centering around the social group or the gregarious instincts.

Under the first heading appear those instinctive actions which prompt us to seek food, flee from danger, fight or pull hair when in a desperate situation. The care of the offspring during their periods of helplessness is a manifestation of the race preserving instinct.

### Modifying Instincts

Oftentimes the instincts are modified by habits; at least their outward manifestations are veneered by conventions or past personal histories. One might desire to follow the advice of *Life* and "obey that impulse"—but it might prove embarrassing on the ward. The maternal instinct is frequently manifested in opposite and unexpected ways, especially in unmarried maternity patients. In such cases, however, one is dealing with altered instinctive manifestations which are understandable in the light of the previous articles of this series.

After this digression, we will take up the third group of instinctive activities, the social instincts. Some insects, such as bees and ants, live a co-operative existence. Consequently some of their activities must be directed toward preserving the group regardless of any disastrous outcome to the individual. Man also lives a somewhat co-operative existence. In man this group of instincts centers around gregariousness. An inner drive makes man seek the company of his fellows. Prolonged solitude plunges him into dire distress. Snubbing by his friends brings abject misery. These instances show the result of the thwarting of the social instincts.

On the more positive side we find man organizing clubs that he may associate with his fellows, or going down-town evenings to mingle inanely with the crowd. We do not relish a meal in solitude; congenial table companions are the best appetizers. It is not enough just to be with others, we usually want to be like others, to be in the swim, to be in fashion, to be up-to-the-minute.

### Conscious Application

We must appeal to the instinctive equipment of mankind if we wish to stimulte action in others. Advertisers apply psychology consciously; nurses will also find it advantageous to capitalize man's instinctive equipment in engineering the human element in the sick room. These instincts do not manifest themselves in any rigid and invariable manner. Minor variations are continually occurring. The maiden lady may detest the unspeakable male (compensation) but still just adore music by male quartettes. The sex instinct is here being manifested as frankly as in "A Skin You Love to Touch."

### Composite Results

This generalized exhibition of instinctive tendencies gives the nurse some latitude in producing specific manifestations. The pleasant nurse, for example, it is not merely likable as she radiates the gospel of happiness. There is also an indication of social approval by her actions. Thus she appeals to the social instincts and, to some extent, to the second group of instincts as well.

The patient who dreads an examination or an operation will be prepared for the ordeal when told it means a quicker return to home and the home folks. To be told it has to be gone through with, so why worry, merely irritates an already touchy spot.

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Attractive china, a flower on the tray, and savory food may not stimulate the anorexic patient to eat. But these encouragements plus a liked friend or a pleasant nurse at the meal hour may be an irresistable combination. This is one of the reasons why anorexia is less common on wards than in private rooms.

Certain sex differences which control

*(Courtesy American Red Cross)*

This carefree baby also appeals to the instinct of parenthood. However, it appeals to a more limited number of readers than the poster THE GREATEST MOTHER.

the effectiveness of appeal to the various instincts should be carefully noted. The fact that time is saved is much more effective with women than with men. Men are more responsive than women to sympathy and family affection, strange as it may seem; safety (self-preservation) also appeals more strongly to men. To be up-to-date appeals more to the man while the woman prefers quality. It is better psychology to tell the woman of the skill of her physician rather than that her operation is of the latest mode, etc.

These are only a few suggestions regarding the appropriate manner of making an instinctive appeal. The serious nurse may receive further suggestions by carefully analyzing the instinctive appeals used in national advertising in the leading magazines.

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### Ophthalmia Neonatorum

A summary issued by the National Committee for the Prevention of Blindness shows that in 44 states the reporting of babies' sore eyes to the local health officer or to a physician is now compulsory. The only states in which such legislation has not yet been enacted are Arizona, Nevada, Texas, and Wyoming. The use of a prophylactic medication at birth is required by law of physicians and midwives in 24 states, of physicians only in 2 states, and of midwives and attendants only in 2 states. Free prophylactic outfits are distributed in 28 states and popular educational leaflets on the prevention of infantile blindness are distributed by state departments of health in 35 states. In only 17 states are births reported early enough to be of assistance in prevention of blindness work. The significance of such legislation becomes apparent when we realize that "ophthalmia neonatorum would practically never occur if a prophylactic wereused in the eyes of every infant immediately after birth, and if every case of redness, swelling, and discharge from the eyes of infants were promptly and adequately treated."

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# THE SPOILED CHILD "SICK ABED"

## INGENIOUS SICKROOM METHODS

GERTRUDE M. TROTH, R. N.
New York City, New York

THE SPOILED CHILD is at all times a difficult person, and when it is ill it is indeed an unhappy one, for while it may cry for the moon and other unattainable things, during its illness it will only get what the doctor orders, which is frequently castor-oil and mustard plasters. The spoiled child is the innocent victim of its parents' love and ignorance, and when it is ill the nurse should do all she can to make the child a happy, lovable little being. Any child, sick or well, spoiled or unspoiled, will instinctively revolt against any new controlling influence. That is only natural. Therefore, at first, the nurse who is called in to care for such a child must approach it through its parents, preferably the mother.

Here the nurse meets her greatest difficulty in dealing with the child—the parents. Very often she finds the parents with greater mental handicaps than the child, and with stronger wills to oppose all her efforts. A workable way of persuading both mother and child that you are their friend is to allow the mother to give the medications and treatments for the first day or so (under your direction). This pleases the mother, who loves to feel that she is helping, and who hates being banished from the sick-room. This will also give the child an opportunity to become accustomed to you. No nurse is popular with a patient—child or adult—who introduces herself by plunging into her professional duties of treatments, medicine giving or temperature taking.

Unless the child is very sick and in need of some immediate attention, just ignore it. Sit down and talk to the mother—not about the child or other sick children, but about something exciting that has happened to you recently. If your conversation is exciting enough, the child will become interested, first in what you are saying, and finally in you. Explain to the mother just what you are trying to do and get her to help you, if possible.

It is never wise to suggest a game to a spoiled child. Your patient is sure to oppose it. Instead, try starting a game or a puzzle yourself, talk about it, seem perplexed, or lose some important piece (where the child can see it) and you will be surprised how very quickly it will become interested, tell you where the missing piece is, suggest ways and means to you, and finally, disgusted at your stupidity, offer to show you just how to do it.

Always try to hold the child's interest in play over to the next day. If you are doing a picture-puzzle or reading a story, leave it unfinished. This impending pleasure will speed the morning's bath and treatments. Suggest it just after breakfast, and if the child has been kept interested, it will see the advisability of hurrying through the morning routine, just to "see if we can finish it before the doctor comes." Do most of the playing for the first day or so, and let mother do the work, but as soon as possible work in some sympathetic authority.

When you have earned the child's interest and respect, you have made a big advance; it is then safe for you to take over the helm, and give mother a rest. With a spoiled child you have to be especially firm. You must hold your point when very often it is far easier to give in. Try to get the parents' help in this, and persuade them, above all, not to weaken, as parents are apt to do under tears or coaxing. A child will often pretend lack of comprehension, so it is best to wait and make your requests or com-

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mands clear when the child is attentive.

Praise is important in the sick-room, and an occasional reward is always encouraging. Do not confuse a child with bribes. If it is bribed with one piece of candy today, it will want two pieces tomorrow and three the next day, and eventually there will be tears. If the child takes its medicine well, praise it, and be sure to tell everyone that comes into the room about it, overwhelm the child with praise. If you give it enough reputation between doses, it may feel obliged to live up to it, and may develop a sense of pride about medicine taking that will extend to other things. It is never wise to force medicine unless it is absolutely necessary. Such a course often only frightens the child and upsets it, while most of the medicine is spilled or coughed up over the bed-clothes. The nurse can only learn from experience the best methods of approach in medicine giving, as every case is different, and every child an individual; the nurse can only study the nature of the child, and by exercising infinite patience work out for herself a way of dealing with it.

Hardly less difficult, and certainly not less important, is the question of feeding the spoiled child when ill. Here you must be firm with the mother. If the child's appetite is poor, it must be tempted with things that you know it likes, but never pleaded with nor coaxed. Under no conditions should food be discussed with the child. Do not allow the mother to suggest food to the child, or to coax or bribe, as nothing is as discouraging to a poor appetite as the constant sight and mention of food. A poor appetite can be tempted by attractive looking trays, small portions of appetizing food, or perhaps the promise of a dainty dessert.

If the child plays or sulks over its food, reprimanding will seldom help matters. Just pay no attention to the child, and after a little time quietly remove the tray, and do not give any food until time for the next meal.

All this discipline may sound like very stern treatment for a sick child, but a large amount of gentleness and sympathy can be so interwoven with the firmness that the discipline will not be recognized as such. The nurse's task is not a small one, but it is only by her discipline, understanding and, above all, her consistency and patience that tears are banished from the sick-room.

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## THE HOSPITAL'S ROLE IN RURAL CENTERS

"It is useless to talk about child welfare for those regions where there are no doctors, nurses or hospitals. A new task awaits the women whose indomitable energy was so large a factor in bringing about the adoption of the maternity bills. Their help is needed in the solution of the problem of rural medical service, for unless some solution is reached the new laws for the benefit of mothers and babies will fail of their intended effect in large areas of the State. * * * The first thing to be done is to make country districts more attractive places in which to live, from the professional, social and economic points of view. Any moderate sized town should be able to support a community hospital with laboratory, clinics, nurses and consultation and diagnostic facilities as well as it supports a community high school. Even the small village can make a modest beginning with a little hospital which will greatly economize the time of the one or two local doctors. With the facilities offered by such hospital centers young graduates of our leading medical schools will be found more willing to settle in rural communities."—*Herman Biggs, M.D., New York State Health Commissioner.*

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# THE PREPARATION OF CATGUT*

## RAW MATERIAL TO FINISHED PRODUCT

CATGUT, probably a corruption of old English word "kitgut," meaning fiddle, is made from the intestines of meat-producing animals, chiefly the sheep. The most careful manufacturers assume the entire control of the animal from the slaughter of the sheep to the finished product.

The intestine of the sheep is about sixty feet long. Only the upper or smaller part, beginning at the stomach, is used for catgut.

(*Courtesy Johnson & Johnson*)

Crosssection of sheep intestines, showing outer muscular layers and mucous layers in the central portion. In the preparation of catgut, all except the sub-mucous coat is removed.

One manufacturer receives the twenty-four-foot small intestines from about six thousand sheep each day, and these represent the "kill" of the previous day. This is considered an ideal situation since the intestines are full of fecal matter which would putrefy if it were not immediately eliminated.

Dry sheep intestines, also salted gut, can be purchased wherever animals are slaughtered; but many manufacturers feel that the raw material in this form would not produce catgut of the greatest flexibility and tensile strength. Too, the action of salt is believed to have a deleterious action upon catgut material, not only upon the physical character of the gut itself, but in relation to its absorption in the tissues.

The processing of the intestinal material and the preparation of catgut from it is extremely simple in principle. In this country carbonate of soda is used to bring the intestinal tissue into the soft adhesive condition necessary to form the solid cord called catgut, when it is twisted or spun. Throughout Europe potassium carbonate, or potash, is still used as of old.

(*Courtesy Johnson & Johnson*)

Enlarged section of intestines of sheep, showing various layers. In the preparation of catgut, the mucous spongy layers are removed, being valueless in catgut, and forming a ground for bacterial development.

The time of processing prior to spinning is about a week. About one-half of the supply of sheep intestines taken into the factory can be turned into surgical catgut. Through tearing, breakage and defects considerable material is totally lost. Some of it can be utilized for musical instruments and tennis racquets.

As nurses know, the intestine is made up of four distinct layers. The central layer of soft tissue is called the mucous layer, which is capable of absorbing the fluid content of the stomach as it is delivered to the intestine. Around this inner one is the so-called submucous layer, and over this two muscular layers, one with lengthwise fibers and one with fibers running crosswise or around the intestine. (The whole, of course, is covered by a serous membrane.)

* Excerpt from a contribution by the scientific department of Johnson & Johnson, published in *Notes and Abstracts.*

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According to the best microscopic experts, the finished catgut is reported to be practically entirely the submucous layer.

As previously mentioned, the processing and handling of the tissue is carried on largely in alkaline solutions. This is the same condition maintained in nature, i.e., the soft slippery, elastic condition of the intestine is maintained by bathing them constantly in an alkaline fluid.

The processes through which the intestines pass, in the manufacture of catgut are as follows:

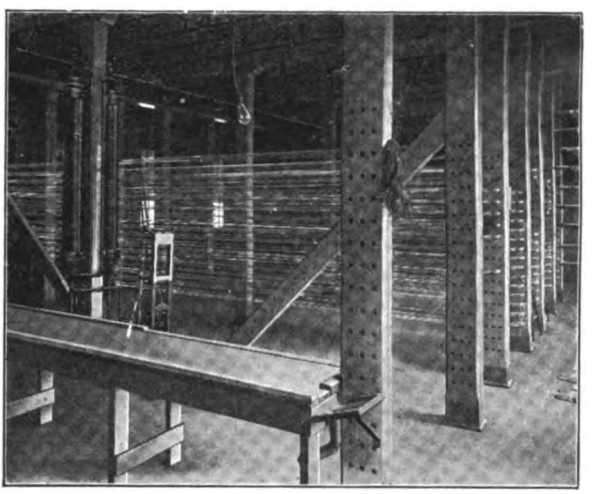
The fecal contents are largely removed by stripping the gut through the clenched hands. They are then kept in cold water. They are of a light pink color, and cannot be put into process until they are conditioned for several days and this pink color disappears. This is somewhat similar to the cold-storage conditioning of meats and fowls. Care and skill are necessary here, for if not properly carried out the remaining fecal matter will decompose and ruin the gut.

When the proper stage or "condition" has been reached the gut is split in half, by drawing the tubular gut over a curved pointer of metal or wood. This pointer has set in its far end a sharp knife blade, so that, as the tube is drawn over the pointer and against the projecting edges of the blade, it is split into two halves and two ribbons are produced.

Now, the intestine is made up of two distinct halves, or sides, as they are termed. One is called the "roughside," and that is the IN-side of its curves as it lies coiled in the abdomen; the other is the "smooth-side," which is the OUT-side of the coils. Hence the smooth side will, after splitting, always be found to produce a ribbon that is longer by several feet than the rough side.

The purpose in making a curve to the pointer is to cause the curves of the intestine to follow the curve of the pointer, and hence the two sides are automatically separated and the rough-side will, of itself, run to the right, and the smooth-side to the left of the operator, or vice versa.

The tubular gut having been split into two halves, which are now in ribbon form, and these ribbons having been sorted out into two classes, known as rough-sides and smooth-sides, we are now ready for further processing. Before the smooth-sides, however, can be put through the first cleaning operation, it is necessary to remove from them a membrane known among workers as "the thread." This thread is in reality a thin membrane lying on the surface of the smooth-side, and as it is not firmly adherent to the tissue it will, unless removed, come loose in the later cleaning processes and cause tangling. The removal of this thread is done by hanging the smooth-side ribbons over the end of an upright wooden board and scraping the surface carefully with an edged tool until the thread is cut through, after which the ends of the thread are turned back and stripped from the rest of the tissue. This requires the work of an expert.



(*Courtesy Johnson & Johnson*)

The gut-twisting and drying room. This room is enameled throughout, and the table in the foreground is made of heavy glass.

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The ribbons are next rapidly passed through a cleaning machine, which gives them their first rough cleaning and removes the remaining fecal matter and most of the mucous layer. This is a very simple machine, consisting of a smooth faced drum, over which the ribbons are drawn by a pair of rollers, and as the ribbons pass over the drum they are played upon by a stream of warm water and beaten or brushed by the paddles of a revolving device like a paddle wheel.

The preliminary machine cleaning is succeeded by hand-scraping and cleaning, and then the ribbons of gut are put through a prolonged treatment of slow soaking and cleaning called "sliming." This sliming process is carried out in great detail, and it is in this treatment that all but the submucous layer of the original tissue is removed. The apparatus used for scraping or sliming off the loosened tissue is a device for drawing the ribbons over a pair of blunt-edged knives.

The ribbons are now sorted for length and cut accurately so as to fit the drying-racks. Some have been torn and broken in process. On the end of each ribbon is tied a loop of cotton cord. These looped strands are now subjected to a bleaching process, where both the peroxides and sulphurous acid are in use. There are varying opinions as to the best procedure. It is, however, recognized that while this treatment is called "bleaching," yet it is not done wholly for the improved color that results. Both the peroxides and sulphurous acid have distinct effects on the texture and physical characteristics of the finished catgut.

The next process is spinning or twisting the ribbons to make the cord of catgut. These are made up of one or of several "ply." The finest is one ply and makes, when finished, No. 000 and No. 00 surgical catgut. No. 1 surgical catgut is made of two-ply, and No. 2 of three-ply, but there is always some variation in the finished sizes, necessitating grading or gauging after the gut has been dried and smoothed.

Immediately after spinning, the gut is removed to a drying room and stretched very tightly over pegs placed in holes in heavy wooden posts. Little or no artificial heat is used in drying. The required length of time varies for each size, but is never less than forty-eight hours, and for the larger sizes a week or more is required. When the strands are thoroughly dry, they are smoothed with fine sandpaper, and upon the expertness of this work depends the smooth roundness of the strand.

After this smoothing process nothing remains to be done except to remove the catgut from the drying posts, cut it up into the desired lengths and sort it out by gauge of diameter into different sizes.

These are then ready for preparation in tubes or envelopes for the later processes of sterilization.

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## A SPECIFIC FOR HOOKWORM

Accumulating evidence indicates that carbon tetrachloride, a cheap and common chemical, may be used to cure hookworm in human beings.

The discovery of the efficiency of the drug in removing these parasites was made by Dr. Maurice C. Hall, of the United States Department of Agriculture, who tested it on dogs, and even tried out its effects on himself. Reports issued by the U. S. Public Health Service show that relatively heavy doses to monkeys produced no symptoms of poisoning and no noticeable change in any of the organs. Perhaps this chemical will prove effective in curing the disease.

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# NURSING PATIENTS DURING THE CLIMACTERIC PERIOD

DOROTHEA O. CLIFFORD

THE "change of life" is not a diseased condition, but a physiological process, a readjustment of the organism resulting from the cessation of one of its functions. Its dangers and discomforts are very frequently exaggerated, and much of the dread of it experienced by women is unnecessary. Women who have had good health at puberty, suffered little during menstruation, and are in generally good condition at the onset of the climacteric usually suffer little inconvenience. Almost all, however, have enough symptoms of one kind or another to lead them to consult a doctor, and not a few, especially among women of the leisure class, come into the hands of a nurse. The care needed is often more mental than physical, and the nurse who will be the most successful with such patients is the one who best understands not only the symptoms that commonly appear at this trying period and how to alleviate them, but also the physical disturbances that are so frequently present. Another reason why nurses should be familiar with these facts is that many women who do not become actual patients, and who dislike to discuss the subject with a doctor, will often talk freely with a nurse if occasion offers, and are sometimes in great need of advice, and especially of reassurance.

The menopause marks the end of the period allotted by nature for child-bearing, and the organs used for that purpose gradually atrophy. Cessation of function on the part of the ovary means not only no further production of ova, but also the loss of the internal secretion of the ovary, which, we are told by the leaders of the new science of endocrinology, helps to make personality. It is no wonder, then, that there not only has to be a considerable readjustment of the processes of circulation and nutrition, but that a rather violent shaking up of the whole organism sometimes results. If there are no especially weak spots in the body, and the readjustment occurs gradually and evenly, unaccompanied by any pronounced excess or deficiency among the other internal secretions, discomfort and inconvenience should be slight. Those who suffer least are women who have not used their sex organs to excess, have no injuries resulting from childbirth, and live a rational and hygienic life during the critical years; there is every reason for them to look forward to post-climacteric years of healthy, happy and useful life. Single women are usually freer from unpleasant symptons than the married.

A great many disorders are attributed to the menopause which have nothing to do with it, except that they may occur at the same time. Women are apt to lay all the ills that their time of life is heir to, which happen to make their appearance coincidentally with the cessation of menstruation, to the "change of life." It is quite true, however, that any weak point in the body machinery is more likely to become manifest at this time of organic readjustment, and it is the part of wisdom for even the healthiest women to have a medical examination occasionally.

The worst danger of the climacteric period is the development of malignant disease of the sex organs. This is more common among married than single

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women, and especially so where there have been neglected lacerations of the birth canal. The principal symptom which suggests the possible presence of uterine cancer is severe bleeding, or very prolonged or frequent slight bleeding. Menstruation seldom disappears all at once, and occasional reappearance of the flow is of no evil import, and is to be expected; but where it becomes a profuse hemorrhage, lasts for several weeks, or becomes almost continuous, immediate and thorough examination is called for. Uterine cancer is far from hopeless, if it is discovered before too large a tract is involved; if entirely extirpated it may never reappear. When too long neglected, however, it becomes incurable. Pain is usually a late symptom.

A very large variety of symptoms may be complained of by women passing the climacteric. Probably the most universal is the nervous disturbance of the circulation commonly known as "heat flashes," caused by a transient fullness of the superficial blood vessels, especially of the head and neck, and followed by sweating. The sensation is that of a sudden violent blush. It may be so severe as to be very noticeable and extremely embarrassing, or so slight as to attract no attention. In one case known to the writer the heat wave that enveloped the body was so intense that the victim would be awakened from sleep by it, and in spite of the coolness of the room would throw off all the bed covers and at times even her night clothing. In another case there was little or no flushing, but a sudden breaking out of perspiration about the head, neck and chest. These attacks have been known to occur as often as every fifteen minutes, but are ordinarily much more infrequent and irregular. If they cause too much discomfort, as in the first case cited, they can usually be controlled by the administration of mild sedatives by a physician.

The nervous irritability that is inevitably present in some degree may also show itself in many other ways. Palpitation of the heart, rapid or irregular heart action, may lead a woman to fear serious heart disease. Digestive disturbances are very common, including abdominal pain or distress, flatulence, and either diarrhea or constipation. There may be a very considerable rise in blood pressure. Headache is often complained of, neuralgia, broken sleep and intense nervousness. Leucorrhea is practically universal, but if there is anything unusual in the appearance or odor of the discharge medical advice should be sought without delay. Pruritis vulvae is a not an infrequent symptom, sometimes causing considerable annoyance.

Mental symptoms are sometimes very pronounced, and may be of any grade of seriousness, from hysterical attacks to actual insanity. A tendency to melancholia is not unnatural in women of reflective temperament, for the physical changes now taking place force upon their attention the fact that youth is over, and that the life-path before them will henceforth lead down-hill. Dwelling upon the real and fancied dangers of their condition, and the restrictions and disabilities of age, they may become hypochondriacal or morbidly depressed, or develop strange obsessions or abnormal impulses. The change of balance between the internal secretions, resulting from loss of function on the part of the ovary, may cause what seem like extraordinary changes in the personality.

Very little in the way of drugs or actual treatment of any kind is usually needed in these cases, nearly all of the measures required coming under the head of hygiene, physical or mental. There are few conditions where a nurse has greater opportunities to practise

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those phases of psychotherapy which form so important a part of her work—reassurance, encouragement and inspiration toward cheerfulness, hopefulness, interest in and enjoyment of life, and a realization that the climacteric period is not the end of all things for a woman, but merely a preliminary to years of increased usefulness and comfort, undisturbed by the periodical handicap of earlier life. Self-centered and hypochondriacal women may easily at this time sink into confirmed invalidism, and a nurse who is capable of grasping the situation, and is armed with up-to-date knowledge on the subject, can often do more than anyone else to ward off this danger, and help her patient into a state of mental and physical equilibrium.

All measures which conduce to health at other times are useful at the menopause. Exercise in the open air is of special importance; it tones up the muscles, induces deep breathing, and leads to free perspiration, thus aiding in removing waste products from the body, and can be used as a means for promoting all sorts of interests, from social intercourse to bird or tree study. The common use of the motor car has greatly decreased the amount of walking done by either women or men, and many motorists would be much the better for a brisk daily walk of two or three miles. Golf is as good a game for the middle-aged woman as for the middle-aged man. One woman who passed through the climacteric period with scarcely any inconvenience attributed her well-being to bicycle riding, which was much in vogue at that time. Women who are in business would do well to walk from home to office, rather than ride, where this is practicable, or else to take a brisk walk at the noon hour. Getting overtired, however, from any form of exercise, is unwise, for vital force is below normal at this period, and the woman unaccustomed to exercise should begin very gradually. Light gymnastic exercises, night or morning, are usually beneficial, but it is well to consult a physician as to their advisability. Massage, properly given, is especially good for women who can or will take little exercise; it tones up both the nervous system and the circulation, and is particularly beneficial where obstinate constipation is present.

Keeping the skin active is very important. As to the best form of bathing, a physician is the proper judge. The cold plunge is seldom advisable for any except the very robust; women sometimes persist in its use when it does not invigorate but debilitates them. The cold sponge, however, can be taken by almost anyone, and is valuable as a tonic measure, besides lessening the tendency to take cold.

The question of diet is often a troublesome one. Over-eating is especially a sin of middle age, when the pleasures of the table are usually more enjoyed than in earlier life, and when the need of body-building material is very much lessened, as the period of growth is over, and the amount of physical exercise taken is usually small. An excess of food clogs the system, and puts a heavy strain on the excreting organs, besides producing over-weight. As a tendency to grow stout is common at the climacteric, avoidance of over-eating at this time is especially desirable; and physicians who have had large experience in reducing weight by dietary methods state that such a regimen often results in improvement of some of the most trying nervous and circulatory symptoms accompanying the menopause, particularly the "heat flashes." The patient may think she needs "building up," but the average woman will do better on less rather than more food than she is in the habit of taking. Violent changes in diet are sel-

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dom advisable except in emergencies, but patients who are hearty eaters, especially if they are growing stout, will do well to cut down the quantity eaten of all kinds of food except fruit and green vegetables. A reducing diet can be arranged by this means as well as by cutting off altogether a few specially fattening foods, and much more comfortably. Sweets and starches are, however, the principal weight producers; but meats and other nitrogenous foods, while not fattening, put a heavy burden upon the kidneys, and should be partaken of sparingly at this time of life, when any weakened organ is apt to seize the opportunity to go on strike. Moderation in the use of proteid foods is the surest road to prevention of kidney disease for the woman at the menopause.

As indigestion, either gastric or intestinal, is extremely common at this time, all dishes known to be difficult of digestion should be partaken of sparingly, if not omitted entirely from the menu. The digestive power is weakened, like the other bodily functions, by the readjustment of the physical balance, and while a special diet may not be necessary, abstention from elaborate meals and rich dishes will do much to avert digestive difficulties.

### Constipation

Constipation, only too frequent at any age, may be a special foe at this period, and there is no time when it is more important to prevent it, since the body already has enough to struggle against without the poisoning resulting from the retention of waste products in the digestive tract. A laxative diet is a great help to this end; such a diet includes a large proportion of fresh fruits and vegetables, the coarser cereals, brown bread and stewed prunes and figs.

Probably the most important thing that can be done for a woman at this period, aside from surgical intervention in cases where actual disease is present, is to keep her, as far as possible, in a normal and cheerful mental state. The woman who is the mother of a family and busy with household cares, or who is engaged in a strenuous business or professional life or deep in outside interests of one sort or another, has little opportunity to worry about her condition; but the woman of leisure, especially if she is of the introspective type, is apt to brood over the advance of age, to magnify her symptoms, and to produce, by constantly dwelling upon the subject, discomforts and disabilities that she might otherwise escape. Many women are haunted by a fear of going insane. Only too often they withdraw from social relations, go out-doors but little, spend most of their time lying down, lose appetite, and become mentally and physically depressed. A variety of interests, wholesome hobbies, something definite to do, whether it be a "job," some form of philanthropic or good citizenship work, or social duties, will be more beneficial than a sojourn in a sanitarium or all the special treatments in existence. Many minor ailments, which grow upon one when dwelt upon, almost disappear when resolutely ignored. Middle age, as we have remarked, is not the terminal stage of existence, but a time when a woman, with broadened sympathies and enlarged experience, freed from the limitations and responsibilities of the child-bearing period, may enter upon a larger development of life, with every hope of years of happiness and helpfulness. In influencing women toward this view of the post-climacteric years, the trained nurse, to whom others of her sex turn naturally for counsel in matters regarding health, will be serving not only her patients and friends, but the world at large as well.

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# ASSIGNMENT OF THE DELANO RED CROSS NURSES

CLARA D. NOYES, R. N.
Director, Bureau of Nursing, American Red Cross

THE AMERICAN RED CROSS, through a special committee appointed for that purpose, has chosen the first two "Delano Red Cross" nurses, provision for whose support was made in the will of the late Jane A. Delano. They are Miss Stella Fuller, who has been assigned to Alaska, and Miss Bertha R. Steeves, whose work will be among the islanders off the coast of Maine. Both are to enter upon their new duties without delay.

Miss Delano's interest in public health nursing was in part based upon her own first hand knowledge of the field presented by remote, isolated communities where this service was most needed and least apt to exist. In her early career she was stationed at the mining camp in Arizona belonging to the Copper Queen Mining Company. Her home was a two-room tin shack; her means of locomotion a Pinto pony; and her constant companion an Army revolver. Not that the miners would have molested the woman who was their best friend, and often the saviour of their womenkind in the hour of their accouchements, but in those days the Apaches frequently went on the war path, and as she went her lonely rounds it was always the better part of caution to "tread softly and carry a big stick."

Miss Stella Fuller, the "Delano Nurse" assigned to Alaska.

Her interest in the cause of the people thus cut off from nursing care and health education never waned. In her will she left a substantial fund, in memory of her parents, supplemented by the proceeds from the sale of her textbook, "Home Hygiene and Care of the Sick,"* to be used for the maintenance of public health nursing services in localities that would otherwise be without the ministrations of a community nurse.

Notwithstanding the progress made in public health nursing in the past few years, poverty and isolation are two menaces that must ever threaten certain portions of our population. Many such localities still remain in the United States and her island possessions, as well as in Alaska. Into these places the Delano Red Cross nurses will go, carrying the gospel of health education, sanitation and hygiene, and bringing that best of all gifts, the capacity for self-help and the appreciation of higher standards of living. It will be a labor of consecration, patience and devotion and one that will bring the highest measure of compensation to the unselfish worker. To be a

* This book, recently revised by Miss Anne Hervey Strong, is the official textbook used by the American Red Cross classes.

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Delano Red Cross nurse will be the highest honor the American Red Cross can confer upon a member of its personnel.

Nurses and localities are to be chosen with the maximum of discrimination, vision and exactitude. The nurse will be required to give assurances that she can serve for not less than three years, for the success of the enterprise necessarily rests upon the permanence and whole-souled zeal of the nursing personnel, and if subjected to frequent change, the project might be marred irrevocably in the making. Self-sacrifice is a *sine qua non* in the Delano Red Cross Nurse.

### The Choice of Localities

Conditions which determine the choice of localities are as follows: (1) It should be ascertained that no funds for the salary of the nurse are available from Federal, State or County sources, or from agencies or individuals in the locality. (2) Lack of local funds should not be due to transitory conditions, such as crop failures, drought, disasters, etc. (3) Localities should represent established settlements, and not temporary ones, such as might be found in lumber camps and mining towns. (4.) It should be possible to make satisfactory living arrangements for the nurse. (5) It should be possible to get about the locality by some means of transportation.

It might be well if other organized work were within reasonable traveling distance as a settlement, church, school, or similar undertaking. This would mean that some ground work had already been done, making it unnecessary for the nurse to reduce her work to the most elementary terms. It would also provide companionship, and some means of cooperation in the care of the sick. The nursing service should not be in any way attached, however, to the settlement or school.

In selecting the nurses for this service the personal equation will be a determining factor, but certain definite requirements are essential—that the nurse have good health and no unfavorable family history; that her family not be dependent upon her in any way, in order to avoid the possibility of her being called home in the middle of her term of service.

In addition to being an enrolled Red Cross nurse, she should have a good education and training. It would be well if she also had some teaching experience. She must have had public health nursing experience of not less than two years. Some of it should have been independent work and some of it outside of cities.

Preference will be given to nurses between the ages of 30 and 40.

### The Choice of Nurses

Recommendation of nurses who are qualified for this service by character, training and experience may be made either to the division directors of nursing or to the director of nursing at National Headquarters, or the nurses may themselves apply.

Both Miss Fuller and Miss Steeves have had rich experience in public health nursing, the former, who is a graduate from the Milwaukee County Training School, having been State Supervising Nurse of the Wisconsin Anti-Tuberculosis Association for one year and, more recently, the assistant director of Red Cross Nursing Service in the Southern Division, with headquarters in Atlanta. Miss Steeves, a Canadian by birth, has taken out her first papers and took her training in the Newton (Massachusetts) Hospital School of Nursing. She did duty afterward as superintendent of the Ottawa Hosiptal; in the Henry Street Settlement (New York); in Pasadena, as a school nurse; and in the University of California, as an instructor in Home Hygiene and Care of the Sick.

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# THE USE OF ANTITOXINS—II

## THEIR MECHANISM IN THE TREATMENT OF DISEASE

ROBERT A. KILDUFFE, A.M., M.D.

Director of Laboratories, Pittsburgh Hospital, Pittsburgh; Director of Laboratories, McKeesport Hospital, and Serologist, Providence Hospital

### STANDARDIZATION OF ANTITOXIN

ANTITOXINS are graded according to the number of antitoxic units contained in a cubic centimeter.

Standardization is accomplished by an elaboration of a method originated by Behring and Ehrlich.

For this purpose a series of guinea-pigs weighing 250 grams are injected with increasing amounts of toxin. The smallest amount of toxin sufficient to cause death within four days is known as the Minimum Lethal Dose or M.L.D. A second series of pigs of the same size is then injected with this M.L.D. of toxin and, at the same time, with increasing amounts of the antitoxin to be standardized. The smallest amount of antitoxin which serves to protect the pig against the M.L.D. is thus ascertained and *a unit is one hundred times this amount* or the amount needed to protect one hundred 250 gram guinea pigs against a fatal dose of toxin.

Owing to technical difficulties as yet unsurmounted, there are only two antitoxins which can thus be standardized: those against diphtheria and tetanus toxins. All other antitoxins must be given by volume.

### THERAPEUTIC VALUE OF ANTITOXIN

It must be remembered that antitoxins have no bactericidal value, their therapeutic efficiency depending entirely upon their action in neutralizing and rendering inert the toxin for which they are specific. Obviously, therefore, if they are given before the toxin has united with the body cells, with resultant cellular damage and destruction, they can prevent such action by rendering the toxin harmless before it attacks the cells; if given later, they can only prevent the action of such toxin molecules as are still free and unattached to the body cells. The keystone of successful antitoxin treatment, therefore, lies in the early administration of sufficient amounts, the object being to produce an excess of free antitoxic bodies in the blood in amounts not only sufficient to neutralize toxin molecules already present, but also such others as may later be produced.

The most striking results in antitoxin treatment are obtained in diphtheria and the treatment, if begun early in sufficient amount, is absolutely curative. If it were possible to begin treatment on the first day of the disease with a sufficient amount of antitoxin, the treatment of diphtheria would resolve itself into antitoxin and rest in bed.

Careful analysis of cases grouped according to the day of the disease in which antitoxin was begun conclusively demonstrates that the earlier and more vigorously the treatment is begun the greater the chances of ultimate success and vice versa.

In determining the size of the initial dose one must be guided by four factors: (*a*) The age of the patient; (*b*) the day of the disease; (*c*) the general condition of the patient, and (*d*) the site and extent of the lesion.

Elaborate statistics to prove the value of antitoxin in the prophylaxis and treatment of diphtheria are hardly necessary in these days, though readily available. It is generally admitted and readily demonstrable that there is practically no mortality in cases receiving antitoxin in sufficient amount on the first or second day of illness.

While the results of the therapeutic use of tetanus antitoxin are not as brilliant as those obtained in diphtheria, it, nevertheless, possesses a distinct curative value in direct proportion to the time at which it is admin-

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Delano Red Cross nurse will be the highest honor the American Red Cross can confer upon a member of its personnel.

Nurses and localities are to be chosen with the maximum of discrimination, vision and exactitude. The nurse will be required to give assurances that she can serve for not less than three years, for the success of the enterprise necessarily rests upon the permanence and whole-souled zeal of the nursing personnel, and if subjected to frequent change, the project might be marred irrevocably in the making. Self-sacrifice is a *sine qua non* in the Delano Red Cross Nurse.

### The Choice of Localities

Conditions which determine the choice of localities are as follows: (1) It should be ascertained that no funds for the salary of the nurse are available from Federal, State or County sources, or from agencies or individuals in the locality. (2) Lack of local funds should not be due to transitory conditions, such as crop failures, drought, disasters, etc. (3) Localities should represent established settlements, and not temporary ones, such as might be found in lumber camps and mining towns. (4.) It should be possible to make satisfactory living arrangements for the nurse. (5) It should be possible to get about the locality by some means of transportation.

It might be well if other organized work were within reasonable traveling distance as a settlement, church, school, or similar undertaking. This would mean that some ground work had already been done, making it unnecessary for the nurse to reduce her work to the most elementary terms. It would also provide companionship, and some means of cooperation in the care of the sick. The nursing service should not be in any way attached, however, to the settlement or school.

In selecting the nurses for this service the personal equation will be a determining factor, but certain definite requirements are essential—that the nurse have good health and no unfavorable family history; that her family not be dependent upon her in any way, in order to avoid the possibility of her being called home in the middle of her term of service.

In addition to being an enrolled Red Cross nurse, she should have a good education and training. It would be well if she also had some teaching experience. She must have had public health nursing experience of not less than two years. Some of it should have been independent work and some of it outside of cities.

Preference will be given to nurses between the ages of 30 and 40.

### The Choice of Nurses

Recommendation of nurses who are qualified for this service by character, training and experience may be made either to the division directors of nursing or to the director of nursing at National Headquarters, or the nurses may themselves apply.

Both Miss Fuller and Miss Steeves have had rich experience in public health nursing, the former, who is a graduate from the Milwaukee County Training School, having been State Supervising Nurse of the Wisconsin Anti-Tuberculosis Association for one year and, more recently, the assistant director of Red Cross Nursing Service in the Southern Division, with headquarters in Atlanta. Miss Steeves, a Canadian by birth, has taken out her first papers and took her training in the Newton (Massachusetts) Hospital School of Nursing. She did duty afterward as superintendent of the Ottawa Hosiptal; in the Henry Street Settlement (New York); in Pasadena, as a school nurse; and in the University of California, as an instructor in Home Hygiene and Care of the Sick.

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# THE USE OF ANTITOXINS—II

## THEIR MECHANISM IN THE TREATMENT OF DISEASE

ROBERT A. KILDUFFE, A.M., M.D.

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### STANDARDIZATION OF ANTITOXIN

ANTITOXINS are graded according to the number of antitoxic units contained in a cubic centimeter.

Standardization is accomplished by an elaboration of a method originated by Behring and Ehrlich.

For this purpose a series of guinea-pigs weighing 250 grams are injected with increasing amounts of toxin. The smallest amount of toxin sufficient to cause death within four days is known as the Minimum Lethal Dose or M.L.D. A second series of pigs of the same size is then injected with this M.L.D. of toxin and, at the same time, with increasing amounts of the antitoxin to be standardized. The smallest amount of antitoxin which serves to protect the pig against the M.L.D. is thus ascertained and *a unit is one hundred times this amount* or the amount needed to protect one hundred 250 gram guinea pigs against a fatal dose of toxin.

Owing to technical difficulties as yet unsurmounted, there are only two antitoxins which can thus be standardized: those against diphtheria and tetanus toxins. All other antitoxins must be given by volume.

### THERAPEUTIC VALUE OF ANTITOXIN

It must be remembered that antitoxins have no bactericidal value, their therapeutic efficiency depending entirely upon their action in neutralizing and rendering inert the toxin for which they are specific. Obviously, therefore, if they are given before the toxin has united with the body cells, with resultant cellular damage and destruction, they can prevent such action by rendering the toxin harmless before it attacks the cells; if given later, they can only prevent the action of such toxin molecules as are still free and unattached to the body cells. The keystone of successful antitoxin treatment, therefore, lies in the early administration of sufficient amounts, the object being to produce an excess of free antitoxic bodies in the blood in amounts not only sufficient to neutralize toxin molecules already present, but also such others as may later be produced.

The most striking results in antitoxin treatment are obtained in diphtheria and the treatment, if begun early in sufficient amount, is absolutely curative. If it were possible to begin treatment on the first day of the disease with a sufficient amount of antitoxin, the treatment of diphtheria would resolve itself into antitoxin and rest in bed.

Careful analysis of cases grouped according to the day of the disease in which antitoxin was begun conclusively demonstrates that the earlier and more vigorously the treatment is begun the greater the chances of ultimate success and vice versa.

In determining the size of the initial dose one must be guided by four factors: (*a*) The age of the patient; (*b*) the day of the disease; (*c*) the general condition of the patient, and (*d*) the site and extent of the lesion.

Elaborate statistics to prove the value of antitoxin in the prophylaxis and treatment of diphtheria are hardly necessary in these days, though readily available. It is generally admitted and readily demonstrable that there is practically no mortality in cases receiving antitoxin in sufficient amount on the first or second day of illness.

While the results of the therapeutic use of tetanus antitoxin are not as brilliant as those obtained in diphtheria, it, nevertheless, possesses a distinct curative value in direct proportion to the time at which it is admin-

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istered and the amount given, and many cures of developed tetanus are on record. In the prophylaxis of this disease, however, it is absolutely efficacious, as is most graphically shown by the statistics of Fourth of July injuries before and after its discovery. Antitoxins are also available for several other diseases, dysentery, meningococcic meningitis, pneumonia and pneumonococcic infections, snake bites, streptococcus infections, anthrax, bubonic plague and cholera. While none of these approach in effectiveness those for diphtheria and tetanus, definite results have been obtained, notably in meningococcic meningitis and Type I pneumonia.

### The Cause of Serum Sickness

No discussion of antitoxins could be considered complete without some reference to what is known as "serum sickness," a manifestation of anaphylaxis on the part of the individual to whom the antitoxin is given.

Anaphylaxis (derived from two Greek words meaning "without protection") is the term used to denote a condition of unusual and exaggerated susceptibility to foreign proteins.

Time and space will not permit a résumé of the causes underlying the production of the phenomena grouped under the name of anaphylaxis and it suffices to say that in its most marked form the condition is characterized by a rapid fall in the blood pressure and temperature, together with a spasmodic contraction of the involuntary muscle of the bronchioles causing an inspiratory asphyxia accompanied by paralysis and death.

Fortunately severe manifestations are rare in man, the milder form commonly called serum sickness being that most frequently seen. This is characterized by some elevation of temperature, an urticarial rash which may be quite marked and extensive, and joint pains sometimes of marked severity.

### Treatment of Serum Sickness

The treatment is purely symptomatic; hydrotherapy for the fever, salicylates for the joint pains, and soothing lotions for the rash. The best treatment lies in the prevention of the condition. Bearing in mind that in man the incubation period required before sensitization or oversusceptibility to a foreign protein occurs is about seven days, subsequent injections should always be given not later than five days after the first.

Cardinal points in the avoidance of serum reactions and other manifestations of anaphylaxis may be grouped as follows:

1. The indications for the use of a serum should always be clear and distinct and no serum should be given "just for luck."

2. The patient should, if possible, be questioned as to any history tending to indicate hypersusceptibility to proteins, such as asthma, "hay-fever," food rashes, and the like. If necessary a skin test after the manner of a von Pirquet reaction may be made with the serum to be used.

3. Atropin sulphate may be given before the injection or, at all events, should be at hand, because of its value in counteracting involuntary muscle spasm, as should adrenalin also to counteract falling blood pressure.

### Effective Results

Even where sensitivity exists, however, antitoxin may be used for serum sickness. It is never fatal and always temporary, disappearing in a few days without treatment, and, when time permits, the patient may be desensitized and his hypersusceptibility overcome by methods which it would be too long to detail here.

In brief, it may be said that in diphtheria and tetanus there are, in general, no contraindications to the use of the antitoxin, which should be relied upon to the exclusion of any other method of treatment at present known.

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# THE UNUSED BYWAYS OF ECONOMY

## THE BAEDEKER TO CONTENTMENT

By A Fellow Traveller

IT was one of those chance meetings which one makes when travelling abroad that occasionally develops quickly and ripens into delightful companionship.

She was at least sixty, an active little person, well dressed, with crisp white cuffs and collar and a hat that showed judgment. She was "doing" Warwick Castle, and intimately linked with the memories of that age-old castle—its green lawns and white peacocks—will be the picture of that little woman, sturdy in her independence.

Later, in Leamington, where we had our tea and ate the noted but not very good Banbury Cross buns, she talked quite freely about herself. She was a trained nurse. Her home was in Washington, D. C., but for one year she was away and she was enjoying each day, through rain and sunshine, for she was visiting all the places she had always longed to see. With an expression that savored more of Wall Street than of our peaceful capital she told us that every farthing she spent she had saved herself—not in a savings bank, or in bonds or stocks, but through a life insurance policy.

Perhaps it is a far cry from quiet, turf-swarded Warwick Castle with its green-black shrubs to thrift—but on that brilliant June afternoon I, for the first time, saw insurance as a vital, living thing.

Many thinking women in the business and professional world are now carrying insurance, but I still find some who believe it is a "die to win" proposition. To you who may have this idea I would say: "Dream a dream, then take an endowment policy in an old line insurance company and make your dream come true."

Then there are many believers in insurance who carry good-sized policies, but do not realize the elasticity of their contracts. I was interested to hear a doctor tell of the use she made of her loan value During the war she wanted more money to put in Liberty Bonds. Her surplus was limited at that time, so she borrowed on her insurance policy and bought the bonds. Her reason was patriotism, but she also increased her estate. Incidentally the coupons helped her carry the loan and pay a portion of her insurance deposits.

Insurance policies are good assets in one's credit standing. If you are planning your own business venture—a sanitarium in the United States or a nursing home in Canada—you will find that banks are more ready to listen when a loan is desired if the applicant carries insurance—and the type of insurance is known to have added weight.

As an investment insurance holds its place. By some it may be classed as grandmotherly, but its very safety makes its appeal. I could mention many successful business men who carry insurance for this reason only—because it is strong and sure. It is well to remember that it is the quickest known way to create an estate and that the estate is guaranteed 100 cents to every dollar, regardless of any fluctuating market.

In the matter of interest returns, one must not overlook the great feature of protection. Many death claims are paid after only one or two years' deposits have been made. A return of one thousand dollars on a yearly premium of

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thirty-two or thirty-five dollars deposit makes even a highly speculative investment look pale. In the matter of returns, the "guaranteed income certain" and "life option" often double the deposits many, many times. Insurance companies laughingly believe that an annuitant never dies. Please remember, too, that with the scale of dividends the face of any policy always exceeds the amounts deposited.

The ease with which an insurance estate is made makes a strong appeal, especially to women who are living pretty close to margin. Each year just a stated amount salted away with the knowledge of saving systematically gives a feeling of freedom to use and spend the remaining income.

Above all there is the overwhelming comfort in knowing that an insurance policy protects your dear ones against any emergency which may come. Just become very ill and visualize your mother or your young sister struggling along without your help, and the picture will drive you to some kind of protection. An insurance policy is a great help toward peace of mind.

Some day we shall use the term "insuring one's earning capacity or one's economic value," for no one can place a monetary value on a life, but the earning power has a direct claim on every individual. There are years spent in preparation to acquire knowledge and skill; physical and mental strain are lavished on our strength to acquire the positions we hold, and then this brain-training which gives us power to hold our place in the world we use for years without staking a penny's worth of insurance upon it. We do not treat a Ford car this way.

One's earning capacity will not last forever, and one's strength cannot always carry the burden. There is a turn in the road when one must rest, and to rest one must have money. Writing directly to women who have gloried in their independence, I would urge provision now to prepare for that rest period when you must be less active—when you cannot work.

Think ahead twenty or thirty years from now, and when the next insurance agent calls on you do not send out word, "I am too busy" or "I am not interested." Protect your earning capacity for your dear ones while you may.

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## THE INFINITE

*(After Leopardi)*

I always loved this solitary hill,
And yon green hedge that from my roving glance
Shuts off the low horizon's farthest sweep.
For as in meditation here I sit
I come to sense beyond that distant line
Immeasurable space and stillness deeper far
Than any silence known to mortal ears,
Where for a time my heart can know no fear.
And as the wind goes soughing through the leaves
I listen, and compare that silence infinite
With this soft sound. Then in my mind wells up
The thought of all eternity, of days
Long past and dead; then of the day that is
And what it means to me. And so, deep down
In this immensity of thought I sink;
And sweet it is to drown in such a sea.

FRANCIS ROGERS in *The North American Review.*

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# THE RELATION OF NURSING SERVICE TO THE CLINICAL LABORATORY PART VIII

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## CEREBRO-SPINAL PUNCTURE

IN syphilis and in various meningeal infections and toxemias it becomes necessary to resort to an examination of the cerebro-spinal fluid. For this, the spinal canal is tapped between the third and the fourth lumbar vertebrae (See Fig 1.)

The usual tray set up for this purpose consists of a spinal puncture needle (FIG. 1, B.), tincture of iodine for preparing the surface and for marking out the position of the tap which is usually in a straight line with the crest of the pelvic bones; three sterile test tubes at least six inches long and of liberal diameter; a small hypodermic syringe and a local anaesthetic solution; some gauze or cotton sponges; a pair of sterile rubber gloves; adhesive strips and the usual dish of alcohol or whatever solution may be used to keep the needles in a sterile condition. The physician usually provides his own spinal puncture needles.

## THE PATIENT'S POSITION

The patient is placed in one of two positions, either seated in a chair astride and facing its back, or reclining on one side in bed. When the latter position is used the services of a strong person are enlisted to grasp the patient under the knees and about the upper part of the body and bend the upper part of the body forward as far as possible so as to bring the spinus crests of the vertebrae into prominence and increase the intervetebral spaces to their maximum. The patient should be kept at perfect rest for twenty-four hours after the tap to ward off the possible headache and fainting spells liable to result from the removal of the fluid. Some physicians give an intravenous injection of from three hundred to five hundred cubic centimeters of physiological salt solution immediately after removing the spinal fluid. In these cases a hypodermoclysis outfit would be a part of the "set up."

In cerebro-spinal tuberculosis, meningococcic meningitis, and in tetanus following a bacillus tetanus infection, a spinal puncture is frequently resorted to at frequent

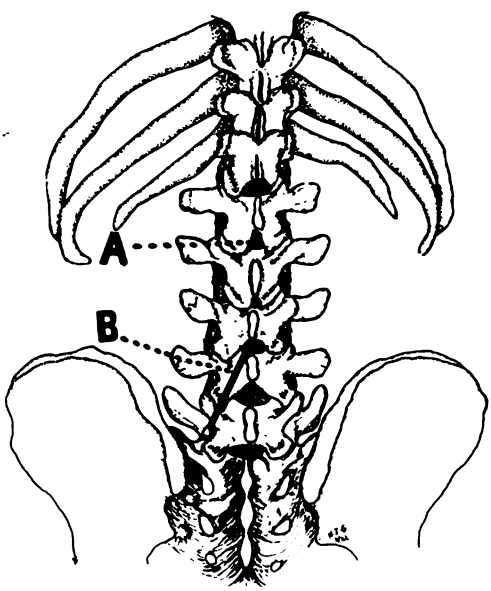


Fig. 1

intervals as a therapeutic measure. In the latter two infections the fluid removed is replaced in part by the respective antiserum.

For the general clinical or cytological examination the three sterile test tubes are provided to permit the dividing of the fluid into fractions. The first fluid obtained is occasionally contaminated with blood from the insertion of the needle. When such is the case, the fluid is allowed to flow into the first test tube until it comes blood free when it is collected into the second tube. At times the latter part of the flow is col-

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lected into the third tube to afford a means to contrast the fluid from the higher areas of the spinal canal with that from the lower level of the spine.

Be sure to label the tubes carefully indicating which is the first, which is the second, etc. Also note the time of the examination and the rate of the flow. The latter is usually expressed as drops per minute. For the general cytological examination the specimen must be blood free and must be collected and sent to the laboratory uncontaminated. When considerable time must elapse between the tap and the examination, the addition of a few drops of sterile potassium oxalate or sodium citrate to each tube will prevent clotting which makes it impossible to count the cells accurately. Sterile tubes containing dry powdered oxalate or citrate can usually be obtained from the laboratory.

### Tetanus Infections

Tetanic conditions may be due to reflex nerve irritation; to the effects of toxic products acting on the nerve elements; and lastly as the result of a tetanus bacillus infection. The first results from a mechanical cause, the second from toxic substances elaborated in the body or introduced from without. The last usually results from wound infection by the spores of the bacillus tetanus. In most cases the clinical history and the symptoms indicate to the physician which type of tetanus he is handling. The spinal puncture is arranged for diagnostic purposes to obtain corroborative evidence and to administer the antitetanus serum.

### Rabies

When a person or an animal has been bitten by an animal suspected of having rabies, the diagnosis is established by the destruction of the offending animal and the careful examination of certain parts of its brain to detect the Negri bodies which are usually found within certain nerve cells of animals infected with rabies.

For success in establishing a diagnosis it is very important that the brain tissues be in a fresh condition. Consequently it is not advisable to kill the animal immediately. It should be confined where it cannot do further harm until suitable arrangements have been made to send it to the diagnostic laboratory. If the specimen is sent a considerable distance, the head is usually severed from the body and packed liberally in ice to preserve it while in transit.

Where an efficient local health organization is maintained the local health officer attends to the destruction of the animal and sends the head to the local or the state laboratory where such examinations are made. This is the advisable procedure since the health authorities can in this way detect an epidemic of rabic animals and promptly inform the local and state authorities to introduce ordinances for muzzling, quarantine and the destruction of animals at large, so that the epidemic may be readily controlled.

### Pleural, Peritoneal and Pericardial Diseases

The pleural, peritoneal and pericardial sacks or cavities normally contain a limited quantity of serous fluid. Infection in these cavities or in adjacent tissues or non-infectious lesions in neighboring tissues or organs, may cause these spaces to fill with excessive quantity of fluid or with pus.

For diagnostic purposes some of the fluid is aspirated from the cavity. The set up for this purpose usually includes two sterile aspirating needles, a ten to thirty cubic centimeter sterile exploring syringe, sterile towels and sponges, a hypodermic syringe with a local anæsthetic (at times a general anæsthetic), tincture of iodine, collodion, the usual cotton swabs, bowls for solutions required to disinfect the skin, sterile test tubes or a sterile glass stoppered bottle, and at times sterile gloves and sterile sheeting.

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The fluids aspirated in these cases are of two general classes—transudates and exudates. The transudates usually result from pathological conditions without the cavities proper, the fluid accumulating because of vascular or circulatory disturbances. Such fluids are usually of a non-inflammatory origin, are clear and as a general rule contain very few cellular elements. They do not coagulate spontaneously, they seldom contain micro-organisms and have a specific gravity of 1.018 or less.

Exudates are of inflammatory origin. They usually contain considerable cellular material, albumen and seromucoid. They tend to coagulate on standing and have a specific gravity above 1.018. Bacteria are usually present. Exudates are usually classed as serous serofibrinous, seropurulent, purulent, putrid, or hemorrhagic. Sometimes the rupturing of lymph vessels into the cavities introduces fat globules which cause a more or less milky appearance. When this is the case the fluid is designated as chylous. When this milk-like turbidity is due to proteins in fine suspension or to fine debris from broken cells, the fluid is designated as chyloid. Such types are occasionally encountered in carcinoma and tuberculosis of the peritoneum.

Nurses should see that these transudates and exudates which are collected with aseptic precautions are placed in sterile containers taking great care that fluid and container are not contaminated. In cases of suspected tuberculosis a very generous specimen should be sent to the laboratory as the chances of detecting tubercle bacilli are greater when a larger quantity of fluid is sedimented for the bacteria.

The proper preservation of tissues and organs removed by operative procedures for pathological examination is a comparatively infrequent duty for the nurse outside of the hospital. Within such institutions definite standards of procedure are usually maintained.

### Kind of Examination

It is always best to receive instructions from the physician as to the kind of examination desired. If it is to be sectioned for tissue abnormalities, the specimen is best placed in a four per cent formaldehyde solution.* Do not use alcohol as a preservative unless formaldehyde is not available as it distorts the tissues and will cause considerable delay if a rapid frozen tissue examination is desired. Should it be necessary to use alcohol, an approximately fifty per cent strength should be applied, not the full strength. Denatured alcohol can be substituted for the pure grain alcohol. This may appear turbid when diluted.

If the tissue or organ is to be examined for bacteria it must not be preserved with either formaldehyde or alcohol but should be promptly forwarded under aseptic precautions. If, for any reason, it must be delayed it should be kept as cold as possible to prevent undue autolytic decomposition. Note without fail, besides the usual data, the kind of tissue or its location, how preserved and for what it is to be examined.

* Formalin (or solution of formaldehyde, 40 per cent), one part; physiological salt solution (or water), nine parts.

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## Rural School Nursing

The essential measures for improving the health of rural school children include the provision of sanitary schoolhouses and environment; control of communicable disease; periodic health examination; provisions for correction of defects; more extensive use of the school nurse; provision for warm lunches at school; provision for wholesome play and recreation; efficient health teaching, and better training for rural teachers, including training for health work.

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# Teaching Methods

*(Summarizing Talks at the Seattle Convention)*

EVERY paper read at the instructors' session conducted by Miss Nellie G. Brown, served to emphasize the importance of the laboratory method of teaching—the observation of facts at first hand plus the exercise of judgment in selection and correlation.

As Miss Nellie Hawkinson of the Massachusetts General Hospital pointed out, the first battle is won when hospital executives realize the importance of laboratory teaching and open the purse strings to secure the necessary facilities.

Knowledge gained at first hand by personal experimentation is driven in upon the field of consciousness by the senses of sight, touch and hearing. The nurse who has examined pasteurized and unpasteurized milk under the microscope has a more vivid realization of the difference than could be gained by pages of description.

In teaching, a distinct line should be drawn between class and laboratory work. To save the time of the student all materials for demonstration should be assembled before the class meets. Often class demonstration is preferable to individual work, in that it saves time and conveys a unified impression.* Notes of laboratory work should be written up before the student leaves the laboratory. The drawings should be made with the apparatus before the student and some notes and interpretations added. The drawings should be labelled, preferably from memory as a surer test of understanding. Notebooks must be carefully corrected by the teacher in order to discover the student's grasp of the matter.

The equipment for laboratory work need not be elaborate. A light room, with running water and gas attachment is sufficient. One microscope should be available for two students, if possible.

Miss Hawkinson later discussed the application of the laboratory method to the teaching of anatomy and physiology. Materia medica can be taught by showing the pupil the raw drug product, its medicinal form, and then tracing its action by graphic records. The department of pharmacology at Harvard has facilities for demonstrating the action of drugs on animals. However, few schools can make use of such facilities.

### Bedside Clinics

Miss Mary F. Power, University of California School of Nursing, emphasized the value of bedside teaching to visualize normal and diseased conditions. She advised that cases be chosen with great care and that pupils be instructed in the points to be observed before visiting the case. Good questioning at the bedside will bring out important points. Beside clinics (in ward or private rooms) should never be conducted without obtaining the permission of the patient and very ill patients should not be disturbed for purposes of instruction. Points in anatomy can be cleared up by excursions to the museum. The lesson points must be strengthened by discussion at the following period.

The vivid impressions which students gain from clinics are often proved by

*Miss Helen Wood in discussing the same question at Stanford University mentioned that accurate attention may be secured by having one pupil carry out the demonstration while another pupil acts as supervisor. Both pupils are especially accurate under this method and the class is also on tip toe to notice defects.

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their answers at examination; class lectures with pupils seated and relaxed can never prove as stimulating as bedside observation.

Miss Lake, of Ann Arbor, cautioned against the use of post mortem specimens to teach living physiology, although such observations are valuable in showing the placement of the viscera, etc.

As was pointed out, clinical bedside teaching when many patients are observed avoids the possibility of a "fixed picture." In many hospitals the physicians and internes take every opportunity to demonstrate important clinical features to the student nurses.

Miss Gilman urged that in assigning nurses to ward duty they be permitted to remain on cases for a period long enough to permit them to observe the whole clinical picture of the cases under their care.

Different methods were suggested for supplying laboratory and clinical instructors at little cost. The instruction of the hospital's dietitian can often be exchanged for the instruction of the chemist or bacteriologist at the high school. The salary of an instructing pathologist can often be financed by the outside pathological work drawn to the hospital. In San José, California, the repetition of endless lectures before the students in various hospitals has been obviated by bringing all the students in busses to the high school where specialists give them lectures in pediatrics, etc.

Under the title "The Place of the Teaching Supervisor," Lillian Clayton of the Pennsylvania General Hospital, Philadelphia, discussed the value of a connecting link between the administrative and teaching forces. Too often the head nurse is more interested in getting the work done than in teaching the nurse how to do it. The clinical ward teacher could help in retaining the good in the old system by so correlating work that pupils would have the opportunity to attain finished technique and not lose the human attitude. Care must be exercised, however, lest any division in responsibility mean less valuable service to the patient.

One of the best talks of the whole convention was delivered by Miss Helen Stewart, Victoria Public Library, Victoria, B. C. She conceived the use of books as tools in the forming of a workable theory of life.

Too often, she pointed out, the specialist sees only the picture in his own frame and fails to correlate his own special knowledge with the great scientific and social horizon. The well balanced individual arrives at a judicial viewpoint by sifting evidence from all available sources of knowledge.

One other point was much discussed at the instructors' section, *i. e.*, the use of intelligence tests to estimate the pupil's mental capacity. This subject was carefully analyzed by Miss Alice L. Lake of the University of Michigan, where the tests developed by Professor Thorndike and utilized by the Army have been tried out. She reported that except in two cases the intelligence per cent paralleled the ability of the pupil as evidenced in subsequent work. Miss Goodrich cited a recent government report which indicated that the presence of fatigue or physical debility might vitiate the accuracy of mental estimates in individual cases. Miss Lake reported that the prejudice against an "intelligence test" had been obviated by terming it a "probable ability test."

The idea which has dominated nursing education since the Kansas meeting—centralized schools, preferably with university affiliation—was advocated by Miss Stewart's report and mentioned at almost every session.

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# Points for Industrial Nurses

## COMMENTS ON THE QUESTIONNAIRE TO INDUSTRIAL NURSES*

GERTRUDE ELLSWORTH, R. N.
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TO answer the questionnaire sincerely and implicitly would epitomize the old saying, " Let the chips fall where they may." Basing my opinion on twelve years' experience in industrial nursing I feel safe in saying that the constructive character of the work of the graduate nurse in industry is commensurate with her own ability. The field may include first aid, health education, sanitation, ventilation, employment, personnel management, social welfare, etc.

### CO-OPERATIVE SERVICE TO THE PATIENT.

A few years ago I visited an industrial plant employing a full time doctor and several nurses. The nurses were not allowed to do any dressings, however slight the injury, until the doctor had given the order. Later I talked with one of the nurses who had been at this plant and she remarked, "I wouldn't have any initiative left if I had stayed in that place." The nurses were continually changing. When I pressed her for a reason, she told me she thought other nurses left for the same reason. The question arises: Why train to be able to render expert services to an individual or company if we are not permitted to use this training and experience as a guide to know how much we may do and when to call assistance? I firmly believe that few graduate nurses of reputable schools are willing to take responsibility that belongs to a doctor. Industrial nurses in the past have had considerable influence and opportunity in persuading employers to engage a physician. Often they have explained to the employer the conditions arising which will necessitate the decision of a physician rather than a nurse. The position of the doctor and the nurse in serving a group of people in an organization does not differ from the same combined service (teamwork) in caring for a private citizen. In other words, they need one another.

### PROFESSIONAL RETICENCE.

Often an employer wishes to know the details of an employee's condition, especially if he is interested, to any extent, in the human element of his personnel, in fact, he expects his nurse or doctor to give him this information. Our observation has shown that the same employer delegates to other officials or department heads certain responsibilities assuring them that he wants results not the details. The doctor and the nurse should be placed on the same footing and not be called upon to betray the personal confidences of those who have signified their faith in them.

One instance will explain this more clearly. Seven cases of venereal disease were noted by an employer in a monthly report of his dispensary. In much alarm, he visited the nurse in her office and wanted to know who the men were. She refused to tell him, saying that she disliked to betray the confidence the men had placed in her.

* The questionnaire and summary appeared in the July and August, 1922, issues of THE TRAINED NURSE AND HOSPITAL REVIEW.

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"But we must protect the other men," he said, "even if we let these fellows out." The nurse informed him that these seven men had come to her seeking advice as to treatment and cure. She had instructed them where to go and she was keeping a check on their treatments. She also told her employer that she did not know how many more of his men who were afflicted were not honorable enough to seek proper advice and treatment. He readily saw her viewpoint and conceded to her wishes.

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### Industrial Illness from Excessive Vibration

Two points of many cited by Dr. W. Gilman Thompson in a recent issue of the *Long Island Medical Journal* apply directly to conditions which the nurse may detect in industrial plants. In the first, a young woman reported dysmenorrhoea, insomnia, and a highly neurotic condition. It was found that she stood all day at her factory work upon a floor that was constantly jarred by the vibrations of a heavy stamping machine. The machine was jacked up, the vibrations were stopped and the patient's symptoms disappeared. Oftentimes treating the environmental conditions gives far better results with industrial diseases than treating the patient's symptoms and leaving the external conditions unimproved.

The second condition is quoted from Dr. Lanza of the U. S. Public Health Service. His attention was called to the fact that locomotive engineers were complaining of sciatica on the right side only. The engineers were in the habit of sitting with the right hip balanced upon a narrow bench as they looked out of the cab window. The incessant heavy vibrations of the locomotive jarred the right leg and gave rise to the painful symptoms. Sawing off the forward end of the benches, so that the engineers could sit squarely and comfortably, cured the sciatica and prevented its recurrence.

The same nerve fatigue has been experienced by order clerks who permit their elbows to rest on the desk while phoning, and by cash girls who send and receive change carriers in department stores. The use of rubber pads for the elbow, a change in the height of the telephone or cash carriage or other small adjustments often eliminate the condition entirely.

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### First-Aid Treatment of Wounds

1. Iodin destroys a layer of tissue over the wound surface without selection. This must be removed before healing can begin and furnishes a favorable culture medium for bacteria.

2. The teaching that every industrial wound is potentially infected is misleading and has done harm. With proper cleansing and débridement almost every such wound will heal without clinical infection. The body cells and fluids can take care of the usual bacteria remaining. Do mechanical débridement with forceps and knife or scissors; follow with chemical débridement with sodium hypochlorite solution.

3. The use of this solution may be varied according to the severity of the wound.

(a) In slight wounds, pour on the outside of the dressing without skin protection or tubing.

(b) In wounds of moderate severity use a short rubber tube without tying or punching, protecting the surrounding skin with sterile vaseline. Patient applies the solution with a medicine dropper.

(c) In severe lacerated wounds, use the Carrel technic.

4. Employees should not be permitted to treat wounds where well-equipped dressing stations and trained nurses or

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surgeons are available. The teaching to use iodin before sending the case to the doctor is pernicious and increases the frequency of infection.

5. When wounds are received far from doctors or dressing stations, where several hours must lapse before a surgeon or trained nurse can be seen, the iodin dressing of wounds by trained laymen is permissible, but these cases should be sent to the surgeon as soon as possible.

6. Iodin is a lazy man's dressing and its use usually accompanies a faulty technic. It is far inferior to Dakin's solution, Ochsner's fluid or dichloramine-T. Silver nitrate, bichloride of mercury, iodin and carbolic acid coagulate albumen and favor infection. They also, by this very coagulation, block up the lymph channels and so prevent outpouring of lymph into a wound, so necessary for its germicidal powers.

7. Clean technic, thorough cleansing, proper suturing, drainage, splintage and rest, are the things that save lives and limbs.—*Colcord in Pittsburgh Medical Bulletin.*

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## Nurses Study Industrial Plants

Under the direction of Miss Phoebe Campbell, an instructor of nurses in the Cincinnati General Hospital, Cincinnati, the graduating class has been making profitable excursions to industrial plants.

On one outing they observed the manufacture of podophyllin at the laboratory of the Wm. S. Merrell Company, where two huge percolators extract this medicinal product from May apple roots. They also witnessed the manufacture of salicylates from birch oil as it is carried out at this establishment.

Such field work gives the nurse a "close-up" view of the opportunities in industrial nursing and, if the excursions are made in factories which manufacture hospital equipment, supplies or pharmaceuticals, brings a broader viewpoint in hospital service.

## Early Detection of Tuberculosis in Industry

The method of seeking out the early or incipient cases of tuberculosis arising in an industrial establishment depends upon several means of routine practice:

A. Physical examination of all applicants.

B. Protecting old employees by eliminating at once from the plant those who have developed the disease.

C. Supervision by semi-annual or annual physical examinations of all employees.

D. Follow-ups and investigation of all cases of illness reported in which there has been an absence from duty, and a physical examination made in certain types of cases before the employee is permitted to return to work.

Other types of suspicious cases should be assigned to a nurse to have temperature and pulse watched morning and evening for stated periods; also a weight chart maintained. If an abnormality occurs, the employee should be relieved from work until a final diagnosis is made.

Through the efforts of the visiting nurse other cases of tuberculosis are often found existing in other members of the family which, had not their presence been discovered and means taken to make the home safe for the remaining workers, additional cases of disease might sooner or later develop. If the nurse is tactful, she can often influence other workers in the household who are apparently healthy to visit their private physician or a dispensary and undergo an examination. It is surprising how often we find other members of the family suffering with the disease, either active or latent, and these would have escaped our notice until at least they had retrograded into advanced cases, had not the homes been visited and a systematic follow-up instituted.

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* Abstracted from an address by Dr. Mervyn Ross Taylor delivered before the Pennsylvania Tuberculosis Society, January 26, 1922.

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# Department of Public Welfare

## EXAMINATION OF SCHOOL CHILDREN*

With very few exceptions cities and towns are not prepared to spend the amount of money necessary to give each school child a complete physical examination each year. Up to the present, the programs for the physical examination of children have been based upon a desire to do a large amount of work and examine a correspondingly large number of children rather than upon any definite scientific standard as to the number of times such examinations are needed or as to the results we may reasonably expect to follow examinations of this type.

This being the case, is it not time for us to face the situation frankly, revise our programs in accordance with definite knowledge, and find out, if we may, how our limited funds can be spent in the way that will be most helpful to the children and in the most economical way as far as the community is concerned?

An intelligent survey of the problem presupposes knowledge on the following points:

(1) When physical defects occur; that is, at what age they may be found for the first time.
(2) How many physical examinations are necessary during the school life of the child?
(3) When physical examinations are most necessary in relation to the age of the child.

In order to answer these questions in a direct way, a study was made in 1909 by the Bureau of Child Hygiene of the Department of Health of New York City. This study included an analysis of physical defects found in a total of 356,292 children who had been examined. Physical defects were tabulated by sex and age groups—6 to 8 years, 8 to 10 years, 10 to 12 years, 12 to 14 years, and 14 years and over. In 1921 a similar study was made to show what difference, if any, existed in the incidence of diseased conditions, and to determine whether or not post war conditions had caused any alteration in either sex or age incidence of the physical defects previously noted.

In analyzing the results in this study of physical defects found in school children the following points seem worthy of emphasis:

1. The less common and more chronic physical defects, such as pulmonary disease, cardiac disease and nervous disease, remain at about the same level throughout the school life, and are apparently influenced little, if at all, by the school environment.

2. Defective hearing and defective vision show a steady and persistent increase from the entering age to the leaving age throughout the school life of the child. In the case of defective hearing, however, the increase is relatively small; in the case of defective vision, the increase is more marked.

3. Malnutrition, defective nasal breathing (implying the presence of adenoids), hypertrophied tonsils or diseased tonsils and defective teeth, show their highest incidence either at the entering age or at the eight or ten year period, thereafter showing a fairly persistent and regular decline.

4. While the incidence defects in all age groups is lower in the 1921 study than in the 1909 study, the relative age incidence remains approximately the same, the percentage of defects found at each age bearing about the same relative position in both studies.

5. The physical examinations and follow-up work for school children in the years intervening between 1909 and 1921 have evidently reduced the total number of physical defects, with a resultant raising of the health standards of the children examined. They have not, however, resulted in a change in the relative age ratio of the physical defects encountered.

The conclusions reached as a result of this study are:

### Conclusions

1. The most important physical examination to be made in the school life of the child is the one occurring at the time the child enters school for the first time.

2. In order to make the work of health supervision of school children effective, a complete physical examination of each child should be made before the eight to ten year period. If this can be done with 100 per cent. efficiency, combined with follow-up that is 100 per cent. effective and 100 per cent. of treatments obtained, it should not be necessary to make regular physical examinations after the eight to ten year period, reliance being placed after that time upon the routine inspection of the children in the classroom. This routine in-

* Abstracted from a paper by Dr. S. Josephine Baker appearing in the *American Journal of Public Health*, June, 1922.

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spection will permit the nurse, doctor or teacher to pick out the cases of physical defects that have been in any way overlooked during routine physical examinations or which have originated after the eight to ten year period.

3. An annual test for defective vision is desirable.

4. Unless the amount of money appropriated for school medical inspection is large enough to allow a complete and thorough physical examination each school year, the officials in charge of such work are not justified in spending any money in having physical examinations made after the eight to ten year period unless the full health needs of the children below that age period have been met.

5. A logical deduction that might be drawn from this study is that great emphasis should be placed hereafter upon the pre-school age period as the time when physical defects should be prevented or corrected.

This study would seem to show that the expenditure of time and money to make annual physical examinations of school children is not warranted and seems to be unnecessary. Analysis of the age and sex incidence of physical defects in this study shows that proper and adequate physical examinations made in the early life of the school child—that is, before the eight to ten year period—are essential, and if these are properly followed up and suitable treatment obtained, the appropriations for this work will be spent in the most economical way, the child's health will be more thoroughly protected and future disease and the sequelæ of physical defects be more adequately guarded against than by any of the present methods of school health supervision.

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## Business Principles Bring Increased Returns

The application of modern business principles to welfare agencies, and the increased returns on the funds contributed effected thereby, are described in a report just made public by the U. S. Department of Labor through the Children's Bureau. This report is the outgrowth of requests for advice which came to the Children's Bureau from organizations in various cities. It embodies the experience of members of the staff whose services were loaned for studies and consultations, and the results of a study of methods used by 200 nursing agencies in both large and small communities.

The immediate results of the reorganization of the first agency studied, affecting both the nursing staff and the office force, were: (1) a marked increase in the nurses' time available for field work, due to elimination of duplicate clerical work on their part, and to increased office clerical assistance. (2) An increase of office output, due to redistribution of duties and orderly routing of clerical work. (3) Increased accuracy in handling records and office detail. (4) Elimination of lost motion, with its waste of time, energy, and space, accomplished by standardizing routing duties and rearranging the office equipment. In addition to these immediate results the new system laid the foundation for orderly development and future economical administration of the association's affairs.

If high standards of nursing service are to be maintained, strict requirements regarding the education, training, experience, and character of the nurse must be compensated by adequate professional salaries. The skilled nursing staff, moreover, must be supported by a skilled office force, intelligently and adequately equipped and directed.

The report is written with full knowledge of the financial limitations which hamper many struggling societies. The subjects include: The principles and methods of staff organization; selection and training of employees; office location and arrangement; selection of office furniture, equipment and supplies; planning case record systems; filing; financial administration, and publicity methods. It includes a bibliography, and an appendix giving details of four record systems in use by different types of nursing organizations.

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## Regimen for Cardiac Children

The following regimen is carried out at the Mineola (L. I.) Home for Cardiac Children:

"Each child, upon admission, is tested to learn its exercise tolerance. The daily program is based on the results of this examination. As the child's cardiac condition improves it is permitted and encouraged to do more physical exercise.

"Each forenoon there is a thirty-minute period when those permitted exer-

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cise have setting-up drill, graduated in severity as the period advances. The exercises are given by a trained instructress and each child is permitted to take as much of the exercises as it can without sustaining abnormal circulation or physical reaction. The valvular lesion gives no clue as to the vigor of the exercise the child may take.

"As time goes on the children develop an increased exercise tolerance and are able to undertake many forms of exercise. Outdoor gardening is used, not only because it stimulates interest, but also because it develops perseverance and endurance by its sustained exercise requirement. Croquet, handball, push-ball and baseball, as well as walking and dancing are used for the same reasons. Quiet games, basketry, etc., too, are taught, so that the children are not only kept interested and precision of muscle action developed, but they learn methods of entertainment which do not require physical exercise. Thus they are afforded some means of diversion and interesting entertainment to occupy their time when forbidden the more energetic physical pastimes.

" Luncheon is followed by a one-hour rest period for every child. The program is repeated in the afternoon. At eight-thirty the children are in bed.

" Some of the severe cases have continued to show slight elevations of temperature with or without enlargement of the liver. With prolonged rest outdoors such cases have not made sufficient improvement to warrant the continuation of treatment. Seven, eight or nine months' residence shows little or no increase of cardiac efficiency. The same period might very well have brought definite improvement to seven or eight other children. The question of the policy of doing the greatest good for the greatest number is thus brought to the fore."

**Dr. Watters Appointed as Consultant**

The appointment of Dr. Ethel M. Watters of San Francisco as consultant in the administration of the Sheppard-Towner Maternity Act has been announced by the U. S. Department of Labor through the Children's Bureau. Since 1919 Dr. Watters has been director of the Bureau of Child Hygiene in the California State Board of Health, and is a well-known pediatrician. All but six states have to date accepted the provisions of the act. In most states the administration will be in charge of the child hygiene divisions of the state boards of health. Plans under which the individual states will administer the funds locally vary with local needs and resources.

Dr. Watters studied medicine at Leland Stanford and Johns Hopkins Universities, receiving her degree from the latter. In addition to her services as Director of the Bureau of Child Hygiene she has been sanitarian of the Bureau of Social Hygiene in the California State Board of Health, and physician to various children's homes and institutions in San Francisco.

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**How to Fight Mosquitos**

One of the natural enemies of the mosquito is the dragon-fly or mosquito-hawk, which feeds on them in the larval stage and also when both insects are mature. Fish, especially young gold-fish, perch, trout, bass and top-minnows will feed on the wiggle-tail. These should be placed in all pools of water which cannot be oiled or drained. Oil placed on the water forms a thin film which prevents the wiggle-tail from coming to the top for air. Death of the larva is the result.

To prevent mosquitoes biting, rub oil of eucalyptus, oil of citronelle, oil of pine, or oil of lavender on the hands and face. —*Louisiana State Board of Health.*

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The Hospital Review

# HOSPITAL ADMINISTRATION AND THE TRAINING OF HOSPITAL EXECUTIVES

IN February 1920, the Rockefeller Foundation called a conference of representative workers to discuss the means of securing properly trained hospital executives in sufficient numbers. Subsequently, the following committee was appointed to make appropriate recommendations on the training of hospital executives: David L. Edsall, M.D., chairman, W. L. Babcock, M.D., Elizabeth Flaws, S. S. Goldwater, M.D., Annie W. Goodrich, Paul Hanus, Rev. Charles M. Moulinier, S. J., Frederic A. Washburn, M.D., Willard C. Rappleye, M.D., executive secretary.

The valuable report of the committee first outlines the functions of the hospital in the changing program for health conservation, and from this basis works out the requisite preliminary and basic training for hospital executives.

## Preliminary Requirements for Training

The development of leaders is more a matter of selecting promising individuals and of providing opportunities for them than it is of designating and giving any preconceived instruction. The need of judgment, poise and temperamental fitness are indicated in a preliminary requirement which may be spoken of as maturity, though not synonymous with age. The complexity of the problems and the various fields of contact of the hospital demand of an executive a mental training and general fund of information which may be suggested by an educational requirement. With proper elasticity in interpretation, a university degree or its equivalent should be a prerequisite for the training. While it may not be possible to prescribe the content of the preparation, it obviously would be desirable that it include the elements of such subjects as biology, psychology, social science, physiology, bacteriology, chemistry and physics. Those with medical training and a fund of knowledge, aptitude and ability in administration have the greatest opportunity to contribuse to the broad program. These requirements are in themselves insufficient without evidence or promise of executive capacity as such, the imagination to visualize programs and policies distinct from details, ability to manage personnel and groups and to act upon as well as to make wise decisions.

The subject matter of a "course" in hospital administration is entirely subordinate to the qualifications, ideals and ability of the student, yet obviously the executive must have relative knowledge of the various activities in the field and such knowledge is best secured through actual training. What may be designated as an elementary or basic course could be designed to present the objectives, ideals. function, organization, contacts and general features of hospital administration, serving at the same time as a method of learning the aptitudes as well as the limitations of the student. Such a training should embrace theoretical and practical work in hospital-community-health problems. An intermediate course can well be provided for those who, for one or several reasons, will not take a full course of training. The major concern and the greatest contribution, however, should be in advanced work by and with a group of properly qualified individuals with vision, adequate training and industry who can be developed into a group of leaders and investigators in the field of community health.

The length of these various phases of a common course must be determined in part by the subject matter to be covered and by practical considerations of the student and the field to be served. Consensus of opinion is that the basic course should probably be not less than twelve nor more than eighteen months. Since it requires about four months to adequately cover a period of practical instruction in hospital operation, and a period of two months should be allowed for visiting other institutions and for final conferences, a total period of fifteen months seems to be the optimum length of the basic course, allowing a full nine months (corresponding to a university year) for the theoretical demon-

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stration work. Possibly additional work in summer sessions should be given.

MATTER REQUIRED FOR BASIC TRAINING.

Without attempting to set up a schedule of subject matter, the following list of major topics for the theoretical training is given largely in an attempt to present something concrete and to designate the relative importance of each for a symmetrical preparation for hospital administration.

I. *Public Health* (20%). Major disease groups, their causes, methods of treatment and prevention; communicable disease control, community, institutional; social factors in disease, ignorance, poverty, vice; vital statistics, hospital statistics; statistics of morbidity for community, patient's records; health insurance, sickness insurance, contract medicine; mental hygiene, delinquency, relation of crime to mental diseases; community sanitation and hygiene, application of principles to hospital; industrial hygiene; relation of hours of work, sleep, diet, fatigue and normal physiology to health and disease; activities of public health departments, state, national; organizations in field of public health, their aims, ideals and operation, group medicine, visiting and public health nursing, etc.

II. *Social Sciences* (15%). General definitions, principles, history; standards of living, poverty, education, recreation, unemployment; urbanization, causes, results of concentration of population; principles and agencies of relief, voluntary, governmental, local; health as a sociological problem, responsibility of government for health protection; rural problems, factors relating to health; principles of community organization, political science, economics; tendencies in sociology; publicity; state medicine, problems incident to it.

III. *Organization* (15%). Fundamentals of organization, responsibilities, governing boards, machinery for administration; internal hospital organization, departments, advisory groups, delegation of activities and responsibilities; external contracts, agencies of the community, professional groups, political machinery; correlation of laboratory, X-ray, radium, social service, nursing dietetics, ambulance service, visiting nurses, operating rooms, out-patient department, follow-up and after-care services, etc.

IV. *Hospital Functions and History* (10%). History of medical and nursing practice, traditions and education; present tendencies in medicine and nursing, various suggestions to meet problems; history of laboratories, social service, dietetics, special therapies, their relationship to each other and to other activities; history of hospitals and their tendencies, foreign and American; position of hospital in community activities, present conception, tendencies; functions of hospitals and modifications of such functions; methods of care of sick, hospital and other methods.

V. *Business Science* (10%). Definitions, theories of production and distribution; distribution of industrial risks, insurance of various kinds; cost accounting and interpretation, elements of bookkeeping; budget making, various types of accounts, collections; purchasing and selling, financing of capital and maintenance charges of hospitals; various forms of revenue, endowments, sustaining funds, community chests, state or municipal support, contributions, bonds, trust funds; records of performance of departments; office records and reports.

VI. *Institutional Management* (10%). Principles, definitions, purposes, lines of responsibility and contact, management of departments such as kitchen, laundry, engineering, office, units of the hospital, store-room, housekeeping, etc.; economies and methods of curtailing expenses of operation.

VII. *Personnel Administration* (5%). Labor problems and labor management; psychology of work; efficiency, rewards, methods of increasing responses of workers; functions of labor in production; handling professional groups and departments.

VIII. *Community Hospital Needs* (5%). Classification of hospitals; needs of the community for medical and nursing services; needs for hospitals and dispensaries, for various types of hospital beds, determining factors of industrial and social life, area to be served, population to be served, living conditions, etc.; distribution of hospitals and their size, relative to present and probable demands; other facilities in community for medical and nursing care; support in sight for an adequate program.

IX. *Physical Plant* (5%). Location, construction, ventilation, heating, lighting, refrigeration; maintenance, alterations, repairs, equipment, depreciation, fuel consumption, etc.

X. *Jurisprudence* (5%). Elements of contracts, testimony; responsibilities of and legal requirements for the practice of medicine and nursing; legal responsibility of hospital in matters of autopsies, accidents, compensation, operations, laboratory findings, professional care; principles of privileged communications; professional testimony.

At the completion of this academic-demonstration-conference period of nine months, six months of practical work should follow under educational supervision, the first four months to be spent in one hospital and the major part of the last two months to be spent in visiting hospitals of different types, sizes and organizations with the aim of learning adaptations and modifications which are necessary to meet different situations. A final period could be best spent in a seminar of interpretation conferences and discussions. This whole course would not produce a finished hospital executive but should provide a reasonably good background for future development either in the field of practical hospital and community health administration or for more advanced work in health economics.

RESEARCH IN HEALTH PROBLEMS.

The usefulness and very existence of any possible training center will be both measured by and dependent upon the spirit of investigation. Research activities must be inseparably identified with such a center if it is to realize the fullest conception of its function. Many of the problems fundamental to the economics of health and disease, to hospital needs, construction, organization, support, functions, finance, management, community service, bed distribution, educational activities, accountability, rural medical and nursing needs, group practice, urban demands, laboratory service and dispensary activities are inadequately solved. There is pressing need for real investigation into these and many kindred subjects and such studies may well be considered within the domain of such a possible training-research center.

Wherever the teaching center is located, it must be reasonably accessible or likely to be developed in the near future, the facilities, machinery and teaching personnel necessary for presenting the fundamentals of the sub-

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jects discussed previously. Such material and personnel are represented for the most part in well established Schools of Arts and Sciences, Business Administration, Medicine, Nursing, Public Health, Engineering and where well developed hospitals, dispensaries and social agencies are available. All of these need not necessarily be present in the same city but a close educational supervision must be provided. The training suggested contemplates contribution from a number of sources but of greater importance than the mere contributions are the vision, teaching ability and attitude of those who will have charge of the instruction and supervision. The training should be under university supervision and the immediate direction of an individual of adequate university caliber, with a departmental staff and organization appropriate to this problem of training and research.

Wherever possible, courses now in existence and present personnel should be utilized. Problems incident to assembling material and mobilizing courses and personnel in several major universities and hospital organizations to apply on a comprehensive training program cannot be handled by someone whose time and energy are largely taken up by other activities. Any possible training-research center should be effectively articulated with other activities in the local environment and should merge its interests and problems with those of other groups with which it has contact.

The growth of a sense of community responsibility in matters of health is leading to a demand for co-ordination of the diversified activities and professional groups concerned with these problems. The hospital represents in general the common ground of most of these activities and groups and a type of organization which may readily be adapted to the functions of co-ordination, education and service. It occupies a strategic position in the whole field of community health and provisions for the adequate training of hospital executives would constitute a fundamental contribution of the entire program. The development of personnel and the furthering of our knowledge of organized community efforts looking toward the conservation of health and the prevention of disease should be a fundamental to any plan of training.

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# OCCUPATIONAL THERAPY PROGRAM

This year the American Occupational Therapy Association will hold its convention with the American Hospital Association. The following interesting program will be presented:

**Monday, September 25**

9 a.m. Registration and credentials. Members are requested to bring their membership cards with them.

10 a.m. Meeting of House of Delegates. Delegates should present letters signed by the president or secretary of the local society stating that they have been appointed to act as delegates.

2.30 p.m. Opening Session
Invocation
Address of welcome
Address of the President—H. J. Hall, M.D.
Observation of Patients' Reactions the Guide to Further Treatment—L. J. Haas.
Men's Occupational Therapy in Convalescence—Frederic Brush, M.D.
The Educational Significance of Occupational Therapy.

**Tuesday, September 26**

10 a.m. Business Meeting
Reports of Officers and Committees
Election of President

2.30 p.m. Occupational Therapy in General Hospitals
a. The Hospital Workshop. Winifred Brainerd, Presbyterian Hospital, Chicago
b. Work on the Wards.
c. Work in Dispensaries.
Discussion
Round Table on Recreations. a. Music. b. Dancing. c. Physical exercises. d. Games. e. Theatricals.

**Wednesday, September 27**

10 a.m. Reports from States

2.30 p.m. Financial Side of Occupational Therapy
State Hospitals—H. W. Pollock, M.D.
Incorporated Hospitals—L. J. Haas
Sanitaria a. Tuberculous b. Psychopathic
The Economic Side of Work in Hospitals.
Round Table on Training Courses, Conducted by Miss Ruth Wigglesworth.

**Thursday, September 28**

10 a.m. Reports from States (continued)

2.30 p.m. Experiences in Hospitals for Ex-Service Men
General Hospitals. Miss Geraldine Lermit
Neuro-Psychiatric Hospitals.
Tuberculous Hospitals.
Round Table on Records—Conducted by H. M. Pollock, M.D.

**Friday, September 29**

10. a.m. Crafts best suited for the Mental and Nervous. Round Table conducted by W. R. Dunton, Jr., M.D.

11. a.m. Crafts best suited for the Tuberculous. Round Table conducted by T. B. Kidner

2.30 p.m. Crafts best suited for Bed Cases. Round Table conducted by Mrs. Mary F. Steinbach

3.30 p.m. Crafts best suited for the Physically Disabled. Round Table conducted by Miss Bowman.

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# HOSPITAL CONVENTION PROGRAM

*Atlantic City, September 25-28*

ATLANTIC CITY, a splendid exhibit of the newest and best in hospital construction, equipment and supplies, and the well-rounded program which follows—all insure a banner meeting of the American Hospital Association at the Million Dollar Pier, September 25-28, 1922.

**Monday Morning, September 25**

Registration.

**Monday Afternoon, September 25**

2 p. m. *Opening General Session.*

President, George D. O'Hanlon, M. D., presiding.

Invocation.

Address of Welcome—Hon. Edward I. Edwards, governor of New Jersey.

President's Address—George D. O'Hanlon, M. D.

Report of trustees—Executive Secretary.

Report of treasurer—Robert J. Wilson, M. D.

Report of executive secretary—A. R. Warner, M. D.

Report of membership committee—*Chairman,* Walter H. Conley, M. D., superintendent, Metropolitan Hospital, Welfare Island, N. Y.

Second report of committee on forms and records with particular reference to annual reports.

Opening business.

4:30 to 6 p. m. *Study of Exposition.*

**Monday Evening, September 25**

8 p. m. *General Session and Section on Construction*

President George D. O'Hanlon, M. D., presiding.

*Chairman,* E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago.

Report of special committee on floors—*Chairman,* Frank E. Chapman.

Report of exposition committee on buildings—Construction, equipment and maintenance—*Chairman,* S. S. Goldwater, M. D.

Round table discussion—Construction section—*Chairman,* E. S. Gilmore, presiding.

**Tuesday Morning, September 26**

9 a. m. *General Session*

President George D. O'Hanlon, M. D., presiding.

Reports of exposition committee.

General furnishings and supplies—*Chairman,* Harold W. Hersey, M. D., of the Joint Administration Board, Columbia University and Presbyterian Hospital, New York.

Clinical and scientific equipment and supplies—*Chairman,* A. B. Denison, M. D., assistant director, Lakeside Hospital, Cleveland.

Food and food equipment—*Chairman,* C. W. Munger, M. D., superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich.

Laundry equipment and supplies—*Chairman* W. P. Morrill, M. D., superintendent, Shreveport Charity Hospital, Shreveport, La.

Address—(Subject to be announced) Royal S. Copeland, M. D., Health Commissioner, New York City.

11 a. m. to 2:30 p. m. *Committee Meetings, Study of Exposition and Lunch.*

**Tuesday Afternoon, September 26**

2:30 p. m. *Section Meetings*

Dispensary (in the theater)—*Chairman,* John E. Ransom, superintendent, Michael Reese Dispensary, Chicago.

Dietetics (in the convention hall)—*Chairman,* Miss Lulu G. Graves, supervising dietitian, Mt. Sinai Hospital, New York.

Discussion on Children's Departments in Hospitals—Frank Howard Richardson, M. D., of the Children's Diagnostic and Nutrition Clinics of North Carolina, and Children's Department of Brooklyn Hospital, Brooklyn, N. Y.

The organization of Dietary Departments in Hospitals—Marion Peterson, Lakeside Hospital, Cleveland.

A Round Table Discussion on Hospital Equipment.

4:30 to 6 p. m. *Study of Exposition*

**Tuesday Evening, September 26**

8 p. m. *General Session*

President George D. O'Hanlon, M. D., presiding.

Report of special committee on renovation of gauze and standard dressings—*Chairman,* A. B. Denison, M. D., assistant director, Lakeside Hospital, Cleveland.

Address—"The Liability of the Hospital"—John A. Lapp, managing editor, *The Nation's Health,* Chicago.

Report of dispensary committee—*Chairman,* John E. Ransom, superintendent, Michael Reese Dispensary, Chicago.

Report of legislative committee—*Chairman,* C. G. Parnall, M. D., medical director, University Hospital, Ann Arbor, Mich.

Address—"The Hospital Problem in Relation to Modern Medicine"—W. C. Stoner, M. D., Cleveland, Ohio.

**Wednesday Morning, September 27**

9 a. m. *General Session*

President George D. O'Hanlon, M. D., presiding.

Report of nomination committee—*Chairman,*

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D. L. Richardson, M. D., superintendent, City Hospital, Providence, R. I.

Appointment by president of three tellers for the voting.

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Address—(Subject to be announced) Dr. George D. Stewart.

11 a. m. to 2:30 p. m. *Committee Meetings, Study of Exposition, and lunch*

**Wednesday Afternoon, September 27**

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Address—"The Association for Next Year."—The new president.

Adjournment.

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Program of scheduled visits to hospitals and special demonstrations in both New York and Philadelphia.

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# DISINFECTION AFTER CONTAGION*

ROBERT J. WILSON, M. D.
Director of Hospitals, Department of Health, New York City

THE whole question of the disinfection of infected premises and articles of equipment depends entirely upon whether or not there is present living organisms that cause disease. To determine when fumigation by disinfectant gases and other methods of disinfection and sterilization should be used, it is necessary to fix a time at which it is supposed living organisms may be reasonably expected to be present. This time limit is based upon the results of experiments carried on in experimental laboratories as to the length of time that some of the common infectious organisms live after being exposed to deleterious influences such as drying, the effect of exposure to sunlight, dilution by dissemination through the air, etc. There must also be considered the character of the organism itself; for instance, the influenza bacillus succumbs immediately to drying; the tubercle bacillus resists drying and the effects of sunlight for months. In the former instance disinfection is not indicated, in the latter, owing to the character of the organism and its persistence, the possibility that a single organism might cause infection in a susceptible person makes it necessary to disinfect premises that have been infected, even though months have passed since the last patient was removed from them.

Theoretically, at the termination of the recognized periods of quarantine described in the pamphlet on the control of communicable diseases (Miscellaneous Publication No. 24 of the U. S. Public Health Service), all of the vegetative forms of organisms that cause the disease have succumbed to the deleterious conditions mentioned above and there is no longer any infected area to be disinfected. On the other hand, if a case of acute infectious disease has died in a premise or has been removed therefrom and other non-infected persons are to immediately occupy such premises, then every recognized means of disinfection, including fumigation by thoroughly ridding these premises of living organisms, should be used. Such a process includes the use of a fumigating gas, preferably formaldehyd, followed by a thorough washing of those parts of the premises which might reasonably be suspected to have been infected by the hands or discharges of the infected person who occupied them and finally, in some instances, such as tuberculosis and leprosy, the premises should be thoroughly renovated by painting every exposed surface.

Statistical figures, as a general rule, fail to give the information sought and that is not better illustrated than in the figures submitted to me.† The diseases mentioned—scarlet fever, diphtheria, influenza and streptococcus—are all caused by vegetative forms of organisms, *i. e.,* streptococcus and diphtheria certainly are, and the other two are the result of infection of unknown organisms probably having the same general character of vegetative organisms. We know, in advance that it is ridiculous to fumigate, disinfect or take any other account of the influenza bacillus provided that it has been permitted to entirely dry because it is dead. We know that the diphtheria bacillus, under the influence of drying and sunlight, succumbs quickly. The same is true of streptococcus. We believe that the scarlet fever organism is entirely absent from the premises at the end of the quarantine period recommended by the Public Health Service. Such being the case, and without a knowledge of the time that passes between the end of quarantine and the time that the disinfection took place in the questionnaire, leaves us in a doubt as to any value to be placed upon the answers to this question. There is one thing we can be sure of: repainting and varnishing, after these particular diseases, is unnecessary.

In the second question, as to the sterilization of laundry, there is again to be considered the character of the organism we are dealing with. The known ones, diphtheria and streptococcus and, by inference, scarlet fever and influenza, being of the vegetative type, succumb to a heat equal to that which coagu-

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lates albumin. This is far below the boiling point of water, ranging from 61 degrees to 80 degrees C. Why practice anything further than the simple process of boiling it? In the sterilization of dressings supposed to be infected with spores, it is quite another question, especially if these dressings are to be used again in surgical cases. The habit of using 3 to 5 per cent carbolic acid solutions for sterilization of clothes and goods that cannot be boiled is to be commended. Carbolic solutions have a penetrating quality in addition to their disinfecting value that makes them desirable as compared with plain watery solutions of some other disinfectants.

Third question: The effect of plain drying for the time necessary to sterilization in this way of the various organisms named will produce the death of the germs. If an organism of more resistant nature is being dealt with, autoclave sterilization is the only sure method of attaining the desired result.

Fourth question: Not to carry out the provision of this question relative to simple cleanliness would be gross neglect of sensible hospital administration.

Fifth question: The unanimous reply that at least a thorough cleaning is practiced on the fixtures and equipment that have been in intimate contact with the patients is evidence that hospital superintendents, generally, are alive to the necessity of protecting their patients and staffs against infection after such cases have been in the hospital.

When disinfection is indicated by the nature of the disease and the conditions surrounding it, it should be done. To determine when this is indicated, hospital superintendents and superintendents of training schools should take advantage of the reports and literature of the United States Public Health Service and follow the instructions and advice it gives. Such procedure will result in safe and approved standard methods in which the Public Health Service will be glad to co-operate.

## Travelling to Atlantic City

As formerly, delegates will be able to take advantage of special railroad rates in attending the convention provided they hold active, associate or life memberships. Applications for reservations should be made direct to Mr. W. E. Blachley, Division Passenger Agent, Pennsylvania Railroad, Room 504, 323 South Wells Street, Chicago, not through your agent.

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double fumigation with formaldehyd—"before and after cleaning."

II. Is linen routinely sterilized other than by ordinary laundry process in case of: (A) Scarlet Fever; (B) Diphtheria; (C) Influenza; (D) Streptococcus?

*Answers*—As the answers gave the routine practice for the four diseases almost invariably the same, the same figures apply to each.

*No* (without comment)—9.

*Yes* (without comment)—69. *Yes* (specifying the following methods): Autoclave—5; Boiling—9; Soaking in formaldehyd solutions varying in strength from 1 per cent to 40 per cent—22; Soaking in carbolic solutions from 2 per cent to 10 per cent—9; Soaking in creosol solutions varying from 1 per cent to 5 per cent—10; Soaking in lysol solutions varying from 1 per cent to 5 per cent—13; Soaking in other solutions—7. *Total. Yes*—144.

III. Are the mattresses sterilized other than surface cleaning—as in an autoclave—in case of: (A) Scarlet Fever; (B) Diphtheria; (C) Influenza; (D) Streptococcus?

*Answers*—As there was practically no variation in the answers for the four diseases, the same figures apply to each.

*No* (without comment)—24; *No* (with the method of surface cleaning specified as follows): Formaldehyd solutions varying from 2 per cent to 10 per cent—11; Carbolic acid solution (5 per cent)—9; Creosol solutions varying from 2½ per cent to 5 per cent—3; Lysol solutions varying from 1 per cent to 5 per cent—11; Other solutions—4; New or washed ticking—3. *Total No*—65.

*Yes* (method not stated)—15; *Yes*, and specifying the method as follows: Autoclave—41; Special formaldehyd fumigation—12; Formaldehyd fumigation with the room—36; Dry heat sterilization—3; Mattress destroyed—1. *Total Yes*—108.

The discrepancy between the combined totals (173) and the number of questionnaires (156) is accounted for by the reported routine using two of the above listed methods and, therefore, counted twice, as: "fumigated with the room then sent to the autoclave."

IV. Are the walls and floors cleaned with soap and water or other solutions before new patients are admitted in case of: (A) Scarlet Fever; (B) Diphtheria; (C) Influenza; (D) Streptococcus? See answers to V.

V. Is the furniture cleaned with soap and water or other solutions before the admission of new patients in case of: (A) Scarlet Fever; (B) Diphtheria; (C) Influenza; (D) Streptococcus?

*Answers*—The same answer was almost invariably given for each of the four diseases for both the fourth and fifth questions, so the same figures apply to each disease and to both the fourth and fifth questions.

*No*—3.

*Yes* (method not stated)—1. *Yes* (using the following methods): Soap and water—132; Formaldehyd, 2 per cent—1; Carbolic acid, 2 per cent to 5 per cent—8; Creosol, 2 per cent to 5 per cent—15; Lysol, 1 per cent to 5 per cent—15; New paint, varnish or wax—7; Other solutions—5. *Total Yes*—184.

The discrepancy between the combined totals (187) and the actual number of questionnaires (156) is accounted for by reports of routine combinations as "gone over with 5 per cent lysol solution then washed with soap and water." Such replies were counted with "soap and water" and also with "lysol solution."

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# Gleanings

### After-care in Tonsillectomy

Whether the operation has been under general anesthesia or under "local," the patient, following operation, should be placed in bed, on the side, with but a small pillow under the head, so placed that secretion may by gravity run out of the mouth. By so placing the patient, the nurse can readily note should there be unusual hemorrhage.

Should it be known that the patient is a bleeder, for several days prior to operation, calcium lactate should be given in doses of 10 to 15 grains, three times daily. As soon as the patient can conveniently swallow, following the operation—say on the second day—this drug should again be given.

Where a tendency to unusual bleeding is evidenced during operation, due to unusually large vessels, lack of blood coagulation, etc., Dr. Hugh Miller frequently employs a pack as follows: A bunch of cotton is selected of such a size that when firmly compressed it will thoroughly fill the fossa. Into this pack is worked a quantity of powdered sulphate of iron. This is packed securely into the tonsilar fossa and held there with tongue depressor for a few minutes. When the depressor is removed, there is a flat, smooth surface internally—no ragged edges hanging down to annoy the patient—and the pillars fit neatly around the pack. When the pack is removed it is necessary to secure a good hold before traction is made. This pack may also be used in case of secondary hemorrhage.

Dr. Miller interdicts the use of gargles which tax the use of the neck muscles and may bring on hemorrhage. The patient, however, wishes to be doing something in this line, so an alkaline is prescribed to be used as mouth wash only, twice daily. On alternate days, after forty-eight hours, a 10 per cent. solution of silver nitrate is gently applied into the fossa. Patients usually find this application grateful, if the solution does not reach the mucous surface.

For the relief of pain, Dr. Miller prescribes a mixture of acetanilid and aspirin chewed dry. The medicine is given one-half hour before meals, and at bedtime. This combination produces constitutional relaxation and comfort, for which the patient is exceedingly grateful.—*Eye, Ear, Nose and Throat Monthly.*

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### Has Your Thermometer Been Tested

Recent tests made by the New York Department of Health on new thermometers show a high percentage of inaccuracy in recent importations. The solution of this problem would seem to lie in a prohibition of the sale of any clinical thermometers without the certification thereof of the United States Bureau of Standards. Are you sure that your thermometer is accurate?

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### The Cod-liver Oil Binder

Eustace Thorp, O.B.E., L.R.C.S., reports excellent success in the use of the old fashioned cod-liver oil binder for marasmic or premature babies. His directions are as follows: Procure a flannel binder, wring it out in the oil and apply to the baby's abdomen. Keep moist with a sufficient quantity of oil to

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ensure that the binder is wet with it throughout the twenty-four hours. Change the binder once weekly or twice at the most. Babies rapidly put on weight and firmness where these simple rules are carried out. Our results are very excellent, and those who have not tried this method will find very encouraging improvements after its use. In many cases the binder may be dispensed with in about a month. Cod-liver oil is cheap and in its pure form more efficacious than in any other, and if it is provided for the baby, the baby alone gets it.—*Nursing Mirror.*

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### The Prevention of Goiter

The ultimate cause of simple goiter is totally unknown. The immediate cause is a lack of iodin. The enlargement, therefore, is a symptom of the iodin needs of the organism. It may follow certain types of infection; it may result from any factor which interferes with the normal utilization of iodin; or it may result from experimental deprivation of iodin.

The administration of minute doses of iodin, therefore, is accepted by some authorities as a preventive measure.

The administration of 2 gm. of sodium iodid in 0.2 gm. doses, distributed over a period of two weeks, and repeated each autumn and spring has been tried in certain cases. This amount of iodin is excessive, and far beyond the needs of the individual or of the ability of the thyroid to utilize and store it. One gram distributed over a longer period would be better. The form or mode of administration of iodin is of little consequence. The important thing is that iodin for thyroid effects should be given in exceedingly small amounts, and it is believed that most of the untoward effects recorded are due to the excessive doses employed, or, more concretely, to the abuse of iodin. The results of two and one-half years' observations on school girls in Akron are as follows: Of 2,190 pupils taking 2 gm. of sodium iodid twice yearly, only five have developed enlargement of the thyroid; while of 2,305 pupils not taking the prophylactic, 495 have developed thyroid enlargement. Of 1,182 pupils with thyroid enlargement at the first examination who took the prophylactic, 773 thyroids have decreased in size; while of 1,048 pupils with thyroid enlargement at the first examination who did not take the prophylactic, 145 thyroids have decreased in size. These figures demonstrate in a striking manner both the preventive and the curative effects. The dangers of giving iodin, in the amounts indicated, to children and adolescents are negligible. David Marine and O. P. Kimball in *The Journal of the American Medical Association* (October 1, 1921.)

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### Acute Appendicitis in Children

Ordinary colics are distinguished by the absence of localized tenderness and fever, by their short duration and by the fact that the pain is less intense.

Appendicitis and intussusception are two of the most serious acute conditions in a child's abdomen and we should constantly have them in mind when searching for the cause of any abdominal disturbance.

If there is doubt as to the diagnosis, stop all nourishment by mouth, flush the bowels with enemas, supply the system with fluids by the Murphy drip and if there is elevation of temperature, apply the ice bag to the abdomen. Above all, avoid giving any cathartics by mouth. The pernicious habit of giving castor oil, etc., in every abdominal disturbance in children has been the cause of many ruptured appendices.—McCauliffe in *Journal of the Iowa State Medical Society.*

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### Controlling Eczema in Infants

In investigations conducted by O'Keefe, more than 60 per cent. of breast-fed infants with eczema showed protein sensitization by skin tests; in no case was there sensitization to human milk, nor did any mother show a skin reaction to the protein to which her child responded. Forty per cent. of the infants showed a positive reaction to egg proteins, 39 per cent. to cow's milk, 5 per cent. to oats and 2 per cent. to wheat Elimination of the food involved from the mother's diet gave apparent cure in 40 per cent. of the cases, and definite improvement in 20 per cent. more, a grand total of 60 per cent.—*Journal of the American Medical Association.*

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### Nursing in Pulmonary Tuberculosis

Rest is usually indicated in cases of persistent cough, and it is gratifying to note what twenty-four or forty-eight hours under covers will often accomplish—not only the entire body but the lung itself is placed in a state of minimal activity by this treatment and the inflamed part is favored as well as relieved of the irritation of greater quantities of air coincident with exertion. Again, a fairly constant temperature is established, which greatly relieves the vasomotor system and offers it an opportunity to pull itself together and overcome conditions of congestion, etc.

The intestinal tract should be given scrupulous attention, and a laxative is usually in order, which, besides reducing the toxemia, helps in the adjustment of the circulatory embarrassment.

The skin can be deputized, and the hot bath, Turkish baths and mustard footbaths, as well as the local use of mustard, iodin, and camphorated oils as all valuable assets, active chiefly by virtue of their eliminative and counter-irritant properties.

The irritative cough, dependent on dryness or lack of secretion in the upper respiratory passages, can often be relieved by such measures as the sipping of small quantities of olive oil or swallowing small pieces of vaseline, supplemented by inhalations of a preparation containing menthol, chloroform, alcohol and creosote. A few drops of which are placed in a mask and inhaled for a period of fifteen minutes. This measure is quite valuable where pulmonary hemorrhage threatens.—*Therapeutic Gazette.*

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### Simple Remedies

Sometimes scratches and skinned places cause continued bleeding. For these use equal parts of finely powdered alum and tannic acid on the spot. (Alum and tannin are the basis of nearly all styptic powders used by barbers.)

#### Chapped Hands

For chapped hands and faces there are few things to equal a preparation of equal parts of glycerin and alcohol; a little rose water may be added if desired.

#### Toothache

Toothache is always unsatisfactory to treat, for in many cases no relief is afforded until the offending tooth is removed. Dip a piece of cotton in tincture of opium, and let most of the alcohol evaporate, then place in the cavity. Another good preparation is made of half a dram of oil of cloves mixed with one dram each of alcohol and creosote. Apply to the cavity with cotton. —*Nursing Times.*

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### Warding Off a Cold

The common cold has three stages: the first, soreness of nose and watery discharge, curable by taking brisk outdoor exercise; second stage, fever, curable by a day's rest in bed; third stage, swollen membranes and accumulation of pus, which cannot be cured, and may take days, or even weeks, for recovery.—*Lancet.*

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# Editorially Speaking

### A Time Limit?

When a nurse enters a new field of work, her employer usually requests a certificate of training from the superintendent under whom the nurse has received her education. Is this always necessary?

The name of the nurse is duly recorded in the annals of the hospital school. The hospital's records should show the exact content of the course at that time and the nurse's ability to master it. Other records should also be on file with state boards showing that she has passed the state board examination. One might expect that these credentials would be sufficient to prove eligibility to take up further educational courses, to enter government service or to handle the work of a health organization. NO! Twenty years after the nurse has graduated, when experience in hospitals, in visiting and school nursing over the whole period should give a true estimate of ability, the nurse still refers to her former principal for a "certificate of professional training."

Often the superintendent is asked to "give an estimate of the applicant's personality." This is manifestly ill-considered. A mist of twenty years may distort values, at least prevent a clear focus. In the memory of the principal, previous faults, virtues, or ability may be rolled into mountains or smoothed into oblivion. In addition those years may have ripened the experience of some graduates and revealed the weaknesses of others. Only recent employers could give a fair estimate of the present personality of the applicant.

These conditions indicate that the value of the certificate of professional training depends largely upon the length of time elapsing between graduation and inquiry. Where school records are faulty and state records incomplete, the superintendent might be the court of last resort. But why hark back to the superintendent in every case? Why not set a time limit, after which the superintendent should not be referred to under ordinary conditions?

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### New Sources of Information

The story of the manufacture of catgut, which appears in another part of this issue, is indicative of the wealth of instructive information available through the scientific laboratories of the country.

We have all learned to look up to our great foundations which are carrying out valuable research for the improvement of health and social conditions, but we sometimes forget to utilize the equally valuable contributions developed in our reliable commercial laboratories.

How often do you discard the directions accompanying a medical preparation without glancing at the contents? And yet that product may have been perfected after years of the most careful research, and the exact manner of its application decided upon after the most exhaustive tests. The time which elapses between the discovery of a new principle in the laboratory and the application of that principle in the field of practical medicine is proof of the degree of exact research involved.

Literature issued by reliable laboratories should be studied for the educational

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information which it contains. Do you absorb this information so that you are able to utilize medicines and supplies in the most helpful way? Do you keep the product protected from light, heat or moisture, as directed, so that it retains its full strength?

Be assured that the man of science has tested his product under every conceivable circumstance. He knows the most advantageous way to apply it, and when the physician under whom you are working asks you to use a solution or apply a salve, follow the directions carefully, unless the attending physician issues other orders.

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**The Importance of Menstrual History**

To nurses who are called upon to take the patient's history in gynecological cases the following points brought out by Dr. Onslow D. Gordon, Jr., are especially pertinent:

The menstrual history should be noted in the following manner: First: Onset of the patient's menstrual history. Did she begin menstruating at the usual age? or was there evidence of some congenital abnormality or endocrine perversion even in her youth? Second: The patient's standard menstrual type. This is usually established after about one year of menstrual life. Third: The time and character of the original deviation from the normal. Fourth: The bleeding history of the past few weeks or months. The bleeding history is especially important in establishing a differential diagnosis. Extra-uterine gestation, for example, gives the following picture. The patient's normal menstrual condition is followed by a short period of amenorrhea. In the large majority of ectopic gestations trouble dates from about the sixth week after the last menstrual period. At about this time the primary accident occurs. The accident may be tubal rupture or as is more frequently the case, so called, tubal abortion; at this time the patient usually begins to bleed vaginally. The bleeding is usually characteristic, it is not the scanty metrorrhagia of malignancy, it is not the sudden profuse flow coming from a clear sky as does the bleeding of uterine abortion, it is a flow resembling normal menstruation in amount and usually lasting several days. Then comes another short period of amenorrhea followed by more scant bleeding.

As the nurse is usually successful in obtaining information along these intimate lines of questioning, it is especially important that she realize the importance of recording the smallest detail of significance.

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**Negative Criticism**

Dr. Snow gave a very interesting address on the interrelation of health workers at the Seattle convention. Our interpretation of the discussion which followed (as reported in the August issue) has brought down the thunder. If the atmosphere is cleared, we can sustain the rebuke.

Let us talk it over. The individual who takes up nursing has in herself an untutored social and helpful attitude toward her fellowmen. The impulse is the drive of service. Is this interest in human beings as individuals intensified during the period of nursing education? Yes, in some cases; no, in others.

Adherence to soulless routine, satiation with human suffering, grilling discipline —all present in some hospital schools— leave their mark. You recognize it occasionally in the impersonal attitude of the clinic nurse, or the unnecessary brusqueness of the nurse on the ward—a mark that is distinctly unsocial. The same surroundings may bring other nurses into a greater appreciation of the personality of the individual, a greater facility in developing his capabilities.

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Let us consider this appreciative nurse as the average hospital graduate. She possesses the basic *health* knowledge which must be applied in the school, in the home. Has she all the knowledge needed to apply it?

Take the school nurse, for example. She can detect symptoms of disease, she can nurse illness in the home, she can advise the mother about food, clothing, habits. Could she utilize and mold family or outside environment to bring about the child's greatest physical and mental development? Could she estimate the mentally defective child? Could she apply the principles of psychology in teaching health and prevention? Not without further study.

Take the field of hospital social service. Miss Richmond classifies the acts of social workers under the following heads:

A. Insight into individuality and personal characteristics.

B. Insight into the resources, dangers and influence of the environment.

C. Direct action of mind on mind.

D. Indirect action through environment.

The nurse in her cloistered hospital environment has had extended experience in the functions noted under A and C. Only in chance contacts has she had experience in the social environment (outside of the hospital) which is included in the experience noted under B and D. Could she utilize the experience of social workers? Not without further training.

Nurses, of all the workers engaged in health work, are most conscious of the situation. Perhaps this is the result of their nursing education. With life and death in her hands the nurse learns to be sure of her knowledge before she acts. She possesses fundamental knowledge of the biological sciences, she possesses perfection in the technique of their application. The nurse, therefore, will always be the basic *health* teacher.

We did not mention this? No, we thought nurses considered this axiomatic. We were, however, so extremely anxious that nurses handle the fields allied to health only when they have the education and experience to do the work with the sure accuracy of the expert, that we actually offended by our earnestness.

We had intended to express criticism of others in a negative way by censuring the faults in ourselves. It usually hurts less and accomplishes results. Now we will be flat-footed. The nurse recognizes her strength and her weakness. She is endeavoring to fill out her knowledge and experience so that she can be of the greatest use. Are hospital social workers studying the causes of disease and the means of prevention with the accuracy of the nurse? Are teachers who have studied the art of imparting knowledge studying the exact health knowledge which they should impart?

At present, because of lack of correlation, functions are overlapping. This is not true in rural districts where workers of any kind are inadequate, but it is true of urban health work. This may mean that health working material is wasted in the process.

The nurse, as the basic health teacher, the social worker as the adjuster of social impairment, the statistician as the check upon efficiency—all are needed and all will function best if they understand their exact work in relation to the whole and concentrate upon it.

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### Can You Write a Paper?

A new book on "The Writing of Medical Papers," has just been issued by Maud H. Mellish, editor of The Mayo Clinic publications. Nurses who are working up special articles for publication will find these suggestions very helpful.

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# The Editor's Letter-box

**The Editor Is Not Responsible for the Views of Contributors. All Letters Must Be Accompanied By the Name and Address of the Writer**

## FOR BED SORES AND CRACKED NIPPLES

DEAR EDITOR:

As I have had excellent results from the application of the following in those cases where this treatment was ordered, I take this opportunity of passing the idea on to others.

Bismuth subnitrate and castor oil worked into a smooth paste and rubbed well into points of pressure, will keep a patient free from bed sores, also an application of castor oil (10 parts) and bismuth (one part) to nipples will keep any mother free from cracked or sore nipples. The nipples should be well washed with boric acid solution before the baby nurses.

*Caution*—These preparations must not be allowed to stand on painted or enameled tables without placing glass or porcelain under them, as they will destroy the enamel.

CAROLINE M. HOFFMAN, R. N.

## QUALIFICATIONS AND COMPENSATION

DEAR EDITOR: In answer to the question raised by a practical nurse in Iowa, I submit the recommendations recently drafted by the Medical Society of Virginia, and the Virginia State Nurses' Association through a joint committee:

### COURSE OF TRAINING

(1) It is recommended that schools for nursing aides be opened in any hospital of ten beds or more, but that this course be not given in hospitals which are now conducting a successful school for regular trained nurses. A school of this kind must be supervised by at least one graduate nurse.

(2) It is recommended that the course be one year, of twelve months, all of which shall be served in the same hospital, at the end of which time if the work has been satisfactory to the authorities of the hospital, the pupil will receive a certificate as trained attendant, which entitles the graduate to take an examination before the State Board of Nurse Examiners, which, if passed, entitles her to a certificate of Licensed Attendant.

### QUALIFICATION:

Pupils must be between the ages of 18 and 45, giving evidence of good moral character, physically able, and a preliminary education equal to the eighth grade in the public schools.

Classes might be formed every six months, with one month as a preliminary period. Hospitals should furnish living expenses, uniforms, books and an allowance of not less than $5.00 per month.

### COURSE OF STUDY

The points covered should include:

1. Qualifications, deportment and personal hygiene.
2. General hygiene, care of the home, cleanliness, ventilation, sanitation, disposal of waste, germ theory, household and sick room.
3. Food, care and preparation, plain cooking for the family and the sick.
4. Ethics, etiquette of the sick room, adaptability to sick room and the family.
5. Every day care of the sick: Bed making, lifting, moving, rubbing, special arrangements for comfort, prevention of bed sores, cleansing and sponge baths.
6. Methods of disinfection, and sterilization of utensils.
7. Temperature, pulse, respiration, observation of urine, defecations, record keeping, etc.
8. Treatments, enemata, douches, catheterization, fomentations, poultices, etc.
9. Giving of medicines, and instructions regarding, moving, rubbing, special arrangements for com-
10. Care and feeding of children, well and ill.
11. Elementary nursing in maternity cases.
12. Special invalid cooking and serving of food.
13. Bandaging.
14. Emergencies, medical and surgical.

### CONDITIONS OF PRACTICE

It is recommended that a special uniform be designed and copy-patented, and used throughout all the schools in the State, and used after graduation. This committee also recommends to the physicians of the state of Virginia and the nurses of the state, and the public in general, that the pay for licensed attendants be not more than $18.00 per week under existing economic conditions.

THE ONLOOKER.

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# In the Nursing World

**Articles in this department, whether bearing signature or not, are contributed and do not necessarily represent the ideas or policy of this magazine.**

## CALIFORNIA NURSES MEET

The California State Nurses' Association met at the Hotel Vendome, San Jose, California, on June 19. The morning was occupied by registration and committee meetings.

After the reading of the roll call at the afternoon session the reports from the 19 districts were given by the district presidents. These were followed by the reports of the association's officers: Mrs. Ella Congelman, president; Nellie L. Cole, first vice-president; Mary Clary, third vice-president; Mrs. Julia H. Taylor, secretary, and Miss Saunders, treasurer. Miss M. A. Waterman, editor of the association's journal, was the next person to give a report. The session ended with the reading of the reports of the northern and southern Red Cross accomplishments.

The invocation given by Rev. A. W. Noel Porter opened the evening session at 8 o'clock. City Attorney Archer Bowden, representing City Manager Clarence Goodwin, then gave a brief but appropriate address of welcome to the delegates. Another welcome address followed by Miss Louise Groth, president of the 12th district. This was followed by a response from Mrs. Ella Congelman, state president. The rest of the evening was spent in enjoying a well planned social program.

Mrs. Margaret Sirch, P. H. N.; Centralization of Relief, Dr. Charles A. Pease.

"Board of Directors' Duty to Public Health Nursing Service," Miss Mary Cole, P. H. N. Discussion, Mrs. W. P. Lyon, San Jose; Miss Florence Body, San Mateo county Red Cross.

Santa Barbara was chosen as the next meeting place.

Officers elected were as follows: Ella B. Congelman, Stockton, president; Miss J. F. Peterson, Pasadena, first vice-president; Mary K. Clary, San Francisco, second vice-president; Miss J. H. Taylor, Galt, secretary, and Clara A. Saunders, San Francisco, treasurer.

Directors elected were the following: Lillian L. White, Oakland; Mrs. M. A. Adams, Sacramento; Mrs. Clara S. Lockwood, Pasadena; Mrs L. C. Zeitschs, Richmond, and Mary L. Cole, Santa Barbara.

Officers elected by the State Association of Public Health Nurses: Mrs. Eleanor Hagan, president; Miss Josephine Breen, first vice-president; Miss Agnes Talcott, second vice-president; Miss Helen Parks, secretary, and Mrs. Ethel Fisher, treasurer. The following directors were elected: Vivian Carr, Rachel Miller and Geneva Orcutt.

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## SOUTH CAROLINA

At the 1922 meeting of the South Carolina Hospital Superintendents' Association held in Greenville, S. C., on July 13, the following officers were elected:

A. L. Southers, of Anderson, president; F. O. Bates, of Charleston, secretary-treasurer; Miss Etta L. Robins, of Camden, first vice-president; Edwin Hughes, of Greenville, second vice-president; Mrs. B. M. Sigmon, of Chester, third vice-president, and the following were placed on the board of trustees: Miss Myrtle Webber, of Gaffney; Dr. C. W. Kollock, of Charleston; W. K. McDowell, of Charleston; the Rev. W. M. Whiteside, of Columbia; Dr. C. F. Williams, of Columbia; Dr. E. A. Hines, of Seneca.

The South Carolina Hospital Superintendents' Association will convene in Charleston, April 29, 1923.

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# Some Reasons Why

## Lister's Sanitary Napkins are used and recommended by Nurses:

(1) They are all cotton,—having a pad of absorbent cotton encased in soft surgical gauze.

(2) They are made in three sizes,—large, medium and small.

(3) The Napkins are generous in size and have long tab ends.

(4) The Napkins are inexpensive so that after using they may be burned or destroyed.

(5) It is easy to obtain Lister's Napkins, for they are available at all druggists.

(6) They are made by Johnson & Johnson —the world's largest makers of Surgical Dressings.

Be Sure to Specify Lister's

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NEW BRUNSWICK, N. J., U.S.A.




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## PERMANENT STATUS FOR ARMY SCHOOL OF NURSING

At present the Army School of Nursing exists only by an order of the Secretary of War.

Until the recent war the army maintained a small standing corps of nurses in time of peace, and when it needed large numbers, recruited them from Red Cross nursing service. But during the World War the army opened its own training school to fit women for service, and it proved a successful venture. The first class of 505 young women was graduated last June.

Preparedness, from the point of view of the corps, means a permanent training school for nurses, corresponding in a general way with the training school for officers at West Point.

Accordingly, Congress is to be asked to give this important school a military status so that it may be a part of the army, and so that the student nurses may have the relative rank of cadets, instead of the status of civilian employes of the Medical Department of the Army.

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## ROCHESTER PRACTICAL NURSES ORGANIZE

On August 1, the practical nurses of Rochester, New York, met to form an association whose first object is the protection of the public from imposition by persons not qualified to care for the sick. Mrs. Daisy Howard presided at the meeting at which the following officers were elected: President, Mrs. Lillian Kiemle; vice-president, Mrs. D. C. Myers; secretary, Mrs. Daisy Howard; treasurer, Mrs. Anna Werner.

Although the organization is open to all nurses who can furnish satisfactory references, it is primarily for undergraduates and practical nurses. New members will be received on application, provided the applicant can furnish the name of at least one physician who recommends her and the name of a patient whom she has cared for and who will recommend her.

Miss Katherine C. Knorr, one of the speakers, stressed particularly the pretentions of unqualified women who advertise themselves as nurses. She did not condemn the practical nurses who are fitted to care for the sick, but she denounced the work of those totally inexperienced.

The association plans to meet every month at 77 Main Street. Each meeting will be addressed by a physician.

## TEXAS NURSES HOLD CONVENTION

The annual meeting of the Texas State Nurses' Association opened June 19 at the Texas Hotel with about 100 nurses in attendance.

The meeting was called to order at 9:30 o'clock for registration and a few minutes later invocation was pronounced by the Rev. R. L. Nolan, of St. Patrick's Catholic Church. The address of welcome was delivered by Mayor E. R. Cockrell and another address of greeting was delivered by Dr. Bacon Saunders, in behalf of the Tarrant County Medical Society.

Miss Helen Holliday, of Dallas, president, in her annual address, advocated the drafting of a new nurses' registry law, and pointed out the necessity for social sympathy between the nursing organization and the public.

An increase in membership from 588 to 800 was reported by Miss A. Louise Dietrich, El Paso, state secretary. Donation of about $400 to the Delano Memorial Fund and around $200 to the nurses' relief organization was mentioned by Miss Dietrich, and she also gave in detail her trip of organization in October and November, when she addressed nurses and doctors in Amarillo, Fort Worth, Dallas, Waco, Austin, Galveston, Houston and other cities.

Reports from six alumnæ associations which have reorganized to conform to the new constitution and by-laws were made by delegates just before the close of the morning session. Consideration of two questions, "What should Constitute the Basis for Formal Contract for Registration by Reciprocity?" and "Is a Minimum Law Practical for All States?" on which the national association asked discussion, was begun. The drafting of a new state law will be the outcome of this discussion. A legislative committee was appointed Wednesday morning to put the matter before the Legislature. The committee is composed of Miss Grace English, of Carlsbad; Miss Terry Webster, of Wichita Falls; Miss A. Louise Dietrich, of El Paso; Miss Mayme Carter, of Amarillo; Miss Elmer Rembert, of Dallas; Miss Ethel Clayton, of Galveston; Miss Wilma Carlton, of Temple; Mrs. E. L. Buent, of San Antonio; Miss May Wood, of Houston, and Miss Mary Grigsby, of Waco.

The following papers were read in the afternoon: "A Higher Standard of Preliminary Education for Student Nurses," by Miss Helen Bingston, Wichita Falls; "The Graduate Special Nurses on Duty in the Training School," by Miss E. L. Brient, San Antonio;

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# The Foetus as a Mineral Parasite—

IT has been definitely established that during gestation the foetus acts as a mineral parasite.

If the mother's diet during these eventful months is deficient in mineral salts imperatively demanded for the development of the mineral structure of the child, the deficiency is made up at the expense of the mother's tissues.

This brings about a corresponding loss of vitality both for the mother and for her prospective offspring.

It is for this reason that a liberal quantity of Grape-Nuts with milk or cream will be found of value in the diet of expectant mothers; to provide an adequate mineral content in the mother's blood during the period of utero-gestation, and also an adequate mineral content in her milk during the subsequent period of lactation.

The high food value of Grape-Nuts is shown by the fact that Grape-Nuts contains 95.25% of solids, including 11.88% of protein; 78.76% of carbohydrates (of which 48.24% is soluble, as dextrin, reducing sugars, etc.) and 2.27% of mineral salts.

These salts include:

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| Potassium chloride | 4.55% | Calcium phosphates | 5.42% |
| Sodium chloride | 34.33% | Magnesium phosphates | 24.20% |
| Calcium sulphate | 1.96% | Iron phosphate | 0.62% |
| Potassium phosphates | 22.87% | Silica | 2.02% |

Grape-Nuts with milk or cream is well suited for supplying the elements required by the developing child; it is admittedly a good all-round food for the mother.

***Samples of Grape-Nuts,*** for individual and clinical test, will be sent on request to any physician who will write for them.

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"The Personality of the Nurse," by Mrs. Joe Smith, Amarillo; "Laboratory Work," by Miss Sadie Goble, Temple.

The evening session, held on board a large motor boat, included papers by Mrs. Sabins, of Austin; Miss Mary Smith, of Dallas; Miss Sophie Rudwick, of Galveston, and Miss E. D. Greene, of El Paso.

## WISCONSIN

Public Health nurses of Wisconsin plan to hold an important conference at Madison, Aug. 14-19. The tentative program includes:

Aug. 16: "What may be accomplished under the Sheppard-Towner act," Dr. Ethel Watters, Children's Bureau, Washington. "Maternity and child hygiene program of Wisconsin," Mrs. Mary P. Morgan, director bureau child welfare and public health nursing. "What the Child Welfare Special is doing," Dr. Blanche Horner-Rivers, pediatrist, state board of health.

Miss Viola L. Nohr, county nurse, Manitowoc, Dr. R. C. Halsey, Lake Geneva, A. M. Murphy, La Crosse, Dr. C. R. Bardeen, Madison and Dr. H. L. Prince, Sparta, will give addresses.

Aug. 17: Mrs. Mary P. Morgan, presiding. "Nutrition clinics," Dr. Naboth Pearce, professor of pediatrics, University of Minnesota. Dr. Edgar J. Huenekens, professor of pediatrics, University of Minnesota; Dr. C. H. Davis, Milwaukee, and Miss Helen C. Peck, supervisor of prenatal work, Infant Welfare Society, Minneapolis, will also speak.

In the afternoon Miss Edith Foster, Milwaukee, will preside. Dr. Ethel Watters, Washington, D. C.; Dr. Edgar J. Huenekens, University of Minnesota; Dr. Naboth Pearce, Minneapolis; Miss Pauline Camp, state department of public instruction; Dr. George P. Barth, director of hygiene, Milwaukee health department; Mrs Barbara Fletcher, Grant county nurse; Miss Anna Leutscher, Rock county nurse and Miss Ruth Pfeil, Rusk county nurse, will give talks.

Aug. 18: Miss Adda Eldredge, president American nurses' association, presiding. Miss Bertha Brecht, Walworth county; Miss Agnes Bill, Trempealeau county; Miss Palma Grahn, Vernon county; Miss Jemima Bill, Kaukauna; Miss Bertha Schultz, Outagamie county; Miss Nina Gross, Milwaukee; Miss Myra Kimball, supervising nurse, La Crosse health department, will give talks.

In the afternoon, Miss Nelly van Kooy, Wisconsin Anti-Tuberculosis Association, will preside. Miss Gertrude Burnson, Dane county nurse, Miss Aimee Zillmer, Miss Theta C. Mead, Viola L. Nohr, Manitowoc county, Miss Anna Thompson, Bayfield county and Miss Aimee Zillmer will speak.

Aug. 19: Miss Myra Kimball, La Crosse, will preside, Miss Nelly van Kooy, Milwaukee, Miss Jeanette Hays, West Allis, Melba Roach, board of vocational education, Miss Nellie van Kooy, Dr. Maybelle Park, state board of control, Miss Helen Stimson, Kimberly, Miss Mary Dunwiddie, field advisory nurse, are scheduled to speak.

## YALE HONORS MISS NUTTING

In tendering Miss Mary Adelaide Nutting the honorary degree of master of arts, Yale University has recognized the "devotion, courage, faith, skill and magnificent perseverance which have made her today one of the most useful women in the world."

Indirectly this honor proves that trained nurses are ranking among the foremost workers of the world. Yale has granted this degree to only six other women—Mabel Boardman of Red Cross fame; Julia Lathrop of the Children's Bureau; Cecelia Beaux, the artist; Katherine Bement Davis, the sociologist; President Mary E. Woolley of Mount Holyoke College; and Madame Curie.

## NORTH CAROLINA NURSES TO MEET

The North Carolina State Nurses' Association will hold its annual convention at the O. Henry hotel, Greensboro, N. C., on September 5, 6 and 7, members of District No. 4 Nurses' association, of which Mrs. Dorothy Hayden is president, being the hostesses.

The four North Carolina delegates who attended the national meeting held at Seattle, Washington, on June 26, will be present at the convention and will submit reports of the work that was accomplished there.

Other papers to be read at the convention are "The Value of Trained Women for Tuberculosis Work," by Dr. L. B. McBrayer, of Sanatorium; "Mental and Nervous Cases and Their Care," by Dr. Louis Beall, of Black Mountain; "Venereal Disease Nursing," by Miss Ann Doyle, R. N., of the U. S. N. public health service; "Maternity and Infant Welfare," by Ann Stevens, field director of

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**Cantilever Dealers**

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Los Angeles—505 New Pantages Bldg.
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Milwaukee—Brouwer Shoe Co.
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Toledo—LaSalle & Koch Co.
Topeka—The Pelletier Store
Trenton—H. M. Voorhees & Bro.
Troy—35 Third St., (2nd floor)
Utica—Room 104 Fidelity Bldg.
Washington—1319 F Street
Waterbury—Reid & Hughes Co.
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Wichita—Rorabaugh's
Wilkesbarre—M. F. Murray
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the American Hygiene association; an illustrated lecture on cancer by Dr. J. W. Long; "Community Parasites," Walter J. Matherly; "Class A Hospitals and Class A Training Schools," Hariett Lesowski; "Public School Clinics," Dr. G. M. Cooper; "Growing Pains," Jane Van de Vrede; "State Responsibility for Mental Defectives," Mrs. Clarence A. Johnson; "The Backward Child and the Public Health Nurse," Columbia Munds; "Sign Posts on the Road to Progress," Jane Van de Vrede.

Important sessions for private duty nurses, instructors and public health workers, including practical demonstrations, and informal round tables will fill every minute of the three-day program.

## RECONSTRUCTIONISTS MEET

At a meeting of the Consolation House Convalescents' Club, Inc., held at the main office of the company on July 31, Mr. and Mrs. George Edward Barton were authorized to open a Tea Room Chapter of the club in Clifton Springs, N. Y. This will be the first and model link of similar reconstruction units which will stretch across the United States.

Miss Minnie Goodwin, R. N., R. A., superintendent of nurses, Children's Hospital, Washington, D. C., and Miss Julia May Leach, R. N., superintendent of Somerville Hospital, Massachusetts, were appointed a special committee to protect and develop the interests of the nursing profession in the club.

ISABEL G. BARTON,
Secretary.

## NEW YORK HEALTH OFFICERS MEET

The Annual Conference of Sanitary Officers and Public Health Nurses of New York State was held at Saratoga Springs, June 27-29.

Dr. Hermann M. Biggs, State Commissioner of Health, opened the conference by introducing Governor Nathan L. Miller. Following the Governor's address Dr. Victor C. Vaughan, for many years Professor of Hygiene in the University of Michigan and now Chairman of Medical Sciences, gave an interesting talk.

Other speakers of the first day's session included: Dr. Livingston Farrand, President of Cornell University; Dr. George E. Vincent, President of the Rockefeller Foundation; Professor George C. Whipple, of the Harvard Engineering School, and Dr. H. W. Hill, of the Institute of Public Health, London, Ontario.

On Wednesday, June 28, Dr. Richard A. Bolt, Director of the American Child Hygiene Association, discussed the reduction of maternal mortality and Dr. E. V. McCollum, Professor of Biochemistry at Johns Hopkins University, spoke on the nutrition of children. The remarkable results recently obtained in the economic rehabilitation of tuberculosis patients was discussed by Mr. Edward Hochhauser and Dr. E. S. McSweeney of New York. In the afternoon a special session for health officers was devoted largely to a discussion of the Schick test and the control of diphtheria.

Special meetings for public health nurses were held on Tuesday and Wednesday afternoons, and papers were given by Bailey B. Burritt, Director of the New York Association on Improving Conditions of the Poor, Miss Frances Meyer of the State Charities Aid Association and other speakers.

## MASSACHUSETTS NURSES MEET

(*See July Number for Report of First Day's Session*)

The Wednesday morning session of the Massachusetts State League of Nursing Education was chairmaned by Melissa J. Cook, president.

The opening address was delivered by Anna C. Maxwell, A.M., on "The Supervisor and the Head Nurse as Educators."

An address on "Student Government in Schools of Nursing," was given by Miss Marie Knowles, superintendent of the Newton District Nursing Association, Newton, Mass., and Miss Ruth Sleeper, R. N., assistant instructor of theory in nursing, Massachusetts General Hospital, Boston.

A round table discussion on Administrative and Educational Problems, was led by Miss Sally Johnson, superintendent of nurses, Massachusetts General Hospital, Boston, assisted by Miss Nellie Hawkinson, R. N., instructor of theory in nursing, Massachusetts General Hospital, Boston.

The afternoon session included a discussion on thrift and deferred annuities by Harry N. Haven of the Massachusetts Mutual Life Insurance Company, and the annual reports of the Treasurer, Miss Esther Dart; Corresponding Secretary, Miss Mary E. P. Davis; Eligibility Committee, Miss Jessie E. Catton, chair-

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man; Finance Committee, Mrs. Roger Homer, chairman; Publicity Committee, Miss Mary Alice McMahon, chairman; Relief Fund, Mrs. Susie Albert, chairman; Speakers' Bureau, Miss Bernice W. Billings, chairman; State Red Cross Committee, Miss Jane F. Riley, secretary; State League of Nursing Education, Miss Harriet Harris, secretary; League of Private Duty Nurses' Section, Miss Minnie Hollingsworth, president; Public Health Nurses' Section, Miss Anna J. Foley, secretary; Committee for Recruiting Candidates for the Training Schools, Miss Bertha W. Allen, chairman; Committee on Revision of By-Laws, Miss Carrie M. Hall, chairman.

Miss Carrie M. Hall, superintendent of nurses at the Peter Bent Brigham Hospital, was re-elected president at the closing session.

Other officers elected were: Vice-presidents, Miss Sally Johnson, superintendent of nurses, Massachusetts General Hospital, and Miss Marion Seaver, superintendent of nurses, St. Luke's Hospital, New Bedford; recording secretary, Miss Mary A. McMahon, superintendent of nurses, Boston State Hospital; corresponding secretary, Miss Mary E. P. Davis, Norwood; treasurer, Miss Mary M. Riddle, Newton.

Miss Sally Johnson was elected president of the Massachusetts State League of Nursing Education, with Miss Jessie E. Catton of the Lawrence Central Hospital, as vice-president, and Miss Ruth Humphreys of the Newton Hospital, as secretary-treasurer.

Following tea, which was served by the Guild of St. Barnabas, Trinity Church parish house, Copley Square, the nurses attended the 5th annual nurses night at Pops.

## VERMONT

The Randolph Sanatorium Alumnae Nurses' annual meeting was held in Bonnie View Cottage, Mari-Castle Park, August 1. The following officers were elected: President, Mrs. Alice D. Fuller; secretary and treasurer, Mrs. Nina C. Burridge.

Anecdotes and current events were told by each member present. Letters were read from some of the absent members. Hereafter a meeting will be held once a year, the first Tuesday in August. It was voted to give Sanatorium Aid Society $25.00 for a free bed.

NINA C. BURRIDGE.

## TALKS TO MOTHERS

The Maternity Center Association of New York City has issued a series of twelve "Talks to Mothers." Their action is the first national attempt to impress women with the vital importance of complete maternity care.

Dr. Haven Emerson, former Health Commissioner of New York City and an active members of the Medical Advisory Board of the Maternity Center Association, estimates that only one woman in seventeen in the United States receives the benefit of modern medical and nursing science at childbirth. The result is that each year more than 20,000 die in childbirth, more than 100,000 babies die under the age of one month, and more than 100,000 are born dead. According to the latest figures issued by the Children's Bureau, Washington, eighteen countries, including Italy, Sweden, Japan, Spain, France and New Zealand, have a lower maternal death rate than the United States.

The scope of the pamphlets is suggested by their titles: "Life's Richest Offering," "A Message to Husbands and Wives, Too," "The Growing Life," "Keeping up Appearances," "Watch for Nature's Signals," "Preparation for the Newcomer," "Getting Ready for the Great Event," "The Day Your Baby Comes," "The Lying-in Period," "Starting Baby Right," "After-Care of the Mother," "The Foundation of Child Life."

It is planned to distribute the pamphlets through nursing and public health organizations which are closely in touch with local community conditions. Expectant mothers will be encouraged to present their cases to local health workers and receive personal advice and direction.

The burden of the message, in fact, is that the woman should see her doctor or nurse as soon as she knows she is going to have a baby and remain under their care until her final examination, six weeks after the baby is born.

## STUDENT PUBLICATIONS

*The White Cap* is the title of a quarterly magazine issued by the Ardmore School of Nursing, Hardy Sanitarium, Ardmore, Oklahoma. Though the editors modestly dub it "the initial publication," it is filled with breezy stories and quips that bespeak a live school interest. Other nursing schools could do likewise and show results in the growth of extra curriculum interests. Call again!

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Kellogg's Bran, cooked and krumbled, should not be confused with common brans which become so irksome for the patient to eat. Kellogg's Bran is delicious, its nut-like flavor and krumbled crispness appealing to the most fastidious taste.

And, results from its use are really wonderful! Physicians recommend Kellogg's for mild and chronic constipation cases, prescribing it with confident expectations. It is particularly valuable in bed-ridden and old-age cases—when two tablespoonfuls should be served with EACH MEAL. Ordinary constipation can be permanently relieved by eating two tablespoonfuls EACH DAY.

Kellogg's Bran is most appealing to the appetite as a cereal, sprinkled over other cold or hot cereals or in countless bakery products. It is often served in gravies, soups, etc., imparting an attractive nut-like flavor. Make muffins of Kellogg's Bran today. See the recipe in this advertisement. All grocers sell Kellogg's Bran.

*Kellogg's*
**BRAN MUFFINS**

¼ cup sugar; shortening size of an egg. Cream shortening and sugar together. Add to this—1 egg, 1 cup sour milk (or sweet milk), 1 cup Kellogg's Bran, 1¼ cups flour, 1 level teaspoon soda (or 2 teaspoons of baking powder if sweet milk is used), pinch of salt. Mix well. This will make one dozen muffins.

*Kellogg's* *Look for this signature W.K. Kellogg*

**the original BRAN - *cooked and krumbled***


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## THE BABIES' ALUMNI

A hundred abreast, like Solomon's wives coming down the steps to meet him, the members of Manhattan's very youngest set had proceeded to their afternoon class. They left behind them a brigade of baby carriages, trailing pink blankets from which forsaken bears and rabbits peered, that filled the corridors of the Lying-In Hospital, New York, in solid formation and seemed likely to burst out into Second Avenue, already full of babies. "The class was in splendid voice," reports Miriam Storm in the *New York Post.* Not one intended to be weighed without a struggle. It was not exactly a chorus, but it was certainly stunning part work, and pierced the doors of the room where the Baby Class was in session, as it has been these eighteen years.

Eighteen years of babies—so many that the total count of them has been lost. Every day new members, every day departing alumni who have reached the age of two. Long before the hour of the class they began to ride vociferously in from the swarming districts near by, and from considerable distances, too. The nurses and doctors know them all for these children were born in the hospital and are considered members of the Babies' Class for 730 days.

Probably 100,000 babies have been graduated into wholesome childhood from this extraordinary school. The attendance in 1921 was 10,731.

The babies who register at the Woman's Hospital, New York, as their first hotel, are followed up in even grander style. This hospital sends out birthday cards to its one time wee guests. Their mothers then bring them to the hospital for a complete physical examination and incidentally retain their interest in the hospital for many years.

The Mary Immaculate Hospital, Jamaica, Long Island, has an annual mothers' day when mothers and babies return to the hospital for social tea and health guidance. In 1922 National Hospital Day was used as the day of reception. The mothers returned to the hospital and gossiped over old times. The sisters and nurses used this opportunity to interest them in the proper care of their children and insure return visits for further guidance.

Several rural nurses in the West have their own pet alumni classes. One nurse starts each child she brings into the world with a dollar savings account. Every time she comes into the neighborhood she calls upon the lad or lassie, pinches its cheeks to bring the dimples and the wee legs to test their sturdy character. The mother soon acquires the habit of reporting progress in weight and other important points which keep the nurse in touch with the baby's welfare.

There are tricks in all trades! And the Babies' Alumni is one trick that is worth learning.

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## PERSONALS

Mamie Burt, superintendent of nurses, Peck Memorial Hospital, Brooklyn, N. Y., severed her connections on July 1 after four years' service as head of the nursing staff. At a farewell dinner given by the Alumnae Association she received many beautiful gifts and a purse containing $60. The position has been filled by Miss Bertha Stirton.

Naomi Frey resigned as head nurse of the York Hospital, York, Pa., on June 16. Miss Frey graduated from the hospital in 1921.

Elizabeth Carter took up her new work as city visiting nurse in Springfield, Ohio, in the middle of June.

Dr. Clarence O. Cheney has been appointed assistant superintendent of the Utica State Hospital, to be in charge of the Marcy Division. Dr. Cheney is a graduate of Columbia University and the Physicians and Surgeons College of New York City.

Ellen Louise Dandridge has been engaged to give visiting nursing service to the colored population of Springfield, Ohio. She entered upon her work August 1.

Mrs. Alice Flash has resigned her position of chief nurse at the Letterman General Hospital, San Francisco, after three years' service. Mrs. Flash plans to retire at Beverly Hills, Los Angeles.

Mrs. Thomas Llewellyn, a graduate of Packer Hospital, Sayre, Pa., has been appointed superintendent of the State Hospital, Blossburg, Pa.

Beulah Ness, assistant superintendent of nurses at the York Hospital, York, Pa., resigned on June 16. She has been succeeded by Elizabeth Findlay, of Toronto, Canada. At the annual meeting of the board of directors Mrs. Katharine Apple, the superintendent, was re-elected, indicating that the directors are in accord with her administration of affairs at the institution.

M. Louise Pugh has resigned as superintendent of the Homeopathic Hospital, Wilmington, Delaware, to follow her family to California.

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# Physicians tell us

That surprisingly few Mothers pass through pregnancy, confinement and convalescence, without suffering from Hemorrhoids, or lesser rectal troubles likely to develop into Hemorrhoids.

With proper treatment, at the right time, few of these cases need ever reach the stage of *necessary* operation. ANUSOL SUPPOSITORIES, prescribed by physicians of all nations, for nearly a quarter of a century, score some of their best results in the Hemorrhoids of that period.

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## KENTUCKY PLANS UNIVERSITY SCHOOL OF NURSING

The Louisville City Hospital Training School for Nurses will affiliate with the University of Louisville in the September term as a step toward the higher education of nurses.

First year subjects, including anatomy, physiology, chemistry, bacteriology and nutrition, will be taught at the university, while nursing will be taught at the hospital.

Some additions will be made in the lecture courses for the second and third-year students, and lectures will be given by staff members of the medical department of the university.

The College of Arts and Sciences of the university and the training school will coordinate work and offer for the first time a course leading to the degree of bachelor of science in nursing.

Students will follow a specially prescribed course at the college for two years and then take up the three-year nursing course in the training school. Upon completion they will be given a degree from the university and a diploma in nursing from the training school.

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## PUBLIC HEALTH SERVICE

The assignments, transfers, and reinstatements in the nursing corps of the Public Health Service during the months of June and July have been as follows:

Mary McSweeney, reinstated as Acting Chief Nurse, U. S. Marine No. 18, St. Louis, Mo.; Martha Adams, reinstated at U. S. Marine No. 21, Stapleton, N. Y.

Hannah Flahive, transferred from U. S. Marine No. 82, Norfolk, Va., to U. S. Marine No. 2, Boston, Mass.; Amanda Lee Lange, transferred from U. S. Marine No. 11, Louisville, Ky., to U. S. Marine No. 3, Buffalo, N. Y.; Lillian Wilson, transferred from U. S. Marine No. 3, Buffalo, N. Y., to U. S. Marine No. 21, Stapleton, N. Y.; Bertha Diener, transferred from U. S. Marine No. 5, Chicago, Ill., to U. S. Marine No. 15, Pittsburgh, Pa.; Catherine Hughes, transferred from U. S. Marine No. 14, New Orleans, La., to U. S. Marine No. 9, Fort Stanton, N. M.; May Kennedy, transferred from U. S. Marine No. 82, Norfolk, Va., to U. S. Marine No. 14, New Orleans, La.; Minerna Bailey, transferred from U. S. Marine No. 15, Pittsburgh, Pa., to Rosebank (N. Y.) Quarantine; Anne Fellows, transferred from U. S. Marine No. 82, Norfolk, Va., to U. S. Marine No. 21, Stapleton, N. Y.; Mary Clay, transferred from U. S. Marine No. 82, Norfolk, Va., to U. S. Marine No. 43, Ellis Island, N. Y.; Anna O'Rourke, transferred from U. S. Marine No. 82, Norfolk, Va., to U. S. Marine No. 43, Ellis Island, N. Y.; Nell Ross, transferred from U. S. Marine No. 82 Norfolk, Va., to No. 43 Ellis Island, N. Y.; Susan Campbell, transferred from U. S. Marine No. 82, Norfolk, Va., to No. 70 New York City; Margaret Connolly, transferred from U. S. Marine No. 82, Norfolk, Va., to Rosebank (N. Y.) Quarantine.

Annie McNulty assigned to U. S. Marine No. 7, Detroit, Mich.; Winifred Warren, assigned to U. S. Marine No. 7, Detroit, Mich.; Lucy Shackelford, assigned to U. S. Marine No. 13, Mobile, Ala.; Edna Bachelder, assigned to U. S. Marine No. 14, New Orleans, La.; Pearl Morton, assigned to U. S. Marine No. 18, St. Louis, Mo.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

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Reinstatements: Rosella McDonough, U. S. Marine Hospital No. 5, Chicago, Ill.; Hildur Steinburg, U. S. Marine Hospital No. 5, Chicago, Ill.; Sarah G. White, U. S. Marine Hospital No. 9, Ft. Stanton, N. M.; Isabelle Connell, U. S. Marine Hospital No. 19, San Francisco, Calif.; Lillian Pinkham, U. S. Marine Hospital No. 19, San Francisco, Calif.; Laura Moline, U. S. Marine Hospital No. 19, San Francisco, Calif.; Laura Zwanzig, U. S. Marine Hospital No. 19, San Francisco, Calif.; S. Gertrude Simpson, U. S. Marine Hospital No. 19, San Francisco, Calif.; Margarite Mattice, U. S. Marine Hospital No. 70, New York City, N. Y.; Ella Oliver, U. S. Marine Hospital No. 82, Norfolk, Virginia.

Transfers: Irene LeDuc, U. S. Marine Hospital No. 21, Stapleton, N. Y., to U. S. Marine Hospital No. 2, Boston, Mass.; Clara Tappmeyer, U. S. Marine Hospital No. 14, New Orleans, La., to U. S. Marine Hospital No. 11, Louisville, Ky.

New assignments: Ruth Breed, U. S. Marine Hospital No. 9, Fort Stanton, N. M.; Mamie Littleton, U. S. Marine Hospital No. 9, Fort Stanton, N. M.; Tommie Cousins, U. S. Marine Hospital No. 14, New Orleans, La.; Ethel Furyear, U. S. Marine Hospital No. 14, New Orleans, La.; Dorothy O'Connor, U. S. Marine Hospital No. 21, Stapleton, N. Y.; Josephine Taggert, U. S. Marine Hospital No. 21, Stapleton, N. Y.; Minnie Hayes, U. S. Hospital No. 20, Savannah, Ga.; Emma Colebourn, U. S.

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Marine Hospital No. 43, Ellis Island; Theresa Tuttle, U. S. Marine Hospital No. 82, Norfolk, Va.; Stella Hicks, U. S. P. H. S. Quarantine Station, Rosebank, N. Y.; Grace Calahan, U. S. P. H. S. Quarantine Station, Rosebank, N. Y. LUCY MINNIGERODE,

*Superintendent of Nurses.*

## GRADUATIONS AND GRADUATIONS!

If the doubting Thomases could read all the accounts of graduations which find their way to our desk, they would never mention nurse shortage again. An exaggerated statement, you say. Perhaps. But if you could see the piles of formal invitations and informal descriptions, you might sanction the hyperbole.

We had intended to give a detailed account of each graduation. Under the circumstances this is impossible. In the July issue we gave a hurried summary of the graduations in the states of Alabama-North Carolina with part of Ohio. The rest of the story is told in the notes which follow. To date, Pennsylvania heads the list, New York second, and Michigan third. This is because we received few notices of graduations in the large cities. If New York City, Philadelphia and Chicago had sent in their quotas, Pennsylvania might stand in third place.

Here are the others. Every Alumna should show her pride in the record of her school by welcoming its new graduates.

### Ohio

On May 18, nine nurses graduated from Springfield City Hospital, Springfield. On May 19, twenty-seven stepped from St. Vincent's Hospital, Toledo. On May 24, eight nurses finished training at the Flower Hospital, Toledo. On May 25, Massillon City Hospital, Massillon, graduated six. On May 31, the Robinwood Hospital of Toledo graduated three. On May 29, Youngstown Hospital, Youngstown, graduated ten. On June 2, St. Ann's hospital of Cleveland, graduated four, and from the Ohio Valley Hospital at Steubenville graduated four more. On June 4, seven were graduated from St. Alexis School of Nursing, Cleveland. At the Aultman Memorial Hospital at Canton, Ohio, seven were graduated on June 22.

### Oregon

Thirty-seven nurses graduated from the Good Samaritan Hospital, Portland, on May 12, and on May 19, three more received diplomas from the Homeopathic State Hospital.

The extension course in public health nursing, offered by the University of Oregon, graduated the following students on June 19: L. Fern Bristol, Josephine Brook, Claudena Holm, Grace C. McDowell, Frances Lackass, Helen A. Weston and Freda Hagen. At the same time Miss Helen Hartley and Miss May Brownell received the degree of bachelor of science and Miss Eleanor Spall and Miss Elsa Burner had conferred upon them the degree of bachelor of arts. Miss Eleanora Thomson is in charge of the public health nursing course.

### Pennsylvania

On April 18, twenty were graduated from the Lankeman Hospital, Philadelphia. April 24, forty-three received diplomas from the Mercy Hospital, Pittsburgh. In Reading, at the Reading Hospital, twenty-one were graduated.

In May, nine nurses were graduated from the Pittsburgh Hospital, nine from the Mercy Hospital at Altoona. On May 12, twenty-one from the Conewaugh Valley Memorial Hospital, Johnstown. From the Germantown Dispensary and Hospital, Germantown, eleven were graduated on May 12. The Allegheny General Hospital, Pittsburgh, graduated thirty-one on May 16. On May 18, eighteen were graduated from the Jefferson Medical College Hospital, Philadelphia, and eleven from St. Joseph's Hospital, Lancaster. On May 16, seventeen young women were graduated from Misericordia Hospital, Philadelphia. and on May 19, eight graduated from the Kensington Hospital for Women.

On May 23, the following hospitals graduated nurses, the Harrisburg Hospital, Harrisburgh, eleven; St. Mary's Keller Memorial Hospital, Scranton, four; York Hospital and Dispensary Association, York, eight. On May 24, at the seventh annual commencement exercises, four received diplomas from the Homeopathic State Hospital, and at the Mercy Hospital of Johnstown, eight were graduated also. On May 25, the Hahnemann Hospital, Scranton, graduated the following nurses: Mary Parker Dikey, Margaret A. Fitz-Gerald, Ruth L. Greene, Emily W. Baldwin, Jean G. Burke, Ruth E. Gill, and Lucile M. Ruffo. On May 25, the McKeesport Hospital, McKeesport, graduated ten. On the same day, St.

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2. The food must be well balanced, for a deficiency in one element means the ineffective action of the other food elements.
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Agnes' Hospital, Philadelphia, graduated twelve, and the Lancaster General Hospital, Lancaster, twelve more. On May 26, the Hanrot Hospital, Erie, graduated six, and at the Wilkes-Barre City Hospital, twenty were graduated. The Jewish Hospital Association of Philadelphia, on May 30, graduated fourteen. On May 31, the following hospitals graduated nurses: St. Joseph's Hospital, twelve; Miner's Hospital of Northern Cambria, five; Suburban General Hospital, Bellevue, seven. In June the following hospitals held commencements: On June 6, four were graduated from the Sacred Heart Hospital, Allentown, and six from the Scranton Private Hospital. On June 8, Chester Hospital, Chester, graduated three and Easton Hospital graduated ten. The University of Pittsburgh, June 14, graduated seven.

On June 14, Abington Memorial Hospital graduated five, Nesbitt West Side Hospital, Doranceton, June 16, eleven, and on June 17, ten graduated from the White Haven Sanatorium. Ten nurses graduated from the State Hospital, Hazelton.

State Hospital Training School, Pa., graduated the following nurses this year. Estella Elizabeth Burke, St. Nicholas, Pa.; Margaret Ann Dinlocker, Hazleton, Pa.; Edith Carolyn Lentz, Freeland, Pa.; Anna Elizabeth Breslin, Locust Gap, Pa.; Ara Mae Kern, Slatington, Pa. Edna Brandt Good, Lancaster, Pa.; Nellie Loucette Bachert, Summit Hill, Pa.; Esther Anna Clark, Lancaster, Pa.; Ethel Mae Hoffmann, Mount Carmel, Pa.

## Rhode Island

On May 4, fourteen nurses received diplomas from the St. Joseph's Hospital, Providence. On May 23, eight graduated from the Homeopathic of Providence. The Newport Hospital, Newport, graduated ten nurses on June 8.

## South Carolina

On May 25, four nurses were graduated from the Greenville City Hospital. On May 31 five received diplomas from the Baker Sanatorium at Charleston. On June 6, Greenwood Hospital graduated three nurses, and on June 15, seven graduated from the Columbia Hospital, Columbia.

## South Dakota

The graduation exercises of Sioux Falls Hospital, S. D., were held June 23. The following nurses received diplomas: Katherine Sprague, Ruth Bruseth, Luddie Hagre, Esther Nelson, Florence Case.

## Tennessee

The Memphis Baptist Hospital, Memphis, graduated fifteen nurses on April 12. On April 21, three young women graduated from the King's Daughters Hospital, Columbia. On May 17, seven nurses were graduated from the Knoxville General Hospital. On June 8, the Woman's Hospital of the State of Tennessee, Nashville, graduated fourteen young women.

The Gartley-Ramsay Hospital, Memphis, Tennessee, graduated the following nurses this July: Miss Marie Johnson, Centerville, Miss.; Miss Birdie Thorne, Memphis; Miss Nellie Rosebrough, Batesville, Ark.; Miss Francis Pittman, Ackerman, Miss.; Miss Josephine Dickey, Tampa, Fla.; Miss Viola Moore, Bradford, Ark.; Miss Eizabeth Greene, Memphis.

## Texas

On May 8, seventeen received diplomas from the Baptist Sanitarium and Hospital, Houston, on May 12, twelve from the St. Mary's Infirmary, Galveston.

## Utah

On May 19, eight were graduated from the Utah-Idaho Hospital at Logan.

## Vermont

On May 16, the following nurses were graduated from the Rutland Hospital Training School: Mary E. Shedd, Evelyn C. Sjostrom, Ruth H. Benedict, Mae M. Chalmers, Jene Mary Hilliard, Eugenia M. Thompson, Gladys M. Lawton, Alta E. Ridlon, Pearl A. Churchill, Gertrude E. Reed. On June 2, twenty-three nurses graduated from the Mary Fletcher Hospital, Burlington, and on June 8, ten nurses from the Fanny Allen Hospital, Winooski.

## Virginia

On April 10, eleven young women were graduated from the Hampton Training School for Nurses, Hampton, and on April 27, eleven received diplomas from the Norfolk Protestant Hospital, Norfolk.

## Washington

On May 12, fifteen nurses graduated from the Tacoma General Hospital, Tacoma. May

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# A Delightful Test

## To bring you prettier teeth

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24, from the Sacred Heart Hospital, Spokane, seventeen nurses received diplomas. At St. Mary's Hospital, Walla-Walla, on May 25, five nurses were graduated. On June 8, at the twentieth commencement exercises of St. Joseph's Hospital, Tacoma, fourteen nurses were graduated.

## West Virginia

On May 12, nine were graduated from the Ohio Valley General Hospital, Wheeling, and on May 18, five received diplomas from St. Mary's Hospital, Clarksburg.

## Wisconsin

On May 25, six were graduated from St. Joseph's Hospital, Ashland, and nine more on June 7, from the Madison General Hospital.

## ADDENDA

Since the foregoing list has been compiled we have received word of the following graduations:

The Middlesex Hospital Training School, Middletown, Conn., graduated the following nurses this year: Natalene Barbero, Edna Brower, Florence Carlson, Lucy Hall, Mary A. Hubbell, Mabel E. Johnson, Margaret Pederson and Ida Peterson.

The following nurses graduated from the Georgia Baptist Hospital Training School this year: Winifred Madden, Roberta Florence, Sarah Brundage, Jeanette Sullivan, Louise McWhorter, Elyora Randall, Edna McDaniel, Julia Grant, Willie Lee Treadwell, Ora Muse, Esther Smith, Ella Head, Julia Holley, Amanda Holloway, Willie Lasseter, Marian Parrott, Pearl Adams.

On June 16, the following nurses graduated from the School of Psychiatric Nursing at the Chicago State Hospital: Alta Henry Elkins, Ruth Russell Harmon, Augusta M. Bigler. Miss Carolyn E. Gray addressed the graduates. One hundred and thirty-six students have taken post-graduate or affiliated courses at the hospital during the year.

## Massachusetts

The graduation exercises of Malden Hospital were celebrated on June 15. The address was delivered by Miss Emma Anderson, superintendent of the New England Baptist Hospital. Mr. E. F. Bickford gave a fatherly talk to the graduates when conferring the diplomas. His message to Malden nurses is applicable to every graduate nurse:

"These years spent in training are but the beginning of your preparation. If you have learned how to study, the time has not been spent in vain. A great author once said of another literary genius: "If I did not see him for a fortnight, I was astonished at the progress he had made in the interim." The same thirst for knowledge should distinguish all efficient graduate nurses. The following nurses receive diplomas: Eva Marguerite Cook, Thelma Maude O'Neil, Margaret Ellen McQuaid, Lillian Maude Atkinson, Florence Johnston Finlayson, Gladys Vivian Young, Alice Francis Walsh, Kathleen Pemberton Hanscom.

On Saturday, June 10, graduating exercises were held at Long Island Hospital, Boston Harbor. The address was delivered by Dr. David Johnson. Other speakers were the Rev. George O'Connor, Dr. Geo. O'Brien and Dr. H. Mella and Miss Mary Riddle, R. N.

Acting in Mayor Curley's absence Councillor Ford gave diplomas to the following graduates: Isabel McInnis, Della A. Murphy, Mary Oliviera, Anna E. Fredericks, Daphne May McDonald, Anne J. Zalla, Alva E. Bryant.

The presence of two former superintendents of the hospital, Miss Matice and Miss Grant, added to the pleasure of the graduation exercises of the Anna Jaques Hospital, Newburyport, Massachusetts, on June 29. The Florence Nightingale pledge was impressively administered by Miss Violet L. Kirke, the able and beloved superintendent of the Anna Jaques Hospital, who also has general supervision of the training school.

Diplomas were presented by President Little to the following graduates of the training school: Miss Esther Barr, Providence, R. I.; Miss Emma Knickle, Lunenburg, Nova Scotia; Miss Helen Daley, St. John, New Brunswick; Miss Nellie Brown, St. John, New Brunswick; Miss Inez Raimey, Lunenburg, Nova Scotia; Miss Arline Gavitt, Pawtucket, R. I.; Miss Kathryn O'Neil, Amesbury.

## Michigan

On July 3, the St. Mary's Training School for Nurses, Grand Rapids, Mich., held its graduation exercises. The class was addressed by the Rev. James E. Reardon, D. D. The following nurses received diplomas: Anna M. Zagunis, Bernice M. Wing, Grace M. Carpenter, Lucille H. Middleton, Kathryn I. Long, Irene A. Fortier, Elizabeth M. La Londe, Rose C. Buerele, Ann L. Keating, Ella L. Hansen, Anastasia R. Dwyer.

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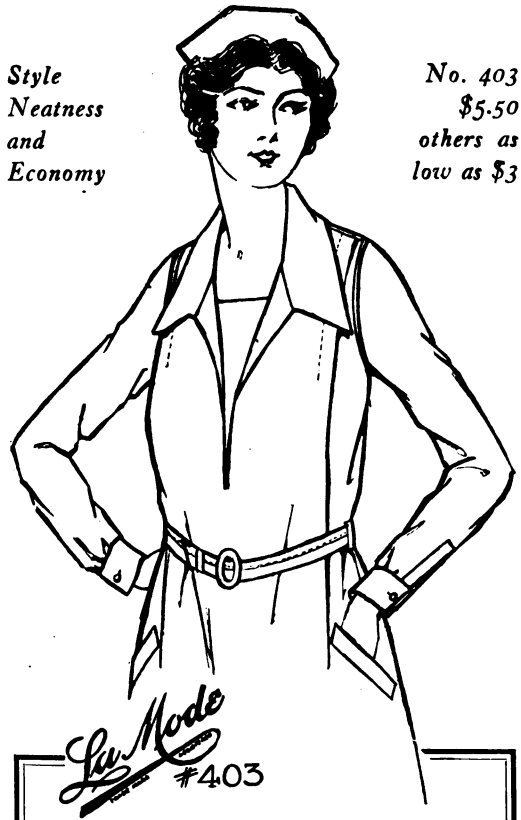


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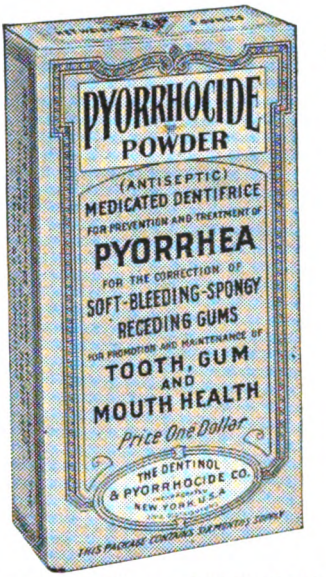


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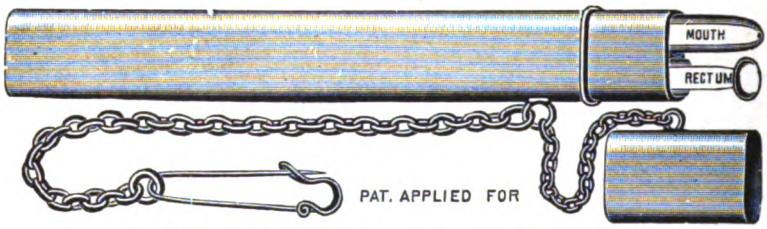


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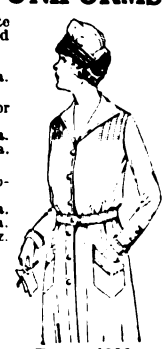

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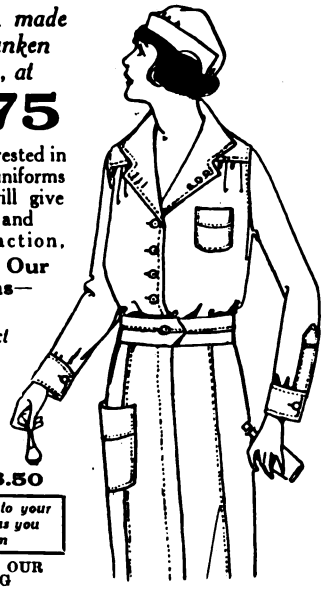

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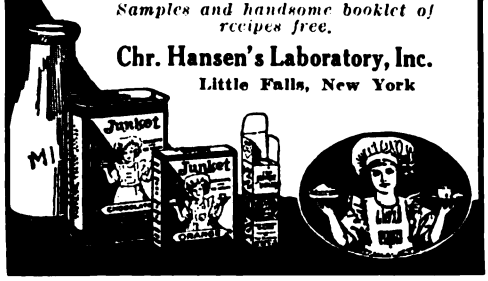


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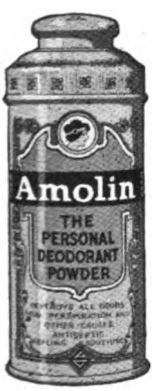


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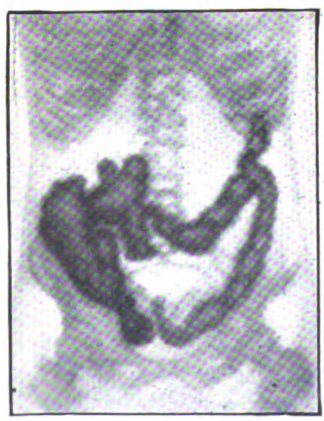

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Vol. LXIX OCTOBER No. 4

# The Trained Nurse and Hospital Review

**A Monthly Magazine Devoted to Trained Nursing in Private Practice, in Hospitals, Institutions, and Public Health Service**

*Editor,* CHARLOTTE A. AIKENS
*Managing Editor,* META R. PENNOCK
*Advertising Director,* CAROLINE DEXTER

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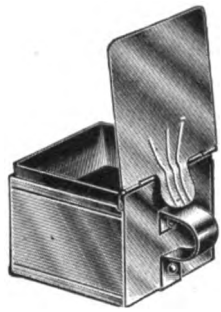
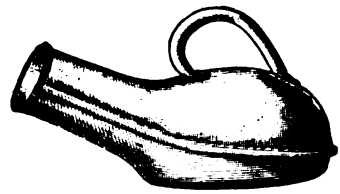

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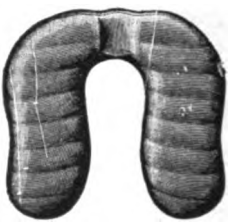

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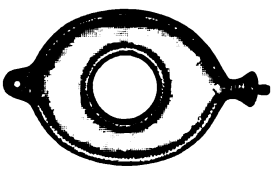

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# The Trained Nurse and Hospital Review

ESTABLISHED 1888

Vol. LXIX NEW YORK, OCTOBER, 1922 No. 4

# ATTENDANTS FOR CONVALESCENTS

## SPECIALIZATION TO MEET A DEFINITE NEED

WILLIAM RUSH DUNTON, JR., M. D.

Assistant Physician, The Sheppard and Enoch Pratt Hospital, Towson, Md.

THE major part of this paper was written early in 1920, when the shortage of nurses was more acute than it is at present. At that time the plan was proposed to relieve local conditions in the hospital with which I am connected. During its elaboration I became convinced that the scheme is a good one and might be used as a basis for training a special type of nurse. It was submitted to several nurses who have been conspicuous by their service in training schools and in the advancement of nursing education. Their general opinion was that "the time was not right" for advancing such a plan, but the objection of at least two was that the use of the term "nurse" was dangerous because of the opportunity it gave for abuse in registration. This is because the general public does not readily differentiate the R. N. (registered nurse, not royal navy) from the nurse who is less fully trained. This objection is well founded, because it is fairly well known that a number of women who have served in hospitals as ward maids, who have taken a part of the training course, or who have had some other hospital connection, make use of this as an endorsement of their claims to nursing ability.

The title at first proposed for this special type was "convalescent nurse," which was soon shown to be unfortunate, as it brought to mind a nurse who had been sick and was convalescent. A transposition of words to "nurse for convalescents" was objected to for the reason stated above. "Nursing companion" met with the same objection, so that I am somewhat at a loss to know what title to use. The last seems to me to be most appropriate, because these women would be expected to serve as both nurses and companions, the latter function being the most prominent. Yet the simple word "companion" is not sufficient. The term "mental nurse" would also be incorrect because these young women would be asked to look after the physically convalescent, although they might equally well serve as nurses for mental patients who are not too sick to be cared for in their homes.

The title "nurse's aide" has been recently suggested to me by a nurse who realizes that something must be done by the nursing profession if it wishes to continue to function with full obligation to supply all varieties of nursing service to the public as it has in the past. Personally, I am more concerned with the nursing values of this suggested type of nurse than I am with the title bestowed upon her.

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The discouraging reception given this plan by the nurse consultants caused me to abandon my idea of publishing it and my manuscript was laid aside. A paper by D. Laird, published in the *American Journal of Insanity* (April, 1921), has emboldened me to revise my paper for publication with the hope that there will be a more general discussion of the subject and some plan of licensing special types of nurses may be devised by the nursing profession.

### The Tendency Toward Specialization

It may be generally admitted that the tendency of the day is towards specialization. This tendency is found in practically every industry and in many professions. It is natural that this should be so because as knowledge grows it becomes increasingly impossible for one human being to retain in mind all of the information which has been garnered relating to his or her profession. Also, in all things which require manual dexterity we know that practice makes perfect; that is, if we confine our manual activities to one or a few movements, we acquire considerable facility and grace in making them.

It is rather obvious that the surgeon operating upon a case of appendicitis is insistent upon the skill of his nurse assistant in operative technique, in the preparation of instruments, dressings, and in their handling during the operation. He is indifferent to the fact that she may be a splendid obstetrical nurse. The obstetrician, on the other hand, demands a broader knowledge from his nurse. She must be well trained in medical and surgical nursing, have some knowledge of pediatrics and especially skilled in obstetrics. Some training in mental nursing would tend to round out her knowledge and increase her value, this including the art of companionship, which has been neglected by our school for nurses. It would appear obvious that an obstetric nurse should be more broadly trained than the nurse who specializes in medical or surgical nursing, or even the nurse who goes under the title of general nurse but refuses obstetric, mental or nervous cases.

It appears inevitable, therefore, that the tendency of both physicians and nurses is towards specialism. Unconsciously at first, we find after a time that we are looked upon by the community as being especially fitted to care for a particular type of case. Again, unconsciously at first, we later discover that we are trying to fit ourselves to deserve this reputation. Although we have conscientiously studied to keep up our knowledge of general nursing or general medicine, we have unconsciously taken a greater interest in the study of those articles which pertain to the subject of our repute.

It is commonly said that the more general knowledge one has the better he is able to go through life and the more he can do in his chosen work. Theoretically and, at times, practically this is true. But let me ask you a few questions: First, if some one dear to you is found to be suffering from appendicitis and you are asked which of several surgeons you prefer to have called in consultation, do you not select one of this group because you believe that he has specialized in and is expert in the treatment of appendicitis? Again, suppose another loved one sustains a head injury, do you not think of one surgeon who has specialized in head surgery as the person to be called? And is not this surgeon a different person from the one you called for the appendicitis case? If it is suggested that the appendicitis man be called, do you not refuse to have him and insist upon calling in the brain surgeon? If you are honest, I am sure you have answered these questions affirmatively.

Let me ask a few more questions. Presumably a few years ago you studied algebra, probably enjoyed it and did well. Have you recently tried to help a younger person with his or her algebra? If so, were

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you not a bit ashamed that you did not know more about it? Did not the thought come to you that the time spent in studying algebra might have been employed more profitably on something which would be of service to you today? Possibly you have voiced this thought, and some one has consolingly said: "Oh, but it was such good mental training!" Do you really agree with this? Does not there come to mind other studies which would have been of more service and which would have provided equally good mental gymnastics? Since you have been a practicing nurse and have specialized more or less, do you not feel that there were one or more studies which you had during your course which you wish had been given less fully, and that the time so given might have been spent on the things which you practice now?

Just one example. The average nurse is probably better trained in dosage and solutions than the average doctor, yet the average nurse gets called down hard if she ventures to correct or criticise the orders of the average doctor.

I recognize that much that I have said is debatable from both practical and theoretical standpoints. I also admit that what I propose is not ideal, but we are confronted by conditions which demand practical "workable" ideals, and we must make the best of them.

There exists a steadily increasing demand for nurses, a demand which it has been impossible to supply. During April, 1920, at one nurses' directory in Baltimore there were 242 calls for registered nurses, of which but 62 were filled; in other words, 180 trained nurses were needed and could not be supplied. Putting it still differently, but 25 per cent of the calls for trained nurses could be filled. Not only was there a deficiency of registered nurses but the so-called practical, or untrained, nurse or attendant was asked for 142 times and 87 of these were not filled, or 61 per cent of the attendants called for were not supplied. I have recently checked up these figures. The same condition, although to a lesser degree, still obtains.

Analysis has shown that in very many cases of illness the services of a trained nurse are required for but short periods during the hours she may be on duty. The patient does, however, require a trained companion during convalescence, for without one recovery is retarded. Usually the nurse is retained until it is quite "safe" for the patient to do without her; and by "safe" is meant that the patient will not overexert herself by bathing, dressing, coming downstairs to meals, or the many things which the nurse has done to economize the patient's strength during convalescence.

I believe that a woman with special training could do these things quite as well and if her services were employed during convalescence this arrangement would release the more highly trained nurse for duty with more acute cases. As a rule, the convalescent patient requires bathing, other parts of the toilet, a tray service and a certain amount of amusement. In order to train this form of nurse, it is believed that the following studies are necessary:

1. A course in the bathing, hair dressing and other services associated with the toilet of the patient. It is believed that this could well include the use of the safety razor for men patients.

2. A brief course in dietetics, laying especial reference upon the palatability and attractive service of food.

3. Invalid occupation. This would probably be the most prolonged part of the course, and would include games, puzzles and bed occupations.

4. Surgical dressings. It is desirable that the nurse possess the ability to make dressings or to assist the attending physician in applying dressings when it is desired. It is believed that affiliations could be made with hospitals so that experience could be gained, and it is believed that one

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month in a surgical dispensary would be sufficient for this training.

5. Temperature and pulse-taking. It is desirable that the nurse be taught these points, in order that she may notice any abnormalities and call the attending physician's attention to them at once.

6. Cultural courses, consisting of lectures or courses of reading, covering art, literature and music. These courses should be as broad and as comprehensive as possible, and be given with the idea of making the nurse as much of a companion to a cultivated patient as it is possible for a young woman to be who has not had the time nor the opportunity for the cultural advantages which a patient may have had.

It is unnecessary for the nurse companion to know anything of materia medica. She should only be expected to give medicines according to the physician's directions, and this does not require special training.

It is believed that work of this sort would give opportunity to persons of agreeable personality, but who are disqualified by health or some other limiting condition for taking the three years' course of study and rather strenuous work required, to care for the sick in a pleasant yet useful way. There are many nervous invalids for whom a person trained in this way would be well adapted. It is believed that the training of nurse companions would work to the material advantage of the hospital because by utilizing this specialized type of attendant patients could be given more individual attention and therefore would be apt to recover more rapidly.

It is also conceivable that many women who, because they are between 35 and 50 years old, are not eligible for nurse's training might well qualify for this work, especially if they belong to the cultured class of society and have had the advantage of travel, reading and contact with educated people. It is to be emphasized that personality is a most important asset in this type of nurse. Tact and common sense are absolutely necessary.

I believe that it would be possible to train women to qualify for the care of convalescent patients in from six to twelve months. A woman of good personality, with a proper cultural background, can acquire the necessary technical training in six months, and it is conceivable that certain women may be able to do so in less time.

The younger woman who has had fewer cultural advantages would require a longer period, because she must attend culture courses until she has made of herself a good companion. It would be too much to expect that pupils would get this part of the training at the hospital, or, at least, from the hospital staff. Physicians and nurses are too specialized along technical lines. It might be possible to employ a school teacher who is qualified for this work, or a librarian of experience, who would be more likely to have the broad view necessary.*

With a shorter period of training, the probability of a longer professional life than available to the trained nurse, and lessened responsibility, it would seem but just that the wage paid to the companion for convalescents be lower than that available to the nurse. Like everything else, it will be fixed by supply and demand.

From a recent interview with a nurse, who is also interested in the training of nurse companions, I have learned that several states have passed laws licensing attendants and conferring upon them the right to use the letters L. A. (licensed attendant). It would seem most feasible to apply this title to the group I have been discussing, as they could then secure registration.

* Further comment on this matter may be found in the chapter upon Training Courses in my book, "Reconstruction Therapy."

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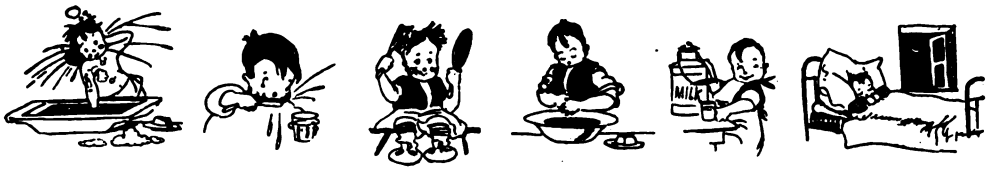



*Courtesy World's Health*

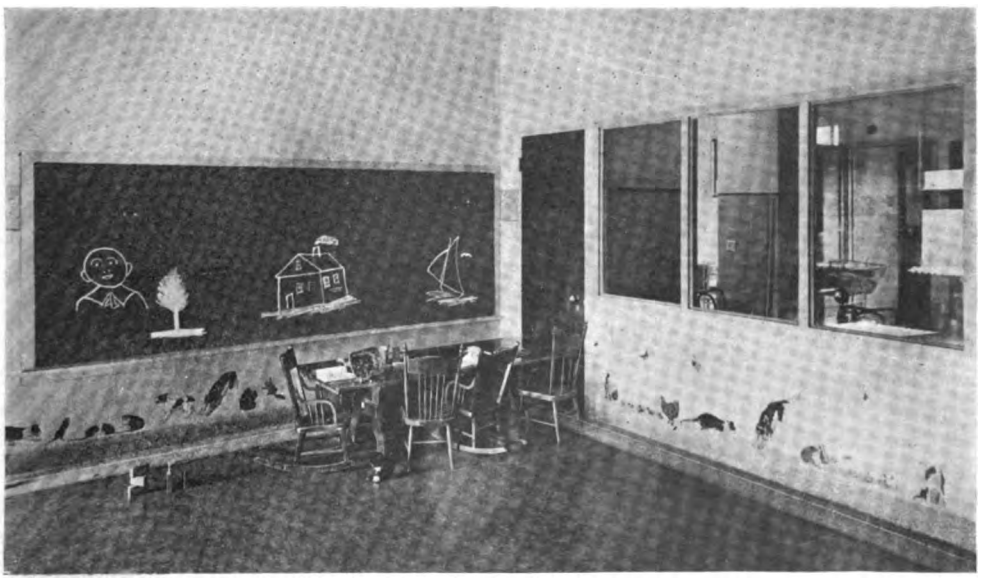
# AMUSEMENT AND EDUCATION ADAPTED TO CHILDREN'S WARDS

## NEW METHODS OF TEACHING HEALTH

SPOTLESS walls and germless ceilings may have their charm for the sophisticated adult, but primitive children welcome color, animal pictures and Wonderland friezes on hospital walls. The presence of jocular Old King Cole not only makes the child feel at home in his new surroundings, perhaps amused, but the bowl helps him to "down" the morning gruel. That, however, is the end of this tale, not its beginning.

Though we hardly agree with the Russian scientists that red dados promote recovery in scarlet fever, the color and feeling tone of hospital walls are especially important in children's wards. Cold blue-gray and sickly green are decidedly depressing in a room with northern exposure, while a warm gray or carefully selected yellow cream are stimulating. Proper shades at the windows obviate glare.

With the wall tinted, the next step is positive decoration. This may be achieved by pasting birds, beasts and nursery characters in appropriate positions on the wall. The application of several coats of varnish brightens the colors of the cutouts and insures a smooth, sanitary surface which may be washed down. Nursery jingles, remodeled into health rhymes, and good health habit panels are also effective. Pudgy figures done in bright colors please the tiny children,



The kindergarten room at the Bridgeport Hospital

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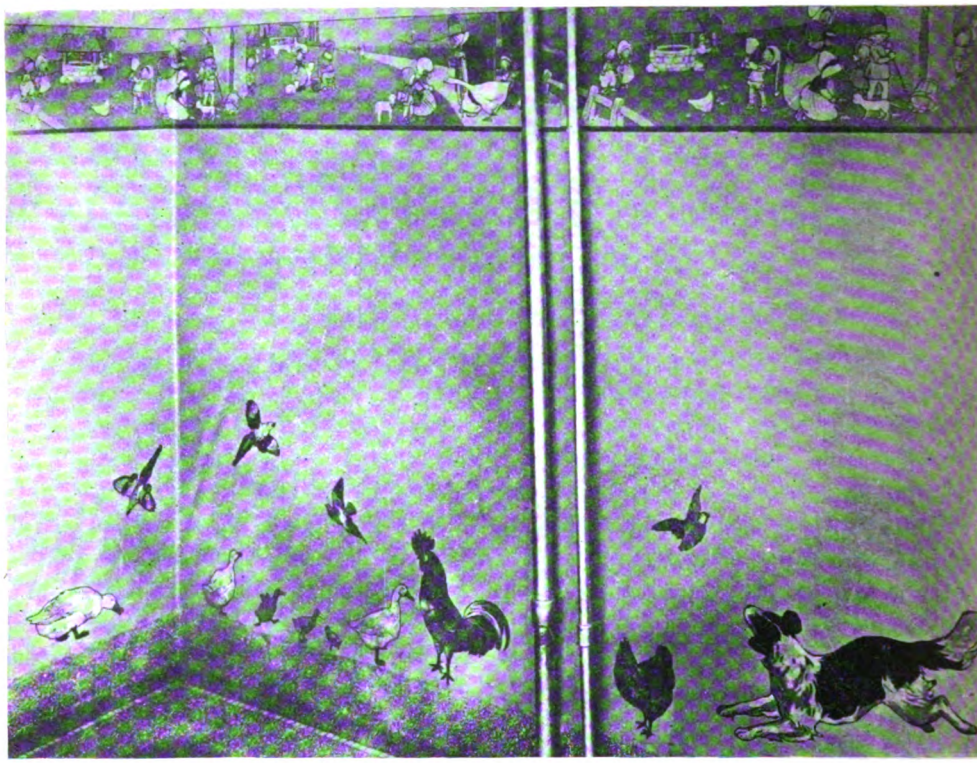

A fascinating corner in the nursery of the Bridgeport Hospital

while the cartoon style shown in the heading catches the fancy of the more matured.

The accompanying photographs, taken at the Bridgeport Hospital, show the happy use of decoration with a purpose. The true therapeutic value of diversion and amusement for children in pain is demonstrated almost daily. Brightly colored balls attract the fancy of the wee baby, while bedcover tracks and landscapes occupy the older boy.

Quite recently we happened upon a new departure in cutout work—an assorted package containing a highly colored bird, a brown monkey, a mallard duck, a frog, a French bull pup, and a red-combed rooster. When carefully cut out and pasted—a task which taxed the ingenuity of the six- to ten-year old children—the birds or animals made fascinating little shapes in three dimensions. A sportive parrot which balanced on the crib of the ward's pet baby was especially attractive. The cutouts, manufactured under sanitary conditions, are supplied in sealed tissue envelopes. The fact that the same cutouts were used as favors at one of the nurses' parties indicates the scope of appeal for these lifelike models.

During convalescence the hours may be profitably filled with occupational diversion or a resumption of school work. The ambitious child often delays his own recovery by fretting over the 'rithmetic which he is missing. At the Bridgeport Hospital a grade teacher gives regular instruction to the convalescents, singly or in groups, as the situation warrants. The kindergarten tables are often surrounded with eager children.

The health education which the nurse imparts is perhaps the most important. Even a brief hospital stay provides op-

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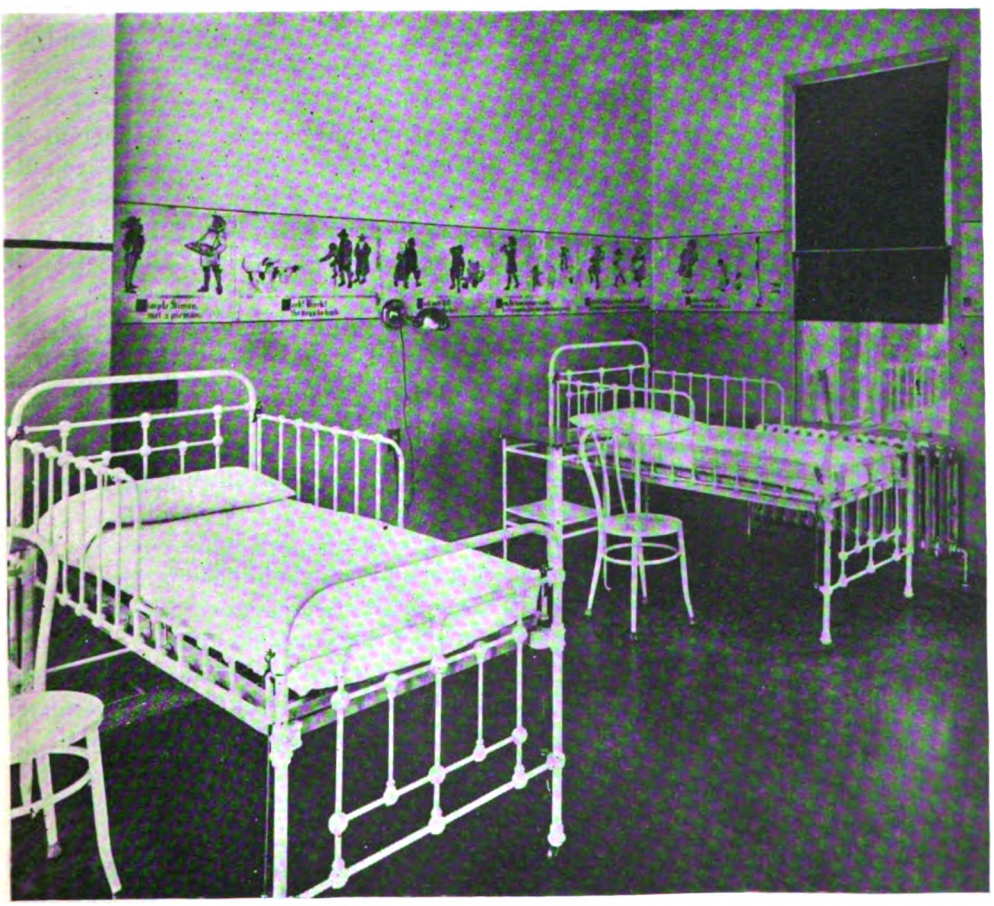
portunities for the establishment of permanent health habits under the best auspices. When the school nurse urges a "full" bath each day, sleeping with windows open, washing hands before meals, eating prunes or fresh fruit at least once a day—a thousand obstacles beset the child's path. No hot water; father does not believe in open windows; washing hands is a nuisance when the sink "will not run away." The child in the hospital, on the other hand, flourishes upon the health rules which the nurse formulates and helps the child to carry out.

If the nurse makes him conscious of the whys and wherefores of each movement, the child is always a good little sport willing to play the game.

"Teeth washin' and baths is a pipe here," confided Dick, whose pajamaed chest was rapidly expanding at the nurse's praise, "but, Jimminey Crickets, how I hate to keep my foot up all the time."

"Of course, that is hard," agreed the nurse, "but if you let the blood get into that foot by putting it to the floor it will hurt and you won't be able to run on it so soon. That is why you score five points for every perfect day. Now, Phoebe, in the next cot, gets five points if she drinks her milk every day. Downing her milk is just as hard for Phoebe as keeping your foot up is for you." And Dick is satisfied.

In a Western hospital the health scores



Simple Simon, Jack and Jill and the other companions from Nursery World troop around the walls

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| Week 1. | | | | | | | Week 2. | | | | | | | Health Rules. | Week 3. | | | | | | | Week 4. | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sun | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat. | Sun. | Mon | Tues. | Wed. | Thurs. | Fri. | Sat. | | Sun | Mon. | Tues. | Wed. | Thurs | Fri. | Sat | Sun. | Mon. | Tues. | Wed. | Thurs. | Fri. | Sat |
| | | | | | | | | | | | | | | 1. This morning I washed my face, hands, neck and ears, and cleaned my nails. . . . . | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | 2. I brushed my teeth in the morning and in the evening . . . . . | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | 3. I washed my hands before each meal . . . . | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | 4. I took a full bath on the days named . . . | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | 5. I slept ten hours last night with windows open. | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | 6. I breathed through my nose and not through my mouth. . . . . | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | 7. I held myself straight, whether sitting or standing. . . . . | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | Total points. . . | | | | | | | | | | | | | | |

(*Courtesy World's Health*)

A sample score card. A Western hospital prints these in blank—nurses and children working together fill in the suitable rules.

are so closely contested that the youngsters beg for more "hard" rules which carry high scores. This hospital prints the score cards in blank, and the children and the nurse plan out health stunts which fit individual conditions. A rating of 80 per cent. in the carrying out of the health rules, which the child thus sets for himself, gives him the right to choose the Sunday evening story, select the Sunday dessert or demand some other coveted privilege as a reward of merit. And the faces of the children as the reckoning is being computed are drawn with anxiety lest they fall below the mark.

Instruction under these conditions imbues the child with a respect for health habits which is permanent. The child, his parents and the whole neighborhood are the gainers.

## A MODEL COMPILATION ON STANDING ORDERS

In June, 1922, the Lakeside Hospital, Cleveland, published a second edition of the "Professional Standing Orders including History Forms." The revision has been edited by Dr. Horace Marshall Korns, assistant visiting physician at the Lakeside Hospital. Two years' experience with the use of unified general orders has demonstrated clearly the superior utility of this method of administering the details of clinical work.

At the request of executives of the American Hospital Association, the type of this report covering eighty pages (40 of which are blank to permit the addition of modifications, changes, etc.) is being held so that any other institution may have this carefully planned draft of standing orders reprinted for its use. The name of the individual hospital can be substituted for Lakeside, any material eliminated and any other material added as desired.

These orders are more complete than usual and contain in definite form important detail often assumed and not formulated. This makes them especially valuable to pupil nurses as well as serviceable in helping the smaller and younger hospitals to begin the development of corresponding documents. The editing, arrangement, indexing and general form appeals to us as especially good. This book can undoubtedly help many hospitals in the mechanical formulation of their orders.

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# HOSPITAL SOCIAL SERVICE*

## ITS AID IN DIAGNOSIS AND THERAPY

ELIZABETH COSGROVE
Social Service Department, Mercy Hospital, Pittsburgh, Pa.

THE meaning of this phrase—social service in a hospital—will depend upon two things: first, one's conception of the purpose of a hospital; and second, one's conception of the purpose of social work. A careful analysis indicates that these purposes are supplementary; the hospital aims to make patients well and to keep them well; social work, with its constant aim of keeping people in the trend of normal living, concerns itself with health as an essential to a normal life. The social worker aims to keep the patient from meeting the necessity of going to a hospital, aims to remove him from the hospital as soon as possible, and, after removal, aims to keep him from returning there. In other words, the social service department works with the hospital in an attempt to make the treatment carried on within the institution a permanent product. Those of clear vision who come in contact with the sick are realizing the value of the statement made by Miss Mary Richmond that "socialized medicine begins to treat not only the disease but the patient in his individual environment—a marriage, as it were, of medicine and social work." **

### HISTORICAL BASIS

Hospital social service is not a new discovery. As early as 1636, it was known in organized form in France, having been instituted there by St. Vincent de Paul. Through the centuries since that time, the Catholic sisterhoods have been performing the essential duties of hospital social service departments. Hospitals have increased in numbers and in size out of all proportion to the number of women entering the sisterhoods. Consequently, some of the sisters' functions have been, of necessity, transferred to lay workers. (This same extension of hospital function has led to the employment of social service workers in all hospitals.)

Perhaps the functions of a well developed social service department are not, as yet, as clear cut as many would like to have them. Those who know the possibilities of a useful department insist upon using their efforts in the performance of functions pertinent to the goal.

### THE IDEAL PURPOSE

The department reaches a development closest to the ideal when it serves as a *diagnostic* and a *therapeutic department.* It can aid the physician in making diagnoses by supplying information about a patient's home conditions and personal habits, when such information could never be obtained by a hospital interview; it can give details of a patient's family history; it can furnish the knowledge of what factors in a patient's environs were responsible for the present illnesses. A social service department performs its therapeutic work by attempting to remedy the social maladjustments that cause and prolong illnesses—such as poverty, bad housing, poor sanition, insufficient food, improper diet or immoral surroundings. These conditions are found to be most important in cases of tuberculosis, syphilis, nephritis, mental diseases, malnutrition, industrial diseases, and in the obstetrical field.

* Paper read in Symposium at annual meeting of the Catholic Hospital Association, Washington, D. C., June 20 to 23.

** What is Social Case Work? page 211, by Mary E. Richmond. Russell Sage Foundation, 1922.

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The department can also render a variety of subsidiary services. Patients that logically belong to another institution can be transferred. Those who have no desirable place to go upon discharge can be looked after. When necessary an interpreter, legal assistance, reading material or employment can be furnished. If a patient is permanently handicapped, provision for his future occupation and welfare can be made. To see that patients receive real convalescent care when necessary, to be sure that they understand and carry out the advice given them in the hospital, and to look to it that they return as frequently as ordered to dispensary or hospital—these are important steps towards the securing of end results. The use of the record department of the hospital is indispensable for carrying out this work.

Dr. Richard Cabot thus generalizes the function of the social service department in the hospital: "To focus upon each individual patient all the forces of helpfulness existing in the charities, the churches, the labor unions, lodges, and other voluntary associations, as well as the opportunity for education and recreation of which the patient may be especially in need."*

### The Scope of the Work

It is impossible, and impracticable, for the social service department of the hospital to do intensive work on a great number of cases; it is possible, however, and wise, to direct patients to the other social agencies in the community when their social needs cannot be relieved while in the hospital, or through visits to the dispensary. It is impracticable for the hospital social service department to attempt to act as a specialist in child placing, relief, public health nursing, or to perform any functions which existing agencies are already doing well. In a few instances, intensive work is necessary with cases in which the health problem is paramount; when the health situation has been remedied, these cases, too, are transferred to an outside agency. The social service department uses and coordinates with the hospital organization every resource in the community, especially those relating to the improvement of public health.

### Educational Service

The department has a profoundly important educational service to render to the community, as well as to those within the hospital walls. It can teach the patients to carry into their homes and into their neighborhoods, the beneficent influences of the hospital to prevent the increase and the spread of disease. Miss Richmond claims that "the trained case worker interprets the community to the hospital and the hospital to the community."

The social service department is the logical resting place for the responsibility of instructing the nurses, medical students, and internes as to the necessity of understanding a patient's social background and the relation between that background and his physical and mental disabilities. This can be done through lectures and frequent interviews.

The administrative division of the hospital and the social service department have a reciprocal duty towards each other. The social service department owes a sterling loyalty to the administration; it brings the viewpoint of an unbiased outsider and is therefore in a position to offer friendly, constructive criticism. It is able to counteract the narrowing influences of routine work. By coming into contact daily with numbers of sick people for whom there is no

* Hospital Social Service Quarterly, May, 1919, page 96.

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hospital bed available, the social service department is able to show the administration the need for the extension of hospital service and of dispensary facilities. At staff meetings complaints which are made frequently to the social worker by patients can be cleared up and their causes removed when possible.

On the other hand, the administration owes the social service department the opportunity to perform its own functions and not to burden it with minor and unimportant duties which other departments of the hospital do not find it convenient or agreeable to assume. The social service department operating under an understanding superintendent is not called upon to make financial investigations. In fact, some hospitals have found it a money economy for the administration to employ a financial investigator. In the absence of such a special agent, however, the social service department is willing to determine as accurately as possible, the individual patient's responsibility to pay, in order to protect the hospital and staff from impostors. It realizes, as keenly as do the possible recipients of fees, that payment for service received enhances the value of that service, and enables the patient to retain his self-respect; however, it realizes, also, that there is a point at which payment of hospital bills frequently means dispensing with actual living necessities.

### Extending the Service

Valuable data for research along special lines can be obtained if records of a useful sort are kept by the social service department. The value of these records will increase as the service broadens. There is no reason for the limitation of the activities of this department to the non-paying patients in a hospital. The wealthy, as frequently as the poor, suffer social ills. Many believe that the day is within sight when physicians will use the department for all classes of patients.

If the hospital social service department is to perform the essential functions outlined here, the necessity for employing workers of a high type is obvious. A social worker must be educated in a pure sense of the word; she must have a knowledge of the history and tendencies of modern society; she must know and be able to interpret the varying phases of economic situations. With insufficient training she will be unable to handle case work and to appreciate its possibilities and its limitations. The hospital social worker must know the fundamental principles of hygiene, the causes and manifestations of the important antisocial diseases; in addition, she must be able to work intelligently with the members of the medical profession. A mere acquaintance with psychology is not sufficient; human behavior is a subject for prolonged and intensive study. Special training in one of the hospital's activities is inadequate for a social worker. A kind heart cannot serve in lieu of knowledge. As Michael M. Davis, Jr., remarks: "Kind hearts in social workers are of just the same value as honesty in bookkeepers. Honesty is essential, but does not teach a clerk to keep books."*

Nor can one person perform well all the arduous tasks that come to the social service department of a hospital. The social service department must be composed of well equipped workers, in sufficient numbers to carry out the full aims of the service. Hospitals operating without a social service department of a high type diminish every year. Those institutions that are still without such a department might do well to ask themselves if they are granting to each patient his right—that is, the right to adequate service.

* Dispensaries: Davis and Warner.

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# CONTINUATION SCHOOLS AS THE FEEDERS OF INDUSTRY

## HEALTH IN THE PRE-INDUSTRIAL PERIOD

CHRISTINE R. KEFAUVER, R. N.
Acting Supervisor of Industrial Hygiene, Department of Health, New York City, New York

"SO Jimmie's gone to work," said the nurse, as she bathed the new baby, now two days old. "Your fourth child will be supporting the family, Mrs. O'Flaherty, before your ninth is out of its cradle."

"It do be a pity," said the mother, "but then he'll be took care of at the continuation school. And he needs to be took care of. The teens is the critical time in the 'upbringin'."

And Mrs. O'Flaherty was right. From the standpoint of physical, mental and moral development perhaps no period of human life is more important than that of adolescence.

The individual at this time is in a state of flux. Thrust into the work-a-day world, where for the first time he associates on a plane of equality with adults, he is confronted with conditions and obliged to make decisions for which nothing in his past life has prepared him.

He chooses his occupation blindly and with entire disregard of his fitness or efficiency. As a result "square pegs in round holes" are to be encountered everywhere in the industrial world. This is not fair to the individual, since it frequently forces him into an occupation for which he is utterly unsuited, mentally and physically—an occupation which undermines his health and retards his economic advancement. It is equally unfair to society, which is obliged to care for the physically unfit and to suffer financially and otherwise through economic maladjustments and inefficiency.

In previous times the youth of working age was apprenticed or "bound out" by his parents or guardians, to some trade or profession. Here, again, the preference or special qualifications of the individual were ignored, and as the apprentice was not free to leave his employer, he frequently suffered ill-treatment and injustice.

Today only ten per cent of our school children * ever get beyond the elementary grades, and only very few make any effort to supplement their education thereafter. To such imperfectly educated children, the industrial field is naturally restricted and in the majority of cases a very definite limit is set to their economic advancement.

### THE GREAT UNSCHOOLED

The great majority leave school as soon as they are old enough to obtain working papers. This age and the educational and physical requirements differ in the various states. In New York, the required age is 14, where the elementary course has been completed, between 15 and 16 years where six years' school work has been completed, and between 16 and 17 years, irrespective of the child's education. Where working papers are issued, attendance of the child at a continuation school is required until he has reached 17 years of age. The law further provides that by 1926 provision shall be made to accommodate all minors up to 18 years.

Previous to the inauguration of these schools the boy or girl desirous of con-

* In New York City.

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tinuing his or her education was obliged to attend an evening school, either public or private. This was unfair to the child who was already fatigued with a day's confinement in a shop or factory, and badly in need of rest and recreation. It meant that the young worker must be out late at night and this, especially in the case of young girls, was undesirable.

Dressmaking, designing and machine work under conditions which simulate shop surroundings

The average night school of New York conducted as it is for adults who are largely foreigners, is little suited to meet the requirements of the young adolescent. As a result the children frequently became discouraged and dropped out. In the end this failure discouraged them from making any further attempt to rectify their educational defects.

In the continuation schools, the conditions are quite different. Here, for the first time the child discovers a definite relation between academic knowledge and its practical application. For instance, arithmetic is taught from the standpoint of square feet of lumber, amount of cement, bricks, plumbing, etc., needed to construct a building, the amount of material required to make a gown and the measurements necessary to draft a pattern, etc. Drawing takes on a new importance to the child when its relation to commercial advertising, architecture, etc., is discovered. Geography and history assume new interest because the boys and girls going into commercial houses must be conversant with the different grades and values of commodities produced in different parts of the world. This stressing of the value and practical application of purely academic information is constantly impressed upon the student by means of the rotation between his job, the school workshop and the class room.

We who see the end results in adult industry are especially interested in the question of vocational guidance.

Various occupations are open to the child and he is assisted in making his choice by a vocational instructor, whose business it is to talk to the student, find out what he wishes to do and what he is most fitted to do, and also what factors in his previous training fit him for the work he is interested in. This is a most important part of the work of the con-

Boys studying garment making under careful instruction

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tinuation school, because here, as nowhere else, an intelligent effort is being made to fit the job to the child.

Instruction is given in the following subjects in the continuation schools:

I. Woodworking, carpentry, cabinet making, building, concrete work.
II. Auto mechanics, home mechanics.
III. Sheet metal.
IV. Commercial and poster advertising, costume illustration, cartooning, show card writing, sign painting, trade drawing, architectural drawing, estimating, plan reading, blue print reading, sign painting layouts.
V. Bell wiring, lighting.
VI. Clerical work, salesmanship, bookkeeping, office machine operating, typewriting, stenography, office practice, business arithmetic, business correspondence.
VII. Millinery, flower making, lamp shade making, novelty work, hand or crochet bead work, embroidery — all styles — white and colored.
VIII. Sample mounting, sewing and dressmaking, pattern drafting and grading, costume designing.
IX. Cooking, laundering, marketing, home decoration, home sanitation, household managing.
X. English to foreigners, high school preparatory, commercial law.
XI. Banking.
XII. First aid to the injured.

When the child has made a choice of the occupation he desires to follow, he goes into the shop or division where it is taught. Here he gets the practical side of the work, and "learns by doing." But this is only a part of his education, as in addition he must spend four hours a week in the classroom acquiring the theoretical side of his vocation. The employment division of the school finds work for him, if he is not already employed.

In addition to teaching, the teacher spends one and a half hours daily in visiting employers. This aids him in keeping industrially up to date, and also gives him a first-hand opportunity of seeing the practical application by his pupils of the knowledge acquired in school. These daily and weekly visits to shops and factories by a representative of the school where the child is a student allows of a check-up, as the student's progress and efficiency are reported upon by his employer. Also his difficulties are discovered and it becomes possible to straighten out these difficulties later in the classroom or school shop.

The result of all this is most important and far-reaching. There is a direct point of contact between the school and the student's occupation. Work, other than professional, assumes a new dignity in the eyes of the student, because for the first time he is made to realize that industry also requires special preparation, and that the individual who blunders haphazardly into a job has not the same chance to succeed as the person who has made an intelligent study of his chosen occupation and prepares to engage in it efficiently.

### Health Oversight

Since the pupils in the continuation schools are workers, it is only natural that they should be the special concern of the Division of Industrial Hygiene of the New York City Department of Health. Through the co-operation of this division it has been possible to make physical examinations of the pupils and give advice and aid in the correction of defects. A table of the physical findings is given below:

The pupils examined ranged from 14½ to 18½ years, inclusive.

Males examined: 1,852; defects found, 2,678; normal, 374.

* Females examined: 269; defects found, 511; normal, 51.

† Incidence of disease, according to occupation:

*Clerical.*—Males examined: 160; defects found, 194. Females examined: 85; defects found, 72.

*Messengers.*—Males examined: 478; defects found, 584.

*Electricians and Jewelers.*—Males examined: 31; defects found, 60.

*Foods, Drugs and Chemicals.*—Males examined: 96; defects found, 130.

*General Housework.*—Females examined: 76; defects found, 127.

*Laborers, Drivers' Helpers.*—Males examined: 177; defects found, 227.

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* It is the policy of the Department of Health to have a woman physician examine the girls and, therefore, owing to the limited number of women physicians available in the Division, the number of girls examined is much less than that of boys.

† In some cases, several defects were found in the one person, hence, the total number of defects found.

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*Leather Goods.*—Males examined: 32; defects found, 62.
*Mechanics' Helpers.*—Males examined: 103; defects found, 155.
*Millinery and Embroidery.*—Females examined: 27; defects found, 56.
*Packers and Merchandise.*—Females examined: 56; defects found, 117.
*Painters' Helpers.*—Males examined, 15; defects found, 32.
*Printers' Electrotypers.*—Males examined: 93; defects found, 139.
*Plumbing and Metals.*—Males examined: 78; defects found, 109.
*Textile Operatives.*—Males examined: 76; defects found, 107. Females examined: 77; defects found, 139.
*Woodworkers and Cabinet Makers.*—Males examined, 42; defects found, 135.
*Unemployed.*—Males examined: 471; defects found, 744.

By grouping the defects under general headings, the following conditions were observable: General diseases (tuberculosis, anemia, diabetes, etc.): Males, 78; females, 31. Nervous diseases and defects of special senses (ear, nose): Males, 290; females, 110. Circulatory System: Males, 81; females, 20. Respiratory System: Males, 1,238; females, 70. Digestive System (including defective teeth): Males, 1,044; females, 199. Diseases of the Skin: Males, 83; females, 18. Diseases of the Bones: Males, 65; females, 32. Pelvic Complications: Females, 38.

In analyzing this table, some very interesting points may be noted. By far the largest number of boys examined were employed as messengers and errand boys, a comparatively unskilled occupation and presenting very little opportunity for advancement. This group presents a very high rate of physical defects.

### Defects and Unemployment

The unemployed group presented the greatest number of physical defects. It is an interesting speculation whether the prevalence of poor health in this group was the cause or the result of unemployment.

The enormous prevalence of disturbances of the respiratory and digestive systems gives serious ground for thought, since these conditions play such an active, causative part in increasing the susceptibility to malignant disease of later life.

It is felt that the inculcation of principles of public health, sanitation and accident prevention in the minds of these young workers, not only benefits them individually, but stimulates them to spread such teachings and example in the shops into which they go. If the worker can be taught the value of a thorough annual or semi-annual physical examination, if he can be shown the subsequent correction of the defects discovered, if he can be convinced that his body is worthy of at least as much consideration as the machine he operates, and which, if he is a careful workman, he regularly cleans, oils, and overhauls, it will go far

Hats and hat shapes which rival Fifth Avenue creations

toward reducing industrial hazards and eliminating conditions which predispose to occupational diseases. When it is realized that the worker's health is his principal capital, it is easy to see what far-reaching effects such instruction in his youth will entail in later life.

It is hoped that as time goes on and the value of these schools is more thoroughly appreciated, it will be possible to get an appropriation for nurses and doctors whose entire time may be devoted to the examination, follow-up and care of these pupils.

We will then be spared the shocking spectacle presented in the last draft when a total of 687,486 or 212.06 per 1,000 of our young men between the ages of 18 and 30 (the most productive years of

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their industrial lives) were rejected as physically unfit for military service. This showed as nothing else could, that if so large a proportion of young men were physically handicapped, it is only fair to assume that an equal number of young women were equally below par.

### The Seriousness of Physical Handicap in Adolescence

Such poor physical condition at this early age is a most serious problem to the country at large. This is the age in which the largest proportion of marriages occur, and it is an axiom that the children can not be strong and healthy if the parents who bear them are not.

The atmosphere in these continuation schools is one of the most remarkable things about them. The teachers are helpers and fellow-workers with whom the pupils consult and discuss their difficulties. There is an air of *camaraderie* and interest which is quite different from that of the graded schools from which most of these pupils have just emerged.

Strange as it may seem, some people oppose the continuation schools. The employer resents the supervision which the law requires where continuation school pupils are employed. He objects to the child absenting himself to attend school, being himself too short-sighted to see that the ultimate result will be a more efficient worker. He objects to the increased age requirement of the young workers who enter industry as a result of the continuation schools, because they are not content with the meagre wages paid to the child of 14, and can not, therefore, be used so successfully to beat down the wage of the adult worker with whom they compete.

Other sections of the public, well-meaning individuals with "single-track" minds, see in every law which aims to make education or sanitation compulsory an invasion of personal liberty. If followed to its logical conclusion their point of view would result in an individualism so extreme as shortly to result in the nullification of all law. Furthermore, there is no argument against the compulsory continuation school which does not apply with equal force to all compulsory education.

Opposition from a third source is furnished by those parents who regard their children as economic assets. They would, if the law did not prevent, deprive them of any education whatever, and make of them wage-earners as soon as they leave the cradle. Such people are bitter in their denunciation of what they consider an interference with their "rights." That the child might have rights never enters into their calculations.

### Overcoming Opposition

The last source of opposition, which comes from the children themselves, is the most natural and the most easily understood. They look forward to the freedom from restraint which school discipline represents to them, not knowing in their youthful ignorance that life holds a much sterner discipline with which to bind them. Naturally they think that they know all there is to know, and are anxious to try their fortunes in the industrial world.

As these groups gradually realize the real value of the continuation schools, the increased physical and industrial efficiency of the fortunate children who have been trained for industrial work, the scope of the preventive health work will be broadened. The monetary outlay thus expended will be repaid many times in the creation of intelligent, industrial groups who will be interested in their work, proud of their efficiency and conservative of their health.

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# THE EXISTING HOSPITAL SYSTEM AND RECONSTRUCTION†

GEORGE EDWARD BARTON, A. I. A.‡

SINCE occupational therapy is instituted quite as much for the benefit of society as for the patient, it is impossible to deal properly with the subject without considering many fundamental problems of sociology and economics. Don't dare say this paper is doomed to be dry. I shall put my remarks in a style that is easily downed in hot weather and leave the more formal and dignified retort to my critics.

As a premise it is necessary to remind you that the position of the analyst of social conditions is not unlike that of the chemist—his duty is to state his findings without reference to his feelings.

At the present time any suggestion that the hospital, the medical professions, or the great charitable organizations are not absolutely perfect will perhaps be regarded as equivalent to an attack upon the very foundations of Christianity. But I could no more be excused for not stating conditions as I find them than could a nurse in the "lab" who declared a Wassermann negative when she had found a positive because she "was so sorry for the patient's mother."

The year 1914 will be regarded by future annalists as having seen the birth of other conditions quite as important as the war. To the unemotional student of social conditions, the war, with all its horrors, was but an incident in the progress of human endeavor. It was the inevitable and the long-expected result of an attempt of a part of humanity to force its beliefs upon the whole of humanity. The trend of the passing civilization was to legalize itself into a condition of legality, and, while declaring its disbelief in perpetual motion, to make a machine to make a machine which would make a machine unnecessary—to drug itself into a condition of druglessness.

> *It would require an army of over 43,000,000 continuously in contact with the enemy for a year, or over 4,000,000 for ten years, to produce the cripples unable to engage in their former occupations alive at this moment in the United States alone.*
>
> T. NORMAN DEAN.

Though hospitals and civilized institutions had been founded upon the assumption that the alleviation of pain and the sanctity of human life were of the greatest importance, hardly a day of war was required to prove that, far from actually believing those tenets to be true, "civilized" man was concerned only with the infliction of injury and death upon that neighbor whom he had deceived himself into a protestation of loving.

The hospital immediately showed itself in need of important alterations. Under war conditions, the problem admittedly was no longer to save distress and pain and death regardless of the expense of time, energy and money, but, on the contrary, in the shortest possible time, with the least possible equipment and waste, to discharge a patient not to a sunny convalescence, but back to the trenches, where again he could inflict a like injury upon the enemy.

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† Mr. Barton's first article on this subject appeared in TRAINED NURSE AND HOSPITAL REVIEW, June, 1914.

‡ President of the Consolation House Convalescent Club, Inc., Author of "Occupational Therapy;" "Re-education"; "Teaching the Sick," etc.

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It will surprise many to find that *this horrible condition had been preceded by one so very much worse* before the war as to have engrossed the attention of many who, like myself, believed the system of curing the sick to be ineffective and wildly extravagant not only of money, but also of time and energy, and, most important, of that human life, the perpetuation of which was claimed as its strongest prop.

In the words of Mr. T. Norman Dean, M. A., statistician, of the Ontario Workmen's Compensation Board, Toronto: "The pleas for the adequate care of war cripples are not specious arguments. Yet it would require an army of over 43,000,000 continuously in contact with the enemy for a year, or of 4,000,000 for ten years, to produce the number of industrial cripples unable to engage in their former occupations, alive at this instant in the United States alone."*

History shows that almost every achievement of man is accompanied by corollaries, inevitable consequences to his main accomplishment. The "cure" of any social condition is usually accompanied by the creation of a new, perhaps worse, predicament.

No action, be it "good" or "bad," which has been performed by a large number of people for a considerable period of time *can be changed only in itself.* It has become a "human institution"** and is like a great tree the trunk of which is measurable and the foliage obvious, but whose roots stretch out unseen underground and cannot be estimated.

One of these roots may have found its way into the joint of a drain pipe. The tree uprooted, the drain is opened, and as a result a whole community contracts typhoid, which "of course, was not intended at all!"

It is the recognition of such fundamentals of human conditions which mark the difference between the anarchist, the Bolshevist and the "reconstructionist," reference to whom you see now in the newspapers. These "reconstructionists," long students of social conditions, were not made by the war, but were squeezed into activity by it. So far as I know, they have never formed a working organization. In many cases the leading minds were at first ignorant of each other's existence and each one doubtless considered himself sole author and originator of his ideas concerning the remaking of society's institutions.

### The Real Facts

At the beginning of 1914 hospital—and the term is used in the broad sense—conditions could perfectly be compared with a saturated solution. The introduction of one more crystal would result in the sinking (unchanged) of that extra bit to the bottom of the beaker (the lowest strata of society), or in crystallization or precipitation. Some of you may remember that under certain conditions the addition of one bit more to the saturated solution results in the precipitation of a whole lot more than the bit itself—that, vulgarly speaking, the liquid refuses to not only accept the extra burden, but also to continue to carry the burden already laid upon it.

Simultaneously, in far distant points all over the world appeared men who declared exactly the same fundamental premise—*the necessity for and the possibility of the reclamation of the human discard.* Who said it first nobody knows. and only the small fry cares. These men are above the sentimentality of sob-sister stories, above the supplement pictures of how a man with no head can be taught to chew gum with his toes.

The vital, hopeful aspect is not that Monsieur A, or Mr. B, or Signor C, did so and so on such a date, but that they

* *The Vocational Summary*, Nov., 1918 (Vol. 1, No. 7).

** To be distinguished from "a social institution" in the sense of a prison, hospital, etc.

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all without knowing of each other did almost exactly the same thing on almost exactly the same date.

If we regard the terrible (and true) condition shown by Mr. Dean's words as being the result not of war, but of peace conditions, we see that (before the war) our hospital situation was already inadequate for the needs of society, and that, like the saturated solution, it needed but a bit more to either fail or to produce the precipitation or the crystallization—OF WHAT? Of the patient? Of the nurse? Of the doctor? Of the taxpayer? Of the philanthropist?

As they say in vaudeville: "I don't know! You don't know! They ain't nobody knows!"

"Civilization" was making more and more patients every year. With a total bed capacity of about 600,000*, the United States made 9,000,000† hospital patients and 735,000‡ serious industrial accidents every year. With 6,665** institutions for the care of the sick at the time of this summary (for the three years before the war) 1,000 hospitals annually were added, thereby adding some $200,000,000 yearly to the $1,500,000,000 already invested, with an annual outlay for maintenance approaching $250,000,000. As many men were necessary for hospital trustees as were allowed in the standing army at that time (100,000), and there were nearly twice as many doctors on hospital staffs (65,000) as civil service positions (33,464) necessary for running the Federal government in the city of Washington.

It seems needless to offer further excuse for those of us who wonder at the egotistical self-satisfaction of a people who can give unqualified praise to this civilization, when all the hellish ingenuity of the arch-fiend war-lord himself *failed to inflict upon his enemies in war a condition which even equalled the conditions which we annually inflicted upon ourselves in peace.*

In brief, that is why some of us felt justified in our efforts to change the institutional system, way back in 1914. The hospitals at best cared for a comparatively small proportion of the sick. The shortage of nurses was already keeping the superintendents awake o' nights. To raise funds the charitable institutions were forced to adopt methods in some places closely akin to blackmail. The doctors had been forced by the unreasoning demands of society to assume a dictatorial power in the community equalled only by the priesthood in the Middle Ages, and forced also to specialize along lines which, however valuable, are not meeting the needs of an industrial condition which demanded a specialization impossible for the doctor to assume. The taxpayer, in spite of his ignorant and unreasoning fear of the bacteria pictured to him, could not afford to keep pace with the unceasing cry of "more hospitals; more clinics; more money, or ye surely die." The philanthropist wondered by what miracle of finance he could continue to give away his capital and yet give still more again next year.

The deficiency of the old system was the result of too great interest in the scientific and too little in the utilitarian development. Had half the money spent upon scientific investigations been devoted to the needs of industry instead of medicine many of the problems of the hospital would have solved themselves. The fault was less that of the doctor (or of the hospital itself) than that of the thoughtless "benefactor." Many people with money and the profound assurance of ignorance specified exactly the limits of their donations to experts who feared

* *Modern Hospital*, "Salutatory." Vol. I, No. 1.
† Ibid.
‡ Final report of Senate Commission on Industrial Relations, p. 95.
** *Modern Hospital.*

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to criticise the terms lest they lose the gift.

The greatest of the many structural weaknesses of the old system lay in the fallacy that the words "Discharged Cured," as written upon the hospital records, were as unassailable as the word "Died." This nomenclature but erroneously emphasized the assumption that an individual could be "sick" one day and "well" the next.

Few patients are sick one day and well the next (even if the hospital *is* crowded); few who require medical and nursing aid one day should be handed over to their loving friends and family* on the day following.

It was very pretty and not without value that endless talk by some of the charitable organizations and churches and social service workers, that perpetual babbling of the necessity for emphasizing the higher side of man, of introducing into the wobbly mind of a sick boilermaker a realization of the spiritual satisfactions assured solely by an appreciative understanding of the esthetic standards of superlative design.

All of us passed through this vague condition of immature idealism, but by a cataclystic concatenation of contiguous circumstances we were forced to realize that when all was said and done, what the sick man (and his helpers) really needed and wanted most was the restoration of his ability to work, to live independently and to make money.

The "reconstructionists," who had undertaken the solution of the problems of the institutions for the sick, asked themselves: "Is there no way, other than that now employed, by which the sick and crippled and sinful and insane may be treated as successfully as now and without this intolerable drain upon society?"

But the introduction into the old hospital system of any money-making occupation was so fraught with danger and difficulty, was so opposed to the old system, and (in some cases) so opposed to existing law as to be practically impossible.

Obviously, if this new work (at that moment only a dream) was to be of real benefit to society, its attainment could not be procured by the Bolshevists' method of destroying the existing institution. The new regime must be brought about:

First, by such vocational advice and instruction as would discourage the entrance of the young or the convalescent into an occupation dangerous from a therapeutic standpoint, and

Second, by training the convalescent for such active remunerative life as would minimize the danger of relapse.

Nothing could be planned which would add work to the nurse's duties. Nothing could be planned which would increase the cost of sickness or convalescence to the patient, the patient's family or society. On the contrary, some way must be found by which the patient could be made partially or wholly self-supporting, to his own therapeutic advantage.

Finally, this must all be so accomplished that no appeal be made to society for working funds.

Such was the problem which (with perhaps childish impertinence and effrontery) we publicly announced our intention to solve† in the United States.

It can't be done? Have patience! In the following articles the author will describe the proposed workings of this plan, giving explanatory notes to show how its functioning is expected to assist the sick man, society, the philanthropist, the medical profession, and the nurse who views approaching age with foreboding.

* When will modern surgery discover the operation for that ever-present need—the *family ectomy?*

† "Occupational Therapy," THE TRAINED NURSE AND HOSPITAL REVIEW, June, 1915.

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# ASPECTS OF MENTAL HYGIENE

## EMOTIONAL FATIGUE—THE SUBCONSCIOUS

HELEN MOLYNEAUX SALISBURY

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IN the February issue I discussed the nurse's part in controlling the simple physical manifestations of nervousness. This article will discuss her role when the trouble is in the mind. By that I do not mean imaginary ills, but real, definite irregularity in the emotions and thoughts—habits of the mind. Perhaps the patient has no physical, organic disease, but is what we call "merely nervous." Of that situation we shall speak later. But perhaps he is suffering from some definite, physical disorder which is periodically or chronically made worse by exciting the emotions, arousing fear, anger, worry or depression. What, then, can a nurse do to help? She *cannot* moralize, she *cannot* scold; or if she does, she is likely to get into trouble. But she can be informed. She can have a vivid and accurate knowledge of what really happens within the body of her patient when he is under the influence of a strong emotion like fear or anger.

Every nurse knows that if her patient gets "worked up" over some happening, his temperature is likely to go up. But does she know why? Does she know that in the race's long struggle for existence, fear and anger have been emergency measures for the purpose of raising the temperature, releasing energy, speeding up the heart, stopping digestion and generally fitting the individual for running or fighting? Does she know that her patient's blood, once he is aroused, is charged with adrenal and thyroid secretions which must somehow be worked off before his breathing will quiet down, his temperature drop and his digestion continue? The patient cannot run and he cannot fight, as he was intended to do when afraid or angry. He cannot even get up and let off steam by cleaning his room or playing the piano as a well person might do; so perhaps the safest thing for him to do is to blow up his nurse. There are times when she may do him more good by serving as a punching bag than by any kind of ministrations. But if by chance she does not know how to rebound, if she shows by the slightest sign that she is taking the matter personally she arouses more emotion, makes the patient boil at his own lack of consideration, calls forth more of the harmful secretions—and fails.

### AVOIDING EMOTIONAL FATIGUE

But there is a more helpful side to the story. The person who knows the facts can frequently help another person in avoiding to call up an out-of-place emotion, and show that person how to pick one which makes for mental and physical health. The patient may not, in his abnormal condition, care at all about the feelings of his family or nurse, but he does want to get well, and if you tell him something besides platitudes, he will usually listen.

I know a woman who has had the habit of getting emotional over trifles all her life. If, when she goes out, she meets any little disappointment, she comes home quite useless with a sick headache and all the other signs of emotional indulgence. On several occasions I had told her what harm she was doing herself, and her invariable reply was that she had always been like that and that she couldn't help it. One day I took the time to tell her in greater detail just what was happening in her body

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and why. Backed up by the facts I had learned from Dr. Crile's facinating book, "The Origin and Nature of the Emotions," I painted as vivid a picture as I could of the intricate changes that had taken place inside her body, changes which would have been appropriate and efficient, if she had been going to pitch into battle with her fists, but which were highly inefficient and uncomfortable to a person trying to live up to the standards of civilized society. This little lecture on physiology proved to be effective where preaching and scolding had failed. "Why didn't you tell me all this before?" said my friend. "You surely have opened my eyes!"

There are other eye-opening facts which might be highly useful to your patient. For example, there are those more encouraging facts which have to do with the physical effects of invigorating feeling tones. I have never seen a person who was not impressed by the account of what happens to his various organs as a result of pleasant emotions —the increase of stomach-juices and the stimulation of stomach-contractions which together make up digestion, the deepening of respiration, the strengthening of the heart-beat, the secretion of the proper chemicals, the up-building of muscular tissue. Of course we all tend to forget after a while, but at the time the listener resolves never again to let himself entertain anything but exhilarating emotions. In a serious illness, such a resolve might even turn the tide.

Then, too, the more facts the nurse knows, definitely and accurately, in terms of physiologic action—the firmer will be her own determination to keep her patient happy. If she remembers the experiments which show how much more blood stays in an organ, when the mind is centered upon that organ, she will do everything in her power to keep her patient's mind off himself, by giving him plenty of other interesting things to think about. The mind cannot stand a vacuum, and one reason why sick people think so much about themselves is simply that they have not much else to think about. There are times when it is more important to read to a patient than to bathe him. I know that from personal experience—not from being the nurse, but from being the patient.

Then there is the whole question of suggestion. The account of what the organs of the body can do in response to a suggestion—either one from outside or an auto-suggestion from within—would sound like a fairy-story, if it were not backed up by scientific verification. It is important for every person to know these facts, but it is vital for any one who has to spend his life with people who are already handicapped by a sick body.

### True Suggestion

Just here I am tempted to sound a note of warning. There are people who seem to think that the clever thing to do with a sick person is to tell him how well he looks and to assure him that there is nothing much the matter with him. This kind of thing fools nobody, and it is very likely to make the patient angry. It assumes either that he hasn't much intelligence or that his troubles are merely imaginary; and neither of these assumptions is likely to increase his up-building emotions.

True suggestion does not mean dishonesty. It is not an assertion of something which is untrue. Many times it means skill in avoiding the wrong suggestion rather than care about giving the right one. As a rule it involves not so much your positive assertions as the look in your eye, the expression of your face, the tone of your voice, the little side-re-

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marks that you let slip—all those subtle and elusive impressions which the sub-conscious mind sees so unerringly, and which the anxious mind of the patient pounces upon with hawk-like rapidity.

So much for cases where the body is at least partly to blame. But what about that whole class of ills which are purely "nervous"—due, we are told to non-physical conditions? At this point I am conscious of a certain hesitation. For if all knew the facts that are commonly accepted by the leaders of scientific thought and by an increasing number of doctors and laymen, there would be very few nurses called for nervous cases of this type. And, furthermore, what is to be the attitude of the up-to-date nurse, if she happens to be called on a case under the direction of a physician who is still laboring under the idea that "nerves" are always a matter of tissue impairment and that they are to be cured by rest and diet, baths and massage? Frankly, I do not know. But, fortunately, this kind of doctor is fast disappearing. And no one wants to hold on to a false idea, even when a knowledge of the truth might prove embarrassing. It is important that nurses, as well as the rest of the world, should be informed on this subject which has so much to do with the happiness of mankind.

The story of nerves is so closely bound up with the warp and woof of the whole of human life, and especially with the sub-conscious part of it, that it is almost impossible in brief space to tell it at all, much less to tell it convincingly. But here in skeleton form are the main facts:

1. In spite of appearances certain nervous disorders are not accompaniments of physical conditions but are purely emotional, with their roots deeply embedded in the unconscious makeup of the personality. These conditions involve no impairment of nerve tissue and the word "nerves" is simply the left-over of an outworn idea.

2. Whatever physical symptoms there may be present are of secondary nature and are either the physical effects of harmful emotions or are the unconscious and symbolic acting-out by the body of the weakness and pain which really belong to the personality itself.

3. The trouble centers in those great fundamental instincts which are common to the race and which so frequently come into conflict with the dictates of civilized society.

4. Although physical measures cannot do the slightest good, these types of nervous patients are repeatedly being cured by modern methods of analysis and re-education, which reveal to the patient what is taking place within himself, and show him how to handle his warring forces in more comfortable and more useful ways.

If you have not heard these things before, you will of course not believe them now. No one ever does at first. But this summary statement shall have served its purpose if it arouses any reader to ask questions and to study further in the rapidly growing literature of this fascinating subject.*

When all the world is awake to the facts, the trained nurse will be released from unnecessary ministrations to nervous patients and will be free for those patients who really need her care.

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* It is impossible to give here even a condensed bibliography of the subject, but by way of suggestion we mention the following:

1. Books dealing with the influence of mind on body:

Crile: The Origin and Nature of the Emotions.
Hudson: The Law of Psychic Phenomena.
Brown: Faith and Health.
Jackson and Salisbury: Outwitting Our Nerves (Chapters 3, 4, 6, 15).

2. Books dealing with nervous disorders:

Freud: A General Introduction to Psychoanalysis (for deeper study).
Prince (and others): Psychotherapeutics.
DuBois: The Psychic Treatment of Nervous Disorders.
Jackson and Salisbury: Outwitting Our Nerves.

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# THE LABORATORY—ITS RELATION TO THE NURSING SERVICE—IX

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## HUMAN MILK

OCCASIONALLY, when a child is not thriving on its mother's milk, the nurse is asked to reserve a sample for examination. A simple matter? I hope to show you that this service of the nurse, like many other points covered in this series, is not as simple as it may seem.

We must take into consideration the fact that the milk at different intervals after parturition varies considerably in composition. What is a normal milk for a newborn child will not prove satisfactory for a child two months old.

As you know, the milk of the first few days differs so much from the milk obtained later that it is given the distinctive name of colostrum. This has usually a lower percentage of fat, casein and milk sugar (lactose) than milk. Its albumen content is as high as sixteen and one-half per cent, while milk has only about one per cent.

The following table*, which shows the transition in cows from colostrum to nor-

TABLE I.

| Time after Calving | Specific Gravity | Fats | Casein | Albumen | Lactose | Ash | Total Solids |
|---|---|---|---|---|---|---|---|
| Immediately | 1.068 | 3.54 | 2.65 | 16.56 | 3.00 | 1.18 | 26.93 |
| After 10 hours | 1.046 | 4.66 | 4.28 | 9.32 | 1.42 | 1.55 | 21.23 |
| After 24 hours | 1.043 | 4.75 | 4.50 | 6.25 | 2.85 | 1.02 | 19.37 |
| After 48 hours | 1.042 | 4.21 | 3.52 | 2.31 | 3.46 | 0.96 | 14.19 |
| After 72 hours | 1.035 | 4.08 | 3.33 | 1.03 | 4.10 | 0.82 | 13.56 |

TABLE II.

Difference in Fat Content in Different Portions of Cow's Milk (Van Slyke)

| | Per Cent of Fat in the Milk | | |
|---|---|---|---|
| | Cow No. 1 | Cow No. 2 | Cow No. 3 |
| First portion drawn | 0.90 | 1.60 | 1.60 |
| Second " " | 2.60 | 3.20 | 3.25 |
| Third " " | 5.35 | 4.10 | 5.00 |
| Fourth " " (stripping) | 9.80 | 8.10 | 8.30 |

TABLE III.

Analysis of Fore Milk and Strippings (Eckles and Shaw)

| Breed | Kind of Milk | Specific Gravity | Fat | Protein | Sugar | Total Solids |
|---|---|---|---|---|---|---|
| Jersey | Fore Milk | 1.0349 | 1.59 | 3.45 | 5.74 | 10.46 |
| | Stripping | 1.0314 | 5.92 | 3.25 | 5.64 | 14.56 |
| | Fore Milk | 1.0358 | 1.37 | 3.32 | 5.23 | 10.06 |
| | Stripping | 1.0274 | 6.92 | 3.13 | 4.75 | 15.16 |
| Holstein | Fore Milk | 1.0323 | 1.42 | 3.00 | 5.31 | 9.43 |
| | Stripping | 1.0265 | 5.82 | 2.81 | 6.06 | 13.57 |
| | Fore Milk | 1.0333 | 0.88 | 3.00 | 5.23 | 9.24 |
| | Stripping | 1.0284 | 4.80 | 2.87 | 4.85 | 12.06 |
| Shorthorn | Fore Milk | 1.0343 | 1.31 | 3.19 | 5.71 | 9.84 |
| | Stripping | 1.0283 | 6.23 | 3.06 | 6.10 | 14.38 |
| | Fore Milk | 1.0350 | 1.35 | 3.25 | 5.44 | 10.34 |
| | Stripping | 1.0298 | 5.54 | 3.19 | 5.74 | 14.32 |
| Ayrshire | Fore Milk | 1.0340 | 1.09 | 3.70 | .... | 10.14 |
| | Stripping | 1.0244 | 10.00 | 3.45 | 4.91 | 18.35 |
| | Fore Milk | 1.0384 | 1.64 | 4.15 | .... | 11.50 |
| | Stripping | 1.0283 | 7.88 | 3.76 | 5.35 | 17.17 |

* Pathologist, Muhlenberg Hospital, Plainfield, N. J.

* Compiled by Leach.

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mal milk will serve as an illustration. The figures denote parts in one-hundred, or the percentage of the total.

The comparative tables given on page 324 show the facts more clearly and concisely than many wordy paragraphs.

This is not the only variation in the composition of milk. It has also been shown that milk varies in composition at different hours of the same day and that the fore milk, middle milk and stripping at any milking period differ. Tables II and III show how much individual samples will vary.

These few comparisons and a few moments of reflection will show you how worthless the results from the analysis of human milk may be if the tests are not based on proper sampling.

In determining the nutritional value of a diet, the composition of the entire food supply for twenty-four hours should be considered. In infant breast feeding we have to consider: (1) that normally there is only a slight variation in the relative and in the quantitative values of the fat and the other solids; (2) that the different portions of the milk drawn from the same breast at one feeding time (as shown in the preceding tables, II and III) will show a marked variation; (3) that the quality of the milk may vary in both breasts—one may be composed of an over supply of fats and the other deficient in all solids.

### Sampling Human Milk for Analysis

As the variation in composition during an entire day is comparatively slight, a very satisfactory method of sampling would be to take the entire milk from each breast at the feeding period, mix it well and reserve about an ounce for the examination. This can only be done if the child can be bottle-fed with the drawn milk. However, as most breast-fed children cannot be fed from a bottle, we must resort to a less satisfactory method.

Turn to the table by Van Slyke (Table II), showing the fat content of the four fractions of milk. If you divide the milk drawn into three fractions instead of four by making the first include part of the second and combining the rest of the second with the third to form a middle fraction, this first fraction mixed with the stripping milk will approximate the composition of the middle or second fraction. On this basis if we take the first third of the mother's milk, then apply the child to the breast for its food —and subsequently strip the breast of its residual milk, we will have an approximately average sample of milk from that breast. The first drawn milk and the stripping milk should be thoroughly mixed. At the next feeding period this process is repeated with the other breast. If the doctor wishes to test the functioning of each breast, submit the milk drawn from the right and the left breast in separate containers, otherwise mix together to form one sample.

### Obtaining a True Sample

It should be unnecessary to warn nurses that the breasts should be well cleaned before the samples are taken. The milk should be collected by the aid of a sterile, dry breast pipe or breast pump. For the benefit of those who have not used both the pipe and the pump we will explain that the vacuum created in the former is produced by aspirating with the aid of an attached fairly stiff rubber tube long enough to reach the mouth, whereas the pump is provided with a rubber bulb for this purpose.

To secure an air-tight contact of the breast pipe or pump moisten the edge which comes in contact with the breast with a little sterile water. Do not use much water and do not use petrolatum (vaseline) unless you are careful to employ a very limited quantity. By using much water you may dilute the milk,

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while by using an excess of petrolatum some of this may become mixed with the milk and cause a higher fat content determination than is correct.

The milk should be transferred to a sterile dry bottle and kept well refrigerated until it is forwarded for analysis. At least one ounce of milk should be reserved as the sample. If results are not urgent, collect the first drawn and the strippings from each breast at two feeding periods, as this will give a sample nearer the average.

If, for any reason, especially in hot weather, the milk is liable to spoil before it is received by the analyst, it is advisable to add one drop, and no more, of a solution of formaldehyde to each ounce of milk. Do not add boric acid, chromate or other solids or liquids. These will alter the specific gravity which is an important thing to determine in such an examination. It is a guage of the quality and a valuable check on the results of the fats and solids determinations.

Specific gravity, percentage of fats and of the solids not fat are the points which are usually necessary to determine. Experiment has shown that the lactose (milk, sugar) and other constituents, with the exception of the fats and proteins, are very constant. At times the physician will want a more complete examination. Unless this is specially requested, however, the analyst usually makes only the routine examination as the additional determinations increase the cost of the service.

[The next article will give important facts concerning cow's milk.]

## WAXING HOSPITAL FLOORS

French and Belgian hospitals use the following practical and sanitary method of waxing old and new wood flooring. The floor is first thoroughly scrubbed, then washed with a warm solution of potash. A mastic is prepared by mixing together 1 part raw sienna, 1 part raw umber, 2 parts finest whiting, and 2 parts liquid fish glue. This makes a stiff, plastic mass, which is used to fill cracks between boards and fill up any depressions and knot holes.

Paraffin wax is placed in an iron pot over the fire to melt. It will melt at between 113 deg. to 122 deg. Fahr. if derived from coal-tar, and from 89 deg. to 126 deg. Fahr. if from bituminous shale, and will boil just below 446 deg. Fahr. The paraffin wax must be stirred the whole time and should not more than half fill the pot, while it is well to have at hand a box of sand or dry earth to extinguish flames in case of accidents. The wax should be spread by means of ladles with spouts, as thinly as possible in strips about three feet wide. It soon begins to solidify in the form of a transparent jelly.

At this stage it is necessary to remove any superfluous wax by means of a wood plane or a scraper at the end of a pole. The wax must be taken off in thin shavings, while the wax is still warm and soft. It soon hardens and is then difficult to deal with. The surface is rubbed over with iron filings or other suitable fine abrasive, in order to get a perfectly smooth, polished coating. For parquet or new boards one kilogramme of wax will suffice for four square metres. If the wood is old and spongy, rather more will be required.

If well done, this surface will remain in perfect condition for two years. To keep the floor in good condition no periodical waxing and elaborate polishing are necessary. All that is needed for cleaning is the passing over the boards a cloth dipped in some antiseptic fluid and then polishing with a woolen cloth.

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# THE AFRICAN MAN—II

## A STUDY OF PRIMITIVE EMOTIONS

AGNES S. WARD, R. N.

General Superintendent of Nurses, Department of Public Welfare, New York City

ONE needs only to think of Dr. Livingstone's boys to realize how fine are the emotions of these developing African men. We are, doubtless, all familiar with the story of how, in spite of the superstitious horror of the dead among the tribes about them, Livingstone's boys, Susi and Chuma, preserved the body of their master, disguised it to appear as ordinary baggage and performed the Herculean feat of conveying it safely, together with every article belonging to him at the time of his death, to the coast.

Their finer feelings, so little understood, are well illustrated by the story told by Herbert Ward in "A Voice from the Congo."

Seeking fire for my pipe, I once entered a small native hut. Within, all was dark and smoky. A smouldering fire was burning in the middle of the hut, from which I extracted the necessary ember. In front of me I perceived a crouching figure. At once I gave the ordinary native salute, but I received no reply. Extending my hand I discovered, to my horror, that the figure was a smoke-dried corpse. Emerging from the hut I met the owner, who seemed much disturbed. The figure within was that of a favoured wife of his, and with great reluctance he at length explained to me, in his native idiom: "I loved her too much to put her in the ground."

One could hardly expect such fineness of spirit from men who are often cruel. We should bear in mind, however, that if they are occasionally cruel, often they are kind. Herbert Ward also speaks of the cannibals as follows:

The impression I received from personal intercourse was that the cannibals of the forest were infinitely more sympathetic than the people of the open country. The cannibals are not schemers, and they are not mean. Though in direct opposition to all natural conjectures, they are among the best types of men, representing the most enlightened and enterprising of the Congo communities.

It is impossible for us to conceive what must be the state of mind of the victim, presently to be put to death, who is led around the village so that the favored ones may select the portion of the body they prefer to have as their share, such portions being marked off with chalk. It is astonishing how the mind adjusts itself under the circumstances, and, while the strain is tremendous, yet, in spite of this, these people are happy in a way that we cannot understand. One young man whom I knew quite well was singing lustily after he had been condemned to death and, when questioned as to how he could be so happy under the circumstances, said to me, "Oh, time enough to worry, when they begin to cut."

A recent writer tells us that cannibalism greatly increased among the cannibalistic tribes during the recent war—a fact, which, if true, certainly has great psychological interest. Practically all tribes that give up this practice speak of it later only with reluctance and seem to have a sense of shame that they should ever have indulged in it.

Another peculiar phase of the African mind is illustrated by the story told by the traveler who met a slave caravan in which the poor captives were in a most pitiful and wretched condition, yet they were singing lustily. When asked how they could sing in their miserable state, they answered: "We are singing because we are thinking about the time when we can return to this earth and torment our captor."

Both men and women have a keen sense of humor and are bright and witty.

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while by using an excess of petrolatum some of this may become mixed with the milk and cause a higher fat content determination than is correct.

The milk should be transferred to a sterile dry bottle and kept well refrigerated until it is forwarded for analysis. At least one ounce of milk should be reserved as the sample. If results are not urgent, collect the first drawn and the strippings from each breast at two feeding periods, as this will give a sample nearer the average.

If, for any reason, especially in hot weather, the milk is liable to spoil before it is received by the analyst, it is advisable to add one drop, and no more, of a solution of formaldehyde to each ounce of milk. Do not add boric acid, chromate or other solids or liquids. These will alter the specific gravity which is an important thing to determine in such an examination. It is a guage of the quality and a valuable check on the results of the fats and solids determinations.

Specific gravity, percentage of fats and of the solids not fat are the points which are usually necessary to determine. Experiment has shown that the lactose (milk, sugar) and other constituents, with the exception of the fats and proteins, are very constant. At times the physician will want a more complete examination. Unless this is specially requested, however, the analyst usually makes only the routine examination as the additional determinations increase the cost of the service.

[The next article will give important facts concerning cow's milk.]

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Their sense of honor and their nicety in a point of discrimination is keen. For instance, on one occasion I was lost in the jungle and was found by two of the native men. We were three days' journey from home and the natives did not know us at all. However, the moment they saw me they said, "Oh, Mamma, you are lost," and, seizing my two hands, ran with me at top speed, until we heard the calls of the men in the caravan, who were searching for me. As soon as we heard these voices they dropped my hands and said good-bye. I then asked them to go all the way. They at once wanted to know if they would be paid for the rest of the journey. They had not thought of pay as long as I was in danger; it was simply their duty to help me. Even after they found our men, they did not want pay for what they had done before we heard the call of the caravan.

Nor is courage lacking. Stanley says, "No other body of men in the wide world that I am acquainted with could have borne such a period of hunger so meekly, so resignedly." Another writer says, "They are the bravest boys in the world." Another, in thanking the boy who had saved his life, says, "Mpangi, if I had a son I could wish nothing better for him than that he might be as courageous and as faithful as you are."

I have quoted so fully from writers on Africa because I wanted the verification of their broader experience to show certain native characteristics not generally understood—innate sympathy, tender emotion, loyalty and courage.

In spite of their courage, however, they are great cowards in war. In fact, I never knew anyone to be hurt in war on the Congo. At the first sign of smoke everyone runs. This ends the war and the matter is then settled by law-suit.

Secret societies abound in Africa. Some of them are very powerful organizations. Membership in these associations gives the native men both social and political prestige. One society even prohibits the eating of food that is not especially prepared for its members. The origin of these secret societies is not known but it is thought that they may have originated with some of the early Portugese coast settlers, the custom gradually spreading inland. They are of some value in that they help to hold the people together. The lack of organization and leadership is most apparent in all the tribes. It is this lack of leadership that makes it possible for a mere handful of white people to treat the natives outrageously and still be permitted to live.

To turn to aesthetic outcroppings. In spite of their crude state, the African men have a remarkable appreciation of form and decoration. Their kettles and water jars, their only utensils, are always of perfect design, and the patterns on their mats are beautiful. The workmanship on their bracelets, anklets, spears and knives, is marvelous, especially when we consider the crude implements with which they do art work.

Since the man is considered superior to the woman, we shall doubtless be astonished to learn that probably more men than women are put to death by the system of poison-giving. This is doubtless due to the fact that commercially the woman is worth more, and the wise witch-doctor is, therefore, more cautious in accusing her of witch-craft.

True, we see much that seems contradictory in the African makeup. It seems cowardly to run in battle; yet it is most courageous to sing gaily while waiting to be put to death. I might multiply these incongruous illustrations indefinitely, but, if what I have said helps to call forth a spirit of interest and sympathy for the African people, and perhaps a worker or two for Africa, I shall feel that I have not written in vain.

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# Points for Dietitians

## ESSENTIAL FOOD FACTORS
### OUTLINING A TALK TO PATIENTS

BENJAMIN HARROW, Ph.D.*

Associate in Physiological Chemistry, College of Physicians & Surgeons, Columbia University.

THE science of nutrition was founded by Lavoisier, the French chemist, who flourished during the days of the French Revolution. With the help of his balance he not only disproved the whole phlogiston theory, but established certain fundamental relationships between the amount of food taken in by the body and the amount of heat given off by the body. He showed that the heat so given off is due to the "burning" or oxidation of food stuffs containing the elements carbon and hydrogen, carbon dioxide and water being the end products of this reaction.

In the hands of Voit and Pettenkoffer, in Germany, and Atwater and Benedict, in this country, an instrument for measuring the heat evolved by the body, the calorimeter, was gradually perfected. With the help of this instrument, man's calorific needs were ascertained. It was found that man needs from 2,500 to 4,500 calories per day, depending upon the type of work that he pursues. This meant but one thing: that enough food had to be eaten so that when it was oxidised in the body, 2,500 to 4,500 calories were produced.

#### PROPORTIONATE CALORIC INTAKE

A little reflection will show that satisfying calorific requirements does not necessarily solve the problem. For suppose I require 3,000 calories per day to keep me in trim, and I decide to eat enough tomatoes to do so, I find that one pound of tomatoes represents a fuel value of 100 calories, which means that I can get my 3,000 calories by eating 30 pounds of tomatoes a day. That, of course, is absurd; no one wants to, and no one can eat 30 pounds of tomatoes per day. If, however, we distribute our calories by eating mixtures of carbohydrates, fats and proteins in several kinds of food, our bodies take to the food quite kindly. We may select a diet consisting of 100 grams of protein (about 30 grams to the ounce), 100 of fat, and about 500 of carbohydrate. Experiments have shown that one gram of protein when oxidised in the body yields heat to the extent of four calories; that one gram of fat under identical conditions will yield nine calories; and one gram of carbohydrate, four calories. The total energy value to be obtained from the selection we have made is therefore 3,300 calories.

If now we include a satisfactory proportion of mineral matter, and satisfy the needs for water and oxygen, we ought to live quite happily!

#### THE AMINO-ACIDS

But yet other factors have to be considered. Gelatin is a very typical protein, yet a not very satisfactory one. The reason for this was made clear only after Kossel and Emil Fischer had elucidated the chemistry of proteins, and had shown that these substances are to be considered as combinations of simpler chemical units—the amino-acids. An examination of gelatin showed that it lacked two of these amino-acids, tyrosin and tryptophane. Further, and what is far more to the point, the addition of these acids to a diet in which the only source of protein was gelatin, made that

* Author of "Vitamines—Essential Food Factors."

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diet satisfactory. This has led to the view that it is not so much the proteins but rather the amino-acids which go to make up the proteins that are so important.

The next step in our onward march is best illustrated by making use of an experiment worked out by Professor Hopkins of Cambridge. Professor Hopkins took two sets of rats—which we shall call A and B—in about the same stage of development, and of about the same weight, and fed A with the isolated constituents similar to those which can be obtained from milk (protein, fat, sugar and mineral salts) and B with the same substances plus a minute quantity of fresh milk. The rats belonging to series A lost weight and showed decided pathological symptoms; those belonging to series B steadily gained in weight. On the eighteenth day the diets were reversed, so that now the A group was getting the extra milk and the rats in B group had theirs cut out. Almost immediately A began to gain in weight and B to lose in weight.

### The Vitamine Factor

The amount of milk added was so small that it could not have added anything material to the energy value of the food. Besides, the energy value of the foodstuffs was more than sufficient. And in so far as the most careful chemical analysis could show, the whole milk added was itself composed of nothing but protein, fat, carbohydrate and mineral salts, with the rest of it very little more than plain water. In other words, the chemical composition of whole milk did not materially differ from the chemical composition of the constituents isolated from milk. Was the difference due to something in the milk other than fat, protein, carbohydrate and mineral salts? If so this "something" must be present in exceedingly small quantities, since the addition of two five-hundredths of a pint of whole milk was sufficient to exhibit some striking effects.

The name "vitamine" has been given to the substance or substances—such as the "something" in milk—which, though present in minute quantities in foods, are absolutely essential to a continuation of the life process.

At least three well-defined vitamines have been detected, which for purposes of identification we shall call fat-soluble A, water-soluble B and water-soluble C. The presence of all three of these vitamines is essential to our well-being. As a matter of fact very few foods contain all three. Milk is one of the rare exceptions, but even here the quantity of vitamine C that it contains is dangerously small. It is only by eating a variety of foods that we assure ourselves of a liberal allowance of all three types of vitamines.

### Diseases Due to Vitamine Deficiency

At least two common diseases have been identified with vitamine deficiency. One of them, beriberi, involving a general paralysis of the system, is due to lack of water-soluble B; the other, scurvy, involving choppy gums and loose teeth, is due to lack of water-soluble C. Rickets, and infant diseases, where the bones are undeveloped, may be due *in part* to a deficiency of fat-soluble A; and pellagra, of which much has been heard lately, is perhaps also caused, *in part,* by vitamine deficiencies.

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## Hospital Encouragement of Breast Feeding

An English pediatrist believes that the average mother resorts to bottle feeding because she becomes discouraged by apparent non-success and follows the advice of her neighbors and friends.

The maintenance of a small ward where such cases could be admitted for a short time to correct small errors in diet and habits, while the mother is in a cheerful atmosphere would result in successful breast-feeding in many cases.

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**The Dietetic Value of Raw Eggs**

Recent tests on healthy persons by Rose and MacLeod at the Teachers' College of Columbia University, New York, have failed to disclose any occasion for severe condemnation of the use of the raw egg in dietetics. When the whites of from ten to twelve eggs a day were included in a simple mixed diet they were well utilized, the average coefficient of digestibility calculated for the raw egg white alone being 80 per cent., as compared with 86 per cent. for cooked whites in the same diet. The absorption varied with the method of preparation, being less for raw egg whites taken in their natural state than when beaten light. A mixture of whites partly beaten and partly unbeaten gave an intermediate value. In no case was there any sign of indigestion, such as discomfort or diarrhea, though one or two subjects found the diet slightly laxative. Since the quantities referred to may be regarded as maximal in dietary practice, one may agree with Rose and MacLeod that it seems unnecessary to emphasize unduly the difference between raw and cooked eggs, especially if the raw eggs are beaten. — *Journal of Biological Chemistry.*

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**Convalescent Diet for Gastro-duodenal Ulcer**

The diet for the first month out of bed (a period of four weeks is usually required in bed) consists essentially of only four foods, namely, eggs, fresh milk and cream, well cooked cereals, bread and crackers and nothing else in the food or fluid line (excepting plain water) should be taken. The eggs may be eaten raw or cooked in any form, or may be taken in the milk. The milk may be warmed if desired, but should not be taken too hot or too cold. The ten-minute modern breakfast foods or any form of oatmeal should not be eaten, the old-fashioned forms of ground corn, farina, rice, tapioca or sago, well cooked being the best. The bread should not be too fresh (one day old), any of the sweetened or unsweetened crackers can be used and all forms of simple cake, providing there are no nuts, raisins, seeds or preserved fruits in it.

The total amount of food in one day should be: four eggs, one quart (four tumblerfuls) of milk, one-quarter of a pound of fresh unsalted butter, or one-eighth of a pound of butter and an extra quart of milk, two rolls or four medium thick slices of white bread, one-quarter of a pound of baker's cake or crackers, one-half pint of fresh cream, and one-quarter of a pound of cereals.

The suggested food is given at regular intervals of four hours during the day, making sure that a strict regularity is preserved and that the foods are divided up rather evenly in quantity for each time. A glass of plain fresh milk and perhaps a few crackers should always be taken between meals and before retiring and an extra glass of milk during the night if there is distress in the stomach.

After the eighth week the eight, twelve, four and eight o'clock meals are diversified with the following selections, plain milk being taken midway between meals and the alkaline powders one hour after each feeding: Puree or creamed soups (barley, rice, peas, beans, celery); gruels (flour, cracker, barley, Indian meal, farina). Plain crackers, baker's cake, pound cake, toast, rolls, jellies, rice, tapioca; ground or mashed vegetables; puddings, rice tapioca, bread, cracker; custards, vanilla and chocolate, blanc mange, whips and souffles; gelatines, plain ice cream, malt, milk cocoa, cocoa and chocolate.

This is kept up for four months when the following diet is prescribed. The general plan of the diet is to take three moderate sized meals at regular intervals

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during the day, and to take supplemental meals of milk, re-enforced with cream, cocoa and crackers between meals and before retiring. Altogether food should be taken at least five times during the day. All of the solid foods should be tender, cut very fine on the plate and thoroughly masticated before swallowing. Olive oil may be taken before the main meals in hypersecretion and hypermotility.

Foods permitted for main meals are: beef, lamb and chicken, roasted or broiled and taken only once a day; fish, any kind and in any form excepting fried, taken once a day; eggs in any form, other than fried, and taken once a day; cereals (with the exception of oatmeal and shredded wheat biscuits) well cooked and taken with cream in the mornings; vegetables, any that are well cooked and mashed with the exception of green vegetables; tubers, such as baked or well mashed white potatoes, squash, parsnips, and turnips; desserts, any made of milk, cereals and jellies, no fruits, berries or nuts. Butter, cream, milk and cereals and eggs still remain the main foods of the daily diet. If the symptoms become marked again these should be the main articles of the diet for a while, when the more general plan may be followed. The best drink at the meals is vichy or any alkaline water.

At the end of six months a normal diet is resumed.—Bassler in *New York Medical Journal.*

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### Dietetic Treatment of Cancer?

Success in the use of low proteid diet, preferably a single protein diet in cancer cases, is reported by Allen. An exclusive milk diet has also been found advantageous.

In a case diagnosed as carcinoma by several Pittsburgh physicians, a diet of whole wheat bread and milk, with cottage cheese, was given for eight months with permanent success. In another, an extreme case, given up after the subject had been prepared for operation at the Galesburg, Ill., Hospital, whole (brown) rice, with raisins, prepared in the fireless cooker (a complete, low-protein diet), was followed for more than a year, the patient recovering slowly and remaining well for nearly four years.

Changes in diet should be made gradually; and the subject's likes and dislikes should be duly considered. The chief consideration is uniformity of diet. —*Medical Record.*

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### Dried Milk

According to Dr. Timothy Leary, professor of pathology in Tuft's Medical School, Boston, the changes produced in milk by powdering are: (1) Slight loss in acidity; (2) soluble salts of calcium are converted into insoluble salts affecting the action of rennet; (3) lactose is unaffected; (4) albumin and globulin are partially coagulated, caseinogen is not coagulated, but all observers seem to agree that it is more readily digestible after heat; (5) chemical changes in the fats are slight, the fat globules of reconstructed milk are generally larger than those of fresh milk; (6) ferments are destroyed; (7) dried milks differ in their capacity for reconstitution; (8) the curd produced by rennet in reconstituted milk is flocculent and finely divided, in contrast to the firm, tough, cohesive clot produced in raw milk.

As a rule, Dr. Leary believes, dried milk is better borne by the infant's stomach than cow's milk, whether used raw, boiled or sterilized. Full cream powdered in tins keeps for three months or longer; thin milk powdered in tins keeps for over a year. As to hygienic cleanliness, Dr. Leary believes that dried milk is safer than cow's milk. It also has the added advantage of preventing milk delays in times of strike.

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# The Hospital Review

## ENGLISH VENTILATING SYSTEMS FOR OPERATING ROOMS

At the London Hospital, the air destined for the operating theater is first passed through water, and then filtered through seventy-two screens of asbestos wool. It is then warmed and enters the theater through a special shaft. Before operations superheated steam is blown over the operating room to kill micro-organisms. The dampness left on the wall surfaces, tables and floors, prevents the suspension in the air of dust particles which might be disturbed by operators and nurses in moving about.

The Plenum system of ventilation is used at St. Thomas Hospital. The rooms containing the cleaning, warming, and air-propelling apparatus are situated on the floor above the theatres. The air first passes over a series of steam pipes, next through a double screen formed of cocoanut fibre continually kept moist by running water, thence over the principal heating pipes, till it reaches the fan. The steam pipes are, of course, used only in cold weather, while in summer the wet screen somewhat cools the air which will have arrived at the rotary fan freed from its grosser impurities such as soot and fog. By means of this fan the air is forced into the rooms, from which it can only escape by a system of ducts which lead to the open air. The pure air inlets are at some distance from the floor, the air in emerging from them being given an upward direction, while the extract ducts are near the floor; the air must therefore pursue a downward course in passing out of the rooms. The inlet and outlet ducts are so placed in the theater that the general trend of the air is from the patient towards the spectators. There is no attempt at extraction, but since there is a slight plus pressure in all the rooms and the air will naturally find its way to the open by the outlet ducts, there is no fear that foul or foggy air will be drawn in through cracks or doors, for, even if a door is opened, the pure air will rush out but no unfiltered air will gain admission.

### Effect of Excessive Heat on the Surgeon and His Assistants

R. P. Rowlands, M.S., F.R.C.S., surgeon to Guy's Hospital, believes* that the ideal operating room theatre should be kept at a temperature of about 65 degrees F., well ventilated and devoid of an excess of moisture. Most operating theatres are kept at a much higher temperature, and many are so stuffy and moist that it is difficult to do the best work in them. It is, of course, known that a stuffy, moist atmosphere adds seriously to the bad and unpleasant effects of excessive heat.

"It is a matter of common knowledge that excessive heat is detrimental to good and expeditious work. This is confirmed by the researches of Professor Leonard Hill and others investigating the causes of industrial fatigue. They prove that the capacity for work rapidly decreases with a temperature rising above 65 degrees F., and that a vitiated atmosphere, laden with moisture, adds to the bad effect of heat. A surgeon and his assist-

* Lancet.

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ants working under such conditions for hours on end cannot give their best work, however anxious they may be to do so. The very endeavor to do the best under these bad conditions adds to the strain, always great, which has been accentuated by the multiplication and increasing extent and complexity of modern operations. The headache and fatigue, commonly experienced after a long day in the operating theatre, are chiefly due to the heat and bad conditions, and can be largely avoided by improving these conditions, as I know from experience. It is not really necessary for the surgeon to be bathed in perspiration while he is doing his work. Moreover, some of the sweat may infect the wound.

"It is not uncommon to see nurses and students faint during their first experience of these hot theatres. They gradually become acclimatized, but also become anemic and drift into poor health if they have to work for long under these conditions. Unfortunately, some of the leading surgeons of the past decade were, in all good faith, powerful advocates of the hot theatre and seemed to enjoy it. Their example has been, and still is, too slavishly followed, so that the absolute need of a high temperature has become a hallowed tradition which is very difficult to destroy. From an economical point of view, unnecessary expense is incurred in providing the means of keeping theatres excessively hot and ill-ventilated. It is impressed on the architect that a high temperature has to be easily raised and he spends much time and money in making arrangements to meet this demand."

The theatre is chiefly for the patient, and it has become a tradition that it must be kept hot in his interest. Fresh air is feared because of the dust it may carry into the wound, and the vapor of one or more sterilizers is too often allowed to saturate the air with moisture. Are such conditions to the advantage of the patient? It is, of course, admitted that he must be kept warm so that he may not suffer unduly from shock, but this ideal is attained, in the large majority of operations, by keeping him well and warmly clothed and by carefuly avoiding exposure of any part of the body except the wound, the rest being covered with dry, sterile towels which prevent unnecessary radiation, convection, and evaporation from the surface of the body. For very prolonged operations, which should be rare, it may be necessary to heat the table also, due care being taken not to burn the patient.

### Heat vs. Shock

"When the theatre is unduly hot and stuffy my experience is that shock is more severe, and the patient perspires so freely that he and his clothing are often drenched. This great loss of liquid lowers the circulation and general vitality so that saline axillary infusions have often to be given during and after the operation to make up the deficiency. Under more normal conditions a saline enema after the operation is sufficient. Many years ago I was considerably surprised to find that collapsed patients needing urgent operations carried out in their own homes, which could not be heated to the temperature commonly prevailing in our operating theatres, did at least as well as those operated upon in the theatres. These observations made me think that we might be too infatuated with the hot theatre and led me to try reducing the temperature of my own, with great advantage to the patients."

Again, it does not seem reasonable to move the patient from a cool ward into a theatre about 20 degrees warmer, and then back again—while he is still unconscious and suffering from shock—through cold corridors, into the lower temperature. It is probable that the risk of pulmonary complications is thereby increased.

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# BLOOD SERVICE IN THE BOSTON CITY HOSPITAL LABORATORY

In 1920 the Boston City Hospital inaugurated a special laboratory service for blood cases. During the first two years 372 patients have been treated and 875 blood examinations made.

The objects of this plan are, first, to improve the study and clinical care of patients with diseases of the blood and second, to advance research in the same class of cases. The research work is being carried out in cooperation with the Department of Medicine of the Harvard Medical School, the Massachusetts General Hospital and the Peter Brent Brigham Hospital.

In accordance with the plan adopted, all cases admitted as anemia, hemorrhagic disease, leukemia, pseudo-leukemia, and Hodgkin's disease are assigned to the First Medical Service, unless specifically recommended for some other assignment.

The special clinic thus constituted is in charge of the Senior Visiting Physician of the First Medical Service, who is responsible throughout the year for the clinical care of the blood cases, and acts as consultant upon such cases in other services. A surgeon is associated with the clinic, and to him, by vote of the surgical staff, all surgical blood cases are assigned. He has charge of the transfusions and also does other operations, such as splenectomies, upon cases on the Blood Service.

The laboratory is in charge of a salaried director. The routine work is performed by four women technicians. An opportunity is also given to the house officers, especially those associated with the First Medical Service, to do their routine blood work in the laboratory under the supervision of the director.

In connection with this work the laboratory has a list of blood donors, which has averaged about 100. At present the number is but 20. The list comprises students, hospital employees, and persons in all walks of life. The blood of each donor is grouped by the Moss method and the Wassermann reaction is done, the tests being repeated from time to time. The donors are registered on a card catalogue, with addresses and telephone numbers, so that a donor of the desired group may be quickly obtained. They are paid $50 for each transfusion of 500 cubic centimeters of blood, the money being deposited at the Superintendent's office in advance by the patient.

The laboratory has supplied serum for agglutination tests (in connection with the selection of transfusion donors) to seven hospitals in the United States and Canada, to Boston physicians and to other clinics in New England.

The most important function of the laboratory and clinic is, of course, research work and in this direction the results have been most gratifying both in quantity and quality.

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**Medicine in Foreign Languages**

Postgraduate courses in Spanish and Portuguese as well as English will be given this autumn at the New York Polyclinic Medical School and Hospital. Among the instructors in the courses, which began September 18, are Prof. Damaso Rivas, of the University of Pennsylvania; Dr. J. A. Lopez, of the University of Syracuse; Dr. R. Ruiz Arnau, former president of the Academy of Medicine at Porto Rico; Prof. A. Freire de Carvalho, of the University of Rio de Janeiro; Dr. E. Hurtado, of the University of Bogota, Colombia; Dr. F. H. Rivero, former professor of the Central University of Venezuela, and Prof. William Sharpe, of New York.

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**Fixed Basis for Charges**

The needless irritation because of "extras" on hospital bills is always present. The computation of the cost of drugs, anesthesia, dressings, laboratory fees, etc., over a representative period, with a subsequent pro-rating of the total and the addition of that amount to the cost of the room is the solution at the Rockford, Illinois, Hospital.

Often, however, when the patient needs little attention, is kept on liquid diet, etc., he wonders what the $5 or $6 room charges include. The short, concise rules which govern the private pavilion of the Rhode Island Hospital at Providence, give the situation clearly. If all hospitals would print a definite statement of the basis of charges, the difficulty would soon be obviated.

*Nursing:* The regular nursing force is quite sufficient for the necessary care of the patient unless the patient is very ill. The charge for the exclusive services of a graduate nurse is $6.50 per day, which includes the charge of $1.50 made for the maintenance of the nurse at the hospital.

*Medical Service:* Persons entering the hospital as hospital cases, that is, not as private patients of any member of the staff, will be expected to pay fees for professional services in addition to the charges made by the hospital for the board and room of patients. If the services of a specialist or consultant are needed, it is expected that such specialists and such consultants will render separate bills for their services.

*Visiting Hours:* Patients may be visited daily (subject to the order of the doctor in attendance) from 9 A.M. to 9 P.M. The visiting is limited strictly to these hours, and the friends and relatives are expected to accommodate themselves, as exceptions will be made only in case the patient is critically ill.

Relatives of patients are not permitted to remain over night with patients except in cases of critical illness, when permission is granted by the superintendent.

Relatives or friends are not permitted to occupy a room with a patient except in the case of parent and child, when $5.00 per day will be added to the cost of the room, which charge will include the meals for the parent. In the event of critical illness rooms may be engaged by friends at the regular rates. The hospital reserves the right to withdraw this service upon due notice if the room occupied by the friend is needed for a patient.

*Telephones:* There are telephone connections in all bedrooms. Instruments may be installed at the patient's expense, with the permission of the attending physician or surgeon.

*Gratuity:* No person employed in or connected with the hospital is permitted to receive gratuities from patients or from the friends of patients. All are requested to respect this custom as failure to do so will render the employee liable to immediate dismissal.

*Rates:* The rates for private rooms range from $7 to $11 per day, according to the size and location. Those at $7 per day are for the patients occupying beds in two-bedded rooms. The charges include board, ordinary medicines, the divided attention of the regular nurses on duty. A charge of $15 is made for the use of an operating room or a delivery room, and includes dressings and ordinary drugs. A charge of $5 will be made for laboratory work ordered by the physician in charge of the patient. Special charges will be made for unusual laboratory work *as per schedule of prices.*

An additional charge is made for *x*-ray examinations or treatments (in proportion to the amount of work done) for massage, for rare and expensive drugs and for wines, mineral waters, etc

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### The Cost of Nursing Education

The report on the cost of nursing education as submitted by Miss Ada Belle McCleery, chairman of the subcommittee appointed by the Committee on Education of the League, gives the composite data supplied by 36 schools (not by the Evanston Hospital Training School, alone, as erroneously stated in the August issue). The facts, gathered through a comprehensive questionnaire, are systematically grouped under the following heads: Enrollment; Income; Expenses (including cost of recreation, maintenance, uniforms, cost of illnesses of students, monthly allowances, educational costs through affiliation, cost of actual instruction, cost of supervision, cost of textbooks, general and reference library expenses, breakage, and costs incidental to graduation); Value of Student Work. The report also contains a study made by Miss Jammé which evaluates the costs of student maintenance at the University of California with figures of the Industrial Welfare Commission as to the value of service.

When the details of this report are published, hospitals will appreciate fully the *independent* monetary basis necessary for adequate nursing education.

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### Philadelphia Plans a Diphtheria Hospital

Philadelphia plans an innovation in special hospitals with the opening of an Intubation Hospital for children suffering from diphtheria.

On the two floors of the new building, which are equipped with every needed appliance in the treatment of chronic conditions requiring intubation, there is room for fifty-seven children.

On the first floor is a girls' ward and a boys' ward. On the same floor are shower bath rooms, a dining room, an operating room and two classrooms. One of the classrooms is for scholastic work, and the other for occupational training. A teacher will be assigned by the board of public education to teach the children, all of whom are between 2 and 12 years of age.

The second floor of the hospital has glass-lined cubicles for thirty-seven patients and is intended for laryngeal diphtheria cases. Another operating room and the shower and slab bath rooms are found here, as well as on the first floor. There is not a tub in the building.

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### Waste in Anesthesia

The Bremerman Urological Hospital of Chicago has issued its first year book —though the period covered by the report is approximately two years. The hospital, opened with sixteen beds in addition to *x*-ray department and pathological laboratory, operating rooms, etc., was designed to treat diseases of the kidneys, bladder and kindred ailments. At present it has a capacity of fifty beds.

Discussing the question of waste in the operating room and in the department of anesthesia the report states:

"In most hospitals these departments are operated at a loss. This fact is proven by a careful study of the reports of other hospitals that we have perused. There is greater opportunity for waste in this department than in any other except the kitchen, as the operating surgeons are usually far from economical in their use of supplies.

"Tubes of catgut and yards of gauze are sometimes willfully wasted by the operator. There is no reason why this should occur if the department superintendent is particularly watchful and is not backward in calling definite attention to the matter. It has been our practice to carefully compute entire cost of overhead in this department to the smallest item and we have arranged fees for the operating room which will accurately

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cover expense with a small percentage of profit.

"We have known of hospitals where the gauze, sponges and pads used in the operating room were laundered and sterilized and repeatedly used. We feel that the expense for laundering is greater than the use of new and fresh gauze. This opinion has been reached after a very careful estimate. By careful manipulation and practice of economy, we have lowered the overhead of the operating room to less than two cents per day per patient. Our overhead for anesthesia is a trifle higher than the similar expense in most hospitals for the reason that as the vast majority of our cases are kidney and bladder in character, we administer gas and oxygen anesthesia. Besides this department is under the supervision of an expert anesthetist, these facts produce an overhead of approximately two and one-half cents per day per patient."

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### Hospital Inventions by Laymen

John J. O'Connor, of New York City, who sustained a fractured skull and broken leg, wrist and elbow in a fall from the "L" three days before receiving a summons for overseas service in the World War, has devised a new Balkan frame which is endorsed by Dr. William Healey and Dr. W. Gilman Thompson of the Reconstruction Hospital, New York.

Although wracked with pain and trussed up in a Balkan frame, the patient insisted on having drawing materials brought to him and when these were rigged up, he rapidly sketched the rough idea of an improved Balkan frame.

This contrivance is a wooden, oblong frame fitted over the outside of a bed and projecting slightly over the bed line. It supports at the top, wooden beams to which are attached pulleys. Through these pulleys pass weighted ropes which are attached to the patient's body at carefully determined points. Hip, knee and foot are raised and supported so exactly that the ends of the fracture are held together perfectly for reuniting. By means of the pulleys the patient can exercise the leg to prevent the muscles from becoming flabby and the joints stiff.

Another New Yorker, Mrs. George Thompson, has invented a garment to be worn by the sick and bed-ridden.

This is how it "works": The back and front of the garment (whether it be pajamas or the old-fashioned night-gown) are made in two parts and are fastened together with snappers. In examinations of the heart and lungs all that is necessary for the nurse to do is to detach the snappers at the neck and shoulders and turn down one half of the front of the garment.

The sleeves are also attached by snappers, and one pull will bring an entire sleeve away so that a hypodermic injection may be given, the examination of a fracture made, or a soiled sleeve may go to the laundry.

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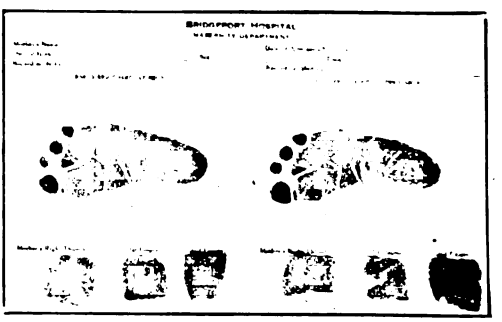
### Identifying Footprints

The Bridgeport Hospital, Bridgeport, Conn., uses the footprint method to identify its wee babies. As soon as the child is born, the print of the right foot is carefully registered. On the same card are placed the print of the mother's thumb, and two fingers. When mother and child leave the hospital, these prints are taken again as a final check.



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# Gleanings

### Sodium Citrate to Control Bleeding

The administration of sodium citrate intramuscularly, intravenously or subcutaneously, results in prompt and pronounced shortening of coagulation and bleeding time. This is a hitherto unrecognized pharmacological action of the drug.

The shortened coagulation time is of two or three hours' duration with gradual return to the normal within twenty-four to forty-eight hours.

The sodium citrate curve occurs not only in individuals with normal coagulation and bleeding time, but in those in whom there is pathological prolongation, notably in jaundice.

It does not occur in blood diseases characterized by blood platelet deficiency—hemophilia and purpura. These diseases appear to compromise the sole contraindication to the use of sodium citrate for the control of bleeding.—Neuhof and Hirshfeld in *Annals of Surgery.*

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### Rickets

Recently clinical investigations on the conditions incident to rickets have been carried out in Vienna by a group of experts. At the time the disease was widespread and severe in the city, and many opportunities for study were available. The preliminary report to the Accessory Food Factors Committee has been published. The conclusions based upon the observation of many cases show:

1. That rickets developed during winter and spring under excellent hygienic conditions in infants receiving a diet, composed of fresh milk from stall-fed cows to which sugar was added, and was prevented in the case of children receiving a diet, containing cod-liver oil, more milk, and less carbohydrate. Both milks were low in vitamin A.

2. That it did not develop in summer on either diet.

3. That it can be cured by cod-liver oil and by exposure to sunlight, or to the radiation of the mercury vapor quartz lamp.

4. That the first six months of life is a period of special susceptibility to the onset of the disease.

5. That it may develop in an infant whose general condition is good or improving, and that healing of the bones may occur without relation to the improvement in the general condition.

The particular features of this investigation were the strict control of diet and of other external conditions and the use of regular roentgen examinations for accurate diagnosis of onset, developments and healing of the disease.

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### Cleansing the Skin of Infants

The skin of a baby is very delicate; the cells secrete a protective covering of oil which is exuded on the surface of the skin and, if not removed, tends to become acid through bacterial action. Soap is the usual cleansing agent but this may prove dangerous if it removes the surface cells and exposes the lower cell layers to take up water into their substance. Excoriations and raw areas may result. Prolonged soaking and the use of strong or gritty soap should be avoided and the use of powders, such as starch or talc, substituted.

Certain skin troubles may exist at the time of birth. Very soon after birth the

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skin sheds, beginning about the fourth or fifth day; it is completed about the fourteenth day. If the child be weakly the state may be similar to scarlatina, and has sometimes been mistaken for hereditary syphilis. There is usually no germ in the skin of a new-born child, but very soon these germs appear, and are ready to take advantage of any admission to the lower cells.

SUPPURATION

Perspiration is rarely present before the end of the fourth month, and then only on the forehead. In rickets perspiration is excessive, but any acute illness may be attended by perspiration. Powdering with a simple dusting powder and sponging off gently with a little sweet oil is the best method of cleansing. If there is any sign of broken skin an antiseptic should be applied at once and the skin protected. Boracic powder is a remedy to be relied on in dry congenital affections, but sometimes this irritates the skin. If the least suppuration is not covered the baby will soon spread the pus over the skin. This pus will soon grow into boils from these germs. Of course if a baby happens to get its hand to the right spot it fills its nail with the poison from that little pustule, and then there will be evil wherever that hand strays. Wrap it up to prevent this spreading, and dress it as soon as possible with a simple ointment.

RASH FROM OVERHEATING

If babies are bundled up too tightly this leads to sweat which soon develops into eczema or boils. A much more common rash is generally called "red gum." This is often thought to be caused by the teeth, but it is caused by over-heating. Use dusting powder and relieve the baby of some clothes and the rash will disappear. Sulphur is a safe remedy for these diseases, but it must be used in a very mild form.—*Nursing Times.*

## Specifics for Hookworm

The drugs used in treating hookworm diseases are oil of Chenopodium (made from the seed of a plant which grows in Jamaica—commonly called "American wormseed"), Thymol (made from the garden thyme of England) and Compound Jalap Powder. These medicines are given in capsules. As a preliminary purge, compound jalap powder is given in doses of 20 to 30 grains for an adult, on the day before treatment; for treating, the jalap is mixed with the powdered thymol, and 40 grains of each drug are given, in two doses at a two-hour interval, for a treatment. In using Chenopodium, the jalap is placed in the capsule, and the oil dropped upon it; 24 minims of the oil, given in two doses, being the treatment for an adult.—Washburn in the *Jamaica Gazette.*

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## Vomiting in Children

*Pyloric Stenosis* is caused by an enlargement of the circular muscular coat of the pylorus, resulting in gastritis and diminished size of the pyloric orifice. At birth the child appears normal and is apparently quite well for the first 10 weeks of post-natal life; then vomiting takes place, accompanied by extreme loss of weight and constipation. The vomiting is characteristic, being projectile. Examination after food reveals marked peristalsis from left to right of the abdomen above the umbilicus. Medical treatment consists of washing out the stomach with sodium bicarbonate, to reduce the gastritis. The treatment is long and unsatisfactory; the mortality is high; only 13 per cent. of cases recover. The surgical treatment consists of gastro-enterostomy (29 per cent. cases recover); or of Ramskett's operation, in which the muscular coat of the pylorus is divided from the top of the inner curvature, allowing the mucous membrane to

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bulge, so enlarging the pyloric orifice. The success of the operation depends on the after-treatment, which is left in the hands of the physician; 46 per cent. of cases recover.

*Cyclical or Recurrent Vomiting* is peculiar to children belonging to neurotic families. It may easily be detected by the smell of acetone. The treatment consists of large doses of sodium bicarbonate to restore the alkaline properties of the blood and glucose to assist in breaking down fats. Children of this type have difficulty in digesting fat and need a starch diet; they are prone to asthma and nervous affections.

*Acute Pyelitis.*—The onset is sudden; there may be a rigor accompanying the rapid rise of temperature; the urine reaction is acid. The treatment consists of doses of citrate of potash varying from 60-100 grs. in 24 hours, as the bacillus coli cannot thrive in alkaline urine.—*Dr. Leonard Parsons (England).*

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### Tartar Emetic

The two parasitic conditions in which tartar emetic acts as a specific are the Leishman-Donovan infections commonly known as kala-azar and bilharziosis or schistosomiasis. The drug in conjunction with atoxyl is also used in African trypanosomiasis and is regarded as the most promising form of treatment, but this disease does not concern us directly. In the two former conditions, however, there is every indication that it is only a matter of time before they will be regarded as of first importance.—Wood in *Southern Medicine and Surgery.*

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### Chiggers

Pulex penetrano, the common chigger or jigger of the South, deserves its onomatopoetic name. The pregnant female burrows into the skin, deposits her eggs as they mature and then emerges again. When the chigger is expelled artificially or by suppuration, the whole stock of eggs, not yet matured, are deposited in a lump and will not hatch. The longer the chigger remains in the skin the more eggs she deposits. The eggs containing foreign protein are the potential source of serious complications. The chigger itself or its eggs may cause sensitization from subsequent bites a year or two later.

Most of the complications are of staphlococcic origin. The secondary infection may be due to bacteria carried in by the parasite or to scratching and bruising the skin to stop the itching.

Treatment should be instituted as soon as possible after the infection has occurred. A single hot bath with lavish use of strong soap, such as common laundry soap, followed by the application of tincture of iodine to each chigger bite is usually sufficient.—*Bulletin Chicago Medical Association.*

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### Sodium Chloride for Headaches

Prof. Henry Kraemer, University of Michigan, has called the attention of the profession to the benefit obtained in tension headaches by giving sodium chloride in large doses of 10 or 15 grains.

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### Symptoms of Acidosis

The symptoms of acidosis in the milder forms are weakness, anemia, shortness of breath, palpation, nerve pain in various locations, or tenderness of nerve; legs swelling below knees. Of the severer forms, there is also dilated pupils, swollen gums, cardiac dilatation, muscular atrophy, various paralyses, hemophilia.—*Medical Herald.*

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### Neuralgia

Oil of peppermint applied with camel-hair brush gives instant relief in superficial neuralgia.—*Medical Summary.*

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# Book Reviews

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The chapters run as follows: Diagnosis, home conditions, medical indications, treatment away from home, the rest treatment, ventilation and health, open-air treatment, cleanliness, infection and its limits, precautions against infection, pyrexia and its treatment, food and diet, symptomatic treatment, specific remedies, general remedies, special methods of treatment, treatment of complications, graduated exercise, recreation and occupation, after care and the industrial positions, and appendix.

The chapters on food and dietetics, rest, pyrexia, graduated exercise and after care (with special reference to industrial replacement) are worded clearly and interestingly and should be especially valuable to the nurse engaged in this work. A. K.

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The Healthy Baby. By Richard H. Dennett, B.S., M.D. Second Edition. The Macmillan Company, 1922.

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those simpler disorders, which are not supposed to require the advice of a physician, in a very direct and practical way. The section on the nervous child is particularly sane and sensible.

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Management of the Sick Infant. By Langley Porter, B.S., M.D., M.R.C.S., L.R.C.P., and William E. Carter, M.D., San Francisco, Cal. 654 pages, 54 illustrations. C. V. Mosby Company, St. Louis.

This book codifies in an easily read form the points which are helpful in handling sick children. A special section is devoted to practical methods of treatment. Illustrations and explanations simplify many of the difficulties of treating and handling sick babies. In these descriptions little is taken for granted or left to the imagination of the reader.

R. S.

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Notes on Gynecological Nursing. By Félicie Norton. Scientific Press.

Another handy little book in the pocket series! The material is largely a collection of notes from Miss Norton's wide experience in this field. The book is written especially for the undergraduate.

The chapters are short, but packed full of information, and deal briefly with the anatomy and physiology of the female generative organs; with menstruation and its disorders; with diseases, displacements and growths, together with their treatment, and descriptions of the usual gynecological and obstetric operations undertaken for their removal or relief.

R. S.

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**Tales that Amuse**

It is much to the advantage of the nurse if she has read a number of cheerful, humorous stories and is ready to select from this group such a book as will furnish a pleasant hour now and then for her patient. Among the many, many books that have been used for this purpose and enjoyed are the following:

Pigs Is Pigs (Butler), Skinner's Dress Suit (Dodge), Dr. Luke of Labrador (Duncan), At Good Old Siwash (Fitch), Custard Cup (Livington), Joyous Adventures of Aristide Pujol (Locke), Tillie; a Mennonite Maid (Martin), Peace of Solomon Valley (McCarter), The Corner Stone, Come Out of the Kitchen (Miller), Parnassus on Wheels (Morley), A Thin Volume (Perkins), Mrs. Wiggs of the Cabbage Patch (Rice), Twenty-three and a Half Hours' Leave (Rinehart), When a Man Marries, Silver Sixpence (Sawyer), Rudder Grange (Stockton), Prairie Wife (Stringer), The Need of a Change (Street), Penrod (Tarkington), Seventeen, Wood Carver of 'Lympus (Waller), Rejuvenation of Aunt Mary (Warner), Dear Enemy (Webster), Daddy Long Legs, Rose-Garden Husband (Widdemer), Cathedral Courtship (Wiggin), The Mansion (Van Dyke).

The following books make little people happy:

The Brownies, Their Book (Cox), Cinderella's Granddaughter (Gilchrist), The Mutineers (Hawes), High Benton Heyliger, Nelly's Silver Mine (Jackson), The Jungle Book (Kipling), The Boy's Life of Edison (Meadowcroft), The Tale of Peter Rabbit (Potter), The Real Mother Goose (Wright), the James Whitcomb Riley Reader, The Children's Book (Scudder), Heidi (Spri), A Short History of Discovery (Van Loon).—*Pacific Coast Journal of Nursing.*

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The lists and tables at the end of the book which relate to clothing, height, weight, poisons and their antidotes, etc., are very good. The book deserves its popularity. It is one which nurses can recommend to mothers as both practical and authoritative. M. G.

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Management of the Sick Infant. By Langley Porter, B.S., M.D., M.R.C.S., L.R.C.P., and William E. Carter, M.D., San Francisco, Cal. 654 pages, 54 illustrations. C. V. Mosby Company, St. Louis.

This book codifies in an easily read form the points which are helpful in handling sick children. A special section is devoted to practical methods of treatment. Illustrations and explanations simplify many of the difficulties of treating and handling sick babies. In these descriptions little is taken for granted or left to the imagination of the reader.

R. S.

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Notes on Gynecological Nursing. By Félicie Norton. Scientific Press.

Another handy little book in the pocket series! The material is largely a collection of notes from Miss Norton's wide experience in this field. The book is written especially for the undergraduate.

The chapters are short, but packed full of information, and deal briefly with the anatomy and physiology of the female generative organs; with menstruation and its disorders; with diseases, displacements and growths, together with their treatment, and descriptions of the usual gynecological and obstetric operations undertaken for their removal or relief.

R. S.

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**Tales that Amuse**

It is much to the advantage of the nurse if she has read a number of cheerful, humorous stories and is ready to select from this group such a book as will furnish a pleasant hour now and then for her patient. Among the many, many books that have been used for this purpose and enjoyed are the following:

Pigs Is Pigs (Butler), Skinner's Dress Suit (Dodge), Dr. Luke of Labrador (Duncan), At Good Old Siwash (Fitch), Custard Cup (Livington), Joyous Adventures of Aristide Pujol (Locke), Tillie; a Mennonite Maid (Martin), Peace of Solomon Valley (McCarter), The Corner Stone, Come Out of the Kitchen (Miller), Parnassus on Wheels (Morley), A Thin Volume (Perkins), Mrs. Wiggs of the Cabbage Patch (Rice), Twenty-three and a Half Hours' Leave (Rinehart), When a Man Marries, Silver Sixpence (Sawyer), Rudder Grange (Stockton), Prairie Wife (Stringer), The Need of a Change (Street), Penrod (Tarkington), Seventeen, Wood Carver of 'Lympus (Waller), Rejuvenation of Aunt Mary (Warner), Dear Enemy (Webster), Daddy Long Legs, Rose-Garden Husband (Widdemer), Cathedral Courtship (Wiggin), The Mansion (Van Dyke).

The following books make little people happy:

The Brownies, Their Book (Cox), Cinderella's Granddaughter (Gilchrist), The Mutineers (Hawes), High Benton Heyliger, Nelly's Silver Mine (Jackson), The Jungle Book (Kipling), The Boy's Life of Edison (Meadowcroft), The Tale of Peter Rabbit (Potter), The Real Mother Goose (Wright), the James Whitcomb Riley Reader, The Children's Book (Scudder), Heidi (Spri), A Short History of Discovery (Van Loon).—*Pacific Coast Journal of Nursing.*

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# Editorially Speaking

### Windows

Not many centuries ago, English lords and knights were taxed in proportion to the windows in their dwellings. Even today, windows are symbols of civilized prosperity. They open upon the wholesome, ozoned world without; they permit the entrance of light, air and sun—the silent stayers of disease.

But we were thinking, especially, of mental windows which bring the knowledge, energy and inspiration of other personalities into our lives. Are you living in a one-man, windowless hovel, or do you gather force and vitality from the ends of the earth?

In the middle ages, high and mighty isolation was possible but undesirable. In 1922, with wireless speeding past our doors and aeroplanes circling over our heads, this isolation is a thing of the past. The mental hermit is useless to himself and the world about him.

Consider the student in the windowless house! She takes down the lectures hurled upon her roof; she cons the books on her two-foot shelf; she gives a blind hand service in the wards. Put a window in. At once a strong light rests on the slides of the microscope; it penetrates the corners of the biological and chemical laboratories; it falls upon the specimens in the museum; it shines upon the hundreds of books on the reference shelves. Immediately the student is fired with energy. She looks upon knowledge as a living thing. She asks penetrating questions of head nurses, instructors, physicians.

Consider yourselves as graduate nurses. Are you living in windowless houses breathing stale air from the bygone days of training? Or have you built in huge French windows which light up the books bearing 1922 copyrights, disclose institutes, conferences, conventions, lectures, demonstrations, post-graduate courses and hospital visits? You need large, clean windows through which the light of science may enter.

Then of the stained glass windows which filter the light in warm colors and carry energy to the soul. If you wish to bring verve to others you must drink often from the sources of inspiration—the workable ideals of our real thinkers, the teachings of the Great Philosopher.

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### Extending the Scope of the Dietitian

In small hospitals the dietitian is sometimes classed as a desirable but expensive luxury. "Finances will not permit," and the subject is dismissed.

This is a fruitless way to attack any important problem and especially the problem of dietetics which modern medicine has found so invaluable. The way to cover the expense of the dietitian's salary is to increase her usefulness in the hospital and the community.

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**This panel of light, one of a group of three windows which glorify the Red Cross Building in Washington, was given by the Woman's Relief Corps. It portrays Sister Filomena, famed for her healing ministrations, attended by her hand maidens, Mercy, Hope, Faith and Loving Charity.**

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Take her field within the hospital. The dietitian is especially fitted to be the buyer of all food supplies. She knows values, she can study the market, she has the freedom from executive duties which permits her to " shop " for the best food and purchase it at the least cost. In the smaller hospitals she might supervise the checking of deliveries, the methods of storage, the distribution of supplies, etc.

As an instructor in chemistry (if the hospital maintains a school of nursing), of course, in dietetics and perhaps as instructor in certain phases of laboratory work, the trained dietitian is especially qualified. We know of two hospitals where the dietitian has also served as the house-mother at the nurses' home.

Then visualize her opportunities as a field dietitian to supplement the work of the dispensary staff. Michael Reese Hospital, Chicago, has found this service especially valuable. The dietitian goes into the home, makes her own estimate of the facilities of the family for preparing special dietetic food, estimates the understanding of the person upon whom the actual preparation depends, and then maps out the diet according to the physician's orders. The dietitian who undertakes out-patient work must possess, in addition to her knowledge of dietetics, cookery, food chemistry, etc., the social service aspect toward the work. This instruction means the ability to instruct the patient definitely as to the means and methods of preparing food and the medical character of the treatment. It is often very difficult to explain the importance of a " food prescription." Needless to say, these out-patient excursions give the dietitian a wonderful opportunity to teach proper health habits. Often the dietary regimen of the whole family is revamped after one of the members has " taken the food cure."

These constitute some of her openings in the hospital. Could the town or city in which the hospital is located bear part of the expense of her salary in return for lectures she could deliver in the schools, or at community centers? Could she teach cooking in the schools? Could she cooperate with visiting nurses or physicians in the locality in an advisory capacity?

These are just some of the possibilities. Dig into your own problem from the local viewpoint. If the hospital needs a dietitian—and every hospital does—use these means of covering her salary in value received.

## THE GOSPEL OF HEALTH

Three persons out of four are utterly unaware of the general causes of their own ill-health, and of the ill-health of their children. They talk of their " afflictions," and if they be pious people, they talk of the "will of God" and of the " visitation of God." I do not like to trench upon those matters, but when I read in my Book and in your Book that *" it is not the will of our Father in Heaven that one of these little ones should perish,"* it has come to my mind sometimes with very great strength that may have a physical application as well as a spiritual one, and that the Father in Heaven who does not wish the child's soul to die may possibly have created that child's body for the purpose of its not dying except in good old age. When one sees an unhealthy family, then in three cases out of four, if one takes time, trouble and care enough, one can, with the help of the doctor who has been attending them, run the evil home to a very different cause than the will of God; and that is to a stupid neglect, a stupid ignorance, or, what is just as bad, a stupid indulgence.—*Rev. Charles Kingsley.*

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# The Editor's Letter-box

**The Editor Is Not Responsible for the Views of Contributors. All Letters Must Be Accompanied By the Name and Address of the Writer**

## Points on Reorganization

DEAR EDITOR:

Many points of adjustment necessary under the reorganization were discussed at the Seattle Convention in the round tables directed by Miss Sarah E. Sly. Nurses who were not present will be interested in the following cases:

One point of adjustment has been found difficult of solution in many localities, i.e., the situation where the official residence of a member falls in one district or state, while her nursing interests are located in another. This conflict is most noticeable, perhaps, in New York-New Jersey, Philadelphia-Camden, Minneapolis-St. Paul, Kansas City, Kansas-Kansas City, Missouri. The situation has special significance in those locations where the nursing laws are widely variant as between Kentucky and Indiana or Missouri and Kansas. In such situations the non-registered nurses are able to affect the economic conditions of registered nurses. The units involved (districts or states) were asked to work out equitable arrangements, referring all rulings, however, to the national committee on reorganization before putting them to a vote.

Another division of energy is experienced by those whose alumnae associations are not located in the districts in which they are registered. Arrangements for this adjustment vary in different localities. Usually the member is permitted a vote, when present, in her alumnae affairs, although her real force and interest are thrown toward the state and district in which she works. It was generally felt that absentee members should not be permitted to hold office in Alumnae Associations since administrative work would become sporadic and ineffectual under such conditions.

Another question most frankly discussed bears upon the participation of married nurses in alumnae affairs, although they do not, perhaps, become members of the district or state. It was realized that the very splendid services which could be rendered by married nurses, due to the greater latitude in the distribution of their time, were assets needed by the Alumnae Associations in publicity and administrative lines. For this reason Miss Sly believed that the constitution of each alumnae association should provide for all alumnae under some classification. At Hackley Hospital, Michigan, those married nurses who cannot be induced to contribute to the support of district or state are entered under an associate membership which gives them voting privilege in the affairs of the Alumnae only. Other localities have extended the privilege of honorary membership to those who are unable to contribute to the support of the Alumnae Association. Such provisions are necessary to retain and utilize the interest of Alumnae members in improving the conditions of the school, etc. However, many married nurses with leisure for constructive work should be urged to support and advance the interests of district and state, in order that a wider and more representative body may direct the efforts of the body and interpret its purposes to the community.

G. D.

## How Long Will You Live?

DEAR EDITOR:

The abridged life tables based upon the 1920 United States Census (covering 74 per cent of the total population) show that the expectation of life at birth is 55.23 for white males and 57.41 for white females. According to these tables the longest lived people in the United States are the Kansans, the expectation of life at birth in Kansas being 59.73 for white males and 60.70 for white females. If a record as a standard of comparison be desired it may be found in the figures for females in the county of West Sussex, England, whose expectation of life, the highest ever published officially by any country, was 63.05 in 1911-12.

A comparison of the figures of 1910 and 1920 within the "original registration states" shows that the expectation of life for white males has advanced from 50.23 in 1910 to 53.90 in 1920, an increase of 3.75; and for females it has advanced from 53.62 to 56.33, an increase of 2.71.

How do the statistics for nurses compare with the figures for the general population?

R. S.

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## THE HOSPITAL ASSOCIATION IN RETROSPECT

DEAR EDITOR:

Nearly twenty years ago, when, as a young hospital superintendent, I was facing the problems of a new institution with an inexperienced board of directors, I received my first invitation to attend the American Hospital Association Convention. That year the attendance was about seventy-five persons. The old guard, Dr. Rowe of Boston City Hospital, Dr. Fisher of the Presbyterian Hospital, New York, Mr. Ludlam of the New York Hospital, and others, who had helped bring the organization into existence were clearly discouraged. The attendance was small. Were the results commensurate with the years of effort? The subjects of interest had been discussed again and again, pro and con. Indeed, it was seriously advocated that the convention be held only once in two or three years.

The subject of nurses and nursing had never been given a place on the hospital program. A live wire dangerous to all who touched it! Some, however, felt that since the reputation of the hospital in the community and the goodwill of its backers depended more on the quality of its nursing than upon any other one feature, nursing should take its place on the program and in the work of the association. One pompous medical superintendent was so opposed to the subject that he threatened to resign forthwith.

Since that day much water has flowed under the bridge. The restatement of the objects of the organization, its reorganization and rechristening resulted in an appeal to a much larger constituency. The plans of those who were active in the reorganization have now been realized to a large extent.

To me, and to other hundreds of hard-working superintendents of struggling institutions, these fall meetings have meant much. I have brought my problems—diverse and puzzling—with the knowledge that if my particular problem was not formally slated for the program, I would meet others who had conquered similar difficulties in their institutions and would gain new methods from conversation with them.

Some of the questions aired in those far-off days are still found on convention programs—flooring, the non-professional help, etc. But we now have a body of literature on many questions which can be referred to for aid. This exact information has been collected through the medium of the Association.

The establishment of a central office and the employment of a paid, full-time secretary marked a great advance. The Association has aided many struggling superintendents. I can remember the joy that I felt when the Association first went on record as recommending the employment of a graduate nurse as night superintendent. This decision meant much to the superintendents of smaller hospitals, as well as many other bolstering decisions which have been rendered.

The concrete aid furnished by exhibits was another advance. I remember well in the earlier years when models of interesting devices for hospital work, equipment for occupational therapy work (I believe history repeats itself in the exhibit of the American Occupational Association this year), and other definite aids were introduced as the forerunners of the important exhibit and discussion which will form an integral part of this year's program.

These are only a few of the many ways in which the Association has helped me and my institution care for the sick in the best manner possible. I feel that no superintendent can afford to isolate herself. She must belong to the Association.

JUNIA, North Carolina.

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## PICTURESQUE ITALY

DEAR EDITOR:

I am sending you a copy of our report (Dispensary of S. Domenico di Fiesole, Florence, Italy)—just issued—thinking it may be of possible interest as you were good enough some time ago to publish some details of our work in earlier days.

In the last number of the magazine appeared an article which I found very helpful in regard to practical electrical treatments. I have translated part of it into Italian and have posted it in our little electric treatment room for reference. It is always pleasant to know when an article "touches the spot," so I thought I would let you know that your magazine is appreciated in foreign lands.

JULIET TURNER.

(We wish "you all" could leaf through the pages of the report and see the, to us, fascinating illustrations. You will in a few months, however, for we have asked Miss Turner to describe current conditions in this Italian setting where she is assistant superintendent.—EDITOR.)

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# BAND-AID Saves Time

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BAND-AID—a strip of "Z O" Adhesive Plaster with a gauze pad in the center—is very useful for bandaging small cuts and wounds.

Nurses in charge of First Aid work in factories find BAND-AID a time saver and convenience.

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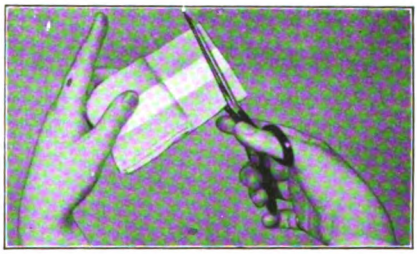
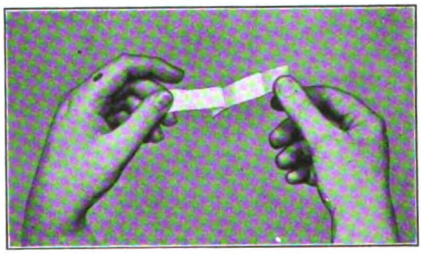
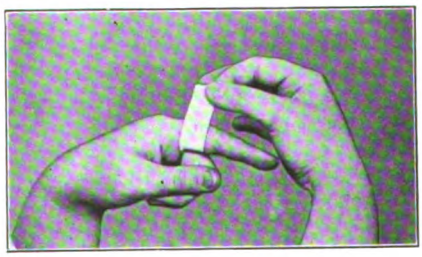


Cut off piece you need



Remove protective covering



Apply to the wound

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NEW BRUNSWICK, N. J., U.S.A.




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# In the Nursing World

Articles in this department, whether bearing signature or not, are contributed and do not necessarily represent the ideas or policy of this magazine.

## ENGLISH PUBLICITY METHODS

During July, the English College of Nursing and the Association of Hospital Matrons, have departed from conservative English traditions to give an interesting exhibit of snap shots from scenes of a nurse's life and training at the Woman's Exhibition which was held at the Olympia.

During the fortnight, the exhibit was presided over by members of the profession connected with London hospitals.

Fortunately for the organizers, ample space was at their disposal, and the long enclosures, painted white and spotlessly clean and fresh, made an admirable setting for the exhibits divided into the following sections:

*Theoretical Training.*—In this first section was shown all the apparatus used by the nurse in her preliminary school—cookery, bedmaking and other branches.

*General Wards.*—Four beds with lay figures, and every possible requisite for a ward were on view—lotions, stands and models of all kinds.

*Children's Ward.*—Four cots containing most fascinating doll babies and also an incubator.

*Special Departments.*—Orthopedic apparatus; creosote chambers for chest cases, with miniature nurses and patients; utensils and dietary lists for courses in housekeeping, and information regarding professional careers formed this section. Here were shown some 30 dolls correctly dressed in the uniform of various hospitals. These included Whipps Cross Infirmary, the Hospital of St. Cross, Rugby, various fever hospitals, the large London schools, Birmingham General Hospital, Bristol Royal Infirmary, and many others. The Army, Navy and Air Force uniforms were also in evidence, and masseuses and public health nurses took their place among the dainty little ladies. The Ministry of Pensions Nursing Service was not forgotten, and district nursing was represented in the homes of the poor and private nursing in the homes of the rich, where a smiling maternity patient and her newly born babe were comfortably ensconced.

*Museum.*—St. Bartholomew's Hospital sent beautiful contributions to the Museum—old cups and candlesticks, one dating from 1720; bleeding cups with measurements, prints of an old Rahere ward, taken from the *Lancet* of 1832, and of the builder of the hospital, Edward VI. From St. Thomas's came the Nightingale medals, and many relics of Miss Nightingale, including old prints of wards at Scutari, and a graceful etching of the great lady as a young girl.

*Pleasure.*—The social side of a nurse's life was not overlooked. The dainty bedroom, with fixed wash basin, wardrobe, table and bed; the pleasant sitting-room, with curtained lattice window, and deep chintz-covered armchairs were cleverly arranged and typical of all modern nurses' quarters. Round the walls of the sitting-room were illustrations of a nurse's pastimes—swimming, hockey, tennis, reading, while a piano testified to her ability to indulge her musical taste.

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## UTICA PLANS CENTRALIZED NURSES' SCHOOL

Faxton, Homeopathic, State, St. Elizabeth and St. Luke's hospitals, Utica, New York, are planning to organize a centralized training school for nurses.

The Utica school will be the first central training school in New York State, and the first in the country to be under the direction of a special professional educational director. For this reason its progress will be watched by the entire profession.

By the terms of the plan accepted by the hospitals, besides the superintendent of the training school of each member hospital and one other representative of its board, three other persons are to be chosen, one of them to be the superintendent of the public schools of the city.

Nurses from the several hospitals will meet at the Academy for daily study and instruction according to the schedules which will be arranged. Miss E. P. Reid plans to take charge of the school.

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direct their patients to use this beverage instead of coffee, as no harm can result.

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## IMPORTANT MEETINGS

The Thirteenth Annual Meeting of the American Child Hygiene Association will be held in Washington, D. C., October 12-14.

The Fifth Annual Convention of the American Dietetic Association will be held in Washington, D. C., October 16-18 with headquarters at the Hotel Willard.

The Tenth Annual Meeting of the Mississippi Valley Tuberculosis Association will be held at Milwaukee, Wis., October 9-11.

The annual meeting of the Missouri State Nurses' Association will be held in Columbia, October 24-26.

The Twenty-third Annual Convention of the New York State Nurses' Association will be held at the Hotel Pennsylvania, New York City, October 24-26. The League and the New York State Organization for Public Health Nursing will meet on the first day.

The annual meeting of the Oklahoma State Nurses' Association will be held in Muskogee, October 25-27.

The Pennsylvania Graduate Nurses' Association will meet in Wilkes-Barre, Pa., on October 23, at the Hotel Sterling. Nellie G. Loftus is chairman of the reception committee. The program is in the hands of Esther T. Tinsley.

An important meeting of the Wisconsin State Nurses' Association and the League will be held in Oshkosh, October 4-6.

## NURSES' INSTITUTE HELD AT FORT COLLINS, COLO.

Red Cross nurses from seven States of the Southwestern Division recently attended an institute at Fort Collins, Colo., held at the Colorado Agricultural College. The purpose of this institute was to train the Red Cross public health nurses in nutrition work and home economics as well as in rural sociology, psychology, and in organization and publicity methods. Several of the college instructors were among the lecturers. The health school consisting of a group of under-nourished children was used as a clinic in some of the classes, thus making it possible to bring together the nutrition specialist and the public health nurse on common ground.

## GOOD HEALTH WEEK

Good Health Week, sponsored by the leading manufacturers of the country, will be celebrated October 23-30. The movement is planned to interest the layman in that portion of public health work in which he may do his part. The idea has already been endorsed by the Secretary of Labor, Hon. James J. Davis. The secretary of the promotion bureau, William F. Hatch, may be reached at 209 Grand Avenue, Milwaukee, Wisconsin.

## Columbia Institute of Public Health

An institute of public health has been established at Columbia University under a bequest of over $700,000 in the will of the late Joseph R. DeLamar.

The new institute will be primarily for research. It will also afford instruction to students of medicine and others, and, as Mr. DeLamar's will provides, it will engage in giving wide publicity in popular form to the results of scientific investigation. Dr. Haven Emerson has been appointed professor of public health and administration.

## AIDING THE FEEBLE-MINDED

An important contribution to the subject of "Speech Correction in the Feeble-Minded," by Selma Juergens, special speech teacher, Cleveland, and Dr. Walter B. Swift, director, Normal School for Speech Education, Boston, Mass., was read before the National Society for the Study of the Feeble-Minded, which recently met in Cleveland. The report showed that almost all the cases in the class for the mentally backward improved. Some of the cases had as many as fifty defects. Still other cases had only two defects. The letter Z was the most frequently found defective sound; and the letter P was not found defective at all. Most of the defects were at the back of the mouth. The sounds made in the front of the mouth were less frequently defective. Reprints of this article may be had from Dr. W. B. Swift, 110 Bay State Road, Boston, Mass.

## AMERICAN HOSPITAL ASSOCIATION PROGRAM

The full program of the American Hospital Association Convention, which will be held in Atlantic City, New Jersey, September 25-28, appears in the supplement which follows.

These pages also include the programs of the Protestant Hospital Association, September 23-25, the American Occupational Therapy Association, September 25-29, and the American Association of Hospital Social Service Workers, September 26-28.

(*News items are continued on page* 354)

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# Twenty-Fourth Annual Meeting
*of the*
# American Hospital Association
## September 25-28, 1922

GEORGE D. O'HANLON, M.D.
*President*

**Monday Morning, September 25**

Registration.

**Monday Afternoon, September 25**

2 p. m. *Opening General Session*

President, George D. O'Hanlon, M.D., presiding.

Invocation.
Address of Welcome—Hon. Edward I. Edwards, Governor of New Jersey.
President's Address—George D. O'Hanlon, M.D.
Report of Trustees—Executive Secretary.
Report of Treasurer—Robert J. Wilson, M.D.
Report of Executive Secretary—A. R. Warner, M.D.
Report of Membership Committee—*Chairman*, Walter H. Conley, M.D., superintendent, Metropolitan Hospital, Welfare Island, N. Y.
Second report of Committee on Forms and Records with particular reference to annual reports.
Opening business.

**Monday Evening, September 25**

8 p. m. *General Session and Section on Construction*

President, George D. O'Hanlon, M.D., presiding.

*Chairman*, E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago.
Report of Special Committee on Floors—*Chairman*, Frank E. Chapman.
Report of Exposition Committee on Buildings—Construction, Equipment and Maintenance—*Chairman*, S. S. Goldwater, M.D.
Round Table Discussion—Construction Section—*Chairman*, E. S. Gilmore, presiding.

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For many years the authoritative and standard series. Used in hundreds of Hospital Training Schools and in countless institutional and personal libraries. Constant revisions keep these books abreast of the latest scientific discoveries and professional methods.

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**Pope's Manual of Nursing Procedure,** devoted solely to nursing methods and surgical and medical treatments. Price $2.00.

**Dock's Materia Medica for Nurses.** Seventh Edition. Completely rewritten and reset. Price $2.25.

**Higgins' Psychology of Nursing,** the first book written for Nurses on this subject. Teacher's Manual sent free to those interested. Price $1.75.

**Pope's Quiz Book for Nurses,** containing State Board Questions and Answers. Useful in the most practical way. Price $2.50.

**Pope's Essentials of Anatomy and Physiology,** especially adapted for the use of Nurses. A new book, just off press. Price $2.90.

**Dock and Nutting's History of Nursing.** The comprehensive, definitive work on the subject. Price, Vols. I and II, $7.50. Vols. III and IV, $7.50.

**Dock and Stewart's Short History of Nursing.** A condensation for class use of the longer work in four volumes. Contains all the salient facts. Price $3.00.

**Pope's Physics and Chemistry for Nurses.** Well adapted to those pupils who enter training schools without any previous knowledge of either subject. Price $2.50.

**Pope and Carpenter's Essentials of Dietetics.** A text book for Nurses and a practical dietary guide for the household. Price $1.75.

**Pope's Dietary Computer.** Enables an accurate estimate to be made of food values. Price $1.25.

**Pope's Medical Dictionary for Nurses.** Perhaps the most satisfactory book of the kind. Price, cloth, $1.50, flexible leather, thumb index, $3.00.

**Dock's Hygiene and Morality.** A valuable contribution to the literature on the social evil. Price $1.50.

**Struthers' "The School Nurse."** Valuable to those whose work is among children. Price $2.00.

**LaMotte's "Tuberculosis Nurse."** A handbook for practical tuberculosis workers. Price $2.00.

**Cadmus' Manual of Obstetrical Nursing,** prepared for use in connection with text books of Obstetrics Price $1.25.

Copies of any of these volumes will be gladly sent to instructors for examination with reference to class use. Complete descriptive circular on request.

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*Educational Department*

NEW YORK


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# Convention Program—*Continued*

ROYAL S. COPELAND, M.D.
*Commissioner of Health, New York City*

**Tuesday Morning, September 26**

9 a.m. *General Session*

President, George D. O'Hanlon, M.D., presiding.

Reports of exposition committees:
General Furnishings and Supplies—*Chairman,* Harold W. Hersey, M.D.
Clinical and Scientific Equipment and Supplies—*Chairman,* A. B. Denison, M.D.
Food and Food Equipment—*Chairman,* C. W. Munger, M.D.
Laundry Equipment and Supplies—*Chairman,* W. P. Morrill, M.D.
Address—Health and Hospitals—Royal S. Copeland, M.D., Health Commissioner, New York City.

**Tuesday Afternoon, September 26**

2:30 p. m. *Section Meetings*

Dispensary (in the theatre)—*Chairman,* John E. Ransom.
Dietetics (in the convention hall)—*Chairman,* Miss Lulu G. Graves.
Discussion on Children's Departments in Hospitals—Frank Richardson, M.D., of the Children's Diagnostic and Nutrition Clinics of North Carolina, and Children's Department of Brooklyn Hospital, Brooklyn, N. Y.
The organization of Dietary Departments in Hospitals—Marion Peterson, Lakeside Hospital, Cleveland.
A Round Table Discussion on Hospital Equipment.

**6 P. M. (Place to be announced)**

Rotary dinner. "The Hospital Phase of the Crippled Children Movement."

**Tuesday Evening, September 26**

8 p. m. *General Session*

President, George D. O'Hanlon, M.D., presiding.

Report of Special Committee on Renovation of Gauze and Standard Dressings—*Chairman,* A. B. Denison, M.D., assistant director, Lakeside Hospital, Cleveland.
Address—"The Liability of the Hospital"—John A. Lapp, managing editor, *The Nation's Health,* Chicago.
Report of Dispensary Committee—*Chairman,* John E. Ransom.
Report of Legislative Committee—*Chairman,* C. G. Parnall, M.D.
Address—"The Hospital Problem in Relation to Modern Medicine"—W. C. Stoner, M.D., Cleveland, Ohio.

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# Convention Program—*Continued*

ANNIE W. GOODRICH, R.N., Sc.D.

**Wednesday Morning, September 27**

9 a. m. *Section Meeting*

Trustees (in the convention hall)—*Chairman,* Arthur A. Fleisher, President Jewish Hospital, Philadelphia, Pa.

Round Table Discussion

**Wednesday Afternoon, September 27**

2:30 p. m. *Section Meetings*

Nursing (in the theatre)—*Chairman,* Miss Laura R. Logan, superintendent of nurses, Cincinnati General Hospital, Cincinnati, Ohio.

A Discussion of the Report of the Rockefeller Committee and its Effect in Practice upon the Hospital Nursing Department—Amy M. Hilliard, R.N., Superintendent of Nurses, Samaritan Hospital, Troy, N. Y.

The Use of Ward Helpers—S. Lillian Clayton, R.N., Director of Nursing, Philadelphia General Hospital, Philadelphia, Pa.

The Role of the Hospital Nursing Department in the Community Health Program—Annie W. Goodrich, R.N., Director of Nursing, Henry Street Settlement.

Discussion.

Administration (in the convention hall)—*Chairman,* C. G. Parnall, M.D., medical director, University Hospital, Ann Arbor, Mich.

"The Training of Hospital Executives"—Willard C. Rappleye, M.D., Executive Secretary of the Rockefeller Committee.

Discussion—Winford H. Smith, M.D., Director of Johns Hopkins Hospital; Frederic A. Washburn, M.D., Director of Massachusetts General Hospital; Daniel D. Test, Superintendent of Pennsylvania Hospital.

Report of the Committee on Hospital Forms and Records—A. C. Bachmeyer, M.D., Superintendent Cincinnati General Hospital; F. E. Chapman, Superintendent Mount Sinai Hospital; John F. Bresnahan, M.D., Superintendent Bridgeport Hospital.

**Wednesday Evening, September 27**

8 p. m. *General Session*

President, George D. O'Hanlon, M.D., presiding.

Report of Nomination Committee—*Chairman,* D. L. Richardson, M.D.

Appointment by president of three tellers for the voting.

Report of Constitution and Rules Committee—*Chairman,* Richard P. Borden, trustee, Union Hospital, Fall River, Mass.

Address—Standardization: Its Value—George D. Stewart, M. D.

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## Convention Program—*Continued*

ASA S. BACON
*President 1922-1923*

**Wednesday Evening, September 27**

*Section Meeting*

Miss M. Antoinette Cannon presiding

Social Service (in the theatre)—*Chairman*, Mary E. Wadley, Social Service Department, Bellevue and Allied Hospitals, New York.

"What Social Service in its Hospital Means to a Community." W. H. Matthews, Director, Bureau of Family Rehabilitation A.I.C.P., New York City.

"How a New Jersey County and its Hospitals Got Together"—John L. Montgomery, executive secretary, Monmouth County Organization for Social Service; Mrs. Lewis S. Thompson, member, New Jersey State Board of Control.

"How a Small Community Can Maintain Social Service in its Hospitals"—Annette Cowles, superintendent, Children's Free Hospital, Louisville, Ky.

"Social Work with Problem Children"—Mary Tobin, director social work, Neurological Institute, New York City.

General discussion.

**Thursday, September 28, 9 to 11 a. m. Theater**

General Session, President O'Hanlon presiding.

Report of the Committee on the Training of the Hospital Social Worker—*Chairman*, Michael M. Davis, Jr., executive secretary, Committee on Dispensary Development, New York.

Address—Public Health Work in Pennsylvania, J. M. Baldy, M.D., Commissioner of Public Welfare for the State of Pennsylvania, Harrisburg, Pa.

**2:30 to 4:30 p. m. Theater**

Round Table—*Chairman*, Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago.

**8 p. m. Theater**

*Closing General Session*

Announcement of election results. Reports of any other committees.

Program.

Closing business.

The new president, Asa S. Bacon, takes the chair.

Announcement of committee appointments.

"The Association for Next Year," the new president.

Adjournment.

**Friday and Saturday, September 29-30**

Scheduled visits to hospitals and special demonstrations in New York and Philadelphia.

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# Hospital Social Service Workers Semi-annual Meeting

HAVEN EMERSON, M.D.
*Columbia University, New York City.*

President, M. Antoinette Cannon, New York.
First vice-president, Ruth V. Emerson, Boston.
Second vice-president, Gertrude L. Farmer, Boston.
Third vice-president, Marian A. Tebbets, Minneapolis.
Secretary, Lena R. Waters, Johns Hopkins Hospital, Baltimore.
Treasurer, Margaret S. Brogden, Johns Hopkins Hospital, Baltimore.

**Tuesday, September 26—Section Hall, 4:30 P. M.**

"The Hospital as a Social Institution"—Haven Emerson, M.D., Columbia University.

Discussion: By two social workers.

"Teaching the Social Aspects of Medicine in Medical Schools"—Introduction: A Brief Survey of the Situation—Dorothy Ketcham, director of Social Service, University Hospital, Ann Arbor, Michigan.

Discussion: Frank Billings, M.D., and others.

**Wednesday, September 27—Section Hall, 4:30 P .M.**

Business Session

**Theater, 8 P. M.**

General Session on Social Service. (*See Program of American Hospital Association.*)

**Thursday, September 28, Theater, 9 a. m.**

Report of the Committee on the Training of the Hospital Social Worker. (*See Program of American Hospital Association.*)

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# American Occupational Therapy Association Program

HERBERT J. HALL, M.D.
*President*

**Monday, September 25, Convention Hall, 9 a. m.**

Registration and credentials. Meeting of House of Delegates.

**Convention Hall, 2.30 p. m.**

Invocation—Rev. Wm. Blatchford, rector of St. James' Church.

Address of Welcome—Hon. Edward F. Bader, mayor.

Address of the President—H. J. Hall, M.D., Devereaux Mansion, Marblehead, Mass.

"Observation of Patients' Reactions the Guide to Further Treatment"—L. J. Hass, Director of Occupations, Bloomingdale Hospital, White Plains, N. Y.

Abstract:—When the new case has been introduced to the proper task does the carefully planned and controlled machinery of therapeutic occupations run smoothly, with little further attention, the desired result being attained? Experience shows the problem is not so simple as this. The planning of the treatment has only begun and must continue through the patient's stay in the hospital. Those applying various forms of occupational treatment must observe the patient's progress expressed in reactions. These are read, carefully weighing the information contained. This guides and aids in further treatment.

Therefore it is essential that there exist some definite method of receiving and recording information concerning the new case and observing his reaction to the treatment. All of this information is thus available to guide those who plan and present occupational treatment. The paper presents such phases of this problem as:

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## Occupational Therapy Program—*Continued*

1. Method of receiving information—How recorded.
2. Records kept of observations, progress.
3. Instructor's weekly report. Work accomplished record.
4. Factors to be considered in planning treatment.
5. Examples of treatment adaptation as applied to—The underactive case, The overactive case.
6. Changes in treatment to meet relapse—When no added precautions are required. When conditions demand precautions.
7. Changes to meet various degrees of coordination.
8. Retraining for those who lack self-reliance.

"Experiences in Directing an Occupational Therapy Association"—Miss Idelle Kidder, St. Louis.

"Men's Occupational Therapy in Convalescence"—Frederic Brush, M.D., Medical Director, Burke Foundations, White Plains, N. Y.

Abstract:—Why should occupation therapy be impressed upon men during their trying recuperations from illness? The convalescent state—its physical and psychological conditions. Certain lasting good to be accomplished in this period only through occupational therapy. Difficulties and peculiarities of the problem, because of the average short-term of application and the widely differing personnel. Highest success is in the adaptation and use of constructive everyday tasks near at hand. Sitting and shop occupations essential. Organization, methods and details as resulting from an experience with 20,000. Applied to special classes—orthopædic, cardiac, neuropsychiatric, adolescence, surgical wounds, etc. Case reports, Lantern slides.

**Tuesday, September 26—Convention Hall, 10 A. M.**

Business Meeting.

Reports of Officers and Committees.

Election of President.

**Section Hall, 2:30 P. M.**

Occupational Therapy in General Hospitals.

a. "The Hospital Workshop"—Miss Winifred Brainerd, Presbyterian Hospital, Chicago.

b. "Work on the Wards"—Miss Elsie Hassenstein, Cook County Hospital, Chicago.

c. Work in Dispensaries—Miss Dorothy Hunton, Barnes Hospital, St. Louis.

Discussion.

Round Table on Recreation: a. Music, Mr. van de Wall; b. Dancing and Physical Exercises, Miss E. M. Husby; c. Games and Theatricals, Mrs. M. A. Harrington.

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# Occupational Therapy Program—*Continued*

**Wednesday, September 27, Section Hall, 10 a. m.**

Reports from States.

While certain members have been requested to prepare formal reports of the O. T. activities of their respective states, it has been impossible to assign all of the states to individual members. This is especially the case in the Southern and Western states so that members are requested to come prepared to check up the reports and supply missing information. It is desired that these reports will serve as an enumeration of the hospitals and other institutions carrying on occupational therapy, state and local societies, individual activities, and all other information which will be of value.

**Section Hall, 2:30 p. m.**

Financial Side of Occupational Therapy.

"State Hospitals"—Dr. H. W. Pollock, State Hospital Commission, Albany, N. Y.

"Incorporated Hospitals," L. J. Haas, Bloomingdale Hospital, N. Y.

Sanitaria: a. Tuberculous. b. Psychopathic.

Round Table on Training Courses. Conducted by Miss Ruth Wigglesworth, Boston School of Occupational Therapy.

**Thursday, September 28, Convention Hall, 10 a. m.**

Reports from States (continued).

**Convention Hall, 2:30 p. m.**

Experiences in Hospitals for Ex-Service Men.

General Hospitals.

Neuro-Psychiatric Hospitals.

Tuberculosis Hospitals.

Round Table on Records. Conducted by H. M. Pollock, M.D., State Hospital Commission, Albany, N. Y.

**Friday, September 29, Convention Hall**

10 A. M. Crafts best suited for the Mental and Nervous. Conducted by W. R. Dunton, Jr., M.D.

11 A. M. Crafts best suited for the Tuberculous. Conducted by Mr. T. B. Kidner, Institute secretary, National Tuberculosis Association.

2:30 P. M. Crafts best suited for Bed Cases. Conducted by Mrs. Mary F. Steinbach.

3:30 P. M. Crafts best suited for the Physically Disabled. Conducted by Miss Bowman.

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# Protestant Hospital Association Plans Special Program

C. S. Woods, M.D.
*Vice-President*

Pliny O. Clark, Denver, Colo.
*President*

Frank C. English
*Executive Secretary*

**Saturday, September 23, First Presbyterian Church, 1 p. m.**

(One block from Board Walk on Pennsylvania Avenue)

Invocation.
Address of welcome. Rev. H. Moore, president, Atlantic City Ministerial Union.
Response.
Address of president. Pliny O. Clark, Denver, Colo.
Report of secretary. Frank C. English, Cleveland, Ohio.
The Church Hospital:
"Its Support," C. B. Hildreth, St. Luke's Hospital, Cleveland, Ohio.
"Its Administration," C. S. Pitcher, Presbyterian Hospital, Philadelphia.
"Its Vision," C. S. Woods, M.D., Indianapolis, Ind.

**First Presbyterian Church, 8 p. m.**

"How to Secure Hospital Publicity"—Ralph Welles Keeler, director of publicity, Methodist Hospitals and Homes Association, Chicago.
"The Relation of the Church to the Hospital"—Rev. Herman L. Fritschel, Milwaukee Hospital, Milwaukee, Wis.
"Essentials in Hospital Organization"—N. E. Davis, D.D., Methodist Hospitals and Homes Association, Chicago.

**Sunday, September 24, Morning**

Special services in all churches of Atlantic City.

**Afternoon (Place to be Announced)**

"The Gospel of Healing." Representatives of all churches.

**Monday, September 25, First Presbyterian Church, 8:30 a. m.**

"The Office of the Steward"—Rev. C. O. Pederson, Brooklyn.
"The School for Nurses"—Miss Maude Howell, Milwaukee, Wis.
"The Place of the Chaplin."
"The O. P. D. and the Church."
"The Staff."
Round table discussion, led by Dr. C. S. Woods, Indianapolis.

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# Officers and Committees, 1921-1922

## OFFICERS

President, George D. O'Hanlon, M.D., superintendent, Bellevue and Allied Hospitals, New York.

President-elect, Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago.

First vice president, Malcolm T. MacEachern, superintendent, Vancouver General Hospital, Vancouver, B. C.

Second vice president, Harold W. Hersey, M.D., Joint Administrative Board, Columbia University and Presbyterian Hospital, New York.

Third vice president, Miss Harriet Hartry, superintendent, St. Barnabas Hospital, Minneapolis, Minn.

Treasurer, Robert J. Wilson, M.D., director, Health Department Hospital, New York.

Trustees: George D. O'Hanlon, M.D., chairman; Asa S. Bacon, Louis H. Burlingham, M.D., Rev. Maurice F. Griffin, Miss Mary M. Riddle, R.N., H. E. Webster, Daniel D. Test, Richard P. Borden.

## SECTION OFFICERS

*Administration:* C. G. Parnall, M.D., chairman; Nathaniel S. Faxon, M.D., secretary.

*Dietetics:* Miss Lulu G. Graves, chairman; Miss Marian Peterson, secretary.

*Nursing:* Miss Laura R. Logan, R.N., chairman; Miss Clara B. Pound, R.N., secretary.

*Out-Patient Service:* John E. Ransom, chairman; Frank E. Wing, director, secretary.

*Social Service:* Miss Mary E. Wadley, chairman.

*Trustees:* Arthur A. Fleischer, chairman; Henry C. Wright, secretary.

*Construction:* E. S. Gilmore, chairman; Oliver H. Bartine, secretary.

## STANDING COMMITTEES

*Nominations:* D. L. Richardson, M.D., Charles F. Diehl, Miss Margaret Rogers.

*Membership:* Walter H. Conley, M.D., Miss Charlotte Jane Garrison, C. J. Cummings.

*Constitution and Rules:* Richard P. Borden, A. O. Fonkalsrud, M.D., Miss Mary E. Surbray, R.N.

*Out-Patient Work:* John E. Ransom, A. K. Haywood, M.D., Alec N. Thomson, M.D.

*Legislation:* C. G. Parnall, M.D., Paul F. Fesler, F. O. Bates.

## SPECIAL COMMITTEES

*Hospital Forms:* A. C. Bachmeyer, M.D., F. E. Chapman, John F. Bresnahan, M.D.

*Interrelations:* John E. Ransom, Herman Smith, M.D., Asa S. Bacon, E. T. Olsen, M.D.

*Hospital Flooring:* Frank E. Chapman.

*Hospital Subsidy:* Howell Wright, Winford H. Smith, M.D., Daniel D. Test.

*Dressings:* A. B. Denison, M.D., *chairman*, Miss Claribelle Wheeler, R.N., Sister Cornelia, Sister Patricia, Sister Amadeus, Sister Agnes Therese, Guy I. Clark.

*Training for Hospital Social Work:* Michael M. Davis, Jr., Frank Billings, M.D., Miss Ida M. Cannon, Miss S. Lillian Clayton, J. E. Cutler, M.D., Miss Annie W. Goodrich, Miss Mary C. Jarrett, John A. Lapp, Winford H. Smith, M.D., Porter R. Lee, M.D., Roger Irving Lee, M.D., Miss Kate McMahon, Lewis A. Sexton, M.D., George D. O'Hanlon, M.D., A. R. Warner, M.D., Frankwood E. Williams, M.D., Miss M. Antoinette Cannon.

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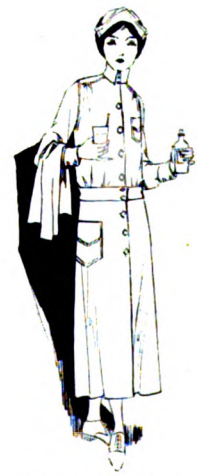

**Nurses' Uniforms** (illustrated B) white linen finished cambric—convertible collar—same model comes in chambray or striped seersucker. **Sizes, 34 to 46. No. 3073.** **2.75**

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## NORTH CAROLINA NURSES MEET

The Twentieth Annual Convention of the North Carolina State Nurses' Association met in Greensboro, N. C., September 5, 6, 7, 1922, at the O. Henry Hotel. Tuesday morning up to eleven o'clock was devoted to business, including the reading of the secretary's report, by Harriett Lesowski, and the treasurer's report, by Jessie McLean.

At eleven o'clock the address of welcome for the Guilford County Medical Association was delivered by Dr. J. T. J. Battle, and for the Greensboro Nurses' Association by Flora Mathews. The response was made by Rose Ehrenfeld of Raleigh.

After a profitable roundtable luncheon the League session was opened by the vice-president, Virginia McKay. The minutes were followed by the treasurer-secretary's report, read by Gilbert Muse. An account of the Seattle meeting followed. At three o'clock Walter J. Matherly gave an interesting talk on "Community Parasites" followed by a discussion on the relation of a Class A Hospital to a Class A Training School, by Harriett Lesowski.

Discussion followed on: Who shall define policies of Hospital Inspector? What is Sufficient Equipment? What is a Standard Curriculum? At 3:30 P. M. Mrs. T. Adelaide Goodno, state president Woman's Christian Temperance Union, gave an interesting talk followed by addresses by Mrs. C. O. Burton, president Guilford County Parent-Teachers' Association, and Miss Neta Gressett, president Business and Professional Woman's Club.

Tea was served at 5:00 o'clock at St. Leo's Hospital by the Sisters of Charity.

On Tuesday evening, at 8:00 P. M., after a Community Sing and a Reading by Miss Lucy Pratt, Dr. Louis Beall discussed "Training for Mental and Nervous Cases"; Dr. L. B. McBrayer, Sanatorium, N. C., spoke on "The Value of Trained Women for Tuberculosis Work"; and Dr. G. M. Cooper, M.D., Director Medical Inspection of Schools, discussed "Public School Clinics in North Carolina."

After the invocation by the Rev. Clyde Turner on Wednesday morning, Dr. Watt Cole was scheduled for an important address on Orthopedic Surgery. The business session, conducted by Columbia Munds, was followed by Mrs. Hayden's interesting report of the Seattle convention.

The Wednesday luncheon of which Flora Mathews was hostess, to state officers and former presidents, was followed by a Red Cross roundtable directed by Blanche Stafford and an interesting report of progress by Jane Van de Vrede under the enlightening title "Growing Pains."

Subsequently, the private duty session presided over by Alethia Lord covered the following papers:

"Definition of a Class A Training School," Fannie V. Andrews; "Should Psychiatric Nursing Be Part of a Training School Curriculum?" Maye E. Lowe; "How Can Private Duty Nurses Help Public Health Nurses?" Mary R. Batterham; Report of the Private Duty Section from the secretary, Frances M. Ott; "Should Practical Nurses Stand a State Examination"—a discussion led by Athelia Lord.

Tea was served at the Burrus-McCain Hospital.

The evening session, after a hearty community sing, followed by a musical selection, covered the following important topics: "State Responsibility to Her Mental Defectives," Mrs. Clarence A. Johnson, Commissioner State Board of Charities and Public Welfare; "The Nurse's Part in the United States Veterans' Bureau," Katherine De Vine; "Cancer," an illustrated lecture by Dr. J. W. Long.

The reception which followed was held at the Westeley Long Hospital.

The Thursday session, devoted exclusively to public health, was opened by the invocation of the Rev. Wade Smith. The business session discussed the advisability of forming a state association. The formal morning session presided over by Clara Ross covered an address by Anne Doyle, Supervising Nurse, Venereal Disease Division, U. S. P. H. S.; a paper on "The Backward Child and the Public Health Nurse," Columbia Munds, Supv. Nurse, Wilmington, N. C.

Glimpses of the National Convention. American Child Hygiene Association, Rose M. Ehrenfeld, Division P. H. N., State Board of Health.

National Conference of Social Workers, Alice Ward, Wayne County, P. H. Nursing.

National Organization, P. H. Nursing, N. S. Cutchins, New Hanover County, P. H. Nurse.

The afternoon session, over which Rose M. Ehrenfeld presided, included an important address by Helen Wedgewood, associate field director of the American Child Hygiene Association and important demonstrations of public health nursing points by May Stockton, Cabarrus County, P. H. Nurse; Elizabeth Simpson, Rockingham County, Red Cross

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Nurse; Cleo Hobbs, Bureau Medical Inspection, State Board of Health; Pearl Weaver, Henderson County, Red Cross Nurse; Mrs. I. C. Hanna, Supv., Asheville P. H. N. Association; Percy Powers, Supv., Winston-Salem Nursing Association.

From 4:30 until after 6 the following round-tables were in progress: Industrial Nursing, led by Miss Lawes, Chairman Nursing Section Southern Textile Workers; City Staff and School Nursing; Rural Nursing, Rose M. Ehrenfeld, Division P. H., State Board of Health and Katherine Myers, State Red Cross Supervising Nurse.

Pearl Weaver, Hendersonville, was elected president. Other officers chosen were: First vice-president, Lois Toomer, Wilmington; second vice-president, Rose Batterham, Asheville; secretary, Harriet Lesowski, Raleigh; treasurer, Jessie McLean, Greensboro.

Mrs. Dorothy Hayden, of Greensboro, retiring president, and Miss E. A. Kelly, of Fayetteville, were selected to serve on the state examining board.

Subsequently the guests were entertained by the Guilford County Medical Society.

At the evening session Jane Van De Vrede gave a splendid talk on "Sign Posts on the Road of Progress," and Anne Stevens, director of the N. O. P. H. N., gave a summarizing address.

## UNITED STATES PUBLIC HEALTH SERVICE

The assignments, transfers and reinstatements during the month of August have been as follows:

New assignments: Flora Lampre, U. S. Marine Hospital No. 2, Boston, Mass.; Georgianna Selby, U. S. Marine Hospital No. 12, Memphis, Tenn.; Gwen Andrews, U. S. Marine Hospital No. 14, New Orleans, La.; Pearl Jordan, U. S. Marine Hospital No. 14, New Orleans, La.; Hannah Thayer, U. S. Marine Hospital No. 17, Port Townsend, Wash.; Jennie Mayes, U. S. Marine Hospital No. 18, St. Louis, Mo.; Anna B. Davis, U. S. Marine Hospital No. 43, Ellis Island, N. Y.; Nora Spencer, U. S. Marine Hospital No. 82, Norfolk, Va.

Transfers: Marion Lynch, U. S. Marine Hospital No. 18, St. Louis, Mo., to U. S. Marine Hospital No. 2, Boston, Mass.; Nell Copps, U. S. Marine Hospital No. 20, Savannah, Ga., to U. S. Marine Hospital No. 14, New Orleans, La.; Anna O'Brien, U. S. Marine Hospital No. 17, Port Townsend, Wash., to U. S. Marine Hospital No. 19, San Francisco, Calif.; Anna O'Rourke, Roseband Quarantine to U. S. Marine Hospital No. 43, Ellis Island, N. Y.; Nell Ross, Rosebank Quarantine to U. S. Marine Hospital No. 43, Ellis Island, N. Y.

Reinstated: Edna Roberts, U. S. Marine Hospital No. 17, Port Townsend, Wash.; Josephine Vandergon, U. S. Marine Hospital No. 19, San Francisco, Calif.; Lila J. Porter, U. S. Marine Hospital No. 82, Norfolk, Va.

LUCY MINNIGERODE,
SUPERINTENDENT OF NURSES.

## CONFINEMENT SERVICE FOR MINNEAPOLIS

The Minneapolis Visiting Nurses' Association is trying out special confinement service for a circumscribed district. A nurse will be provided for the first 24 hours or longer, if the case requires it. A fee of $5.00 will be charged those who are able to pay it; a smaller charge will be made for those families who cannot meet this cost and some will be cared for free. Upon the success of the work in this district will be based the expansion of the service under the director, Miss Alma Haupt.

## A CIRCUS TO RAISE A SICK FUND

"Right this way, ladies and gentlemen, to see the bearded lady, the fat lady, and Hoto the laughing wonder!"

This was the cry at the circus given by the Nurses' Alumnae Association, of the Delaware Hospital, on the lawn of that institution. All the seven wonders of the circus were done by nurses and student nurses. The affair was for the benefit of the nurses' sick fund. "Hot dogs," which are to be seen at all real circuses were there as well as ice cream and all sorts of other sweets. An orchestra furnished music for the dancers.

The cast of the circus was as follows: Miss Lucile Rolph, the most beautiful lady; Miss Madeline Neese, Hoto, and the director of the show; Miss Mary Hammel, the Sheik; Miss Florence Crowl, Hawaiian dancer; Miss Sadie Donnelly, rough-rider; Misses Margaret Hille, Mildred Abbot, Charlotte Kuhn and Mabel Lewis, Pearl Seebold, dancers.

Madame Zira, otherwise Mrs. Valeria Duffy, kept the fortune-telling booth crowded.

Miss Anna Stuffle, chairman of the committee, acted as master of ceremonies, prettily costumed in breeches, coat and waistcoat.

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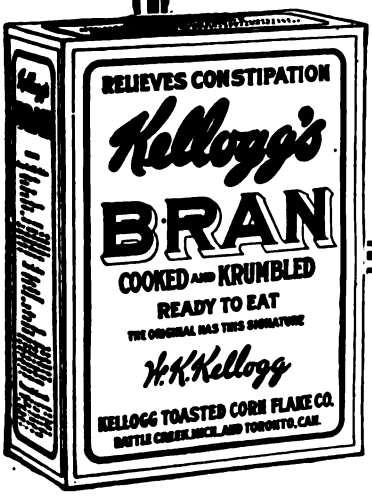
# *Aid your patients with* KELLOGG'S BRAN *It is delicious*




**Nurses find that Kellogg's Bran, cooked and krumbled, is a great help speeding the recovery of patients. In a natural way it sweeps the bowels without irritation. Kellogg's Bran is particularly recommended for chronic, old-age and bed-ridden cases, when it affords great relief.** Patients of this class may eat at least two tablespoonfuls in some form with each meal. For mild constipation, physicians advise two tablespoonfuls each day.

Permanent relief is assured when Kellogg's Bran is used regularly. It can be eaten as a cereal, sprinkled over other cereals or used in many ways in baking and cooking. Recipes are printed on every package.

Do not confuse Kellogg's Bran with common brans. Kellogg's is delicious, its flavor and krumbled crispness being most attractive. Try it yourself and know how good it is and how helpful. It will greatly improve your own health and fit you for trying duties. We call your attention to the recipes printed in this advertisement. Make some bran bread or bran griddle cakes today. All grocers sell Kellogg's Bran.

*Kellogg's*
**BRAN BREAD**

2 cups Kellogg's Bran; 1 cup boiling water; 1 tablespoon shortening; ⅓ cup molasses; 1½ teaspoons salt; 1 compressed yeast cake soaked in ⅓ cup lukewarm water; 4 cups flour. Pour boiling water over bran. Let stand ½ hour. Add melted shortening, molasses, salt, yeast and flour. Beat well and let rise. Turn into buttered bread pans. Let rise again and bake for one hour.

*Kellogg's*
**BRAN GRIDDLE CAKES**

1 cup Kellogg's Bran; 1 cup flour; 1 tablespoon sugar; ½ tablespoon butter substitute; ½ teaspoon salt; 1 teaspoon baking powder; 1 cup milk; 1 egg. Mix dry materials, add egg slightly beaten and milk and butter substitute. Beat thoroughly and bake on a hot griddle. Serve with butter and syrup. This will make 20 cakes.

*Kellogg's* *Look for this signature W.K. Kellogg*

**the original BRAN - *cooked and krumbled***

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Members of the alumnae in charge of the booths were: Misses Rose Heeran, Alice Shute, Irene McDonald, Doris Wilt, Margaret Prendergast, Janet Bailey, Mary Flaherty, Mabel Shute, Eleanor Drogan, Mrs. Arthur Whittier, Miss Katherine Miller and Miss Catherine Shute.

## "COME OUT OF THE KITCHEN"

In addressing public health nurses of Minnesota recently, Mrs. Ruth Haynes Carpenter touched a practical point when she said:

"The work of the nurse, whether she be a visiting nurse, an infant welfare nurse, a school or industrial nurse or a nurse on private duty or in the hospital, has to do with the most basic thing in human society—health, the saving of life. But the mere physical saving of a life is of worth only in terms of citizenship, achievement, richness of living, not only for this individual life but also in its relation to the common welfare.

"Hence, nurses, as well as doctors and musicians, will find a new richness and significance in their work if they will look out over narrow professional boundaries and see what is going on in the world at large. They should take an active interest in politics in its larger and better sense, in the proposed city charter, in books, art, music.

"In making out your program for next year you should include on every program a discussion of some topic not directly related to nursing. And, in doing so, you will discover surprising and valuable relationships between your work and that of others. Your meetings will have a freshness and vitality that cannot be had with 'shop talk' alone."

## SOCIAL ASPECTS OF MENTAL DISEASES

A series of lectures on mental hygiene has been announced by The New School for Social Research, 469 West 23rd Street, N. Y. Sixteen well-known psychiatrists will combine in giving the course, each lecturer dealing with a phase of the subject to which he has given special attention. While the more important mental disease groups will be discussed, emphasis will be laid upon the social aspects of these diseases.

## NURSES' HOME AT SOISSONS

With Miss Anne Morgan as sponsor, the corner stone has been laid for a new nurses' home at Soissons.

## RED CROSS ROLL CALL

The Annual Roll Call for Red Cross membership for 1923, will be held from Armistice Day, November 11, to Thanksgiving, November 30. Between those dates approximately 3,300 active Chapters at home and abroad will carry on a systematic canvass for support of the peace time work of the nation's officially designated volunteer relief society during the ensuing year. As a result of the Roll Call last fall the American Red Cross now has a membership of approximately 4,500,000 adults. About 6,000,000 school children are enrolled in the Junior American Red Cross.

An innovation this year will be the uniform card-indexing of the millions of Red Cross members. The stub of each card, of a size handy for card case or pocketbook, will be given each person enrolling as a certificate of membership.

## SOCIAL ACTIVITIES AT ST. BARNABAS TRAINING SCHOOL

When the large or main class of probationers enters St. Barnabas (usually in September) a lawn party or picnic is given as a reception. Later in the month a dance is given for the whole school in the classroom.

In October a Halloween party is planned—small plays or special programs are worked up for the occasion. A dance follows. The alumni are always invited to this affair and all nurses come masked or in "hard time" costume.

A large Thanksgiving dance is given in November when the nurses invite boys as dancing partners. In December preparations for the Xmas gala affair absorb all interests. For two or three days before December 25, the packages are being collected. On Xmas eve the big tree is lighted and Santa Claus and his brownies distribute the many packages. Songs are sung and a small program is given.

On New Year's Eve a dance is held at the Home or at All Saints' Church. During January a few small dances are held and Miss Dorothy Rhodes, the superintendent of nurses, holds several "at homes."

Two big events for the Seniors are held in February. First is the Senior-Intermediate dance given at the Nurses' Home. This is a formal occasion and usually very well attended by the two classes and their friends. Then comes the big formal dance given by the alumnae for the Seniors either at Nurses' Home or at Curtis' Hotel.

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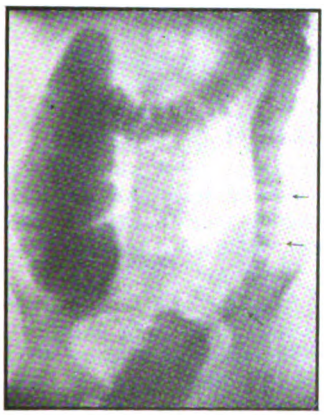
*Dangers of Constipation No. 2—*

# Dilatation *and* Spasticity



*Diseased Colon, darkest portion shows dilatation; arrows indicate spastic condition.*

A COMMON form of intestinal constipation is dilatation and spasticity of the colon.

A prominent medical authority states that laxatives of all sorts increase the spasticity of the intestine. Whereas, liquid petrolatum lubricates and protects the sensitive surface of the spastic bowel, at the same time softening the intestinal contents so as to permit passage through the bowel without mechanical irritation.

Nurses can administer Nujol with every confidence in its suitability to all forms of constipation. The action of Nujol closely resembles that of the natural lubricating mucus secreted in the bowel, which is deficient when constipation exists. Nujol takes its place, lubricates the bowel contents and so assists their expulsion from the body. As Nujol is not a laxative it cannot gripe. And like pure water it is harmless and pleasant. Nujol is prescribed by physicians and is used in leading hospitals throughout the world.

Send for nurse's sample and special 16-page booklet, "On a Case", to Nujol Laboratories, Standard Oil Co. (New Jersey), Room 760 44 Beaver Street, New York.

*For Constipation*

# Nujol

REG. U.S. PAT. OFF.

*A Lubricant; not a Laxative*

*Normal Colon, made distinct by means of barium meal*



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In March everything is usually quiet until after Lent. Then the picnic breakfasts and suppers are introduced and last through the summer and into the autumn.

In May or the first of June Miss Hartry gives a picnic at her cottage, "Just a Mere Lane," for the Senior class. This means eating and games in a delightfully informal atmosphere. The alumnae banquet for the graduating class is given at Donaldson's tea rooms. Music and speeches fill a full evening. At the end of all these festivities comes the graduation exercises and then the nurses settle down to a few informal parties during the summer months until a new class is ushered in.

## WEST VIRGINIA NURSES MEET

The Sixteenth Annual Meeting of the West Virginia State Nurses' Association, held at Wheeling, August 31 and September 1, was called to order by the president, Mrs. Susan Cook. After the invocation by Rev. J. J. Brittingham and the address of welcome by Mayor Thomas J. Thoner, Miss Margaret Peterson responded for the visiting nurses. Mrs. Cook's able presidential address was followed by the secretary and treasurer's report made by Mrs. R. J. Bullard; a report of the State Board of Nurse Examiners by the secretary, Miss Jessie A. Clark, principal of the Ohio Valley General Hospital; a report of Distric No. 1, by Miss W. Louise Kochert; a report of District No. 2, by Miss Anne McGee; and a splendid account of the Seattle convention by Mrs. Cook.

The afternoon session for superintendents was opened at 2 P. M. by the chairman, Miss Margaret J. Leathem, superintendent of Cook Hospital, Fairmont. During the afternoon the following speakers were scheduled: Dr. Harry M. Hall; Sister M. Euphrasia, Supt. Nurses, St. Joseph's Hospital, Parkersburg, on "Moral Character of the Nurse"; Mary M. Hudson, Supt. Nurses, King's Daughters Hospital, Martinsburg, on "The Appearance of a Nurse," read by the president; Miss A. M. Giffen, R. N., Supt. Nurses, Hoffman Hospital, Keyser; Harriet Linn, Supt. Nurses, Davis Memorial Hospital, Elkins, on "Hospitals and Alumnae"; Maggie M. Davis, Supt. Nurses, Mason Hospital, Clarksburg, "The Outlook for the Future in the Field of Nursing"; Anna M. O'Neill, Chief Nurse, Operating Room, Ohio Valley General Hospital, Wheeling, on "The Operating Room and the Nursing Material Needed for It"; Nell Robinson, Supt. Nurses, Forman Hospital, Buckhannon, on "Efficiency in the Small Hospital."

The Friday morning session, devoted to public health, was opened by the invocation of Rev. Father Weber, of St. Joseph's Cathedral. The following speakers were scheduled: Anna Strong, of the U. S. Public Health Service, Washington, D. C., spoke on "Venereal Diseases"; Mrs. Jean T. Dillon, R. N., Director, Division of Child Hygiene and Public Health Nursing, gave a "Report on Public Health Nursing from the Biennial Convention"; Permalia Shields, Bureau of Venereal Diseases, State Department of Health, Charleston, talked on "Social Hygiene"; L. N. Harris, M. D., spoke on "Some Aspects of Venereal Control"; John W. Gilmore, M. D., on "Tuberculosis"; Hazel Wedgewood, of Washington, D. C., connected with Child Hygiene Work, gave an interesting account of the field and Sue Imhoff, Industrial Nurse, Beech Bottom Branch, Whitaker-Glessner Steel Plant, spoke on "First Aid."

Reports from the private duty sections of both districts were given by Margaret Peterson and Ethel Giammini. The following interesting papers were read:

"What It Means to Be a Nurse," Mrs. Imogene Weaver Davis, Bluefield; "The Nurse on Active Duty," Nelle R. Cleary, Parkersburg; "The Alumnae," Margaret Peterson, Weston; "Private Duty in Homes," Margaret Schwinn, Wheeling, "The Yesterday, Today and Tomorrow of Private Duty," Helen M. Fair, Clarksburg.

Huntington was chosen as the convention city for 1923. Mrs. Susan Cook was re-elected president. Other officers elected include: First Vice President—Mrs. Maggie Clarksburg. Second Vice President—Miss Lulu McMahon, Wheeling. Secretary-Treasurer—Mrs. R. J. Bullard, Wheeling (re-elected). Directors—Miss Margaret Peterson, Weston; Miss W. L. Kochert, Wheeling; Miss Nellie Robinson, Buckhannon. All directors were re-elected.

## BROADCASTING PREVENTION

The Boston Dispensary Clinic is broadcasting an attractive folder in a popular fashion. Under the title "The Four Hundred," the folder emphasizes the necessity for periodic physical examinations, the doctor's effort to keep people well, the diagnostic function of the clinic, the visiting hours, etc. The comic line drawings add charm to the deckle-edged paper used for the leaflet.

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# Dioxogen

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## Antiseptic Efficiency Without the "Unknown Quantity"

Never was the necessity for prompt and effective antisepsis in the care of emergency or infected wounds, so widely and thoroughly recognized as it is today. As a logical consequence, never was there a time when the value of Dioxogen as an all round antiseptic was more evident.

This is easy to understand on the part of the many medical men who stop to realize that the germicidal efficiency and tissue healing properties of Dioxogen are due entirely to the **pure, active oxygen** it is able to carry directly to the wound or place required. Naturally they have come to prefer Dioxogen to those poisonous and essentially irritating germicides like iodine, carbolic, bichlorides and so on, the toxic dangers and possible injurious effects from which are always an "unknown quantity."

The use of Dioxogen in cleansing infected wounds and injuries assures maximum antiseptic efficiency with gratifying freedom from the "unknown quantity" of toxicity and tissue irritation.

FOR FIRST AID TREATMENT OF WOUNDS—Two tablespoonfuls to four or five of warm water makes a suitable solution for general use.

**THE OAKLAND CHEMICAL CO.**
**59 FOURTH AVENUE, NEW YORK CITY**




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## HOSPITAL CONSTRUCTION

A gift of $600,000 in cash and a tract of land worth $100,000 have been given to the Reading Hospital by Ferdinand Thun, Henry K. Jansen and Gustav Overleander, the latter the new vice president of the National Association of Hosiery and Underwear Manufacturers. The hospital management will have the services of Dr. S. S. Goldwater, of New York, an expert in the laying out of such institutions.

The acquisition of property at 109-111 Wood Street, valued at $200,000 by the Homeopathic Hospital, Pittsburgh, Pa.; and the purchase for $42,000 of additional land adjoining that in Center Avenue, where the hospital is located, mark the resumption of the $1,000,000 building program of the board of trustees.

Architect George E. Lowe has just completed the plans for the large addition to the Kingston City Hospital and has had the plans approved by the State Board of Charities. The completed plans call for an addition of two new sun parlors and two new isolation wards on the first floor, which will add greatly to the comfort of the patients and the effectiveness of the hospital equipment. Over both present men's and women's wards on the first floor will be constructed new fireproof wings supported upon a skeleton structure steel frame which will be entirely independent of the present structure. This two story addition will contain four two-bed wards and fourteen private rooms with all the mechanical equipment necessary for a highly up-to-date hospital. On the front, over the two new sun parlors, will be constructed new balconies which will be accessible from the rooms adjacent by means of French doors. These new wings are also to be entirely separate from the old building.

Rex Hospital, Raleigh, North Carolina, is now constructing a new children's ward and operating room, made possible by the generous gift of W. H. Williamson. The children's ward will be provided with a separate entrance, having a terraced porch in front which will open on the lawn, separated by the cement walk from the main hospital grounds. It will contain private rooms and a public ward accommodating in all about twenty beds. There will also be a detention room for preliminary examination of all patients admitted; also a rest room for mothers and a diet kitchen where especially prepared food can be made under the charge of trained dietitians. The sun porch will be provided with windows which can be closed in winter and opened in the summer, so that the children may be comfortable in all seasons. In front there will be flowers and shrubbery and a fountain.

The Uniontown (Pa.) Hospital has just been given between two and three hundred thousand dollars for the building of a nurses' home. Some years ago the hospital was presented with a big lot near the Shenango Valley Hospital for a nurses' home.

The Sacred Heart Hospital, Allentown, Pa., is planning to begin building the new nurses' college, which will adjoin the hospital at the southwest corner. Owing to the greatly increased number of probation nurses enrolled at the hospital since the last graduating exercises, it has become immediately imperative that building activities begin as soon as possible in order to provide adequate facilities.

St. Joseph's Hospital, Paterson, N. J., is planning to begin the construction of a $200,000 nurses' home, which will be known as the "Sister Mary Clare Memorial Hall." The plans of the architect, William T. Fanning, have already been approved by Mother Alexandrine.

A beautiful $40,000 nurses' home will be erected in the near future by Mrs. K. G. Roebling, of Spring Lake, for the nurses of the Ann May Memorial Hospital. The nurses at the institution have needed just such a home for a long time and through the generosity of Mrs. Roebling their needs will be remedied. The building will contain 40 sleeping rooms as well as a large living room in which the nurses may hold informal parties.

Plans for enlarging the Nurses' Home of the Springfield Hospital, Springfield, Mass., are now under consideration. About $100,000 will be appropriated for the work. Edward F. Stevens is preparing the plans.

Miss Marie Robertson, superintendent of the Jamestown General Hospital, Jamestown, N. Y., has been authorized to proceed with improvements at the contagious hospital. The upper floor is to be remodelled to provide more room for nurses' quarters. This floor is not in use at the present time and the repairs will cost in the neighborhood of $500.

Contract has been let for the construction of a new municipal hospital group near Lake

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# No Growth Without Vitamines

The Bio-Chemical Laboratory of the University of Cambridge recently conducted an exhaustive investigation to determine whether the vitamines known to be present in the raw materials from which VIROL is manufactured were present in their active state in the manufactured VIROL as sold to the public. This report, which fully proves the presence of the vitamines in VIROL, will be sent to any medical man on application.

## Advantages of VIROL

It contains the vitamines.

It is a well balanced food.

It is easily absorbed in the most delicate conditions.

VIROL exercises a remarkable influence on growth and development. It is a food of great value for expectant and nursing mothers, in anæmia, malnutrition, and all wasting conditions.

# VIROL

*Sole Agents for United States*

**Geo. C. Cook & Co., Inc., 59 Bank Street, New York**




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Montebello, Maryland. About $658,600 will be spent upon the work. The bids include the installation of electric call systems for nurses and physicians. The Price Construction Company will handle the work.

The Protestant Hospital, Columbus, Ohio, plans to erect a 150-bed addition which will cost $300,000.

The Middletown Hospital, Middletown, Ohio, is about ready to build a $135,000 addition.

The Lake Forest (Illinois) Hospital has received $100,000 for permanent construction. This legacy was provided for in the will of Delavan Smith, in honor of his mother.

Trustees of the Deaconess Hospital, Green Bay, Wisconsin, have engaged Oppenhamer and Abel to draw plans and specifications of the new nurses' home.

Trustees of the Geneva City Hospital, Geneva, Oregon, are planning an annex to the nurses' home which will accommodate forty-five students with the superintendent and assistant superintendent.

Broad Street Hospital, New York, has leased the five-story building at 8 State Street which, after alteration, will be used as a nurses' home.

The King County Association of Graduation Nurses plans to erect a clubhouse at Seattle, Wash. Bonds for $200,000 will be floated to cover the expense.

## PITTSBURGH RED CROSS REUNION

The Pittsburgh chapter of the American Red Cross with a membership of 581 overseas nurses held a reunion picnic at Kennywood Park in the latter part of August. Athletics, a first-aid contest, dancing, a band concert and patriotic demonstrations filled an afternoon with enthusiasm. The first-aid contest was under the direction of Major J. M. Shields, national field representative. The reunion committee was composed of Dr. C. H. Garwood, chairman; Mrs. Daniel Beech, Mr. McSwigan and Augustus K. Oliver.

A memorial service in honor of Jane A. Delano was held in the Presbyterian Church, Massillon, Ohio, on July 26. The Rev. R. H. Kirk, pastor of the church, delivered the principal address and nurses from Massillon, Akron, Canton, Alliance and Ravenna were present.

## SOUTH DAKOTA NURSES MEET

Despite railroad conditions the South Dakota State Nurses' Association Convention held at Rapid City, August 23-25, was well attended. A very interesting program was carried out. Unfortunately, Minnie Ahrens of Chicago was unable to attend. The reports from the Seattle Convention were especially interesting. Ellen McArdle was elected president. Carrie E. Clift, of Rapid City, was reelected corresponding secretary and Mabel Wood was named recording secretary. Miles Hickok, of Chamberlain, was reelected treasurer.

## TWENTY-FIVE YEARS OF SERVICE

In this age when employees come and go in a constant procession, it is a noteworthy institution in which a domestic worker has spent twenty-five years of continuous service. The Rochester General Hospital reports the retirement of a faithful aide after this period of continuous service. A party, attended by 77 employees and a gift, marked the departure of this careful worker.

## COLORED NURSES MEET

On July 12 and 13 the Louisiana trained registered nurses of the negro race held an annual conference at the Flint-Goodrich Hospital. About fifty delegates attended. The following officers have been elected for the coming year: Louise J. Ross, president; B. C. Burhell, vice-president; Helen Payne, secretary; Sarah A. Hall, treasurer; S. A. Carter, chairman of the finance committee.

## MARRIAGES

Minnie Benson, a graduate of the Portland Sanitarium, and private duty nurse in Aberdeen and Hoquiam for the past eleven years, to Clarence Tryon, Tacoma, on July 22.

Josephine Adelia Parker, a graduate of the Children's Hospital, San Francisco, to John W. McLetchie of Melrose, Mass., on August 19. Miss Parker has been connected with the operating room of the Methodist Episcopal Hospital, Brooklyn, N. Y.

Ella B. Ward, a graduate of the Burbank Memorial Hospital Training School, Fitchburg, and for the past thirteen years industrial nurse with S. Slater & Son, Inc., has resigned to marry Edward Brown, Worcester, Mass. Mrs. Daisy Armstrong, who has been Miss Ward's assistant, will continue her work.

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# *Standard Equipment*

**The six sizes—new-born infant, two months, four months, one year, four years, and adult—meet every teaching requirement. Their dimensions are standard in each case. They are made of stockinet and cotton batting, waterproofed with high-grade, flexible paint. The two largest sizes may be purchased with internal reservoirs for demonstration and practice of various methods of douching, catheterization and internal irrigations.**

*The* CHASE HOSPITAL DOLL and *The* CHASE HOSPITAL BABY are demonstration manikins—substitutes for the living subject in teaching the proper care of children, the sick and injured. They are the result of thirty years of experience and experiment.

Teaching can best be accomplished through standardized equipment. That is why *The* CHASE HOSPITAL DOLL and *The* CHASE HOSPITAL BABY have been in daily use for years all over the world by the leading Hospitals, Nurses' Training Schools, Home Nursing Classes, Baby Clinics, Mothers' Classes, and by Visiting Nurses and Baby-Welfare Workers.

They are made of the best materials obtainable for the purpose. They are unusually durable, withstanding years of hard usage. And whenever necessary they can be repaired and refinished so as to be as good as new. *The* CHASE HOSPITAL DOLL and *The* CHASE HOSPITAL BABY permit of great flexibility and wide latitude both in the demonstration and practice of medical, surgical, and hygienal principles.

Every well-equipped organization engaged in these works finds it necessary to install one or more of our models, as Standard Equipment, in order to accomplish the best results.

We shall be pleased to send you our latest catalogue.

## *The* CHASE HOSPITAL BABY

**M. J. Chase**

**24 PARK PLACE**
**PAWTUCKET, R. I.**



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Rosemary Schwan, a graduate of Hahnemann Hospital, Philadelphia, to Fred Fertig of Helfenstein, on July 31. Both Mr. and Mrs. Fertig were formerly residents of Lancaster, Pa.

Marie Frey, a graduate of the Reading Hospital, to George Knoll of Fleetwood, Pennsylvania, on July 21.

Sara Alberta Nunn of Dundas, Ontario, a graduate of the Crouse Irving Hospital (1917) to Henry E. Dodd of Syracuse, New York, on July 25. Mr. Dodd is supervisor of schools in the twelfth district, Syracuse, New York.

Esther Austin, formerly of Ogdensburg, New York, to John Andrews, of Massena, on July 31. Mrs. Andrews is a graduate of the Hepburn Hospital. Mr. Andrews is a graduate of Colgate University.

## MISS PAI TAKES POSTGRADUATE WORK

After five years of professional service in Peking, China, Hsiu Lan Pai, has returned to the United States to take special work in anesthesia at Johns Hopkins Hospital. Miss Pai first came to the United States in 1911. She completed her training at Presbyterian Hospital, New York and then took special work at Henry Street Settlement before returning to the Rockefeller Institute.

## PERSONALS

Miss Ethel A. Ackerman, graduate nurse of Northwestern Hospital, Minneapolis, Minnesota, has been appointed full time instructress of the Mansfield General Hospital, Mansfield, Ohio.

Miss Ingleborg Anderson, a graduate of the Moore Hospital, Brockton, Mass., has been made night supervisor there.

Sarah H. Barber, assistant lecturer on Speech Correction and Development in Northwestern University, last summer gave a summer course in the University of Utah, Salt Lake City, Utah, June 7-July 19, 1922.

Mrs. Sarah Colgan, night supervisor at the Backus Hospital, Norwich, Connecticut, has resigned. She is succeeded by Miss Kathleen Riley.

Miss Anna K. Essig, superintendent, and Miss Villa Harpsman, assistant superintendent, have resigned from the Coatesville Hospital, Coatesville, Pa.

Mrs. Erma M. Hoshall has been appointed assistant director of the Bureau of Nurses, Health Department, Baltimore, Maryland, to succeed Mrs. Serena S. Bridges, resigned.

Miss Ella Kirk, Miss Rosaline Canning and Miss Alfreda Brown, graduates of the McKinley Hospital, Trenton, N. J., were given a reception at the nurses' home, August 25.

Miss Florence Potts has resigned her position as superintendent of the Hospital for Sick Children, Toronto. Miss Potts had been associated with the hospital for nineteen years, first as night supervisor, then as assistant superintendent and for several years as superintendent of the hospital and training school.

Miss E. Priscilla Reid has been appointed as director of the Utica Central School of Nursing. Miss Reid is a graduate of the Nurses' Training School of the Fort Wayne General Hospital with post graduate training at Teachers' College. Miss Reid has had nine years' versatile experience as instructor and director of nursing schools in Rochester.

Jessie M. Robinson has been appointed public health nurse with the New Hartford Board of Health, Oneida County, New York. The nursing program is under the direction of the county secretary, Mrs. Harriet Churchill, of Utica.

Miss Schauber, assistant superintendent at the Victory Memorial Hospital, Waukegan, Illinois, has resigned to accept an executive position at the County Hospital, from which Miss Paradise recently resigned.

Miss Mary A. Shellabarger, a former Red Cross nurse, who has been stationed in Montenegro and Albania, has taken up her residence on her ranch in Colorado. Before accepting the assignment for service abroad Miss Shellabarger had staked out her claim of 320 acres of arable land with good water rights.

Cora Louise Sherwood, a graduate of the Lawrence General Hospital (1919), with postgraduate work at Simmons College, has taken up work as public health nurse at Gray, Maine. She will serve New Gloucester, Gray and North Yarmouth.

Margaret A. West has been appointed superintendent of the General Stephen H. Gale Hospital, Haverhill, Massachusetts.

Nina Wooten, superintendent of the Woman's Hospital, Nashville, Tennessee, has resigned to take a much needed rest at Ashville. She will be succeeded by Dr. Anna E. Bowie.

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# GUDE'S PEPTO-MANGAN

(*Liquid—Tablet Form*)

**furnishes the absorbable organically combined iron**

that encourages the construction of red cells.
The red cells include the Hemoglobin—
The hemoglobin supplies the Hematin—
The hematin combines with the iron—
The iron carries the oxygen—
The oxygen stimulates the waste and repair
that constitutes life and living.

It is thus of unquestioned value in ANEMIC, CHLOROTIC and DEVITALIZED CONDITIONS.

*Literature, samples and further information from*

**M. J. BREITENBACH CO.**

**53 Warren Street New York City**

Our Bacteriological Wall Chart or our Differential Diagnosis Chart will be sent to any Physician upon request.

# When the patient needs more water

as is often the case in febrile conditions, impaired liver and kidney function and especially in constipation, it is often difficult for the nurse to accomplish such an important and often vitally necessary result.

# Horsford's Acid Phosphate

a teaspoonful to a glass of water with sugar added to taste, supplies a refreshing and mildly tonic acid drink that will be relished and retained even when the stomach rebels against water given alone.

HORSFORD'S ACID PHOSPHATE is invaluable in fevers, during convalescence, after operation, to relieve diabetic thirst, and as a mild general tonic.

**Send for Sample if desired**

RUMFORD CHEMICAL WORKS, PROVIDENCE, R. I.

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# Nature Improved Upon

MILK is the great natural food. But it has its shortcomings for sick, convalescent or infant feeding. These have been obviated and overcome by DRYCO.

**DRYCO** is dried milk, from which the water has been extracted by the rapid process—2 seconds at 212°F. The protein is changed into colloidal form, preventing large tough curd formation. The fat emulsion is changed to a free fatty acid easily digestible. It is bacteria free.

A glass ⅔ full of DRYCO mixed with hot water has double the milk solids of ordinary milk! It can be made into thin gruel, thick paste, added to soup, bouillon, etc.

DRYCO is palatable, easily prepared, entirely digested. Hence DRYCO is the ideal feeding for acutely ill patients, during convalescence and cachexia and in infants.

The nurse who uses DRYCO solves the feeding problem.

***Send for literature, directions how to prepare, etc.***

**THE DRY MILK COMPANY**

**20 PARK ROW, NEW YORK CITY, N. Y.**

***"An International Institution for the Study and Production of Pure Milk Products"***

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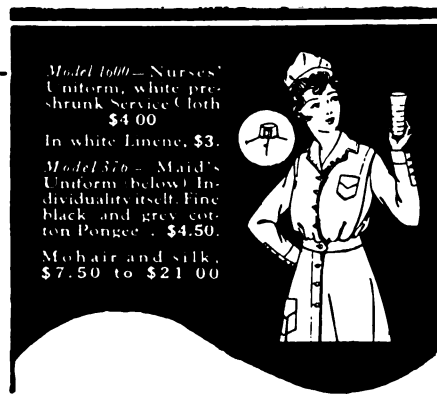


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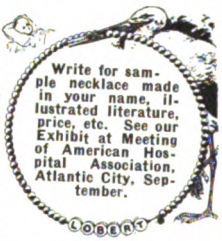


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The rate for advertisements for hospitals, training schools, health boards, etc., is five cents per word, with a minimum charge of $3.00. To nurses advertising for positions, the charge will be $2.00 for fifty words or less. No display. Addresses are included in the count.

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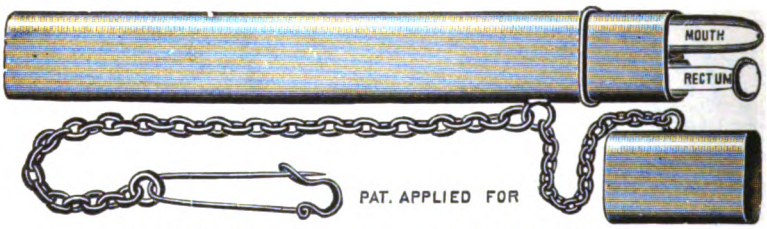


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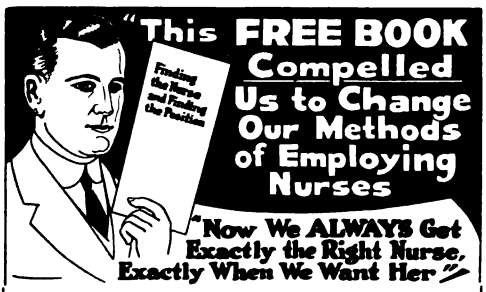


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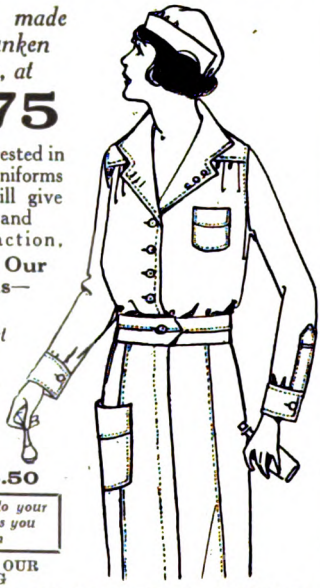

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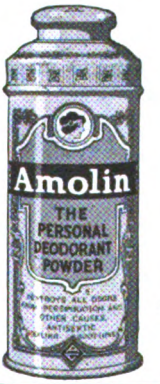


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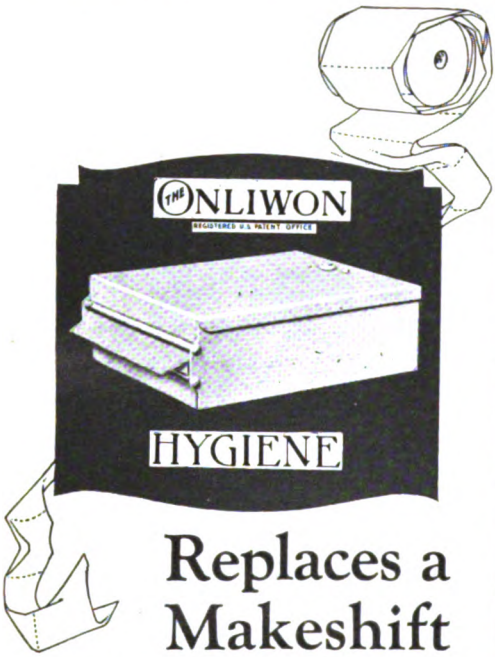


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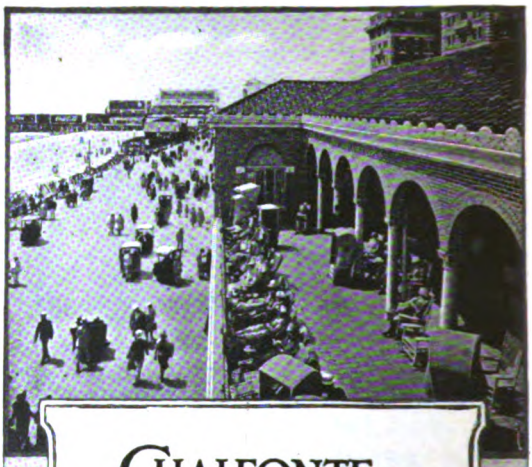

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Vol. LXIX NOVEMBER No. 5

# The Trained Nurse and Hospital Review

Managing Editor, META PENNOCK
Editor, CHARLOTTE A. AIKENS

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**STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912,**

of The Trained Nurse and Hospital Review, Published monthly at New York, N. Y., for October 1, 1922.

State of New York }
County of New York } ss.:

Before me, a Notary Public in and for the State and county aforesaid, personally appeared J. K. Erbeck, who, having been duly sworn according to law, deposes and says that he is the Business Manager of The Trained Nurse and Hospital Review and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management, etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 443, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business manager, are:

Publisher, Lakeside Publishing Co., 342 Madison Ave., N. Y.
Editor, Charlotte A. Aikens, 342 Madison Ave., N. Y.
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2. That the owners are. (Give names and addresses of individual owners, or, if a corporation, give its name and the names and addresses of stockholders owning or holding 1 per cent. or more of the total amount of stock.)

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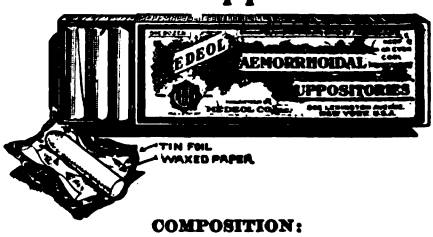


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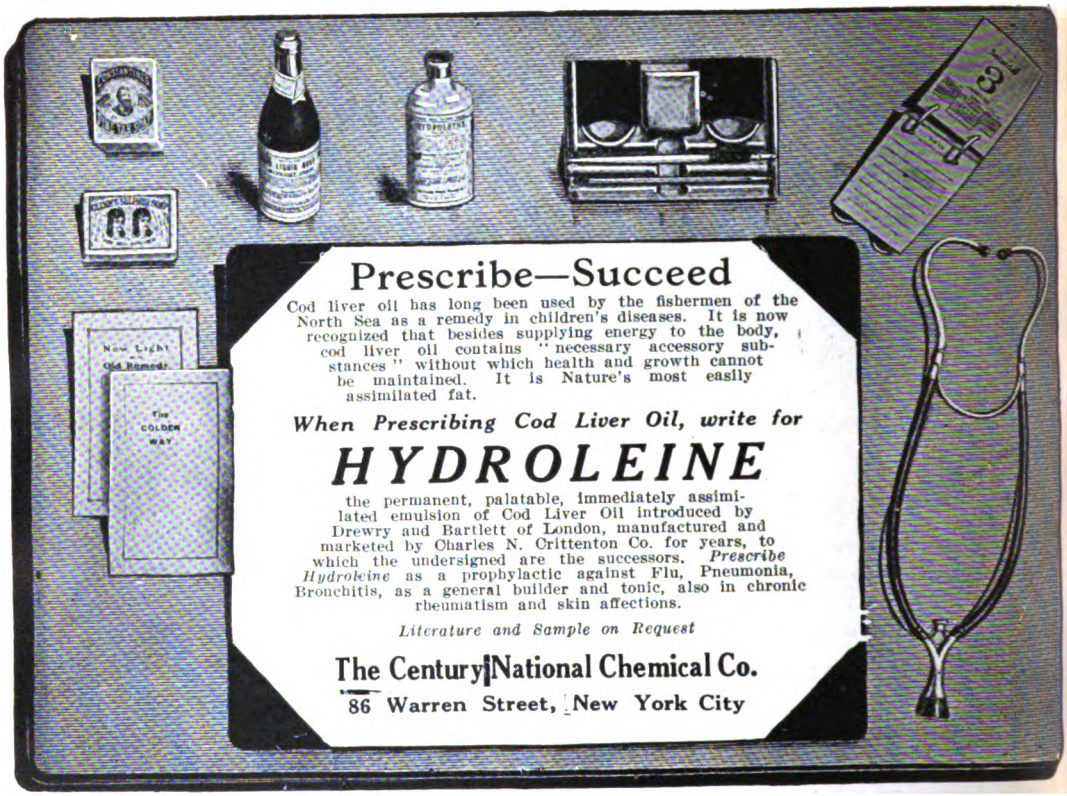


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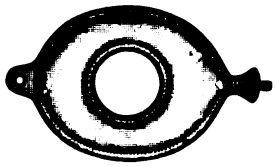

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# The Trained Nurse and Hospital Review

ESTABLISHED 1888

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# REFINING THE PERSONNEL*

## A HOSPITAL WELFARE PROBLEM

MAUDE LUCILE HOWELL, R. N.

Superintendent Milwaukee Children's Hospital, Milwaukee, Wisconsin

MUCH has been said about refining the hotel business and other lines of work. Very little is being admitted, however, in the hospital field, although many of us realize that the hospital personnel needs, at least, a checking up.

We must consider the welfare of the girls we bring into our institutions. The average American girl has ideals. She is good potential material. She may be inarticulate, but she is plastic, imitative and desires to be useful. After she becomes a part of the hospital personnel, what is the hospital doing for her as an individual? Are we helping to mold the Sairey Gamp or the Florence Nightingale type of young woman? If we have with us the selfish, thoughtless, unprincipled hospital worker, how are we trying to convert her into a higher minded, more self-sacrificing, devoted individual?

In attempting to discover the chief problems that are confronting those of us who are responsible for the conduct of our hospital employees, we are impressed with the fact that everybody seems willing to admit that the whole situation must be solved by the hospital executives; no outside body has the will to solve them for us. The hospital atmosphere is created by the board of directors, the superintendent, doctors, nurses, dietitians and social service workers.

### THE PROBLEM

To inculcate the ideals of service, honor, integrity and self-disinterestedness in the hospital employees is at once a privilege, a duty and a problem. In its solution we are confronted with the lack of understanding of the hospital social problem. The training school to a greater or lesser extent takes care of the problem for the student nurses through its class organizations, its Y. W. C. A. and its other activities. In additon, the superintendent of nurses keeps a watchful eye over the social life of the student nurses. (That is, some superintendents do, some do not. If the nurse attends morning prayers or chapel service, the duty of the superintendent seems to cease.) In most cases much is being done for the well-being, and happiness of the nurses by surrounding them with all the home comforts, and by providing them with means for recreation.

But who looks after the general help-

* Paper prepared for the meeting of the Protestant Hospital Association, Atlantic City, N. J., September 23-25, 1922.

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ers, the floor maids, the laundry and kitchen workers, when they are not about their duties in the hospital? Let us rid ourselves of the goary old traditions which have too long carried us along, and let us bring a new spirit of helpfulness into our entire organization. Let us have a social director who supervises the social activities of all hospital workers, and let us provide attractive, comfortable living places for all those engaged in hospital work. This director need not be a paid worker. She must be a person interested in girls and able to coordinate their activities and direct their entertainments.

As yet, however, we are touching exteriors. The creation of high ideals in the hospital personnel and the fixing of firm standards of service and conduct are educational and psychological problems. How are they to be met? First, in order that there may be no question in our minds, we must state in definite terms just what we aim to accomplish.

Second, we must choose our personnel with these standards in mind.

Third, we must learn to use all accepted educational and psychologcal methods in "putting across" our ideals.

### Teaching by Example

The particular information which we have to impart to our employees is not merely a bundle of facts which they can acquire from lectures or from books. It cannot be merely learning what should be done; it must be acquiring the habit of doing, the habit of thinking and reacting in a certain way under certain conditions. If we are to accomplish this, the deeds of others will be a much more effective means of instruction than mere words. Laxness on the part of some—whether they be persons in authority or maids from the kitchen—will permit the entrance of undesirable habits.

It is an admitted fact that in the last few years a certain carelessness in many matters has grown up among women and girls in America. Throughout the centuries when man had the upper hand, he reserved for himself the privilege of gaining wealth, of training his mind, of making laws and also of breaking them. Now that women have attained for themselves the privileges in professional, political and business lines, some of them seem to feel that they must accept also the questionable privileges of neglecting standards of conduct.

### The Question of Smoking

If we have in our hospitals persons who are careless in speech, thoughtless or cruel in their treatment of patients, too free or easy in their manners, keep late hours, who smoke or who are cynical or indifferent to the things that are worth while, their influence is going to oppose the atmosphere which we wish to create. To speak concretely. There is much division of opinion concerning the propriety of smoking by women. It seems to me that in an institution where physical endurance, steadiness of nerve and quickness of reaction are essential qualifications, any habit which tends to lower the physical standard of an individual is a menace to the interests of the individual and to the institution.

If we can employ in our institutions persons with a clean, healthy attitude toward life, persons who possess a certain natural refinement of character, we will be able to man our hospitals with the men and women after whom our students and workers may pattern.

My plea, then, is for the maintenance of a high degree of good, old-fashioned respectability in our hospitals, for the creation of a standard of conduct and a spirit of service in the staff, the nurses, the office, and all employees which will make our hospitals true refining places.

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# THE NURSE AND HEALTH DIAGNOSIS

## HER ROLE IN NUTRITION WORK

WILLIAM R. P. EMERSON, M.D.

Professor of Pediatrics, Tufts College Medical School, Boston, Mass.

THE nursing situation is undergoing an epochal change. The position attained by the splendidly trained bedside nurse can never be assailed and the group which she forms is a unit of incalculable value in health work. But the bedside nurse is like a good soldier whose business it is to carry out the instructions given her. She obeys and reports, and there responsibility ends. Progress in preventive medicine, however, is developing a new type of nurse—a woman who is primarily a health diagnostican, ready to initiate action.

Let us digress, for a moment, to analyze this situation. The physician is trained in the diagnosis of *disease*. When a patient appears the assumption is that he is sick and the task in hand for the doctor is to find the disease and, if possible, its remedy. If, however, the child patient is not "sick" in the usual sense of the term, the physician finds it difficult to stop and give a physical-growth examination to the child who is not in evident need of immediate care. He rebels at the question: "Is this child physically fit?" He has not been trained to give an answer to it. Alike in medical school, hospital, clinic and his own practice his attention has been centered upon disease and its mastery, and not upon the subject of normal growth and normal, natural development.

*Dr. Emerson needs no introduction to nurses. They have eagerly watched the scope and success of his work as chairman of the committee for Nutritional Clinics for Delicate Children—a committee composed of such specialists as Dr. L. Emmett Holt, Professor Irving Fisher, Dr. E. V. McCollum, Professor Graham Lusk, Dr. Lafayette B. Mendel and Miss Mabel Skilton, nutrition worker. This close delineation of the rôle of the nurse in nutritional work will be followed by Miss Skilton's article on the conduct of a class clinic.*

The army not only asks concerning the men who are to fill its ranks—"Has this man any disease?" but also, "Is he physically fit for service?" The examiner must weigh and measure each candidate, compare him with the best standards of fitness and development, and make a complete physical examination before he can be accepted.

The insurance company is interested in disease but it is concerned as well with all the items of record which indicate whether a man is or is not a good risk. There must be a record of family history and a history of the individual's health.

The physician is finding that he needs to learn to detect danger signs of unfitness, such as the beginnings of naso-pharyngeal obstruction and spinal curvature, early indications of ptosis, the poor nutrition that precedes tuberculosis, retardation in growth, etc.

These same standards required by the army and the insurance companies for the adult are being recognized as the best standards for preventing disease among children. They are difficult of attainment in adult life but during the growing period they can be attained in practically every instance.

For the detection of conditions stand-

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ing in the way of normal growth a new type of nurse is necessary. She must be trained to discover these early deviations, the causes of which are often not medical but rather social in their origin.

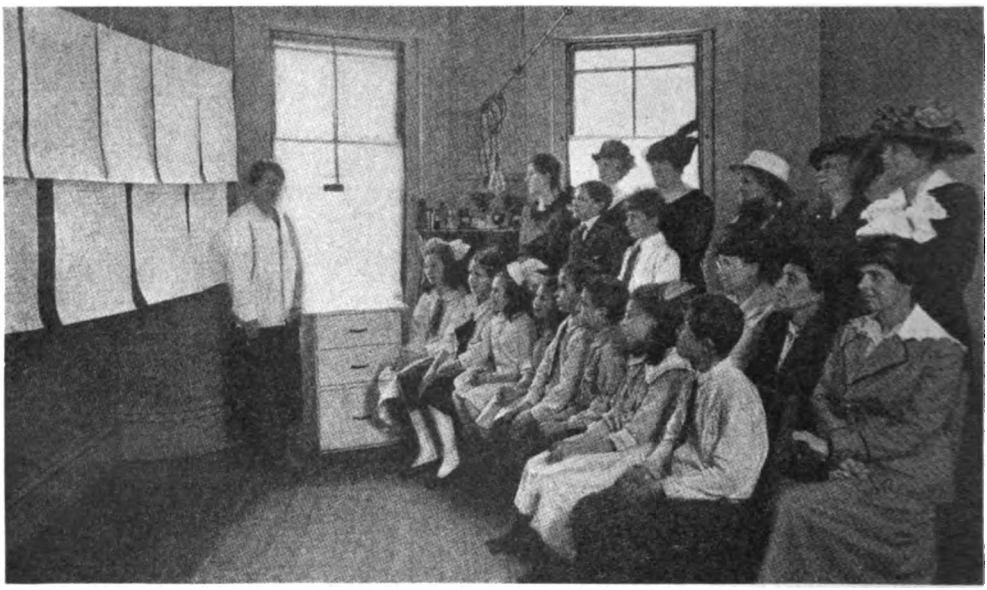
The principle so long established in the care of infants has been found to apply equally well throughout the entire period of growth—i. e., failure to make growth is one of the first and most significant signs of an impaired condition.

As we mentioned before, this new type of nurse is primarily a health diagnostician. For the accomplishment of this work she needs in addition to her general training special, definite instruction and teaching. In making a health diagnosis the following steps are necessary:

*First,* the child should be weighed and measured to see if his weight is in proper proportion to his height. Any failure to come up to average relationship between weight and height calls for investigation and explanation.

*Second,* an adequate family and individual health history should be made a matter of careful, detailed record.

*Third,* a complete physical-growth examination must be made. The items in this record apart from those which are concerned with the vital organs can be made by a well trained nurse. Among these are such matters as pediculi, carious teeth, defects of the eyes and hearing, mouth breathing, spinal curvature, round shoulders, pronated feet and fatigue posture.



*(Courtesy Nutrition Health Clinics for Delicate Children)*

A nutrition class composed of children of Irish, Hebrew, Portuguese-negro stock and their mothers

*Fourth,* a complete social examination should be made.

*Fifth,* there should be a careful investigation of the child's food and health habits.*

In time we shall come to consider that every child has a right to a complete physical-growth examination at least once a year. In this way the beginnings of the falling away from health can be detected and a positive program inau-

* A full discussion of the method of taking the health history and of making the social and other examinations will be found in "Nutrition and Growth of Children," by Dr. William R. P. Emerson, chapters II, III, IV, V, VI (Appleton, 1921).

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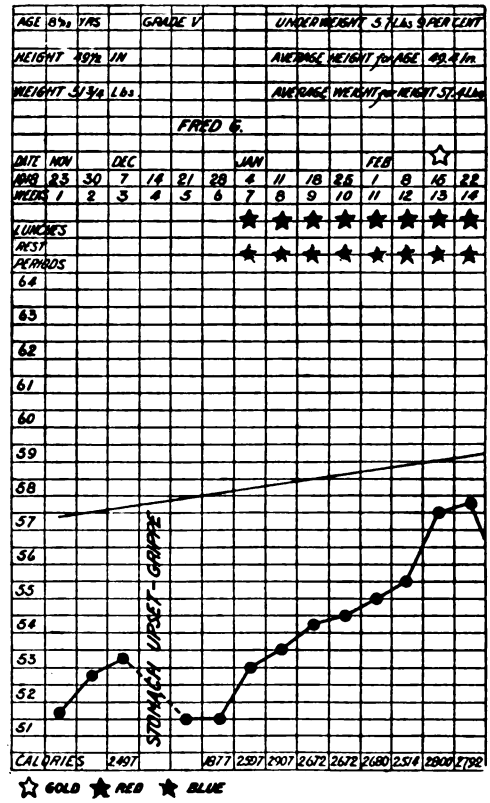
gurated to bring the individual back to normal health conditions. At present it is difficult to provide such an examination for all children; however, the development of the new type of nurse will be one of the best means of reaching all the children. In the meantime it is most important to begin with those children whose needs are greatest. Weighing and measuring furnish the best method yet devised for selecting the cases which have already begun to fall below normal standards. *I have never found any child who is habitually seven per cent or more underweight for his height who does not show other clear signs of malnutrition.*

Each child who is found to be in this class should receive the examinations which we have been discussing, and the nurse's report to the physician in a particular case might run somewhat as follows: "Philip True is 9 per cent underweight for his height—this is more than a year's retardation in growth. The usual social causes which might be responsible for his condition have been ruled out by the results of the social examination. He shows fatigue posture and round shoulders. Mouth breathing calls for an examination with reference to naso-pharyngeal obstruction. His list of activities and his diet have been properly checked up. The weight chart does not show any gain after four weeks. I am referring him to you that the medical causes of his condition may be determined and corrected and thus a program made out for bringing him up to normal health."

A nurse who is working on this basis is no longer a chore girl or a disguised nurse maid but has become a health diagnostician. The health nurse must be recognized as a positive factor in diagnosis and her report should be considered of equal importance with that of the orthopedist or other specialist.

It is no longer "See that the child takes this tonic," but rather "What are the child's home condition, his food habits, his daily program of activity, study, rest and sleep? What are the occasions of fatigue and faulty hygiene that are leading him to lowered resistance and disease?" These social factors are of as much importance in




A representative health chart showing progressive gain

discovering the fundamental cause of the child's condition as are the medical factors, and they must be eliminated before recovery takes place.

An important means of increasing the range of the nurse's work still further is the use of the class method. The detail of carrying out a health program is very great and the class method makes it possible to deal with a group of twelve or fifteen at one time in as efficient a manner as two or three can be handled. In

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addition, the interest of both parents and children is stimulated through working in a social group. The possible monotony of health instruction becomes full of human interest and pleasant associations in a group meeting. The trained nurse serving as nutrition worker becomes the executive officer of the meeting responsible for its failure or success.

This class method also reduces the necessity of making visits or calls at the homes of the children, as parents and children come to one place instead of the nurse going to many. Home visiting is an important but time wasting tool; for this reason it should be used only in those situations in which it serves better than does any other means. It has been too often the only opportunity for the nurse to secure direct contact with the human factors of her job. This relationship is necessary to bring into play the parent's and the child's own interest—a fundamental requirement which admits of no substitute. When, however, the parents are required to be present at the examinations which are made and their attendance is regular at class meetings and conferences there is available not only the individual interest but also the social factor in the form of co-operation or mutual aid and even of competition.

## WORKING ESSENTIALS

*Any child habitually 7 per cent underweight for his height is malnourished and needs attention.*

*The child can be made well in his own home through the establishment of good food and health habits.*

*Full cooperation of parents is necessary. Helpful changes should be made along the lines of least resistance.*

*All removable defects which interfere with nutrition should be eliminated so that the child is "free to gain."*

*Forenoon and afternoon lunches and rest periods should be required until the child reaches normal weight.*

*School activities and home organization should be planned to secure plenty of fresh air and prevent fatigue.*

*The class method economizes time, pools experience, and utilizes social and competitive instincts to gain results.*

Thus it is possible in place of the deadening routine to which many school and other health nurses are subject—endless visits and endless reports, little appreciation for hard work and little satisfaction for actual achievement of permanent results—to substitute a well-planned program of worth while work, results of which can be tested with precision and accuracy. The nurse is paid for her work in terms of human progress.

Here is a new field for the forward looking nurse. No one has seen better than she the results of failure to make early and adequate diagnosis. She has seen hundreds die of conditions that could have been prevented and thousands of children go on year after year without any remedying of known defects or search for rock bottom causes. No one can better appreciate the waste of time and energy that comes from teaching one child at a time. No one has suffered more from lack of physical strength to accomplish the series of visits. Instead of performing this mechanical round these nurses of the new day become health diagnosticians — executive officers in an association for health—able by a planned and organized community program to be efficient factors in the attainment of health.

---

### Health a Financial Asset

The introduction of a part-time medical service in a small industrial plant with 115 employees resulted in a reduction in the daily absence rate from 6 per cent. to 2.7 per cent., and lowered the labor turnover from 25 per cent. to 14.7 per cent.—*Journal of Industrial Hygiene.*

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# THE NURSING OF EYE CASES—I

## DISEASE OF THE CONJUNCTIVA

L. KINGHAM

Superintendent of the Operating-room, Weymouth and Dorset County Royal Eye Infirmary, Weymouth, England

TO nurse eye cases from an intelligent point of view it is necessary to begin this series with a brief outline of the anatomy of the eye. The eye is a ball about one inch in diameter, and consists of three coats:

1. *Sclerotic*—A tough white membrane which with the cornea forms the outermost coating of the eye. Its junction with the cornea is called the sclero-corneal junction. Wounds in this region are most serious and in rupture of the globe caused by severe blows trauma usually takes place here.

2. *Choroid*—A delicate brown membrane which gives the pupil the black appearance as it shines through the retina.

3. *Retina*—The innermost tunic and perceptive structure of the eye, which consists of rods and cones, is transparent and is an expansion and continuation of the optic nerve which is the organ of sight.

We really see with our brain. Looking into the eye is the same as looking into a room the walls of which are covered with black paper. This black appearance is the choroid (the black coat).

There are six muscles which move the eye in various directions, paralysis of which causes squint or strabismus.

1. ***Superior Rectus***—Moves eye upward.
2. ***Inferior Rectus***—Moves eye downward.
3. ***Internal Rectus***—Moves eye inward.
4. ***External Rectus***—Moves eye outward.
5. ***Superior Oblique***—Moves eye downward and outward
6. ***Inferior Oblique***—Moves eye upward and outward.

Their origin is attached at one end to the bones of the orbit and at the other they are inserted into the walls of the eyeball. The bony orbit is padded with fat to prevent concussion.

The eyelids are lined with a delicate membrane called the conjunctiva (inflammation of which is conjunctivitis); this forms a kind of bag, which covers the whole of the eye itself, the edges of which are joined to the edges of the eyelids where the lashes grow. This membrane is transparent, is only visible when inflamed or blood-shot, and is quite loose to allow the eye free movement.

The iris is the colored part of the eye (inflammation of it is called iritis). It acts as a curtain. As we draw down a blind in a room on a summer day to keep carpets, furniture, etc., from getting faded and spoiled by the sun rays, so this curtain or iris spreads over the front of the eye in a strong light and prevents too much light from entering and so protects the delicate structure inside. Under these conditions the pupil, which is a round, circular hole or window, will be seen to be very small. Test this out. In a strong light the iris expands and the pupil becomes smaller. In the dark the reverse action takes place, and the pupil grows larger. People with long sight (hypermetropia) usually have small pupils. People with short sight (myopia) usually have large pupils.

The cornea is a horny, transparent substance like a watch glass in shape; it consists of several layers. It covers the pupil and iris. Variation in the curvature of the cornea causes a defect of vision known as astigmatism. Inflammation of the cornea is called

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keratitis. Inflammation between the layers is known as interstitial keratitis.

The lens by which we see objects at various distances is a transparent double convex jelly-like substance, held in its place by ligaments and enclosed in a capsule. The space between the lens and the cornea is the anterior chamber, and contains a clear, watery liquid, the aqueous fluid. The eyeball itself contains the vitreous humour, which is a jelly-like fluid.

The eyelids and eyebrows serve to protect the eye. The eyebrows keep the perspiration from the forehead from running into the eyes. The lids protect the eye from dust, and when asleep keep the cornea from getting dry. At the outer corner of each eye is the tear duct, which pours out a fluid to keep the eye moist. These tubes unite and form the lachrymal or tear duct, which leads the fluid into the nasal cavities. There are two small pin holes on the inner edges of the lids called the puncta. These open into the canaliculus, then into the tear bag or lachrymal sac, and then into the nasal duct.

### Diseases of the Conjunctiva

*Conjunctivitis*—This condition may vary in severity from the very slight catarrhal to gonorrheal ophthalmia and ophthalmia neonatorum. As you know, the two latter are very contagious and equally damaging. The nurse has to be careful of her own eyes, as a particle of discharge spurting up into the eye will carry infection. The treatment consists in washing out the eyes with lotio acid boracic, lotio hyd. perchlor. (1-5,000 to 1-10,000) or zinc sulph. (grs. ii to the ounce) for the milder cases. The eyes should be washed out with an undine irrigator.

The cornea in infants is as thin as a piece of parchment. Consequently great care is needed never to press on the eye itself, but only on the bony orbit. The slightest pressure may cause perforation, and the iris will prolapse, the lens may escape through the wound, and the child will be blind for life. Argyrol or protargol drops may be ordered or atropin.

In gonorrheal opthalmia the unaffected eye is usually covered with a shield (an ordinary watch glass fixed on with strapping). The patient should lie on the affected side to make sure that the discharge does not run into the unaffected eye.

### Gonorrheal Infections

In gonorrheal ophthalmia and ophthalmia neonatorum the lids are usually painted with nitrate of silver (grs. v to x to the ounce). This must be done very carefully. The lids must first be everted; this can be done quite easily with practice. Tell the patient to look down at his feet, then take hold of the lashes, and the lid will turn inside out. The lower lid is much easier to do; tell the patient to look up and draw the lower lid down. In an infant it is very easily done, especially if the lids are very swollen; both can be everted at the same time. Take a small glass rod, roll a piece of wool securely round one end, dip this into the nitrate of silver (which should be poured out into a small watch glass), dry the lids with a piece of wool. Be sure the wool on the rod is not too wet—just enough for the wool to absorb—and touch the lids all over. *Do not let the nitrate of silver drop on the eye or it will damage the cornea.* Dry the lids carefully with some damp wool afterward. The eyes may be washed out afterward with lotio boracic or hyd. perchlor. Some physicians use saline solution, which neutralizes the silver. Drops may be used (grs. ii to the ounce); these will not damage the cornea. They do much good, as they get

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well into the conjunctival sac. The painting is usually done once in the twenty-four hours. When attending to these two latter cases the nurse should wear a gown with short sleeves (English practice), rubber gloves, and goggles, and the gloves should be washed through lysol or carbolic between each case. All articles, plates, etc., cutlery, washing materials, dressing bowls, droppers, towels should be kept separate and sterilized after each using.

### Detecting Ulcers

The cornea should be examined at intervals to see if there are any signs of ulceration or haziness, which is usually the commencement of ulceration. The surgeon will probably order atropine if such is the case. An ulcer can form in a few hours and damage the sight permanently, as the patient is in a very unhealthy state to begin with, and once an ulcer forms it usually spreads rapidly, and nothing will arrest it. If an ulcer forms, the treatment is as noted below for ulcers. When putting drops into an eye, never let the dropper touch the eye or lids, or you will carry infection.

*Trachoma or Granular Lids*—This is very contagious. It is very rare in England and the United States, although common in the East. The same precautions should be taken as in ophthalmia neonatorum and gonorrheal ophthalmia. The lids are usually painted with silver nitrate (grs. v to x to the ounce). Sulphate of copper may be ordered. The lids are everted as before described, but in these cases the copper stick must be put well under the upper lid, drawing the lid away from the cornea (when everted) so as not to touch it. It is best to put cocaine (5 per cent.) in the eye three times at three-minute intervals before painting and once after, as it is a very painful process, and cannot be done thoroughly unless the patient is under cocaine. An operation called expression is sometimes tried. The granules are pressed out with Knapp's roller forceps. This is done under cocaine (sometimes solid is used); an ice compress is applied afterward for half an hour to keep down the swelling.

*Wounds of the conjunctiva* heal rapidly. If large they are stitched with black silk, as it is more readily seen than white.

### Preventing Adhesions

*Burns of Conjunctiva:*—For burns cocaine is instilled (5 per cent.) at three-minute intervals three times. If caused by hot metal or iron, this must be all scraped away, causing as little injury as possible. The eye should be washed out afterward with a weak solution of sodium bicarbonate, and a drop of castor oil instilled. A glass rod is passed around the lids daily to prevent adhesions, as these would limit the movement of the eye.

(The next instalment will discuss the nursing of diseases of the cornea.)

---

## Hours for Health Nurses

Often health visitors rebel at the "useless" Saturday morning, which is too short for many calls. Several agencies have substituted evening calls instead. It is found that in many homes an evening visit is much appreciated where the parents are out at work during the day. It is occasionaly useful to be able to have a talk with the father of the family, who is, of course, not generally at home in the day time. A further advantage is that the health visitors get an intermission of two whole days in their duties every week. This rest makes the nurses able to do effective, concentrated work during the five full days.

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# SUPERVISING THE CHILD'S SLEEP

## EDUCATION IN HEALTH HABITS

L. E. Eubanks
Seattle, Washington

SLEEP stands next to air as a prime essential of baby life. Normally, the infant is his own best manager in this; but nurses should so inform themselves as to be able to meet abnormal conditions.

An infant that is well will sleep nearly all the time during his first two weeks of life, waking only to nurse. During the second month he should average about twenty hours out of twenty-four; then the waking periods may be gradually lengthened. From thirteen to fifteen hours' sleep is about correct for the average child of one year. After the second year most children who are encouraged to take an hour's nap daily will not require more than ten hours of sleep at night. Few can do on much less than ten hours until they are ten or twelve years old. Maybe they can but they should not.

### Causes of Sleeplessness

Habit is very important, not only for the baby but for its care taker, mother or nurse. To be able to rely on the little ones' sleeping at certain hours and for definite periods is a great convenience for the nurse with other duties. Be particular that the sleep is not interrupted; if you wake him often to "show him off," etc., you may expect a restless infant very soon. If he must be moved while sleeping, wait forty-five minutes or an hour after sleep begins, for it is then most profound.

If the child does not sleep, there is some real cause. Allowing for certain constitutional differences—some always sleep more readily than others, no baby will stubbornly resist Morpheus without reason. All of us should remember that singing is not always best. Though "music hath charms," baby is not always musically inclined; and disagreeable noise will make him restless. The order in which the senses (after these are developed) relax to sleep is, sight, touch, taste, smell, sound. It has been scientifically pointed out that carrying a child about in a brightly lighted room is a very poor method of putting it to sleep. When successful, it merely furnishes another proof of the power of habit; for the fact is that accomplishment of the first requisite, lulling of the sense of sight, is most difficult under these conditions. Any unspoiled baby will sleep best in his crib, in a dimly lighted room. Freedom from any binding clothes, proper ventilation without irritating drafts, and quiet are conditions the little one has a right to demand. Nervous children are often enabled to sleep more readily by having the nurse's hand on the crib. It lends the little dependent restful assurance.

### Odor as a Sleep Disturber

Not all those in charge of infants appreciate the potency of odor as a sleep disturber. A mild one will seldom actually wake the child, but an observer may notice restlessness as a result. If you are caring for a child who needs sleep you are justified in barring out any visitor who is noticeably perfumed. Parenthetically, I cannot resist saying that visitors should know that the medley of odors in a bedroom, especially a sick chamber, is bad enough at best, without their adding to it. If a baby's stomach is out of order, perfume is liable to cause vomiting and thus drive away repose.

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Hunger frequently causes sleeplessness. Most babies will fight sleep until the stomach is satisfied, and sometimes a little milk even "over schedule" does less harm than the fretting for it. Avoid forming the habit, however, and if the child's appetite seems very exceptional a physician's examination is advisable.

Overheating rooms is a common cause of sleeplessness. On sultry nights the skin all over the body may itch and burn, and there is nothing better for this than the tepid bath. When the irritation is confined to one spot cold compresses relieve, but they must not be carried too far.

Prolonged fits of crying will, of course, keep a child awake. They should be avoided in every possible way, though be very careful in the giving of drugs. Use no soothing medication for which you do not have the doctor's sanction.

### Proper Air Space

The baby, or any child, is liable to one danger in sleeping of which perhaps ninety per cent of the uninitiated never think—the danger of loss of vitality by sleeping with adults. It is bad enough for two persons of like age and physical condition to sleep together; but for a child, especially if it is not robust, to sleep in the same bed with a grown person, and repeat it night after night, always means a more or less serious reduction of the youngster's health.

I have personally heard a mother explain that she let her twelve-year-old boy use the tiny bedroom and her twenty-five year-old daughter have the big one, because the little fellow "required less air space." Such a mistake, though it might seem natural, is very serious, for the truth is that the need of oxygen is particularly imperative for the growing child.

### Points on Respiration

While on this subject of the comparative requirements of adults and children, a prominent physician says: "Respiratory need is but one factor that enters into the question of cubic space for an infant. Equally important elements are the temperature of the air, its humidity, the barometric pressure and the rapidity of its motion. All these are determining factors in the heat expenditure of the body. According to Lusk, the heat production of a new-born infant is 2.6 times that of its mother, based upon calories produced per kilogram of body weight.

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Mlle. Georgine Eldin, Mlle. Jeanne de Joannis, Mlle. Georgette de Leveleau

**Three French nurses who have recently matriculated at Teachers' College. During their stay in this country they will cover a course in administrative work as practiced in American schools of nursing, which will be amplified by observation in the best hospitals of the country. Mlle. de Joannis is superintendent of nurses at the Rue Amyot Nursing School, Paris. Her companions have been engaged in public health work directed by the American Committee for Devasted France.**

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The surface area per kilogram of a small body is two or three times greater than that of a large body. The smaller the animal or child, the greater the relative surface exposed for evaporation and for giving off or receiving heat. The infant and adult have relatively different needs because of the disproportion between the weight and surface area. A 15-pound child develops 90 units per hour while a 150-pound man at light exercise develops about 40 units per hour. A man ten times heavier than the child produces only four and one-half times as much heat. An infant breathes one and a half or two times as fast as the adult. These deductions from careful experiments demonstrate that the requirements of the infant are relatively much greater than those of the adult."

### Teaching the Child

As the child grows older he should be led to think for himself on the subject of sleep—and other health requirements. To teach the value of regular hours for sleep is not enough; he must understand that quality is just as important as quantity; that there is something wrong if he fails to secure refreshment, a renewal of strength, energy and ambition from his rest.

Sleep is natural; nothing could be more logical than relaxation after effort. If your child is normally busy during the day and has a chance to sleep at night, yet cannot, there is reason. Usually, you can wager that the cause is positive—that it is something he has done, rather than a failure to do something. There is where the child needs that knowledge of self and health-laws that you should have taught him. Young people in their middle teens hate to come to their elders with specific troubles, but are glad to help themselves with any information they have previously acquired, or can pick up without having seemed to seek it.

I do not need to remind nurses that this "picked up" information is not reliable; it may or may *not* be correct. Even what you yourself have said on a previous occasion may be inaccurate as applied to his case at this particular time. Fortify the child, at the very earliest time he can understand you with knowledge of health laws—*that* is the proper course.

You are apt to find most difficulty with mental causes. Physical reasons for sleeplessness are usually easy of removal, a poorly ventilated room, a lumpy mattress, a late supper of unwholesome foods, etc., can be quickly "cured." But nervousness, the kind that keeps one awake, is much harder to get at—particularly with children, since they can seldom understand themselves, and when they do, often desire to conceal the cause.

Delicately organized children are far more susceptible to nervous disturbances than many people believe. The assumption that a young person will sleep just because of his youth, that "nothing can keep him awake," etc., explains many cases of reprehensible parential neglect. Watch the child's evening occupations very closely; many "entertainments" of the present day are playing havoc with the sleep of young people, especially boys. And the worst feature is that they feel too guilty to ask help—that is, from the right source, their parents or the nurse.

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Democracy must show its capacity for producing not a higher average man, but the highest possible types of manhood in all its manifold varieties, or, it is a failure. No matter what it does for the body, if it does not in some sort satisfy that inextinguishable passion of the soul for something that lifts life away from prose, from the common and the vulgar, it is a failure. Unless it knows how to make itself gracious and winning, it is a failure. Has it done this? Is it doing this? Or trying to do it?—*James Russel Lowell.*

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# MAKING GOOD ON THE SECOND LAP

## A BOOST FROM THE RIGHT SOURCE

AGNES JAMES, R. N.
Cincinnati, Ohio

A FEW days ago I was discussing every-day religion with one of those broad, comprehending clerics who are all too rare. A remark he made fitted oddly with a subject often in my mind. He said: "Most people have the mistaken idea that God is always snooping around to see if we are doing wrong or not—He isn't. He gives us a right to our sins, as well as to our virtues and He understands them, and when we are all ready to tell Him about them, He not only forgives, but often turns them to our good, and then He forgets them." That sounded good sense to me, which is more than can be said of some other viewpoints of human frailty.

Any graduate nurse who has passed the bloom of her first youth and who employs the region from the shoulders up for anything but ornamental purposes, must have been struck by the number of her associates who reach a point where the practice of nursing has become unsupportable, and where they feel that at any cost they must get out of it. And one after another they enter other fields of activity, one into a tea-room, another into real estate, another, writing game, others beauty parlors and agencies of different sorts—a whole array of them with fifteen or twenty years of valuable experience which is no longer an asset, because they are "fed up" with the only way in which they can employ it.

*Somewhere and somehow there is a leak in the nursing profession which must be stopped. In our journeys we see the good sense, originality and executive ability of our older nurses—the very backbone of the profession—being diverted to outside activities. Miss James does not "say it with flowers" unless, forsooth, they are left growing in the pot. She digs down into the roots and remedies the soil.*
—EDITOR.

Now from where I am in life, in every sense of the word, I'd like to give a little advice to the young nurse who is not looking to marriage as a goal, and who at present sees nothing better than a long stretch of her chosen profession. It is this—take a certain percentage of every dollar you earn, salt it down and *forget* it; don't use it for any professional activity, but put it by for a possible contingency in your viewpoint.

Making good on the second lap of the race is just as vital as making good on the first to which so much attention is given.

But who cares a whoop about the older nurse or what she is headed for? So far, disillusionment, monotony and weariness are problems which each nurse must work out for herself, and many a sanitarium houses a fighter trying to get her "second wind" to go on. Therefore, I say, look ahead and forestall that expression of appropriate sympathy in your friends, by being equipped for a temporary cessation of ministering to sick people and getting acquainted with whatever other interest may be cooped up in you. Travel, write a book (poetry if you like), take up horticulture, interpretive dancing or whatever appeals to you, not as a disgruntled nurse, but one still attached to

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her profession, let out of school for awhile, but prepared to refind in it the only game worth the effort and glad to go back to it for the many years when her service is of the greatest value.

There ought to be some way to prevent the great loss, economic and personal of the women who leave nursing when they ought to be its most valuable asset. Experience of incalculable value is let slip by because its owner has reached a point when the thought of giving a bed bath and the very word "case" are a menace to sanity. It seems to me that a scheme could be evolved whereby this mutiny, caused by endocrine disfunction or what not, could be forestalled and prevented by a judicious cultivation of another outlet for activity and resultant recuperation of the senses worn out by routine.

### Organized Support

Why not equip a department for making good on the second lap; feature it as part of a graduate nurses' association and by funds and encouragement support any new activity of any member who has a record of fifteen or twenty years of creditable service to the profession. Would it not be as good to announce: "We have just published our Miss Smith's novel," or, "Our Miss Jones is taking a course in architecture and is making a great hit with her suggestions on plumbing," as to vote that "it has been moved and seconded that flowers be sent, etc.?"

If I had spent 'steen years toiling in the mountains and then felt I must get away from it all, own a bored poodle and a batik tea-gown, think of my joy and gratitude if the right people understood and said: "Go to it, and all our support is yours." The reaction to such encouragement would, I venture to say, be constructive every time and would be expressed along lines both creditable and profitable. Under these conditions an association, sometimes a scattering place in which old graduates are lost track of, would be a vital agency, giving to and receiving life from every field of activity that lies within the compass of human endeavor.

It is not given to all of us to be able to satisfy our mature life with a continuation of the old routine or to feel a thirst for professional laurels, and a recognition of this period of mal-adjustment and a diplomatic and practical way of meeting that situation would be a sensible programme for any organization. But let it be on the basis that within broad limits each aspirant for a boost is entitled to it for any purpose she may decide, and that the only qualification necessary shall be a conviction that the years ahead are the start and not the end of honest endeavor in whatever line she may choose.

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### Cleansing Glassware

Dr. E. Brian of Paris suggests that all dispensers of beverages be required to cleanse their glassware in two separate waters, the first a strong solution of hydrochloric acid, which, does not injure the glassware, but destroys rapidly all micro-organisms which contaminate it. The barkeepers should wear rubber gloves. The glassware is then thoroughly rinsed in running water to remove all traces of the acid.

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### Soothing Scratches

Often nurses are called upon to treat some little hurt that may be too insignificant to bind up, but which may be irritated by water, dust, or the clothing. In these cases paint the places with flexible collodion; it forms a perfect coating that will protect the spot for some time. Remember that the ether in the preparation is inflammable, so do not put it near a flame while applying it.

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# BLOOD GROUPING

ROBERT A. KILDUFFE, A.M., M.D.

Director, Laboratories, Pittsburgh Hospital; Director, Laboratories, McKeesport Hospital; Serologist, Providence Hospital.

THERE are few procedures more spectacular in character than the transfusion of blood from one human being to another, and it is, indeed, striking to observe the physical change which takes place in a pale, exsanguinated patient as new, fresh blood is introduced into his circulation. "Behind the scenes," as it were, however, though not spectacular, is the story of patient, persistent laboratory investigations which render this method of treatment possible.

## HISTORICAL INCIDENCE

When the transfer of blood from one human being to another for extensive blood loss or destruction was first introduced as a method of treatment, all that was demanded of the donor was that he be apparently healthy and free from communicable diseases as far as could then be determined. As the method grew in general use disastrous results began to be reported without demonstrable cause, as the donor used with good result in one case, was the cause of severe reactions in another, even fatalities sometimes occurring.

Because of these reactions the method began to fall into disrepute. It was rescued by the intensive investigations of various laboratory workers. They discovered that when two specimens of blood from different individuals were mixed occasionally the corpuscles of one or the other were agglutinated or clumped, and, sometimes, even dissolved or hemolysed.

After a great deal of study and experimental work it was found that all human bloods could be separated into groups with reference to their content of agglutinins and hemolysins, the classifications most widely adopted being that of Moss which follows:

Group I. Serum: agglutinates, no corpuscles. Cells: agglutinated by the sera of groups II, III, and IV.

Group II. Serum: agglutinates corpuscles of Groups I and III. Cells: agglutinated by sera of groups III and IV.

Group III. Serum: agglutinates corpuscles of Groups I and II. Cells: agglutinate by sera of II and IV.

Group IV. Serum: agglutinates corpuscles of groups I, II, and III. Cells: not agglutinated by any serum.

No mention is made of hemolysins in this classification because hemolysis does not occur without agglutination while agglutination may occur without hemolysis.

The discovery of these blood groups at once explained the disastrous results of transfusions made at random by the agglutination or hemolysis of the corpuscles of either donor or recipient when these belonged to incompatible groups.

A study of the four groups shows:

(a) Individuals in Group I, because their cells are agglutinated by the sera of all the other groups, may be donors only for members of their own group; as their serum does not agglutinate the cells of any other group, however, they may be recipients from any other group and they are, therefore, known as "universal recipients."

(b) Individuals in Group II may receive blood from Groups II or IV but may give blood only to members of Groups II or I.

(c) Individuals in Group III may receive blood from Groups III or IV and donate blood to members of Groups III or I.

(d) Individuals in Group IV may receive blood only from members of their

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own group but, because their cells are not agglutinated by any other group, they may donate blood to any and are, therefore, called "universal donors."

It is obvious from the foregoing that before a transfusion is undertaken the blood of both recipient and donor must be tested to determine their suitability for mixture. One method of doing this is to determine the group to which each belongs. This has the advantage of being simple in technic and rapidly performed and the disadvantage of necessitating a constant source of supply of either cells or serum of Groups II and III.

### Testing Donors and Recipients

The technic is as follows: Upon one end of a clean glass slide is placed a large drop of a suspension of known Group II corpuscles which have been thoroughly washed in normal salt solution to remove all traces of their native serum; at the other end is placed a similar drop of a like suspension of known Group III corpuscles. To each is added a drop of the serum to be tested, the two mixed, and the slide allowed to stand for thirty minutes being frequently observed. Agglutination is evident to the naked eye by imparting a granular or mealy appearance to the drop; hemolysis imparts a red color to the fluid.

If no agglutination occurs in either drop the serum belongs to Group I since such serum agglutinates the cells of no other group.

If agglutination occurs in II and not in III the serum belongs to Group III. Group III serum agglutinates the cells only of Groups I and II.

If agglutination occurs in Group III and not in II the serum belongs to Group II because such serum agglutinates the cells only of Groups I and III.

If agglutination occurs in both II and III the serum belongs to Group IV.

A second method of making the test has the advantage of not requiring either known cells or serum with the slight disadvantage of taking a slightly longer time. In this method serum and cell suspension from donor and recipient are mixed in a series of small tubes as follows:

Tube 1. One drop of patient's cells + four drops of donor's serum.

Tube 2. One drop of donor's cells + four drops of recipient's serum.

Tube 3. One drop of patient's cells + four drops of patient's serum.

Tube 4. One drop of donor's cells + four drops of donor's serum.

Tube 5. One drop of patient's cells in normal saline.

Tube 6. One drop of donor's cells in normal saline.

The test is made in the first two tubes; the others are controls to rule out spontaneous agglutination and non-specific hemolysis due to the action of the salt solution, etc.

After gentle shaking the tubes are placed in a water bath at 38° C for one hour at the end of which time they are observed and the reading made. Agglutination and hemolysis are readily discernible to the naked eye.

### Determining Paternity

A recent and very important observation concerning the influence of heredity in the determination of blood groups indicates that this test may become of considerable importance in the determination of paternity in illegitimate children.

Iso-agglutination, the phenomenon upon which the differentiation of bloods into groups is based, is the term used to denote the agglutination of red cells by contact with serum from another individual of the same species. In the study of this phenomena the important observation was made that, in embryologic development, the specific agglutinability

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(agglutinogen) of the red cells appears first and is usually present at birth, while the specific agglutinative character of the blood (agglutinin) which is to differentiate the individual throughout life may be absent at birth and may not appear for several months. More recently it has been observed that the factors determining the placing of the blood of an individual in a certain group were hereditary and followed Mendel's law.

The practical application of these observations has a marked medico-legal value in establishing paternity where it is a matter of dispute for, according to present information, the inheritance of blood groups may be shown in the following table, taken from Ottenberg:

| Parents | | Child |
|---|---|---|
| I and I | give only | I |
| I and II<br>II and II | give only | I and II |
| I and III<br>III and III | give only | I and III |

From this it is seen that a Group I child may be the offspring of any combination of parents; experimental data have also shown that all unions containing a member of Group IV, and all unions of Groups II and III may give rise to offspring belonging to any of the four groups.

If, therefore, the blood of the child belongs to the correct group for the alleged parents then the child *could,* though not necessarily, be their offspring. If, however, the child's group is wrong for the parents, then the child must have a parent other than one of those asserted.

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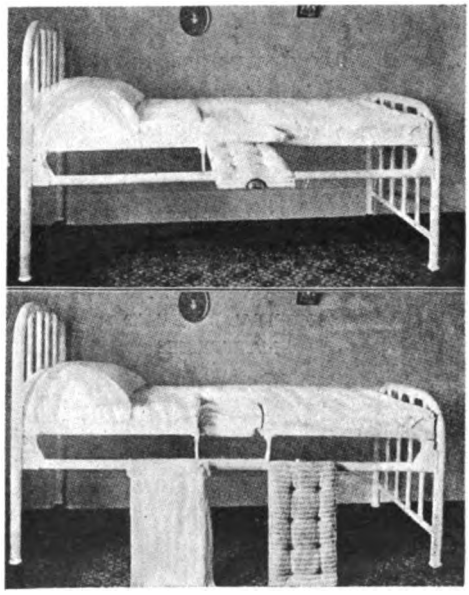
### A Nursing Convenience

A special hospital bed designed for use in the care of bed-ridden patients was exhibited at the Atlantic City Convention.

As the photographs show, the hospital bed of usual type is fitted with a metal run way which supports the bed pan in proper position with edges *below* the resting surface of the bed. For cases requiring continuous drainage the pan is arranged as in the lower half of the illustration. For the usual case where the bed pan is requisitioned at intervals, the bed is operated as follows: The bottom slide is first drawn out which permits the top pad to drop away from the patient. Body friction is thus eliminated and the pan can be inserted without the patient's knowledge.



**Equipment for nursing bed-ridden patients**

To replace the pads when the bed pan is withdrawn, the top pad is placed under the patient and the lower pad gradually inserted to raise the upper pad to the patient's body. The mattress when in use is covered at top and bottom with two draw sheets, another being used to cover the center portion. The upper portion of the small mattress may be covered with an ordinary pillow slip. The arrangement not only minimizes agony for the patient but it saves the nurse's time and the hospital linen, since in cases of accident only the small pillow slip has to be changed.

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# THE AMERICAN RED CROSS AND SCHOOL NURSING

ANNA L. STANLEY, R. N.*

Supervisor of School Nursing, Department of Public Instruction for the Commonwealth of Pennsylvania, Harrisburg, Pennsylvania

DR. G. STANLEY HALL asks a question which our educational system must answer and quickly. "What shall it profit a child if he gain the whole world of knowledge and lose his own health?"

The answer which must be given, if we are to build national efficiency, is voiced in many statements by our leading educators and hygienists.

In our more progressive communities, the work of health conservation in the schools is being prosecuted vigorously and with notable results. But if we are to go forward at a pace which will be really encouraging, we must greatly increase the number of citizens who take a live, constructive interest in health measures.

## EXAMINATION AND CORRECTION

In any plan of health supervison, the two workers who are indispensable to its ultimate success are the physician and the nurse. The school physician, if he is properly qualified and devotes sufficient time to the work, is one of the most important factors in raising the health standards of the community. In cities where the work is properly organized, the physicians have done inestimable good by pointing out removable defects which were interfering with the progress of the children in the school, by preventing epidemics, by bringing about improvements in school equipment which make the environment more healthful, and by starting proper health habits of thought and action among pupils.

The work of the school physician is of little avail if there are no school nurses to follow up his work. The physician finds the defects in the child, the school nurse follows the case through and sees that the defects are remedied. She is the liaison officer between the medical inspector, the school teacher and the parents. Most cities which

Examining children at the Mulberry Health Center, New York. The child which proved the healthiest on entering school was given a prize

have school nurses today have altogether too few and as a result, in most instances, less than half of the physical defects which have been discovered have been corrected. The maximum number of pupils that a nurse can look after is twenty-five hundred, and this number should be reduced to two thousand as rapidly as possible. Communities having or establishing school nursing ser-

* Formerly acting as specialist in school nursing for the American Red Cross.

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vice should use this standard in their estimates of cost. Whether our children are to grow up physically fit or not is in a great measure answered by whether we are willing to pay something for their health. The average cost for school health service is small in comparison with other items in the school budget, yet no other expenditures yield such returns to the health and prosperity of the community. It is a vital matter for every citizen to know whether or not there are enough school nurses in his community.

### The Rural Situation

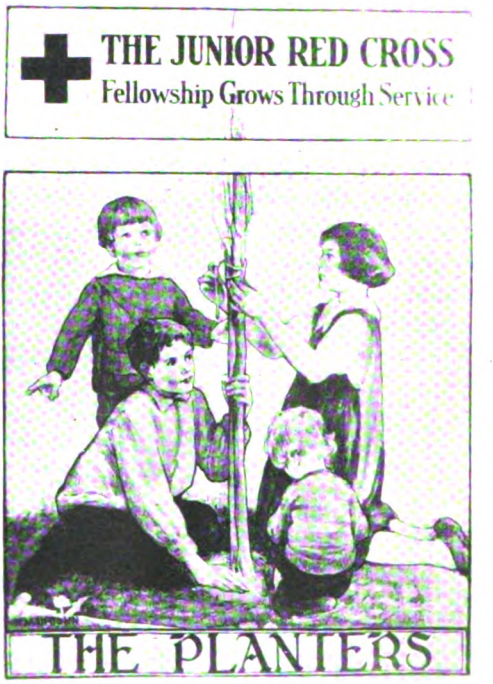
This discussion, so far, has referred more especially to health supervision in cities and larger towns. Of no less importance, however, is this service in small towns and rural communities. That the need for this work is great no one can deny. The same physical defects are found in pupils in rural schools as are found in pupils in city schools. Generally speaking, however, there are no clinical facilities for the correction of physical defects. In addition, the school houses and grounds are found often to be in wretched physical state. These conditions are mentioned here, not in any spirit of criticism, but merely to emphasize the necessity for health conservation in rural schools.

### Developing a Rural Program

This brings us to the question, "What is being done about it?" The remainder of this article shows what the Red Cross is doing about it.

The Public Health Nursing Service of the American Red Cross, organized on a country-wide basis, comprises in the neighborhood of twelve hundred nurses. At least eighty per cent. of the nurses are rendering service to the rural schools. In some counties the nurse is giving full time to the schools, that is during the school year, and in others a part time service is furnished to meet the need.

The entrance of the Red Cross Public Health Nurse in the school is made either by request or approval of the superintendent of schools. Before she can set up any sort of working program, it is necessary for her to obtain certain information from the superintendent of schools, such as the area of the county, name and location of schools, number of pupils, length of term, kinds of roads and best ways of reaching the schools, means of transportation, and which schools might need her first attention.




This year the Red Cross Roll Call will be held from November 5-30. Your aid will "put over" the Red Cross health campaign

No plan of school nursing work can accomplish its purpose without the advice and cooperation of the local physicians. One of the responsibilities of the local Red Cross chapter employing the nurse is to make this first contact with them. A meeting is sought with the local doctors of the community, and

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plans for the service are discussed in so far as these plans relate to the medical profession.

In those communities where no provision exists for the physical examination of school children by doctors, and since the best results can be obtained only when the pupils are examined by doctors, it is important that the matter be considered at this first meeting or conference, and efforts made to arrive at plans thoroughly satisfactory to the school authorities and to the medical profession. It not infrequently happens that arrangements are made whereby the physicians volunteer to conduct the physical examinations in the school as a demonstration to show the necessity for this work. Again, it may be found that the doctors cannot arrange for volunteer medical examination, but the nurse is authorized to make inspections of pupils and refer her findings to the respective physicians.

THE COMMUNITY COOPERATION

There is every reason to believe that the better informed the community is concerning its school nursing work, the more support that work will receive. To that end there is always a conscious, definite effort directed to keeping the community informed, particularly members of the school board and parents.

Each year we find an increasing number of school boards which, having had this Red Cross demonstration, are assuming their legitimate responsibility in providing for this phase of health supervision in the schools.

It will be remembered that this procedure of the Red Cross with reference to the school nursing work in the smaller towns and rural districts is identical with the procedure adopted by so many of the visiting nurse associations in the larger cities throughout the country, in the early days when school nursing was in its infancy.

The contribution which these voluntary organizations have made and are still making is of priceless value, and it is to be hoped that the Red Cross will continue to function in this phase of public health nursing, working toward the time when it shall become a public service.

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**New Recruiting Opportunities**

In Bridgeport, Connecticut, the teaching of the home nursing course in the public schools has been placed in the hands of the Bridgeport Hospital Training School for Nurses. Such an arrangement, which will give nurse instructors intimate contact with high school pupils, not only insures up-to-the-minute nursing practice to the students, but it gives these instructors an opportunity to interest school girls in nursing.

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**Hartford Publicity**

During the week of October 9th the Hartford Visiting Nurses' Association engineered a successful campaign for funds. One unique feature of the campaign was the miniature illustration of the nurse's regulation bag which was broadcasted through the mails. When opened the inside depicted the interior of the bag with the picture of the bottles as contained in the actual bag. Instead of the various labels bearing the names of the medicines that are contained in them they bore the names of the different services that the association renders the public. It also carried an appeal to the public, the back carrying the message that "This is the bag of the Hartford Visiting Nurse association. It goes with the nurse into many homes. Now it comes to you with a message?"

The active work was in charge of Miss Harriet Leck, Miss Nellie Ogilbie and Miss Margaret Bulkeley, supervisor of the general nursing department.

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# THE ROLE OF THE HOSPITAL NURSING DEPARTMENT IN THE COMMUNITY*

ANNIE W. GOODRICH, R. N., SC. D.
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*"The hospital—not a salvage for human wreckage, but a coordinator of activities—professional, economic and social—in their application upon the problems of health."*

*The idea in the above quotation dominated the thought of almost every speaker at the recent convention. As Miss Goodrich has developed this theme from every angle, with especial appreciation of the function of the nurse, we have hesitated to excerpt the material. Her address, therefore, is reprinted almost in its entirety.*—EDITOR.

THERE are, we believe, some who do not agree as to the importance of the role of the hospital in the new health conception. For ourselves it matters not how intense or intelligent is our appreciation of the new outlook on health sublimated recently into the term "positive health," or that we are in complete agreement on the importance of approaching the subject of health from the normal rather than the abnormal standpoint, we still believe that we have to deal in the matter of the health of the community with certain facts, such, for instance, as:

(a) The tendency of all normal individuals rich or poor to be indifferent to the subject of health until rapped into attention by the presence of a personal handicap or the handicap of some individual with whom they are concerned.

(b) That the prevalency of defects has brought all classes of society to demand the service of those health agents designated as physicians, nurses and dentists—this fact giving these practitioners the opportunity of wide and frequent contact and the advantages of accepted authorities.

(c) That these defects in any given unit of population increase in almost direct ratio with the decrease of the wage scale which connotes a decreasing body of knowledge (I refuse to say intelligence) as well as opportunity concerning the procedure necessary to change the situation. "The destruction of the poor," said Solomon, "is their poverty."

(d) Only a comparatively small number appear to be ready as yet to subscribe to the practice of preventive medicine, even though believing in the theory. Evidence of this may be found in the failure to support the Shepard-Towner Bill the Red Cross Peace Program and in the general habit of institutions and organizations, primarily concerned in the care of the sick, to limit their function to a given situation and to fail to assume the responsibility of health education relating to such a situation.

The following story illustrates these facts:

The young wife of a professor called for advice and assistance concerning her new born baby that had cried all night. She stated that she had just returned from the hospital and that she was totally ignorant as to its care, such as bathing, diet, etc. She had called the visiting nurse service and was told that it was impossible to send a nurse, as the organization was obliged to give precedence to the sickness cases and the daily program was more than filled.

In this episode we have almost a complete picture—the young mother not alertly seeking information before leaving the institution, in fact, not until the baby became ill, did she awaken to her educational needs; the hospital and the visiting nurse service functioning in exact accordance with the tenets of curative not preventive medicine. This episode did not occur in New York but in the numerous places where the incident has been repeated, it has invariably brought forth a story almost its exact counterpart.

### THE SITUATION

The preceding facts seem to me to summarize as follows: The prevalency of defects; the place in the family life accorded to physicians and nurses by a society still indifferent to its health needs; the scientific equipment as expressed in hospital machinery and personnel now required for the effective dealing with defects; the increasing use of these institutions for maternity cases; their continued and extended use as laboratories for the preparation of health workers of varying types—all these conditions demand that the hospital, of strategic importance in health problems function either as the health center within a given area or at least as a definite link in the chain of health activities required for a community health project. To do this effectively, however, will necessitate reconstruction of its program, method and system.

### THE HOSPITAL RESPONSIBILITY

Mr. Bailey Burritt of the Association for Improving the Condition of the Poor, in writing on "The Family as a Unit in the Control

* Excerpted from an address delivered before the Nursing Section of the American Hospital Association, September 25-28, 1922.

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of Disease," opens his paper with the statement that "public health nurses and public health authorities must increasingly take the family into account if we are to hope for further substantial reduction in morbidity rates, and particularly if we are to hope for marked progress toward the goal of making every individual a strong, healthy, able-bodied citizen over a considerable period of years."*

The making of the family unit of hospital responsibility, if consistently carried out, will require that the entire personnel of the institution shall experience the life within its walls that will most effectively and enduringly impress upon them the essentials in health habits for their personal life not less than for the lives they are directing or being prepared to direct.

### The Health of the Hospital Personnel

One is tempted to digress, if digression it should be called, to discuss the changes that would immediately be effected if the hospital interpreted its case responsibility as extending to its large and varied personnel and in terms of the hospital family rather than of the individual.

The consideration and direction for instance of the life of the internes, their hours, their housing their diet. I recall a recent recital by an overstrained interne of consecutive days and nights of service with its attendant complications of sleep and food, and my mind is crowded with memories of conditions reacting upon patients as well as the hospital personnel which a health program for all might have averted.

### The Working Unit

The assuming of the hospital family as the unit of responsibility would bring about other much needed adjustments, the most outstanding of which would be the limitation of the hospital function to a given area of unit of population with a resultant coordination and correlation of all health agencies, educational or remedial.

Progress in the direction of this unification idea there has been. The slow but steady development of the central schools of nursing, the growing relationship between the school of nursing and the university, the increasing cooperation between social and health agencies, the numerous experiments, such as that of Framingham and Mansfield, or in New York where a number of projects are under way in which three or more organizations have come together—are definite achievements toward this end, but in relation to the output of convincing presentation of the need as expressed by progressive social and health authorities, and in the face of the possibilities for rapid and great achievement through complete unification of means and ends, they are agonizingly slow and intolerably aloof.

It has been said that "the real task for workers in the field of mental hygiene is translating insight into influence," so also might it well be said concerning the task of all health workers, for despite these evidences of progress almost incredible situations exist through failure to act in terms of community development and well-being.

### Utilizing Clinical Material

In the light of present day knowledge surely a local situation is astounding that results in the sending of students of a school of nursing of a state having a population of 2,500,000, which would represent approximately 1,000,000 children to the East year after year for a course of pediatrics; or the sending of students in a city having a population of approximately 700,000, which means over 14,000 births yearly, to an adjoining city for a course in obstetrics. One hesitates to call attention to these facts lest the students be withdrawn from the distant institutions and thereby lose the opportunity of an essential experience. On the other hand, the loss to the locality of needed service and the economy of time and money which a different adjustment would mean demands careful consideration and a speedy solution of the problem.

### The Need of Affiliations

Recently we visited one institution for orthopedic cases, but which had enlarged its service to include medical cases and was doing rather an interesting piece of work with syphilis. For instance, there was on the day the institution was visited a case of twins, both mentally and physically crippled. The physical condition had been definitely improved but the mental condition was, of course, a life handicap. It was stated that the mother was willing to submit to examination and treatment but that the father had refused both. There was another case which had been watched with great interest; brought to the institution apparently blind, it responded to treatment so rapidly that at the end of two months it was dismissed cured with the sight restored.

To such an audience I need not dilate upon

* *Public Health Nurse*, August, 1922.

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the value of such experience from a social as well as medical standpoint. I think I should add that the head of the institution was keenly anxious to have students from the various schools for a period of two or three months and did not desire to establish a separate school. The failure, however, to affect this cooperation was leading to definite plans for its establishment.

These illustrations could be presented literally by the hundreds. Students are deprived of experience, or service is not rendered mainly because of the wrong point of view as to the relation between these organizations and institutions and the community at large, the keynote of which is struck in the still frequent phrase—"our school, our patients, our family." What creates ownership of students, of patients, of families? Education for which the student pays in service, sickness care rendered to a particular member, relief given for a particular care.

Annie W. Goodrich, R.N., Sc.D.

### Community Responsibility

Born of philanthropy rather than coming into existence through the felt needs of the members of the community whom they serve, these organizations and institutions, finest flowers as it were of a passing system which have sown the seeds for a new social order, to serve effectively, indeed to survive in democracy, must know themselves to be responsible *to* the community not *for* the community whom they serve. Their roots today must be sunk deep in community ownership* in order to receive the support—moral and financial—for effective functioning.

Here, too, in the matter of financial community support we can also strike an optimistic note, for we find evidence of development in the most experimental stage it is true, but nevertheless quite definite.

In a recent issue of a magazine called *Co-eperation*** we find the following:

"Since 1904, the workers of Madrid, Spain, have maintained a health department in the co-operative society. (La Mutualidad Obrera.) This provides complete medical care for eight dollars a year for each member. There are seven clinic-hospitals in different parts of the city, each equipped with about ten beds, an up-to-date operating room, a dental clinic, consulting rooms, an immaculately tiled kitchen, and a garden for convalescents. Each has a staff of physicians, surgeons and nurses. The drug store connected with each hospital furnishes medicines free of charge to the members and sells to non-members at the current price. The co-operative society supplies the hospitals with provisions. Each member pays 66 cents per month to the society. For this, besides the benefits of membership, he receives free medical aid, major operations, consultations and advice at any time.

Again in New York City under the title of Manhattanville Society, an experiment of this nature is being carried on, based on the computation of three organizations that their service, if subscribed to by 5,000 people, could be supported at the rate of $6.00 per capita subscription.

We are quite sure that when the hospital assumes the place in the health program which Dr. Rappleye has so justly assigned it, the many greatly needed readjustments will speedily follow:

The common ground upon which the patient, the community and the professional groups meet and representing the general type of organization which, with proper amplification and development, can best meet the problems suggested, is the hospital. It evidently occupies a strategic mid-position and has open to it a great opportunity and corresponding obligation not as an institution for the salvage of human wreckage but as a co-ordinator of activities—professional, economic and social—in their application upon the problems of health.

In such a conception, the hospital represents not the administration alone but a co-operative organization of workers and leaders devoted to the ideals of their respective professions.*

The tendency of physicians and nurses to overemphasize the physical aspects of the case, with their resulting disregard or minimizing of the social factors directly affecting it, has been advanced as a distinct handicap in their effective functioning as health workers. This even has been given, indeed, as one of the important reasons for the creation of social workers without medical or nursing training. A careful consideration of the question leads to the conclusion, while fully accepting the fact of this tendency and also the place in the health program of this type of social worker, that this is not the best solution of the difficulty.

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* It is my belief that an effective transfer from philanthropic to governmental support is not possible because of the present tendency to control through symbol rather than intelligent common consent. The subject of symbols has been adequately dealt with by Walter Lippman in *Public Opinion*, Part V.

** *Cooperation*, October, 1922.

* The Principles of Hospital Administration and the Training of Hospital Executives, page 10.

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### Inter-relation of Hospital Personnel

The purpose of a hospital or dispensary is to meet the needs of the physically or mentally defective individuals, whatever may be the contributing or underlying cause of such defects. Beginning with the chief executive down through the various departments wherever the medical situation dominates, there is definitely required a medical or nursing personnel. In the course of effective and economic service, such personnel should be relieved as far as possible of the non-medical features of the case through the service of other workers skilled in such features; not less also in the cause of economic efficiency, should the medical worker be expected to have such knowledge of the non-medical aspects of the case as to understand the importance of their relation and furthermore to deal with such aspects where the body of the work will not justify the two specialists.

### Social Training

This implies a knowledge of the technique of case work for both physicians and nurses. It will possibly be taught more effectively by a social worker than a physician or nurse, but whoever teaches the subject, let me add, will probably do so with better effect if prepared through a course in teaching methods. The same could be said concerning the technique or the science, for such it has come to be, of administration. Such knowledge should be required for every administrator today, but to select a physician merely because of such knowledge to administer a business house or to select a business man to administer a hospital is, we believe, poor judgment, because of the waste of medical knowledge on the one hand and the handicap of the lack of it on the other. It would, however, be equally poor judgment to appoint as chief executive for either position a person with a predominatingly research type of mind. In the personnel of the business concern today would probably be included physicians and nurses, while the personnel of all modern hospitals includes nutrition workers, statisticians, librarians, accountants, engineers, and an almost endless variety of medical and non-medical workers.

### Function Follows Purpose

In short, the purpose or function of the institution should determine not only the type but relation and distribution of its personnel. Whatever may be the processes through which the result sought may ultimately be effected, it is desirable that a person seeking such result through an institution created for its attainment should be as immediately as possible related to those whose discernment in the matter has been sharpened to a point through training and experience. The failure to appreciate the importance of such adjustments has been and still is one of the outstanding weaknesses of hospitals and dispensaries, due mainly to inadequacy of funds and *ipso facto* an insufficient and inefficient personnel.

The introduction and rapidly increasing number of private patients, since, *their* demands must be given consideration, have been beneficial; but the overcrowding and understaffing of departments, such as dispensaries and public wards still obtains. Personally, we do not believe that the development of new types of workers is needed so much as the provision for a different and broader content of education for the medical and nursing personnel, and the use for their respective specialties of a sufficiently large and varied staff to enable courteous and intelligent investigation and direction through the now labyrinthine procedure in every case.

The picture as I see it is kaleidoscopic, calling for an immediately close relationship with certain members of the group today and with other members tomorrow, while certain no less essential workers (the pharmacists, for instance) may have no first hand contact with the case at all.

### Essentials in Evolution

The essentials in the process of social evolution have come to chart themselves in my mind as follows:

(a) *The machinery or material necessities*, such as funds, buildings and equipment—their function never, I think, more finely expressed than through Dr. John Finley's interpretation of Rathenau's idea in his "New Society:"

"For one of the high ends of economics is conceived to be to increase the flow of earthly goods to the sacrificial places where the material is subtilized to become spiritual."

(b) *The personnel for research*, which—with seeming flippancy but profound truth—has been defined by James Hervey Robinson as "the diligent search that enjoys the high flavor of hunting."

(c) *Education*—which is the dissemination of knowledge so obtained—"Democracy demands," says Professor Kayser, "that the truth be intended and be followed by exposition, by interpretation, by evaluation in terms which the educated layman can understand."

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types of health workers should be based on as similar a body of scientific knowledge as possible in order not only that there shall be a complete current of understanding between workers representing the three essentials—research, education, and practice—*but because constructive functioning in a creative scheme demands of every worker a modicum of each.*

### The Nurse's Preparation

For the nurse, and it is with her function that this paper is especially concerned, I believe that this underlying body of science should be of college grade and should be obtained through the first two years. Following this, she should have not less than two and better three years of hospital experience. The value of the hospital as a laboratory cannot be too greatly emphasized. The congregation and variety of cases makes possible, in a few months, an experience that it would otherwise take years to obtain, but in this bedside experience should be included those diseases now prevalent, such as mental, tuberculosis, pediatrics. Furthermore, definite and comprehensive experience should be given in obstetrics and adequate experience as well as instruction in normal child life. The period of case experience should be of sufficient length and continuity to fix impressions and enable experimentation for end results.

Briefly summarized, the outstanding essentials of this group are as follows:

(a) A broad general and professional preparation. Specialization in each and every department or subject under direction, for example, to prepare for teaching—pedagogy. An adjustment of time that will insure the essentials we have mentioned for a constructive program—research, education, practice—their proportionate part.

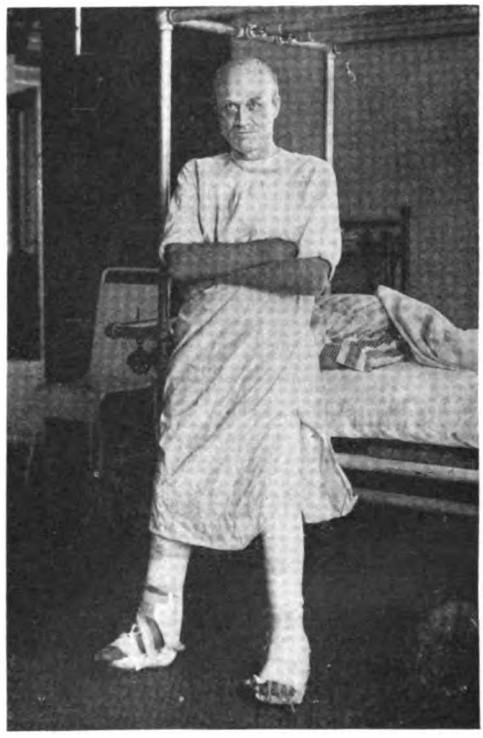
(b) Opportunity for enlargement of life through varied experience such as a rotation of executive and teaching experiences, group conferences, exchange experiences with other institutions and organizations.

(c) The placing, so far as possible, of all personnel directing the various phases of the health movement on the executive and teaching staff of the school.

(d) Free discussion and participation in determining all questions relating to the organization and administration of the school, its laboratories—the hospitals—and, as far as possible, outside organizations with constant emphasis on the interrelations of all persons and departments concerned in the project.

Finally the hospital as an exponent of health should provide for its entire personnel sanitary surroundings, adequate and suitable diet, and a properly proportioned daily life from the standpoint of occupation, intellectual development, recreation and rest.

Such a program, such a policy, on the part of the hospital *through the educational force of example*, would result in a steady outpouring into the stream of life workers whose deepened sense of social responsibility not less than their scientific intelligence permeating the social structure will accelerate immeasurably the community health and well-being which we are seeking.



*(c) Keystone View Company*

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# NURSING PROBLEMS

## MEETING THE NEEDS OF THE PUBLIC

LAURA R. LOGAN, R.N., Chairman
President of the National League of Nursing Education

A DISCUSSION of the Rockefeller-Goldmark report by Amy R. Hilliard, superintendent of the Samaritan Hospital, Troy, N. Y., opened the nursing section of the convention. She urged that more colleges open their doors for the theoretical instruction of nurses with good hospitals serving as working laboratories. Where college affiliations were not available she mentioned the value of centralized group teaching with adequate facilities and trained teaching staff plus affiliation to secure well-rounded experience.

### THE NEED FOR ENDOWMENTS

To divorce the administration of the training school from the exigencies involved in hosptial financing, she urged the use of endowments. The wise hazard that "student nurses had already paid off more debts than all the trustees in the country" and might be retired from that responsibility was appreciatively received by the audience. In degveloping the nursing school as a distinct entity Miss Hilliard advised that the interests of the school be protected through *direct representation on the board of trustees.*

To secure the public from malpractice and misrepresentation, she urged that hospitals and nurses work for the better control of nurses' registries. In this connection she deplored the flooding of the country with nurses graduating from the so-called "short term" courses. In conclusion she emphasized three points:

(1) That the education of the nurse must be developed to fit her for the field of public health.
(2) That endowments are necessary to place schools on a genuine educational basis.
(3) That the growth of nursing schools is commensurate with the vision of the teaching personnel.

### THE TWENTY-EIGHT MONTHS' COURSE

A spirited discussion on the merits of the twenty-eight months' course then ensued. Miss Mary McMillan, superintendent of the Presbyterian School of Nursing, Chicago, suggested that those hospitals equipped to give a well rounded three year course without taking advantage of the student by requiring unnecessary repetition or the performance of non-professional duties continue to do so; but, that hospitals with less facilities give the twenty-eight months' course. Pupils would then be free to select the type of school which would meet their individual requirements. She believed that the college girl might cover the course in twenty-eight months without professional loss.

Miss Katherine Kimmich, superintendent of nurses at the Bridgeport Hospital, brought out the point that the twenty-eight months' basic course was intended *only* to fit nurses for private duty nursing, "specialing" in hospitals, etc., accordingly, nurses planning such careers would not be burdened with educational experience intended for those who expected to take up public health work, administration or other fields requiring intensive specialization.

Miss Elizabeth A. Greener, superintendent of nurses at Mt. Sinai Hospital, New York, considered the experiment worth trying out.

Miss Elsie M. Lawler, superintendent of nurses at Johns Hopkins Hospital, Baltimore, believed that the twenty-eight months' course was too short unless properly safeguarded.

### DISADVANTAGES

S. A. Stephan, superintendent, Columbus, Ohio, may have put his finger on the spot when he said: "If you give some nurses shorter courses than others, how can the future employers of nurses differentiate?" *(For example, the nurse who has taken the twenty-eight months' course is willing to accept without a qualm a position as school nurse, industrial nurse or instructor and unfortunately school boards, hospitals and private employers employ her with the same nonchalance.)

That the course (be it twenty-eight months or three years) may be educational throughout is safeguarded through the use of ward helpers as discussed by Miss S. Lillian Clayton, superintendent of nurses, Philadelphia General Hospital.

### WARD MAIDS

To avoid ambiguity, Miss Clayton began by defining the terms—"ward helpers," "ward maids" and "trained attendants," as follows:

We will understand the "ward maid" to be

* This remark, made when discussing the subject of trained attendants, applies as well in this context.

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a person employed by the hospital, for the purpose of performing general domestic duties in a department. No previous training and no educational standards are required, except such standards of personal integrity and faithfulness to duty, as would be desired in a servant wherever employed. The salary and hours should be such as prevail in any given locality. The same references should be required as would be expected in a home upon the employment of a servant.

**Laura R. Logan, R.N., President National League of Nursing Education**

### Ward Helpers

The second group of workers, we will term the "ward helpers." This group should have more intelligence than the first group. No particular educational standards need be required, except that they speak and read the English language. Their personal appearance and conduct should be such as to be acceptable to the patients. They should receive no training, nor should they have duties that could in any way be interpreted as nursing experience. Their hours and salary should be the same as those given ward maids, or perhaps the salary might be somewhat higher. Their position as ward helpers, should not be considered as experience qualifying them in any way to serve the public in the care of the sick, whether the sickness be acute, convalescing or chronic.

Among the duties they may perform are dusting, cleaning utensils, caring for linen, arranging flowers, taking patients to sun parlors, $x$-ray laboratories, arranging trays, feeding patients, etc.—in other words, the duties of these workers are not fixed. The three important points to be remembered are (1) that the workers are employed as workers, not learners, (2) that they receive no instruction, and (3) that the result of this experience will in no way prepare them for the care of the sick, nor should they expect it to do so. In order that there be no misunderstanding as to this, thereby causing discontent and friction, they should be thoroughly acquainted with these facts before being employed.

### Nursing Aides

The third group of workers we will for the present term "attendants." These women should have completed grammar school; they should be properly qualified physically; they should receive from the hospital, maintenance, uniforms and a small allowance. A carefully prepared outline of training both practical and theoretical should be given, covering eight or nine months. At the end of this term they should receive a certificate and should be ready to leave the hospital. If they remain after the completion of their course they should receive a salary. This salary should be determined by the standard of salaries in a given locality. Hospitals desiring this class of workers, and not giving a course for attendants should employ them as stated above.

The content of such a course should be determined by a state board of examiners for the registration of nurses. The type of institution in which this training may be given should be determined by state laws and the *worker and patient, should be protected by proper legislation.*

The use of these groups by any given hospital will be determined by its type of patients, its economic necessity and by its interpretation of its own function in the community. *The hospital believing that it has an educational function in the community,* therefore desiring the most scientific care for its patients, will provide a personnel making such care possible.

### An Economical Policy

Ward maids and ward helpers will be employed in such numbers as to make possible the use of all scientifically trained persons to the best advantage. Persons who by virtue of their high grade of intelligence, personality,

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training and experience have been employed for these services will be detailed only to the actual care of patients, and to the making and recording of scientific observations. This applies to graduate and student nurses.

This will be an economical policy also for by so doing, the course of training for the student nurse can be shortened, and the graduate nurses employed will be fewer in number, when their time can become concentrated upon the patient, his personal and scientific care.

The same hospital will employ trained attendants for such patients as do not need the time of the student nurse, or of the graduate nurse. In this age of specialization all of these workers may have a place.

In the hospital caring largely for chronic patients, all three groups of workers can be employed with a sufficient number of graduate nurses, to make the care of the patients safe. Again, specialization will promote economy in administration, as well as making safe and scientific the care of the patients. The adequate use of these three groups of workers in hospitals, is largely a matter of education and of adjustment.

### The Hospitals' Obligation to Its Workers

What obligations do employing organizations have toward these workers? The organization admitting these groups should know that it can do so without exploitation. In the case of the first two groups, proper working hours, living conditions and fair treatment will prevent any such accusation.

In the case of the third group, the responsibility of the hospital lies: (1) in being able to provide proper working and living conditions; (2) in providing the proper supervision while this training is being received; (3) in using all its influence to secure proper state laws for the registration and supervision of these workers after graduation, and last but not least in *absolutely refusing to prepare such a group of workers unless it can be done in perfect fairness to the group, to the patients and to the public.*

### The Hospital's Obligation to the Public

In considering the hospital's obligation to the public we note these points:

*First*—The hospitals should not employ any more helpers than are needed in performance of their particular duties. By doing otherwise these workers will eventually assume nursing duties, which will subsequently lead to a misrepresentation of themselves to the community, thereby rendering them dangerous factors to public health. The institution must not make it possible for them to imitate nursing procedures, which they are incapable of performing scientifically, resulting thereby in reducing the patients' faith in the hospital.

*Second*—In the case of the patient in the hospital, no one, regardless of his financial standing in the community, if critically ill, should be subjected to the care of this group, for there will exist a lack of confidence on the part of the patient, whose care depends upon them, and the well-being of the patient may be seriously affected by the lack of necessary intelligent care.

*Third*—If attendants are trained, the hospital should consider it necessary to have as satisfactory a reputation for its attendants' school, as it would for its nurses' school.

*Fourth*—Hospitals should refuse to train attendants until the necessary legislation has gone into effect, making it impossible for the medical profession and the public to employ them, under any misrepresentation as to their preparation.

This trained attendant has been tried in many hospitals, private homes and public health organizations. There is no question as to her value but this value has been limited because the principles, as stated above, have not been observed.

### Actual Results

An example of the foregoing statement can be given from the experience of the Visiting Nurse Association in Cleveland. In 1918 that Association announced a department of attendant service. That service was planned to provide sick room and household assistance in families which could not afford a private trained nurse or where full time skilled nursing care was not needed. She was to be called on in emergencies. The training given by the Visiting Nurse Association covered the simple forms of sick room care. The salaries offered ranged from $10 to $15 per week. Very soon the salaries had to be increased to $18 to $20 per week, but these soon became prohibitive.

The Association charged $1.50 per week for the visits of a supervisor but the families did not want the supervision. They liked the attendant but they did not see the need of supervision. If the family needed an attendant a second time they employed her without the supervision of the Visiting Nurse Association. The attendant soon acquired that "little knowledge which is a dangerous

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thing." Ultimately, some of these women whom the Visiting Nurse Association had trained, followed the example of the practical nurse, and began charging $20 to $25 per week to other families and to other physicians. Without regard to the actual value of her service, she fixed her own price and her own standard of work.

Thus it became evident that the Attendant Department of the Visiting Nurse Association of Cleveland was not fulfilling the purpose for which it was designed, namely that of supplying assistance to households of limited income which could not afford graduate nurses.

The question arose with the association: To what extent would it be responsible for turning these slightly trained women back into the community as nurses?

If the public fully understood the difference between graduate and practical nurses, if the public could be depended upon to exercise the amount of discrimination necessary. then the public could defend itself. But we know that the public cannot do this. It therefore becomes the duty of hospitals and of organizations to protect the public in so far as possible. Because of this in April, 1920, The Cleveland Visiting Nurse Association announced that after a trial period of more than two years the Department for Attendants had been abandoned.*

This brings us to that part of the report, made by the Committee appointed by the Rockefeller Foundation, which considers: "The Field for a Subsidiary Type of Nursing Service." In this section, we find that private physicians, health administrators and hospitals need two types of nursing service but emphasizing the fact that these two types should be provided, *"according to the type of illness and not economic grounds."* In this connection this committee has found that the margin, between the average annual income of the private duty nurse and that of the domestic servant, is not so great as to permit of the existence of an intermediate grade on a salary level very much below that of the present registered nurse. This committee recommends the use of these workers for the mild or chronic cases. They further remind us that "of the three hundred thousand male and female nurses in the United States in 1920 slightly more than one-half are of grades below the standard of the graduate nurse." This class of workers is a real fact and it fills a real need.

* Statements from the *Public Health Nurse*, April, 1920.

The Rockefeller committee's conclusion of the matter is "that steps should be taken through state legislation for the definition and licensing of a subsidiary grade of nursing service, the subsidiary type of worker to serve under practicing physicians, in the care of mild and chronic illness and convalescence, and possibly to assist under the direction of the trained nurse by certain phases of hospital and visiting nursing."*

Charlotte A. Aikens, second vice-president of the American Hospital Association

As Miss Clayton stated, if the hospital associations and the nursing organizations unite in their efforts, and have the same objective for the use of these workers much of our present problem as to how to supply adequate care for the sick will be solved.

The questions of attendants brought on another discussion. It was pointed out quite clearly that the training of attendants would not necessarily change the *economic difficulty* (since trained attendants, it was found, could and would ask the same remuneration as the fully trained nurse, in many cases) but rather meet the *numerical shortage* felt in certain sections.

As Miss Minnie Goodnow pointed out, with only 150,000 girls graduating from the high schools of the country each year and the required number of probation nurses necessary in our schools each year to meet the quota reckoned at 25,000, would mean that one high school girl in every six must take up nursing. Failing to gain that quota the only alternative, she felt, resided in the training of the nursing aide.

* Quoted from Miss Goldmark's report of the work of the committee.

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# THE LAUNDRY QUESTION*

## A STUDY OF COST AND EQUIPMENT

W. P. Morrill, M.D.
Superintendent, State Charity Hospital, Shreveport, Louisiana

COST and satisfactory service are the two problems in the laundry, and while the latter question is all in favor of the hospital laundry, many small hospitals have not considered that practicable because of the conviction that the cost of equipment and overhead of operating was so great as to prevent any economy in installing their own equipment. For this reason especial effort has been made to secure information on this question. Though the definite figures obtained are rather meagre, they are fairly conclusive. But admitting for the sake of argument that the actual direct cost would not be reduced, there is so great a reduction in indirect costs as to make the hospital laundry a paying proposition, even though the cost per pound is no less.

### The Commercial Laundry

In the first place, the high-class commercial laundry catering to a family trade is not very anxious to do the hospital's work, because their customers do not relish the idea. While they may do it, if offered, they surely will not make concessions to secure it. If they do take it, they will often require that certain badly stained or soiled pieces be washed out before being sent. This either causes serious delay in waiting for the pieces to dry or subjects the linen to serious danger from mildew. The stains to which hospital linen is subject are of such different character from those found in ordinary commercial work that unless the laundry uses special methods, for which the hospital will pay well, the stains will either not be removed or, if they are, it will be by such drastic methods as to seriously impair the life of the linen.

Another feature that enters into it is the question of the delays incident to sending laundry out, and its effect on the size of stock that it is necessary to keep in circulation. It is perfectly possible by scheduling collections to have all ward linen from the morning change and all operating room linen used up to one o'clock. This materially reduces the amount of stock in circulation and the leakages which always accompany large stocks.

### Economy of Hospital Laundry

The studies available from larger hospitals indicate savings from operating their own laundries to be from 30 per cent to 60 per cent, depending on the size of the plant and the ability with which it is managed. The last three or four years have seen developed machinery and processes which make it possible for the small hospital plant to do only three or four hundred pieces nearly, if not quite, as efficiently and cheaply as those in the larger hospitals.

The four points to be considered in the installation and operation of a hospital plant are: personnel, location and equipment, supplies, and processes. In the smallest plant, suited for hospitals of 50 to 75 beds, it will usually be found that with the janitor or engineer to run the washer and extractor, and even the flat work ironer, one woman, with perhaps some part-time help, will be able to do all the hand ironing. The introduction of powdered soap, doing away with the old process of soap cooking, and of the cold starch process, making necessary only one loading of the washer and one extraction, and the use of the press has so reduced the amount of labor that the amount of work accomplished by a small personnel is really surprising.

### The Small Hospital Problem

All who have had experience agree that the best location for the laundry is in a separate building, but as this is hardly feasible for the small hospital it is suggested that it be located close to or in connection with the boiler room, thus making it possible for the engineer to properly supervise the machinery or to assist in its operation. Likewise the boiler room usually is sufficiently well isolated from patients' rooms that this location will also prevent the noise, steam and odors becoming a cause for complaint on the part of patients. But wherever located, the space must be sufficient in floor area to provide wide passageways for the handling of baskets, ample ceiling height, ventilation and light.

The equipment hardly can be discussed in detail in this report, but suffice it to say that a washer, an extractor and a flat work ironer

* The report of the chairman of the Committee on Laundry Equipment and Supplies, upon which George F. Stevens, M.D., and R. L. Henry, M.D., also served.

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are the basic units and can be secured in sizes to meet the requirements of hospitals as small as 25 beds. One of the first units to add after these three is a press, as it is at least four times as efficient as hand ironing on those articles to which the flat work ironer is not suited. Unless a large amount of personal work is done, very little hand ironing will be necessary. For such as is done there should be provided electric irons, preferably two for each board.

All machinery should be equipped with proper safety appliances, all belts and pulleys well housed in heavy screen frames, or, better still, the individual units should have individual motor drives, as this allows greater freedom in placing machines and is a real economy in a small plant by reason of the fact that the different machines will not likely all be needed at one time.

### Accessory Equipment

In the larger laundries many accessory machines will be of service. The first to be mentioned is the dry-room tumbler, judicious use of which greatly reduces the necessity for a dry room and at the same time makes possible the renovation of pillows and woolens much more satisfactorily than they can be done outside. After this come dryers, collar and cuff machines, neckband machines, dampeners, rotary edgers, bosom presses, collar shapers, conveyer dryers, etc., all of which it would be out of place to discuss here, as the laundry which needs them will need to give the subject much deeper consideration than is possible at this time.

### Laundry Supplies

*Water.*—The matter of supplies is the one to which least consideration is usually given and which at the same time is the source of much dissatisfaction, though often unsuspected. And the first and most important supply is water. The nearer we can get to the old rain barrel, the happier will be our lot. Most city water supplies are not only hard in their natural state, but are chemically treated to make them fit for human consumption. The lime contained in them unites with the soaps to form an insoluble lime soap which permeates the thread and produces that harshness which makes the linen so disagreeable to the skin and at the same time makes the fabric brittle and very materially decreases the life of the linen, because, after, all, the real wear and tear on linen is in the laundry and not in use.

Hard water likewise wastes supplies. According to one authority, for each degree of hardness there is a theoretical soap waste of 1.3 lbs. per thousand gallons. As the average washer takes about fifty gallons, it is evident that with water of twenty degrees of hardness it amounts to a waste of 1.3 lbs. per washer load. And water of twenty degrees hardness is not unusual at certain seasons of the year. A further difficulty with hard water and the resultant insoluble soaps is a surface deposit on the linen producing a dirty gray tinge and the so-called soap specks. The best remedy for this is in some form of water softener, of which the zeolite type or some modification of it is easily the most efficient. The economy following the installation of a plant of this character will apply in the boiler room in equal degree as in the washroom, and will be especially noted in the domestic hot water supply. One commercial plant claims a saving of 53 per cent in their soap bill over a period of eight months.

### Soaps, Bleaches, Bluings

*Soaps.*—Soaps are a chemical compound of an alkali with a fat, with glycerine as a by-product. For laundry purposes chip soap has held the field for some years and many reliable brands are on the market. But even the reliable brands vary widely in water content, running from 12 per cent up to 20 per cent, and if adulterated even much more. The water does no particular harm, but the careful buyer will object to paying soap prices for it. In the more recently introduced powdered soaps the moisture may run as low as 8 per cent. In any case it is well to test purchases for moisture occasionally, which can easily be done by weighing out a given quantity, say ten pounds, drying for 24 hours in the dryroom, or in a warming oven or hot air sterilizer, and reweighing. Divide the initial weight in ounces into the difference between the weights before and after drying in ounces and the quotient will express the percentage of water. Care must be exercised, however, to take the sample from the middle of a freshly opened barrel, as the soap near the surface always loses some of its water by evaporation, and would thereby give a false result, unless sophisticated, which makes the soap gain by absorption. Salesmen have many modified soaps to present and many claims for them, but there is no reason for more than one standard soap in any laundry, and it often happens that they have simply modified the soap with soda and are selling the soda at soap prices. The introduction of a

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successful powdered soap has made possible the elimination of the old soap cooking and the nasty mess that usually surrounded the soap tanks. This has not only resulted in economy of time, space and material, but is an economy of soap, as the washerman will usually adjust the amount used more carefully if given a comparatively small scoop and required to mix the soda with the soap as he puts it in the washer.

*Alkali.*—Contrary to general belief, alkali has no detergent action of its own and is used only on account of its power of increasing the detergent action of soap. The alkali generally used is sodium carbonate, though some hospitals recommend tri-sodium phosphate as a "break down." Its value is questioned and has not been demonstrated in laboratory tests. There are, however, other reasons for the use of alkali: (a) The presence of soda decreases the tendency to the formation of calcium soaps. These water softeners, which treat water by the ordinary salt principle of mass action, remove the hard substance. (b) Certain dirts on soiled linen contain acids which the alkali will neutralize, and (c) some greases contain free fatty acids which the alkali will convert into soap, thus aiding the detergent process.

*Bleaches.*—Bleaching is either a process of oxidation or reduction. The almost universally used sodium hypochlorite or javelle water is undoubtedly the best, and in hospital work is particularly useful on account of its bactericidal action, it being best described as an impure Dakin's solution, and the identical material with which Semmelweis 80 years ago laid the foundation of hand disinfection in obstetrics, reduced his death rate from puerperal fever by 90 per cent, won for himself a lunatic's cell, and for motherhood practically immunity from the scourge which in his day attacked every tenth mother. It is not necessary to use bleach on hospital linen at every laundering and when it is used it should be rather light—not over two quarts of javelle water to a standard washer with six inches of water in the wheel. Javelle water is prepared by the solution of 10 pounds of bleaching powder (calcium hypochlorite) and 10 pounds of soda ash in 30 gallons of water. Stir well and allow the calcium carbonate to precipitate and then dip or, better, siphon off the clear supernatant liquor.

*Sour.*—There are two reasons for the use of a "sour" in the laundry process: *First,* to neutralize the alkaline materials remaining from preceding processes, and *second,* to remove certain stains which respond to acid but not to alkali. The most satisfactory sour is acetic acid, used in the proportion of three to five ounces to a washer with six inches of water. If there are iron stains in the fabrics, the addition of oxalic acid in the following manner may be required: Dissolve one pound of oxalic acid crystals in one gallon of hot water. Use equal parts of the oxalic acid solution and of 36 per cent acetic acid, two to two and one-half or even three ounces of each to a standard washer load.

*Bluing.*—Bluing is used to cover up the grays, a process which with softer water and more carefully controlled processes is gradually becoming less and less necessary. Blues are of two types, the insoluble, simply an exceedingly fine insoluble powder like ultramarine or cobalt blue, which acts by simple deposition on the surface of the thread, and the more common soluble or aniline blues, which are actually absorbed by the fabric. The aniline blues have from four to thirty-five times the bluing power of the insoluble blues and have the added advantage of being more easily adjusted to the required tint. An insoluble blue you can't rinse; a soluble blue you can.

*Starch.*—There are two types of starch process in general use. The one known as the cold starch process is rapidly growing in favor by reason of the fact that it eliminates the starch cooker and eliminates one extraction process. A satisfactory grade of starch will be supplied by any reputable supply house. They may offer you prepared starch. *Ordinary starch* is all you need.

### Washing Processes

When the soiled linen is received in the laundry it should first be sorted according to the character of the fabric, size of pieces and character of soiling. The following list gives a fair idea of classification: bed linen; dining room linen; operating room linen; uniforms, white; uniforms, colored; shirts and waists; collars and cuffs; sox and stockings; underclothing; overalls; colored aprons, etc. All blood-stained linen should be given a preliminary soak in lukewarm water, not over 100 degrees, after which it may take the course of all white work. The ten processes which follow may easily be reduced to five. These processes were worked out through the Mellon Institute, working in conjunction with the Laundry Association:

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1. Five minutes, lukewarm, 3 inches of water in cylinder after goods are saturated.
2. Fifteen minutes hot suds, 3 inches, water, sufficient soap to make 6 inches of suds on top of water. If powdered soap is used, add one part soda to three parts dry soap—if water is fairly soft increase soda according to hardness of water.
3. Repeat (2).
4. Five minutes hot rinse, 6 inches of water.
5. Repeat (4), adding two quarts of javelle water.
6. Five minutes hot rinse, 6 inches of water.
7. Repeat (6).
8. Warm water 6 inches, add 4 ounces sour and run ten minutes. Blue. Ten minutes.
9. Cold water to cool goods, five minutes. If cold starch process is used, the starch may be added directly to this load and run at least five minutes after addition of starch.
10. Extract.

In loading extractor care must be used that articles are not entangled, as entangling leads to tearing of goods. Also extractor must be evenly loaded so that as it runs there will be no vibration. Neglect of this precaution is not only injurious to the machinery but dangerous to the operator. Safety covers should always be used. If water of good quality is used, it is not always necessary to use bluing. In washing colored goods temperatures above 120 degrees are injurious to the colors. All flat work can be taken direct from extractor to flat work ironer, and the same applies to such work as is ironed on the press. Articles that require hand ironing must be dried partly first. This may be done in the open air, in which case they will require dampening. However, if a small tumbler is available, they may be partly tumbled and then taken directly to the ironing boards.

### Linen Accounting Methods

This subject cannot well be dismissed without a word as to linen accounting methods. Many methods have been devised, some simple and some intricate. In general it will be found that the less forms you have the more practical will be your system, and the more closely you adhere to some form of exchange system in issuing clean linen the more satisfactory will be your results. One very satisfactory system is to use a slip the form of the ordinary commercial laundry slip, except that the name of the various articles are printed at the left, the right being occupied by three blank columns headed, respectively, "Your count," "Laundry count," "Issued." The person or department sending the laundry fills in the first blank column and retains a copy. On arrival at the laundry the bundle is counted and sorted and the indicated entry made in the second column by the laundry. If this agrees with the first column, the goods go on into work. If, however, they do not agree, it is put aside and the sender notified or put into work as circumstances indicate. As soon as corrected the record is transcribed into the regular laundry record book or, better, on to a daily report sheet. The slip then goes to the clean linen room and becomes a requisition for clean linen, though the amount issued may be increased or decreased by proper authority. In any case, the completed slip remains in the linen room as a record and the individual to whom the bundle is delivered has the duplicate made originally to check against. This system is sufficiently flexible to meet changing conditions and is sufficiently accurate and detailed for small hospitals. Large hospitals may desire a more detailed system, though this system has worked successfully in one hospital of two hundred beds whose employes are well below the average in education and accuracy.*

## COMMITTEES APPOINTED

When Mr. Asa S. Bacon, superintendent of Presbyterian Hospital, Chicago, assumed office for the year 1922-1923, he appointed the following committees:

Asa S. Bacon, President 1922-1923

Constitution and Rules: Richard P. Borden, trustee, Union Hospital, Fall River, Mass.; George S. Hoff, secretary, Lake View Hospital, Danville, Ill.; John M. Peters, M.D., superintendent, Rhode Island Hospital, Providence, R. I.

* A special bibliography, prepared with this report, is available in mimeograph copies. Apply to the American Hospital Association, Chicago, Ill. Particular attention is invited to the "Manual of Standard Practice for the Power Laundry Washroom," issued by the Laundry Owners' National Association, which is based on the researches conducted by the Mellon Institute of Pittsburgh, acting in behalf of the above association.

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Nominations: George F. Stephens, superintendent, General Hospital, Winnipeg, Canada; Charles S. Woods, M.D., Indianapolis, Ind.; W. P. Morrill, M.D., superintendent, Shreveport Charity Hospital, Shreveport, La.; Lewis A. Sexton, M.D., superintendent, Hartford Hospital, Hartford, Conn.; C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.

Membership: The Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis.; Miss Margaret Cummings, superintendent, Buhl Hospital, Sharon, Pa.; Sister Geraldine, St. Elizabeth's Hospital, Youngstown, Ohio.

Out-Patient Work: Alec N. Thompson, M.D., director, Department of Medical activities, American Social Hygiene Association, New York.

A. K. Haywood, M.D., superintendent, Montreal General Hospital, Montreal, Canada; Walter Niles, M.D., dean, Cornell Medical College, Ithaca, N. Y.

## TENDENCIES IN HOSPITAL PLANNING*

S. S. Goldwater, M.D., Chairman

The following tendencies in hospital planning are noted not from the standpoint of construction (which is outside the province of The Trained Nurse) but because they indicate important changes in hospital function and administration:

1. A growing disposition to inquire into the needs of a community before making plans, thus avoiding wasteful duplication and overlapping. The committee strongly endorses such inquiries.
2. A marked tendency toward concentration in planning to economize in the use of building materials, and to facilitate medical, administrative, nursing and domestic service.
3. The development of general plans through the putting together of the plans of individual departments each conceived from the standpoint of precise needs; in other words, scientific, synthetic, technical planning rather than the adoption of loosely conceived general schemes, dominated by conceptions of architectural design. With the new point of view, architects generally are now in accord.
4. A widespread demand for convenient facilities for outdoor treatment. In practice there is observable a shifting of emphasis from roof to veranda as a means of outdoor treatment and the consequent lifting of the taboo on pitched roofs, which, while not universally approved, are reappearing in important multi-storied hospital buildings.
5. A demand for a reasonable measure of privacy for patients occupying semiprivate and ward beds, resulting in the subdivision of a considerable part of large open ward of former days into small wards, individual cubicles or even small individual rooms.
6. A more liberal use of plumbing fixtures, especially of individual waterclosets in connection with private rooms, and of washbasins in both wards and private rooms. There is not, however, a proportionate increase in the number of private baths.
7. The use of single rooms in nurses' homes for both graduate and pupil nurses.
8. An increase in the allotment of space in nurses' homes for teaching purposes (lecture rooms, demonstration rooms, science laboratories, study rooms, libraries, etc.)
9. Efforts to obtain central and accessible locations for diagnostic laboratories and for treatment rooms of every description.
10. The reservation of considerable office space for social service and follow-up work.
11. Failure on the part of many medical staffs to urge the allotment of adequate space for out-patient work.
12. A diminishing use of small dumbwaiters for food service, large service elevators being required for the more modern types of heated or insulated food carriages.
13. The reconstruction of the whole question of centralized versus decentralized nursing service, experimenters being disposed to transfer a part of the fixed equipment of pantries, sink rooms, utility rooms and chart rooms, away from the traditional nursing station of the individual ward unit, and to locate this equipment centrally to the whole hospital. These measures are based on a theory of administration which involves the separation of nursing service into two parts, namely, actual bedside work, and the preparation of utensils, dressings, medicaments, and indeed of all materials and supplies which are used at the bedside or administered to the patient.
14. A feeling that serious efforts should be made toward the standardization of fixed equipment. Standardization is favored by the open-mindedness, the disposition to investigate or scientific curiosity, and the readiness to imitate, which may be said to be characteristic of the American mind.

* Excerpts from the report on Buildings prepared by S. S. Goldwater, M.D., chairman; R. G. Broderick, M.D.; Frank E. Chapman; Pliny O. Clark; C. G. Parnall, M.D.; John M. Peters, M.D., and Wiley E. Woodbury, M.D.

## THE ANNUAL REPORT*

Since the annual hospital report is prepared for two purposes: (1) publicity; (2) as a permanent record, it should contain the following essentials:

1. Table of contents.
2. Names of board of trustees, officers, committees, auxiliary groups, etc.
3. List of attending medical staff, designating rank and service.
4. Acknowledgment of gifts (form and type, as determined by the board of trustees).
5. Report of president of board of trustees.
6. Report of treasurer,

*Corporation accounts.* (Show present and part year figures for purposes of comparison.

Statement A.—Assets and liabilities, showing all capital holdings, investments, etc.

Statement B.—Income and expenses.

*Operating accounts.*

Statement A.—Income (compare two years). Show in detail, as follows, according to Scheme 1 or Scheme 2 of the American Hospital Association standard chart of accounts.

Statement B.—Expenses. Show distribution of expenses (compare two years) in detail as follows, according to American Hospital Association standard chart of accounts.

Statement C.—Resume of operating accounts (compare two years):

Total income.

Total expense.

Surplus or deficit.

7. Report of administrative officer:

The first part of this section should contain tables pertaining to certain vital statistics and the remainder should consist of detailed reports con-

* An abstract of the report of the Committee on Forms and Records composed of F. E. Chapman, M.D., John F. Bresnahan, M.D., and A. C. Bachmeyer, M.D.

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cerning the activities of the various departments of the hospital, such as nursing, social service, dietary, pharmacy, laboratory and the domestic and mechanical departments.

8. Statistical tables (compare two years).

Table A.—Service rendered:

Census (last day, previous year); patients admitted, births, total patients treated, patients discharged, deaths, census (last day, present year), patient days' care, normal, maximum census (date), minimum census (date), average daily census, average patient stay in hospital, number deaths within 48 hours, number deaths (institutional), mortality rate (excluding 48 hours death), autopsies (number), operations (number of major and minor), total hospital operating expenses, per diem capita cost.

Out-patient department: Number of visits, number of new patients, total out-patient department operating expenses, average cost per visit.

Table B.—Financial classification of service (compare two years). Admissions and patient days of: Pay patients, part-pay patients, free patients, totals.

Table C.—Patients denied admission (compare two years). Lack of accommodations; referred to non-staff physicians, communicable diseases, unsuitable (list causes), hospitalization unnecessary, totals.

Table D.—Analysis of service (compare two years). Medical, surgical, obstetric, specialties enumerated as to number of patients, days' care, per cent. days' care.

Following the above statistical tables, various departmental reports should be inserted.

9. Report of attending medical staff:

A. A brief review of the work of the attending staff, including lists of special studies made and articles published by the staff—clinical, laboratory and x-ray. In larger hospitals this section would probably be elaborated to show the various professional departments.

B. Professional statistics. The existing medical nomenclatures are not sufficiently comprehensive and are lacking in uniformity. Until a uniform nomenclature can be compiled through the collaboration of allied interests, the committee does not feel that any one of them can be recommended as a standard. Therefore, it does not recommend the publication at this time of professional statistics.

## RECLAMATION AND STANDARDIZATION OF GAUZE DRESSINGS*

A. B. Denison, M.D., Chairman

THE committee advises that when gauze is purchased with a view to reclaiming the weight selected be the lowest count gauze which will preserve the balance between new and old gauze—that is where the new gauze in circulation through various channels just supplies the normal decrease in the supply of washed gauze and no more. The committee recommends the use of 24-20.

### Reclamation

The process of reclaiming consists of soaking the gauze over night in cold water in a washer reserved for gauze washing. In the morning the gauze is washed in several changes of cold water, then several of hot water, bleached and dried in the centrifugal drier. Bacterial counts show that the gauze is sterile at this point but usually, as a matter of extra precaution, it is run through the formaldehyde autoclave. It is then pulled out straight in the gauze room, wrapped in packages and sterilized again.

### Standard Dressings

The Cleveland Hospital Council specifications were used as a basis of work: 36" x 36", 36" x 18", 18" x 18", and 12" x 12". The following standard dressings were exhibited:

Large Abdominal, 12" x 18" (cut gauze, 36" x 36").

Perineal Pads, 9" x 4½" (cut gauze, 18" x 18").

Medium Abdominal, 9" x 12" (cut gauze, 36" x 36").

Small Tape, 18" x 1½" (cut gauze, 18" x 3").

Small Tape, 24" x 2" (cut gauze, 24" x 12").

Square Tape, 18" x 18" (cut gauze, 36" x 36").

Large Tape Sponge, 36" x 9" (cut gauze, 36" x 36").

Small Sponge, 1" x 1½" (cut gauze, 4" x 4").

Medium Sponge, 2½" x 3" (cut gauze 9" x 9").

Large Sponge 6" x 4½" (cut gauze 18" x 18").

Goitre Roll, 4½ yds. x 4" (cut gauze, 4½ yds x 36").

Medium Tape Sponge, 36" x 6" (cut gauze, 36" x 36").

Abdominal Roller, 72" x 6" (cut gauze, 72" x 24").

Bed Pad, 16" x 24" (cut gauze, 36" x 36").

* The following is abstracted from the report of the committee composed of Claribelle Wheeler, Sister Cornelia, Sister Patricia, Sister Amadeus, Sister Agnes Therese, Guy J. Clark, and the chairman.

## NEW OFFICERS ELECTED

The officers elected for the coming year are as follows: President-Elect, Malcolm T. MacEachern, M.D., Vancouver General Hospital, Vancouver, B. C.; First Vice-President, A. K. Haywood, M.D., Montreal General Hospital, Montreal, Quebec; Second Vice-President, Miss Charlotte A. Aikens, Detroit, Mich.; Third Vice-President, R. G. Broderick, M.D., Alameda County General Hospital, San Leandro, Cal.; Treasurer, Robert J. Wilson, M.D., Health Department Hospitals, New York; Trustees, The Rev. Maurice F. Griffin, St. Elizabeth's Hospital, Youngstown, Ohio, and A. C. Bachmeyer, M.D., Cincinnati General Hospital, Cincinnati, Ohio.

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# FOOD SERVICE*

C. W. Munger, M.D., Chairman
Grand Rapids, Mich.

THE subject of the construction and proper operation of the dietary department is such a vast one that this report cannot attempt to cover it. As to the location of the kitchen—

The location of the kitchen is a matter which has often been debated, the three locations most used being, the ground floor or basement, the top floor of the hospital, or a separate building. Each one of these locations has its advantages and the committee holds no particular brief for any one type.

All three of these locations for kitchens are to be found among the five hospitals represented on the committee, and each superintendent is evidently well satisfied with his or her arrangement.

### Labor Saving Devices

It is the opinion of the committee that the following should be found in every hospital kitchen:

An electrically driven machine or machines which will chop meat and vegetables, and which may be used as a bread crumber.

A butter cutting device which makes it possible to use bulk tub butter rather than the more expensive print butter.

An electric mixer which can be turned to various uses.

An electrically driven meat slicer.

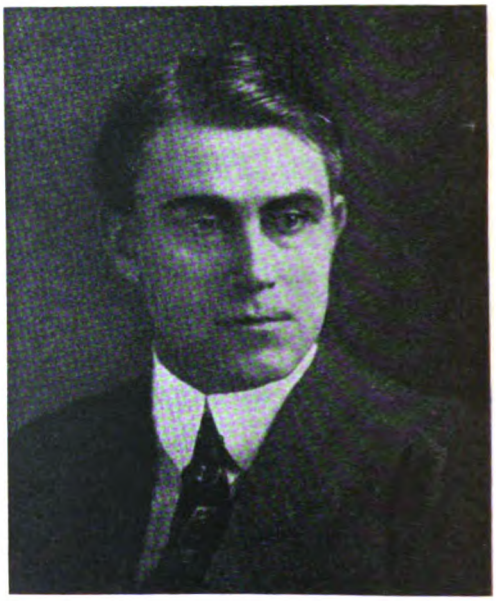
An electrically driven bread slicer, with efficient safety devices.

An electrically driven vegetable parer.†

Fireless cookers used overnight in the preparation of cooked cereals are economical and efficient.

It is advisable that as much cooking equipment as possible be heated by steam. Both copper and aluminum steam heated equipment have been found satisfactory. Copper cooking utensils must frequently be retinned if in constant use. With aluminum there is no such disadvantage. Copper utensils if well cared for (which, however, entails considerable work) probably present a more desirable appearance than aluminum. Meat, vegetables, soups and cereals may be cooked in steam jacketed containers with ease and efficiency.

A recent innovation is a low temperature vapor cooker which is heated by means of steam but which does not employ live steam as a cooking agent. This new device cooks at a temperature of less than 100° Centigrade, and while it requires a longer time for cooking, the amount of steam used is comparatively small and the results, in the experience of the chairman, are an improvement over the ordinary steam cooker for certain articles. In meats, for example, there is certainly less shrinkage and when thoroughly cooked they retain more of the original juice than is the case with ordinary boiled meats.



Malcolm T. MacEachren, M.D., President-Elect

### Fuels

Coal gas is perhaps the most desirable fuel for use in preparing food which must be baked or roasted, or cooked on top of the stove. Electricity, natural gas and petroleum oil are satisfactory and practical where local conditions make their use economical.

The gas, or other type of stove should be

* Abstract of the report of the Committee composed of Dr. F. R. Nuzum, Med. Director, Santa Barbara Cottage Hospital, Santa Barbara, Cal.; Dr. E. T. Olson, Supt., Englewood Hospital, Chicago, Ill.; Miss Rena Eckman, Household Director, University of Mich. Hospital, Ann Arbor, Mich.; Dr. C. S. Woods, Supt., Methodist Hospital, Indianapolis, Ind.; Miss Alice E. Thatcher, Supt., The Christ Hospital, Cincinnati, O., and the chairman. Read at Atlantic City, N. J., Sept. 26, 1922.

† This device will not pare potatoes so that they are ready for cooking. They must be gone over by hand and the eyes removed. There is some saving of time, however, and a very marked saving of potato because when the work is done entirely by hand the parings are very much thicker, with a resultant waste which includes that portion of the vegetable immediately beneath the skin which is said to be richer in vitamins and other health giving substances.

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of ample size, properly located from the point of view of unnecessary steps and have as few projecting surfaces, shelves, et cetera, as possible to simplify the matter of cleanliness. The stove, as well as all the heated equipment, should be grouped under one or more hoods which are connected with powerful ventilating fans for the purpose of carrying away heat and odors. One of our committee has found that wire bound glass hoods with nickel trimmings are especially desirable from the point of view of appearance, cleanliness, and lighting.

Electric, gas or steam coffee machines should be installed in a battery. There should be at least two urns in case of difficulty with one. In most hospitals it is desirable to have three or more urns for coffee and one or more for tea, cocoa, et cetera. In the majority of cases steam will be found most suitable for heating these urns.

The hospital executive who permits the use of old fashioned milk can and dipper for milk to be used for drinking purposes is probably making a grave error. Moreover, he is at fault if he does not periodically check the purity of the milk supply by means of bacteria counts made in the *hospital laboratory* since counts provided by health department or other agencies are accurate at the time the counts are taken, but give very little idea of the condition of the milk when it actually reaches the hospital. The dietitian and the superintendent of the hospital should know and assure themselves of the purity of the milk when received by the hospital, and take every precaution to see that it is not further contaminated or neglected after it is received. Two of our committee have had excellent results in the use of refrigerated milk urns so constructed, as to be easily scalded and steamed daily. Where whole milk is used, as it should be for drinking purposes, an urn which delivers the proper percentage of cream for each glass of milk seems entirely desirable.

### Dishwashers

The modern type of dishwasher is a vast improvement over hand washing. For hospital use the automatic dishwasher which does not sterilize the dishes fails to perform an important function.

The many supposedly non-contagious cases which later become contagious are sufficient argument for the sterilizing of every dish used in the institution.

### Food Conveyers

By some the steam table is preferred with containers sent up on the elevator and placed in the steam table on the ward; others use the food cart, heated by hot water or by electricity, or the newer type of food cart constructed on the principle of the fireless cooker or the vacuum thermos bottle. The hot water conveyor has been criticized because of inefficiency and because of its greater weight which requires more current for the elevators. The electrically heated device has been said to overheat the food at times and to give it a warmed-over taste. The third type of food cart has been in use for a shorter period. Either for that reason or because it is superior, we have heard fewer criticisms of this type.

The diet kitchen, as well as the main kitchen, should be conveniently located to the service elevators or dumb waiters which communicate with the various nursing units. Convenient to both kitchens we should place the cold storage rooms, well refrigerated and of ample size, but not so large as to be wasteful of the refrigerant. They should contain convenient shelves, hooks or tables, and should be so constructed inside as to make absolute cleanliness easy.

In the preparation of special diets for diabetic, nephritic, hypertension, gout and obesity patients, it is well to have a section of the general kitchen set side for this work. A good gram scale for weighing foods is a necessity. Washed bran can be provided both quickly and satisfactorily by the use of running water with an electric mixing machine or a baby mixer in the diet kitchen. A standard cream separator is a great time saver in the preparation of sugar-free cream and milk

### The Dietary Personnel

In order that the hospital diet kitchen may be most efficient, it is first of all important that there be a thorough understanding of dietetics on the part of the physician. *It can scarcely be said of any of our staffs that* 100 *per cent of the men are capable of scientifically cooperating with the dietitian in this regard.* Also, there must be a *mental* equipment on the part of the dietitian (and her assistants) that permits not only the care of dietetic orders as written, but a knowledge of dietetics so broad that she can discuss with the physician or patient, or both, the best methods of obtaining the desired result. A hospital is not prepared to render as efficient food ser-

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vice unless its dietetic department can, and does, teach dietetics to physician, and patient, as well as pupil nurses.

*The chief dietitian should control the entire food problem of the institution.* Assistant dietitians for the preparation of special diets should be provided if needed. The presence of pupil nurses and pupil dietitians in the department stimulates the superior officers to set the best possible example. Efficiency of employees is all-important. Salaries should be as generous as possible, and the department should be so managed that there is not the constant change in personnel as is so often seen.

The committee recommends a detailed, accurate accounting system for the dietary as well as other departments, to eliminate carelessness and waste. A yearly budget for the dietary department has a desirable effect, and does in no way curtail the work. The computation of the percentage of waste of various articles of foods to determine what foods are most acceptable to patients and staff, and the size of servings are important factors in avoiding waste.

## GENERAL FURNISHINGS AND SUPPLIES*

W. D. Hersey, M.D., Chairman

To meet the demand for a hospital bed of rigid construction, firmly locked and capable of withstanding hard usage, with castors of such size and movability as to allow ready transportation of the bed from one part of the ward to another when desired, there have gradually been several satisfactory beds constructed. These are now supplied with adjustable springs, modifications of and improvements on the Gatch type of frame, controlled by hand or adjusted by cranks or ratchets. The tendency to finish the metal bed frames in various colors to correspond with the general color scheme of the room, has been a gradual development.

Special room equipment is now being supplied by complete room units in metal, including beds, cabinets, dressers, tables, wardrobes and other pieces. Monel metal has also become a close competitor with other metals in the construction of table tops. Many superintendents have furnished their private rooms with wooden furniture.

The average hospital mattress should be of hygienic construction, covered with durable material and capable of being sterilized; the better the grade purchased, the longer it may be expected to serve. The comfort of the patient should also be considered. Curled South American horse-hair comes the nearest to fulfiling the above requirements. On the other hand, very satisfactory reports have come from the users of other material. Goose feathers are generally conceded to make the best pillows and these should be covered with high grade ticking.

Hospitals are urged to standardize their sizes for sheetings, pillow-cases, toweling and blankets used, not only in order to obtain uniform bids from dealers, but also that the same sizes may be encountered throughout the institution. To detect filler in cotton goods rub the cloth between the hands; the filler will dust out leaving a much inferior surface.

Standardization of all equipment and supplies should be carried to the greatest practical degree, since, if definite standards are established, the manufacturers can turn out a smaller variety of goods, the dealer may reduce the amount of his stock and the cost to the consumer is correspondingly lower.

## FLOORING

Frank E. Chapman, Chairman

The exhaustive report of the Committee on floors is representative of the scientific service rendered to hospitals by the American Hospital Association members. The committee submitted 56 floor materials to tests which would estimate abrasion, resistance to pressure, fire resistance, absorbency, acid and alkali resistance and staining. The full report in printed form is available to association members. The following recommendations show the practical value of the findings:

1 **Private Rooms**
First choice, reinforced rubber, terrazzo in blocks.
Second choice, battleship linoleum, concrete with integral hardener and coloring.
Third choice, soft mastic.

2 **Wards**
First choice, reinforced rubber, terrazzo in blocks.
Second choice, battleship linoleum, concrete with integral hardener and coloring.
Third choice, soft mastic.

3 **Service Rooms (see note)**—Utility, service kitchens, toilets, baths.
First choice, reinforced rubber, flint tile (various colors).
Second choice, battleship linoleum, slate.
Third choice, soft mastic, concrete with integral hardener and coloring.

4 **Corridors**
First choice, reinforced rubber, terrazzo in blocks.
Second choice, battleship linoleum, concrete with integral hardener and coloring.
Third choice, soft mastic.

* Abstract of the committee composed of Louis H. Burlingham, M.D., K. H. Van Norman, M.D., and the chairman.

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**5 Service Corridors**
First choice, no recommendation, asphalt mastic.
Second choice, concrete with integral hardener and coloring
**6 Operating Rooms**
First choice, reinforced rubber, terrazzo in blocks.
Second choice, battleship linoleum, concrete with integral hardener and coloring.
Third choice, soft mastic.
**7 Kitchens**
First choice, no recommendation, quarry tile.
Second choice, terrazzo in blocks.
Third choice, concrete with integral hardener and coloring.
**8 Offices**
First choice, reinforced rubber, terrazzo in blocks.
Second choice, battleship linoleum, concrete with integral hardener and coloring.
Third choice, soft mastic.
**9 Laundry and Comparable Services**
First choice, no recommendation, concrete with hardener and coloring.

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## CONTROLLING FOOD WASTES

Miss Rena S. Eckman, household director, at the University of Michigan, gives the following suggestions for control of waste of food on wards:

(1) Serve smaller portions; (2) Serve second portions to those wishing it from a general serving dish taken to the ward; (3) Ascertain individual preference as to beverages, quantities of bread and butter, individual dishes; (4) Inspect for waste under separate kinds of foods.

Also these suggestions for Control of Waste of Food in dining rooms:

(1) Serve smaller portions, giving second serving as desired; (2) Allow for individual choice through self-service or by selection from menu; (3) Serve cold foods from service dish on tables.

A recent survey by Miss Eckman gives these figures:

| Percentage of Waste | Percentage on the Wards | Percentage in Dining Rooms |
|---|---|---|
| Prunes | 7.7 | 5.2 |
| Oranges | 26.0 | 21.05 |
| Grapefruit | 46.4 | 33.2 |
| Cornflakes | 51.3 | .... |
| Oatmeal | 25.5 | 3.38 |
| Wheatena | 10.4 | 7.35 |
| Bread } Toast } | 26.8 | 16.0 |
| Milk | 6.7 | .... |
| Butter | 4.1 | 7.4 |
| Pot Roast of Beef | 14.0 | 35.4 |
| Irish Stew | 13.9 | 11.2 |
| Roast of Veal | 18.0 | 14.4 |
| Cold Meat | 20.0 | 31.2 |
| Meat Pie | 5.8 | 11.2 |
| Hamburg Steak | ... | 11.8 |
| Potatoes | 14.4 | 34.7 |
| Tomatoes | 12.9 | 16.03 |
| Peas | 9.2 | 16.8 |
| Stringed Beans | 4.16 | 15.8 |
| Rice Custard | 15.3 | .... |
| Apple Pie | ... | 5.41 |
| Chocolate Ice Cream | 11.5 | 7.22 |
| Pie with Hard Sauce | 13.7 | 2.5 |
| Pears (canned) | 7.73 | 10.7 |
| Peaches (canned) | 11.2 | 3.66 |
| Ginger Drop Cakes | 11.3 | 6.5 |
| Oatmeal Cookies | 3.4 | 1.93 |
| Cup Cakes | 5.9 | 8.8 |

# THE 1923 CALENDAR

Last year, as you know, the League issued an artistic calendar—"Early Leaders of American Nursing." This contribution to graphic nursing history contained the portraits of Sister Helen, Linda Richards, Alice Fisher, Lucy Lincoln Drown, Louise Darche, Diana Kimber, Anna Caroline Maxwell, Isabel Adams Hampton, Lavinia Lloyd Dock, Isabel McIsaac, Sophie Palmer and Jane Archer Delano. The pictures of these representative nurses, printed in soft sepia on heavy, dull-coated, cream board, were supplemented by colorful facts and incidents. In many instances the calendar was sent as a Christmas gift so that its purposeful message from pioneer days might serve as an inspiration through the year.

The 1923 calendar adds a second chapter to the graphic story. This year the pictures of twelve co-workers will be similarly featured. The many intimate and hitherto unrecorded facts which are included in the new calendar will make it especially prized by students and graduates.

### Copies for Christmas

Copies will be ready for delivery after November 25. The price—$1.00 per single copy—becomes 75 cents if orders of fifty or more are sent to clubs, alumnae associations or nursing schools in one shipment. The entire proceeds from the sale of the calendar will be used in the maintenance and development of League activities. Please make all checks and money orders payable to the *National League of Nursing Education*, 370 Seventh Avenue, N. Y.

Publications Committee,
Isabel M. Stewart,
Ada M. Carr,
Florence M. Johnson,
R. Inde Albaugh, *Chairman.*

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# CONVENTION OF THE PROTESTANT HOSPITAL ASSOCIATION

*(September 23-25)*

"To serve the Christian hospitals of the land and to arouse the Church to a keener sense of her responsibility to her offspring"—these words from the presidential address of Mr. Pliny O. Clark summarize the purpose of the organization.

During the two years of steady growth,* undertaken "with a spirit of coöperation and helpfulness toward any other organization doing a similar work," the association has found itself, and is carrying on with no uncertain results.

## AN EDUCATIONAL PROGRAM
### Its Development

To carry the hospital appeal to the Christians of America has been the goal of the organization. To this end special articles have been sent to 112 church papers of all Protestant communions. As Dr. Frank Clare English framed it, in his secretarial report: "This has been the first direct attempt to interest, as a whole body, the 171,000 ordained ministers and 26,000 lay preachers of America in hospital care of the sick." As he very wisely pointed out: "If it be charged that they ought to be interested anyway, the answer is that they cannot be interested until they know the facts. Clergy do not read hospital journals to any great extent. Through them the people must be told what our hospitals are doing and what they are prepared to do for their sick and special interest must be aroused for the healing of the poor and neglected in remote places." The message can and is being carried to them through the church papers.

For end results the problem must be handled locally. The association is trying to show communities the wholesome service of their hospitals and the limitation of that service due to insufficient support. "There is no sectarian way of administering mercy."

### Massed Action

"All churches and Christians must unite in each hospital field to furnish the ministry of healing." The surveys of the association have shown the need for hospitals in isolated and rural districts. We believe that all the churches within the horizon of a practicable working area should unite in establishing and maintaining an efficient hospital service and one endeavor of the association will be to bring those isolated fields into the light so that Christian support may remedy the condition.

### Recruiting Nurses

One of the purposes of the association has been "to develop side by side with the scientific training of nurses, strong Christian character for leadership which will mean beneficial principles of action and efficient hospital service for every patient." To secure the proper material the call for student nurses has been broadcasted through the church press and the churches. The 7,000 odd hospitals are sharing in the results. "We are very anxious about the educational preparation and moral standing of our nurse candidates. We are asking the very best of our girls to give their lives to this profession. We are concerned about the moral

### THE PURPOSE

To associate hospitals with Christian activities for the purpose of fostering improvement, promoting efficiency, seeking coöperation, and securing adequate (but not duplicate) covering of the field of hospital endeavor.

To study the Christian hospital field; to consider how the individual hospital may best function for its success; to promote all public health interests.

To recruit student nurses for schools of proper standards; to encourage the development of the Christian spirit; to inculcate a real missionary spirit among all officers, pupils, internes and staff workers.

To educate the public in the use of hospitals and adequate general health measures; to print out the educational function of the nursing school; to extend to the practicing medical profession opportunities and facilities for increased efficiency.

To secure church and public assistance for Christian hospitals; to bring hospital aid to the neglected poor and those living in remote regions.

To encourage and aid all Christian hospitals to reach the highest standard of hospital work and Christian service.

* Two hundred paid members were recorded at the close of the meeting.

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and spiritual surroundings of these girls while in training. Cigarette smoking, profanity, coarseness and irreverence should be stamped out. The association has no higher mission than to inculcate the highest standards of Christian morals in its own and all other hospitals. Furthermore, through our publicity we are stressing the importance of the true missionary spirit versus the mercenary purpose."

### Our Obligation to the Patient

"We believe that every hospital should render a spiritual ministry to its patients. It is part of our program to extend the church's spiritual non-sectarian ministry to all patients, nurses, internes and all connected with the hospital. Finally, we need to train doctors and nurses with the spirit of sacrifice to go into our foreign hospitals. We should not fail to provide healing for the afflicted throughout the world."

## THE CHURCH HOSPITAL
## Its Support

This program and all hospital work calls for solid support. As Mr. C. B. Hildreth, superintendent of St. Luke's Hospital, Cleveland, pointed out, however, "only high grade hospitals giving effective community service can expect support. People are interested only in the best."

As a basis for this support he advised that the board of trustees be composed of successful business men of affairs who were willing to give money, time and thought to the execution of the hospital management—not as a dollar-and-cent proposition but as a humanitarian enterprise. "Our experience compels us to admit," he continued, "that *quite a large proportion of doctors and nurses are in their professions more for the remuneration than the desire to administer to the needs and suffering of their fellowmen.* Only those who have the success of the enterprise should form the personnel."

### Effective Appeals

With hospitals of unquestioned standard the next step is to secure good field secretaries to present the hospital needs to the people. "These men must be Christians of the highest type, of good address and well informed regarding hospital work—the routine of entering patients, the nursing staff, the treatment by the medical staff, the percentage of patients benefited and cured. If such men presented the hospital appeals in the 170,000 churches of the country think what the result would be!" These general appeals must be followed up with detailed explanations which may result in substantial gifts, annuity bonds, estate notes and legacies. The chaplain, nurse or physician who interviews a patient restored to health will often find such a person ready to express gratitude in a substantial gift.

"In making appeals," Mr. Hildreth continued, "a statement of what definite sums of money will do, gives a concrete appeal." Endowing rooms or beds, or furnishing rooms with pledges for their upkeep produces valuable funds. Sunday school classes and clubs or organizations are often willing to pledge a fixed sum for upkeep on one or two beds. At St. Luke's Hospital, Cleveland, $50 covers such upkeep and we have twenty to twenty-five such pledges yearly. A brass plate at the head of the bed gives the name of the group making the donation. Persons who show interest but do not give when interviewed are placed on a "prospect" list and circularized with books and pamphlets from time to time.

### Support in Produce

"Support is also available," Mr. Hildreth pointed out, "through donations of fruit, vegetables and eggs from rural sections where the membership has little ready money but is glad to contribute supplies." A poultry club organized by one hospital is very valuable. Groups of an organization pledge themselves to furnish a crate of twenty or twenty-five chickens on a certain date. Shipping periods are so arranged that there is seldom a week in the year when the hospital does not receive poultry enough to provide a chicken Sunday dinner for patients and the hospital family. Other localities furnish potatoes, squash, onions, canned fruit, vegetables. Vouchers covering the market value of the supplies are mailed to the senders to be credited on the yearly church reports. "Christmas and Easter appeals also bring in money and gifts which we can put to good use."

### Funds Through Nurses

Again—"The nurses' alumnae association must be kept interested in the hospital. The nurse can always interest friends and former patients to contribute. In addition, the organization may be able to endow a room which may be placed at the disposal of a sick nurse at any time. I know an alumnae association which has established a nurses' vocational endowment fund to provide scholarships for six months' post-graduate work at Columbia (or

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some other) University. Such endowments might grow to such a size that they would cover the salaries of instructors and perhaps other training school expenses."

"Finally there is the substantial aid furnished by the woman's auxiliary."

"With all these sources at your command it may yet be necessary to carry your appeal direct to the community. In making these requests for funds it is advisable to stress the volume and value of the free and part-pay service also the need for extending this service. A deficit will always secure more ready sympathy than a surplus, provided the condition is not due to extravagance or bad management. Take the public into your confidence; let them know the purpose and work of the institution, how it is run, what is the cost, how supported, what it needs."

## THE CHURCH HOSPITAL
### Its Administration

Public support brings up the question of efficient administration. As Mr. C. S. Pitcher, superintendent of the Presbyterian Hospital, Philadelphia, said: "A church hospital should be better managed than the average hospital."

"In choosing executives," he continued, "never be afraid to employ a good man or woman for fear that later on you cannot afford to pay a high enough salary to retain this service. Hospitals, in the past, have not paid sufficient salaries to attract and hold strong administrative organizations. The ne'er do well who wants a job is often a troublesome individual. Hospitals cannot be properly conducted with this class of help. Having chosen your personnel carefully, sell your ideas to them. Encourage your employees to participate in church work of their own denominations, if they will. If you are the superintendent participate in Sunday school and other church activities, so that you may have the proper perspective of the aims of the constituent churches.

"The hospital should operate in close fellowship with the churches and Sunday schools. Are we selfish in urging that the sick of these organizations should not be crowded out of the hospital beds by the dispensary waiting list? The hospitalization of chronically ill dispensary patients should not be allowed to prevent the admission of acutely ill patients at any time. An equitable number of beds should be assigned to the dispensary service but sufficient beds should be held in reserve for those acutely ill.

"Hospital problems are largely troubles which will never happen. Pray over them as though everything depended on God (as it does) but work as though everything depended on you and the problems* will disappear.

"Do not forget to use tact. From sympathy we get tact, which is the oil that makes life go smoothly. A tactless person is a selfish person. If we forget ourselves and think of the likes and dislikes and of the comfort of others we will be tactful.

"Be real church hospitals. Do not fear to develop the religious work of the hospital. Wherever they go, men take their religion with them. Real religion is a part of us and cannot be left behind. Because the religion of the early Christians was real, though scattered abroad by persecution, they proclaimed their faith in Christ wherever they went. Have daily vesper services in the wards and daily bedside ministrations by the chaplains and deaconesses or church visitors. Live your religion. It will not complicate your administrative problems but will solve them as nothing else will do.

"The injunction: 'Give the world the best you have, and the best will return to you,' applies with equal force in hospital administration."

## THE RELATION OF CHURCH AND HOSPITAL

This quotation brings us to the basis of church support of hospital work. Tracing the relation historically, Rev. H. L. Fritschel, director of the Passavant Hospital, Milwaukee, gave the following brief outline of the evolutionary growth:

In the United States the first Protestant hospital was established in 1849 at Pittsburgh, where the Rev. William A. Passavant, D. D., a Lutheran clergyman, opened the Pittsburgh Infirmary, now the Passavant Hospital. Pastor Fliedner, under whom Florence Nightingale took her nursing training, was present at the dedication. The establishment of St. Luke's

* Mr. Pitcher urged that the association take up for consideration and action the collateral inheritance tax imposed for state purposes upon charitable bequests. This tax small at first, 2½ per cent was later increased to 5 per cent and in one of our states, has recently been increased to 10 per cent.

Such a tax is now an onerous burden upon charitable institutions which draw part of their support, as do hospitals and smaller institutions, from legacies.

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Hospital, New York, by the Rev. William H. Muhlenburg in 1853 was the next Protestant hospital. The 1910 census gives the following figures:

23.2 per cent of total hospitals were Catholic institutions.
8.4 per cent of total hospitals were Protestant.
1.7 per cent of total hospitals were Jewish.

31.6 per cent of church hospitals.

In conclusion, Mr. Fritschel urged that the church take up its obligation to sustain and amplify the work of the hospitals already established and to build more hospitals in isolated communities. The type of service and the extent of Christian care cannot be the same in public hospitals; the church hospital has a special and distinct service which it must expand and adapt to the community needs.

## THE CHURCH HOSPITAL
### Its Vision

For, as Dr. Charles S. Woods summarized in his lay sermon: "The Christian hospital is inspired by a vision of organized Christianity fully conscious of its great obligation to prosecute disease, restore the sick and rehabilitate the cripple through physicians, nurses and social workers which it has trained. The Great Physician healed them *perfectly*."

THE NEED FOR ADEQUATE EQUIPMENT

"As the embodiment of the spirit, the knowledge and the equipment for faithful, effective service, not only for humanity's sake but in fulfillment of the Great Commission, the church hospital should never have to apologize for poor buildings and equipment. The hospital must be made a *perfect* workshop, where physicians may give expert diagnostic and therapeutic service and nurses and attendants may give scientific care without needless labor. The church, we know, will come to our aid when the needs are forcefully and accurately presented.

MEN NOT BUILDINGS

"After all, however, buildings and equipment are dead in themselves. The spirit, character and ability of the personnel make the hospital. Nurses and physicians are His hands, His feet, His mind, doing imperfectly what He did perfectly. Church hospitals must purge themselves of every vestige of dishonesty among their professional men. These institutions should be open only to men who are *capable, ethical* and *loyal*. It is not enough that we conform to the requirements of the American College of Surgeons, we must have and preserve exalted ideals in our hospitals to save them from low standards of professional work and redeem them from unworthy hands." (The same idea was expressed in a paper on "Methodist Philanthropic Institutions" by the Rev. N. E. Davis, corresponding secretary of the Board of Hospitals and Homes, Chicago.)

EDUCATIONAL SCHOOLS

And then of the nursing schools. As Dr. Woods stressed: "We want them to prepare our young women to do *professional* work. These schools must require adequate preparation for entrance and good academic work through the course. And superintendents must not be hampered in attaining these *educational* standards. It is not too much to ask that the schools for nurses in our church hospitals shall at least reach the level of the educational work done in the best hospitals of the country.

"With trained personnel and adequate equipment, we can go out to our churches with this vision of service. The church hospital must make its vision clear to the church; it must ask for money because it deserves it and because the vision cannot be realized without it. We know the church will provide funds when the hospitals show the quality of work they are prepared to do."

## THE CLOSING SESSION
### New Officers

The Rev. J. D. Lacount, D. D., presented the value of the well-taken moving picture to present the hospital need.

An aggressive step was taken in the appointment of a committee to develop the work of the association. The following officers were elected: Dr. Charles S. Woods, Methodist Hospital, Indianapolis, president; Rev. H. L. Fritschel, Passavant Hospital, Milwaukee, vice president. Dr. Frank C. English, of St. Luke's Hospital, Cleveland, will continue his efficient service as general secretary-treasurer. The executive committee is composed of the following members: Dr. Charles S. Woods, Dr. Frank C. English, Dr. James B. Alexander, Arch Deacon B. M. Spurr, Dr. James H. Mohorter, Joseph Purvis, James M. Long, Dr. A. O. Fonkelsrud, Dr. B. A. Wilkes, Rev. H. L. Fritschel, the Rev. C. O. Pederson and Dr J. H. Bauernfeind.

The new year portends a healthy, helpful growth of the association.

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# In the Nursing World

**Articles in this department, whether bearing signature or not, are contributed and do not necessarily represent the ideas or policy of this magazine.**

## TEXAS INSTITUTE

An important institute for nurses was held under the auspices of the Texas League of Nursing Education at Dallas, September 25-29. The lectures covered the following points: Physiology and Anatomy, Retta Johnson, Houston; Nursing Technique, Katherine Duvall, Dallas; Psychology, Dr. J. J. Terrell; Obstetrics, Dr. J. M. Hanna; Obstetrical Nursing, Mrs. Marr; Hygiene and Sanitation, Dr. T. Davidson; Pediatrics, Dr. Gordon B. McFarland and May Smith; Ethics and Nursing History, L. Jane Duffy; Dietetics and Nutrition Problems, Anna Howland; Principles of Pedagogy, Rush M. Caldwell; Drugs and Solutions, L. Jane Duffy; Bacteriology and Laboratory Technique, Miss May Grigsby, Waco.

To those holding teaching positions who must keep abreast of the times such institutes are very valuable. Every teacher should consider it her duty to attend. Let us have more of them!

## MASSACHUSETTS NURSES HOLD FALL MEETINGS

Another echo of the Seattle Convention was heard at the fall meeting of the Massachusetts State Nurses' Association which was held in Gloucester, October 7. At the early morning session, over which Sally M. Johnson presided, notes from the League sessions, as reported by Mary L. Wakefield, were read by Bertha Allen. The private duty section, presided over by Catherine E. Galvin, covered the Seattle convention ideas for private duty nurses; the public health section, over which Helen Fowler presided, received the report in the health field of Mary A. Jones.

The afternoon session was addressed by Congressman A. Platt Andrew. Subsequently, the following nurses gave other reminiscences of Seattle: Carrie M. Hall, of the Peter Bent Brigham hospital, Boston; Bertha Allen, superintendent of Newton hospital; Mary A. Jones, superintendent of district nursing at Fall River; Catherine E. Galvin, private duty, Boston; Ellen C. Daly, superintendent of nurses at the Boston City hospital; Sarah Beatty, of the New England hospital, and Jane F. Riley, retired, of Boston.

Greetings were sent from the association to Linda Richards, America's first trained nurse, who celebratd her fiftieth anniversary on October 7, at her home in Foxboro, also to Mary E. P. Davis, pioneer nurse, and corresponding secretary of the Massachusetts Association, and Lucy L. Drown of Lakeport, N. H., former superintendent of nurses of the Boston City hospital.

## STANDING FOR FRENCH NURSES

An important reform in the nursing profession in France is effected by a decree of the Ministry of Hygiene, which has received the Presidential signature. Hitherto nursing has been an open profession, without any recognized standard of qualifications. In the future it may only be exercised by those who have undergone a course of training laid down by the Ministry and received in approved schools attached to public hospitals, and candidates for the diploma will be examined by boards appointed by the Ministry in places which have a faculty of medicine.

## INDIANA NURSES MEET

The twentieth annual convention of the Indiana State Nurses' Association met in Indianapolis, Indiana, on October 2-4. The following speakers were scheduled to address the meetings:

Dr. J. N. Hurty and Dr. Carolyn Hedger of Chicago; Dr. Charles P. Emerson of Indianapolis, dean of Indiana Medical school; Miss Edna L. Foley of Chicago, director of the Chicago Visiting Nurse Association, and Mrs. W. W. Thornton of Indianapolis, vice president of the Indianapolis Public Health Nurse Association; Dr. W. F. King, Miss Mary J. Horn, Dr. Ada E. Schweitzer, Miss Lilla Hescock, Miss Elizabeth Melville, Miss Dorothy Hammer, and Miss Julia Groscope; Miss W. Culbertson of Cincinnati, O.; Mrs. Helen LaMalle of New York and Miss I. Malinde Havey of Washington.

The following officers were elected: Miss

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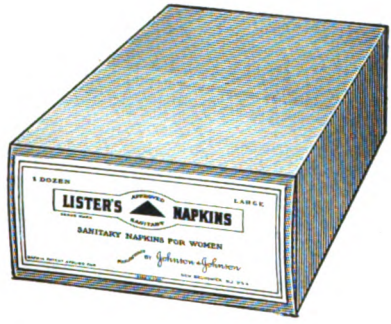


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Ina Gaskill, Indianapolis, president; Miss Lizzie Goeppinger, Indianapolis, first vice president; Miss Lulu Cline, South Bend, second vice president; Miss Eugenia Kennedy Indianapolis, secretary; Miss Mary Peterson, Indianapolis, treasurer; Miss June Gray, Indianapolis, and Miss Ethel Hatfield, Lafayette, directors.

## LA BAL MASQUE

Those who consider nursing all work and no play should step in upon "La Bal Masque" given to graduates, probationers and specials by the students of the Syracuse Memorial Hospital.

The guests were greeted on their arrival by the well known "Gold Dust Twins," Louisa Thompson and Myrta Jenks. The probationers were introduced to the "Chamber of Horrors," presided over by Arlene Tucker as the "Devil," assisted by Mary Griffin and Janet Standon. The first prize for costumes, which were many and varied, was awarded to Margaret Alexander, attired as a fashionable beau brummel. "The Wallace Reed Washingtons" received the second prize.

The buffet supper, in charge of Eva Johnson, included a stunt program directed by Helen Rafferty. Lucy Johnson responded for the officers of the hospital; Dorothy Shenk and Bessie Larabee for the graduates. The classes were represented by Viola Anderson, Dorothy Brown, Emma Marsh, Marian Murry, Leila Murdock, Adelaide Gay and Dorothy Stone.

## PUBLIC HEALTH SERVICE

During the month of September the following assignments, reinstatements and transfers are recorded in the Nursing Corps of the U. S. Public Health Service:

New assignments: Elizabeth Tierney, U. S. Marine Hospital No. 3, Buffalo, N. Y.; Josephine Kohlhas, U. S. Marine Hospital No. 3, Buffalo, N. Y.; Nella Seay, U. S. Marine Hospital No. 6, Cleveland, Ohio; Lyda Hyland, U. S. Marine Hospital No. 6, Cleveland, Ohio; Ruby Hill, U. S. Marine Hospital No. 7, Detroit, Mich.; Mattie Ingram, U. S. Marine Hospital No. 14, New Orleans, La.; Anna Svenson, U. S. Marine Hospital No. 16, Portland, Me.; Bernice Chapman, U. S. Marine Hospital No. 20, Savannah, Ga.; Rosa Regonini, U. S. Marine Hospital No. 43, Ellis Island, N. Y.; Annie Maude Gelino, U. S. Marine Hospital No. 43, Ellis Island, N. Y.; Mary Kiernan, U. S. Marine Hospital No. 82, Norfolk, Va.

Transfers: Anna McCann, from U. S. Marine Hospital No. 7, Detroit, Mich., to U. S. Marine Hospital No. 5, Chicago, Ill.; Anna Darlington, from U. S. Marine Hospital No. 11, Louisville, Ky., to U. S. Marine Hospital No. 9, Fort Stanton, New Mexico; Ida Holbrook, from U. S. Marine Hospital No. 14, New Orleans, La., to U. S. Marine Hospital No. 12, Memphis, Tenn.; Ella Oliver, from U. S. Marine Hospital No. 82, Norfolk, Va., to U. S. Marine Hospital, No. 20, Savannah.

Reinstatements: Mabel K. Adams, detailed to office of Superintendent of Nurses, Washington, D. C.; Ruth Scott, U. S. Marine Hospital No. 11, Louisville, Ky.; Alma Foerster, U. S. Marine Hospital No. 13, Mobile, Ala.; June Exmeyer, U. S. Marine Hospital No. 19, San Francisco, Cal.; Helen Hunt, U. S. Marine Hospital No. 19, San Francisco, Cal.

LUCY MINNIGERODE,
SUPERINTENDENT OF NURSES.

## PENNSYLVANIA NURSES MEET

As the guest of District No. 3, the Graduate Nurses' Association of Pennsylvania is holding its annual convention at Wilkes-Barre.

The speakers include: Dr. George E. Walk, dean of Teachers' College, Temple University, Philadelphia; Helene S. Hermann of Philadelphia, president of the State League of Nursing Education; Harriett M. Gillette, principal of the Philadelphia Episcopal Hospital Nurses' Training School, and Ophelia M. Feamster, Philadelphia. Roberta M. West, secretary of the State Board of Nurse Examiners, will discuss "Nursing Ethics"; Elizabeth F. Giles, of Philadelphia, will speak on "The Value of Staff Conferences and How to Conduct Them." Frances Maltby, of Philadelphia, will tell of the work being done by the Council for nursing education in Southeastern Pennsylvania and Dr. Ellen C. Potter, of the State Department of Health, will speak on "The Relation of the State Department of Welfare to the Public Health Nurse."

## MINNESOTA HOSPITAL MEETING

The executive board of the Minnesota State conference of the Catholic Hospital Association were entertained at noon dinner at St. Mary's Hospital, Minneapolis, on October 7. Later in the afternoon a business meeting was held to plan for the annual State conference, December 5 and 6, at Rochester, Minn. A most interesting program is in preparation and will be ready in a short time for publication.

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# *Is Mineral Starvation a Primary Cause of Disease?*

PHYSIOLOGISTS now generally concede that a demineralized diet reduces the supply of vital energy, and helps prepare a tissue-soil favorable to the growth of pathogenic germs.

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## DR. WHITE HEADS DIVISION

Assistant Surgeon General Mark J. White has succeeded Dr. C. C. Pierce as director of the Division of Venereal Diseases. Dr. White has had a long and wide experience as a public health officer and comes to the Division not only with a thorough knowledge of the venereal disease problem, but with a keen appreciation of the value of nurses and the part they have to play in this campaign. To quote Dr. White: "I feel that after the diagnosis is made, and indeed in many instances before it is made, the nurse with her training in social medicine, her aptitude in gaining the confidence of patients, and her knowledge of the importance of waging unrelenting warfare against disease, is a most important factor in the treatment, control and cure of venereal disease."

The public health nurses of the country may feel that in Dr. White they have a most worthy ally in their campaign for better health.

## REUNION OF CIVIL WAR NURSES

Mrs. Alice Carey Riselay, national president of the association formed by nurses who served in the Civil War, and about twelve other women recently met in Des Moines to attend the national encampment. Only seventy nurses are living of some 3,000 which formed the organization after the Civil War. Mrs. Henry Dougherty of 1174 First Street, Des Moines, will also be among the few to join the reunion.

## AMERICAN OCCUPATIONAL THERAPY ASSOCIATION MEETS

The program of the Sixth Annual Meeting of the American Occupational Therapy Association, as printed in the October issue, was followed with but few changes. The round tables which were to have been held on Friday morning and afternoon were advanced to Wednesday and Thursday evenings in order that some who had to hurry away might have the opportunity of attending them. The sessions of Thursday morning and afternoon were also transposed. The attendance was over 200.

At the first session on Monday afternoon, after the invocation by the Rev. W. M. Blatchford and the address of welcome by the Assistant Mayor, Mr. Armand T. Nichols, Mr. Louis J. Hass, of Bloomingdale Hospital, read an excellent paper entitled "Observations of Patient's Reactions the Guide to Further Treatment." In this the author urged the careful and intelligent use of records and gave illustrative examples. He was followed by Miss Idelle Kidder, recently director of the Missouri Occupational Therapy Association, who detailed her "Experiences in Directing an Occupational Therapy Association." Dr. Frederic Brush, of the Burke Foundation, closed the session by an address on "Men's Occupational Therapy in Convalescence." In this he stated that he was depending less on crafts and more on outdoor occupations.

The business meeting on Tuesday morning was occupied chiefly with reports from officers and committees. The secretary-treasurer, Mrs. Eleanor Clarke Slagle, showed how the activities of the society had grown, so that it had been necessary to secure office room at 370 Seventh Avenue, New York, and to call in clerical help. In his report for the Committee on Publicity and Publications Dr. Dunton narrated the success which had followed the founding of *Archives of Occupational Therapy* and how by this medium prompt publication of papers read before the society had been secured.

### General Hospital Work.

Tuesday afternoon Occupational Therapy in General Hospitals was treated by Miss Winifred Brainerd, of the Presbyterian Hospital, Chicago, who spoke on the "Hospital Workshop," drawing upon her rich experience for much valuable information, and by Miss Elsie Hassenstein, of Cook County Hospital, Chicago, who spoke on "Work in the Wards." It is regrettable that there was not more discussion upon these two papers, but it would appear that the number working in general hospitals is limited, as only seventeen held up their hands when a call was made for them. A round table upon recreations followed. Mr. Willem van de Wall, director of music to the New York State Hospitals Commission, read a paper entitled "Music as a Means of Mental Discipline." The paper upon "Physical Exercises and Dancing" by Miss F. M. Huseby was read by Miss Bertha M. Baugher. Mrs. Gratia Elvidge Harrington, formerly of Bloomingdale Hospital, read a paper on "Games and Theatricals." All of these were most interesting.

On Wednesday morning and Thursday afternoon were read the reports from the various states in which occupational therapy is used. Many of these had to be given in abstract, as time did not permit of their full reading. These, however, are most valuable as giving information of various state activities.

Wednesday afternoon the very important

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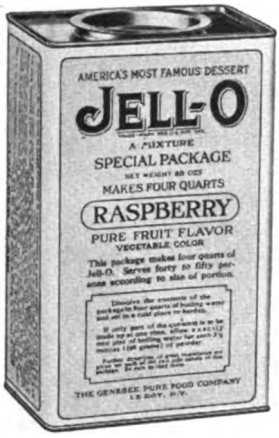


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subject of the financial side of occupational therapy was considered. Dr. Horatio M. Pollock, statistician to the New York State Hospitals Commission, opened the meeting with a paper on "State Hospitals." In this he said that occupational therapy is worthy of support, whether it be considered from a *medical* or an *industrial* standpoint. Mr. L. J. Haas spoke upon incorporated hospitals, while Dr. W. W. Richardson, of Mercer Sanitarium, spoke upon psychopathic sanitaria. Both of these speakers illustrated their remarks by citing experiences in the respective hospitals with which they are connected.

Thursday morning, devoted to "Experiences in Hospitals for Ex-Service Men," brought out much valuable information. The speakers upon general hospitals were Miss Martha R. Emig, Miss Dorothy D. Rouse, Miss Esther Macomber and Miss Willard. Upon neuro-psychiatric hospitals, Dr. Lloyd W. Ziegler and Miss Jennette Moody. Dr. B. W. Carr, of the Veterans' Bureau, spoke upon tuberculosis hospitals. A round table upon records, conducted by Dr. Pollock, closed the session.

### Round Tables On Crafts

The round tables on crafts were well attended and much interest was shown. In fact, all of the meetings were distinguished by the spirit of giving and getting information, which makes such gatherings worth while.

Officers elected for the coming year were: President, Mr. T. B. Kidner, of the National Tuberculosis Association, New York; vice-president, Dr. G. Canby Robinson, professor of medicine, Vanderbilt University; secretary-treasurer, Mrs. Eleanor Clarke Slagle, New York. Members of the board of management: Dr. Philip King Brown, San Francisco; Dr. B. W. Carr, Washington; Mrs. Carl Henry Davis, Milwaukee; Dr. James A. Mattison, of the Soldiers' Homes Management, Washington; Mrs. Elias Michael, vice-president of the Missouri Occupational Therapy Association, St. Louis; Dr. Horatio M. Pollock, Albany; Miss Meta N. Rupp, executive secretary, New York State Society for Occupational Therapy; Dr. Frankwood E. Williams, National Committee for Mental Hygiene, New York, and Miss Florence W. Fulton, dean of the Philadelphia School for Occupational Therapy. Chairmen of commitees were: Research, Miss Mariam Morriss, superintendent of Occupational Aides of the Veterans' Bureau, Washington; Installations and Advice, Miss Harriet A. Robeson, director of the Massachusetts Occupational Therapy Association, Boston; Teaching Methods, Miss Ruth Wigglesworth, Boston School of Occupational Therapy; Finance, Dr. William L. Russell, superintendent of Bloomingdale Hospital, White Plains; Publicity and Publications, Dr. William Rush Dunton, Jr., Sheppard and Enoch Pratt Hospital, Towson, Md.

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## PERSONALS

Anna E. Backman, superintendent of nurses at the Waltham Hospital, has tendered her resignation to take effect November 1. Miss Backman, since her graduation in 1915, has devoted seven full years to nursing work and feels the need of a rest.

Mary C. Beall has been appointed superintendent of nurses at River Pines Sanatorium, Stevens Point, Minn.

Grace V. Bradley, superintendent of nurses at the County Hospital, Omaha, Nebraska, has resigned. Her loyal staff of nurses—Elizabeth Winchell, Lucy Neal, Athelia Krekelberg and Mary Hausman—are also planning to withdraw from the hospital.

F. Elisabeth Crowell, director of nursing service of the Rockefeller Commission for the Prevention of Tuberculosis in France, has been decorated by President Millerand with the insignia of the Legion of Honor.

Mary H. Forrest, superintendent of the Chambersburg Hospital, Chambersburg, Pa., has tendered her resignation to take effect November 1.

Dr. Ransom Green has been elected superintendent of the Taunton State Hospital, Massachusetts, to succeed Dr. Arthur V. Goss, recently resigned, after serving thirty years on the hospital staff.

Mr. Stanton Kohler succeeds Miss Eugenia D. Ayers as superintendent of the Elizabeth General Hospital, at Elizabeth, New Jersey.

Aida Eleanor Langley, instructor of nurses at the Knoxville General Hospital, resigned on September 23, following the resignation of Clara Sanks, superintendent of nurses. Miss Lucile Huff and Miss King, night supervisors, have also withdrawn from the hospital.

When Anna E. Laughlin, who has been superintendent of the Bryn Mawr Hospital, Bryn Mawr, Pa., for the last seven years, resigned her position to become superintendent of the Waynesboro Hospital, Waynesboro, Pa., her pupils gave her a surprise party, which featured an old country school. On cutting

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Kellogg's Bran should not be classed with common brans that are unpalatable and hard to eat. Kellogg's Bran, cooked and krumbled, is prepared to be eaten as a cereal, sprinkled on other cereals or used in making muffins, raisin bread, pancakes and a wide variety of bakery products. You will have no difficulty in getting your patients to eat Kellogg's Bran—it's so delicious.

We request that you personally try Kellogg's Bran. Your physician will recommend it as a permanent relief from constipation. Besides, it contains the vital life-sustaining elements of wheat—the mineral salts, vitamines, etc., which make it a health and strength builder. Eat Kellogg's Bran regularly—as recommended—and see how much better you feel.

**BRAN COOKIES**

1 cup Kellogg's Bran
1 cup white flour
½ cup graham flour
2 tablespoons butter or butter substitute
1 egg
1 cup sugar
¼ cup molasses
½ cup milk
2 teaspoons baking powder
½ teaspoon salt.

Beat together butter and sugar, egg and milk, add the dry ingredients. Drop the mixed batter with spoon in well greased pan. Bake about 25 minutes in hot oven. This will make three dozen cookies.

*Kellogg's* *Look for this signature W.K. Kellogg*

**the original BRAN - *cooked and krumbled***




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a large cake lighted with candles, Miss Laughlin found a traveling clock, the gift of the school. Many more gifts were presented to her at that time as mementoes of the Bryn Mawr Hospital. Miss Katherine Brown, who has been superintendent of the Episcopal Hospital, Philadelphia, Pa., for twelve years, will fill Miss Laughlin's position.

Dr. J. M. Lawler is the newly-appointed superintendent of the New York Polyclinic Medical School and Hospital.

Patience M. Love has resigned as supervisory nurse at the Springfield Hospital, Springfield, Mass., to accept a temporary appointment with the Springfield District Nurses' Association. She will take over the work of Anna M. Crawford, who is enjoying a six months' leave of absence.

Louise M. Mandigo has been appointed superintendent of nurses at the Morton Hospital, Taunton, Mass., to succeed Eileen R. Curley, who leaves to accept the superintendency of the Draper Hospital, Milford. Miss Curley is a graduate of the Massachusetts General Hospital, class of 1915, and during the World War served as head nurse in the base hospital, Camp Wheeler, Macon, Ga.

Mrs. Gillette Martin has taken up her new work as superintendent of the Springfield Visiting Nurse Association, Springfield, Mass.

Miss Mortimer has accepted the superintendency of the Beaver Valley General Hospital, Beaver Falls, N. Y.

Miss Patterson entered upon her work as director of nurses of the Chambersburg Hospital Chambersburg, Pa., on October 1.

Tessie O'Neil, a graduate of Mercy Hospital, Springfield, has resigned her position as executive secretary of the Public Health Association of southern Worcester County to enter work in a wider field. Miss O'Neil has taken special work at the New York School of Philanthropy, has had wide experience in social service at the New York Post Graduate Hospital, Bellevue, and as welfare director with the Springfield Visiting Nurses' Association and the Hampden County Tuberculosis Association. She will be succeeded by Eileen Moran.

Laura Purcell, a graduate of Symmes Arlington Hospital (1915), has taken the superintendency of the Russell Private Hospital, Brewer, Me.

Mr. Joseph W. Purvis has been appointed superintendent of the Baptist Hospital at Memphis, Tennessee.

Dr. Willard C. Rappleye has been appointed superintendent of the New Haven Hospital to succeed Dr. Hersey, who recently resigned to join the joint board of administrative control of Presbyterian Hospital. Dr. Rappleye comes to the position with versatile experience. Entering the University of Illinois after several years' experience in factory management he began with business training as the foundation of scholarship. He took his medical degree at Harvard and since then has filled many important positions, including instructor in biological chemistry in the University of California, acting superintendent of the Pacific colony for the feeble-minded and director of hospitals for the University of California. On account of his experience in hospital work he recently served as executive secretary of the Rockefeller committee on the training of hospital executives.

Cora Louise Sherwood, a graduate of the Lawrence General Hospital (1919), with postgraduate work at Simmons College, has taken up work as public health nurse at Gray, Maine. She will serve New Gloucester, Gray and North Yarmouth.

Carrie H. Tucker has been appointed directress of nurses at the Reading Hospital, Reading, Pa. Miss Tucker served five years as superintendent of nurses at the Elizabeth General Hospital and Dispensary, Elizabeth, N. J. During the World War she was chief nurse of the U. S. Army Debarkation Hospital, at Ellis Island, N. Y. This institution had a capacity of over 1,000 beds.

Angeline E. Wictor, for the past two years a member of the staff of the Bridgeport Visiting Nurse Association, Bridgeport, Conn., has accepted a position as nurse on the President Filmore. Miss Wictor is a graduate of St. Joseph's Mercy Hospital, Sioux City, Iowa.

Henry G. Yearick, recently of the City Hospital, Akron, Ohio, has accepted the superintendency of the Homeopathic Hospital Pittsburgh, Pa.

## DEATHS

Mrs. Sarah Louise Bailey, formerly of Utica, New York, at Maran, Kansas, aged 67. Mrs. Bailey (neé Thompson) was head nurse at Faxton Hospital for a number of years.

Mary Ball, a nurse at the Harlan Hospital, Harlan, Kentucky, in the latter part of June. The tragic circumstances attending Miss Ball's death—she was drowned while on an outing with a party of friends—made the passing especially painful to her friends.

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Mrs. Mary Boyle, at Canton, on June 29, at the age of 65, due to severe burns sustained while nursing Mrs. William Chinchin.

Lila M. Brackett, superintendent of the General Stephen H. Gale Hospital, Haverhill, Massachusetts, on July 9. Miss Brackett had become run down and was taking a much-needed rest when pneumonia set in. A native of Nova Scotia, Miss Brackett has been associated with hospital work for many years.

May E. Brady, a graduate of St. Vincent's Hospital, Bridgeport, in 1915, was fatally injured by a heavy automobile truck on April 18 as she left the office of the Visiting Nurses' Association at the end of her day's service. Miss Brady had served in private duty after her graduation, later entering the service of the Board of Health, from which she resigned about a year ago to take up her work with the Visiting Nurses' Association.

Margaret Van Cleas, a nurse at Lee Hospital, Rochester, N. Y. The funeral was held on September 5.

Mrs. Ida May Davidson, at the home of her sister, Mrs. E. T. Coy, Muncie, Indiana, April 7. Mrs. Davidson was confined to her home almost constantly since she suffered a broken hip last January.

Lena G. Davidson, at Gouverneur, New York, on July 7, after an illness of about two months. In late April Miss Davidson contracted a grip infection while nursing in the Ithaca City Hospital. Pneumonia followed and the lung infection finally made permanent inroads on her health. A graduate of the Oswego City Hospital (1917) Miss Davidson has nursed in the Cornell Infirmary, Ithaca; Allison Hospital, New York, and was active in the smallpox and typhoid epidemics in Moravia.

Reva Gertrude Evans, a graduate of Faxton Hospital, Utica, in 1920, at the same hospital on July 1 from blood poisoning. Miss Evans was loved by all with whom she associated for her joyous, considerate service.

Frances D. Fowler, a graduate of the Homeopathic Hospital Nurses' Training School, Reading, Pa., with post-graduate work in the Lying-In Hospital, Philadelphia, and the Chicago School of Nursing, died at her home, 451 Pennsylvania Avenue, Allendale, on April 29.

Helen M. Fitzgerald, an undergraduate nurse at St. Joseph's Hospital, Elmira, New York, early in July. The funeral was held at her home in Horseheads, on July 7. The following classmates served as honorary pallbearers: Ruth Rowan, Lavine Slavin, Margaret James, Mary Harrison, Clair James, Elizabeth Smith and Doris Hollander.

Bridget Hayes at St. Joseph's Hospital, Syracuse, New York, on July 25. A graduate of St. Joseph's Hospital in 1900, Miss Hayes entered general nursing in Syracuse. For the last two years she has served as public school nurse.

Elizabeth G. Ives, Red Cross Public Health Nurse of the South Suffolk, L. I., County Chapter, was killed recently as she was hurrying to the bedside of a patient.

Elizabeth Knowles, at the Dee Hospital, Ogden, Utah, on July 19, from heart trouble.

Dr. Emma Johnston Lucas, former Public Health Commissioner of Peoria, Ill., on July 28, at Los Angeles, Calif. After graduating from Knox College in 1873 she first became a trained nurse and finally studied medicine. Dr. Lucas was a woman of rare personal charm and mental balance, and these qualities did much to make her the popular and successful physician that she was.

Mrs. Grace C. Makinson, at the State Hospital for Tuberculosis Patients at Mt. Alto, Penn., on July 18. Mrs. Makinson, a graduate of the Maryland State Sanitarium, was idolized by the ex-service men at the hospital.

Viola Mosholder, at the Woman's Hospital, New York City, on July 10.

Mrs. Ethel Moyer (neé Earl), at the Sierra Hospital, Sonora, Calif., on July 27. Mrs. Moyer's tragic death followed the wonderful rescue work which she performed at the Hetch Hetchy Hospital, Groveland, Calif., during a fire which destroyed the hospital building.

Mary Peterson, at Bennington, Vermont, on October 8.

Mrs. Delia Prior (neé McKeon), a graduate of St. Francis Hospital, Hartford, Conn., on her way to Peter Bent Brigham Hospital, Boston, where an operation for brain tumor had been arranged by Dr. Harvey Cushing.

Dr. Laurentine Rouchel at Croghan, New York, on April 24, after an illness of two months. Miss Rouchel entered the third order of St. Francis in 1860 and served in the order until 1878 as Sister Clementine. With Sister Dominica, she opened St. Joseph's Hospital, Syracuse, then became financial manager of St. Elizabeth's Hospital, Utica, after serving as nurse for six years in that institution. During those pioneer days her force in the community kept the hospital's needs before the public and citizens of Utica remember her ministrations with gratitude.

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COMPLETE oral hygiene as practised by nurses and other attendants is not only recognized as good administration, but is a necessary precautionary measure adopted by medical directors, superintendents and superintendents of nurses in the safeguarding of patients.

Interest in sanitary, healthy mouths of hospital personnel grows steadily. The subject will receive even more attention in the future.

Colgate's Ribbon Dental Cream does all that a dentifrice can do in cleansing the teeth and maintaining oral hygiene.

**Colgate's Dental Powder holds a high position among those of the dental profession who prefer a dentifrice in powder form. As with Ribbon Dental Cream, it is based on the same fine precipitated chalk and pure soap.**

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Minnie Shaw, at the home of Dr. Urban T. Kemble, Ureka, N. Y., on July 16.

Mrs. Florence Spencer, formerly of Norwich, Conn., at the home of a patient, Mrs. Mary Fisher, New Market, Va., on July 25, of heart trouble.

Mrs. Herbert C. Stinchfield (neé Brown), wife of the chief surgeon of the Southern California Edison Company, in the latter part of July.

Mrs. Elizabeth C. Stringer at Barberton, Ohio. Mrs. Stringer was engaged in hospital work in Omaha, Neb.

Mrs. Marion Thompson (neé Taylor) at the Roosevelt Hospital, New York City, July 23. As an Army Nurse Mrs. Thompson served at the Reconstruction Hospital, Cape May, at Fox Hills; at the Polyclinic Hospital, New York, and previous to her death was specializing in electrotherapeutic nursing in New York City.

## MARRIAGES

Bertha Ewing (class of 1916 Allegheny General Hospital, Pittsburgh, Pa.), to John M. Stahl, April 12. At home Akron, Ohio.

June Gontz (class of 1915, Allegheny General Hospital, Pittsburgh, Pa.), to Roscoe Mack, April 10. At home, Derry, Pa.

Anna F. Goss of Bangor, Maine, to A. Boyd Fisher of Fort Fairfield, Maine, on May 27. Mrs. Fisher, who has served as Red Cross nurse in Fort Fairfield for the last two years, nursed abroad during the world war.

Mary Homans, a graduate of the Homeopathic Hospital, Newburyport, Mass., to Earl Stephen Merrill, M. D., on August 1. Dr. and Mrs. Merrill will make their home at West Haven.

Laura Jones (class 1919, Allegheny General Hospital, Pittsburgh, Pa.), to Earl Lerish January 10. At home, Pittsburgh, Pa.

Mae La Fleur, recently of Moore Hospital, to James J. Buckingham, of St. Johns, Newfoundland, on September 14.

Margaret Loefler, a graduate of St. Elizabeth Hospital (1921), Lincoln, Nebraska, to Harry Simons. Mr. and Mrs. Simons will make their home at Casper, Wyoming.

Margaret Maher, of Dorchester, Mass., to Prof. Hugh Graham, of Winona University, Minnesota.

Winifred Malone (Class of 1921, Mercy Hospital, Hamilton, Ohio, to John Geiser, Sept. 4, 1922.

Lula N. Maxwell to D. Arthur Foote, M. D., of Omaha, Nebraska, early in July. Dr. and Mrs. Foote will live at Thirty-first and Titus Streets, Omaha.

Alene Ellen Menfzel to Roy M. Pickett, of Cashmere, Washington. Mrs. Pickett graduated from the Sacred Heart Hospital, June, 1921.

Edna Torens, a graduate nurse of the Flushing Hospital, to Glenn G. Smith on September 12.

Harriet Wichard (Class of 1921, Mercy Hospital, Hamilton, Ohio), to Russell Zellers, Sept. 6, 1922.

Hanalula Wilson, a graduate of St. Elizabeth Hospital (1921), Lincoln, Nebraska, to Avery Young. Mr. and Mrs. Young will live in Lincoln, Nebraska.

Alma Jane Woodford, a graduate nurse of the Flushing Hospital, to Frederico Mir on September 12.

## HOSPITAL CONSTRUCTION

On October 10 the cornerstone was laid for the new nurses' home at the Asbury Hospital, Minneapolis, Minn.

Work has been begun upon the addition to the nurses' home at the Bath City Hospital, Bath, Me. The addition will provide for the housing of eight more nurses.

Milford, Conn., is planning the construction of a fifty-bed hospital. The new building, designed by Walter J. Skinner, is planned on the lines of a large country place.

Financial arrangements are being completed for the construction of the nurses' home at the Walker Memorial Hospital, Wilmington, N. C.

The erection of a new nurses' home in connection with the Springfield Hospital, Massachusetts, has actually begun with the letting of construction contracts. The building will cost between $100,000 and $150,000.

On September 8 ground was broken in the construction of the new nurses' home of St. Mary's Hospital, Rochester. The new home, which will cost over $225,000, will accommodate eighty-four nurses

St. Rita Surgical Infirmary, New Orleans, La., which has recently been taken over by the Sisters of Mercy has recently been enlarged to a fifty-bed capacity.

Preparatory work was commenced on September 7 for the erection of a Veterans' Hospital at "Summerfields," Chelsea, near Poughkeepsie, New York.

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**Cantilever Dealers**

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Santa Barbara—Smith's Bootery
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Syracuse—121 West Jefferson St.
Tacoma—255 So. 11th St.
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Troy—35 Third St. (2nd floor)
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Work and amusements take a fresh start at this time of year. Opportunities for advancement come to the business girl. The home woman sets her house in order for the comfort of the family and the social activities of the new season.

Your interest lags, your efficiency is impaired, your joy is lessened if your feet hurt. Comfortable shoes make you forget your feet and let you focus your whole attention on your work and your other interests. They increase your endurance, and hence add to your enjoyment of life generally.

Cantilever Shoes are comfortable shoes. They are modelled on natural lines, with a flexible arch, entirely free from the concealed metal which is in the shank of ordinary shoes.

The flexible arch of Cantilevers, together with their natural sole line, the neat, rounded toe which gives ample room, the well placed medium or low heel, give great comfort to tired, weak feet, correct and prevent fallen arches, and help you in a hundred other ways.

Every pair of Cantilevers is trademarked to protect you. Look over the dealer list at the left of this advertisement. If you do not find one listed for your town, write the manufacturers, Morse & Burt Co., 3 Carlton Ave., Brooklyn, N. Y., for the address of a nearby dealer, and for a free booklet on feet and shoes.

# Cantilever Shoe




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## GRADUATIONS

Thirty-one nurses graduated from the Hartford Hospital Training School on September 29. Dr. Milton C. Winternitz, dean of the Yale Medical School, made the address of the afternoon.

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On October 7, the corner stone was laid for the new surgical annex of the St. Joseph's Hospital, Elmira, N. Y. The Right Rev. Thomas F. Hickey officiated. At the same ceremony the following nurses received their diplomas: Mary Hallinin, Helen Halpin, Margaret James, Marie James, Agnes Milligan, Elizabeth Smith.

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On September 14 six nurses were awarded diplomas for the one-year course at Nopeming Sanitarium, Duluth, Minn. Dr. E. L. Tuohy presented diplomas to the following nurses: Misses Corinna Elizabeth Eales, Antoinette Breole, Elizabeth Bird, Sigrid Selma Rappys, Anna Frances Stukel, Alma Victoria Rosen. These nurses plan to complete the year's course in accredited hospitals. The pupils were addressed by Miss Irene English, of the Northern Pacific Hospital, St. Paul, and Dr. A. T. Laird. Miss Carrie Eppley, superintendent of nurses, presided at the reception which followed.

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On October 4, three nurses graduated from the Good Samaritan Hospital, Marietta, Ohio. The class, Loretta Muller, Elizabeth Zack, and Amelia P. Archer, was addressed by Father Francis Mueller. Father J. J. Cahalan presented the diplomas and medals. Following the chapel services all retired to St. Elizabeth's hall where an attractive program was presented and refreshments served.

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At the graduation exercises of St. Paul's Sanitarium, Dallas, Texas, on July 13, the new nurses' home was dedicated.

Following the celebration of mass Bishop Lynch, with the celebrant and the assistants, formed a procession to the nurses' home, where the bishop blessed the building and dedicated it.

In addressing the graduates Dr. McReynolds said: "You will always be glad that this epoch in your lives is celebrated by the opening of this most beautiful home for nurses that stands without a superior in any part of the world. You will always be glad that your alma mater is a permanent institution destined to grow in power and influence through the years to come. It is today the most important unit of all the Catholic hospitals of America and when you realize that 60 per cent of all the class A standardized hospitals in America are Catholic hospitals you will see how important a part you can play in the responsibilities of this leadership

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## ALABAMA

Sixty nurses have been registered by the Alabama State Board of Nurse Examiners, according to a statement issued August 1. The successful candidates follow:

Mary Malone, Ester Farrar, Dorothy Bever, Maysic McWilliams, Florence R. Miller, Grace I. Glenn, Sula Ruth Stewart, Bertha Clay Sims, Pearl Cockrell, May Ruth Thomas, Violet C. E. Duran, Mary L. Burnett, Inez Mitchell, Inez Wesson, Ester Fowler, Willie May Logan, Florence Foster, Nellie G. Stroher, Lillian Little, Marie Woodruff, Rovie M. Wyatt, Mary Price, Odessa Mason, E. Margaret Chowning, Hattie Simpson, Viola Roberts, Nora H. Martin, Pauline Fletcher, Rella Fowler, Edna B. Bryant, Zadie E. Rains, Velma Thigpen, Bessie L. Cain, Mamie A. Edge, Willie McStephens, Annie Robertson, Valda Gamons, Evie L. Cole, Annie A. Guidry, Johnie Coker, Annie R. Morrison, Julia Gillmore, Grace Vance, Willie May Kukland, Annie Louise Marsh, Mattie Lou Kukland, Alma Luper, Ester M. Polsin, Alice Maddox, Virginia M. Tucker, Frances E. Page, Mattie Fletcher, Mary M. Hatcher, Maude L. Allen, Mattie H. Kennedy, Katherine Kane, Allie M. Kirby, Thelma D. Brown, Gertrude Moran, Ola L. Odom.

The following accepted through reciprocity: Edith A. Sanburn, Alma Murphy, Gussie Bell Bird, Clara Stone, Louise Peel, Catherine Carley, Dema C. Holland, Lillian O. Nelson.

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## CONNECTICUT

### New Britain

The work of visiting nurse associations is growing apace. The reports of associations which we are continually receiving show the volume of constructive work. Just con this record of the New Britain Nursing Association as submitted by Miss Baker for the months of June, July, August and September: Total number of visits, 4,675, including 3,111 nursing visits, 993 instruction visits and 571 visits which were unclassified.

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# Teeth You Envy

## Are brushed in this new way

Millions of people daily now combat the film on teeth. This method is fast spreading all the world over, largely by dental advice.

You see the results in every circle. Teeth once dingy now glisten as they should. Teeth once concealed now show in smiles.

This is to offer a ten-day test to prove the benefits to you.

### That cloudy film

A dingy film accumulates on teeth. When fresh it is viscous—you can feel it. Film clings to teeth, gets between the teeth and stays. It forms the basis of cloudy coats.

Film is what discolors—not the teeth. Tartar is based on film. Film holds food substance which ferments and forms acid. It holds the acid in contact with the teeth to cause decay.

Millions of germs breed in it. They, with tartar, are the chief cause of pyorrhea. Thus most tooth troubles are now traced to film, and very few escape them.

### Must be combated

Film has formed a great tooth problem. No ordinary tooth paste can effectively combat it. So dental science has for years sought ways to fight this film.

Two ways have now been found. Able authorities have proved them by many careful tests. A new tooth paste has been perfected, to comply with modern requirements. And these two film combatants are embodied in it.

This tooth paste is Pepsodent, now employed by forty races, largely by dental advice.

### Other tooth enemies

Starch is another tooth enemy. It gums the teeth, gets between the teeth, and often ferments and forms acid.

Nature puts a starch digestant in the saliva to digest those starch deposits, but with modern diet it is often too weak.

Pepsodent multiplies that starch digestant with every application. It also multiplies the alkalinity of the saliva. That is Nature's neutralizer for acids which cause decay.

Thus Pepsodent brings effects which modern authorities desire. They are bringing to millions a new dental era. Now we ask you to watch those effects for a few days and learn what they mean to you.

The facts are most important to you. Cut out the coupon now.

**Pepsodent** PAT. OFF REG U S

*The New-Day Dentifrice*

Endorsed by modern authorities and now advised by leading dentists nearly all the world over. All druggists supply the large tubes.

**10-Day Tube Free** 947

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Only one tube to a family.




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### Litchfield

At a recent meeting of the alumni association of the Litchfield County Hospital, held at the nurses' home, the following officers were elected: President, Miss Lucy Belden, Winsted; secretary, Miss Katherine Enbsweider, New York; treasurer, Miss Beatrice Truelove, Waterbury.

The graduating class of 1922 was received into membership as follows: Miss Anna Theresa Gannon, of New Haven; Miss Annorah Marie Hughes, of Stamford; Miss Elisie Louie Eitel, of Torrington; Miss Mildred Ella Spencer, of Seymour; Miss Alice Margaret Champion and Miss Robina Pearl Sipprelle, of Canada, and Miss Rose Anna Curtiss, of Norfolk. Members of other classes were enrolled as follows: Miss Helen Jackson, of Waterbury; Miss Vina King, of New York; Miss Catherine Barrett, of Winsted; Miss Helen Neals, of Canada, and Mrs. Nellie Blythe Hoysradt, of Torrington.

The graduating class of 1922 presented the Alumnae Association with a check for $225, representing the receipts of the bazaar held last August.

## MASSACHUSETTS

### Boston

The annual report of the Massachusetts General Hospital gives in detail the amazing service rendered by our large hospitals of the country. The report shows that the General Hospital admitted about 7,570 patients during the year while 296 were admitted at McLean. The total does not include the 28,000 out patients treated during the same period. The maintenance cost for this service was $1,213,898 which meant a deficit of $244,615 despite gifts and bequests.

### Fall River

The Fall River District Nursing Association has received gifts totalling $10,500.

The sum of $8,000 (with yearly income of $500) was donated by Mr. and Mrs. Earl P. Charlton and $1,000 each was contributed by Mr. Arthur Anthony and Mrs. Annie B. Jennings. These gifts will extend the work which is being ably directed by Mary A. Jones.

## NEW JERSEY

Arrangements have been made to permit student nurses of the Trenton State Hospital School for Nurses to take one year of affiliated work at Bellevue Hospital, New York, in order to round out the three-year term.

## NEW YORK

### New York City

Broad Street Hospital's new eleven-story addition at Broad and South streets, which was made possible largely by a campaign for funds in the financial district by the Downtown Hospital Association, is now fully utilized.

Accommodations for at least 100 bed patients, the most modern operating rooms and facilities for clinics will be provided by the addition. Several floors are to be financed by various organizations. The Grand Lodge of the State of New York will finance the Masonic floor; the seventh floor will be known as the Roosevelt Memorial floor for Hamlin Childs. Mrs. James Barber will finance another floor, which is to be known as the Nora Nickle Barber Maternity Floor.

Large downtown organizations—115 firms with a total of 15,000 employees have already contributed to the one dollar a year fund which entitles each employee to efficient service day or night.

In order to meet the need for nurses who have been specially trained in the care of chronic diseases, Montefiore Home, Gun Hill Road and Bainbridge Avenue, New York, is planning to establish a training school. This school is to begin this fall. The curriculum, of course, will be under the direction of the State Commissioner of Education at Albany.

### Buffalo

The state board of regents has revoked the charter granted to the Erie County Hospital, Buffalo, N. Y., to graduate nurses eligible for registration.

## MONTANA

Seventy-nine Montana nurses have been given state certificates as the result of examinations recently held by the state board of examiners.

Nurses to whom state certificates were issued were: Jeanette Matson Fraser, Elizabeth S. Bausch, Augusta M. Nelson, Catherine Helen Furnl, Elva J. Bayne, Leta K Sherman, Beula E. Pratt, Elizabeth Adams, Fern Marie Simpson, Mary Ann O'Malley, Helena C. Mead, Margaret M. Dunn, Myrtle C. Nyberg, Clarice Hanson, Miriam O. Hauser, Mary Ellen Davidson, Lulu B. Sory, Ida Buckholtz, Marie Miller, Lilly C. Morris, Ernestine Looney, Annette Volkenand, Marian L. Logan, Sister Camille de Jesus, Sister Odillard, Sister Mary Gabriel, Florence E. McKenzie, Celestine E. Matter, Kath-

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# Runkel's Cocoa

## In Health and Convalescence

Nathan S. Davis, Jr., in his book "Food in Health and Disease" tells how much more healthful is cocoa than either tea or coffee. He says:

"The **beverage** cocoa differs from tea and coffee in that it is nutritious as well as stimulating. . . . The beverage usually is made with milk, and sugar is added to it in varying quantities. These additions increase its nutritive properties very much. Ten grams of cocoa, the amount usually used to make a cupful, yields fifty to seventy calories. When made with milk and sugar, the beverage will yield 400 calories. The stimulating effect of **theobromin,** the chief alkaloid of cocoa, is different from that of caffein, to which it is chemically allied, in that it does not cause sleeplessness or muscular tremors. . . . It is much better adapted for use by children than tea or coffee, which should not be given to them at all. . . .

"Cocoa is quite as quickly disposed of by the stomach as tea or coffee. Two hundred cubic centimeters, or a cupful of any of them, disappears from the stomach in a little less than two hours if they are made with water, and in two and a half hours if cocoa is made with milk."

**Runkel's Cocoa is delicious**—the beverage that finds eager patients waiting for it. Runkel's is absolutely pure, made from the finest cocoa beans obtainable, free of adulteration, containing no foreign non-assimilable matter. A sample and an authoritative analysis will be sent to you upon request.

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# Runkel's
## All-Purpose Cocoa

*for Drinking, Baking and Cooking*




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erine F. Moran, Till C. Stelmach, Alice G. Mitchell, Eleanor M. Vosen, Bessie Easterbrook, Ella H. Rosevold, May Alice Robinson, Dora E. Wetzesteon, Irene E. Pehlke, Sadie C. Halverson, Florence E. Kiest, Maud Carter, Flora M. Shapland, Phoebe E. Blayney, Amanda M. Robertson, Verna E. Rollings, Martha M. Stuky, Esther H. Miller, Winifred M. White, Sister Joseph Arthur, Laura M. Dogle, Elizabeth C. Zigan, Mary A. Rossman, Mae Agnes Douglas, Lydia A. Gudmunsen, Lois V. Mikesell, Mabel R. Le Bertew, Mary E. Sagar, Luella G. Graves, Edna W. Johnson, Helena K. Smith, Ruby F. Long, Mabel A. Tucker, Mae D. Allen, Marion Barthelmess, Emma Wasnuk, Anne Mae Bradshaw, Stella Irene Youderian, Ellen Cecelia O'Rourke, Elso M. Sieber, Theresa Anderson, Jennie Anderson, Marie M. Williams, Mona Laura Lyndes, Dolores K. Byrne, Ruperta Coughlin, Beatrice Breslin, Hariette O. Stacey, Hazel E. Holcomb, Susan B. Bloes, Myrna M. Wilson.

### Helena

At the annual meeting of the St. John's Hospital Alumni Association, Helena, Montana, Miss Katherine O'Rourke of Boulder, Miss Anna Bradshaw of Helena and Miss Stella Youderian of Roundup, were admitted to membership.

Miss Margaret Muckley, state supervisor of public health nursing, addressed the gathering.

The present officers, Sister Charatina, president; Miss Bradshaw, secretary, and Miss Mary Zogarts, treasurer, were re-elected.

## PENNSYLVANIA

### Philadelphia

The Nurses' Training School of the Jewish Hospital, Philadelphia, has created an educational loan fund to provide money for the graduate nurses of the Jewish Hospital who desire to continue their studies in universities and other seats of higher education. More than $500 has been subscribed as a nucleus for the fund.

This organization wants to raise $5,000 before Jan. 1, when the twentieth anniversary of the founding of the Alumnae Association will be celebrated.

### Pittsburgh

At the annual meeting of the Pittsburgh Hospital Alumnae the following officers were chosen: President, Miss Catherine C. Dillon; vice president, Miss Margaret McDonough; treasurer, Miss Angela Garrigan; secretary, Miss Mary Bihlman; directors, Mrs. Charles D. Terry, Mrs. Joseph M. Alyward and Mrs. John H. Newhouse. Methods of raising funds to help endow a room at the hospital for the nurses were also discussed.

### Allentown

At a recent meeting of the Alumni Association of the Allentown Hospital College for Nurses the following officers were elected: President, Mrs. William Hertz; vice president, Miss Helen Hall; secretary, Mrs. Howard Reuter; fund treasurers, Miss Mabel Buss and Mrs. Claude Clauss.

## VIRGINIA

### Norfolk

Student government has been adopted by nurses at Sarah Leigh Hospital Training School, Norfolk, Va.

Five training school nurses from the senior, intermediate and junior classes together with Mrs. L. L. Odom and Mrs. S. R. Preston, superintendent and assistant superintendent of Sarah Leigh Hospital, constitute the board.

The following nurses have been selected to serve on the board for a term of one year: Miss Jessie Bradley, Hobgood, N. C., president; Miss Maude S. Wiatt, Gloucester, Va., secretary; Miss Lillian White, Windsor, N. C.; Miss Doris E. Rogers, Petersburg; Miss Kathryn Pittman, Norfolk.

## BIRTHS

Mrs. Wm. Doerr (Margaret Lorom, 1916, Allegheny General Hospital, Pittsburgh, Pa.), a daughter, Nancy, April 5.

Mrs. Wm. Gracey (Abigail Zimmerman, 1903, Allegheny General Hospital, Pittsburgh, Pa.), a son, William, March 24.

Mrs. Harry J. Kastings (Cathleen Connell, graduate of Mercy Hospital, Hamilton, Ohio), a son, Sept. 29, 1922.

Mrs. Emmett Lentern (Mary Virginia Frost, 1920, Allegheny General Hospital, Pittsburgh, Pa.), a daughter, Helen Frost, March 30.

Mrs. R. D. Thompson (Sara Sheeder, 1920, Allegheny General Hospital, Pittsburgh, Pa.), a son, Rodney Dean, Jr., March 17.

The United States Civil Service Commission announces an open competitive examination for graduate nurse, and graduate nurse (follow-up), for filling vacancies in the United States Veterans' Bureau and in the Indian and Public Health Services. Applications will be rated as received until December 30, 1922.

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(*Liquid—Tablet Form*)

**furnishes the absorbable organically combined iron**

that encourages the construction of red cells.
The red cells include the Hemoglobin—
The hemoglobin supplies the Hematin—
The hematin combines with the iron—
The iron carries the oxygen—
The oxygen stimulates the waste and repair
that constitutes life and living.

It is thus of unquestioned value in ANEMIC, CHLOROTIC and DEVITALIZED CONDITIONS.

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# Distress After Meals

usually means a temporary disturbance of the interdependent processes which go to form the functions of digestion. Rarely, if ever, are digestive enzymes absent. Usually, the administration of a mild acid, such as phosphoric acid, restores harmony of action.

# Horsford's Acid Phosphate

a teaspoonful in a glass of water, with sugar added to taste, makes a pleasant, refreshing draught which helps to sweeten the stomach, stimulate its secretory activity, and by overcoming the disorder, allay the symptoms.

HORSFORD'S ACID PHOSPHATE is non-alcoholic, uniform in composition, time proven and trial tested during many years of practical use.

**SEND FOR SAMPLE IF DESIRED**

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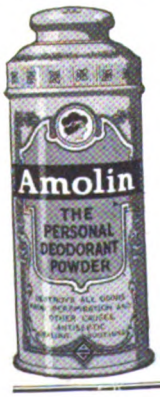
## *Intimate advice*

EVERY nurse owes it to herself, her patients, and her fellow-nurses to be particular about her personal cleanliness. Clean linen alone will not do it—it is just as necessary to be free of all odors arising from perspiration and all other causes.

Amolin is the one safe and effective personal deodorant. It absolutely destroys odors and keeps the body clean smelling. It is especially effective in destroying the odor of sanitary napkins. It heals and prevents chafing—better than talcum.

# Amolin

*The Personal Deodorant Powder*




*Amolin comes in two sizes—30c and 60c—at drug and department stores. Send to us for free sample and booklet of uses.*

THE AMOLIN COMPANY
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## One of Baby's Best Friends

THE causes of infant chafing are many and the results are always annoying—to the infant and those who are caring for it. You can't blame the little ones for getting fretful and restless when their tender skin is irritated.

"Vaseline" Oxide of Zinc Ointment is recommended highly by the medical profession for chafing. It is a pure, simple remedy—not only soothing but healing as well.

Always have a tube or jar of it in your kit or cabinet and advise the use of it in the homes you visit. Your druggist carries it.

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State Street New York

# Vaseline

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OXIDE OF ZINC OINTMENT

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# Frostilla

## FRAGRANT LOTION

## A Skin Comfort and Protection

When your skin is drawn and tired from long tedious hours of duty, Frostilla Fragrant Lotion will refresh it and bring almost instant comfort. It will prevent chaps and roughness. If used regularly each day your skin will be kept soft and smooth always.

Frostilla Fragrant Lotion was first introduced in 1873. Its popularity has grown steadily since that time with women who take pride in their complexions.

Frostilla Fragrant Lotion is not a medicinal product; yet it is most soothing and efficacious in the treatment of minor skin irritations. Patients welcome its cooling, refreshing touch. On the tender skin of babies it will prevent chafing and other common discomforts.

Does the skin of your hands chap and crack in Winter from frequent contact with water? Keep a bottle of Frostilla Fragrant Lotion handy. Rub a little on before drying your hands.

You can purchase Frostilla Fragrant Lotion at any good drug store or toilet goods counter in the United States and Canada. One size bottle only—regular price, 35 cents. The Frostilla Company, Elmira, New York.


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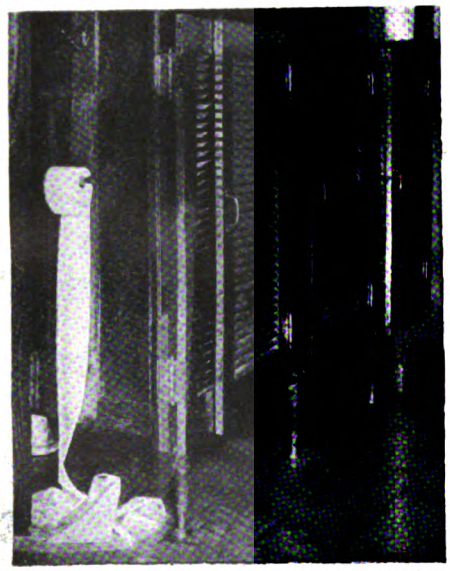
# Which have you—



## Slipshod Equipment or—

**ONLIWON HYGIENE**

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ONLIWON *protects the toilet paper* in a dust-proof, nickel cabinet that operates without insanitary knobs to touch.

ONLIWON *saves toilet paper* by delivering just two sheets at a time.

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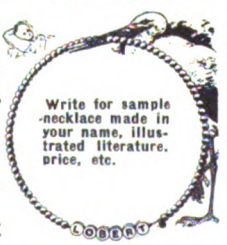


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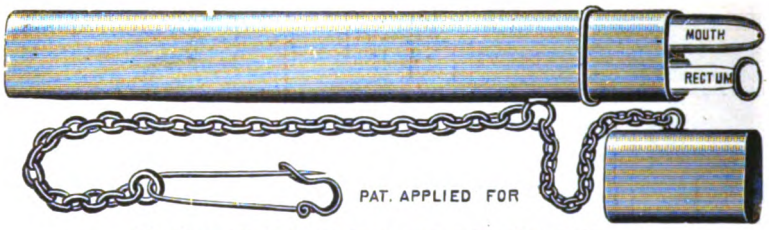


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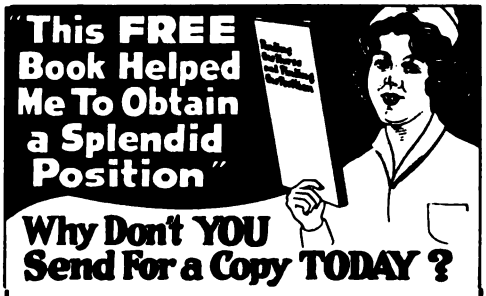


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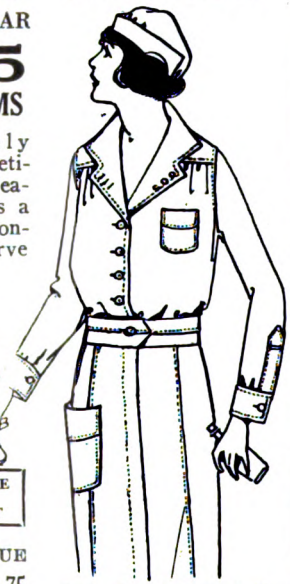

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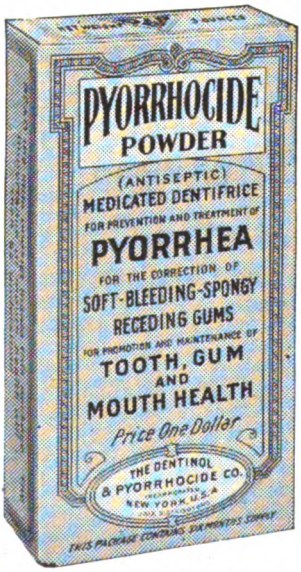


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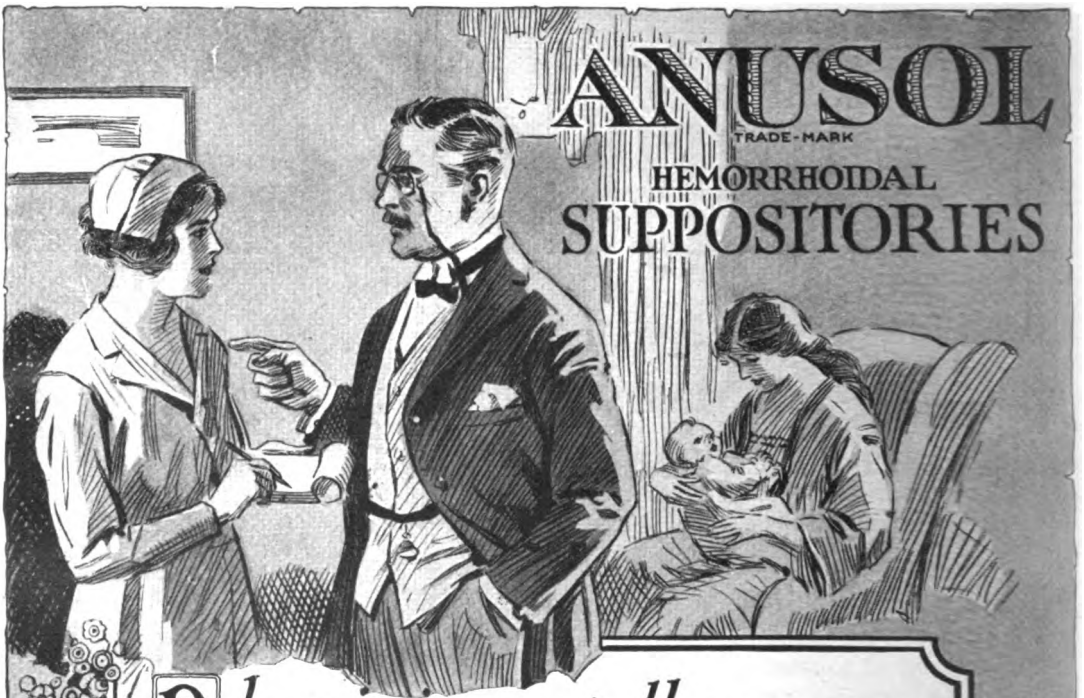


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**Vol. LXIX DECEMBER No. 6**

# The Trained Nurse and Hospital Review

*Editor,* CHARLOTTE A. AIKENS
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of The Trained Nurse and Hospital Review, Published monthly at New York, N. Y., for October 1, 1922.

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Before me, a Notary Public in and for the State and county aforesaid, personally appeared J. K. Erbeck, who, having been duly sworn according to law, deposes and says that he is the Business Manager of The Trained Nurse and Hospital Review and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management, etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 443, Postal Laws and Regulations, printed on the reverse of this form, to wit:

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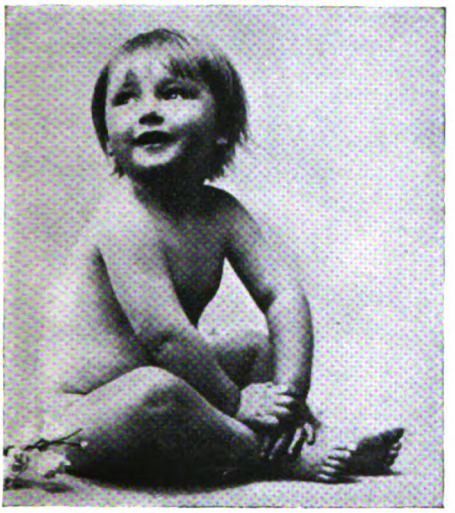

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# The Trained Nurse and Hospital Review

ESTABLISHED 1888

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## THE CHRISTMAS URGE

### THINKING IN WORLD TERMS

WITH the suffocating smoke of Smyrna still in our nostrils and the cries of her foodless refugees in our ears, "Peace on earth, good will to men" becomes a mockery at this season.

Out of the East came Christ. Through Him the groping mysticism of the Orient, the abstract "Oneness" of the Greeks, was reinterpreted in the beautiful religion of Christian brotherhood. Yet two thousand years later we of the West who have flourished and multiplied under His sun are too cowardly or too indifferent to maintain that brotherhood in its Eastern cradle.

We who have bowed our heads in shame at the apathy of the United States toward Europe and the Near East again stand erect at the challenge of Professor Eliot:

> Why does the American Government maintain this weak and ungenerous attitude?
>
> Because it believes that the American people have turned their backs on their history, including that of the five years of 1914 to 1919, and have decided that they will fight no more for other peoples or in the general cause of liberty, justice and peace for mankind.[1]

Only those who refuse to look at the question in world terms can fail to appreciate the irony in this self-answered question. Prof. Charles W. Eliot believes that "the American public is beginning to desire that their government assume a vigorous and generous attitude both at home and abroad, an attitude determined not by cowardly selfishness but by brave disinterestedness."

In retrospect he dares say:

> These five contributions to civilization—peace-keeping, religious toleration, the development of manhood suffrage, the welcoming of newcomers, the diffusion of well-being . . . are reasonable grounds for a steady, glowing patriotism. . . . They are all five essentially moral contributions, being triumphs of reason, enterprise, courage, faith and justice over passion, selfishness, inertness, timidity and distrust. Beneath each one of these developments there lies a strong ethical sentiment, a strenuous moral and social purpose. It is for such work that multitudinous democracies are fit.[2]

To these five contributions he adds another beautiful conception of life and living:

> The American democracy . . . has developed in its men a

[1] Foreign Affairs, vol. I, 1, "The Next Contribution to Civilization," p. 60.

[2] Idem, p. 49.

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greater tenderness toward women and children. . . . With this development has come in married pairs a spirit of sympathetic comradeship and of mutual, affectionate effort for the benefit of children, which is a great improvement on the relations . . . that have hitherto prevailed in other nations or under other forms of government. Now the attainment of happiness is more dependent on good relations between the sexes and on domestic joys than on any other conditions of human life. Therefore, this American contribution to human welfare is fundamental, legitimate and durable; it is a spiritual or moral contribution, not a material one.[3]

These six contributions bring prophetic emphasis upon the contribution of *peace-keeping* which we are ready to make to the world. In 1914, when many American minds were muddling in sentiment or militarism, the same bold mind dared point out that "the immediate duty of the United States is, presumably, to prepare, on the basis of its present Army and Navy, to furnish an effective quota of the international force, *servant of an international tribunal,* which will make the ultimate issue of this most abominable of wars, not a truce, but a *durable peace.*"[4] (The *italics* are ours.) Service for mankind was the spiritual motive which impelled thousands of American men to enter that conflict. Is this motive dead today? Have we as a nation sunk so low that the passion, selfishness, inertness, timidity and distrust which we have long conquered are now our only stimuli to action?

As H. G. Wells has proved so clearly—five days on a powerful vessel brings us into physical contact with France; five hours over ocean cables brings us into mental contact with Turkey; five seconds over trackless skies brings us into radio contact with Germany. How can we preach commercial or moral isolation?

Peace-keeping, religious toleration, the development of manhood suffrage, the welcoming of newcomers, the diffusion of well-being, the happiness of family life—why are we not willing to help other nations in their attainment?

In the cause of well-being — the establishment of world health—we have not demanded isolation. We have civic laws to prevent the spread of communicable diseases; we have state laws to prevent the spread of syphilis; we have national laws to preserve the lives of mothers and children and to prevent the spread of the deadly anthrax. Americans as individuals or through huge organizations are stamping out fever in the tropics, typhus in Serbia, plague in China. Why? Because we touch these people. Their disease is our disease; their health is our health.

But at present in world peace-keeping, the necessary forerunner of every benefit of democracy, we as Americans are spineless. Are we afraid to assume our national obligation to weaker nations? "That fear is now and always has been absolutely unworthy of the American people, false to its history and even falser to its hopes." (*Concluded on page* 506)

THE VISION

We have before us the vision of service. Let him who refuses to aid us in carrying out the Great Commission, look upon his support as an investment which will bring economic returns—the crippled be made useful, the sick man returned to his work and the mothers and babies preserved for productive thought and action.

—*Charles S. Woods, M.D.*

[3] Idem, p. 52.
[4] New York Times, December 11, 1914.

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# EARLY SYMPTOMS OF TUBERCULOSIS WHICH THE NURSE MAY DETECT

LINSLY R. WILLIAMS, M. D.
Managing Director, National Tuberculosis Association, New York City

EVERY public health nurse (and all nurses are public health nurses) should be on the lookout for possible cases of tuberculosis. The problems caused by the disease have innumerable ramifications. They are brought about by subtle changes in the individual's life and environment. Onsets of tuberculosis may be brought on by other diseases, by lack of proper food or insufficient food, by overwork or by many other causes. There are also varieties of susceptibility or tendency to breakdown with tuberculosis.

Whether the nurse is engaged, therefore, in child health in general nursing or even in some of those specialized fields, such as mental hygiene or social hygiene, tuberculosis will be one of the diseases that she will encounter with more or less frequency. It behooves her to know the symptoms of the disease and to be on the watch for those signs that indicate its possible early development.

### THE FACTOR OF RESISTANCE

The period between infection with tuberculosis and actual development of the disease is one of peculiar significance to the nurse and physician. No one can tell how long this interval may be. It may be a week, a month, three months, a year or ten years. But between the time that the individual acquires the germ and breaks down with the disease, there may be many factors that either uphold and sustain his resistance or that cause it to weaken and break down.

Resistance, therefore, is one of the things that the nurse should study and be conversant with. Speaking generally, resistance is individual, but it is also related to race, to sex, to occupation and to many other factors. For example, the resistance of the Italian is one thing as compared with the resistance of the Irishman. The resistance of the negro and the Indian are radically different as contrasted with the resistance of the Swede or the German. Similarly, the resistance of the grinder, the quarryman, or the miner is affected by his work and is in sharp contrast to the resistance of the clerk or the stenographer.

### DETERMINING POINTS

The resistance of men and women varies and so does the resistance of children as compared with adults in middle life. These are factors that the nurse must be conversant with because they all tend to explain why signs and symptoms of tuberculosis are more prevalent under some circumstances than in others and why she should be on the watch for signs and symptoms of this disease in some homes when she would not be likely to find them in others. Resistance may be defined as the wall that the tissues of the body build about the tubercle bacillus, which holds it inactive until some of those forces that have been mentioned weaken or break down the wall and release either the products of the encapsulated germ or the germ itself and turn them into the lymph or blood stream where they may cause constitutional symptoms and set up an active disease process anywhere in the body.

Viewing tuberculosis in this light, the symptoms or signs of the disease may be considered as related not only to an individual who has or has not tuberculosis, but as related especially to individuals in

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accordance with their age, sex, occupation, general environment, etc. Some homes are more likely to breed tuberculosis. In them the nurse should be more watchful than in others. In addition, to the generalized nurse or to the specialized nurse in fields other than tuberculosis, there are certain factors and conditions that should always spell possible tuberculosis.

### Specific Symptoms

Then there are certain real specific signs and symptoms of tuberculosis that may be suspected, even by the layman, others are not so obvious. For purposes of consideration here, let us divide the symptoms of tuberculosis into: (1) those that are perfectly apparent; (2) those that are not so easily detected.

*Fever.* Among those more easily detectable signs, we might mention first of all, *fever.* Fever is an indication of many disease processes, but where it is long sustained and returns frequently in the afternoon or in the evening, it is frequently associated with tuberculosis. In any case, it is always one of those suspicious indications, that should put the nurse on her guard and that should lead her to question carefully the patient with regard to his or her daily life and the manifestation of the febrile symptoms.

### Loss of Weight and Appetite

Similarly, loss of weight, especially if associated with loss of appetite, is a symptom that should be carefully watched and viewed with suspicion. Not every instance of loss of weight is a sign of tuberculosis, but in adults, particularly those who are working, a sudden drop in weight, if accompanied particularly by a loss of appetite or digestive disturbance, is very apt to indicate a tuberculous onset. In young children loss of weight and loss of appetite may not be so suspicious, but even there these points should be viewed with sufficient concern to cause medical examination.

Cough may or may not be a sign of tuberculosis, but where cough lingers for two, three or four weeks or longer and does not readily clear up, and especially where loose sputum is associated with the cough, there should be reason for alarm. The sputum should be examined as quickly as possible and every step should be taken to find out whether the cough is or is not tuberculous. Many cases of tuberculosis, however, develop into a fairly well advanced stage without serious cough, consequently it is a great mistake always to look for cough as a sure sign of tuberculosis. The same thing might be said with regard to fever, but not to the same degree. It surely may be said with regard to the presence or absence of tubercle bacilli in the sputum. Many cases, particularly those where there has been little or slight cough develop to a fairly marked stage of disease without tubercle bacilli in the sputum.

This trilogy, fever, loss of weight and appetite, and cough, make up the more obvious group of symptoms. Any or all of them should cause alarm and should make the nurse apprehensive with regard to her patient.

### Less Obvious Symptoms

The second group of symptoms are more obscure and less easily detected. They are apt frequently to be associated with other conditions and not viewed as tuberculous until it is too late.

Take, for example, such a general symptom as the one that we call a run-down condition. Many things tend to produce such a condition in the body. It may result following sickness with such diseases as influenza or typhoid fever, for instance. It may be brought about by overwork or by worry or grief, or a combination of circumstances that have preyed heavily upon the mind and the body of the individual. Not always does

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a rundown condition indicate tuberculosis; but frequently, if it is associated with a history of tuberculosis or with other symptoms and factors that are inherent in the resistance of the individual, this general loss of tone in the body should be viewed with alarm and should be considered as a suspicious sign of tuberculosis. Viewed by itself, in other words, it may not be alarming, but viewed in connection with many other things, and weighed with these other things, as the nurse should weigh them, it may be reason for serious concern.

Similarly a chronic underweight may not in itself be serious. Some people cannot be fattened and are inclined to be underweight for their age, their height and sex. At the same time if such underweight is associated with conditions of age, sex, nationality, occupation or previous history of the individual or his family that might indicate tuberculosis, this continued loss of weight should be viewed as a possible suspicious sign of tuberculosis.

### Symptoms Noted in Children

In young children, swollen glands, enlarged tonsils, adenoids and certain other conditions of a similar character may indicate danger signs of tuberculosis. They are not always indicative, however. Here again, the possible danger depends not so much in the signs themselves as on these symptoms in relation to other factors.

Taking it all in all, it is extremely important for the nurse to know the history of the individual before determining what is or is not a symptom of tuberculosis. If, for example, in a young child there is an evident history of tuberculosis exposure coupled with a lack of nourishment or with improper nourishment or with a related disease process or defects and impairment of the mouth, nose or throat, there may be a reason for serious alarm. The same symptoms, however, in another child or adult without that history and relationship may not necessarily cause serious alarm. The nurse should appreciate not only the value of the individual and disease, but the significance of age, sex, occupation and those many other factors that statistics have clearly shown have a bearing upon the incidence of tuberculosis.

### Err on the Side of Safety

In conclusion, the nurse's job with reference to tuberculosis is to ferret out any suspicious signs. Since it is not hers to make the diagnosis, she may lean over backwards with regard to her suspicions. It is better to err on the side of safety in reporting suspicious symptoms than "take it easy," particularly in a disease like tuberculosis. Anything that looks like a breaking down of resistance is to be viewed with suspicion.

The nurse must be the eyes of the doctor in detecting these suspicious symptoms. She must call them to the attention of the physician in private practice, in clinic or in some other position. If all nurses in all positions always follow this principle, many more cases of tuberculosis can be detected in their incipiency and many more human lives can be saved.

Thus far we have discussed your individual responsibility toward every patient you nurse and every man, woman or child with whom you are thrown professionally or socially. But you have another obligation in furthering the cause of prevention. The National Tuberculosis Association and its related state and local associations are organized to analyze the conditions that lead to tuberculosis and to provide the machinery for its treatment and prevention. The 1922 Christmas Seal Sale, which is being held this December, must provide the means for carrying on this great nation-wide movement. Nurses are invited and urged to support the seal sale in every way.

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# THE CARE OF PREMATURE INFANTS

## PERTINENT NURSING POINTS

KATHERINE EUNICE SORRELLS, R. N.
Department of Public Welfare, Norfolk, Virginia

PREMATURE babies come into the world with a handicap which can only be overcome by a great deal of care and patience. Because a large part of this careful attention usually falls upon the nurse, I present this paper.

Babies born before the seventh month of gestation rarely survive for more than a few weeks, and many others are allowed to die through ignorance or negligence. However, it is possible to save a great many babies who are born from seven months on, and many of them grow up to be strong and healthy individuals.

### AIR, CLEANLINESS, HEAT, FOOD

In the care of these delicate children four things are extremely important—fresh air, prevention of infection, maintenance of bodily heat and proper feeding. Strong emphasis must also be placed on the importance of perseverance on the part of the nurse for the most hopeless appearing subject may eventually become a strong baby.

We are dealing with an undeveloped body which is not ready for the environment in which it has been placed. Accordingly, the baby should be handled only when necessary and then in the most gentle manner possible. It must be remembered also that should resuscitation at birth be necessary the very gentlest methods possible should be employed and prolonged exposure avoided. No time should be lost in getting any premature baby thoroughly warmed after birth. Oiling every other day is substituted for bathing until the child weighs at least five pounds. The baby may be weighed after oiling, taking great care to prevent unnecessary exposure.

Because of the undeveloped state of the lungs the air should be as pure as possible. Suitable ventilation may be obtained by the window-board device with which all nurses are familiar.

### AVOIDING INFECTION

Infection of any nature is a very serious matter, and for that reason visitors should always be excluded from the presence of the premature. They succumb readily to the slightest infection, a mild bronchitis or fermentative diarrhea being sufficient cause for death.

© *Kadel & Herbert, New York*

Mary Dushman, an incubator baby being cared for in Jersey City, New Jersey. Though the child is twenty-eight days old, it weighs only 30 ounces.

### PROPER TEMPERATURE

Because of the undeveloped heat centers the body heat of these infants is quickly lost and must be maintained artificially. They should not be clothed with the ordinary infant's clothing. A

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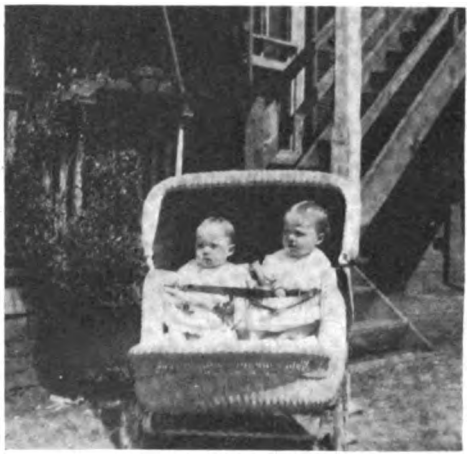
jacket of lamb's wool and gauze or cotton and gauze made with a hood is all that is required while the baby is under five pounds, or as long as there is serious difficulty in keeping the temperature normal. The jacket should be pinned over in front snugly so that no air touches any part of the infant except its face. The bottom is folded over and pinned also. Squares of soft linen or pieces of cotton should be placed under the buttocks as the ordinary diaper is too harsh. Only the bottom of the jacket need be unpinned when changing or taking the temperature, which is always taken by rectum. This should be done just before the feeding and before changing, as the temperature may drop during the slightest exposure, leading the nurse to believe that more external heat is required than is really necessary. In case the body temperature is too high, the external heat should be lowered. Oil is used for cleansing the buttocks. Greatest care, as we have emphasized above, should always be taken to prevent unnecessary exposure or handling.

### Warm Clothing

The temperature of the crib (an ordinary clothes basket will serve) should be kept about 90 F. It should be lined with blankets and hot water bottles placed inside. The baby's temperature should be taken every two hours, the body temperature being a guide to the external heat requirements. The jackets may be changed every day, the one to receive the infant having been thoroughly warmed. It is very important that the temperature of the premature be watched constantly and every effort made to keep it between 98 F. and 99 F. The temperature of the room should be 85 F. or 90 F.

Breast milk for these babies is almost a necessity for a few weeks at least. Frequently the mother of a premature has no milk, so every effort should be made to secure a wet nurse. Often these babies are too weak to nurse any kind of a nipple. In such cases I have found the medicine dropper most satisfactory, and after the baby is stronger the Breck feeder, which consists of a graduated glass tube narrowed at one end, over which end is placed a small rubber nipple, the other end is closed by a flexible rubber cap, so that the milk may be gently squeezed through the nipple.



Pauline and Kathleen Rooks at eighteen months. These twins were born prematurely.

### Proper Feeding

Since the stomach is small and the digestive processes undeveloped, the breast milk is often diluted with equal parts water or milk sugar solution. The first week or two the baby should be fed every hour, for usually one or two drachms is all that it is able to take at one time. If human milk is not obtainable whey is usually given at the start. The feedings should be given regularly, promptly and slowly. Frequently such a baby is so weak that it strangles on a few drops. The importance of the promptness and regularity of the feedings is second only to the importance of the breast milk. Since these babies sleep most of the time no feedings should be omitted on this account. Nourishment

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is the more important. Often the baby may appear to be sleeping when it is too weak to give any sign of life. Where breast milk is not obtainable and artificial food is required, a cow's milk formula is given. Whey may be given at the start, however, if there is difficulty retaining the formula. As soon as the child is able to handle it, cow's milk is the best food.

### Results

In closing, I wish to mention a case, or rather two cases, which came under my own personal care, where breast milk, patience and perseverance achieved most happy results. These twin girls weighed about two and three pounds at birth, losing the first two weeks until one was slightly over two pounds and the other was something under two pounds.

The smaller one had every symptom of a defective heart. Several times I thought she was dead. They were both so weak that they could not make a sound when they tried to cry. Their vitality was so low that it was impossible to keep their body heat above 96 F., regardless of all the external heat applied. They strangled on every drop of milk given them. I am sure no premature baby ever seemed any more hopeless than these. Nevertheless we kept on. They were weighed and oiled every other day and their temperature was taken every two hours, night and day.

### The Value of Breast Milk

The mother had no milk, but as long as they remained in the hospital enough breast milk was obtained to feed them both. After leaving the hospital the feeding problem became very serious. Since it was impossible to get a wet nurse, a number of artificial foods were tried with most discouraging results. As a last resort we were able to obtain a small amount of breast milk from several different mothers each day, which had to be diluted before the babies could handle it. They were too weak to nurse any kind of a nipple, so I fed them for five weeks with a medicine dropper. They were fed every hour, day and night, for about ten days, then every two hours, taking only one or two drachms each time. After five weeks they were able to nurse a small nipple. They had breast milk about six weeks, and in changing from breast milk to cow's milk they had to start with whey. As soon as they were handling the formula satisfactorily, they gained steadily. When they were nine weeks old they weighed four and four and one-half pounds. They were then dressed in ordinary infant's clothing, oiled every other day and bathed with soap and water every other day, and generally cared for like the average baby.

Coming in 1923

"Mouth Hygiene for School Nurses" by Alfred C. Fones, M. D.; a series of articles embracing the important essentials.


## SLIGHT INCREASE IN 1922 MORTALITY

The provisional mortality figures compiled by the Bureau of the Census for the first quarter of 1922 indicate higher death rates than for the corresponding quarter of 1921. For the states compared the death rate for the first quarter was 13.7 in 1922, against 12.6 for the first quarter of 1921. The highest mortality rate for the quarter is shown for the District of Columbia (17.6) and the lowest for Wyoming (9.6). These early figures forecast for the year 1922 a higher rate for the death registration area than the record low rate (11.7) for the year 1921.

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# THE TREATMENT OF PNEUMONIA

## MODERN METHODS OF DIAGNOSIS

ROBERT A. KILDUFFE, A. M., M. D.
Director, Laboratories, Pittsburgh Hospital; Director, Laboratories, McKeesport Hospital; City Bacteriologist, McKeesport; Serologist, Providence Hospital

PNEUMONIA may be defined as an acute infectious disease characterized by an abrupt onset and equally abrupt termination, and by a uniformly diffuse exudative inflammation of entire portions of one or more lobes of the lung.

### THE MORTALITY

Osler has called the disease "The Captain of the Men of Death," an apt characterization when it is considered that in the United States alone the number of deaths from pneumonia reaches the appalling yearly number of 70,000 to 80,000, from 60 per cent to 70 per cent of the cases occurring in males. Though it is true that a large number of cases occur in the extremes of life—infancy and old age—approximately 50 per cent of cases occur between the ages of 20 to 50 or the period of greatest activity so that the economic importance of the disease is obvious.

### SCIENTIFIC RESEARCH

In spite of the tremendous ravages that these figures imply it is only within recent years that the treatment of this disease has been anything more than merely symptomatic and, as always, the evolution of specific, scientific methods had its inception in laboratory studies concerned with the study of the etiologic agent and its mechanism in the production of the infection.

While any of the pyogenic bacteria may, under favorable conditions, give rise to inflammatory reactions in the lung, the organism most frequently and directly concerned in the production of lobar pneumonia is that which is known as the diplococcus pneumonia or, more briefly, the pneumococcus.

This organism, first discovered (1881) in the saliva by Pasteur in France and Sternberg in the United States, is a diplococcus—or micrococcus occurring in pairs. At first, because of its shape—like two spear-heads with their bases together and the points facing in opposite directions—the organism was called the diplococcus lanceolatus or lanceolate (spear-shaped) diplococcus. At the time of its discovery it was not known to be associated with the occurrence of pneumonia in man. Shortly after its isolation, however, its occurrence in the blood, organs, and exudates of a large series of cases of pneumonia was noted by Weichselbaum and others and its causal relationship to the disease established (1884-1886).

### EXACT METHODS OF DIAGNOSIS

It is only within the last decade, however, that the laboratory studies of this disease have culminated in the establishment, largely by workers of the Rockefeller Institute, of exact methods of diagnosis and specific treatment which it is the purpose of this paper to briefly consider.

Effective measures in the etiology, treatment, and control of this disease must necessarily approach the problem from the standpoint of etiology and it is essential, therefore, to consider the salient features of our present knowledge of the pneumococcus.

This organism is a lanceolate diplococcus possessing a capsule of varying thickness. While generally occurring in pairs, short chains are not uncommon so that in

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this, and other ways, the organism has some resemblance to the streptococcus from which, however, it is distinguishable by its shape and appearance and by the fact that it is soluble in bile or a solution of bile salts while the streptococcus is not.

### Differentiation of Types

Of great importance, especially from the standpoint of specific treatment, was the discovery that the pneumococcus is not one but a *group* of organisms, alike in general, but differing in particular characteristics. Four groups or types are known: Type I, Type II, Type III, and Type IV, the last being composed of a still smaller group of organisms the individual members of which have not, as yet, been distinctly separated.

These four types, while all possessing the same general characteristics, have distinct differences. While all are diplococci of more or less lanceolate shape, and all have capsules, and all are soluble in bile, the size and thickness of the capsule varies, which appears in some way to be related to their virulence. Of still greater importance is it that each of these types produces antibodies specific for itself and differing from those produced by the other groups, this being the means utilized to separate them one from another.

Pneumonia, therefore, may well be looked upon not as one but as a group of diseases.

The virulence of the pneumococcus varies but, as a rule, cultures from the blood of a case will kill a mouse in 36 hours when injected in as small a dose as 0.000001 cc.

### Possible Sequelae

While most frequently concerned with the production of pneumonia, it must not be forgotten that the organism is a not infrequent cause of peritonitis in children; of infections in the upper respiratory tract and sinuses, the ear and the meninges; and that, in pneumonia, it may give rise, as sequelae, to empyema, peritonitis, endocarditis, pericarditis, and lung abscesses.

While it secretes a soluble toxin, the exact mechanism by which it produces its pathogenic effects is not entirely clear and several factors may be involved: the setting free of an intracellular toxin, a toxic split-product formed by the destruction of the bacterial protein, or, possibly, the metabolic activities of the bacteria themselves.

### Type Differences

The separation of these types is of great practical importance in the study of the incidence and mortality of the infections. The most frequent is Type I producing 33 per cent of cases; then Type II, 29 per cent; Type III, 20 per cent; and lastly Type IV, 13 per cent, from which it is seen that Types I and II are responsible for over 60 per cent of all cases.

### Types vs. Mortality

Of great interest, also, is the relation between the type of infection and the mortality, the most virulent being Type III infections with a mortality of 45 per cent followed by Type II with 32 per cent, Type I with 25 per cent, and lastly Type IV with 16 per cent mortality.

From these facts it is evident that, though there is considerable variation in the severity of individual cases due to the differing virulence of pneumococci and the individual resisting powers of the individual patients, a knowledge of the type of pneumococci responsible for the infection in a given case is of great significance from the standpoint of prognosis and, as will be seen later, of still greater significance from the standpoint of specific treatment.

It is clear that the prognosis of a Type

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IV infection, as it has the lowest mortality, is much better than that of Type III with a mortality of 45 per cent.

The first step, therefore, in the modern diagnosis of pneumonia is the determination of the group to which the infecting pneumococci belong or, as it is called, the *typing* of the case.

This is accomplished first, by the isolation of the pneumococci from the sputum —which must be true sputum, that is, material *coughed up* from the lung or bronchial passages and not nasopharyngeal mucus *hawked up* from the nose and throat—and, secondly, by testing the culture so secured for agglutination by its specific serum. A pneumococcus agglutinated by a Type I immune serum is thereby determined to be a Type I pneumococcus and so on, Type IV being composed by those pneumococci not agglutinable by any of the three sera. There is, obviously, no Type IV serum as this group is composed not of one but of several organisms.

### Laboratory Isolation

The isolation of the pneumococcus is readily accomplished by the intraperitoneal inoculation of a mouse with an emulsion of sputum and the subsequent recovery of the pneumococci by culture of the peritoneal exudate; or, with somewhat more difficulty, by the direct culture of the washed sputum, the isolation and typing of the organisms taking from 12 to 20 hours.

Following the discovery that the pneumococcus produced a soluble substance capable of producing precipitation of its specific antiserum and therefore, called a *precipitin,* a more rapid method of typing was developed. This consists in destroying the pneumococci in the sputum either by the addition of bile which dissolves them or by boiling and so liberating the precipitin which is then brought in contact with the various immune sera, or by testing the urine of the patient directly for its presence. In either case the fluid obtained from the sputum or the urine to be tested is placed in contact with the various sera. When, in the presence of Type I precipitin, for example, a white ring or cloudiness occurs with Type I serum, II and III remaining clear, this indicates the presence of Type I pneumococci.

This method of typing can be completed in from thirty minutes to one hour but has the disadvantage that, in the early stages of the disease, the precipitin may not be present in detectable amounts, thus necessitating a resort to the cultural methods.

### Antipneumococcic Sera

Following these discoveries concerned with the etiologic relationship of the various groups of pneumococci to pneumonia came endeavors to produce a specific antipneumococcic serum for the treatment of the disease.

It is obvious that for the satisfactory specific treatment of the disease at least three sera would be required and, also, that no satisfactory serum for Type IV infections was to be expected because this type was in itself another group of several varieties.

Because of various inherent complexities of the problem, the attempt has only been successful in the case of Type I infections for which a fairly satisfactory serum has been produced. Like other immune sera it is produced by the inoculation of horses with dead suspensions of pneumococci followed by living cultures in varying dosage; the subsequent bleeding of the animal and the separation of the serum which contains the antibodies.

Because of difficulties, into which it is not necessary to enter here, no satisfactory method of standardization of the serum has as yet been evolved and it is

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administered by bulk without definite knowledge of the exact antibody content.

The consensus of experience seems to show that this Type I serum forms a valuable and specific means of treatment in Type I infections. Its efficacy however, depends largely upon the stage at which its administration is begun and, of course, upon sufficient amounts being given.

It is always administered intravenously with due regard to the possibility of previous serum sensitization and to the possibility of anaphylactic reactions.

Laboratory experiments having shown in other conditions that if a culture of bacteria is brought into contact with its specific serum the antibodies will attach themselves to the bacteria, and further, that if these *sensitized* bacteria—i. e., bacteria with their antibodies attached to them—are heated in an alkaline solution the antibodies are split off, these facts were utilized in an endeavor to secure a solution containing only the pneumococcus antibodies without serum constituents. These endeavors have been successful, the substance being spoken of as ***pneumococcus antibody solution.*** Its clinical use is still in the experimental stage but it promises to be of value.

Laboratory studies have also drawn attention to a drug—ethyl hydrocupreine—a quinine derivative, which has been shown to possess specific destructive action upon the pneumococcus and which has been used with some success in the treatment of the disease so that, little by little, the struggle against this infection progresses.

This brief review suffices, however, to show that modern medicine now possesses several potent weapons:

(a) A means of exact diagnosis of the type of infection.

(b) A prophylactic vaccine as yet of moderate value.

(c) A specific serum for treatment of at least one type.

(d) A specific drug against pneumococcic infection in general.

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# A CREED OF SERVICE

To respect my country, my profession and myself. To be honest and fair with my fellowmen, as I expect them to be honest and square with me. To be a loyal citizen of the United States of America. To speak of it with praise, and act always as a trustworthy custodian of its good name.

To base my expectations of reward on a solid foundation of service rendered. To be willing to pay the price of success in honest effort. To look upon my work as an opportunity to be seized with joy and made the most of, and not as painful drudgery to be reluctantly endured.

To remember that success lies within myself—my own brains, my own ambition, my own courage and determination. To expect difficulties and to force my way through them.

To study my business. To know my profession in every detail. To mix brains with effort, and use system and method in my work. To find time to do every needful thing by never letting time find me doing nothing.

Finally, to take a good grip on the real joys of life. To play the game like a man. To fight against nothing so hard as my own weaknesses.

So may I be courteous to men, faithful to friends, true to God, a fragrance in the path I tread.—*Medical World.*

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# A GOLDEN JUBILEE

## HONOR TO LINDA RICHARDS

WITH friends and associates gathered about her, Linda Richards celebrated her golden jubilee in the last days of October. She was the honored guest of the New England Hospital for Women and Children which was commemorating the sixtieth anniversary of its founding. The speakers on this momentous occasion included Dr. Alfred Worcester, Helen F. Kimball, president emeritus of the hospital, Linda Richards, Bernice Billings, vice-president of the Nurses' Alumnae Association, and Dr. Vincent Y. Bowditch.

To look back upon the history of the training school is to trace the development of the hospital, for its triple purpose—

**To provide for women medical aid of competent physicians of their own sex,**
**To assist educated women in the practical study of medicine,**
**To train nurses for the care of the sick,**

was ever foremost in the minds of its early supporters — Lucy Goddard, Dr. Marie Zakrzweska, Dr. Lucy Ellen Sewall, Dr. Helen Morton, Edna Dow Cheney and its champion, Dr. Henry I. Bowditch. Since the chartering of the institution in 1863, the hospital has always been directed by a woman president and Mrs. Herbert B. Howard holds that position today.

In 1870 the secretary of the hospital reported that "there is a great demand for competent nurses. The few who have faithfully served their term with us find more than they can do." It is this splendid spirit of service which has characterized the life work of Miss Richards. Shortly after her graduation in 1873 she came as night superintendent to the newly organized training school at Bellevue to assist Sister Helen. Subsequently she returned to Boston to organize the Training School of the Massachusetts General Hospital. But it was in 1877, as Miss Richards reported so interestingly in the address delivered at the celebration, that she prepared to visit England in order to study the training methods of Florence Nightingale as carried out in the Training School of St. Thomas's Hospital.

**Linda Richards before the New England Hospital for Women and Children from which she graduated in 1873.**

The story of that visit told in Miss Richards' graphic style is nursing history. We give it in her own words:

"I arrived in London and began making my observations in the training school at St. Thomas's Hospital. It was a large school, and large numbers of young women were receiving valuable instructions there. But on a number of points in actual medical knowledge we were ahead of them in the States, even in the short time we had had training schools.

"I had not been in London long when I received an invitation to visit Miss Nightingale. When I stood before her in her 'town house' in London that spring day, it was the happiest moment in all my life. From the

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time I had read of her when I was a little girl, I had imagined to myself what she would be like. I had seen many pictures of her, too.

"None of my dreams and none of the pictures did justice to her. She possessed a wonderful, indescribable charm.

"On that day, she lay fully dressed, propped up on a bed. For some time she had been an invalid, you know. But somehow she kept me from thinking of that. It was almost as if she had met me standing, and perfectly well. She was a very small woman, but neither did I think of that as she talked.

"She had a great mass of dark brown hair rolled gracefully away from her lovely, clear-skinned face, and setting off a head of exquisite shape—a very remarkable head.

"Speaking in a sweet, well-modulated voice, she gave me a very cordial handshake with her little white, soft hands. It had been a long time since she had done any work that would harden her hands. She had been doing only brainwork.

### Versatility

"And a wonderful brain she had, too. During the Crimean war she studied the construction of ditches for drainage and sewerage in military camps—and other considerations in sanitary engineering, and wrote a book on the subject.

"As Miss Nightingale talked, her big dark blue eyes seemed to go right down into me. She showed a great deal of interest in me personally, but also asked me many general questions about the United States. She seemed to be very friendly toward Americans—and I think she was. It was a big surprise to her, she said, to know of the rapid progress American women had made in medical science—organizing courses and carrying on studies in spite of scanty funds and all sorts of opposition.

### An Organizer

"Miss Nightingale's best pictures were entirely unlike her. The secret was in her expression. Her face had the most extraordinary animation. It would be impossible for any picture to show its constantly changing expression.

"I call her humanity's greatest nurse and remember that along with all her frail charm she was a great organizer and executive. When she started things, they were finished successfully at all odds."

Much of Miss Nightingale's indomitable spirit has characterized the service of her follower, Miss Richards. On her return to Boston she organized the Nurses' Training School at the Boston City Hospital. Eight years later she carried her precious spirit of service to Japan. On her return to America she became interested in working out the details of visiting nursing service in Philadelphia.

Then followed splendid work as superintendent of nurses at the Methodist Episcopal Hospital, Philadelphia, at her own hospital in Boston, at the Homeopathic Hospital in Brooklyn, the Hartford Hospital, the Long Island Hospital and later at the University Hospital, Philadelphia in cooperation with M. E. P. Davis.

### Mental Nursing

Although this service might seem ample for one lifetime, at this point Miss Richards began pioneer work in a new field—state hospitals for the insane—carrying out her ideas at Taunton, Worcester and Kalamazoo before retiring to private life.

On the fiftieth anniversary of her entrance into the nursing field, nurses from East and West send greeting to Miss Richards whose skillful hands, executive mind and beautiful spirit have guided the nursing profession during the years.

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## THE CHRISTMAS URGE

*(Concluded from page 494)*

Professor Eliot gives this program:

The next contribution to civilization should be full participation in the safe conduct of those world affairs through which the enlightened common interest of mankind is served, first by joining heartily the League of Nations for the immediate salvation of Europe and the Near East and then by advocating steadily for all the world Federalism, elastic and progressive law, cooperative management and discipline in machinery industries, the emancipation of children from fear, harsh domination and premature labor, the furtherance of preventive medicine and public health, and the opening for everybody of the delightful and sustaining vision of freedom, aspiration and hope.[8]

We hold it a privilege to pass on this Christmas sermon.

[8] **Foreign Affairs, vol. I, 1, p. 60.**

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*Reprinted from* THE TRAINED NURSE *of December, 1894*

FLORENCE NIGHTINGALE

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# IN DEFENSE OF THE SPECIAL NURSE

MARY CECILE MCNELLIS, R. N.*
Wichita, Kansas

THE lack of co-operation between hospitals and special nurses is one of the outstanding problems before our profession at the present time.

Public demand for the special nurse is becoming greater each day. The large majority of our nurses on graduating enter this field and we cannot deal a blow at these nurses without doing serious injury to the entire profession and to our training schools. As it now exists, the situation is deplorable.

## THE CONS

Superintendents of training schools complain: (1) that the graduate special nurses are a disrupting influence in the school; that they spoil the discipline for pupil nurses; that they have no respect and regard for hospital rules and resent the discipline of the superintendent of nurses; (2) that special nurses cause unnecessary trouble and confusion in serving meals; make unreasonable demands for supplies and for their own comfort, and are careless and destructive with hospital equipment; (3) that special nurses are unethical in their conduct, take unfair advantage of patients in regard to "time off" and charges.

## THE PROS

On the other hand, special nurses complain (1) that the attitude of the superintendent of nurses and supervisors toward them is antagonistic and disrespectful and that student nurses who imitate them also cultivate this attitude; (2) that special nurses are compelled to put up with inadequate rest, very undesirable rooms (if the hospital provides these) and inadequate dressing rooms; (3) that more rules and regulations are laid down for them, as mature women, than for student nurses; (4) that they are boycotted in the diet kitchen and are not permitted the necessary linen and other supplies. (5) That hospitals offer the special nurse little or no chance for advancement in her profession.

Two opposing opinions! Both right on some points, both wrong on others.

We all acknowledge that an incompetent or unethical nurse is usually the result of poor training or of an error of judgment on the part of some superintendent of nurses in accepting such material. A properly trained graduate nurse should stand as an example of all that is good and worthy in the profession, and this nurse is able to fit into a hospital if it is justly managed.

## THE CAUSE OF FRICTION

For the good of the organization, all graduate nurses must conform to the rules of the hospital. I believe that they should report directly to the superintendent of nurses. It is desirable to have as few rules as possible and it is expected that the superintendent of nurses will administer them *wisely and with justice.*

The friction comes, I believe, in the division of executive authority. A special graduate nurse feels that her knowledge and experience in nursing are comparable with that of the head nurse. If the hospital rules so state, she is perfectly willing to take orders from the head nurse as to conditions governing kitchen use, linen supplies, etc., but she considers the care of her patient her own problem. When the attitude of the head nurse makes it difficult for her to give

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adequate service to her patient she rebels.

The situation is always in the hands of the superintendent of nurses. She can estimate the real situation and endeavor to gain the loyalty of those working under her. As a last resort, of course, she has the authority to enforce her rules or to dismiss from the hospital register any graduate who persistently disregards them.

All graduates entering the hospital for the first time should be furnished with a written list of simple, definite rules, also the standing orders. The superintendent who tells you, " I don't consider I am responsible for the special nurses and have no time to bother with them," is laying up trouble for her hospital; on the other hand the superintendent who is constantly on their trail, looking for trouble, who is too autocratic to return the greeting of special nurses, who lets it be known that she considers them a " necessary evil," who is openly antagonistic and encourages her students in unethical conduct or fails to discipline them for it, surely cannot fail to understand why she has an antagonistic element to contend with.

### The Nurse's Obligation

The special, on her part, should do everything to promote a smooth running organization. Rest hours should be taken in the afternoon between designated hours. Nurses should leave and return promptly. Evening hours should not be allowed nor any additional hours other than the designated time. The average superintendent of nurses has enough legitimate worries without the special nurses causing her any unnecessary ones.

The present trend in the housing of pupil nurses is, we believe, highly advantageous. Students need relaxing, comfortable rooms and gathering halls—" mansions," as the cynics comment, are none too good for them. But what of the tendency to give the student nurses all the luxuries and house the specials over a noisy kitchen, under the hot eaves or in any odd corner? Nurses of thirty are sometimes more nervous than the student of twenty; nurses of forty-five may have broken arches, headaches, and need real rest. At times the specials feel as if they have been bribed with friendly care to take up their training and are then relegated to the cellar as soon as they receive their diplomas.

### Living Conditions

Graduate nurses feel that they are entitled to a table in the main dining room and that they should not be expected to eat with the maids, scrub women and other miscellaneous help. A decent dressing room with bath tub and cot would seem to be reasonable demands.

### Nice Discrimination

The special nurse should never have to receive orders from an undergraduate. The superintendent of nurses who sends a student to inform a special of what she should or should not do shows herself lacking in the fitness of things. Specials feel that they are responsible to the superintendent and always accept her direct order in good part. They always resent the posting of a general manifesto in the dressing room when one individual nurse is known to be at fault.

Some time ago a friend of mine, married and retired, went for one night to relieve a special who had been taking care of a member of the family in a very fine hospital. During the night it became necessary to catheterize the patient. This nurse went to the desk where two students were holding an animated conversation and asked very pleasantly if one of them would assist her for a few moments. One of the students replied: " Well, I suppose I could, but it looks as though

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you ought to be able to do it yourself." Some years ago an attitude of this kind was unheard of. We felt honored if a graduate asked us to assist her. Floor supervisors should see that students are not imposed upon in this matter but they certainly should appreciate that respect is due any graduate nurse.

### Adjustments

Hospital equipment destroyed or lost should be assessed against the nurse. We have had a few complaints of overcharge but they have been due in nearly every instance to a misunderstanding about our rates.

The problem of serving meals by the special nurses has been solved in some hospitals by having a special diet kitchen in which they can arrange their trays undisturbed; other hospitals serve either one-half hour before or after the floor trays.

Certain supplies are essential to the comfort of the patient and special nurses should be furnished sufficient linen, dressings, etc., to meet this demand. They should not have to appeal to their doctor, thus causing dissension.

### A Congruous Personnel

A move in the direction of harmony and efficiency would be for the hospitals to select their supervisors and charge nurses from among the most capable of the special nurses. A great many hospital griefs are the direct result of importing nurses into regions absolutely foreign to their environment, both professional and personal. Why not use the nurses who know our staff, our ways, and have worked well and faithfully for our hospitals? Under these conditions, the special feels that she is building her future by every satisfactory case to her credit.

During the war many of the hospitals tried out the system of using seniors as specials instead of graduates. This we found universally unsatisfactory both from the standpoint of the student and of the patient. The principle of it is wrong. We have no right to take three years of any student's time and not be able to offer her remunerative employment at the expiration of this period. We cannot all be superintendents of nurses, surgical assistants and public health supervisors. Some graduate nurses are better adapted to nursing in homes, others to nursing in hospitals. All are necessary, and nurses are unjust in maligning the hospital special as the seeker after "easy" jobs.

### The Superintendent's Move

In the final analysis much of this friction is caused by petty matters that could be adjusted by a little "getting together," a little team work and a little more cooperation. However, the first move in this direction will have to come from the executives of our hospitals.

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## A New Viewpoint

*Texas Siftings* quotes these words of wisdom from a Chinese visitor in America:

**The more I study Americans the more I am convinced that they are mentally diseased. Instead of doing everything in a common sense manner, they try all they can to do it in the very opposite way. At home, for example, you and the other members of your Mutual Health Association would pay Dr. Wun Lung and his assistants each a liberal salary to keep you all well, and pay nothing when you are sick. On this account he and his young men work very assiduously in regularly calling and examining every member of the union, and all of you enjoy comparative immunity from illness.**

**Here in America a physician is paid by the amount of your sickness, and the less you are able to earn money the larger and more onerous is his bill. As a result, some doctors, I am told, yield to temptation and keep their customers sick. The consequence is that those who have the largest number of sick and dying are the richest, most esteemed and influential, while in China they would be ostracized and not allowed to practice.**

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# THE LABORATORY—ITS RELATION TO THE NURSING SERVICE—X

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## COW'S MILK

WHERE, for any reason, the human milk cannot be obtained or used to feed a child, it is customary to resort to other available milk—usually the milk from the cow or from the goat.

Table IV gives the variation in composition of the milk used for human food. The data gives the limits of composition as computed from analyzing a large number of samples.

TABLE IV
Limits of Variation in Composition of Milk from Different Mammals (Leach)

| Kind of Milk | Specific Grav. | Fat | Casein | Albumen | Lactose | Total Solids |
|---|---|---|---|---|---|---|
| Cow's | | | | | | |
| Minimum.. | 1.0264 | 1.67 | 1.79 | 0.25 | 2.11 | 9.68 |
| Maximum. | 1.0370 | 6.47 | 6.29 | 1.44 | 6.12 | 19.68 |
| Mean..... | 1.0315 | 3.64 | 3.02 | 0.53 | 4.88 | 12.73 |
| Human | | | | | | |
| Minimum.. | 1.027 | 1.43 | 0.18 | 0.32 | 3.88 | 8.60 |
| Maximum. | 1.032 | 6.83 | 1.96 | 2.36 | 8.34 | 18.91 |
| Mean..... | 1.0295 | 3.78 | 1.03 | 1.26 | 6.21 | 12.59 |
| Goat's | | | | | | |
| Minimum.. | 1.0280 | 3.10 | 2.44 | 0.79 | 3.26 | 9.84 |
| Maximum. | 1.0360 | 7.55 | 3.94 | 2.01 | 5.77 | 17.98 |
| Mean..... | 1.0305 | 4.78 | 3.20 | 1.09 | 4.46 | 14.29 |
| Ewe's | | | | | | |
| Minimum.. | 1.0298 | 2.81 | 3.59 | 0.83 | 2.76 | 12.98 |
| Maximum. | 1.0385 | 9.80 | 5.69 | 1.77 | 7.95 | 25.53 |
| Mean..... | 1.0341 | 6.86 | 4.97 | 1.55 | 4.91 | 19.18 |
| Mare's | | | | | | |
| Mean..... | 1.0347 | 1.21 | 1.24 | 0.75 | 5.67 | 9.22 |
| Ass's | | | | | | |
| Mean..... | 1.0360 | .64 | 0.67 | 1.55 | 5.99 | 10.36 |

We are most interested in the composition of herd milk, which is the mixed milk from several cows. Depending upon the kind of cows constituting the herd, we will be likely to get milk of the following composition shown in Table V.

Many dairy farms, particularly those producing certified milk, maintain cows of the breeds at the top and bottom of the list given in Table V. The former yield a large volume of milk somewhat deficient in fats while the others yield milk very rich in fat. One certified milk farm for which the writer is testing the milk maintains one Guernsey cow to each six or seven Holsteins, depending upon how the mixed milk averages in fat.

In utilizing milk other than human milk, particularly for infant feeding, we have to contend with an additional factor —cleanliness, to guard against the transmission of disease.

## BACTERIOLOGICAL CONTROL OF MILK

It has been found that certain standard methods will control this quite well. We, have, for example, the tuberculin testing by the veterinarian, by which we can eliminate from supply herds, cows which show evidence of having tuberculosis. We have the statutory laws and regulating ordinances controlling the barns and other buildings in which cattle are housed or milk and utensils are kept. We have experienced dairy inspectors who use standard tests to determine the chemical compositon and standard methods to estimate the bacterial count.

For the scope of this article, it will be necessary to explain only the control methods used for bacteria. Very detailed and extended bacterial examinations are so time-consuming that the relative cost is prohibitive. The following tests are satisfactory.

TABLE V
The Composition of Milk from Some Breeds of Cows (Swithinbank and Newman)

| Breed | Fat | Protein | Lactose | Total Solids |
|---|---|---|---|---|
| Holstein..... | 3.51 | 3.28 | 4.69 | 12.12 |
| Shorthorn..... | 3.65 | 3.27 | 4.80 | 12.45 |
| Ayrshire..... | 3.68 | 3.48 | 4.84 | 12.70 |
| Brown Swiss..... | 4.00 | 4.00 | 4.30 | 13.06 |
| American Grade Shorthorn.. | 4.01 | 4.06 | 4.36 | 13.17 |
| Devon..... | 4.09 | 4.04 | 4.32 | 13.21 |
| Jersey..... | 4.78 | 3.96 | 4.85 | 14.34 |
| Guernsey..... | 5.02 | 3.92 | 4.80 | 14.48 |

* Pathologist, Muhlenberg Hospital, Plainfield, N. J.

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In raw fresh milk as received at the shipping stations, a direct microscopical examination of the stained bacteria in a definite volume of milk affords a rapid and practicable means of estimating the cleanliness and safety of the supply. It reveals all dead bacteria and the non-pathogenic soil bacteria and others growing best at temperatures above 40°C. This method is *not* suitable for milk supplied to municipalities.

For the purpose of public health control those bacteria growing best at 37.5°C. (99.5°F.)* alone are of interest because all bacteria capable of producing disease in man grow best at the normal temperature of the human body.

### Limits of Accuracy

It has been found that when these so-called plate cultures are made, very satisfactory results are obtained. By this method a well mixed sample of milk (or cream) is diluted with sterile water so that each cubic centimeter will contain one-hundredth, one-thousandth, or one-ten-thousandth of a cubic centimeter of the original milk. Sometimes for very low grade milks even greater dilutions are made. One cubic centimeter of this diluted milk is properly mixed in a Petri dish with a nutrient agar culture media which remains solid at 37.5°C. but is liquid above 40°C. These cultures are then incubated for forty-eight hours. The number of colonies of bacteria grown are counted. These, on an average, represent about one-fifth of the total number of bacteria which were actually present in the original milk. Since it represents the class of bacteria to which the human pathogens belong it answers the purpose. *Remember,* this does not indicate the number of soil bacteria present, which usually grow best at 20°C. nor the avian types which grow best at about 40°C.

*The plate cultures being moist and offering a large surface for evaporation will have a temperature of about 37° C. (98.6° F.).

The following are the standards adopted by most municipalities for their milk supplies:

Milk must not contain less than three to three and one-half per cent of milk-fat, nor less than eight and one-half per cent of solids not fat.

Cream must not contain less than eighteen per cent. of milk-fat.

No preservatives are permitted. Cleanliness and thorough refrigeration are demanded instead.

### Standards of Quality

Certified milk, the purest type, is obtained from herds maintained under especially rigorous conditions. The fat content is usually placed at four per cent. with a permissible variation from three and one-half to four and one-half per cent. The bacterial count by standard plate method must not exceed ten thousand (10,000) bacteria per cubic centimeter when delivered.

Raw grade A milk is not quite as rigorously controlled as is certified milk. Its bacterial count must not exceed sixty thousand (60,000) bacteria per cubic centimeter, when delivered.

Raw grade A cream must not have a bacteria count greater than three hundred thousand (300,000).

Pasteurized grade A milk must not exceed a count of thirty thousand (30,000) nor must it be prepared from a raw milk whose count exceeds two hundred thousand (200,000).

Pasteurized grade A cream must not exceed one-hundred and fifty thousand (150,000) bacteria.

Pasteurized grade B milk must not exceed one hundred thousand (100,000) bacteria nor be prepared from a milk showing more than one million five hundred thousand (1,500,000) bacteria.

Pasteurized grade B cream must not contain over five hundred thousand (500,000) bacteria.

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Grade C milk and cream can be marketed only for cooking and for manufacturing. The count must not exceed three hundred thousand (300,000) for the milk, and one million five hundred thousand (1,500,000) for the cream.

Should it be deemed advisable to determine the quality of the milk or ice cream being supplied certain things must be taken into consideration.

### Sampling Dairy Milk for Analysis

Should your clinical analyst decline to undertake these examinations, it is not because he cannot do them but because he is not prepared to undertake such analysis. He may refer you to some analyst who examines the milk for a dairy or a municipality. Such a person having the equipment ready can make such an examination more satisfactorily and at a more reasonable rate than can the average pathologist who is not engaged in milk control work.

The analyst should be notified in advance of your intention to submit milk or ice cream. He will instruct you how to proceed and will arrange his time so as to culture the samples within four hours of the time they were delivered at your residence. This is the time limit required by the standard methods.

An original unopened bottle of milk, or if the supply is loose milk, a sample of the well mixed lot, placed in a sterile bottle with a sterile spoon, ladle or pipe must be submitted. Not less than one hundred cubic centimeters should be sent to the laboratory.

The specimen must be promptly delivered to the analyst. The dealer is certainly not responsible for the bacterial quality of your milk if you allow it to stand for hours in the morning sun on your window ledge or porch, or in a warm room.

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## A LETTER FROM CHINA

Myra L. Sawyer, R. N.

Tehchow, Shantung

Today promises to be an unusually light Sunday. Our day of rest commonly brings a difficult obstetric case, someone whom the native midwives have struggled with for a succession of days, then brought to us for relief from her agony; or, as for the last three Sundays, victims of bandits, again rife in this region, fill the day with emergency operating. This morning the cartyard is empty save for one cart, which brought an epileptic baby, for whom we could do nothing except to try to make the father understand that his child was the

Nurse delegates at the Red Cross Convention held in Washington in early October.

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innocent victim of his own evil ways; and he has eight more children at home, to reap the harvest of his opium, drink and vice. So greatly are we needed in this land, not alone to heal disease, but to prevent it, by teaching the lessons of self-control, sex eugenics, hygiene and common sense!

Come with me to Ming Hu ward, and see our row of little folks, smiling and hobnobbing together despite bandaged legs, eyes or "tummies." Our little Caesarean baby, four months old now, won all our hearts, to what extent we hardly realized until she started a temperature the other day; since then the nurses hang over her basket or haunt my office, to know what they can do to make her well quick. We are watching her carefully and she is gaining, so I hope she has passed the danger point which hangs so threateningly over baby heads in the Orient.

### Scarcity fo Workers

Our staff is depleted now by so many being away on furlough, and one of the doctors who was to come from America has been detained by illness, so the outlook for the year is none too good.

We shall soon have a new nurse, Grace Jevne, from Cook County Hospital, Chicago.

Most days now the temperature ranges from 100° to 108°, with high, dusty winds; and we long for rain. The dike around our compound is a joy in hot weather, as one can usually get a little breeze up there when it is unbearable down on the road. The cool of the evening sees a pajama parade there, men patients taking an airing. We had a perfect cyclone of dust last evening, which lasted two hours and filled every nook of the hospital with grit. We had only a few minutes of the blessed rain we longed for. Now the sky is beautifully cloudless, as if it never intended to let down water. We are, however, exuding it at every pore. It makes me think mirthfully of the days in Roosevelt Hospital, New York, when we wore stiff bishop collars and were compelled to change them whenever they were wilted! Thank goodness, styles have changed, and sensible necks and elbow sleeves reign in the nurses' world.

### Chinese Ruling on the Granting of Diplomas

We have three nurses graduating this year, two men and one woman; but our dear little Miss Chang may not live to see her commencement. She has fallen prey to tuberculosis, and has been off duty a year, fighting it down, but I fear now that we are losing out. I was up with her several times last night, as her heart threatened to give out. Of all the boys and girls whom we have trained, I would give her first place in the ranks.

The Commencement will be held the middle of September. By that time the returns will be in from the national examinations, so that the diploma which gives them the Chinese R. N., and their own school diploma, can be awarded. By the rules of the Nurses' Association of China, our diploma cannot be given until they have won their R. N. Only a certificate is given to those who fail in the national examination. As a member of the Examining Board, I set the questions in Anatomy this year, and it fell to my lot to correct the papers of the 147 nurses who were up for examination. It was a weary, hot job, but an interesting one. Anatomy seems to be as great a bugbear to the yellow race as it is to the white! I still contend that it isn't taught in a manner to make it stick, but I cannot attempt to teach it in this tongue!

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# THE NURSING OF EYE CASES—II

## DISEASES OF THE CORNEA

L. KINGHAM, Registered Nurse

Matron, Weymouth and Dorset County Royal Eye Infirmary, Weymouth, England

*CORNEAL Ulcers:*—These may be traumatic (caused by foreign body) or constitutional. Atropine is usually ordered; hot bathing; yellow oxide of mercury ointment. Atropine is used to keep the iris away from the ulcer, otherwise it may adhere to the wound and be caught up so that the pupil cannot act. This would impair vision. If the ulcer is deep below Descemet's membrane (posterior lining), a scar is the result; this is opaque, and the patient cannot see through it. It is like trying to look through a whitewashed or frosted glass window. If the ulcer covers the greater part of the cornea and there is a large scar sometimes a piece of the iris is cut away from the clear part of the cornea, making a kind of window for the patient to see through. This operation is known as optical iridectomy.

### NURSING CARE

The electric cautery is sometimes used on the edge of the ulcer to prevent spreading by killing the germ. Pure carbolic, which is also used, acts in the same way. In our hospital the ulcer is dried with a piece of blotting paper, and the carbolic applied by means of a match sharpened to a very fine point; this has to be done with the greatest care. The ulcer is then dried again with a piece of blotting paper to absorb any carbolic left behind. Absolute alcohol is used in the same way and for the same purpose. Some surgeons put in oil or ointment afterward with atropine. This operation is done under cocaine. Occasionally pus appears in the anterior chamber; this is the discharge from the ulcer, and is called hypopyon. An incision is made (under cocaine) at the lower margin and the pus let out. This is called paracentesis or tapping, an operation which is sometimes done when there is a severe ulcer which is likely to perforate—the aqueous escapes and so relieves the tension.

### REMOVAL OF FOREIGN BODIES

*Foreign bodies on cornea* are removed by a spud, F. B. (foreign body) needle or discission needles, broad needle. A drop of cocaine (5 per cent.) is instilled three times at three-minute intervals. If the foreign body is small and cannot be detected readily, a drop of fluorescein may be put in and left for a few minutes, and then another drop of cocaine, when the raw surface will stain green. The foreign body should be extracted with as little injury as possible, as an ulcer may be the result. Care should be taken not to push it back into the anterior chamber. Steel is taken out with the magnet, if too deep to be taken out with a needle. If the iris is flat against the cornea, which can be seen by looking sideways, it has probably gone into the anterior chamber, as the aqueous fluid has escaped through the wound. A bandage should be applied, and patient should see a surgeon at once.

When attending to a foreign body the lids should always be everted and examined, as it may be under the upper lid. A 20 lens or a corneal microscope is needed unless the nurse is very short sighted. When a foreign body is on the iris and difficult to remove, the surgeon sometimes cuts the piece of iris away

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with the foreign body. After extraction of foreign body, a pad and bandage should be applied. A drop of castor oil instilled will relieve the pain. Foreign bodies may enter the eyeball and lodge in the vitreous (e.g., glass, chips of stone or steel). The cornea should be stained with fluorescein (as already described), which may show where the foreign body entered, unless the accident happened a few days previously, in which case the wound may have healed. These cases are examined in the dark room, the pupil being previously dilated with homatropine; otherwise the *x*-rays are used.

*Abrasions of the cornea* are very painful, but heal quickly as a rule. If a drop of fluorescein is instilled and a drop of cocaine (5 per cent.) afterward, or the eye washed out with lotion, after putting in fluorescein, the abrasion, where the epithelium has been scratched off, will stain green. This may be used in ulcers, etc., to see the extent of ulceration. A drop of castor oil should be instilled and pad and bandage applied.

### Burns of the Cornea

*Burns of Cornea*—In burns of the cornea cocaine (5 per cent.) is instilled, three drops at three-minute intervals. If caused by hot metal or iron, this is all removed, care being taken to evert the lids. Castor oil and atropine are usually ordered for these cases. It gives the patient great relief to wash out with a weak solution of soda bicarbonate.

*Wounds of the Cornea* are perforating and non-perforating. Perforating wounds are serious; there may be a prolapsed iris (the iris gets into the wound). This has to be snipped off and the iris freed from the wound, and atropine or eserine (this depends on the position of the wound) is ordered to keep it away from the wound. Rest in bed is absolutely necessary; a firm pad and bandage applied, and care taken to keep the wound free from infection. These cases should not be washed before seeing a surgeon, as the patients usually screw up the eye, which makes the prolapse worse. In children the great thing is to try to keep them from crying. The chief thing is to keep the eye from getting septic. As a rule if the patient is a child a general anæsthetic is given for examination, and also to free the iris. In injuries the vision of the good eye should be taken at least once a week and recorded.

(*To be continued*)

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## A NURSES' INSTITUTE

The Bureau of Public Health Education of the New York City Department of Health, in co-operation with the Henry Street Settlement and the American Red Cross, is contemplating the inauguration of a five-weeks institute for graduate registered nurses of the state. One week each is to be devoted to the following subjects:

1. Industrial Hygiene.
2. Preventable Diseases.
3. Child Hygiene.
4. District Nursing.
5. Home Care of the sick.

Nurses may register for the full institute or for any part of it.

Home care of the sick will include some very valuable, practical instruction on dietetics. The scope of this institute will be largely in the nature of a review, to stimulate the interest of the nurse who wishes to brush up on current methods.

The institute is further intended as one phase of the year's plan of public health education, and the nurses taking the course will be given every facility for field work by being assigned to accompany members of the different divisions of the Health Department on their daily rounds, and thus get first-hand knowledge to supplement the technical information given in the lectures.

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**The quay at Smyrna where some 300,000 men, women and children crowded for fourteen days. With the Turks ravaging the streets of the city, this narrow strip of safety soon became filled with terrified Greeks and Armenians who felt a measure of safety within sight of American and British vessels in the harbor.**

# SMYRNA AND THE AFTERMATH

## LEST WE FORGET

A FEW front page headlines, a few long columns of misery and the thousands of women and children of Smyrna pass beyond the fickle American conscience. Perhaps. But at this writing, before the American Red Cross has had time to mobilize its workers, those 240,000 or more refugees are being cared for by Americans, among them the undaunted personnel of the American Women's Hospitals in Southeastern Europe.

Wars, evacuations and massacres are old and horrible experiences to these workers. Since 1917 they have been following the trails of disease and famine through Europe. Blerancourt, Luzancy (where Dr. Hurrell and her staff were honored with French citizenship) and the health and industrial center at Levallois-Parret mark their helpful passage in cooperation with the American Committee for Devastated France. When peace released French physicians for this work, these pioneer women turned their energies to Serbia. Vodena, and later Monister, was skillfully directed by Dr. Regina Flood Keyes and it was into her hands that the American Red Cross poured its funds during 1919. During the same period Dr. Etta Gray as supervisor of the whole Serbian service made her careful survey of conditions throughout that foodless, diseased country and located hospitals and clinics at Strumetza, Pristina, Giljiane, Prelip and Veles.*

**Crippled children of Serbia reached, alas, too late to be benefited by American medical skill.**

Those same trails led Dr. Mabel E. Elliott to Marash, Turkey. As director of this needed hospital unit, it was Dr. Elliott who distributed the food and blankets supplied by the Near East Relief to the freezing populace. It was her calm, beautiful face which stilled the terror of the people during the ghastly siege of the city, and Providence brought it about that Dr. Elliott with three American nurses, Mrs. Mabel Powers, Leila Priest and Griselle MacClaren, held the hospital at Ismid when that city was terrified by Greeks, Turks and Chetas in their turn.

* It was in this hospital that the first nurses' training class in Serbia was established.

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A further journey along the trail brought Dr. Elliott to the hospital in Alexandropol so near to the disaster of Smyrna that she was able to personally direct the medical work at Rodosto, Mitylene, Piraeus and the scattered Grecian islands where the refugees were placed.

Unfortunately, many Americans know these purposeful hospitals by name only; the inquisitive perhaps try to locate them on old maps. If they could see these unclothed, ill-fed people gathered about their doors, if they could touch the ill-formed, emaciated bodies which we of the West call children, if they could reckon the ghastly number of cases—typhus, smallpox, crippled, diseased—which pass through these hospitals yearly, they could never forget.

Yes, wars, evacuations and massacres are old and horrible experiences to the personnel of the American Women's Hospitals; but if you could talk with Dr. Lovejoy, who as directing chairman has been in the thick of the struggle, you would realize that these very experiences prepare her to present the story † of Smyrna in all its naked truth.

I was in Paris en route to Russia when the reports of the Smyrna fire were received. Instantly I changed my plans and took the Orient Express to Constantinople. Here, fortunately, I caught a relief ship just ready to sail. Arrived in Smyrna September 24, I found myself the only American woman there. All the American and other foreign women had been ordered out of the city and had sailed on September 14.

Even from the harbor the sight of the city was a shock. I had visited it some years before and had always remembered its beauty, with its long quay curving along the waterfront for miles and its fine white buildings looking out over the harbor. Now as I saw the city from the approaching ship, the whole center along the quay lay before me a smouldering ruin. At one end stood the Turkish quarter, untouched. At the other end a few of those fine white buildings, spared by the fire, stood out like monuments to the memory of Smyrna. These had been the homes of wealthy residents, who had fled before the oncoming Turks, leaving behind them, unguarded, treasures in rugs, furniture, silver and paintings. It was in one of these buildings, next to the American Consulate, that the relief headquarters had been established and this section became the center for such relief work as was possible under the appalling conditions.

Just what those conditions were, appeared as soon as we left the ship. At least a quarter of a million people were massed together on the quay and the adjoining streets, huddled on the cobblestones, where they had literally been squatting for ten terrible days—hungry, terrified, unspeakably uncomfortable. Both quay and streets were reeking sewers, and the stench from that crowd as it stirred was sickening.

But this was the zone of greatest safety—they dared not leave it. For it was within range of the searchlights on the warships of the Christian nations in the harbor, and they were these wretched people's sole protection from the Turkish robbers. Among these Greek and Armenian refugees was a large proportion of English-speaking people. Many had lived in America; many of the children had been born here; many other educated in the mission schools of the American Board. They paid the United States the compliment of crowding as near as possible to the two American flags hung out over the Consulate and relief headquarters. And some of them wore little shreds of the red, white and blue, as the Turks wear blue beads to avert the evil eye. Sitting under the very guns of the Christian powers, they had believed they would be protected. But they had reckoned without neutrality. By the time I got there they understood. The Turks had issued a proclamation, distributing it by airplane, that all men between eighteen and forty-five were to be deported, though they were civilians, and that all others—men, women and children—who were not out of Smyrna by September 30 should share their fate. This had created panic, for deportation to the interior—a vast unknown country——means death, probably; final separation, certainly. For these huddled crowds on the quay the one hope was ships.

On the 24th eight ships were loaded with refugees and taken away. On Monday only one ship arrived, and the despair deepened. That evening at dusk I went out on the balcony of the Relief House with a young Armenian woman with whom I shared a room, and looked out over the sea of tragic faces. There was a strange moan of many voices passing along the quay, like the murmur of waves or the sound of wind. I said to the Armenian girl, "What are they saying?" And she answered, "They are praying for ships."

This girl and her sister—fine, highly cultivated young women—had been working among refugees since the fire. Their brother was in hiding. I had urged them to take the first ship, lest there should be no more, but they steadfastly refused, because they said if they stayed they might find some one—some American—who would save him. If they went, they would sentence him to death. As for them, they had made up their minds to die rather than to fall into the hands of the Turks. That night when I was ready to go to bed I found the girl kneeling praying aloud for ships, and I felt that I had never heard prayer before—so profoundly trustful was her pleading with God. For the first time I understood the power of the Christian faith that had sustained these people through their suffering. Her prayer finished, the Ar-

† Dr. Esther P. Lovejoy's story was first published in *The Woman Citizen* of November 4.

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menian girl slept like a child, while I lay awake listening to the dreadful sounds on the quay.

Every night they came—those bloodcurdling shrieks that swept along that terrible quay. From the two Armenians I knew what they meant. The Turkish soldiers were among the people, robbing them and stealing away their girls by night, and the women were screaming to the battleships in the harbor to throw on their searchlights and drive the robbers away. For an hour or so there would be deep silence, then again those awful shrieks—and the searchlights flashing again.

Apparatus improvised by American Women's Hospitals personnel in Serbia.

Early Tuesday morning Sept. 26, nineteen ships came into the harbor, and the struggle to reach them began. (Evacuation was demanded by the 30th.)

The quay was divided from the wharf by two iron picket fences about two hundred feet apart, and the people were forced to pass through gates so that they might be carefully examined, and all men between eighteen and forty-five might be detained for deportation. At the iron gates was a double line of Turkish soldiers; farther out on the wharf American sailors were stationed to help the refugees, and at the very end of the wharf, British sailors. For six hours I stood between the two gates. The crush was terrible. All along the first fence there were women trying to get over, or get their children over. Some of them caught on the pickets. Though they were all supposed to pass through the gate, some few got over by means of a bed-spring placed against the fence by an ingenious Turkish guard, who did a good business collecting money from those he assisted.

At the gate the Turkish soldiers kept beating the women back with the butts of their guns in order that they might pass through more slowly. Time after time, as I stood there, I noticed the Turks seize, search and rob women as they passed. Their rings were torn from their fingers, and finally the robbery was expedited by merely striking them across their fingers with canes, which meant—take off and deliver.

Often when a man came through and was seized by the soldiers, he would pay a price and pass on; but before he had gone twenty feet, he would be seized by another soldier, and then another. Finally, he would be detained farther out on the wharf and placed among the prisoners. His money never saved him. At first it seemed strange that the money was not all taken at once, but manifestly this was an arrangement between the soldiers to prevent their officers from getting all the loot. I had been told that the officers objected to the robberies, but while I stood at the gate I saw officers as well as common soldiers participate in the robberies.

Many women and children were crushed, and some of them were forced over the edge of the quay into the shallow water. Just beyond them, in an angle where the quay joined the wharf, a large number of dead animals, with here and there a human body, bloated and putrid, were washed to and fro with the waves.

Every day at the gate was a continuous

Lines on lines of trachoma cases come to the clinic daily. Advanced cases are given intensive hospital care.

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succession of harrowing incidents. Men came through with their families, often carrying an invalid wife or an aged mother. The living burden was torn from their shoulders, and the wives and children, clinging to their men in desperation, screaming and pleading, were forcibly separated from them; the men were beaten with the butts of guns, the women forced on—always with the same Turkish cry—*Haide! Haide!* (Begone, begone.)

By the time the women had struggled to the gate, many had lost their shoes, their clothes were torn, their hair streaming. One poor old lady who had been separated from her people, struggled through naked from the waist down, apparently unconscious of the fact. Another woman who had lost her children, dropped her bundles and with miraculous strength climbed the fence. She was held by a Turkish soldier and beaten in an effort to make her turn back. But acting on the powerful maternal instinct, she kept on. Finally the Turkish soldier put a rifle against her temple and forced her against a building, holding her pinned there. But she would not give in and finally with a shrug of his shoulders he let her go. One man at the moment of approaching the gate slashed his throat with a razor—and escaped. Another man, whose arms were bound behind him, suddenly sprang into the water and drowned. Suicides were frequent on the wharf. Three women were coming along together; two young women and an old woman who had obviously reached the end of her endurance. Finally she fell and the young women knelt beside her, prayed and kissed her hands, and with every expression of tenderness rolled her into the water. And so the thing went on and on and on—throughout the week between the 24th and 30th.

There were a large number of pregnant women in this quarter of a million people and their labors were precipitated by the horrible experiences through which they were passing. A British surgeon at the end of the wharf was taking care of a great many sick and injured people. He told me he knew nothing about maternity work and asked me if I wouldn't watch the crowd for the women in labor and help them in their great trouble.

Day after day I went to the dock early in the morning and remained until the ship loading ceased at night. Children were born on the quay, some on the wharf, but most of the women we got aboard ship before their babies came. The sailors on the wharf soon came to know me and to call me in all of these cases. A British boy called me to a ship just going out where there were three women in need of help. I had time to find only one of them. She was literally packed in with a mass of people—so closely jammed in this awful hole that the place was humid from their breathing. Finally we got the woman out, with great difficulty. Her clothes were ragged, her hairpins were gone and her hair hung down, her shoes were lost, her silk stockings were worn out and her feet were blistered. She was dirty and she stank, like all the rest, but when I examined her I noticed that her chemise was made of fine linen, hand embroidered. She spoke English, and when I asked her sister, who was with her, what she had to wrap the baby in, she opened a little bundle of clothes—all made by hand and exquisitely dainty.

They loaded refugee ships at night only once. At dusk the warships threw their searchlights across to the wharf. In the path of the searchlight away out on the water there were two men swimming for their lives, trying to reach a ship. Two Turkish soldiers were stationed at the edge of the wharf to shoot these men and they shot time after time. The bullets would go beyond them and skip along the water and then again they would fall short. Finally one of the men ceased swimming—I do not know whether or not he was shot; but the Americans were aroused, and they finally went out in American boats and took those men out of the water. Then came the vital question of neutrality. In order to maintain neutrality they could not take these men on board an American ship. On the other hand, the rules of neutrality forbade turning them over to the Turks. So finally they decided just to put them ashore—and the Turks, who were standing not twenty feet away, seized them.

No detail of horror was missing in that wreaking of Turkish vengeance on an innocent, non-combatant population. Their homes burned, husbands, sons, fathers, deported, all means of sustaining life gone, these poor creatures were driven out—to where a leisurely death, aided by famine and pestilence, awaited them in the Islands of the Aegean.

*Haide! Haide!* That was the word. It was the response to all the pleas, the answer to all the prayers. The Turks used this word as a driving term to urge the outcasts onward, and the American and English sailors repeated it without a thought of its meaning because it kept the crowd moving toward the ships. In agony of soul, these people cried aloud to the Christian nations of the world, and the answer was Begone! Begone!

*Haide—Begone* has *not* marked the work of the American Women's Hospitals. As the following excerpts show, Dr. Elliott is bringing the full force of years of cumulative experience to this colossal task of reconstruction:

After starting our work at Rodosto in the latter part of September we came to Mitylene, arriving here October 3 with thirteen cases of food and medical supplies. My first caller was a man over fifty with his aged mother and three children. All the children were born in Rochester, N. Y. His wife was dead, his two sisters were killed at Smyrna and his three brothers lost, probably deported. . . . Made survey of refugee camp. There were many sick, one woman in labor in park which was a mud puddle from the morning rain. On the way met Cornelius . . . my right-hand man at the hospital at Ismid. I had not seen him since that mad

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A line of children waiting for the clinic doors to open. These children have trachoma. All physicians and assistants, men and women, native and American, all nurses, native and American, and all other persons connected with the medical end of the work in Armenia are provided by the American Women's Hospitals, including the nurses' training class of approximately one hundred native girls.

night last year when he fled from that city with all the rest as the Turks came in. He has married Araxia, one of our Ismid nurses who escaped at the same time. Such luck! I am sure of two hands and faithful to help us on this job.

Governor General begged me to take charge of medical relief. Fifteen doctors volunteered for our service. White-wash men already busy on refugee hospital. Met committee ladies (Greek) who offered services, and before night had materials for mattresses, sheets, towels and fifty sheets completed.

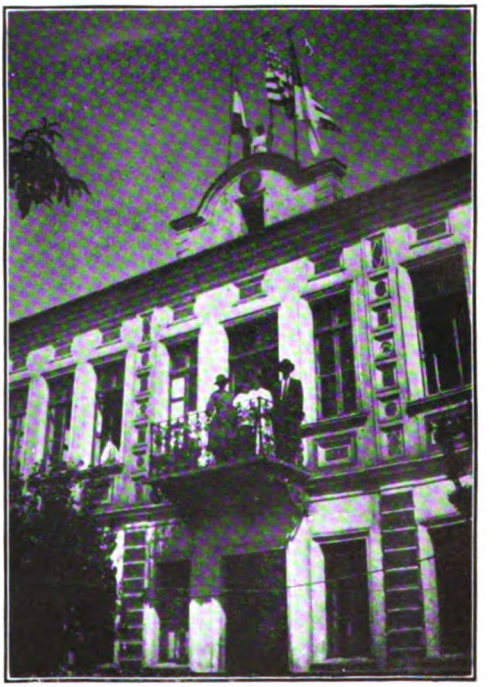
7.30. Mr. Brady asked me to go to Chios to organize medical relief service. Boat left at 10 P. M. with fifteen tons baked bread. Arrived Chios October 5, landed 6 A. M. Fine group of buildings used in normal times as old ladies' home, old men's home, home for insane and hospital all thrown open to refugees. Wonderful blind woman, Irene Constandenede, knows all the paths and buildings and goes about helping, and nobody would guess she was blind. Her spirit has light. She is the linen keeper—has blankets and layettes, clean and in good condition, given three years ago by American Red Cross. Four to six infants born daily and dressed in the old A. R. C. layettes.

Thirty-five orphans (mothers lost in the exodus from Smyrna) already washed and in clean clothes. One family, six children, oldest twelve years, father and mother killed before their eyes. Father had hid seven hundred Turkish liras on each child, hoping the money might save them in case they were separated. They were all searched and robbed save little Patricledes, four years old, who arrived in Chios with his seven hundred liras (about five hundred dollars) safely tucked away in his blouse.

Thousands sleeping in streets, hungry and thirsty. Chios has full quota refugees. No more received. Six ships packed like herring just arrived must move on to Piraeus, with no food or water for two more days' journey. Chios suffering for water. Mules and horses dying for want of water.

Arrived Mitylene 6 P. M. Andy has arrived—bless her—also bread and flour. Thank God! Jennings will not have to jump overboard, as he threatened to do if bread did not come today. The Y. M. C. A. the world round should stop work one minute at high noon and give three cheers for Jennings. He is a man of action like Mustapha Kemal, but he is fighting on the other side. He got the ships, and thousands of people owe their lives to him alone.

11 P. M. The Meggli Hellas just blowing its whistle for departure—leaving for Piraeus with ten thousand refugees and Klutz aboard. From my open window I can clearly hear across the moonlit harbor the cries of the wretched souls aboard starting out once more for God knows where or what.



The hospital at Pristina, Serbia, which was conducted by the American Women's Hospitals, under the supervision of Dr. Irene Tognazzini.

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October 7. Klutz missed his boat and has been on the job here all day. He is sorely needed. McDonald has had little sleep since we came, and Jennings is at the breaking point. Andy and I are deep in the sick end of the work. Emergency hospital already packed. Two clinics and milk depot running full force. . . . Saw some dreadful cases today—young girls the victims of Turkish outrages. One will probably die. They tell hideous, unprintable stories.

Athens, October 11. Jennings and I came over to see members of Government relative to placing rest of refugees from Island of Mitylene. We have already distributed 120,000. There are over 70,000 left and no more islands in the Greek Archipelago to be populated by outcasts. It is wicked to put these poor things, who have had scarcely any food for a month, on barren islands where a goat couldn't exist. An imagination is a sad handicap. I keep imagining myself marooned on one of these barren islands with six children crying for food and all the men of my family killed. No wonder these poor things look out over the water with eager eyes always asking the same question: "Will the Americans come? Will the Americans come?"

October 15. I never saw so many babies in my life and practically all sick. Poor little things, they are too weak to cry. They just whimper. For a month these people have had only bread and very little of that. Nursing mothers by the hundreds have gone four days straight without food and now they get half a pound a day or less—just a "close-up" to starvation. On the boat yesterday was a young mother with six children, whose husband had been taken by the Turks —as all young mothers' husbands have. The baby had been crying the whole day, and the mother pointed hopelessly to her empty breast. There was no food on board for the refugees. By dint of much persuasion I got half a can of the captain's milk. You should have seen that little thing devour it—and never a cry out of it for the rest of the journey—but today I know it has no milk.

Things are terrible at Mitylene. The hospital is crowded and the sick people begging us to take them in. Every day women are giving birth to babies in the street. . . . The woman who is keeping house for us was a lady of wealth a few weeks ago . . . owned a home in Smyrna with ten bedrooms. She and her sister have been sleeping in the streets of Mitylene without so much as a blanket for fifteen days. Her sister is still in the street. I gave her a blanket yesterday and she said she slept well. They are very brave. And there are hundreds, yes, thousands like them.

We need nurses. I must get them from this side. Mrs. Anderson will be stationed at Crete as soon as Mrs. Cruikshank relieves her at Mitylene.

Constantinople, October 18. The Disaster Relief Committee has decided to carry on for another six weeks and still longer if the American Red Cross is not ready to take over the work by that time. All the American Medical Relief Work to date has been done by the American Women's Hospitals* and I am anxiously awaiting for an answer to my cable for more money. Send all you have and get more. We must save these people. . . . There are thousands upon thousands of young mothers with little and big families whose husbands and brothers have been taken by the Turks. They are utterly destitute and utterly helpless.

Athens, November 6. I have bought only the cheapest things and have been just as careful as possible (in spending the available funds). The Greek Government has been very good and has issued orders that I am to have every thing I want if it is to be had.* . . . I am cabling you this morning for funds. We must see this thing through.

May nurses and the American public they can influence pour the strength of service and force of funds into the hands of the American Women's Hospitals,[1] the Near East Relief[2] and the American Red Cross.[3] "We must see this thing through."

## REDUCING MORTALITY

A study made by the U. S. Department of Labor through the Children's Bureau, shows that the New Zealand infant mortality rate is lower than that of any other country in the world. For 1919 the number of deaths of infants under one year of age was only 45 to every 1,000 live births, as compared with 87 in the United States birth registration area.

The most important influence in the recent reduction is undoubtedly, the Children's Bureau report believes, the work of the Royal New Zealand Society for the Health of Women and Children, organized in 1907. This society is subsidized by the Government, and its work has extended to all the principal cities and many of the outlying regions of the Dominion. At a special hospital of the society, nurses known as "Plunket nurses" (in honor of a former Governor's wife) are given intensive post-graduate training in the care of babies, and then employed by the local branches to give free advice and assistance to all mothers of the community. Popular education in "mothercraft" is also promoted through free distribution of pamphlets, publication in the newspapers of a regular column on "Our Babies," and the natural passing on of information among the women of the society.

* The American Women's Hospitals has appropriated over $100,000 CASH for the relief of these refugees.

[1] Sue Radcliffe, treasurer, 637 Madison Avenue, New York City.

[2] Near East Relief, 149 Fifth Avenue, New York City.

[3] American Red Cross, Washington, D. C.

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# THE EXISTING HOSPITAL SYSTEM AND RECONSTRUCTION†—II

George Edward Barton, A. I. A.‡

ANY beneficial reconstruction of the hospital system, in view of the many apparently insurmountable difficulties outlined in the last article, would have been too discouraging to attempt had not the earliest analysis shown the presence of many leaks in the present organization—weaknesses through which poured streams of *time*, of *energy*, of *money*, not only of the hospital workers themselves, but of the society which supported them.

> *Your country did not need you in the war as much as it needs you now.*
>
> *Reconstruction calls you. In its behest you omit not one atom of loyalty to the doctor, not one comma in the book of ethics, not one inflection of your pledge.*
>
> *In addition, it reminds you that you are women with tremendous power.*

### Hospital Waste

Nowhere has the subject of waste in the old hospital system been pointed out so clearly and concisely (although not completely) as in the "Introduction to the Report of the Committee on Hospital Efficiency" submitted to the Philadelphia County Medical Society back in June 17, November 26, 1913, and October, 1914. That report admits:

A waste of money, probably 20 per cent. of the $250,000,000 paid each year for current expenses—

A waste of human labor and opportunity that is incalculable—

Waste of trustees; of medical staff; of nurses; in construction of hospitals where they are not needed; useless equipment and useless duplication—waste in 60 per cent. of hospital supplies—

Half the money spent to maintain beds for convalescent patients in active hospitals—wastage of food in some cases as high as 33 per cent., waste in depreciation, etc., etc.

But with the waste in the existing hospitals we have little to do. The reconstructionists plan no upheaval of the old institution, but the introduction of a new one which shall relieve the pressure upon the old and simplify instead of intensify the difficulties in which the old hospital system now finds itself.

Serious as the above admissions are, they appear trivial when compared with others which, because they are less often squarely faced, may seem new to many readers. These include (1) the appalling amounts of time wasted in sickness and in convalescence by those who are ill; and (2) the childish and silly waste of the very finest qualities of womanhood as typified in the nurse diverted to non-productive use.

The following figures give a vague idea of what the time wasted in convalescence means to society. I present them here not as argument and not in statistical form, though such would be quite as justifiable as are many of the arguments and figures now presented to prove that in a given number of years there will be no more tuberculosis or cancer or old age.

### Waste Through Convalescence

If we disregard all sickness and disease among all classes of society except artisans and craftsmen, we find that there occur annually (among such alone)

† Mr. Barton's first article in this series appeared in the October, 1922, issue.

‡ President of the Consolation House Convalescent Club, Inc., Author of "Occupational Therapy"; "Re-education"; "Teaching the Sick," etc.

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"13,400,000 cases . . . involving a total economic loss of nearly three-fourths of a billion dollars."* Now if only *one half* of those cases could devote *but one hour of the entire convalescence* to doing something, we have 6,700,000 hours, or (if the producer works on the basis of a 50 hour week) 134,000 weeks, or (on a 50 week year) 2,680 years of time wasted *annually.*

Don't jump to the conclusion that I shall suggest that a patient in the Sims' position should practise boiler making—even for an hour! Many books will be filled with such problems as what should be taught.

### The Role of the Nurse

My object now is not to "start something" with the economist, the statistician, or the doctor: my object is to make *you nurses* realize that there is a whole important side to sickness that you and the doctors and the old hospital system failed to consider and which to society and the sick man himself is quite as important as is any development of the *x*-ray room. Time is one of the most important factors of industrial life.

If some method could be found by which even a very small percentage of this wasted time could be utilized either directly or secondarily for either the patient himself or for society, a very important saving could be effected. In other words the reclamation of this wasted time might result in a new element in society, one which could be moulded from the beginning to new standards and become a factor of vast economic significance.

If in my analysis of certain of the conditions in the nursing profession which follows I omit many of the so-called "burning questions," it is less because I am ignorant of them than because they all seem trivial and unworthy of association with a greater need. Let me point out at once that one of the reasons why the nurse has had difficulty in attaining her proper authoritative position in the health field is less the fault of the doctor's attitude of supremacy than of her own incompetence *to state her case in other than nursing terms.* Away from the ward office or the class and "heads" tables the real practical problems of the nurse have not until the last year or so, been frankly discussed and as very few persons even doctors would understand the conversation there, society in general is ignorant of the nurses' real needs.

Again, no person of intelligence with a knowledge of the difficulties of rebuttal will enter a discussion verbal or written without a clear understanding of the meaning of the words to be used, in other words "a definition of terms." With all its claims to exact science, the hospital is full of ill-defined words.

What is a "general" hospital?
What is a "major" operation?
What is a "drug"?
What constitutes routine procedure?

### Borderlines

Nowhere is this vagueness more clearly shown than in the question of the status of the nurse.

To the onlooking analyst it seems as though the doctors and nurses consider health and hospitals as their own personal affairs and consider that society has no right to enter the discussion. This attitude can be accepted in argument only if the nurses and the doctors cease to ask society to support them not only in their work but in the time, energy, and money wasted in their disagreements.

This *was* and in some cases still *is* the situation. My next article will attempt a solution in which the nurse may aid in this work of reconstruction.

* Dr. W. Gilman Thompson, page 6, The Occupational Diseases—D. Appleton & Co., 1914.

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# Editorially Speaking

## THE TRAINED NURSE AS TEACHER

Opinions are queer things. We do not knowingly build them. They just grow, like vines from the soil of the mind and their branches are shaped and molded by unanalyzed impressions.

A recognition of this fact will explain the nursing controversy in Michigan.[1] Here a group of sincere men and women, thinking only in terms of *curative* medicine, have evolved certain opinions about the function of the nurse. In part, they believe that the nurse "should be possessed of sufficient knowledge to correctly take the temperature, pulse and respirations and should be able to recognize the advent of unfavorable symptoms and should, at the appearance of such symptoms, be possessed of sufficient common sense to immediately notify the physician thereof and place the responsibility upon him."

Another group of equally sincere men and women believe with Kate Douglas Wiggin that—"To cure is the voice of the past; to prevent, the divine whisper of today." They have evolved certain other opinions about the possible function of the nurse. They see the physician teaching his sick and well patients hygiene and right living; they see the sanitarian controlling the incidence and development of disease through legislation, mass instruction and general oversight (through national, state and local organizations); they see also the function of this newer worker, the nurse, who will supplement the work of the physician and sanitarian by teaching, teaching and then teaching again these health lessons to children in the schools, to mothers in the homes and to workers in offices and factories.

Unfortunately, the opinions of both factions are well-developed vines grown in the mind soil of those who hold them. If, as Dr. Snedden pointed out at a recent meeting, the present-day vocational tendency aims to prepare workers for specific service, it also aims to educate with a view to future "up-grading." Apply this in Michigan. Why not educate both types of nurses—the woman prepared to serve in the sickroom only and the woman who is further equipped to teach other nurses and to guide well and ill patients toward health?

The real teacher studies her work practically and theoretically. She goes into the wards and performs the actual nursing procedures until her technique is perfect and automatic (but not beyond that point); she goes into the laboratory to study the meaning of facts as they exist (not as reported to her by hearsay); she studies the actual disease entities as the cases are treated in the hospital. She can only impart knowledge with clear force if she acquires it at first hand.

Nurses and physicians who are asking for broader educational opportunities for pupil nurses are quite as anxious as their critics to produce the "aseptic conscience," in fact, they realize that full realization is accomplished only when hand service is directed by accurate, mental conception. They also believe that nurses should only study and remember knowledge which will be of cer-

[1] *Jour. M. S. M. A.*, November, 1922.

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tain use in their work. Obviously, however, those who are to develop and perfect this nurse of the future must have a clear conception of her preventive as well as curative role, and they must be free to plan her study with a view to its realization.

With the splendid teaching and clinical facilities available at the University of Michigan and its associated hospital, it seems unfortunate that sincere misunderstanding prevents their full use. The eight-hour schedule and class-work during daylight hours were accomplished only after hard labor. The concentrated preliminary course has been born after much planning. The possibility of training several types of workers (provided their functions are carefully differentiated) does not seem impossible.

To-day when we see physicians and surgeons working upon parallel social and scientific levels, despite the long centuries of evolution which preceded the surgeon's recognition, we are encouraged to wait for enlightened public opinion to establish the status of the nurse-teacher. The surgeon's emancipation in France came through the foundation of the Academy of Surgery (1731) and the ordinance of 1743 which required the arts degree as a requisite. Perhaps the emancipation of the nurse-teacher is approaching.

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## INDEX NOW READY

After December twentieth, the long-delayed index of volumes LXVI and LXVII will be available for distribution.

The new index covering the material under author and subject (with sufficient cross-indexing) will no doubt be welcomed by librarians.

The index for volumes LXVIII and LXIX will be available by January twentieth. The publication department would appreciate it if those desiring sets of either index would file requests if they have not already done so.

The indexes will be mailed as third class matter, separate from the magazine. Please watch your mail carefully.

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## A SERVICE PROBLEM IN SMALLER HOSPITALS

Some six to seven hundred hospitals have been approvide by the American Medical Association as suitable for the proper training of internes. At present the number of graduating medical students is quite insufficient to fill the available interneships. Naturally these few internes can locate in the larger institutions where the abundance of clinical material, and the highly specialized organization and equipment provide diversified opportunity.

This means that many of the smaller approved hospitals lack interne service. Who does their work in these hospitals? The superintendent of nurses, the operating-room nurse—sometimes the superintendent's assistant, the anesthetist, or the laboratory assistant—give treatments, assist at operations, supply first aid treatment in minor accident cases, make blood and urine tests, take histories, etc., without, in most cases, having received special training for these tasks. They have learned to do by doing.

In discussing a possible substitute for the missing interne, Dr. S. S. Goldwater advocates* the inauguration of a course of training for non-medical clinical aides. In other words he proposes that suitable hospital schools or universities offer nurses a course of twelve to eighteen months in length which would fit them to handle all the work of the interne except diagnosis and treatment and some of the more difficult clinical procedures. The course, he suggests, would include "Anesthesia, First Aid, Surgical Dressings, Laboratory Technique, History Taking, Operating-room Technique and

* *Modern Hospital*, October, 1922.

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Clinical Records" with stenography and typewriting as optional courses.

Perhaps several hospitals which are now giving post-graduate courses for nurses in anesthesia and laboratory technique might broaden their course to embrace the necessary training. Hospital schools prepared to give such a course would soon be swamped with calls for their non-medical clinical aides.

The small hospitals need this resident service. Under the present conditions the visiting staff is hampered, the hospital purpose is curtailed and the service to the patient delayed. If especially qualified nurses could handle this work why not prepare them to do it?

Some nurses feel that we are already branching too far afield in the specialized work which we as nurses are undertaking; others feel that the need felt in many of the smaller hospitals justifies the training of non-medical aides. Such specialization, it would seem, would not in any sense pocket the future possibilities of these nurses since responsible supervision along such diversified lines would prepare them for individual work in hospitals and health centers.

## COURSES IN TUBERCULOSIS NURSING

Wherever nurses gather in discussion, the need for specialization in tuberculosis nursing is emphasized. To meet this need, a three-months' course has been inaugurated by the Glockner Sanatorium and Hospital Training School and the Colorado School of Tuberculosis. The wealth of clinical material available at Colorado Springs and the scientific treatment of the cases makes this the ideal situation for such a school.

The course includes thirty pertinent, carefully planned lectures by tuberculosis specialists backed by careful class instruction, demonstrations and quizzes given by Sister Marie Gerald, R. N., superintendent of nurses, Jessica Ryle, R. N., Elsie A. Kempf, R. N. and Irene Hunnekins, R. N., occupational therapist.

The demonstrations are given at the Glockner Sanatorium and Hospital and the Free Tuberculosis Clinic with field work under the Visiting Nurses' Association. All practical work is supervised by graduate nurses. Instruction, quarters, sustenance and eight dollars per month will be given to those taking the course in return for seven hours daily work on the halls.

Since the course is open to only ten nurses (graduates from accredited schools or senior students from affiliated, accredited schools), those wishing to enter with the January 1, 1923 class should make arrangements at once.

## SUPPORTING STUDENTS IN CHINA

Two student nurses in China secure their education each year because many graduate nurses in the United States contribute to their support. This practical expression of sympathy and appreciation, which burdens no one, helps not only the Chinese girls but their instructors who are spreading the gospel of health and godliness throughout China.

The yearly contributions to the Florence Nightingale Missionary League are again due. The dues—one dollar per year and as much more as the friends of China care to give—should be sent to Minnie Goodnow, treasurer, Children's Hospital, Washington, D. C.

How splendid if we could help ten Chinese girls instead of two, or assume the support of a native student nurse in Africa and India besides! We can if you will send your share.

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# Hospital Review

## THE DIETETIC TRAINING OF PUPIL NURSES*

IN scanning the field of dietetic instruction of nurses, it is evident that great variation exists in the length and scope of the courses given at present. Such variation is probably due to (1) the degree of organization and scope of the food departments in the hospitals, (2) the size and economic status of the hospitals which determine the teaching staff and equipment and the clinical material available, and (3) the varying length of the courses in nursing—two years to three years and one-half with university affiliations.

Accordingly, the subject has been considered not so much from the standpoint of the number of hours spent on dietetics and the method of giving the course, but rather of the type of material given, its distribution, and the placement of emphasis. The purpose of this report is to fix some standard from which adaptations might be made by various organizations.

The course should consist of a thorough knowledge of the following:

*A.* Food: Its relation to the human body; Its classification; source; selection; cookery; sanitation and care.
*B.* The steps in the preparation of the food by the body for its use as: Digestion; absorption; metabolism, etc.
*C.* Fuel value of foods and method of calculating dietaries.
*D.* Conditions affecting food requirement and method of modification to suit various conditions. Normal adult and child feeding.
*E.* Application and modification from the normal to all necessary therapeutic conditions.

The time alloted to and the emphasis placed upon the various phases of the work will necessarily be modified by the organization and standard of each institution.

### The Method of Presentation

The methods used in giving dietetic instruction are the following:

*A.* Lecture.
*B.* Lecture and laboratory practice.
*C.* Lecture and diet kitchen practice.
*D.* Lecture and serving kitchen practice.
*E.* Lecture with practice in the general kitchen. (Usually in the smaller hospitals.)

Lecture alone is most unsatisfactory. Lecture with laboratory practice is without a doubt the ideal from the standpoint that closer check may be made upon uniform instruction. Lecture with diet kitchen practice is very good if the hospital affords a sufficient amount of clinical material offering enough special work, and if provision is made to supplement any work which is lost. Lecture and demonstration is not the best as we all realize that more is gained by the pupil in actual preparation of food than in the observation of its preparation, but this method is better than no application of theory whatsoever. Lecture with only serving kitchen practice does not offer adequate training in food preparation. Lecture with practical work in the general kitchen is not to be recommended unless most carefully handled as such a method is conducted at the expense of the instruction and strength of the pupil.

Whatever method is required, it is essential that the dietetic instructor take the responsibility in seeing that work is well supplemented, if necessary, in order that the nurse will acquire dietetic knowledge to meet a certain standard and that the dietitian will also see that only that work which is of educational value to the pupil nurse should be done by her.

In the actual planning of the course in dietetics—*first,* decide upon a standard; *second,* study the extent of the curriculum of the school in order that proper correlation may be made with other subjects without overlapping, or omitting essential material; *third,* determine at what period in the nurse's training, the dietetics and therapeutics are to be given; *fourth,* decide how much time can be alloted to that instruction; *fifth,* determine upon the teaching method adapted to the organization of the institution, viz., lecture and laboratory practice, etc.; *sixth,* choose the material to be included in the course, its presentation to your group, distribution and emphasis on the various phases; and *lastly,* obtain a good supply of educational material to use as a source of information in instruction, such as books, charts, bulletins, etc.

* Excerpted from the Report of the Subcommittee on Education of the American Dietetic Association as distributed at the Fifth Annual Meeting of the association, October 16-19, 1922.

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### Where Shall the Line of Demarkation Be Drawn?

Nursing educators are not agreed as to whether the dietetic instruction should be specialized or whether it should be a broader training applicable to more fields than nursing. To illustrate this point consider: "Is a knowledge of deep fat frying or making of pie crust essential in a course in cooking for nurses since we all maintain that those foods should not be partaken of by patients?" Our nurses are not students in home economics, yet require a good dietetic training since the present day trend in medicine is much in that direction.

Three courses have been planned, one of 45 hours, one of 60 hours, and one of 90 hours. The meal plan is used as much as is practicable. In the 45-hour plan the work is covered too rapidly and much essential material is necessarily omitted. The scope of the 60-hour plan is greater; as a result the material may be covered much more thoroughly. The 90-hour plan provides almost ideal conditions, as the work is thoroughly covered and there is more time for repeated application.

In the courses outlined* suggestions are made as to what should be included in theory and what might be the application in the laboratory. A demonstration column illustrates how the practical work may be shown in case a dietitian does not have a teaching laboratory but must resort to demonstration entirely, which is very frequently the case in a small institution. The outlines consider the theory with the laboratory or the theory with the demonstration as two methods of presentation not one with theory, laboratory and demonstration.

The 90-hour plan is the one recommended as the standard from which modifications may be made to suit specific organizations. Other recommendations are:

1. That the class periods not exceed two hours in length.

2. That not too elaborate note-books be required by the pupil nurse as she does not have time to keep them.

3. That the class consist of lectures, reviews, discussions by pupils, special reports, etc.

4. That too much outside reference work be not assigned but that reports (one or two in number) or a term paper be presented by each pupil in order that she may learn to collect essential material and present it in the proper manner.

5. That sources of educational material both for the reference of the instructor and the pupil nurse be available.

## THERAPEUTICS

The 45-hour course covers thirty hours in general dietetics and fifteen hours in therapeutics; the 60-hour course, forty hours in general dietetics and twenty hours in therapeutics; the 90-hour course, sixty hours of dietetics and thirty hours of therapeutics. These outlines are too extensive for reprinting. We publish below the outline covering the instruction in therapeutics for the 90-hour schedule.

### Liquid Diet

Lesson I

*Theory*—General discussion on abnormal feeding. How modified from general feeding. Discussion on invalid's tray. Study of liquid diet and its application to such conditions as post-operative feeding, fevers, etc.

*Laboratory*—Preparation of liquid diets. (1) Refreshing—orangeade, grape nectar, fruit punch, etc. (2) Nourishing—egg chocolate, malted milk, eggnogs, etc., coffee. (3) Stimulating tea,—broths. Demonstrate use in eight feedings.

*Demonstration*—Preparation and serving of liquid nourishments as listed under the laboratory plan.

### Soft Diet

Lesson II

*Theory*—Show how diet is increased from liquids. Give list of foods allowed. Make application again to the diseases mentioned in previous lessons.

*Laboratory*—Meal plan for one day: 8 A. M.—Stewed fruit, milk toast; 10 A. M.—Egg malted milk; 12 M.—Cream soup, mashed potatoes, ice cream, bread, butter, milk; 2 P. M.—Orangeade; 4 P. M.—Rice with cream; hot chocolate; 6 P. M.—Poached egg, vegetable puree, blanc mange, milk.

*Demonstrations*—Show meal plan for one day—food preparation being mostly a review problem. Bring out the necessity of variety in the diet and the meeting of the dietary requirements of the individual.

### Light Diet

Lesson III

*Theory*—Discuss purpose of its use. Give a list of foods as built up from a soft diet. Discuss food preparation and service.

*Laboratory*—Meal plan for one day: 8 A. M.—Stewed fruit, cereal, bacon, toast, coffee; 10.30 A. M.—Malted milk, baked breast of chicken, mashed potatoes, grape sponge, bread, butter; 3 P. M.—Fruit punch; 6 P. M.—Creamed oysters on toast, pear salad, custard tapioca, bread, butter, tea.

*Demonstration*—Use meal plan for a day as suggested in the laboratory plan.

### Typhoid Diet

Lesson IV

*Theory*—Discuss the necessity of a high protein and high calorie diet, the necessity of using non-irritating foods and the use of as great a variety as is possible in order to keep the patient from tiring of his food.

*Laboratory*—Meal plan for a day: Diet to be quantitative and qualitative. Stage in treatment and quantity allowed may be selected by the instructor.

*Demonstration*—Illustrate meal plan for a day, showing special food preparation, methods of distinguishing of foods, serving, etc.

* Mimeograph copies are filed in the office of The Trained Nurse and Hospital Review. Doubtless other copies may be obtained from the secretary of The American Dietetic Association.

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## Convalescence Diet

LESSON V

*Theory*—Show how how diet from the previous four lessons has been built to this stage. Contrast it with an ordinary diet, giving a list of foods that should not be used.
*Laboratory*—Meal plan for a day: 8 A. M.—Fresh fruit, cereal, bacon and eggs, toast and coffee; 12 M.—Stock soup, roast beef, creamed carrots, brabant potato, pineapple salad, charlotte russe; 6 P. M.—Chicken salad, creamed potato, buttered asparagus tips, apple sauce, oatmeal cookies.
*Demonstration*—Same as laboratory plan.

## Forced and Artificial Feeding

LESSON VI

*Theory*—Discuss foods to be used in such dietaries. Discuss also the condition to which applicable, such as emaciation, tuberculosis, etc. In artificial feeding, discuss foods to be used, method of administration and conditions to which applied.
*Laboratory*—Meal plan for a day, illustrating forced feeding. Instructor to select foods of highly nourishing and easily assimilable character to place in a full diet. For the artificial feeding make several nourishing liquid foods which might be administered through a tube.
*Demonstration*—Use the same plan as suggested for the laboratory preparation.

## Gastro-Intestinal Feeding

LESSON VII

*Theory*—Discuss the purpose of the dietary management. Show how the diet progress from the earliest stages of treatment through fourth week management. Students to be made familiar with the various specialists treating the disease.
*Laboratory*—Prepare a meal plan for a day for one of the early stages of management. Then prepare a plan for the last stage in the management. If time permits demonstrate the addition of foods throughout the whole period of management.
*Demonstration*—Use the plan suggested under laboratory.

LESSON VIII

*Theory*—Discuss cause of bowel disorders, dietetic care of the same, showing principle involved. Take into consideration low residue diets, bland diets, anti-constipation and specified bulk diets.
*Laboratory*—Prepare a meal plan for a day for a bland diet, and an anti-constipation diet. Demonstrate a low carbohydrate, a low residue diet, for fermentative colitis.
*Demonstration*—Use the plan suggested under the laboratory outline. Demonstrate as many of the various types of diet as time permits.

## Diet in Diseases of Metabolism—Protein

LESSON IX

*Theory*—Discuss special food preparation in conditions where type and quantity of protein is limited or modified. Apply to all diseases, wherein limit and type of protein needs to be considered such as nephritis, diseases of the heart and blood vessels, nervous disorders, gout, etc.
*Laboratory*—Prepare a meal plan for a day for a diet in nephritis, diet to be a specified quantitative with limited liquids. Instructor to determine diet and meal plan to be used.
*Demonstration*—Use the same suggestions as offered under the laboratory plan.

## Diseases of Metabolism—Carbohydrate

LESSON X

*Theory*—Discussion from previous lesson to be continued. More time being spent in summing up the diseases, showing how all fall into a general dietary plan.
*Laboratory*—Prepare another quantitative diet, to be limited also in salt content.
*Demonstration*—Use the same suggesions as offered under the laboratory plan.

LESSON XI

*Theory*—Discuss diet in which limited carbohydrate is a primary factor. Food most applicable to the condition and its preparation. Discuss the underlying principles of the dietary management in diabetis.
*Laboratory*—Preparation of a quantitative diet for a day for a diabetic. This diet to be one illustrating a very low carbohydrate tolerance. Emphasize special food preparation and accuracy.
*Demonstration*—Plan may be the same as suggested in the laboratory outline.

LESSON XII

*Theory*—Continue and conclude the discussion of the previous lesson.
*Laboratory*—Preparation of another quantitative diet in which the carbohydrate tolerance is much greater.
*Demonstration*—Plan may be the same as suggested in the laboratory outline.

## Diseases of Metabolism—Fat

LESSON XIII

*Theory*—Discuss use of low fat and low carbohydrate diet in cases of obesity. Discuss limitation of fat also in cases of diseases of the liver and gall-bladder.
*Laboratory*—Prepare a quantitative diet for obesity. Instructor to determine type of problem to be fulfilled.
*Demonstration*—Plan to be the same as suggested under the laboratory outline.

## Miscellaneous—Review

LESSON XIV

*Theory*—Discuss diet in which the selection of minerals needs to be considered, such as anemia. Discuss also deficiency diseases and foods which must be used to satisfy each requirement.
*Laboratory*—Preparation of a meal plan for a day in which sources of minerals in food is emphasized, also one in which the dietary accessories are well represented.
*Demonstration*—Same as suggested in the laboratory outline.

Sources of material for dietetic instruction follow. This list is not as complete as it might be had there been more time to complete it.

## BOOKS

| *Author* | *Text* |
|---|---|
| Locke | Food Values |
| Atwater and Bryant | U. S. D. A. Bulletin No. 28 |
| Lusk | Science of Nutrition |
| Friedenwald and Ruhrah | Diet in Health and Disease |
| Garter, Howe and Mason | Nutrition and Clinical Dietetics |
| Kellog | The New Dietetics |
| McCollum | Newer Knowledge of Nutrition |
| Eddy | The Vitamin Manuel |
| Fitch | Dieto-Therapy, 3 volumes |
| Gruelee | Infant Feeding |
| Julius Hees | Principles and Practice of Infant Feeding |
| Morris & Talbot | Diseases of Nutrition and Infant Feeding |
| Dennet | Simplified Infant Feeding |
| Emerson | Nutrition and Growth in Children |
| Holt | Food, Health and Growth |
| Sherman | Food and Nutrition |
| Sherman | Food Products |
| Rose | Feeding the Family |
| Rose | Laboratory Manual of Dietetics |
| Farmer | Food and Cookery for the Sick and Convalescent |
| Farmer | Boston School Cook Book |
| Proudfitt | Dietetics for Nurses |
| Pattie | Practical Dietetics |
| Pope | Essential of Dietetics |
| Perry | Dietetics for Nurses |
| Howell | Text Book of Physiology |
| Hawk | Physiological Chemistry |
| Matthew | Physiological Chemistry |
| Leach | Food Inspection and Analysis |
| Fisher | Colloidal Chemistry |
| Buchanan | General Bacteriology |

## BULLETINS

A catalogue of bulletins may be obtained from the Department of Publications, U. S. Printing Office, from which one may select bulletins pertaining to practically every food. These are not listed here as they are too numerous to mention. Bulletins may also be procured from the various departments of agriculture of states or state colleges.

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## CHARTS

Nutritional charts may be procured from any of the large clinics where such work is being conducted, from the U. S. Department of Publications and from the state universities.

The following food charts or exhibits are also valuable:

*Meat*—Institute of Meat Packers, Swift & Co., Armour & Co., Wilson & Co.
*Fish*—Bulletin U. S. Department of Agriculture.
*Eggs*—Cornell Egg Candling Chart; Bulletin U. S. Dept. of Chemistry.
*Cheese*—Not much available material.
*Milk*—National Dairy Council.
*Cereals*—Washburn, Crosby Milling Co., Pillsbury Mills, Whole Wheat Grain Co., Quaker Oats Co., Corn Products Co., Rice Products Co.
*Tapioca*—Minute Tapioca Co.
*Cocoa*—Walter Baker, Ltd.
*Tea*—"Tea Talks," Calumet Tea & Coffee Co., or other large firms.
*Butter and Fats*—Bulletins. Not much material available from firms.
*Fruits and Vegetables*—Langworthy Charts.

This practically covers the field of material and is intended for the use of both pupil and instructor.

## Dietitians Meet

The fifth annual convention of the American Dietetic Association stressed especially the role of dietotherapy in maintaining health and treating disease.

At the opening session in Washington, October 16, Mrs. Agnes O'Dea of Johns Hopkins, Dr. Ruth Wheeler of the Iowa Medical College and Breta M. Luther of the Children's Hospital, Boston, showed the great strides which dietitians have made in establishing their position as consultants in the hospital program.

### Diabetic Diets

Dr. Elliot P. Joslin, in discussing diabetic diets, advised more careful formulation of directions for measuring standard portions. He mentioned that the actual caloric value of a pound of human flesh is not sufficiently considered when regulating diet in metabolic disturbances. Dr. Philip Marsh, of the University of Michigan, showed how the diabetic patient might be educated to aid in preserving his metabolic equilibrium.

Miss Laura Comstock of the Eastman Kodak Company reported an interesting dietetic experiment on a small group of employees. The results of this intensive work will be applied to the whole industrial force. Dr. L. H. Newburgh, of Ann Arbor, discussed the advisable quantity of protein in nephritic diets.

### Dietetics for Children

Mary Swartz Rose of Teachers College outlined ways in which the child's cooperation can be secured in maintaining proper nutrition. Through slides and charts she demonstrated the effect of varying diets with a view to establishing principles of proper diet for children.

Dr. Alfred Hess, after showing the rise and fall of weight curves under varying diet, presented interesting evidence of the value of sunlight in treating rickets. Dr. Hess believes the treatment necessary is not wholly dietetic but includes also exposure to the ultra-violet ray of the sun which is most effective during spring and summer.

### Social Service

In discussing the dietetic field in social service Ida M. Cannon, of the Massachusetts General Hospital, pointed out that the interrelation of workers must be carefully managed so that dietitian or social worker assume the handling of the case as its needs demand. Lucy Gillett, director of the Nutrition Bureau of the A. I. C. P., New York, brought out the bearing of living conditions upon nutrition. As she pointed out, the presence of crowded housing, inadequate ventilation, scanty clothing, and insufficient rest will counteract the good results achieved through the maintenance of proper diet.

### Johns Hopkins Contributions

The final sessions of the convention, held at Johns Hopkins Hospital, were addressed by Dr. William S. McCann and Dr. E. V. McCollum. Dr. McCann by means of slides showed the very startling changes in metabolic processes which may result from slight variations in diet. He stated tentatively that physicians are basing their diabetic diets upon the dietetic requirements of the patient under normal conditions.

Dr. McCollum discussed the physiological effects of diet variation as determined from laboratory tests upon small animals. He pointed out that from the results of tests on guinea pigs and rats, it was possible to determine the effect upon the human system with exactness.

### New Officers

Octavia Hall, chief dietitian of the Peter Bent Brigham Hospital, Boston, was elected president, to succeed Mrs. Mary DeGarmo Bryan of Jersey City, N. J. Other officers elected were: first vice-president, Hallie Corsette, dietitian, Veterans' Bureau, U. S. Public Health Service, Washington, D. C.; second vice-president, Effie Raitt, of the University of Washington; treasurer, Anna Bollen, of the Infants' Welfare Association, 824 East 47 Place, Chicago; secretary, Breta M. Luther, chief dietitian, the Children's Hospital, Boston.

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# Gleanings

## Controlling Constipation in Children

CONSTIPATION in adults can, in over 75 per cent. of cases, be traced to constipation as a child. A history, if taken, will show that practically all their lives they have had to take physics or laxatives. Yet much of this suffering could have been relieved if time had been taken to regulate diet instead of continuously taking medicine.

In treating this condition we must begin with the infant in arms. Most mothers nurse or feed their babies too often and irregularly. Four hour intervals in nursing or feeding, in my experience, have proven the best. I must admit that many children thrive and are not constipated when fed or nursed at all hours of day and night, but I have often overcome constipation in babies, when it does exist, by putting them on a schedule of four-hour feedings.

Too much fat in the food will also cause constipation. This will show in hard, pasty, light-colored stools. In cases of this kind, removing the cream from the milk will often relieve it. Boiling milk will not cause constipation in an infant. This should be a practice in summer as we can never be too careful of our milk supply.

At six months, fruits and vegetables in small quantities, well cooked, and thoroughly mashed or chopped fine, should be given; carrots and spinach, prunes, apple sauce and orange juice, cream of wheat, farina, and strained oatmeal. These, in addition, provide certain elements of nourishment required for the proper growth and development of the child and leave a residue in the bowels and give body to the stools so that the muscles of the bowels will have something to act upon.

In older children the trouble frequently is already started. They have often been physicked in infancy and the constipation may now be chronic. Mothers will often deny that the food they give the child is rich or indigestible. They may insist that the appetite is poor. When questioned closely they will admit that before or between meal times the child may have eaten some candy, an ice cream cone, or perhaps a piece of cake or pie. Frequently the child insists on drinking coffee instead of milk.

Let these children eat food suitable for their age and drink only milk and water, and many children would be spared the curse of constipation.

The formation of habits does a great deal to help out dietetic treatment in this condition. Begin at eight months, set the infant on a proper stool regularly at the same time every day, preferably after breakfast. Keep this up, and soon the child will learn and a regular habit is formed. It is never too late to begin this treatment.

Exercise also helps. Let the baby play on the floor or bed, naked, so that all the muscles, especially of the abdomen, may develop. All forms of play in older children, especially outdoors, act as exercise. But above all else use no laxatives or physics. The greatest curse to humanity is the patented laxatives advertised in the papers and circulars, and so easily obtained at every corner drug store.—*City Health, Detroit.*

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**Stopping Hiccoughs**

The simple type of hiccough requires no treatment in the majority of cases, but should it persist over five minutes the following physiomechanical methods may be tried:

1. Tongue traction for two minutes.
2. Holding the breath and counting.
3. The blowing of a wind instrument such as a bugle, flute or cornet.
4. Galvanism applied to the neck.
5. Lowering of the head and rectal stretching.
6. A sudden shock by taking patient unawares.
7. Sipping of water, hot or cold, or ice.
8. Pressure on the neck over the fifth cervical.
9. Tickle the throat (vomit) and tickle the nose (sneeze).
10. Throw head back and fingers in both ears and swallow water (vagi depressors).
11. Gargle with a bitter solution.
12. Drink lemon juice and salt.
13. Have the patient inhale amyl nitrite.
14. Mustard plaster applied to the epigastrium.
15. Ice bag or ethyl chloride spray to the epigastrium.
16. Stand on hands or head.
17. The flexion of the legs on the thighs and thighs on the abdomen.
18. Compress the supraorbital nerves.
19. Compress the epigastrium with ice.
20. Actual cautery to the abdomen.
21. Arms stretched up vertical, open mouth wide and extend tongue.
22. Pass a stomach tube or an esophageal bougie.
23. Should these simple methods fail a few whiffs of chloroform will usually stop any simple persistent hiccough.

In hiccough caused by inflammatory processes the physician first attacks the primary condition, then the hiccough may be eliminated by the elimination of toxins through gastric lavage with bicarbonate of soda, soap-suds, enemas, purges, emetics, as apomorphine or ipecac. Where the temperature is high antipyretics may be used. Depressants are also efficacious if the patient's condition warrants their use. Hot water bottle to the epigastrium often gives relief to the sense of pressure and pain. In the severe inflammatory diseases as peritonitis, pancreatitis, typhoid, strangulated hernias, ileus and hepatitis, opiates should be administered early. In cholera, morphine and chloroform inhalations relieve the symptoms. In relapsing fever, morphine with atropine and chloroform inhalation or internally seems to give temporary relief. In phrenic and multiple neuritis counter irritation and large doses of salicylates.—Brun in the *New York Medical Journal.*

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**Points for the Operating-room Nurse**

Special points in operating technique as individualized at the Onondaga General Hospital, Syracuse, New York, are outlined by Dr. T. L. Deavor in a recent issue of the *American Journal of Surgery.* The following procedures bear upon the work of the nurse:

The hands are scrubbed for ten minutes with green or Jumbo soap, in running water, rinsed and dried with sterile towels. Special care is used about the palmar aspect of the thumb and index finger, the anterior surface of the wrist and the ulnar side of the forearm and hand. No antiseptics are applied to the hands before or during operations. Alcohol is permitted, if desired, preceding the gloves.

An effort is made to keep the nails clean all the time. The nail file is applied at frequent intervals, when the nails are dry and hard, and not at the time of scrubbing. Pus dressings are delegated to persons—and they wear rubber gloves—who have no part in the operating-room work. Assistants are admonished not to care for infected cases in the office, unless unavoidable, and then only with gloved hands.

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### Putting on Gloves

Dry sterilization is made imperative. The old way of fishing gloves out of solutions of one kind or another has long since been given up. The sterile nurse, with gloved hands, holds the gloves for the operator and assistants. No one gloves his own hands. The gown being on and tied, the hands are powdered by the sterile nurse, from a sterile sifter. (No powder is put in the gloves, as it gravitates to the finger tips and interferes with tactile sensibility.) The nurse then grasps the glove with both hands in such a way as to roll the top outward, covering her own fingers for mutual protection. The glove is held vertically down, never up or out, palm facing the one to receive it, who quickly, but carefully, crowds the hand into it with an appropriate wriggle. As the nurse releases her hold, she pulls the top of the glove well up over the gown. The other hand is treated in the same way. Irregularities are smoothed out by the recipient, but only after both hands are gloved. This makes contamination almost impossible, and surpasses all other methods.

From a careful study of 500 consecutive cases, we found that 90 per cent of all glove punctures during operative work in the series, occurred about the thumb and index finger, palmar aspect, one or both hands, right or left, according to the dexterity of the operator.

### Draping the Field

As far as possible, the protective towels surrounding the immediate field are clamped to the skin, a short distance from the line of incision. Obviously, this cannot always be done; but it can be done nearly always. Rarely, a slight mark is left therefrom, not a serious matter. In and about the inguinal region several clamps are needed to actually surround the field by a firm barrier. In vaginal and perineal work, a sterile towel crosses on a line near the posterior commissure, and is fixed there by three or four clamps. The lateral areas are protected in the usual manner. Laparotomy sheets, with a central opening, are not desirable. Towels clamped about the edge of the incision, though somewhat in the way, are much used. We have had as good results without them.

In face and scalp cases, and in neck and tonsil work, a small sheet, rolled together the long way, is carried under the patient's neck, and the ends spread out fan-shaped across the shoulders and chest. A large sheet overlaps this one and drapes the body. A sterile towel covers the upper end of the table. Not only is the incision well guarded in this way, but the patient's back and hair are much less soiled at the close of the operation. In like manner, special adjustments are used to suit every occasion. Regardless of the region to be operated upon, the drapes are made to keep their place until the work is complete. Each patient wears a tightly fitting cap, all loose hairs being clipped away. The anesthetist has his own sterile cap, gloves and gown.

As an aid to asepsis, all suture material is treated with a warm two per cent chlorazene solution before using. This also softens the catgut, and determines its elasticity, so that one feels a sense of security in every stitch or ligation.

A dry wound and complete apposition are always desired. In abdominal cases, after the peritoneum is closed, and in operative work elsewhere, unless contraindicated, the wound is thoroughly treated with sponges wrung out of two per cent solution of chlorazene. As closure goes on, care is taken to reach every part of the wound, allowing no raw surface to escape. The results have been excellent.

### Adhesions and Sterile Oil

Oil, intended to prevent adhesions, may be used in various ways, i. e., as sterile vaseline on a piece of gauze, or poured in freely from a small vessel. The oil can method, originated by us, is, we believe, very efficient. An ordinary oiler, used by machinists, is kept sterilized and filled with sterile oil, ready for all occasions. The can holds about six ounces. The nozzle, straight or curved, is tipped with a knob-like point, which can be carried into the peritoneal cavity with perfect safety.

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## A Specific for Diabetes

Through the experimentation of Dr. F. G. Banting and an associate in physiological chemistry, C. H. Best, a new method of treating diabetes has been worked out at the University of Toronto. "Insulin," the specific, is obtained from the pancreatic tissue of the cow. The *Canadian Medical Association Journal* reports the following observations.

1. Blood sugar can be reduced to the normal values.
2. Sugar in the urine can be abolished.
3. Acetone bodies (toxic) can be made to disappear from the urine.
4. The respiratory quotient shows evidence of increased use of carbohydrates.
5. A definite improvement is observed in the general condition of the patient.

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# The Editor's Letter-box

The Editor Is Not Responsible for the Views of Contributors. All Letters Must Be Accompanied By the Name and Address of the Writer

## IMPROVISED WATER HEATER

DEAR EDITOR:

At the Royal Hospital for Women we use the following method to keep douche solutions at uniform temperature.

We place the prepared solution in the reservoir, and elevate it in the proper position. We then sterilize an ordinary electric light bulb, wrap several folds of sterile gauze around the connecting wire close to the bulb. When this bulb is attached to a cord of sufficient length, it is lowered into the douche solution. After the current is turned on, water at 120 degrees F. can be maintained at this temperature for over an hour.

E. P., Australia.

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## A SUBSTITUTE FOR WAIVERS

DEAR EDITOR:

At this moment I seem to possess a store of surplus energy which I would like to direct against "waivers" in our nursing legislation. I am told they are necessary to prevent "class legislation" or "retroactive legislation." Naturally I believe in the spirit of fair play so I say "Well and good."

What I want to discuss, however, is the attitude of the nurse toward the waiver.

We have worked for nursing legislation for one reason—to protect the public from malpractice and give it a standard by which to judge competent nursing service. "Waivers", it seems to me, defeat that purpose.

So that I do not bring both pros and cons upon my head let me state a hypothetical case —my own. I graduated from a special hospital which gives fair training in its specialty and quite a bit of general training in an eighteen months' course. I have supplemented that education by a special course in a maternity hospital, a special course in operating-room work, and have been employed by a general hospital to handle general medical cases on the wards for some two years. In addition, I have read copiously and observed assiduously during many years of private duty nursing. I realize that this experience is not comparable with that given in the best schools of nursing but I am morally certain that it is better rounded and more thorough than that given in some of the weaker schools whose graduates are permitted registration on examination.

I have been registered under the waiver in several states. This gives me a feeling that is uncomfortable. I feel as if I were passed along as imperfect goods just because the statement of the law permits it. This is what I should like to offer as a substitute.

I should like to present to the examining board a detailed report of my nursing education and experience—formal and self-taught. If this education and experience were considered comparable to the two-year course required, for example, in New York, I wish I might then have the privilege of taking the examination.

If I passed I would not feel as if I were slipped through a waiver loop-hole but as if I were qualified on a measurable basis.

On one other point I stand as an insurgent. Your faithful reports of the Seattle meeting bring it to my mind. My special hospital and many other special hospitals will not aid or co-operate with their graduates in establishing alumnæ associations. As a result many nurses who have supplemented their preliminary work by all kinds of subsequent training are debarred from membership in State associations (except in certain cases by the courtesy of local districts), I am told, though given the privilege of practicing as registered nurses under the State law.

If the State organizations are formed to maintain standards and to educate all nurses, why not plan some terminology of membership which would include those nurses who should be reached.

Attendance at meetings when not a member places the conscientious nurse as an interloper in nurses' meetings.

I do not feel aggrieved, only sorry that the full possibilities of co-operation are not at present realized.

S. M., New York.

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## THE USE OF COLOR

DEAR EDITOR:

The inspiration of beautifully colored sunsets and sunrises may be captured for hospital patients through large windows.

Color—a bright flower or a flaming ball will divert children in pain. I am so glad that children's wards are being fitted to create cheer. Victrolas in rainy or depressing weather are very valuable in brightening and cheering patients.

If possible, I would have all nurses wear white, a pretty blue or a warm pink while on duty in the hospital. Why not have blue for the Bethesda nurse's street costume and white for social service workers, administrators? If it would not seem irreverent to suggest it, I would urge that sisters of our religious orders wear white while on hospital duty.

Color, especially with mental patients or those who are depressed, may become an important aid to recovery. I wish all our uniforms could be planned from this standpoint.

EDITH KARL, Ohio.

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## CHRISTMAS IN OUR HOSPITAL

DEAR EDITOR:

The Christmas season of 1922 was celebrated in many ways and in many places, but I want to tell you of a place you have probably not given a thought, and of the significance of this wondrous day and its season to its inhabitants. It is at Fort Wayne, our Lutheran Training School for Nurses.

You may visit us on early advent evenings and hear the rehearsal of Christmas Chorals; then all are busy with needle or book, making little remembrances for loved ones at home.

Although the post-man is daily laden down with packages, they are safely guarded from curious eyes by the Superintendent.

Before the momentous day, one jolly evening is spent in the kitchen with all hands busy making delicious sweets and popcorn. The "Home" is given a Christmas dress, the hospital wards are brightened by garlands and small trees.

Imagine you are with us on the day before Christmas when with a joyous spirit all leave chapel for their daily services more happy than usual, perhaps.

In the meantime the doors of the "Home" have been closed for the day, but promptly at three-thirty they are thrown open again. Santa has just arrived on the "Limited" and taking his place beside the beautiful tree, we find gifts for everyone. A merry hour follows. At six-thirty next morning the voices of nurses fill the hospital with Carols. The day force joins in "Joy to the World" just outside the hospital doors before turning to the day's duties. Those having free morning hours attend services and upon returning we all join in eating a dinner "just like mother used to make."

The day is soon over but the Christmas spirit remains to warm our hearts and quicken our service throughout the year.

BESSIE STENKE,
*Student Nurse,* Lutheran Hospital Training School, Fort Wayne, Indiana.

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## INCREASING ATTENDANCE AT MEETINGS

DEAR EDITOR:

Experience in this locality has shown the difficulties to be conquered in having a full attendance at meetings.

Miss Ardell of Cincinnati suggested that district meetings could draw larger and more representative audiences if schedules were arranged for both afternoon and evening meetings. To enlarge the active interest of members, 17 different committees were organized in her district and representatives of every Alumnae Association in the district were placed on these committees to insure the presence of at least one member from each school.

We have tried this scheme during the autumn with good results. I pass it on.

J. D., Tennessee.

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## A SUGGESTION

DEAR EDITOR:

As a nucleus for a scholarship fund, the Jewish Hospital Nurses' Alumnae Association, Cincinnati, Ohio, has received a gift of $100 from one of its prominent graduates. All graduates are asked to help in increasing this fund so that selected graduates may specialize in the diversified phases of hospital work.

M. G.

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# In the Nursing World

**Articles in this department, whether bearing signature or not, are contributed and do not necessarily represent the ideas or policy of this magazine.**

## PUBLIC HEALTH ASSOCIATION MEETS

On October 16-19, the fifty-first annual meeting of the American Public Health Association met in Cleveland. The program included sections on: Public Health Administration, Laboratory, Vital Statistics, Sanitary Engineering, Industrial Hygiene, Food and Drugs, and Child Hygiene, Public Health Publicity and Education and Public Health Nursing.

An interesting part of the general session was a summary and conclusions from a survey of eighty-five city health departments, conducted by a committee under the chairmanship of Professor C.-E. A. Winslow. A symposium on "How can we Safeguard Public Health from Political Interference?" was especially pertinent.

## RED CROSS CONVENTION

When the Red Cross Convention opened in Washington on October 9, with sixty-one nurses present, the world was stirred by the distress of Smyrna. This international disaster brought home as nothing else could, the real work of the organization—to maintain a powerful central organization to give aid in war, pestilence, floods, fires and famines.

This function was clearly outlined by Mabel T. Boardman in her address. She warned the organization that it must limit its work to that provided for in its congressional charter or bring itself in danger of the penalty of losing its charter and surrendering property in Washington which it now occupies by the grace of the government.

It is the duty of public health services, city, county, state and nation, to look after epidemics, she pointed out, and it is without the province of the Red Cross to undertake service that belongs directly to the governmental agencies, except, of course, she added, in small rural communities where the public health services are not up to the highest standards. It is an important function of the Red Cross, she pointed out, to instruct in hygiene and sanitation.

Continued demands by local chapters for funds to carry on local relief work and local peace-time services, Miss Boardman said, would nullify endeavors to raise funds in time of great emergencies such as the present one in the Near East.

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**Pamela Doty, of the Department of Education at Albany; Annie W. Goodrich, of Teachers' College, and Isabel Lount Evans of the New York Chapter of the American Red Cross (also chairman of the committee of arangements), attending the fall convention of the New York State Nurses' Association in New York City.**

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A temporary fund of $100,000 to meet immediate needs was placed at the disposal of the American Red Cross in Athens. The American Red Cross in Paris was authorized to ship $50,000 of canned milk to needy districts.

Coincident with the starting of funds and supplies to Greece, where the Red Cross operations will have their base, the Nursing Service at Red Cross National Headquarters was arranging to meet its part in the emergency. Following a conference between Vice Chairman Hill and Miss Clara D. Noyes, director of nursing, it was announced that a nursing unit is being held ready for dispatch to Europe as soon as it is definitely determined what number of nurses will be required to meet the needs in the territory of Red Cross operations.

### Ready for Syria

As a further result of the conference between Vice Chairman Hill and Miss Noyes, cablegrams were sent ordering Miss Nelson, at Vienna; Miss Schaub, at Budapest; Miss Legros, at Paris, and Miss Evon at Constantinople, nurses in the service of the American Red Cross, to proceed immediately to Athens, to join the force there under Mrs. Charlotte M. Heilman. Mrs. Heilman is a highly qualified American Red Cross nurse, who has been in charge of the child welfare work in Athens since the withdrawal of the American Red Cross Commission in 1920. She has at present as assistants two Greek nurses trained in America and enrolled in the Red Cross Nursing Service. She has also a trained group of twenty young women of Athens to serve as her assistants in home visiting. A cablegram from Athens, received at Red Cross National Headquarters at the time, stated that the nursing group under Mrs. Heilman's direction already was assisting in the care of refugees.

At the session devoted to public health nursing "The Responsibility of the Chapter for the Permanency of the Public Health Nursing Service Which It Has Started," was discussed by Mrs. Malcolm Smith; "How the Chapter May Secure Popular and Public Support for Its Public Health Nursing Service," a paper prepared by Rev. Charles G. Fort, was read by the Rev. Edward C. Fellows; "The Relation of the Public Health Nurse to the Medical Profession," was considered by Dr. C. Howard Witmer.

At the section on Home Hygiene and Care of the Sick, chairmaned by Clara D. Noyes, R. N., Mrs. H. M. Blynd considered "Home Hygiene and Care of the Sick"; Mrs. Lillian Lambert discussed "The Instructor and the Maintenance of Standards"; Mrs. Frederika Farley, R. N., considered "The Feasibility of a Self-Supporting Basis for Classes." "New Plans" were discussed by Mrs. Isabel W. Baker, R. N.

The Nutrition section, chairmaned by Margaret Sawyer, considered: "A Practical School Nutrition Program" for (a) county, (b) city; "A Nutrition Program Under the Itinerant Worker"; "Our Plan for Doing Nutrition Work in Co-operation with Other Agencies," Mrs. Claudia Gilbreath, Chattanooga, Tenn.; and "Nutrition Program as Related to the Nurse," Mrs. Charles M. Knapp, Bronx County Chapter, New York City.

## CHILD HYGIENE ASSOCIATION

The thirteenth annual meeting of the Child Hygiene Association marks the merging of the work of the organization with the Child Health Organization of America. In his presidential address the Honorable Herbert Hoover announced two signal accomplishments during the year: (1) The consolidation of all leading voluntary child welfare associations under the American Child Hygiene Association; (2) the launching of an intensive health campaign (through a $230,000 fund available from the Commonwealth Foundation) in three demonstration cities—one in the far West, one in the middle West and one in the South. "Through voluntary work, infant mortality in the birth registration area of the United States has dropped from 106 per 1,000 in 1918 to 72 in 1922. It is hoped that by intensive work in selected localities to reduce the infant and pre-school mortality to a very low per cent and thus demonstrate the possibilities of protective health work."

The sessions of the three-day convention covered a morning session on "The Training in Nutrition Needs for Child Hygiene Workers," which covered the content of the knowledge which these workers should possess plus training in pedagogy to insure the most vivid presentation of the material. One afternoon was devoted to the pre-school child in city and country. At this meeting, Dr. Schlink outlined nutrition, correct posture, teeth, condition of the nose and throat, protection from contagious disease, personal hygiene and the forma-

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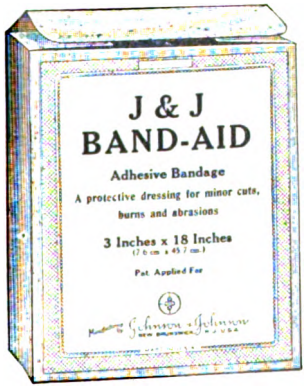
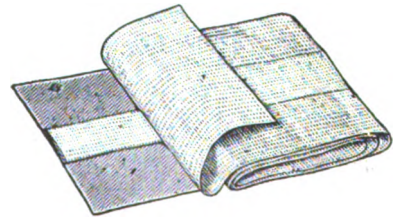
# BAND-AID—Something New

*An Adhesive Bandage*

After the nurse has left the case the mother continues using Band-Aid on her children's cuts and bruises.

Many nurses on private cases in the home find Band-Aid invaluable for bandaging the cuts and scratches of children. The older members of the family will use it also and they appreciate the thoughtfulness of the nurse who suggests Band-Aid to them.



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tion of correct habits, as seven things toward which the attention of those working with the pre-school child should be directed.

Under the chairmanship of Homer Folks, "The Administration of Private Child Hygiene Organizations" was carefully considered from the standpoint of adaptability of service, executive responsibility and financial considerations. At a special session for state and city executives the question of the control of infant mortality through prenatal and obstetrical care, rural supervision, the control of midwives and the treatment of syphilis was discussed.

At the session devoted to nursing and social work, chairmaned by Margaret Stack, R. N., Grace E. Hodgman, R. N., discussed educational standards; Kathleen Edwards "The Nursing Movement," and Winifred Rand, R. N., considered "The Behavioristic Problems of the Pre-school Age."

At the evening session when Harriet S. Leet, R. N., the retiring field secretary, read her report, she received a veritable ovation from her enthusiastic audience.

The Saturday morning session considering maternal welfare was aroused to action by Dr. W. J. Bell, when he pointed out that despite our research and oversight maternal mortality was increasing yearly. Dr. Bell believes that when health nurses are educating mothers all over the country (as they are now doing in Toronto), maternal mortality will be lowered to the irreducible minimum.

Dr. Morse, speaking on the service of an obstetrical clinic to a community, recommended a clinic whose various activities should form by themselves a departmental unit of a general hospital.

Miss Grace Abbott, chief of the Federal Children's Bureau, was scheduled to speak on the Shepard-Towner Act.

The last session considered "The Schick Test," "The Private Physician's Relation to Child Hygiene" and "The Relation of Hygiene to Teeth."

## MISSISSIPPI OFFICERS CHOSEN

The annual meeting of the Mississippi State Nurses' Association, held in Gulfport, October 30-November 1, was the most interesting convention ever attended. Special papers were read by Jane Van de Vrede on Red Cross Work, and Anna Barr, field supervisor of the Metropolitan Life Insurance Company.

Officers were elected as follows: President, Mrs. B. M. Hopper, Meridian; first vice president, Miss Mary Baker, Tupelo; second vice president, Mrs. Irene Trigg, Greenville; third vice president, Miss Rose Keating, Meridian; fourth vice president, Miss J. Smith; fifth vice president, Miss Margaret Krohn, Biloxi; sixth vice president, Miss Sutton; secretary, Miss J. Q. Cameron, Hattiesburg; treasurer, Miss J. P. Cox, Natchez.

## NEW YORK STATE NURSES MEET

Over one thousand nurses attended the annual convention of the three New York State nursing organizations held in New York October 24-27. After business reports were read at the opening session, a valuable discussion considered the question: Shall the State Department of Education Be Requested to Hold One Institute Each Year? Mary Robinson presented a report of the Seattle convention of the League with helpful emphasis.

### Philadelphia Central School

The experimental demonstration of the project of central training schools is so new that we will give a brief abstract of Miss Clayton's summary. Considered as an experimental undertaking, the organizing committee was composed of representatives of the local and state boards of health, the Southeastern Council of Nursing Education of Pennsylvania, the Eastern Council of Nursing Education, the Philadelphia Hospital Association and other interested organizations.

Teaching room and laboratory facilities were obtained at Drexel Institute and the University of Pennsylvania. Teachers from the larger schools volunteered to give their time. The expenses for demonstration materials and carfare were borne by the hospitals whose students were accommodated.

About sixty students from eleven hospitals entered. Educational requirements (above the minimum) differed. (It is hoped that by 1924 all applicants will present high school qualifications in order to form a more homogeneous teaching group.) The curriculum of the National Committee on Education was adopted. Mornings were used for study, rest or nursing demonstrations or assignments in the hospitals; afternoons for lectures, classes and laboratory work.

With intention, the plan was organized on an unstable basis to permit of discontinuance or flexibility in future development. The $1,100 needed for the conduct of the school

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in the winter and spring of 1922 was supplied by an interested organization.

This fall, however, it was decided to continue the school; it was placed upon a firmer footing by the allotment of a $9,250 to $10,000 budget and the appointment of a director. Eventually it is hoped that the hospitals will assume more responsibility for the project so that permanent equipment, buildings and teaching personnel will be available for the complete course (not stopping after the preliminary work as at present.) With the idea that the school, if advisable, may eventually be made a part of the university, the teaching personnel will be selected with a view to its connection with the university staff.

### The Pros and Cons

Miss Clayton's talk was followed by a discussion of the whole scheme by Miss Isabel Stewart of Columbia University. She emphasized the points that: (1) Such a development follows a similar evolution in other professions; (2) such a plan has a sound economic basis; (3) it will permit the utilization of trained teachers and lecturers, and adequate teaching equipment, etc.; (4) students handled in these larger groups will be stimulated to better study through the competitive element brought in. She did not overlook certain difficulties, however, which must be eliminated in individual ways. Chief among these are: (1) Difficult transportation which may be accomplished through motor buses, perhaps; (2) the necessity for having all students who matriculate present like educational standards, so that the well prepared students will not be hampered by poorly prepared students, etc.; (3) the possibility of teaching groups which might become too large to utilize adequate mass instruction; (4) the danger of divorcing theory from practice which can be easily overcome if contacts are made between the school and the individual hospitals where clinical experience is given.

If properly carried out, centralized training schools would develop a cooperative feeling between hospital executives which would be very valuable in forwarding the health program of the community.

Elizabeth Burgess, as retiring secretary of the New York State Board of Nurse Examiners (she leaves to become associated with the Department of Nursing and Health, Teachers' College and will be succeeded by Alice Gilman), reported slight revision of the syllabus with a view to assisting schools giving two years or two years and six months courses. She stressed the following:

(1) The need of training school committees in all hospital training schools to be composed of: (a) A person whose prime interest is education; (b) a trustee; (c) a member of the medical staff; (d) Alumnae representation by an *able* member; (e) a representative of the public.

(2) The value of centralization for at least the preliminary course. Group system of admission to prevent useless repetition by instructors. During the preliminary course students should not be used for general hospital work although they may be considered for special assignment on wards or private rooms. Pupils should be working on the eight-hour schedule and receive one month's vacation yearly.

This year, she advised superintendents of nurses, two additional subjects will appear on examination papers: hygiene and sanitation and mental nursing. Miss Burgess mentioned the need of grading schools.

### The Length of the Course

The evening session covered many important points. In discussing the Rockefeller Report, M. Adelaide Nutting believed that the twenty-eight months' course might be sufficient for preliminary work if properly planned. Miss Nutting cited the difficulty inherent in the training of a subsidiary group. She urged that this group of workers be inspired with the same respect toward the work as nurses or physicians. She felt that those who undertook the training of attendants must feel themselves obligated to provide opportunities for the progressive mental growth and development of these workers in the future. All work, she pointed out, must possess a leading-on quality.

### Professional Interest

"Do You Know Your Profession?" was the challenge which Miss Roberts delivered to the audience. She urged her listeners to carry interest in and information about the nursing profession to all nurses isolated by circumstances or inclination. "Special" and private duty nurses are "the nurse" to the lay public. The cooperation and the support of that public must be gained through their efforts.

In speaking on "The University, the School of Nursing and the Subsidiary Group," Miss Goodrich showed that education must be

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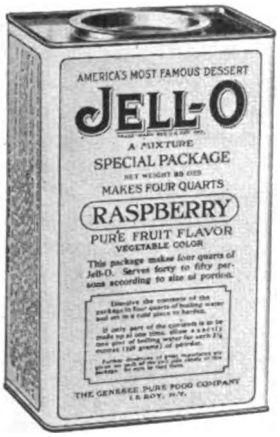


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looked upon as a means* (and a very necessary means) to the great end to be achieved, namely, the broadcasting of new, accurate information so acquired.

Miss Goodrich scored the East for its attitude. The West assumes that all young people will go through high school, and many, college, due to the opportunities afforded in state universities. Statistics show that the East does not compel its boys and girls to finish their preliminary education. The further extension of educational facilities will raise the general level of intelligence. If university education could be made available to all those who are concerned with the use of such knowledge (as are workers interested in physical and mental health), and if their knowledge could be disseminated as quickly as received, we would have achieved the purpose of education.

In discussing the training of nursing aides, Miss Goodrich deplored the placing of any group of workers in a position which would not lead to something higher. She urged that they be aided and abetted in further means of advancement. She advised greater use of affiliation privileges with mental, tuberculosis, and other hospitals.

### Wednesday Sessions

Included in the business reports of Wednesday morning were Miss Burgess' comments on the following points:

(1) In discussing enforcement of the Nurses' Practice Act, Miss Burgess advised that an ethics committee be formed in each district which could sift out information submitted and perhaps, by advice or admonition, bring about enforcement without resorting to legal action. She pointed out that all communications giving information as to possible infringement of the law must include points substantiated by proof; also that they must be signed (although the informer's name would not be used if she desired it withheld).

The person involved is notified of indication of violation; only when persons so notified fail to comply are legal steps taken.

(2) She indicated the growth of an educational conscience as indicated by the facts that several New York state schools had asked the withdrawal of their charter, because they believed they were unprepared to give the best type of nursing education.

(3) The educational qualifications for entrance summarized for the state as a whole gave the following table:

| Preparation | 1920 | 1921 | 1922 |
|---|---|---|---|
| College | 26 | 12 | 20 |
| Partial College | 13 | 4 | 11 |
| High School | 460 | 428 | 678 |
| Two years High School | 309 | 265 | 467 |
| One year High School | 693 | 787 | 1238 |
| Equivalent | 123 | 173 | 277 |

In considering "Principles Effective in Vocational Education," Dr. David Snedden of Columbia showed that the modern educational trend recognized no set standard but rather tended to evaluate the types of work to be handled. In preparing workers to minister to health, this principle might also be applied. However, the type of training must also be adapted to the physical and mental capacity of the nurse. Whatever types and degrees of skill are supplied should be carefully differentiated.

### Vocational Trends

Pratt Institute in its work is developing a "midway" person in the differential types with the idea that such a worker would be "up-graded" at a subsequent time. The tendency seems to caution against "finishing" the worker at the first sitting, so to speak. Physicians build specialties through post-graduate work. If applied to nursing this principle would presuppose the preparation of the worker for the usual work; it would, however, provide more courses for advanced workers to prepare them for leadership. To "waste" this advance training on the young worker is uneconomic. The pick-up (that worker who has matured in his work through five years' experience) is especially valuable as a trainee for leadership.

### Mental Nursing and Psychiatry

In discussing "The Care of the Mentally Ill," Ida Marker stressed the necessity for the early recognition of mental (as well as physical) disease to insure treatment before it is too late. The service of the nurse in prevention can be rendered only if she recognizes the danger signals of dementia praecox, etc.;

* Several college presidents in fall addresses have urged that, since educational facilities offered by colleges are limited, those permitted to profit by such advantages should be those most interested in, and best able to pour this information back into the community. Several educators have attacked these statements as undemocratic, in that all those seeking entrance would not be considered on an even footing. The argument of democracy hardly stands under our present system which lays down financial barriers to many. That men and women who waste four years in higher education (we mean waste it literally, in that they gain little for their own improvement and certainly carry little back to their surroundings) are educated on a false basis, while other purposeful, competent students are barred for economic or other reasons, indicates that a democratic distribution of the benefits of education is not realized at present.

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her nursing service must be backed by knowledge of symptoms, hygiene and specific treatment, as well as an appreciation of the necessary extra-mural adjustments. Harriet Bailey discussed the value of mental nursing to the nurse and Mildred Hurley considered "The Care of the Mentally Ill in Their Homes," from the viewpoint of the follow-up social service worker in (1) ferreting out borderline cases; (2) following up for patients who are on parole because of improvement or arrested condition.

Katherine DeWitt discussed the future of the official organ of the association.

### Endowments, Pensions, Scholarships

Thursday morning was spent in discussing endowments, scholarships, pensions, and other alumnae association problems. At 11:30, in discussing control of tuberculosis, Dr. Edward S. Sweeney emphasized that in the case of tuberculosis the public must be taught working facts about its pathology and course. He pointed out that they must be made to realize that almost all persons had tuberculosis in its quiescent state and the run-down condition or contributing cause produced an active state. He advised nurses to teach their patients to assume a normal attitude toward themselves and their environment after the active stage of the disease passed, just as they would after gout or infection.

### Points for Private Duty Nurses

On Thursday afternoon, Louise Parsons's paper urged that nurses who are being prepared to take up private duty be fitted to meet social and economic situations in the homes of wealth or poverty. She advised that nurses be taught to do competent, aseptic nursing with the minimum equipment available in modest private homes; that they be instructed in correct dress for formal and informal occasions; that they be made familiar with recognized social usage—table manners, forms of introduction, etc.—all the points which, in mid-Victorian phraseology were termed "parlor manners," thought interpreted in a franker, freer spirit today; that they be coached in the proper forms for formal, informal and business correspondence, etc. Agnes Renton discussed the obligation of the "special" hospital nurse toward the hospital in which her work is planned.

Mrs. Anne L. Hansen was elected president of the New York State Association; Mrs. Kline will remain as secretary. Amy Hilliard was elected president of the League. Mary C. Nelson was re-elected president of the New York State Organization of Public Health Nursing.

The report of the Friday session, devoted to the public health, will appear in the January issue.

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## OKLAHOMA NURSES MEET

The Oklahoma State Nurses Association met in Muskogee, October 24-26, with over 150 nurses present. The convention was especially valuable in establishing a unified spirit among the nurses of the state. Important papers on "The Duty of Superintendents Regarding the Acceptance of Public Nurses who Have Previously Been in Training," Mae Mathers; "Conferences to Eliminate Interhospital Friction," Antoinette Light; "Student Government," Katherine Yocum; "Private Duty Nursing," Mrs. Charles Light; "The Attitude of Employing Superintendents Toward Unregistered Nurses," Grace Irwin, and many technical papers by Dr. C. V. Rice and others. Olive Salmon, state president, presided at the meetings.

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## PITTSBURGH IN 1923

The Pennsylvania State Nurses' Association decided to meet in Pittsburgh in 1923. The following officers were elected: President, Miss Margaret A. Dunlop, Philadelphia; first vice president, Miss Netta Ford, York; second vice president, Miss Jennie Huff, Pittsburgh; secretary-treasurer, Miss Gertrude Heatley, Pittsburgh; directors, Miss Wilmelmina Duncan, Pittsburgh; Miss Janet Grant, Scranton.

Important discussions (in addition to those announced in November) included: "Ten Conclusions from the Report of the Rockefeller Report," Lillian Clayton; "School Nursing," Anna Stanley; "The Well Baby," Dr. Noble; "Communicable Diseases," Elizabeth Miller; "The Public Health Nurse and Her Contribution to Literature," Gertrude Hodgman; "Nutrition," Anna L. De Planter; "Education, a Means, not an End," H. H. Zeiser; "The Value of Affiliations," Susan C. Francis; "Central Schools," Mabel Huntley (read by Jane Huff).

Roundtables in venereal disease, Red Cross Work (conducted by Clara D. Noyes) and private duty problems were spiritedly conducted.

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The following officers of the three sections were also installed: Private duty chairman, Miss Rose C. Ford, Wilkes-Barre; vice chairman, Miss Rosalie McIntosh, Philadelphia; secretary, Miss Katherine Hope, Wilkes-Barre.

Public Health chairman, Miss Harriet Frost, Philadelphia; vice chairman, Miss Anna Laurie, Pittsburgh; secretary, Miss Netta Ford, York.

League of Nursing Education, chairman, Miss Helene S. Herrman, Philadelphia; first vice chairman, Miss Roberta M. West, Philadelphia; second vice chairman, Miss Gertrude L. Heatley, Pittsburgh; secretary-treasurer, Miss Mary Rostanci, McKeesport; directors, Miss Sarah M. Murray, Philadelphia, and Miss Roth, Pittsburgh.

## NEW JERSEY ASSOCIATION BECOMES OF AGE

The New Jersey State Nurses' Association celebrated twenty-one years of development at its Atlantic City meeting held November 3-4. Irene Fallon, a graduate of Cooper Hospital, Camden and Martha R. Cameron of Atlantic City were its first president and vice president. The morning session, after the addresses of greeting was given by Mayor Bader and Annie I. Curry, was occupied by the address of Elizabeth Higbid as president and the reports of the secretary, Marie Louis, the treasurer, Jennie A. Manley,—who also spoke of the book table, and the State Board of Nurse Examiners, Mary J. Stone; Dr. W. J. Carrington was then scheduled to address the meeting.

In the afternoon, after the reading of the district reports Miss Squire read a history of the association and Miss Higbid gave an account of the Seattle convention. Jane G. Wick exhibited "A Trip to Healthland," and urged the maintenance of educational standards and the solution of the rural shortage.

On Friday the State Organization of Public Health Nursing continued the discussion on standards. Helen Stephenson, president and Mrs. L. F. Gemmel, supervisor of education and of extension work in the Child Hygiene Bureau urged the maintenance of the highest possible standard for the nursing personnel. Dr. Samuel L. Salasin gave an interesting address on the function of the nurse in public health work.

Hettie Seifert, R. N., Miss Dorothy Deming, field director of the Henry Street Settlement. Frances H. Meyers, R. N., supervising nurse of the New York Tuberculosis Committee, and Linda Meirs, field nurse, discussed the advantages and disadvantages of diversified nursing as opposed to specialized nursing by public health agencies in papers read at the closing session of the sixteenth annual conference of the New Jersey Tuberculosis Society.

The practice obtaining in most states provides for the use of specialized nurses for demonstration purposes with a concentration of all nurses under a central head as the ultimate arrangement. This implies, of course, that the general nurses will be thoroughly grounded in the specialties and that highly specialized personnel be available, perhaps, for unusual cases.

## U. S. PUBLIC HEALTH SERVICE

During the month of October the following changes have occurred in the nursing corps of the Public Health Service:

New assignments: Morvyth E. Gwillim, U. S. Marine Hospital No. 2, Boston, Mass.; Gertrude Meade, U. S. Marine Hospital No. 2, Boston, Mass.; Helen Spruill, U. S. Marine Hospital No. 20, Savannah, Ga.; Elizabeth McDonald, U. S. Marine Hospital No. 20, Savannah, Ga.; Edgar Balaban, U. S. Marine Hospital No. 21, Stapleton, N. Y.; Antonia DesLauriers, U. S. Marine Hospital No. 43 Ellis Island, N. Y.; Edith Hartzel, U. S. Marine Hospital No. 43, Ellis Island, N. Y.; Rosalie Manwiller, U. S. Marine Hospital No. 82, Norfolk, Virginia.

Transfers: Anna Healy, U. S. Marine Hospital No. 15, Pittsburgh, Pa., to U. S. Marine Hospital No. 2, Boston, Mass.; Bridget Regan, U. S. Marine Hospital No. 2, Boston, Mass, to U. S. Marine Hospital No. 8, Evansville, Ind.; Elizabeth Haney, U. S. Marine Hospital No. 8, Evansville, Ind., to U. S. Marine Hospital No. 15, Pittsburg, Pa.; Gertrude Fuller, U. S. Marine Hospital No. 14, New Orleans, La., to U. S. Marine Hospital No. 9, Fort Stanton N. M.; Maude Murry, U. S. Marine Hospital No. 14, New Orleans, La., to U. S. Marine Hospital No. 9, Fort Stanton, N. M.; Emma L. Brown, U. S. P. H. S. Dispensary, Washington, D. C., to U. S. Marine Hospital No. 70, Hudson St., N. Y. C.

Reinstatements: Florence Tidd, U. S. Marine Hospital No. 5, Chicago, Ill.; May J. Austin, U. S. Marine Hospital No. 5, Chicago, Ill.; Florence Straus, U. S. Marine Hospital, No. 21, Stapleton, N. Y.; Aleta Manning, U. S. Marine Hospital No. 21, Stapleton, N. Y.

LUCY MINNIGERODE,
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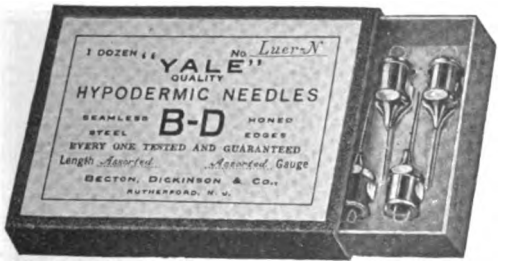


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## IOWA NURSES MEET

Centralization of training schools was the chief subject of discussion at the Iowa State Nurses' Association in Sioux City, over which Amy Beers presided. Margaret Smylie of Sioux City and Dr. Richard Olding Beard of Minnesota believed such a course would raise the educational standards. Sister Redempta of Dubuque believed the arrangement would prevent proper correlation of theory and practice.

In discussing the standard of Iowa schools Anna Drake advised against the lowering of the three-year period until Iowa schools were established on a more educational basis.

That the association should adopt a policy of defensive legislation, working for the enforcement of the present nurses' bill rather than for new legislation at this time, was the general thought expressed by speakers from the floor during the discussion of a legislative program for 1923, which was led by Miss Anna Drake, of Des Moines, state director of public health nursing.

In discussing nursing ideals Father Mahon of the Catholic Hospital Association, said:

"Heart and skill must be manifested in ministrations to the sick. Nurses must recognize there are too many of them who do not measure up to the high ideals. It is an imperative necessity that provision be made for the proper nursing of those of moderate means. Every individual worthy of respect must contribute something to the common good, and the nurse should not be an exception to this rule. If the nurses sacrificed a certain number of days' service and they were pooled, the profession would make great strides in the estimation of the public.

"It seems to be an age of commercialism and grasping, and the medical and legal professions are reeking with it. The nursing profession should be devoted to ideals and expect some sacrifice of its individual members. Preach to the public the need of establishing funds for those who cannot pay for nursing service."

The first day's session was devoted to Red Cross work under the chairmanship of Elizabeth Reynolds. "The Necessity of Wide Cooperation" was discussed. In the afternoon "Publicity Health Plays and Pageants" were discussed. Miss Elsie Witchen, nursing representative of the central division with headquarters at Chicago, presided at the evening session.

One feature of the convention created much interest—an illustrated lecture on the making of antitoxin.

Miss Gyda Bates, secretary of the state association of graduate nurses, presented an extended report of the national convention held at Seattle, Wash.

Rose O'Connor gave an interesting talk on the value of libraries.

Dr. W. S. Conkling urged that nurses serve as educators in the venereal disease campaign.

Amy Beers, of Fairfield, Ia., was re-elected president.

Other officers elected were: Augusta Hefner, of Sioux City, first vice president; Winifred Boston, of Cedar Rapids, second vice president; Nellie R. Morris, of Iowa City, Ia., re-elected secretary, and Adah J. Hershey, of Des Moines, Ia., treasurer.

The private duty nursing section was formally organized, with Winifred Boston, of Cedar Rapids, chairman; Frances Hutchinson, of Council Bluffs, vice chairman, and S. Pederson, of Dubuque, secretary.

## CHICAGO GREETS ILLINOIS NURSES

The annual meeting of the Illinois State Nurses' Association was held at the Congress Hall, Chicago, October, 25-26-27. The attendance at the sessions ran as high as 700 and registrations showed that nurses from all parts of the state were present. Under the direction of the president, Miss Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, Ill., a program on a par with that of the national organization was arranged.

The Wednesday morning session was devoted principally to routine business. An address by the national president, Miss Adda Eldredge; a brief talk by Mrs. Barbara Bartlett, president of the Michigan State Association, and by Miss Helen Scott Hay, director of the American Red Cross nursing service in Europe were other features of the Wednesday morning gathering.

Tuberculosis was the subject which occupied the program of the afternoon session, including a round table on various phases of this disease, a demonstration of the Modern Health Crusade by Miss Frances Cook, crusade director, Chicago Tuberculosis Institute, and an interesting paper on "Tuberculosis Training

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Lowell—The Bon Marche
Madison—Family Shoe Store
Milwaukee—Brouwer Shoe Co.
Minneapolis—25 Eighth St. South
Mobile—Level Best Shoe Store
Newark—897 Broad St. (2nd floor)
New Bedford—Olympia Shoe Shop
New Britain—Sloan Bros.
New Haven—153 Court St. (2nd floor)
New Orleans—109 Baronne St. (Room 200)
New York City—14 W. 40th St. (opp. Public Library)
Oakland—205 Henshaw Bldg.
Omaha—1708 Howard St.
Paterson—10 Park Ave. (at Erie Depot)
Pawtucket—Evans & Young
Peoria—Lehmann Bldg. (Room 203)
Philadelphia—1300 Walnut St.
Pittsburgh—The Rosenbaum Co.
Pittsfield—Fahey's, 234 North St.
Plainfield—M. C. Van Arsdale
Portland, Me.—Palmer Shoe Co.
Portland, Ore.—353 Alder St.
Poughkeepsie—Louis Schonberger
Providence—The Boston Store
Reading—Sig. S. Schweriner
Rochester—148 East Ave.
St. Louis—516 Arcade Bldg., opp. P. O.
St. Paul—43 E. 5th St. (Frederick Hotel)
San Francisco—Phelan Bldg. (Arcade)
San Jose—Hoff & Kayser
Schenectady—Patton & Hall
Scranton—Lewis & Reilly
Seattle—Baxter & Baxter
Spokane—The Crescent
Springfield, Ill.—A. W. Klaholt
Springfield, Mass.—Forbes & Wallace
Syracuse—121 West Jefferson St.
Tacoma—255 So. 11th St. (Fidelity Bldg.)
Toledo—LaSalle & Koch Co.
Trenton—H. M. Voorhees & Bro.
Troy—35 Third St. (2d floor)
Utica—Room 104, Foster Bldg.
Washington—1319 F Street
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*Youthful Ease and Balance—She Wears Cantilevers*

*Over the world, with outspread wings,*
*The Spirit of Christmas broods and sings*
*Of happy, hopeful, helpful things—*
*All for you and me.*
—BERTHA E. JAQUES.

When the "Spirit of Christmas broods and sings" over the world, Cantilever Shoes will help you to put the finishing touch to yuletide decorations with youthful ease and balance. They are one of the "happy, hopeful, helpful things" which give you that "ease of heart" so desirable all the year.

Women who do Christmas shopping and saleswomen who stand long hours, find that Cantilever Shoes keep their feet rested and young feeling, and relieve the strain at this busy season.

The flexible arch of Cantilevers allows the muscles, ligaments and joints to exercise naturally, carrying the body with ease and resilience. The natural sole line, the trim yet roomy toe, the correctly placed medium or low heel all combine to keep the spine straight, the chest up, and give the body greater endurance because it assumes a youthful balance.

Every pair of Cantilevers is trademarked to insure your getting the genuine. Except in New York City they are sold by only one store in each town. If the Cantilever dealer near you is not listed here at the left, write the manufacturers, Morse & Burt Co., 3 Carlton Ave., Brooklyn, N. Y., for his name and address and for a booklet which tells about feet and shoes.

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for Student Nurses and Prevention of Tuberculosis Among Students and Graduate Nurses," by Miss Anna Drake, director of public health nurses, state department of health, Des Moines, Iowa.

The second day was crowded with new ideas. The speakers included Charles B. Lowry, division superintendent of schools, Chicago, whose subject was "The Real Purpose of the Institute"; Professor Elmer E. Jones, of the Department of Education, Northwestern University, who spoke on "Principals of Education," and Professor William B. Owen, Chicago Normal College, who discussed "How the Project Method in Teaching May Apply to Nursing Education."

A series of demonstrations of a Child Welfare Clinic by the Infant Welfare Society, a demonstration of nursing in the home, and a demonstration of a practice class in teaching materia medica to student nurses followed. Miss Frances Ott, chairman of the private duty section of the American Nurses' Association. Miss Milly Brown, chairman, private duty section, Illinois State Association, and Miss Augusta Giller, private duty nurse of Presbyterian Hospital, Chicago, participated in the nursing demonstration, while Miss Dora Saunby, an instructor at Michael Heese Hospital, Chicago, had charge of the practice class.

The Friday morning session was given over to a question box conducted by Miss Bertha L. Knapp, superintendent of nurses, Wesley Memorial Hospital, Chicago. This was followed by a paper on "The Value of Experience in Public Health Nursing to the Student Nurse," by Miss Mabel Binner, supervisor, Visiting Nurse Association, Chicago. The concluding session was conducted by the Illinois League of Nursing Education, over which Miss Carol Martin, executive secretary of the Central Council for Nursing Education, presided. An interesting, helpful address by John A. Lapp, director of the department of social action of the National Catholic Welfare Council, was a feature of this meeting. Mr. Lapp praised the results obtained by nurses in their efforts to standardize nursing education and to insure continued professional development and he asserted that the big problem now before everyone engaged in health service was that of a proper correlation of the efforts of the numerous organizations so that there would be no duplication.

The program concluded Friday night with a banquet at which addresses were made by Dr R. M. Mann, D.D., and Miss Hay.

The association officially approved a plan to establish a cottage for nurses suffering from tuberculosis. This cottage is to be erected on the grounds of the Edward Sanitarium at Naperville.

The new officers of the association are: Mabel Dunlap, American Red Cross, Moline, president; Sarah B. Place, superintendent, Chicago Infant Welfare Society, first vice-president; Nellie M. Crissy, superintendent of nurses, Hahnemann Hospital, Chicago, second vice-president; Mae Kennedy, director of nursing, Chicago State Hospital, secretary; Elizabeth A. Asseltine, superintendent, Victory Memorial Hospital, Waukegan, treasurer.

The following officers were elected by the Illinois League of Nursing Education: President, Mary Cutler, Presbyterian Hospital, Chicago; vice-president, Ida Smith, Evanston Hospital, Evanston; secretary, Dora Saunby, Michael Reese Hospital, Chicago; treasurer, Margaret Daly, Children's Memorial Hospital, Chicago.

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## KNOXVILLE ENTERTAINS TENNESSEE NURSES

The Tennessee State Nurses' Association listened to some very interesting papers at the Knoxville convention. Dr. S. H. Hodge gave an address on "The Use of Radium in Cancer," and Dr. B. I. Harrison lectured on goiter.

Dixie Sample discussed the need of state legislation by the nursing profession; Leah Fletcher, superintendent of the Knox County Industrial School, spoke on the subject, "The Nurse and the Business Woman," and Miss Devine spoke on "The Nurse in Follow-Up of Disabled Veterans," while Miss Chase spoke on venereal disease nursing.

Mrs. Dorothy T. Gould was re-elected president; Mrs. George Blair, vice president; Miss Katherine Andrews, of Chattanooga, second vice president; Miss Annie Feltus, of Memphis, secretary; Mrs. Mary Hathcock, of Knoxville, treasurer; and the following chairmen of committees: Miss Evelyn Chase, ways and means; Miss E. Boyer, publicity; Miss N. Plevis, national relief; Miss Josephine Wright, revision; Miss McIntosh, nominating; and Mrs. C. E. Ferree, assignments and program.

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That surprisingly few Mothers pass through pregnancy, confinement and convalescence, without suffering from Hemorrhoids, or lesser rectal troubles likely to develop into Hemorrhoids.

With proper treatment, at the right time, few of these cases need ever reach the stage of *necessary* operation. ANUSOL SUPPOSITORIES, prescribed by physicians of all nations, for nearly a quarter of a century, score some of their best results in the Hemorrhoids of that period.

Besides, they reduce the need of internal medication to relieve constipation.

Which means better, and more digestible Mother's milk for the Infant, and a quicker return to *normalcy* for the Mother.

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## VERMONT NURSES MEET

The fall meeting of the Vermont State Nurses' Association was held October 7 in the Parish House at Proctor.

Miss Corey, the vice president, presided in the absence of the president, Miss Van Patten, who was ill. About 75 members were present.

Reports of the Burlington meeting and a lengthy account of the Seattle convention by Miss Van Patten were read.

The question of the proper licensing of nurses was carefully discussed.

After supper, served by the Proctor nurses, Miss Gilman of the Good Samaritan Hospital, Troy, N. Y., discussed possible registration laws permitting special classifications and providing a penalty for misrepresentation.

During the social hour which followed, a duet and a violin solo were played by Proctor nurses.

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## MINNESOTA NURSES HOLD CONVENTION AT ROCHESTER

The sessions of the Minnesota State Nurses' Association held at Rochester, were enlivened this year by a stiff talk by Dr. MacCarty, pathologist of Rochester. "To serve the public at the least possible cost should be the basis of all our endeavors," he said. "Anything else must be classed as profiteering."

Dr. MacCarty bitterly opposed the standard of uniform scale of fees in the nursing profession. "It makes the weak appear strong," he said, "and makes the really strong weak. If some nurses are worth $45 a week, some are worth $200 a week and others are not worth fifty cents."

He likened an arbitrary standard of set fees for nursing service to that of "cornering the market," and warned the nursing profession against the contamination with commercialism.

"We are making graduates in medicine but failing in the making of good doctors. We are attempting to make too many specialists and are making them too rapidly. A good doctor does not need all the details of specialization. The same applies to the nursing profession."

Every woman, he said, should be an unregistered trained nurse through proper instruction in home nursing in the public schools.

The opportunity for visiting and consulting nurses, to be called in to give advice just as a physician is called in, was also commented upon.

In closing his address Dr. MacCarty believed that the solution of the present nursing problem "rests in education rather than legislation and public argumentation."

The addresses of Dr. Charles and William Mayo succeeded in pouring oil on troubled waters. Dr. Charles Mayo pointed out that the shortage of doctors in rural districts might be less felt if properly qualified nurses could take charge of rural health centers, care for simple ailments and make arrangements for securing physicians and surgeons in serious cases. He predicted that during the next ten years doctors would more than ever before be the associates of nurses in professional work. More intensive training for nurses who desire to go on with their work was also suggested.

In discussing legislation Dr. William H. Mayo urged that proposed laws be satisfactory to both physicians and nurses. Dr. Mayo advised that the minimum course be limited to two years, with the maximum prescribed by the nurse herself. He thought that the three-year course should be continued for all those who desire specialization.

The medical schools, he said, have in some respects over-reached their mark and he feared that nursing is following the same course. One course open is to train medical students in the care of the sick and leave specialization to the more brilliant students in post-graduate work.

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## NORTH CAROLINA

Fall examinations will be held in Raleigh, N. C., from Dec. 4 to Dec. 7, 1922, for nurses applying for licenses in North Carolina.

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## METROPOLITAN NURSES MEET

Dr. Lee K. Frankel, supervisor of the nursing service of the Metropolitan Life Insurance Company, addressed the nurses of the western division at the Hotel Benson, Portland, in late September. Alice C. Bagley, Pacific Coast nursing supervisor, was present as Dr. Frankel's aid to interest Oregon nurses. Bishop Manning and Bishop Fiske of New York brought out the humanitarian service which the company rendered in aiding and teaching citizens to preserve health. On the following day President Haley Fiske outlined, among other topics, the growth of the nursing service.

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that encourages the construction of red cells.
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that constitutes life and living.

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often affect the nurse herself to such an extent that she "comes off a case" tired out and feeling the necessity for rest and recuperation.

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a teaspoonful in a glass of water, with sugar added to taste, makes a refreshing, mildly acid, thirst-quenching draught, but what is more important, constitutes a valuable tonic, and restorative medicine which helps the nurse while on duty and while resting between cases.

**Send for sample if desired**

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For the nurse herself, Amolin insures freedom from perspiration odors and absolutely destroys the odor of sanitary napkins.

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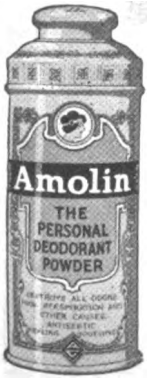


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Always have a tube or jar of it in your kit or cabinet and advise the use of it in the homes you visit. Your druggist carries it.

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"Shake hands with health every day"

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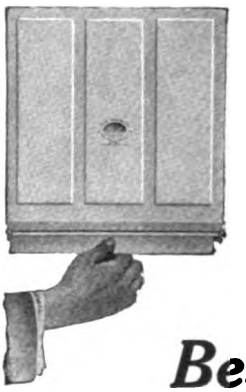

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STATE OF ILLINOIS, Department of Public Welfare.—The Illinois State Training School of Psychiatric Nursing offers a six months' post-graduate course of lectures and practical instruction in the care of mental and nervous cases to registered nurses from accredited schools. The course includes psychiatry, with clinics, psychology, hydrotherapy, occupational therapy and amusements. The field work is performed in wards reserved for the pupils of the school, and accommodation is provided in the home set apart for the training school. A certificate is granted upon the successful completion of the course. Allowance, $35.00. For further information apply to Superintendent of Training School of Psychiatric Nursing, Chicago State Hospital, 64th and Irving Park Boulevard, Chicago, Ill.

THE CHICAGO LYING-IN HOSPITAL OFfers a four months' post-graduate course in obstetric nursing to graduates of accredited training schools connected with general hospitals, giving not less than two years' training. The course comprises practical and didactic work in the hospital and practical work in the out department connected with it. On the satisfactory completion of the service a certificate is given the nurse. Board, room and laundry are furnished and an allowance of $10 per month to cover incidental expense. Affiliations with accredited training schools are desired as follows: A four months' course to be given to pupils of accredited training schools associated with general hospitals. Only pupils who have completed their surgical training can be accepted. Pupil nurses receive board, room and laundry and an allowance of $5 per month. Address Chicago Lying-In Hospital, 426 East 51st Street, Chicago, Ill.

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POST-GRADUATE TRAINING SCHOOL FOR Nurses, Manhattan Eye, Ear and Throat Hospital, 210 East 64th Street, New York City, offers a course in special diseases and operating room training of the eye, ear and throat. The course will be both theoretical and practical. Instruction will be given by means of lectures, demonstrations, teaching at the bedside and in the regular performance of duties. The new residence for nurses, which has been occupied since January, 1918, provides separate rooms and excellent facilities for the comfort of the nurses. A registry is maintained for our graduates at the Hospital, and a limited number of graduates who complete the course of instruction may obtain permanent institutional positions. Graduate nurses from recognized schools will be admitted for a term of three months in the Eye Department, three months in the Ear and Throat Department, or the combined course consisting of six months. Remuneration thirty dollars ($30.00) per month and uniform, board and laundry free. For further information apply to Superintendent of Nurses, 210 East 64th Street, New York City.

THE HOSPITAL FOR CONTAGIOUS DISEASES offers a Post-Graduate Course of three months to graduates of registered schools for nurses. Students have fifty-two hours off duty weekly. The compensation allowed is $42.00 per month, board, room and laundry. Dates for entrance are October 1st, January 1st and April 1st. For information apply to the Supervising Nurse, Philadelphia Hospital for Contagious Diseases, Second and Luzerne Streets, Philadelphia, Pa.

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| Water | 5.62 |
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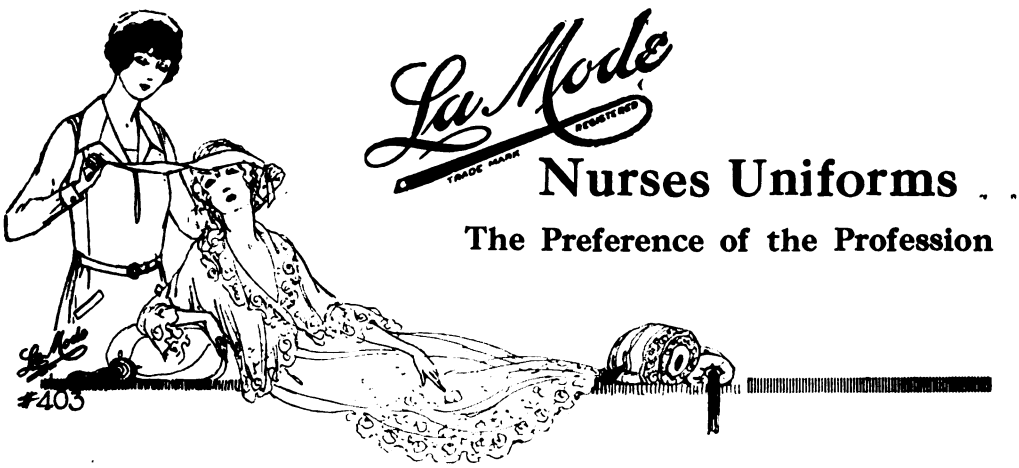


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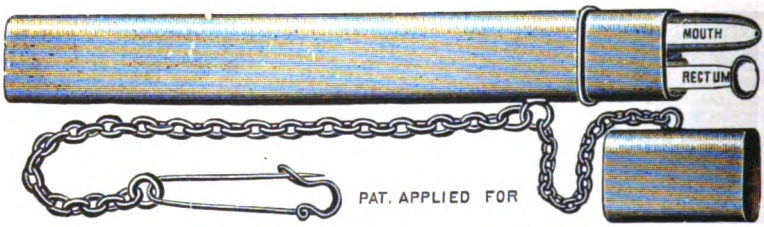


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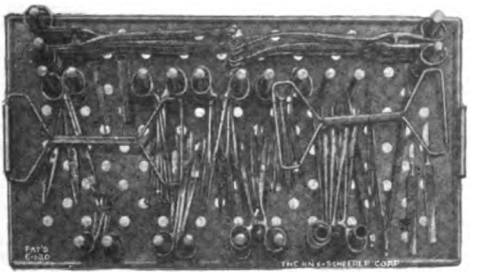

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Four hundred and twelve pages, with 86 illustrations, covering every conceivable subject a nurse is expected to understand, and more—all so arranged under Subject Headings, sub-divided, and cleverly indexed, that information sought may be instantly found. The subjects covered range from Anatomy to Diet for the patient and include

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**By LAURENCE HUMPHRY, M.A., M.D., Formerly of Addenbrecke's Hospital, Cambridge, England**
**First American Edition Revised and Enlarged by W. MYRON REYNOLDS, M.D., New York City**
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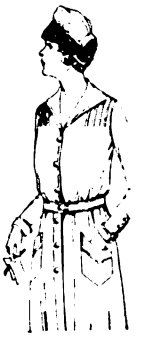

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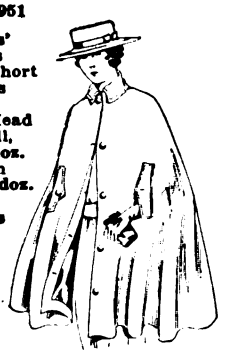

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