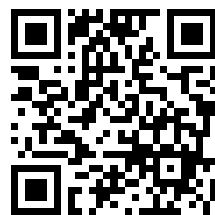

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THE TRAINED NURSE

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The Pioneer Nursing Publication of America

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The Trained Nurse and Hospital Review

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No. 1

The Value of High Ideals to the Trained Nurse

MARY A. MESSER, R.N.

IT MATTERS not what profession, occupation or business a person may choose for his life work, if he does not have a mental conception of perfection he will not reach the highest form of success. This does not mean that the individual with high ideals is a dreamy, visionary sort of person, for it is the person with the highest ideals who is the most practical, for he endeavors to materialize the high standards forever before the mind. Neither does it mean that the idealist is a hero-worshiper only in the sense that any life which has been a marked success always calls forth ambitious longings and the desire to succeed in those who come after.

To the young woman who takes up nursing, high ideals are absolutely essential if she would reach the highest rung on the ladder of success. If she does not enter the hospital with a certain amount of enthusiasm, which daily grows more ardent, calling forth zeal and love for the work, she had best call a halt. If the work means nothing more to her than a life of drudgery, whereby she is able to collect a few dollars for her maintenance, she will find neither happiness nor success. Service given unwillingly only for the thought of the financial compensation will bring no thrill of joy. To older nurses, and to those who have the care and instruction of nurses in training, it is the privilege and duty to inspire high ideals, thus

educating the young nurse to the highest form of service. The probationer should be taught that there is an ideal way of giving the patient a drink of water, arranging the hair or performing any little office in the sick-room.

No nurse can read the life of Florence Nightingale without having high ideals involuntarily formed. The mental picture of Florence Nightingale in the Barrack Hospital at Scutari, going about with her lantern is always an incentive to the nurse on night duty, making her anxious to have the same fortitude, endurance, patience and love for her work which inspired the heroine of the Crimea.

The ideals of Pastor Fleider, Elizabeth Frye and Florence Nightingale which they endeavored to work out in years gone by are becoming realized today. It is therefore just as possible for our high ideals in the care of the sick and the prevention of disease to become real in the future. The individual nurse with high ideals is bound to succeed. She will not be untidy about her own person, in the sick-room or in the care of the patient. High ideals will help her in the matter of etiquette towards her patients, the doctors and her associates in the world outside, as well as in her professional work. She will be clean in word and speech, not given to slang and relating vulgar stories with her

patients, which is not uncommon with many nurses. Her professional work will prosper, for she will read and study, thus keeping abreast with new methods and the progressive spirit of the age. Addison said: "What sculpture is to a block of marble, education is to an human soul." If the nurse would, by much reading and study, endeavor to educate herself, not only in nursing affairs but in all lines, wherever opportunity offers, she will become liberal in her views, broad-minded, with a deeper sympathy for all mankind. Her standard of perfection will not permit her to slide backward, but she will always be in the front ranks. She will not seek to escape hard work but, health permitting, will always be ready for service whenever called. She will be a woman chaste and pure in all things and although she may not become known to the world at large, she will be popular in her own little world. As some one has said: "No life can be pure in its purpose and strong in its strife and all life not be purer and stronger thereby."

Every nurse should form high ideals not only as a duty to herself but a duty which she owes to the nursing profession in general. Our work is broadening each year. New lines of service are opening up for the nurse which did not exist thirty years ago. When a nurse leaves the hospital today, she can to a certain extent choose whether her work shall be private duty or confined to some other of the various and lucrative positions which the time has demanded. It is therefore important that in whatever work she is called, her ideals may be so high that her

work will show up to the best advantage, so that the profession may be raised to a higher standard in the eyes of the public.

To the public, people outside of the profession, people who have little or no interest in the nurse, people always ready to criticize and look for faults, people who are not in sympathy with the work, it is most important that the graduate nurse's life should be so ideal that there will be much less chance for criticism.

More is expected of the nurse today than ever before. The laity are better educated than formerly; indeed, to some extent the outside world has raised the standard of nursing and the profession must not fall short. Therefore, it is very essential that from the probationary period the nurse should form high ideals. First, for her own success; second, for the success of the profession, and third, that the public may have greater faith and less chance to criticize the professional nurse. "Hitch your wagon to a star," as Emerson said, is a good maxim for the nurse, not that she can ever reach perfection, but that high thinking and a certain standard of perfection before the mind may aid to better service and good professional habits.

Having chosen nursing for her vocation, the young woman should give the best that is in her to those she serves, cheerfully and willingly, following out the Golden Rule in daily conduct. If she does this her life will not only be useful but happy, for happiness always follows from right living, right thinking and duties well performed.



Bedside Teaching

ADMINISTRATION OF MEDICINES

AMY A. ARMOUR, R.N.

Former Superintendent New Rochelle Hospital, New York

THIRD PAPER

A VERY common complaint made by the laity and by old graduates about the modern trained nurse is that she is taught too much theory and not enough practical work. But most superintendents will agree that the nurses are taught none too much for them to do their work intelligently, and that the trouble lies elsewhere. They are not kept drilled in each thing till they do it thoroughly. When we think of what a nurse ought to know, and where she fails ignominiously on private duty, if she doesn't know, we must say that she cannot be taught too much, but must be drilled in each point. When a nurse fails to make good, it will be found that she never had seen a certain treatment, or had a misconception of the only demonstration she did see, because of fatigue or absent-mindedness. My chief reprimand during training was about putting a long binder on a maternity case, the demonstration having preceded my work almost two and one-half months. My binder looked good, too. It was the way I went about it.

The policy of "Safety First" should be adopted by every hospital board, in regulating the number of supervisors, to prevent some of the awful catastrophes that occur in the administration of medicine. Here, again, the actual overseeing of a young pupil must go forward steadily for at least two years, and even then we cannot be positive that things will always be safe. From the moment a drug is ordered until the patient who uses it is discharged cured, every means should be taken, in kind, cost, tests, dispensing and administering to be sure that it is

pure, good, correctly handled and effectual. To the "man on the street," giving medicine is the simplest part of caring for the sick, but he makes more noise when a nurse makes an error than if he did so himself. Omitting the responsibilities of the buyer, whether he be a superintendent or a pharmacist, and the dispensing, which should not be at any time undertaken by a nurse, one may consider:

1. The classes in materia medica, combined with arithmetic.
2. The special technique of a hospital in handling its ward supplies.
3. The peculiarities in administering certain drugs.
4. The effects in each case on the patient.
5. The patient's viewpoint, regarding system, regularity, dilution, comfort, promptness of first dose and prevention of errors.

It is usual to have a good lecturer for the subject of materia medica. He can frequently consult the ward medication slips, to make a practical application of points in the abstract class work. The nurses should keep a materia medica text-book in every drug closet, for reference. It is of much benefit, when the effects of a drug are to be carefully observed, and it is also much easier to remember the dosage by doing this. The subject should extend over two years, one-half at least of which should be spent in the arithmetic of drugs. The usual mistake of a poorly trained nurse is to give half a grain of morphine when an eighth grain is ordered, thinking that an eighth is twice a quarter. This is really theory, but the application is practical. Every time a nurse has to alter

a tablet, she should solve the problem on paper and submit it to some one higher up. Even then there is only one in five who can do all such problems correctly. But I do not advocate keeping a nurse's intellect in swaddling clothes by providing her with all strengths of all drugs. Such nurses are no use in an emergency. It is to be hoped that no one will take offence at these blunt observations, or at the submitting of two models to follow.

If a dose of potassium acetate gr. xx be ordered, and the stock bottle is marked grs. xv = $\text{3}\text{r}$, how much should be given?

The answer will be minims or drams.

Arrange what you know so that what you want to find out comes last in the reasoning process.

If grs. xv = $\text{3}\text{r}$ or 60 minims, then gr. r = one-fifteenth of 60 m. = 4 minims,

and grs. xx = 20 times 4 m. = 80 minims.

If strychn. sulph. gr. one-fortieth be ordered, and we have only thirtieths, what should we do?

Take a number of minims of water, for the dissolving of the tablet, such as 12, which must contain the odd factors in 40 and 30.

If gr. one-thirtieth is dissolved in 12 minims of water, then gr. r would require 30 times 12 minims to dissolve it to maintain the same strength = 360 minims (or thirty-thirtieths) and gr. one-fortieth would be contained in one-fortieth of 360 minims = 9 minims.

But the tablet was dissolved in 12 minims. 12 less 9 = 3. Expel 3 minims and give 9 minims.

The time is far past when medical students gave the drugs and the treatments on hospital wards, and had to leave for lecture and thus miss the effects. The chief reason for placing this subject on the nurses' curriculum is, therefore, to ensure the vigilance of a responsible person after drugs are given, to report or correct their physiological ac-

tion. An excellent "drug sheet," being a concise résumé of the commoner medications, was prepared by Miss Rykert while superintendent of nurses at the Post-Graduate Hospital, for her pupils, and may still be obtained there. It contained all the essential facts and could easily be carried around.

The physicians should be shown to their complete satisfaction that the drugs bought are pure and properly dispensed; this being easily arranged by the rulings of a drug committee from the medical board. If there is no pharmacist on the staff, the neighboring druggist will gladly do the hospital dispensing at cut rates to get the private patients' trade.

But internes and nurses are not pharmacists, and ought to have too much to do, in their own sphere, to have the work of a different profession loaded on to them. Besides, they are too hard to find. Unfortunately, many supervisors are too glad to hide in a drug room, far from the disagreeable ward odors and sights, rather than give bedside instruction in the effects to be watched for.

The drug closet should be well lighted, day and night, the key constantly in the hands of the charge nurse, so that no patient or orderly can steal cocaine, alcohol or poisons. If the supervisor walks off with the key she finds in the door, it will teach the nurse to remember. The poisons should be in a separate closet, or in a separate section of the main cabinet, such as the walled-off corner designed by Miss Emmott. The bottles should be a special color and shape, bearing a specially colored label. Any device on the bottles in the way of bells, lights, shape or color should be used to warn nurses that they are in the danger zone. As to oxalic acid and other hospital bugbears, it is not necessary to have them on the premises. The time is gone by for surgeons to paint themselves with K M. O. as did the ancient Britons with woad.

The simple forms of diluting with fresh, cold water, washing the glass after any patient uses it, having plenty of glasses, letting no water stand on the tray, etc., are very essential, but require constant chasing up. Miss C may leave all the tray mussy if she is in a hurry to get off for her recreation. Miss D may bring it into the work room to clean it up and forget it. The night nurse, by the way, should collect all the medicines for her regular orders in the pantry or whatever room she occupies at night, and should keep them under the strongest light, so as to avoid disturbing the patients by choosing or cleansing the bottles.

There are many peculiarities about the administration of drugs, which, if not known, would make them ineffectual or injurious. Each new drug ordered should be read up, and the special features noted:

Iodine—to be given on loaf sugar.

Turpentine—by mouth, on sugar; by rectum, emulsified drop by drop in an oil.

Iron—with a drinking tube, in syrupy vehicles, far back in the mouth.

Licorice powder—dissolved first in whiskey.

Creosotal—in warm milk.

Lassar's paste, or Cantharides—shave the part.

Pills—offered on a spoon, never in the nurse's fingers.

Powders—laid on the tongue.

Mercury inunctions follow a regular schedule: Right axilla, left groin, left axilla, right groin, the nurse wearing a glove.

The alert pupil who asks about all drugs is as valuable as the old nurse with experience in only a few.

Each hospital has its own technique in giving a hypodermic injection. Have you tried giving each nurse her own hypodermic syringe to carry at all times? She will keep it in good condition and always have it ready. On a private corridor it might be wise to have one for any easy-going special nurse who has not one of her own. A drill

should be repeatedly held to enforce all the niceties in giving a hypodermic injection—no leaks, proper direction, depth and location, since a great many are not well given.

Following this comes the long list of modern treatments now relegated to the nurses, such as rectal anesthesia, or the introduction of a vaccine or a serum. The pupils should be taught incidentally the names and addresses of the various laboratories putting up these products, the proper way of keeping the goods, inspection of the date when their fitness expires, and the list of kinds that should be kept on hand. There is nothing to hinder small rural hospitals from being up-to-date in this respect. There will be times when salvarsan must be given and the operating-room nurse should know instantly how to mix it with normal saline, and how to put the apparatus together. Once more let this point be pressed, that graduate nurses who choose any special line of work, for instance, operating-room work, should be urged to come up to a certain standard, every two or three years, composed of questions on the latest technique in anesthesia, preparation of the skin, instruments, etc. An effort, also, should be made at hospital conventions to standardize operating-room technique, which at present varies with every hospital.

Bitter complaints are made by ophthalmologists in even the best of hospitals about the quality and preparation of the valuable drugs they must use, whose effectiveness is marred by one degree temperature too high or too low, or by being produced from an inferior source. This complaint should be respected up to the point where either grade of drug produced the same results, since the surgeon is so earnest, the eye so valuable and the patient so powerless.

In disinfection and fumigation, some uniformity ought to be arrived at, with the help of the pathologists, for all hospitals in caring for beds, bedding, rooms, wards, clothing, utensils, etc., after each sort of

illness. Failing this, one might do wisely to follow the Federal Government methods, where the best experts are employed. To a clever pupil's sensibilities it is very confusing and deadening to be taught a new method by every new head nurse. Here it might be strongly urged to close every hospital ward, in turn, as often as is expedient to clean and fumigate it. But while planning this, do not trust too far your nurses' ability to measure a wall accurately.

The effect of drugs is apt to be lost by a pupil with her nose to the grindstone; that is, dulled by bed-making and back-rubbing in a rushed ward—and the brief visit of the supervising nurse who goes ahead and finds the condition, then makes the pupil find it, is most valuable. Without any help whatsoever, any nurse can feel an over-stimulated pulse or see the blue color of the sclerotics, or an atropine flush, but she may miss the rapid activity of *veratrum viride* in reducing a pulse to the danger point, unless assisted by a vigilant, far-sighted head nurse. This can only be done by the latter keeping tab on all special orders, order books, medication slips and standing orders in the charts. One can do this by meeting the attendings, reporting symptoms, knowing what will be ordered, and arriving on the scene to see the effect.

Insufficient heed is paid to the patient's viewpoint. If he sees a giddy nurse relabeling bottles, to him every dose will be poison. Medicines in hospitals are given in the simplest form, not disguised as by the general practitioner, and the patient will object to taking a certain drug which is of the same nature as he got previously, be-

cause it smells or tastes different. These doubts and fears must be explained away. But it is imperative to have the relabeling of bottles left to the druggist absolutely. When a man is ill enough to come to a hospital, he wants his medicine the minute the doctor orders it, and he should have it. Systems and schedules are for the patient, not for the nurse, and the need of his anxious mind is more important than her convenience. If he comes in at 1.15 P.M. and is ordered infusion of *digitalis* 3ss. q. 4 h., he should get his first dose *at once* and the next about 5, the third at 8, so as to come in on the regular hour. He must not wait till 4. A junior nurse cannot always estimate the dangers of crowding doses, and this necessitates supervision and advice. Any one error in dosage, dilution or administration with one nervous, irritable patient may cause a ferment in a whole ward or cause the physician the loss of the case, in a private family, for employing such a nurse.

The calamity of giving a poison, or an overdose, should be reported at once. The nurses are to be told at all times to report errors at once, without feeling that they will be electrocuted, so that the best antidotes may be employed and the situation retrieved, if possible. "Honesty is the best policy."

The sum and substance of these three sketches on bedside teaching is to urge those women who are at the heads of schools to keep on insisting all the time to have proper assistance in supervision and not to sacrifice their duty to their desire to hold office. Hospitals are too often "penny wise and pound foolish" in these respects.



Efficiency in the Care of the Patient

MINNIE GOODNOW, R.N.

(Continued from December)

UNSATISFACTORY TRAINING OF NURSES—Evade it as we may, we know deep in our hearts that the training we are giving our nurses is not an unmixed success. Miss Mackenzie, of the Victorian Order, stirred the Canadian nurses when she stated recently that "nine-tenths of the students who enter our nurse training schools come out of them changed for the worse." She goes so far as to say, "Dozens of bright, promising women, filled with missionary spirit, eager to help some one to be better, happier and healthier, issue forth from the so-called training schools warped, narrow, mercenary and blase, all their ideals gone, and in most instances gone beyond recall."

While we may not share Miss Mackenzie's extreme view, we know that there is a modicum of truth in what she says. All over the country there is a cry of protest against the inefficiency and unsatisfactoriness and unwillingness of the nurse who is doing private duty. We who train her criticize her as severely as the rest. Even when we contend that it is personality which we are criticizing, we realize that personality is the expression of character, and character is, to a degree, formed by training. Yet we go on saying that we *train* nurses for private duty.

We also contend that hospitals prepare their students for executive positions. There are at the present time two hospitals in the country giving a course in administrative work, these having a total of twelve students per year!

We are claiming to prepare nurses for the many fields which lie open before them: district work, school nursing, store and factory

nursing, insurance nursing, public health work, Red Cross work, and others. Few of us mention these branches to our nurses while they are in training or give them even one talk on each of them. Yet we continue to say that we are training nurses for them. Possibly we are, in the sense that a boy is being trained for a business career when he is taught to read and write.

Miss Nutting, who is considered an authority in nursing matters, in a recent paper read before the New York League of Nursing Education, contends that we are not giving adequate training nor a square deal to our pupil nurses. She suggests for remedies, not the so-called "raising of the standard," by making higher educational requirements for the students who enter, but the providing of better training. She urges the elimination of non-essentials, the giving of reasonable working hours, the hiring of teachers *who can teach*; in short, arranging a training which is that in a real sense, not merely an opportunity to learn something by unguided observation of sick people. Who can say that she is not right? Is it not time to turn our attention to how we can, rapidly and thoroughly, raise the standard of our training, instead of beginning at the wrong end and demanding an improved quality of pupil?

Mr. Gilbreth will doubtless make some definite suggestions for the betterment of work in hospitals. You may denounce them as impractical, but a few years from now you may be adopting them. The care of patients is utterly different from factory work or building, and quite unlike the routine of a business office; still, in each case the problem is the same, that of *getting work*

done and of handling the people who do it. This suggests that the same general principles apply in the hospital and in ordinary life. The working out of the details will naturally differ.

It is here that the efficiency engineers have rendered great service, by finding and establishing certain principles of work. The writer has spent some time during the past year studying these principles and trying to see how they might be applied to hospital work. It is surprising how well they fit into it, and how any attempt to use them shows that they are founded on sheer common sense. Wherever they have been tried, they have proven their value and applicability.

May it be permitted to state these principles and to show how they are related to the very vexed problem of training nurses?

Emerson, an unquestioned authority, gives twelve in number. They are:

1. Clearly defined ideals.
2. Common sense.
3. Competent counsel.
4. Discipline.
5. The fair deal.
6. Reliable, immediate, accurate records.
7. Despatching.
8. Standards and schedules.
9. Standardized conditions.
10. Standardized operations.
11. Written standard-practice instructions.
12. Efficiency rewards.

Clearly Defined Ideals—Our Association some years ago outlined a defined course for nurses' training, and there seems to be no reason to change it at present. What we need is to live up to it.

Common Sense—A great mass of tradition has grown up in our training schools, and it is hard for us who are in daily contact with it to see it in its true light. Dr. Gilman Thompson sometimes attacks it. Can we not have his help and that of others who have his balance of qualities to point out for

us where tradition may be replaced by common sense?

Competent Counsel—This implies cooperation, and Emerson urges it as an essential. The American Hospital Association represents all phases of hospital life, yet it gets only one aspect of the nursing problem. The great nursing organizations have been dealing for years with other phases, and ought to be able to add something to the work done by people whose viewpoint is primarily that of the hospital. Have we been afraid of the nursing associations, and they of us? Is it not possible that cooperation with them might help in the solution of the nursing problem?

Discipline—(Emerson here begins to get down to the individual.) Might there be a flaw in our system of military discipline? Some factories have found that men can work with the greatest exactness, yet happily. Perhaps hospitals need some change in discipline which shall make it not less strict but more sensible and humanitarian.

The Fair Deal—(Emerson considers this a prime factor in success.) It is certainly true that a large proportion of hospitals are not giving their nurses a fair deal. Our nurses give their youth, their enthusiasm, their strength, their very life, and some hospitals fail to render them anything like an equivalent. Sometimes we make our working conditions so hard that they lose entirely the joy of labor, or even the joy of life. May we not this year devote some time and thought to finding new ways in which we may do justice to our nurses?

Reliable, Immediate, Accurate Records—Keep an absolutely accurate and detailed record of what your nurses get in the line of lessons, practical teaching and daily work. Compare it with your printed curriculum. The discrepancies will be illuminating. The remedy is in our own hands.

Despatching—How many of us instruct our nurses in methods of managing work? How many of us know it ourselves? Good

management means doing a large quantity of good work easily. It is not an inborn characteristic, but an acquired one. It is just here that the efficiency engineers can help us out. Is there any reason why we should not consult them?

Standards and Schedules—In these things our training schools are almost wholly lacking. We have no literature nor text-books which more than touch the surface of the art of nursing. Artists have for centuries been taught details of technique; musicians have been drilled in finger exercises; soldiers have been taught how to carry and shift a gun. In nursing, we have always been extremely sketchy in our instructions, have been afraid to go into detail, lest it make a nurse "mechanical." Is one ever afraid that a musician will be mechanical because he knows how to finger correctly instead of being allowed to teach himself to do it in some haphazard manner?

A few hospitals have been working at the problem of standardizing nurses' work, not merely for the sake of having a standard available, but for the sake of improving the quality of work by knowing *just how* to do things. At the Massachusetts General Hospital they have half-unconsciously been using scientific methods for training nurses in practical work, teaching them each detail of movement, as Mr. Gilbreth does his bricklayers, and as all the efficiency engineers are doing in factories and business offices. The Addison Gilbert Hospital at Gloucester had definitely tried out some of this sort of thing, making conscious effort along scientific lines to standardize some daily activities, reduce them in time and in difficulty, and put them into writing, so that they may be available for other institutions. These instances simply illustrate the practicability of these principles.

A committee from the American Hospital Association, working with an efficiency engineer and using hospitals as experiment stations, might get into shape some material

which would put us on the way to efficiency in nursing.

Standardized Conditions—Much has already been said upon this topic, and the Association's committee is doing good work. May we ask that they include nurses' training in their program, making it the integral part of the scheme which it really is?

Standardized Operations—Hundreds of hospitals stand ready to standardize as soon as practical standards are available and something has been done to regulate the conditions under which they work. This part of the program must evidently be postponed until other parts have been worked out.

Written Standard-Practice Instructions—The emphasis is upon the word *written*. Our hospital literature is still small. Many of us are failing in our duty because we do not put into permanent and accessible form the things which we have worked out to a simple and satisfactory conclusion. The idea of a United States Government Hospital Bureau aims at doing this in a large way, but it will need the cooperation of this and other associations before it can succeed in giving the country what it stands in need of.

Efficiency Rewards—Munsterberg, of Harvard, in his "Psychology and Industrial Efficiency," and other experts make much of the principle of reward. Human nature being what it is, there must be a definite reward for a definite service. Professional people will usually accept spoken appreciation, fame, higher position and such things as sufficient rewards. Still, most of us are so bound about by circumstance that any advance must express itself in terms of money to be a very real thing to us. Let us try to impress our hospital boards with the fact that we must pay adequate wages if we are to get competent help, that we must give our nurses real training if we are to have the right sort of young women caring for our patients, and that there must be a definite goal to be striven for in every in-

stance if people are to be expected to strive.

Finally, since we are convinced of the need of greater efficiency in the care of our patients:

First—Shall not the American Hospital Association, both officially and individually push the matter of social service? The Association may furnish the sources of information concerning the work and its results, and each individual make himself a missionary of social efficiency in his own community.

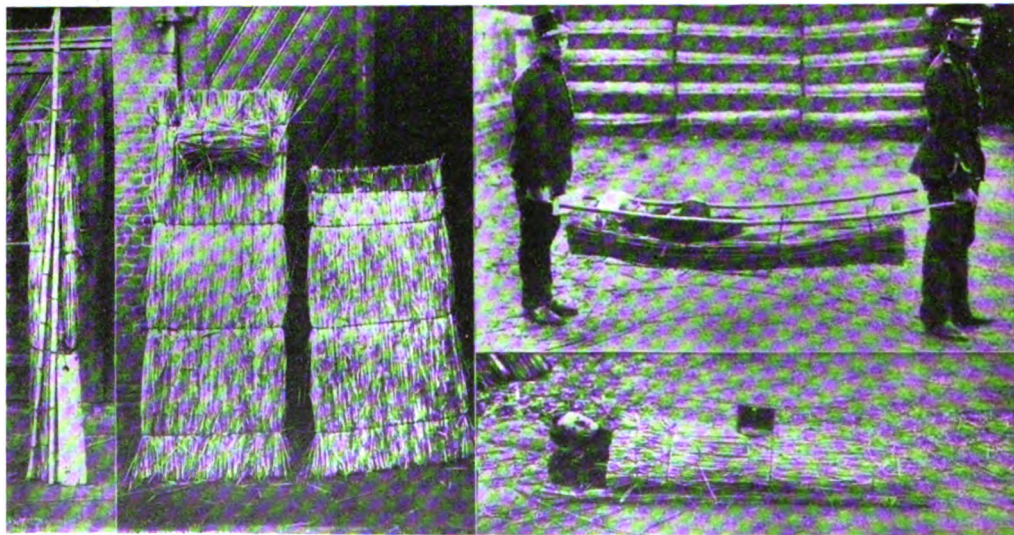
Second—Shall there not be an increased number of communities, urged on by their hospitals, who shall start home nursing associations the coming year? And

Shall not more of the hospitals which have

dispensaries try out the plan of pay clinics?

Many communities stand ready to take up both of these projects, and present conditions under which they might be at once begun, if initiated by an established hospital.

Third—Would it not be worth while for this Association to go frankly into the subject of the training of nurses and attempt to get somewhere near to the bottom of it? Could a committee from the Association, possibly in cooperation with one from the nurses' associations, do any better work the coming year than to try to find out what is the matter with our training schools? Perhaps the following year we might be able to get a committee who should tell us what to do about it.



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The photograph pictures an economical battlefield necessity. It is the invention of Mr. B. Koker, of Capelle, Holland, and is made of straw and rushes in such a way that it is a combination field bed and stretcher. The invention as seen in the photo consists of three parts—the carrying rods, the mattress and cushion, and the cover. At the extreme left is shown the field bed as it appears when rolled up. Next to it is shown the mattress with its cushion of straw and the coverlet. The upper right shows the field bed used as a stretcher; the lower photo shows it used as a bed. When soiled, or after carrying a soldier suffering from contagious disease, the bed is destroyed by applying a match to it.

Another Point of View

EMILY HARRISON BANCE

MUCH has been written of late in nursing journals about the trials and tribulations of nurses—the hardships of the profession, the long hours, lack of proper rest, the self-sacrifice and, last but not least, the peculiarities and the seeming ingratitude of exacting patients.

Dear sister nurses, it is quite true that our calling is in many ways a hard one, but when we consider the many women who are earning their own living, I imagine, if the truth were known, that they all have anxieties and difficulties which must be surmounted if they wish to be successful. Take the woman who is the wife and mother—how enviable seems her place in the world and society to her wage-earning sisters; but many of our married sisters have sorrows, troubles, anxieties and often humiliations, of which we are quite ignorant and quite free.

Many of us have read the interesting novel by Charles Reade, "Put Yourself In His Place," and I think we nurses should sometimes stop and try to imagine ourselves to be in "the patient's place."

As I look back to the time of my hospital training, several cases are clear in my memory. One was an elderly woman, a ward patient, who was suffering from a broken hip. The hip was a long time knitting, and she was in the hospital several months as a patient, and then stayed on employed as a sewing woman until her death a year or so later.

I remember that she was considered by all to be a crank, and when I had charge of the ward for two months of night duty, it seemed to me she was always wanting something or making complaints. I know that often I was quite cross with her, but during those two months I learned her history, how she had a son who had recently ceased writing to her, how she had no money or

relatives and no home to go to should she recover. She was not young and at one time in her life had had comforts, friends and love, and there she was in a ward bed, an old woman, in many ways refined, her rest disturbed by patients coming out of ether, the groans of those in pain and the sadness of those who were dying. She also suffered from lack of the privacy to which she had always been accustomed, and the anxiety because her son had not written and had ceased to send her money, her son whom she had borne in labor and in pain so many years ago.

I often think of this poor old woman and regret that I did not understand the meaning of life then as I am beginning to now. Then I am quite sure I would have been more tender and more kind and would have "put myself in her place."

Next I recall the poor Italian woman who was operated upon for appendicitis and almost died in Room 3. She was continually calling in her own language, and all her foreign friends who came to see her tried to explain to us that she must have things which we knew were contrary to the doctor's orders.

I remember how several of us laughed together in the diet kitchen about the woman and her friends. We laughed and that woman lay in a dying condition and had several little children at home. I have since worked among the Italian people, and I realize now what an occasion of dread and horror that Italian woman's stay at the hospital must have been to her. The Italian women very rarely go to a hospital and are an extremely modest and retiring class. Moreover, they are superstitious and have innate fear of hospitals in general. The pain caused by her operation, the unaccustomed sounds and general atmosphere of the

hospital, the departure of her friends when the visiting hour was over and the long, lonely nights, with only the administrations of alien nurses who couldn't understand her language! Poor woman, how glad I am that you recovered and returned safely to your husband and your little children.

And then, when I was in the children's ward, I remember one little baby who died.

solable. I know that I told her "how thankful she ought to be because the little thing was out of its misery," and then I learned how she washed all day for a living, which explained her late hour of calling. She had a husband who was always drunk, and six other children. Yet she mourned and cried for this dead baby, and we could do nothing to comfort her. As she spoke I



MY PATIENT WHO MAKES PAPER FLOWERS AND PLAYS THE VIOLIN

Of course, there were quite a number who died, but this particular baby had marasmus and was very emaciated, and after lingering for several weeks, quietly died. Every night the child's mother came awkwardly and apologetically into the ward to see the baby. She always came quite late after the other visitors had departed, and had special permission to do so. She was a tired, stolid-looking woman, and she always hung over the child's crib and never said very much to any one. When the few minutes allowed her were up she always leaned down and kissed the baby. When the poor, wretched little specimen of humanity died we all thought it was a blessing, but when the mother came that night her grief was incon-

felt ashamed that I had not noticed her more when she called each night to see her little one, but—I did not know. I was only thinking how hard my work was and here was a poor woman who washed clothes all day to support six children and a drunken husband. Her work was so much harder than mine.

In my present work as visiting nurse for the Metropolitan Life Insurance Company I meet with many obstacles and have my trials. It is quite true that I do not have to be up night after night, without sleep, like nurses on private duty, and I have no differences with the servants. My poor people have no servants. In place of these trials I go into dirty, unsanitary houses, I see little children housed like animals, I see whole

families in poverty because of drunken fathers and husbands, and I am constantly meeting conditions which are extremely hard to cope with.

There are times in the daily routine of our lives, dear sister nurses, when we all feel dissatisfied and discontented, and wonder if it is all worth while.

We say to ourselves: "Why did I ever study nursing?" and "If only I had studied something not quite so trying." Whenever I feel discouraged about my work, I try to think of my patients and the lives some of them lead, especially my "shut-ins." Then, strange to say, I feel thankful that I am well and able to work.

First I think of Mr. S——, who has been confined to his bed for four years. He is a young man only twenty-one years old. Five years ago he had rheumatism, which left him a cripple. The hip and knee joints are hopelessly ossified, and his condition is such that he is only comfortable in his cot, as he cannot sit up straight enough in a wheeled chair. Now, instead of being unhappy and low-spirited, this young man is very cheerful. He makes lovely paper flowers and



MRS. B——, A "SHUT IN" FROM RHEUMATISM

sells them. Then he embroiders beautifully—centerpieces, doilies and napkins. A friend is teaching him the violin, which he is learning very rapidly. Will I ever forget his radiant face when he first played for me, "Silver Threads Among the Gold"? At my suggestion his family secured a typewriter, and he is now becoming quite expert with his typewriting. A carpenter made a table to wheel over his cot, so as to hold the machine in place, and he practises by copying whole pages of the Bible, of which he is quite a student. He hopes some day to make lots of money as a copyist.

His mother takes care of him and his two sisters support the little family. They have very few luxuries, many anxieties, but the young man is reconciled and always cheerful, and it is a pleasure to go and pay him a visit. If he ever complains, the only one who knows it is his little pet canary, who flutters about the room and eats from his hand.

Mrs. B—— is another rheumatic patient who has not left her room for five years. She is only fifty-six years old and, until a few years ago, was extremely active in her home and in her church. She taught a class of girls in sewing school and was intensely



MISS M——, WHOSE SHRINE IS HER CONSOLATION

interested in all church work. Then suddenly her illness came and for five years she has sat in the same room, looked out of the same windows, so crippled that she can't even use her hands to sew. At times she suffers intense pain, but her worst suffering is that of inactivity and that awful feeling of uselessness and helplessness which she cannot overcome, and which must be torture to a woman formerly so capable. Yet she bears all patiently, is a staunch Christian, and whenever I call on her cheers me up with her kind, sweet nature and patient forbearance.

Another chronic patient is Miss M——, who for several years has been in a semi-invalid condition. Sometimes she is well enough to go out of doors and becomes very hopeful, when a relapse sends her back to

her room and to her old pain and discomfort. Miss M—— is a patient who takes great consolation in prayer, and believes faithfully that some day she will be perfectly well. She is a Romanist and prays daily before her shrine to the Virgin, and I know that she often offers prayers for my welfare and happiness.

As I write I can see these three patients living out their lives in their various homes, all of them reconciled to their piteous condition and hopeful that they will some day be well.

But you and I, who at times grow unhappy and discontented in our work, know that they all three have a long, long, painful road to travel before the all-merciful Healer releases them and says "Well done, thou good and faithful servant."



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A WARD IN A HOSPITAL IN BERLIN, IN WHICH FRENCH WOUNDED ARE BEING CARED FOR. ON THE LEFT IS SEEN A FRENCH MILITARY SURGEON.

Nursing in Diseases of the Heart

MINNIE GENEVIEVE MORSE

VIII. ARTERIOSCLEROSIS

ALTHOUGH arteriosclerosis is not a disease of the heart, it is so closely associated with cardiac disorders that it may well be considered in connection with them. Strictly speaking, it is less a disease than a degenerative process incidental to and practically an inevitable accompaniment of old age; few individuals past even fifty years of age are without some trace of it. As the name implies, it is an affection of the blood-vessels, its most pronounced effects being upon the arteries, though the capillaries and even the veins may also be affected. The term *sclerosis* means an increase in connective-tissue formation; this takes place chiefly in the outer coats of the vessels, while actual degenerative or *atheromatous* changes are found principally in the internal coats. The effect of both is to lessen the elasticity of the vessel walls and to prepare the way for aneurism-formation or for rupture.

A very large proportion of the elderly patients who come under a nurse's care have arteriosclerosis as a more or less important factor in the disorders from which they are suffering. Osler says that "to a majority of men death comes primarily or secondarily through this portal." The affection is, however, much more common among men than among women, and those who are engaged in some strenuous form of activity, either physical or mental, are far more likely to show its effects than persons who take life easily, seldom worry, and exert themselves but little. The largest proportion of patients are brain workers, and of the well-to-do classes. To quote Osler again: "Longevity is a vascular question, which has been well expressed in the axiom that

'a man is only as old as his arteries.' The onset of what may be called physiological arteriosclerosis depends, in the first place, upon the quality of arterial tissue (vital rubber) which the individual has inherited, and, secondly, upon the amount of wear and tear to which he has subjected it. Entire families sometimes show a tendency to early arteriosclerosis—a tendency which cannot be explained in any other way than that in the make-up of the machine bad material was used for the tubing." The arterial changes are directly brought about by a progressive disturbance of nutrition of the vessel walls, but the underlying causes are many and varied, and with them vary the chief seat of the disorder and the symptoms which it produces. Men who have been engaged for years in arduous physical labor, of a sort which tends to produce overdistention of the blood-vessels, are apt to show the severer type of arteriosclerosis of the upper extremities. Where long-continued mental overstrain, anxiety or emotion is the predominant causative factor, the cerebral or the cardiac arteries suffer most. The effects of obesity are shown principally in the arteries of the heart and of the lower extremities. Overeating not only puts a strain upon the whole vascular system, but is especially prejudicial to the kidneys, upon which fall an increased burden of elimination, particularly in the case of overindulgence in proteid foods. Constipation, by causing a rise of blood pressure during difficult defecation, may when long continued, become a factor in the production of vascular degeneration. The use of stimulants of all kinds, including coffee and tea, has a tendency to raise blood pressure. Various

toxemias—gout, lead and syphilis—are also among the contributing causes. As a cure of arteriosclerosis, in the sense of regeneration of calcified or atheromatous arteries, is impossible, prophylactic measures on the part of all persons who are approaching later life are of the utmost importance, and nurses as well as physicians may be of great use to their patients by practical advice relative to the life of moderation and self-restraint, which will do much to prevent the early advent of cardio-vascular disease.

Arterial sclerosis may begin in the internal coat of the vessel, producing a gradual obstruction which may progress to actual blocking, or it may begin in the external coat and progress inward. There may be merely isolated patches of thickening or degeneration, a local change in the aorta, or a widespread involvement of smaller vessels. The vessel wall may become much thinned, leading to aneurism-formation, or it may become hard and brittle, easily rupturing when subjected to sudden strain. The embarrassment of the circulation causes increased work for the heart, as in the case of organic cardiac disease, but the consequent hypertrophy of the organ may for a long time compensate for the diminished vascular elasticity and prevent the occurrence of any symptoms calling attention to the condition. Blood pressure tests, however, will usually tell the story; the blood pressure, as measured in millimeters of mercury by the sphygmomanometer, rises with advance in age, and with the increasing rigidity of the vascular system. When the heart can put forth no further effort to propel the blood against the increasing resistance, and fails in muscular power, the pressure falls, and the signs of cardiac insufficiency appear. Many arteriosclerotics present no noteworthy symptoms until they are seized with apoplexy, rupture an aneurism, or die suddenly from the blocking of a coronary artery, but when the condition is such as to produce symptoms these vary with the part of the

circulatory system that is most seriously involved.

Among the earlier symptoms are increased blood pressure, tense radial arteries which roll under the fingers like a quill, tortuous temporal arteries, fatigue on slight exertion, irritability of the vasomotor system, vertigo, abnormal sensations in the limbs and disturbances of the special senses, sleeplessness, neurasthenic manifestations, cardiac irritability, and changes in the disposition. The three principal forms in which the disease presents itself are the cardiac, the cerebral and the renal. In the cardiac form there may be palpitation, tachycardia or bradycardia, cardiac asthma, attacks of angina pectoris (the true variety of which is apt to be associated with coronary sclerosis), epileptiform seizures or the Stokes-Adams syndrome, and in the final stages passive congestion of various organs with edema and all the signs of insufficiency of the heart. The cerebral form may show a wide variety of symptoms, both physical and mental. Headache is most often of a dull frontal type, and usually is noticed most on rising in the morning, passing off in the course of the day. Vertigo is very common, as is insomnia. All sorts of transient disabilities may be complained of: Dimness of vision, roaring in the ears, difficulty of articulation, numbness or weakness of the limbs, and even, in advanced cases, attacks of aphasia, hemiplegia, or paraplegia, which disappear entirely in a few hours, the patient apparently recovering completely. The mental state may be one of either depression or excitability, or there may be slow progress toward dementia. Failure of memory is frequent, while illusions are not uncommon, and may result from the disturbances of the special senses. In the renal form of arteriosclerosis, the symptoms are those of a chronic fibroid nephritis, and prominent among them is an increased secretion of urine with a low specific gravity and comparatively few renal casts. Dropsy may

not appear for a long time, but on the other hand, it may become considerable and general, involving not only the legs but the pleuræ and the peritoneum. Alarming symptoms in this form of the disorder are those indicating the onset of uremia, among which are diminished secretion of urine, going on to entire suppression, headache, drowsiness or sleeplessness, mental dulness, and disorders of vision, which may even reach the point of actual blindness, lasting perhaps for a few hours and then disappearing entirely. Abdominal arteriosclerosis presents such signs as flatulency, eructations and occasional attacks of colicky pain. Sclerotic changes in the uterine vessels may cause marked disturbances, sometimes inducing a suspicion of malignant disease.

The prognosis in arteriosclerosis is always unfavorable, though a careful life and proper treatment may avert the fatal issue for a long time. Says Dr. J. L. Nascher, in his recent book dealing with the diseases incident to old age: "The disease is progressive, and generally destroys the individual, either through exhaustion of the heart or through impairment of some other organ to such an extent as to prevent its functions or through cerebral compression following cerebral hemorrhage. Occasionally an embolus blocks a vessel and prevents the nutrition of a part, causing its rapid degeneration or, in the case of the lungs, causing fatal dyspnea. In the case of embolism, death may also be due to shock."

Arteriosclerotics who come under a nurse's care are usually in an advanced stage of the disease. In many ways these are trying patients. They are usually very nervous regarding themselves, and may be irritable, easily excited, suspicious, or morose. They often show changes from their former disposition which are no less inexplicable to themselves than to their families. They may become childish, unable to attend to their affairs as usual, yet bitterly resentful of any attempt to "manage" them. They may

lose their personal fastidiousness, forget to change their clothing at the proper times, and neglect the evacuation of the bladder and bowels. They are often distressingly conscious of failure of mental power, lose interest in everything not connected with their own condition, and sink into dulness and apathy. There are few disorders in which patients need to be handled with greater tact, understanding and patient kindness.

The care required by these patients depends largely on the predominating symptoms which they present, but there are certain measures which are applicable in practically all cases. One of the most important considerations is that of diet. Many of these patients are given to overeating, which may have been a strong factor in the production of their condition, and such persons may object very strenuously to a sharp restriction of diet. If the situation is clearly explained to them, however, they are more likely to submit willingly to the necessary regimen. Moreover, the nurse can do much to render a restricted diet more attractive by varying it as much as is practicable, and by serving all meals as temptingly as possible. The proportion of proteid foods in the diet is usually reduced; the extractives of meat favor a rise in blood pressure, and an excess of protein puts a heavy strain on the kidneys. The chief necessity is moderation along all lines, and in cases in which little or no exercise can be taken many physicians favor reducing the amount of food to the lowest point compatible with meeting the nutritive needs of the body. Fresh or cooked fruits and vegetables, cereal foods and a fair proportion of milk or buttermilk, usually constitute a considerable part of the diet recommended. Anything inducing intestinal putrefaction should be carefully avoided, as well as anything that is known to disagree with the patient in question. Coffee, tea, alcohol and tobacco are usually restricted on ac-

count of their stimulating effects, resulting in rise of blood pressure. Caffeine-free coffee may be safely used, however, and satisfies the taste while producing no stimulation. It is generally advisable to use as little salt as is practicable in the preparation of food for an arteriosclerotic, though a strictly salt-free diet is seldom ordered. The prevention of constipation by dietetic means has already been considered in the section on "Diet in Heart Disease." If the patient cannot masticate his food properly, it may be chopped fine before being served to him.

The exercise that a patient with arteriosclerosis should take must be definitely prescribed by his physician, and he must not be allowed to exceed the directions given. For most patients a moderate amount of exercise

in the open air is highly beneficial, and mild golf, horseback riding and walking are most generally recommended. The patient should be made to understand very clearly that sudden exertion, overstrain of any kind or getting overtired may have serious results; or, if he is approaching a state of irresponsibility, he may have to be watched constantly lest he make some foolish and harmful exertion. Attempts at gymnastic work, either without superintendence or under the direction of an untrained gymnastic instructor, are unwise, and may have very serious results. Plenty of fresh air, indoors as well as out, is very essential, and the nurse may have to use all her ingenuity and tact to induce the patient to allow his sleeping and sitting apartments to be sufficiently aired.

(To be continued)



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KITCHEN OF A RED CROSS TRAIN SETTING OUT FROM BERLIN FOR FRANCE

Five Years in the Far East

MARY DAVIS LEWIS

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IN THE summer of 1909 my brother persuaded me to go to China. I was born and brought up in North China; my mother and father lived in Tientsin, and as they were anxious to have my little boy with them, I would be left free to do private nursing.

Accordingly I left San Francisco in the early autumn, and began to "hear the East a-calling" very plainly when I reached Tientsin—old familiar sights, sounds and smells greeted me, as well as much of the new, for my recollections antedated the Boxer outbreak, and there were many changes.

The tiny European settlement of Tientsin in the eighteen years of my absence had grown to be a large and bustling city, although it is and always will be hopelessly ugly, built on land reclaimed from the salt marshes, being only a few miles from the sea. A rapidly increasing European population had made a place for the trained nurse and in Tientsin I found a home and work enough to keep me busy, and my little boy was happy with his grandma and his "Mackie-dog."

Five busy and interesting years have passed since then—years which have seen the plague, the revolution, the passing of the Manchu dynasty, the rise of Yuan Shih Kai, China in transition, history in the making. Much of my time has been spent in Peking—that wonderful old city, which has seen the rise and fall of the Ming and Manchu dynasties. She casts a curious spell over most of the aliens who come to live within her ancient walls.

In Peking the hoary past and the twentieth century meet. On the great Hatamen Street I have seen a train of camels from the north, smart carriages, rattling Peking carts,

rubber-tired rickshas, creaking wheelbarrows, the Marquise Li in her Paris hat and frock, seated in a modern touring car; Manchu ladies, gorgeous in spreading head-dresses, embroidered robes and much paint; the ancient Chinese scholar in his long robes, queue and large glasses; the modern student in European or semi-European clothes, children, beggars, dogs and pack mules. And then there are the soldiers of all the Legation guards—American marines, British Tommies and Hindoos, Germans, French Colonial Infantry, Italian marines, Belgians, Austrians, Japanese and Chinese—dwellers from all the nations of the earth.

As you gaze upon this shifting pageant of Peking's busy streets let me impress upon your mind that the smells of which you complain are but a paltry reminder of what they were before 1900; then Peking did not boast a street over which a carriage could be driven, or electric light. The city has been "cleaned up," but it might be improved on, even now.

The walls which enclose the Manchu city of Peking in a rather irregular square are of gray brick, pierced with three gates on the southern side, and two gates on the other three sides; these gates are surmounted by lofty towers. The walls are about fifteen miles long, since the square is irregular.

The only pleasant walk in Peking is on the city wall, which bounds Legation Quarter on the south, fortified near the Hata Gate by the Germans, and at the Chien Gate by the Americans. In time of trouble not only would Legation Quarter be protected by troops on the Wall, but the railway stations of the Peking-Mukden Railway and the Peking-Hankow line, just outside the Wall, also. The Chien Men was destroyed by the Boxers, afterwards rebuilt. Here the

American troops have their wireless mast. From the city wall one gets a panoramic view of Peking. The distant Temple of Heaven is in the Southern City; looking north is Legation Quarter; beyond that the walls and yellow roofs of the Forbidden City, within which lie the extensive palace grounds.

On the Coal Hill in the palace environs

copied from those worn by the great sage himself. Odd musical instruments added their touch of weirdness to the chanting, which, with repeated bowing and kowtowing and offerings of food and drink before the memorial tablets of Confucius and his disciples, comprised the ceremony. It was a gray and dreary day in March, and we listened, shivering, to the strange ceremony,



BRIDGE IN THE SUMMER PALACE GROUNDS

the last of the Ming Emperors committed suicide.

When Yuan Shih Kai was inaugurated president in the Old Imperial Audience Hall, the general public was admitted (after the ceremony), but after all one did not get very far into the Forbidden City. The gaudy decorations were ruined by the heavy downpour following the ceremony, and the colors of the five-barred Republican flag had run badly.

Last spring the Confucian Society revived some ancient rites in honor of Confucius in the Confucian Temple in Peking. Some venerable men wore robes and head-dresses

finding it hard to believe we were really in the twentieth century.

A few weeks later we saw quite a different ceremony—Mass in the Pehtang, or Northern Cathedral, on Easter Eve. Historically the Pehtang is interesting—here the French priests and sisters, with a large number of orphans and converts, defended by a handful of French and Italian marines, withstood the attacks of the Boxers in 1900.

A few miles west of Peking in the low foothills is the Summer Palace, favorite retreat of Tzu Hsi, late Grand Empress Dowager.

A few miles nearer Peking are the ruins of

the Yuan Ming Yuan, the old Summer Palace beloved by Chien Lung and his predecessor, Ka'ng Hsi. Here in a large park, many miles in extent, were artificial lakes and low hills, rockeries, gardens and many buildings—beautiful now, even in their melancholy decay. In 1860, during the war with France and England, the Chinese treacherously made prisoners and murdered

in English under the trees by the Chinese students at Ching Hua Yuan, the college founded by the government with the Boxer indemnity returned by the United States.

Part of several summers have been spent at Peitaiho—a summer resort on the coast, just across the gulf from Port Arthur. It is said that during the bombardment of Port



A STREET IN PEKING

a party bearing a flag of truce. In reprisal the British general looted and then destroyed the Emperor's Summer Palace; in this way many priceless art treasures found their way to Europe. Among the buildings destroyed were several European ones—in the Rococo style of architecture, built under the direction of the Jesuit priests, in favor with the court over two hundred years ago. Here were many fountains, and a selsydra, or water clock. Letters and drawings of the French fathers preserve for us the glories of the Yuan Ming Yuan.

Perhaps it is, after all, not such a far cry from the outdoor theatricals of the old Summer Palace, to "Robin Hood," played

Arthur the sound of the big guns was often heard across the miles of water.

Many have been my amusing experiences with Chinese servants. One "boy" came into the nursery with water for the baby's bath, and said to the Amah, "Already that little baby is bathed every day." This same "boy" said to me one day: "I don't mind bringing up cold boiled water for you to drink, but I will not risk my mistress's life by bringing it up for her." As a rule, a Chinaman thinks cold water a menace to life. Certainly out here cold unboiled water is an effective means of suicide, and to the Chinese habit of drinking quantities of weak tea they owe much. I have often won-

dered how any Oriental lives a week—the survivors must be germ-proof. Passing the Chinese open-air restaurants I am torn betwixt two emotions—a New-York-hospital fear of germs and a born-in-the-East fondness for Chinese food.

One broiling July day in the diner of a Hankow to Peking train, I asked the table boy for cold boiled water. A dignified Englishman near me said: "Pardon me, madame, you must be new to the East; you should not risk water on this train." But I was not new to the East, only perishing of thirst, where soda, ginger beer and such like harmless fluids were not, so I drank my water and trusted to Providence. Since then I have a Thermos flask, and can carry my own water.

In going to and fro I have met many charming and interesting people, among whom two nurses must be mentioned—Miss Elsie Jung, a Chinese girl, who is a graduate of a London hospital—Guy's, I think—and Miss Lambert, of the Anglican Mission, who was given the Royal Red Cross by Queen Victoria for her work in charge of the improvised hospital in the British Legation during the siege of 1900.

My only experience with a Chinese case was a little woman who had sewed for me. When her baby was expected she sent for me, and my methods nearly caused the collapse of the Chinese midwife who was present. "Here is a dirty old rag—don't spoil clean cloth," she said, and "Bathe a little baby he will die." But my little sewing woman answered: "Lu-tai-tai [my Chinese name] knows all about babies, and foreign customs are better than ours. I want my baby to be treated just like a foreigner."

Sad to confess, the exciting events of the past few years have given me no chance of becoming a heroine. My nursing has been but "a tale of common things," mainly obstetrical cases. Volunteering for service in Harbin during the plague, I was told that



OPEN-AIR RESTAURANT

competent police were needed, not *women*; so all that came of that excitement was the inoculation with serum, whose effectiveness was afterwards denied. If the plague kills in a few hours, inoculation can make one miserable for days.

The Revolution autumn of 1911 was thrilling enough in Peking. The air was tense with excitement; rumors absurd or terrible were new every morning. I *heard*, though did not *see*, the explosion of the bomb meant for Yuan Shih Kai. However, my nursing experience was no more exciting than several obstetrical cases among the refugees—inconvenient, but otherwise not memorable in any way.

I was in Tientsin City during the looting and burning on the never-to-be-forgotten night of March 2. I heard the incessant rifle fire of the mutinying troops and the terrifying shrieks and shouts, and saw the scattered fires growing larger, until they united in a great bonfire. Early in the morning of March 3, a trembling servant rushed in to say that the looters were approaching. We packed our valuables and waited, but it proved a false alarm—no one came. However, the women and children "refugeed" to the shelter of the French Concession for a couple of days. When all was quiet again we knew that foreign lives

and property were not disturbed in the almost simultaneous outbreaks in Peking, Paotingfu and other places besides Tientsin. The shooting of Dr. Schreyer and Mr. Day was probably accidental.

My experience convinces me that a private duty nurse does not find life in the Far East satisfactory unless she has relations out here and a real home between cases. The climate is more than some can stand. If one is too old and "sot in one's ways" it is hard to adjust oneself to the changes between English, French and American homes, all more or less affected by the "customs of the country." If one is young and pretty, marriage is the end of a nursing career out here. Belonging to neither one of these classes, but, like Br'er Rabbit, "bred and bawn in de brier-patch," I stay on and enjoy it. Most of my family and friends are here; I can speak a little Chinese and less French; have even had two cases for a French doctor, who spoke almost no English.

The filth and squalor, the poverty and the distressing misery of the Chinese peasant

class is a dark and depressing factor of life. I suppose one grows more or less hardened to it in time, immune, as they say one does to sand-fly bites and sand-fly fever.

For a nurse who is young and strong, good at languages and with an intense desire to use her knowledge for the greatest good of humanity, I can see no better opening than a position in a mission hospital. The Oriental now turns to the foreign doctor for relief, and even submits to major operations. New and very modern hospitals are being built, and modern trained nurses are wanted for them, to preside in the operating room, to oversee and train Chinese girls in up-to-date methods of nursing. Even if Chinese nurses will get married as soon as their course is completed, as wives and mothers they may be lights to lead their neighbors stumbling in darkness. The history of medical missions in China is a wonderfully interesting story; much of it is history, as yet unwritten. The nurse in the mission hospital will help to bring "the good time coming for the meanest and the least."

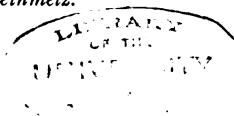
God is Sufficient

Standing at the opening of another year,
Words of comfort cheer us, crushing every fear,
While through the silence comes our Father's
voice,
Bidding us be faithful, making us rejoice.

Onward, then, and fear not, Christians of the day,
For His words shall never, never pass away.
Ringing out the false, bringing in the new,
Let us cease despairing, let us hope anew.

God is all-sufficient for the coming year,
He will never fail us. What have we to fear?
He will still uphold us by His own right hand,
For we are His chosen, in His care to stand.

—Sadie M. Steinmetz.



An Every-day Evil

MARY E. CLARKE, M.D.

IF WE were to question what disease or symptom of disease was most prevalent among the people at large—rich and poor alike—we could not help but give the answer—constipation. It is found in the young and old, those who are poor—underfed, anemic creatures—and those who have so much wealth they lead a life of inactivity.

Some of these cases come to the physician, some, indeed, many consult the nurses of their acquaintance, and more still simply take some drug they know will give relief for the time being, and have no thought along that line for the future.

Many come to the dispensaries with all sorts of complaints—headaches, backaches, nausea, indigestion, depression of spirits, etc., when the sole cause for these ills lies in the one word, constipation. I well remember one of my instructors, while in medical school, saying to patient after patient, in the dispensary: "Madam, if you would only keep your bowels open you would be all right." And he would turn on his heel with the direction, "Write for Rhamnus Purshiana." The big-sounding name of the drug saved the day, many a time, for it was easy to see that many of the women did not believe him as to the origin of their trouble. They would much rather have laid their symptoms to floating kidney or some other aristocratic disease.

The causes of constipation are many—both local and general. It is not of itself a primary condition, although there are cases where it is impossible to assign any adequate cause. Such cases are called idiopathic or habitual constipation.

Let us consider the local causes first.

1. Weakness of the abdominal muscles. This is brought about by obesity, repeated pregnancies, or tumors, causing overdistension.

2. Atony of the intestinal musculature, caused by the bowels having been repeatedly overstretched from gas, hard or large masses of feces.

3. In elderly people there may be an atrophy of the intestinal mucosa preventing the proper peristalsis and secretions.

4. Obstruction to the onward movement of the feces, due particularly to hard masses, the cause of which may be the ingestion of "insufficient fluid or excessive absorption or elimination of water from the intestines."

5. The causes of intestinal obstruction—kinks and bands, new growths, etc.

6. There is also a spasmodic form of constipation seen most frequently in neurasthenic or hysterical women, and due to a spasm of the large intestine.

Aside from these there are the following general causes:

1. We often hear of "hereditary constipation." This is probably due to the fact that the mother—careless of her own habits—did not teach the value of regularity of evacuation of the bowels to her children.

2. That caused by a sedentary life, particularly those who neglect the calls of nature.

3. Chronic diseases of the other abdominal viscera may so alter the secretions of the intestines that their functions may be interfered with.

4. Certain diseases, as anemia, neurasthenia and hysteria, cause an atony of the bowels, aided also by the restricted diet often taken in these cases.

5. Improper or insufficient diet may cause a lack of residue which should be there to stimulate the intestinal activity.

6. The constant taking of drugs is one of the most common causes.

Many other causes might be mentioned, but the above lead us to see plainly that in

prescribing the treatment for constipation, we must if possible find first the cause.

The treatment of constipation divides itself naturally into physical, dietetic and medicinal. The first two should be employed whenever and wherever possible, but we all recognize the fact that sometimes drugs are necessary, especially while waiting for the other methods to work.

One of the easiest methods of overcoming the difficulty, if one will only adhere to it, is the forming of regular habits. This should be begun in childhood—indeed, while the child is a mere baby the mother may begin the formation of a habit which will affect the whole of the future. Immediately after breakfast, when the stimulus of warm food and drink has increased peristalsis, is the best time for an evacuation of the bowels. Even if there is no special desire at that time, after the habit is once formed the involuntary muscles act of themselves, and usually yield a good result. Take time to attend to this, and do not let business, or care of your patient, or any other excuse, deter you from it.

Another physical method of treatment of constipation is by exercise. Walking, rowing, swimming, tennis and golf are among the best, as the abdominal muscles are brought more or less into play in these exercises.

Abdominal massage may also be used in conjunction with exercises. For those who can stand it, a cold morning plunge or sponging of the abdomen with cold water may aid in bringing about contractions.

In addition to other methods, dietetic treatment is very useful. The main things necessary in a diet in the constipated state is something which will leave a large residue. This is chiefly cellulose and fats. This residue furnishes stimuli to the intestinal mucosa.

Such a diet may be obtained by the use of fibrous vegetables rich in cellulose, as corn, string beans, onions, cabbage, tomatoes, let-

tuce and cucumbers. Whole wheat or bran bread is better than that made of white flour. The heavier cereals, as oatmeal, cornmeal and hominy are useful. Juicy fruits, either raw or stewed, should be eaten with each meal if possible.

As beverages, tea, cocoa and chocolate are to be avoided. Coffee or cream may be used. But the most useful of all is plenty of cold water, especially when taken before breakfast, between meals, and before retiring.

As regards the use of drugs in chronic constipation. Powerful cathartics have their use in acute diseases, as a means of emptying the intestinal tract, but certainly not as a means of treatment for any of our every-day constipation. Only such mild laxatives as will leave no bad after-results should be used.

Of these drugs, one of the most useful is rhubarb. This is a stomachic as well as a laxative, and may be used in the preparation of the solid extract, or as the compound rhubarb pills.

Another popular remedy is aloes. This is supposed to exert its influence particularly on the colon, and is especially useful in atonic conditions. Many preparations are seen, but one of the best is our familiar A. S. & B. pill.

Cascara sagrada is extremely useful in chronic constipation, and not only relieves for the time being, but is supposed to act as a tonic, so that after a while the amount taken may be decreased instead of made larger, as with so many remedies.

Of the newer drugs, phenolphthalein is one of the most popular, and is supposed to exert most of its influence on the small intestines.

There are innumerable other drugs which might be mentioned, but if none of the above suggestions give relief, surely the case is one for a physician to search for the cause.

Enemata are useful in cases in which the collection of feces is chiefly in the rectum, but used too frequently may prove as detrimental as drugs.

Department of Public Welfare

Baby-Saving Exhibit

In November Boston entertained for the first time the American Association for the Study and Prevention of Infant Mortality. In connection with the meeting of the Association was the "Saving Babies Exhibit," which added greatly to the interest of the convention sessions. In a room on the ground floor of the library the Milk and Baby Hygiene Association had a most interesting exhibit, including, among other things a group of flags of thirty-five different nations whose babies are being treated in Boston—Chinese, Portuguese, Polish, German, Swedish, Austrian, Hungarian, etc.

A visitor who attended the meetings called attention to the notable fact presented by one of the speakers that the number of deaths from preventable diseases of babies under one year of age in this country, in one year, far exceeded the number of deaths reported so far in the great European slaughter. Later reports from the battle-fields may modify this statement, but it is true that we fail to realize the constant loss which goes on in the average community by the "slaughter of the innocents," as infants and children drop out of life, one by one, as the result of ignorance, bad care and unsanitary conditions.

One of the bright pictures on which to look, in the midst of the tales of the horrors of war, is the picture of the work of the Association for the Prevention of Infant Mortality and kindred associations, as they inspire and cheer and lead those who are spending their lives in the effort to save the little ones of all races, irrespective of the country from which they come.

As is the case with all such exhibits, those



COURTESY OF BOSTON JOURNAL

FLAGS OF THIRTY-FIVE NATIONS WHOSE BABIES ARE
BEING TREATED BY THE BABY HYGIENIC
ASSOCIATION

who most need to see them and to have their lessons brought home were not there. We can all appreciate the point of view of the correspondent who in writing of her visit to the exhibit, said: "The exhibit at the Public Library was very much worth while. But I could not help sympathizing with the scrub woman, who, while pausing for a moment with one hand on her hip and the other carrying her mop and bucket, remarked, 'It's a great pity, mum, that a lot of women wot I know 'u'd orter see these things don't see um.'"

The Trained Nurse Midwife

In an editorial in the *Public Health Nurse Quarterly*, October, 1914, an extract from a letter by Miss Carolyn Van Blarcom, on the subject of "The Trained Nurse Midwife," is quoted as follows: "The further we go with our work, the more we realize the truth of Miss Nightingale's assertions that midwifery is logically a branch of visiting nursing. It has so worked out in England, Australia and New Zealand, and we are working very hard to that end in America." An article in the same journal by Dr. Fred J. Taussig, makes a strong plea for the visiting nurse to fit herself to do the work of a midwife.

Just what attitude the medical profession in America will take in regard to this proposition remains to be seen. It is hardly likely to be regarded with general favor. There is also the serious question of race and language—the question whether the average nurse, trained in America, would be as acceptable to the foreign-born women (who create most of the demand for midwives), as the midwife of her own nationality who could speak her language and who would understand the customs of the country from which she came. The familiar sign, "Italian Midwife," or "Polish Midwife," presents a greater appeal to the Italian or Polish patient than the finest kind of a diploma from an American training school for nurses. In England the midwife deals mainly with English-speaking people.

That the average nurse could with a comparatively short addition to her course become more efficient in the line of midwifery than the average midwife, is admitted, but before we will see the visiting nurse midwife well established in America we will have to see a decided revision of some visiting nurse rules.

One of the most serious criticisms which has come to us of the rural visiting nurse service is the rule that the nurse must not be expected to respond to calls at night. This

criticism has come to us from both physicians and laymen who are sincerely interested in better nursing for rural dwellers. They suggest, and with at least some show of reason, that however valuable a rural nurse may be as an educator, her value as a nursing aid to rural physicians and patients is open to question so long as she is bound by a rule not to respond to calls at night. Unfortunately, babies insist on being born at night, and the visiting nurse midwife will find it very hard to displace the foreign-born midwife so long as she "must not be expected to respond to calls at night."

The tremendous difficulty presented by the polyglot foreign population in our cities, and the impossibility of any American nurse becoming familiar with many of the languages spoken, is a bar to nurse midwifery that exists probably in no other country to the same extent. In American towns of twenty to thirty thousand, it is not uncommon to find as many as seventeen different languages spoken. While the foreign-born woman can secure a midwife of her own nationality the bond of race and language will appeal so strongly that substitutes will not be readily accepted.



Dental Clinics for Juvenile Offenders

St. Barnabas Hospital is cooperating with the Juvenile Protective League of Minneapolis in a very practical way by establishing a dental clinic by means of which children coming into the juvenile court may have their teeth treated. Dr. Newkirk, director of the research department for the league, asserts that "the teeth of 75 per cent. of the children brought into court are in need of care. Defective teeth lead to anemia and malnutrition. Malnutrition means poorly nourished bodies and brains. Defective teeth are a great source of irritation. Irritation is one of the main factors leading to loss of self-control."

The hospital has set apart two rooms for the dental clinic and provides equipment, materials and a nurse assistant.



The Life Extension Institute

Among the new organizations for the purpose of conserving human welfare, the Life Extension Institute, organized by Prof. Irving Fisher, occupies a peculiar position, says the *Medical Review of Reviews*. Its particular function is the making of medical examinations of individuals and then turning over those who are impaired to their family physicians. There is no intent to practise medicine, but it serves the purpose of bringing the person whose health is below par without his knowledge into direct relation with a physician, with the idea of preventing the development of diseases tending to shorten life.

A large hygiene reference board has been constituted for the purpose of communicating existing knowledge to the director of hygiene and adding through study and research to this knowledge. The first work of this reference board is to construct practical rules of hygiene in so far as may be possible. It is not a simple matter to determine the optimum rules of life for individuals. Once such rules are determined, public education becomes necessary to spread a knowledge of them to urge living according to them.

No mere routine physical examination suffices to determine rules of living. The family history, personal history, the general habits as regards diet, exercise, work, play, etc., require equally careful investigation, as does the examination of the eyes, ears, nose, throat, nervous system and other portions of the body. The interpretation of a man's method of living is essential to the adequate diagnosis of his general potential physical status. The aim of the Life Extension Institute is to determine not so much what a man is today, but how he may be kept in the

best physical health during the future years. The preventive side of medicine is here crystallized into an active commercial agency.

Among those who attended the first annual meeting were Prof. Irving Fisher, chairman, Dr. Rupert Blue, Dr. George M. Kober, Edward Bunnell Phelps, Alexander Graham Bell, Gen. William C. Gorgas, Lee K. Frankel, Dr. Hugh Young, Dr. H. M. Bracken, Dr. Mazyck P. Ravenel, Dr. William H. Welch, Dr. S. Adolphus Knopf, Dr. William S. Rankin, Dr. J. S. Schereschewsky, John B. Andrews, Dr. J. H. Kellogg.



Notes

Visiting nurses under the direction of the Toledo District Nurse Association cared for 211 patients in districts during October.

In the dental clinic 20 were treated, and in the dispensary 254. There were 126 new patients. The blind commission looked after 68 cases, among them being 27 new ones. There were 15 typhoid cases and 62 maternity cases.

Miss Roberts, social service visitor, looked after 50 patients, 18 being new ones, a total of 110 visits having been made. A boy whose legs had been cut off by a train was provided first with a portable chair and later with one artificial leg and a crutch, so that he was able to walk again.

Miss Florence Benner, visiting nurse employed by the Domestic Science Association of Richmond, Indiana, is in Reid Memorial Hospital, suffering from an attack of typhoid fever, contracted while at her duties. Miss Benner has had four typhoid fever cases on her visiting list recently.

Miss J. M. Briggs has resigned as district nurse in Springfield, Mass., and the Kings Daughters have engaged Miss Lorraine Greene, a registered nurse from Burlington, Vt., to take her place.

Cleanings

The Early Treatment of Infantile Paralysis

In the annual oration to the Medical Society of London, Dr. Robert Jones emphasized certain principles which should be observed in the early treatment of infantile paralysis. He would make it a general rule that in every case the head and spinal column should be kept at rest from the very beginning of the attack. If the child has much pain in the spine and limbs, as not rarely happens, fixation of the spine and limbs gives more relief than any other procedure. In any case, to keep the spinal cord and head at rest, so far as possible, in acute poliomyelitis is only to act in accordance with the general principles regulating the treatment of inflamed organs or areas in other parts of the body. It is important that this rest, continued through the acute and early convalescent stages, should be continued so as to prevent the adoption of faulty positions by the affected limbs, in order that the deformities that are likely to follow the paralysis may be minimized. Until the tender stage of the disease has passed away—a matter of from three to eight weeks or even more—no active treatment should be undertaken; it is argued that active myelitis may be present throughout the tender stage, so that treatment by massage or electricity would be premature.

Having drawn attention to the importance of complete rest during the early stages of infantile paralysis, Dr. Jones proceeds to point out the necessity for great care when active treatment is at last begun. It is not the nervous part only of the neuromuscular apparatus that is damaged in infantile paralysis. Everybody knows that the

motor nerve cells in the anterior horns of the spinal cord are injured in this disease, but it is not so generally realized that the affected muscles may suffer doubly—first in their nerve supply, and secondly by being themselves overstretched while thus disabled. Hence it is of great importance that from the first they should not be stretched, and to avoid this attention must be given to the position of the limb; and, again, that when massage and active movements are prescribed care should be taken to avoid the possibility of straining or overstretching the injured muscles. The massage must be very gentle at first, the movements must be carefully limited, and the limb must be put up in an apparatus so as to keep the paretic muscles in a position of relaxation until they have improved in tone. The success of treatment depends upon the maintenance of this muscular relaxation continuously until there is evidence that the damaged muscles have begun to recover. When this occurs the position of relaxation may be gradually discontinued.

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Pain in the Back

Pain in the back, often indefinite in its exact location, is frequently a source of chronic complaint in the patient, and of dilemma to the physician. Contrary to the popular belief among the laity, Bright's disease is not especially characterized by pain in the back although in the early congestive stage of an acute inflammatory disease of the kidney and in renal tuberculosis there may be pain of a dull type. The pain of pyelitis or of perinephritis is apt to be rather more severe and refers more directly to the

kidney. If there be an obstructive hydro-nephrosis, the pain is severe and agonizing. A floating kidney which drops and has a kinked ureter will also produce the pain of obstruction. A number of diseases of the spinal cord will produce pain in the back, among these being tabes dorsalis and the various inflammatory congestions of the cord and its membranes. Disease of the vertebræ, osteo-arthritis and metastatic carcinoma are liable to produce backache. Typhoid spine must also be thought of. Very heavy individuals often suffer from pain in the back due to overstrain of the dorsal muscles from carrying excessive weight of the trunk. Aortic aneurysm and other mediastinal growths of large size may produce backache. The dragging of ptosed abdominal viscera must not be forgotten. Among the various inflammatory conditions in the male and female pelvis are prostatitis, seminal vesiculitis, salpingitis, etc. Muscular rheumatism—so-called—and lumbago, as well as the onset of some of the acute exanthems, are productive of backache.—*Denver Medical Times*.



How to Breathe Properly

There are many people in the world who literally do not know how to breathe. The lungs are only half used, and constant colds and catarrhs are the result. Impure blood means an impure state of health, and the blood needs constant supplies of fresh air to keep it pure. When air is taken into the lungs the blood carries it all over the body, and it is of supreme importance that the air should be free from all germs of disease and filth.

Stand loosely clad every morning before a wide-open window, and through the nostrils inhale long, deep breaths of air; at the same time rise to the tips of the toes, hold

the breath for three seconds, then gradually exhale, allowing the body to descend to the heels. When once this habit has been acquired, it may be practised whenever possible, particularly in the open air. By this means all the lung cells will be brought into action.—*Nursing Times*.



Headache

Persistent headache usually finds its etiology in some one of the following, often two or three factors of causation being united:

Anemia, autotoxemia, syphilis, dyscrasias, eye-strain, nephritis, neurosis.

Obviously, headache sedatives only temporize. A headache may require hematics, alteratives, correctives, hepatic and renal stimulants, antiseptics, glasses, surgery, etc. It is more than likely that in addition to medication the patient needs regular rest and sleep, a change of environment, different diet and a judicious regulation of his whole manner of living.—*Medical Summary*.



Burning Feet

When the feet burn and are sore and tender, from much walking and standing, take a teaspoonful of Epsom salts, five drops tincture of capsicum, and put in a shallow basin of warm water, just enough to cover the soles of the feet, and soak them twenty minutes. This will afford relief and cure the burning.—*Exchange*.



Bites and Bruises

A solution of formaldehyde kept in readiness will be found efficient as a local antiseptic for many lacerations or abrasions, and especially for the bites of insects.—*American Medicine*.

Editorially Speaking

Our New Year's Wish

We feel that we can extend no better New Year's wish to our readers than that expressed in the following lines, which came to us from an unknown author:

Fullness of health,
If not of wealth,
And lasting peace,
If not increase.
Beneath God's care,
Thus may you fare;
Through happy days
And pleasant ways;
With love of friends,
Till earth life ends;
Then happy flight
To heaven's light.



The Coming Year

Magazines, like individuals, are apt at this time of year to take a long look ahead and forecast what future months will bring. The making of a successful and practically helpful magazine for a class of readers as varied as is the circle of *THE TRAINED NURSE AND HOSPITAL REVIEW*, is not a matter which can be left to chance. It has to be planned and prepared for, far in advance of publication.

A large part of our readers are hospital superintendents, principals of training schools, head nurses and pupil nurses—all of whom are looking for helpful articles relating to their work. We feel perfectly safe in saying that no magazine in our field offers each year as many practical, helpful articles relating to the training school as does *THE TRAINED NURSE AND HOSPITAL REVIEW*, and the results are seen in the ever-growing list of hospitals to which our magazine goes each month.

No magazine has in recent years given as many practical articles relating to the different special occupations of nurses—office nurses, department store nurses, tuberculosis nurses, infant welfare nurses, private nurses, etc. If one wanted to prepare a booklet on vocations for nurses, one could find ample material for it by going over our files for the last two years.

For the coming year we shall continue our bright, helpful articles on training-school problems and practice. "The Hospital Review" will gather together in brief form the items on management and methods which hospitals have evolved in dealing with a great variety of practical problems. It will devote little space to theorizing and much to practical methods worth passing on.

The isolated private nurse who wishes to understand more of the conditions in disease and of newest methods of dealing with them will be certain to find in every number something to help her in her work.

Our "Letter-Box" has always been a popular feature for the exchange of experiences.

Do you desire an article on any special subject? If so, tell us your desire and we will try to grant it. Tell your friends of the monthly feast of good things for nurses and hospital workers which we are preparing for our readers. Send us a list of your friends who are not now subscribers and sample copies will be sent them. Study our premium list. Send us one or more new subscribers and add a new book to your hospital or library. Won't you show your appreciation of our efforts to produce the best possible magazine by sending us one new subscription with your own, as a practical expression of good-will?

From the War Zone

All the advance that civilization has made seems to increase rather than diminish the horrors of war. Never before, in the history of the world, have we had so many and such terrible forms of killing and wounding men in masses. To add to the general horror of the present war there has been a pitiful lack of cotton, adhesive plaster and material for dressing the wounds of stricken soldiers. A cry has gone abroad in America for every one to assist, by sending a pound of absorbent cotton or a package of bandages. These can be addressed to any of the Red Cross headquarters, where the cotton will be distributed.

All sorts of substitutes for cotton are being tried and suggested. A doctor writing in the *British Medical Journal* describes a cheap, absorbent and aseptic dressing for wounds which have much discharge, as used by the Japanese. He has also used it and proved its value. "Make charcoal of straw by burning straw in a fireplace where the air can be excluded. This is done by blocking up the fireplace with a sheet of tin or board, after lighting the straw. After the fire has burnt out the straw is the same in shape but black. This, put into linen bags, is very absorbent and a deodorizer."

Mr. Charles W. Cathcart, senior surgeon to the Royal Infirmary, Edinburgh, gives in the same journal some interesting notes on sawdust, the value of which as a surgical dressing has been demonstrated by several authorities. Mr. Cathcart himself is using it now in the Royal Infirmary and the Second Scottish General Hospital at Craigleith, and it has been much appreciated, he says, as a dressing for the shell wounds of the wounded German sailors in Edinburgh Castle, and is very valuable, also, in cases of incontinence of urine. "The best kind is pinewood dust; it is passed through two sieves, sent to the theatre sister in a box or sack, and put by the nurse into butter muslin bags, closed with a colored thread.

The filled bags are steam-sterilized; after use the colored thread is pulled out, the sawdust thrown away and the bag washed, boiled and dried for future use. Sawdust is very absorbent and the discharge is so evenly distributed that the bed-clothes are not nearly so quickly soiled as with other forms of dressing. The resin of the wood seems to act as a deodorizer, and probably also as an antiseptic. Sawdust is well adapted for civil or stationary military hospitals. Its extensive use at the present time would save hundreds of pounds. Other materials more portable but more expensive might be reserved mainly for field use."



Nursing Infectious Diseases

THE TRAINED NURSE AND HOSPITAL REVIEW has always had very decided views on the subject of nurses refusing cases of infectious disease, and from time to time we have called attention to this editorially. Not long since we were told of an incident which certainly did not redound to the credit of some trained nurses. In a city not far away, there is a central registry which boasts of being one of the most exclusive in the country. It was natural to suppose that exclusive in this connection would mean highest in all standards of the profession, but when an epidemic of scarlet fever broke out in the city recently, it was found that none of the nurses from this exclusive registry would accept cases of that kind, and so, in the emergency, the nursing had to be done by untrained nurses. This is certainly being *exclusive* with a vengeance.

There is one thing, however, which may be considered in the nature of "extenuating circumstances," in some instances where nurses refuse such cases, and that is, the nurse has been given no opportunity in her training to get experience of this kind, and does not feel competent to undertake it. It is therefore a pleasure to announce courses for training in nursing of infectious diseases,

where a nurse may, if she desires, make up any deficiency in her training..

The Providence City Hospital, of Providence, Rhode Island, offers two such courses to graduate nurses: *Course A*—Furnishes theoretical and practical training in infectious diseases, and in aseptic ward technique, including hospital administration from the standpoint of preventing infection. This course consists of six months' training in the wards, under the direction of the superintendent of nurses and of the nurses in charge of the various wards to which nurses may be assigned. Such nurses will receive ten dollars per month and their room, board and laundry. Upon the completion of the course, if their work has been satisfactory, they will, upon examination, receive a certificate stating their qualifications for nurses in charge of infectious hospitals.

Course B—This course has for its aim the fitting of the private nurse for the care of infectious disease in the home. The course lasts two months and is both theoretical and practical. Such nurses will receive ten dollars per month and their room, board and laundry. Upon the completion of the course, if their work has been satisfactory, they will, upon examination, receive a certificate to that effect. Candidates must be graduates of approved training schools, and must furnish evidence of their character and ability. Nurses should be provided with four colored uniforms of their school; those taking six months' course may wear white uniforms after the completion of two months' service.

The Providence City Hospital is a hospital of two hundred beds, entirely devoted to infectious diseases. Completed in 1910, it is thoroughly modern in construction and administration, the methods employed in the handling of infectious diseases being copied from methods used in England and France. The underlying principle of the construction and management is the disregarding of aerial infection. Different

infectious units containing one or several individuals are physically separated, though they may be in the same building or ward and cared for by the same nursing and medical staff. Extreme care is taken to insure that everything is surgically clean that passes from one unit to another; this provision includes supplies, utensils, nurses' hands, and so forth.



Where We Differ

At the present time in America those interested in nursing matters may, most of them, be divided into three main groups. There is a small group—comparatively small—who would limit the production of nurses, give a small number of nurses who had a full high-school or college course a very carefully worked-out theoretical training, with just enough practical work in the wards to familiarize them with practical nursing duties, and bring them up to the required standard of proficiency, fixed by a few selected people in every State.

This group seems to have the education of the nurse as the primary object, and seems to be concerned little, if any, about the matter of how the sick are to be cared for.

This group, also, has for years advocated the entire separation of the administration training school from the hospital, and its control by a separate board. It is interesting to note that though the Waltham Training School has from the beginning been developed as a separate institution, with its administration entirely in the hands of a separate board composed in part of nurses, every opportunity of discrediting its work has been apparently utilized by this group.

The second group includes a large majority of the hospital superintendents and nurses of the country, and also a large part of the medical profession. This group would place no straw of opposition in the path of those who desire to make the fullest possible preparation theoretically for a nurs-

ing career, but does not believe that it is necessary for *every* nurse to have had a high-school course or a college course, previous to the nursing course. *It believes that the character of the nurse and the spirit she puts into the work is of more importance than a college degree in the sick-room.* It believes that the welfare of the sick is at least of equal importance with the education of the nurse, and that the one has a much closer relation to the other than the first group seems willing to admit. It is inclined to believe that where the sick are properly cared for, the nurses are apt to be well trained in nursing. This group is not willing to concede that the training of nurses as at present carried on has produced too many nurses. It believes that a better distribution of trained nurses is needed, and that some machinery must be brought into existence that will make it possible for the great middle class to have the benefit of their skill. This group believes that for the present, until those in the first group are able to maintain separate training schools, that the training school should be a department of the hospital—not a separate institution controlled and managed by a separate board.

The third group includes those who are either indifferent to the whole nursing problem or inclined to regard the present chaotic situation as affording a chance for profit-making.

There are here and there people who do not fit into either of these three main groups, but at the present time each of these three groups is diligently working along its own line and seeking constantly to win others to its support.

According to the admission of some well-known nurses, who claim to speak with authority, the chief reason for the rapid multiplication of the latter class lies in the fixed fee and rigid rules of various nurses' directories, and the unwillingness of the average graduate to adapt herself to the needs of the average home. This view of the case has

been stated by prominent nurses and also by those who are opposed to them.

The future development of nursing, in view of this three-cornered situation, is hard to predict. The desirability of a high-school or a college education for the nurse who is to have charge of a training school or hospital, is admitted by all. Its necessity for *all* who are to care for the sick is disputed. It is more than likely that in the future all concerned in the development of nursing will come to revise, in some measure, their opinions and their methods in view of pressing human needs. What is most needed at the present time is the open mind and the avoidance of cut-and-dried theories which may read well but do not work out well in actual experiment. We are apt to lose sight of the patient and his point of view altogether. Was the nurse right or wrong who remarked to the editor recently, that she felt what we most needed to do was to try to get the viewpoint of the people who were going to want nurses and who would pay for the service?



Celebrating Holidays in Hospitals

The editors especially desire to receive from a great many readers short descriptive letters telling how you celebrated Christmas in your hospital. Do you follow any particular custom from year to year? Do you have a Christmas tree? If so, who is the Christmas tree for—nurses or patients or servants? Who supplies the tree and gifts?

What suggestions have you for the Thanksgiving or Easter celebration or for the Fourth of July? Will you not write a letter about your celebrations that will help some one else?

How did you spend your Christmas, dear private nurse, welfare worker, or any reader who had experiences worth telling. Remember that while all lives may be commonplace to those who live them, they are often full of interest, pathos, humor or romance when observed by others.

The Hospital Review

CONDUCTED BY CHARLOTTE A. AIKENS

Items of Interest, annual reports, publicity literature, and material descriptive of newer methods and plans in any department of hospital work, should be sent to the editor of this department, at 722 Sheridan Ave., Detroit

What Cornell is Doing in the Cause of Cancer

ANNA MEREDITH LAWSON

About the year 1884 two women, wealthy, anxious to aid their fellow womankind, conceived the idea of establishing a ward for cancer patients in the Woman's Hospital in the State of New York. Both were of the board and both desirous that the advancement of study along such lines should be to the credit of that hospital.

Their plan, favorably looked upon by many, met opposition, and after facing this it was decided that a hospital solely devoted to cancer should be built, and in that year, 1884, the cornerstone of the New York Cancer Hospital was laid.

Looking backward over the old records one finds names that stand out in medical history—they have passed to their reward, and, like "the Pilgrim Fathers who this path trod, are now in heaven and walk with God." Of these men William Tillingast Bull will never be forgotten—first to aid, with keen business aptitude and rare surgical skill, the cause of cancer, he was doomed to fall a victim to the dread scourge some twenty years later. With him worked such men as James B. Hunter, Francis P. Kinnicutt, George F. Shrady, Brayton Ball, George Peabody—these left behind, to follow closely in their footsteps: Clement Cleveland, Henry Clark Coe, George W. Jarman, Charles N. Dowd, Herbert Lawson, Harold Barclay.

In 1899 the name of the hospital was changed to General Memorial Hospital, to meet the popular prejudice against the name

cancer. The work was largely surgical, and as other institutions accepted cases of malignant disease, it was necessary to treat at the General Memorial patients suffering from general surgical troubles. The question of ways and means was one of pressing import, but in 1912 Dr. James Douglas became interested in the work and this resulted in an affiliation with Cornell. The medical staff henceforth must be of Cornell, and its Dean a member of the managerial board. Necessarily, this brought about many changes. The old medical board resigned, many members of the board of trustees doing the same, and the new appointees are all connected with Cornell.

Dr. Douglas's gift was munificent, and the means to an end long sought were at last available.

An exceptionally fine X-ray plant, large quantities, comparatively speaking, of radium, render the equipment nearly perfect, and the research department is making wonderful strides. The new men, Drs. Ewing, Weil, Beebe, Janeway, Coley, Holding and others, are full of zeal and are possessed of singularly open minds—their one object is a cure for cancer, no matter whence it comes nor whose may be the discovery.

Recognition, prevention, therapeutical experiments, all serve the end. Surgery, radium, toxines, science in its advanced form all tend toward one end—cancer control.

The Association for the Control of Cancer recently established, is watching the progress of Cornell research. We must be made to believe that cancer is a dispensation of Providence, not a disgrace to be hidden until the disease has advanced too far. We must impress those we know and love with the full meaning of the word recognition. When any unusual condition arises, go seek the advice of a good medical man, and if he suggests operation, then face an ordeal far less terrible than the disease itself. It is no respecter of persons or places. Crowned heads, denizens of the slums—all are fuel to this everlasting flame.

It is a secret, this cure for cancer, but Cornell has set itself out to find the solution, and with such aids and a broad charity surely it will be reached.

At the General Memorial Hospital a conference is held on every Thursday morning. New cases are seen, old ones watched and discussed, and it is an "open court" where fair-minded men both teach and learn. Stop and think what it means to know that such men as these, standing in the front rank—particularly those of the faculty of Cornell—approach this subject with almost absolutely unbiased mentality, open to conviction. It has been said that medical men are the most arbitrary in the world. When you desire refutation of that argument attend one of the Thursday morning conferences.

This is what Cornell is doing for cancer. Is it not a great effort?



Concerning Authority

The question of who shall be greatest in the hospital kingdom and how much authority the superintendent shall have, is one that presents itself in every hospital at some time. Absence of by-laws relating to this subject, unnecessary and unwarranted interference with the details of internal management by some overzealous board mem-

bers—these add greatly to the perplexity of the situation in many hospitals. Discussing the questions on this subject presented by a Massachusetts superintendent a few months ago, Dr. William H. Walsh, superintendent of the Children's Hospital, Philadelphia, writes as follows: Replying to certain queries contained in your journal of September, regarding division of authority, I beg leave to submit the following:

1. How much authority should the superintendent of a hospital have?

ANSWER—This official should have as much authority as his or her qualifications warrant. The competent medical superintendent should have absolute authority in hospital affairs, and should be in undisputed charge of the institution and its activities. The medical superintendent should be the chief executive officer of the corporation and should not be interfered with in questions of administration by either board or staff. The medical superintendent should not actually treat patients, but it is entirely within his province to see that patients are properly treated and to vigorously intercede for the patient when the best medical and surgical skill is not being applied. It is obvious that this latter function can only be performed by a superintendent who is also a well-informed medical graduate.

2. How much authority has the staff over the superintendent or the superintendent over the staff?

ANSWER—A great many hospitals whose superintendents are not fully qualified are dominated by some member of the staff, and in lieu of a properly qualified administrator this is necessary. The modern medical superintendent is in no way subordinate to the staff nor subject to their orders, and it should be the duty of the superintendent to see that the staff properly perform the functions of their positions.

3. What are the duties of the superintendent?

ANSWER—The duties of this official are so

multitudinous that an enumeration thereof would require more space than the editors will allow. The duties should be readily comprehended when it is stated that the medical superintendent is in charge of the institution and responsible to the board of managers for everything that occurs within its walls. The duties are necessarily modified according to the ability and qualifications of the incumbent.

4. What are the duties of the superintendent of nurses?

ANSWER—The superintendent of nurses, under the medical superintendent, should have charge of the training school and entire supervision over the nursing. The duties of this position often extend to those of house-keeping, etc., in small institutions.

5. How much authority has the staff in regard to the training school?

ANSWER—The staff should have no authority over the training school.

6. In a hospital that has a superintendent, a head nurse, a night supervisor, a graduate nurse as anesthetist, and an interne, where does the interne rank?

ANSWER—It is quite impossible to answer this question as written, as it is ambiguous. If the superintendent is a trained nurse, the interne ranks above her and every one else mentioned in medical matters. If a trained nurse gives anesthesia, she does so under the supervision of a physician—the interne, if he be the only M.D. present.

8. If the anesthetist is paid more than the night superintendent, which one is the superior officer?

ANSWER—Money does not make the man, nor does salary give rank. The plumber may receive a greater compensation than a head nurse, but in hospital circles the head nurse would be considered superior. As before stated, a nurse who acts as an anesthetist must do so under the direction of a physician; she cannot legally assume the responsibility for the possible consequences. It would seem that under these conditions a

nurse who gives an anesthetic is no more important personage than any other head nurse. The night superintendent should be in absolute charge of all nurses under the director.



Reducing the Cost of Food in Hospitals

A certain man in the city of Detroit became interested in a small hospital for crippled children in that city. He decided to ask the readers of a certain paper circulating among the farmers of that State, and especially in the counties adjacent to Detroit, to assist in filling the fruit and vegetable cellars of the hospital with fresh fruits and vegetables from the farms. The appeal was sent out in early November. He suggested that it be a "Thanksgiving shower" of fresh vegetables and fruits to the hospital for crippled children from those whose children were whole and straight and sound in body. Incidentally, he offered to pay the freight on all vegetables and fruits sent. Undoubtedly this helped the end desired more than he deemed possible.

No one was prepared for the food avalanche which, within a week after the article appeared, began to descend on that small hospital for crippled children. Within five days more than twenty tons of fruits and vegetables arrived, with the little hospital for its destination. Temporary bins were put up in the basement, and soon filled to overflowing with apples, potatoes, carrots, beets, cabbages, pumpkins, squash, citrons, popcorn, walnuts, apple butter, canned fruits and crocks of fresh butter from the farms. One whole dray-load of Hubbard squash arrived—till the basement overflowed and there was no room for more.

Still the bags and baskets and crates and boxes and barrels of food continued to arrive. A five-ton truck-load, which drove up to the door of the little hospital, was offered to the Children's Free Hospital and accepted.

Another truck-load of over five tons was offered to one of the orphanages of the city and accepted, and at this writing boxes and barrels and crates and sacks of fruits and vegetables are still arriving.

This story has a moral which many hospitals would do well to heed. While we put forth tremendous efforts to coax dollars from the pockets of grudging or unwilling city givers, and plead "the high cost of living" as one of the chief causes for our special appeals, have we ever tried to tap the resources in the rural districts and counties adjacent to our hospital and asked the producers of foodstuffs to make their contributions to the hospital in the way they can best do it? Is it not a fact that with a little wisely directed effort, hundreds of hospitals could have their storehouses filled to overflowing each autumn with "Thanksgiving showers" of fresh and canned fruit, vegetables and such things, that should very markedly decrease the cost of food for several months?

The superintendent of a church hospital in a Western State told the writer some time ago that every part of her State had been so organized by the appointment of a local committee on supplies that she knew just about what she might expect from every township in that State. Not only staple fruits and vegetables, but crates of eggs, crates of live chickens, tubs of butter and barrels of canned fruits are received. It does not really require a great amount of organization or effort to secure the donation of a crate or two of eggs each week during the greater part of the year, and of butter from other sources. The eggs and butter are donated in small amounts and some local man or woman is secured who will be responsible for the proper packing and shipping.

Another superintendent in a large city has organized a Saturday Basket Guild among the ladies of different churches in the city and adjacent towns. Once a year each

church sends a basket filled with fresh fruits, vegetables, boxes of crackers, canned goods, home-made preserves, jelly and pickles—a variety of food supplies which helps greatly in preventing monotony of the dietary in the hospital. This work is so organized that each church has its special week for sending its donation.

Without doubt there are untapped sources of help in reducing the cost of food in a hospital within easy reach of hundreds of hospitals which this year are feeling the pinch of hard times. This applies particularly to community hospitals which serve a small city and county or district adjacent, and to church hospitals, though the experience in Detroit goes to show that appeals from any hospital doing free work, presented at the right time and in the right way to the right class of people, will find a willing response. In most cases it will be possible to find some individual who will pay the freight charges on arrival of the goods—a wise precaution to observe.



Should Probationers Sign an Agreement?

A correspondent in a recent letter asks the question as to the desirability of probationers signing an agreement at the end of the probation term, to remain till the course is completed.

Without doubt there are varying opinions regarding this question. The experience and observation of the writer would lead her to vote against the practice.

In some hospitals where such a rule exists, the pupil nurse who has been accepted and withdraws before the completion of her term is expected to pay back to the hospital fifty dollars, to compensate in some measure for the time and expense incurred in teaching and boarding her during the period when her services were of little value as compared to the cost. But apparently few hospitals have any plan for enforcing this rule. If a



METHOD OF GIVING SPRINKLING BATH IN BED.
PRESBYTERIAN HOSPITAL, NEW YORK

pupil nurse chooses to leave at the end of six months or a year, and does not choose to pay the hospital the fifty dollars, there is no one ready to enforce the rule. The committee or board which (often thoughtlessly) made such a rule, absolutely refuses or neglects to take any steps to follow up the case, and the superintendent is just as loath to do it as the committee. That rule breaks down so often when it comes to enforcement that it had better never be made. An appeal to the sense of honor, when a probationer is accepted, is apt to be quite as powerful in its effect as the signing of a contract.

Undoubtedly there are those who will say that this is a restless age, that nurses as well as others often have "a roving foot" and that the contract helps to hold the girl steady when she might otherwise be influenced to Snap-shots of non-commercial exhibit, Hospital Convention, St. Paul.

seek a change without any really good reason. In some cases this may be true, but experience fails to show any very marked advantages in favor of the contract plan, unless there are measures provided for enforcing it.

A legal opinion on the matter leans to the belief that when a hospital exacts such a contract it is morally bound to allow the candidate to continue the course whether she shows herself to be unsuitable or not. The attorney consulted claims that a hospital which exacts such a contract is unfair to the nurse unless it at the same time agrees to give her the training to the end of the stipulated term.

This few hospitals will be willing to do without a proviso of some kind. If discipline is to be maintained and the interests of the sick safeguarded, the hospital must reserve the right of dismissal of a nurse



INFANT'S BED, DOLL IN UNIFORM—GERMAN
HOSPITAL, CHICAGO

should she at any time during her training prove her unfitness for the responsibilities she must carry.

Legal opinions are often given without considering all the ethical phases which enter into the relationship of the nurse to the hospital and school.

In reality the hospital assumes a much greater risk than the probationer or pupil nurse. The school is an established thing. The facilities for training are provided. Competent nurses have been graduated. The probationer knows all this when she applies. She assumes little if any risk. She knows that if she is reasonably teachable and faithful and capable and loyal to necessary rules she has nothing to fear in regard to dismissal. It is to the interest of the hospital to keep her till she completes her training, unless she demonstrates that she is untrustworthy or unfit.

Cases of gross injustice and prejudice undoubtedly have occurred in the past, but we believe such instances are growing more rare.

In any case in which an agreement is signed there should be a clause stating that the nurse will be given an opportunity for vindication should she be threatened with dismissal.

After a pupil has completed her probation and been accepted as a pupil, absolute power of dismissal should not rest entirely with one person. There should be a full inquiry by a committee before the dismissal occurs. This is only common justice to the nurse and a safeguard to the superintendent of nurses.



Notes

Mr. Jacob Langeloth, of Greenwich, Conn., recently deceased, has left a bequest, a sum

mounting into millions, to establish an institution known as the Valeria Recreation and Convalescents' Home.

The testator provided that the trustees of the fund for the establishment of the convalescents' home should cooperate on the project with a delegate to be selected by the Chamber of Commerce and with the president of the Charity Organization Society. The institution is to be free from religious tendencies and devoted to "people of education and refinement who cannot afford the charges exacted at health resorts."

Among the improvements now under way in the Homeopathic Hospital, Reading, Pa., are the installation of a silent call system, also of an indirect lighting system for the rooms, an Otis noiseless cushion elevator and Otis dumbwaiters. The kitchen is to be moved to an adjoining building recently purchased, which will be devoted mainly to the care of maternity patients.

A radium department is to be opened at Jefferson Hospital in the near future, according to an announcement made by Dr. Mohler, the superintendent, who said that he had just received word that the initial supply of radium which has been ordered for the hospital has been extracted and is now being tested to standardize its strength.

Twenty-five hundred dollars' worth of radium has been purchased and will be delivered in a few days. The radium will be kept in three tubes; two tubes will contain radium chloride and one tube will contain radium sulphate. The radium is entirely an American product, being extracted from carnotite ore in the State of Pennsylvania.

A charter has been granted to the National Stomach Hospital in Philadelphia, which will conduct a dispensary for the treatment of diseases of the gastro-intestinal tract and allied organs. The new institution will also maintain laboratories for the examination and investigation of the diseases of the organs of digestion; a research department for the special study of the causes and means of prevention of cancer affecting these organs, and a school of dietetics for the study of food values.

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 Stranger's Tribute

To the Editor of The Trained Nurse:

May one who only knew Anna Ascnath Hawley by her "sketches" from the Indian Reservation, and through occasional correspondence, pay a tribute of respect and admiration for one who has gone, yet who has left behind the fragrance of a beautiful life which, it seems from our human viewpoint, ended all too soon. It was with the sense of loss that one feels on hearing of the unexpected death of an old friend that I read in the December magazine of the death of Anna Ascnath Hawley, best known to our readers under her *nom de plume* of "Betty," in her letters from the Indian mission. Though I was not privileged to know her in person, she has for years commanded my secret admiration. I have felt that she was truly one of the world's heroines, and many times as I read her letters breathing of her devotion to her "red children," I have felt ashamed that my own life knew so little of the self-sacrifice which she never mentioned, but which was woven in and through all that she wrote. From the first letter that appeared, signed "Betty," I felt that here, indeed, was a rare character. Her happy, optimistic descriptions of her experiences, her word pictures of her "Indian children," showed a literary gift that was unusual. One rejoiced with her as she described her entrance into the "White House" or her first holiday, just as you felt like weeping with her as she described the "going home" of some of her Indian patients, after she had done her best for them and had failed. One little additional evidence of her beautiful unselfishness which I greatly appreciated was the fact that she insisted on sending me regularly from her lonely post among the Indians her contribution toward the support of Fanny Wilde McEvoy in Detroit. When in one of her letters, enclosing her contribution for Mrs. McEvoy, she remarked that her "Letters from an Indian Mission" were ended, I suggested that they had been so altogether charming I wished that some time she might weave her sketches of nursing life among

the Indians into a book—since America was so pitifully, wofully poor in real stories of the heroism and romance of modern nursing. She replied that my letter gave her just the bit of courage that she felt she needed to inspire her to start the little book. She had thought about it, but wondered if her style was really "fit," and whether she would be presumptuous to try to make her Indian children live "in a book." I very greatly hope that her friends and relatives will try to finish the sketches that she had begun, and that with the sketches may be given to the world the story of her beautiful, unselfish life as she chose to live it—away from the comforts of civilization on that lonely outpost.

CHARLOTTE A. AIKENS.



Training School Problems

To the Editor of The Trained Nurse:

I would like to have the following questions discussed, pro and con, in your magazine. Should pupil nurses be allowed or prohibited from autoing at night with a young man? It is my belief or opinion, that if we consider them trustworthy enough to take the training, we should feel that they can be trusted in all things and at all times, and I feel that if they are going to go astray, they will do so sooner or later, and it had better be sooner, while still under the guidance and care of the hospital authorities, and they can then be discharged, and need not be a disgrace to the profession later. While I think that young women who enter training schools should have had sufficient and proper home training to know what to do, and what not to do, yet I think that it is always best to caution them occasionally and repeatedly concerning their behavior. But I think more can be done for a nurse or any woman by letting her know that you expect nothing but the best of her, and placing confidence in her, and trusting to her honor. It has been argued that nurses should be prohibited from going autoing with young men after dark,

because people will talk and because there are always some who cannot be trusted, for they will do indiscreet things if not worse. I contend that when people do talk, and it is known by the hospital authorities, instructors, etc., then the girl should be informed, instructed, warned, advised, and after a repetition, punished or discharged. They are better weeded out of the profession before they finish their training. If it is possible, I would like to have discussions concerning this question. Another problem about which I would like opinions; I am superintendent of nurses of a small hospital having twenty-five pupils. Just recently a probationer entered, who is known by two of the pupil nurses who have come to me with the following story: When this girl was about fifteen years old, when coming home from school one day, she was persuaded by several of the boys to go to the woods with them, and they took advantage of her. She moved from that vicinity and has led a perfectly moral life since. These girls say that if their fathers knew that she was under the same roof with them they would not allow them to stay. What is the proper and right thing to do in such a case? I would like very much indeed to have these questions discussed in *THE TRAINED NURSE*. M. C. L., R. N.

[EDITOR'S NOTE.—The questions which the writer of this letter raises are practical questions which confront most training schools at some time. We have our own opinions about them. The first question might resolve itself into whether pupil nurses should be allowed to go autoing indiscriminately with men. Married ex-patients masquerading as single men have created problems in more than one hospital. How far should permission be given pupil nurses to go with young men with autos at night? The second question suggests the further question as to whether a mistake made by a girl of fifteen should be sufficient to handicap her future life.]



Creating Interest in the Alumnae Association

To the Editor of The Trained Nurse:

I would like to hear from other alumnae associations as to how they keep an interest in their meetings. Our alumnae association has been organized almost two years, we have twenty-four members; sometimes we have a quorum, sometimes we do not, and seldom more than enough to hold a meeting. I have recently been elected president and am anxious to build it up.

PENNSYLVANIA.

The Hot Water Bottle Accident

To the Editor of The Trained Nurse:

Speaking of hot water bottle accidents, I think A. McC., R. N., in the November number of *THE TRAINED NURSE* somewhat hard in her view toward the pupil nurse. Unless the patient is well enough to know positively the hot water bottle is responsible for his delayed recovery, he should not be told—for several reasons, namely these: the average patient, remember I say "the average patient," on leaving the hospital would do so with an unfriendly feeling toward that institution, and would naturally repeat the account of the accident, and ten times out of twelve, would make it appear much worse than it really was. The report might reach the ears of some one who had intended going to that hospital, but would change their mind from fear they might meet with a similar accident. It might come up at some time when it would mar the nursing reputation of the one who might not have been wholly at fault. All of these would reflect on the hospital when the accident occurred and, lastly, it would add one more prejudice to the trained nurse. No nurse is so perfect or particular but mistakes are bound to come, and the act assumes gigantic proportions when some offending sister instead of ourself is responsible. Unless a nurse is exceptionally careless (and if she is, why was she accepted?) I think it far from right to compel a nurse to remain in the hospital after graduation to repay damages to supplies, etc.

When a nurse has received her diploma I think she should be free to go. I know from personal experience that many times several orders are given in quick succession and, if the one receiving them happens to be a young nurse, is it any wonder that some of the orders may not be properly carried out? I recall a similar experience in the ward when I was a probationer. An accident case was brought in late at night—the superintendent unfortunately neglected to prepare the necessary things in the ward, although she was notified by telephone that a patient was coming. The doctor was in a hurry to get to another patient and showed his displeasure at the lack of readiness on the part of the superintendent, thereby causing her to assume a very injured air. The scene as a whole made a lasting impression on my mind as I happened to be the only nurse in the ward, the others having gone off duty early to attend a hospital entertainment. I was sent from the ward first by the doctor, then by the superintendent, for as many as a dozen things that I knew almost nothing about; meanwhile I

had to look after the other patients in the ward, and I have often wondered if Mr. Smith got the castor oil ordered for him or the hot water bottle ordered for Mr. Brown, or vice versa.

A HOSPITAL SUPERINTENDENT.



The Operating-Room Nurse

To the Editor of The Trained Nurse:

I read with much interest the article by Amy Armour in the November number of *THE TRAINED NURSE*. I fully agree with her in not giving pupils a full term in the operating room who do not show "special aptitude" for that line of work. A nurse who is capable of operating-room work will very quickly prove herself so, and where is the justice to surgeons, superintendents and other nurses to indefinitely keep an incompetent person as scrubbed nurse in hopes of making something of her. It can't be done. I speak from experiences gained during five years of hospital work. I know of nothing more exasperating than to have a blundering scrubbed nurse. Small hospitals in particular are judged largely by the operating-room work, and if special nurses are present that is the time that a poor scrubbed nurse is going to make a poor showing. Then, what kind of a report can the visitors give of the hospital? Surely, they have not gained any new ideas.

A competent, quick-witted scrubbed nurse will make herself so useful that the operation will have been finished without frowns and cross words from the surgeons if the superintendent happens to be called to half a dozen different places at once. If more superintendents would follow Miss Armour's advice there would be better service done the people who entrust their lives to us.

A SUPERINTENDENT OF NURSES.

The Practical Nurse

To the Editor of The Trained Nurse:

I read with interest the articles in *THE TRAINED NURSE* about having practical nurses supervised by trained nurses. Well, there are a number of them here, and I have made it my business to know them and to talk to them and even visit their patients and watch their methods, and I do not believe it would be possible for one of these to be supervised or take an order from any one but the doctor—for they are so sure that they know everything worth knowing, and are ever ready to offer their advice on any question where illness is concerned. I am also interested in the discussions in the nursing journals on the monopoly of the term "nurse" by the trained nurse.

How are those advocating it going to stop families from applying that word to anyone they wish to dignify with the name. A few months ago one of the first ladies in this town was speaking to me about her mother's ill health and I inquired if she was closely confined with her ailing parent. She said, "O, no, mother has a nurse." I inquired further and found mother's nurse was an obliging colored woman who "cleaned house" for people, or did the laundry work, or any other work which she could get to do. Now that was the family using the word nurse—not the colored servant at all—and I notice here, since seeing so much written about the word nurse, that if there is a baby born in a family and a young girl or woman goes and does the housework—washing and ironing, etc.—the family speaks of her as our nurse, yet the woman doing the work mentioned has never at any time called herself a nurse, and is not trying to make the public believe she is. It is the family at fault, and yet all the blame seems to be placed on these poor women who are trying to earn an honorable living. N. E., Ohio.

The Year Is Closed

The year is closed, the record made,
The last deed done, the last word said;
The memory alone remains
Of all its joys, its griefs, its gains;
Memory, and the character wrought
Out of experiences the year has brought;
In all the hand of God we see,
Guiding in love, unerringly—
And so with faith grown strong and clear
We turn to greet "the glad New Year."



GRADUATING CLASS, ST. PAUL'S HOSPITAL, VANCOUVER, BRITISH COLUMBIA

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

War Echoes

The special correspondent of *The Nursing Mirror and Midwives Journal*, London, England, in a recent issue gives the following interesting account of the wounded at Dunkirk:

"I was in London just a week, then received orders from St. John Ambulance Association to start with three other fully trained nurses for Dunkirk, to increase the staff of Millicent Duchess of Sutherland's Hospital, which has been established about a week. Here we are, working in a large cafe, built directly on the sands, facing the sea, at Malo-les-Bains, really a suburb of Dunkirk, about three-quarters of a mile away from the town proper. It consists of two floors, access to the upper being gained by a wide sweeping staircase at the end of the downstairs ward, and, built over the "bar," the long marble counter we find useful for many purposes. A glass partition separates the main room from a wide veranda, which on its outer side, facing the sea, has another glass screen. This veranda has twenty-five beds arranged in it, while the main ground floor room has forty-two. The former is being used as a receiving ward, as the majority of our cases arrive in the night, somewhere about 11.30 p. m., and this arrangement obviates the disturbance of the ward generally. Trains bringing up the wounded do not arrive until late afternoon or evening, and then the unloading takes time. We have some splendid motor ambulances, and these bring up the poor men from the station with as little delay as possible, once all the formalities have been gone through with the French Red Cross authorities.

"Almost all the patients have been wounded some days before they get into our hands, consequently the wounds are in a terrible state, the dressings frequently not having been changed for several days. The results include frequent amputation of limbs on admission, on account of gangrene having set in. All cases are selected by our doctors, and the most seriously wounded and those possessing a chance of recovery are the selected ones. This means a further wait at the station for many hundreds, who must take yet

another journey before they can find rest in a base hospital. They lie on straw in huge sheds, the spectacle being too terrible to describe. Many of the wounded on admission tell us they have not eaten for two days, and they are therefore cold and collapsed, and are truly grateful when they find themselves comfortably settled in bed, with hot drinks, blankets, and bottles.

"The upper ward extends over the veranda. It has at present forty beds, so our total number is just over a hundred. The end of our receiving ward is screened off, and has a few of the twenty-five beds in it, in which are placed patients who are best isolated. As our patients get well enough to travel they are drafted off to make room for more, the English, of whom we have not many, returning to England, and the French going on to Boulogne. In consequence our work is very heavy here, as all are such bad cases, many having several wounds, and, for the reason given, the state of many of the wounds means constant fomentation, both day and night.

"I am on night duty, with three others, and we are always very busy; our hours are 8 p. m. to 8 a. m., but it is frequently later before we finish. The day staff consists of eight, and all are fully trained, experienced nurses. The Duchess takes the greatest possible interest in each and all the patients, and has entire control of every department of the hospital. The staff are all English, including those in the kitchen. The patients are well fed, and we have plenty of suitable invalid foods, except that it is very difficult to procure fresh milk, so we use preserved; also eggs are very scarce. We have jugs of cocoa, lemonade, and Horlick's malted milk left ready for the night, as well as good, clear broth ready on the stove, and, in addition, drinks of tinned milk can be given if preferred.

"There are two orderlies on night duty with us, who belong to the Naval Sick Berth Reserve. They help us well in bringing in the stretchers, undressing the patients, listing the clothes ready to go in store, as well as attending to the central heating apparatus, which is very important, as, having only glass sides, the hospital gets very cold

at night unless plenty of heat is maintained in the pipes. A veranda runs down one side, similar to the one used as a receiving ward, and this is screened to make a small instrument room, a theatre, and a surgical store room. All the building is lighted by electric light, and at the back are numerous little rooms, suitable for pack store and soiled linen, whilst one has been arranged as a scullery. Outside the back entrance are drawn up two bathing machines, and these comprise our larders, and are quite satisfactory ones too.

"At night one looks out to sea, and there is the long line of battleships keeping watch and guard, while silent sentries pace the sands, and the searchlight plays over all. Sometimes the cannon boom all night, and when one nears an English patient's bed he says, 'That's one of our boats, Sister, talking again,' and he turns round with a sigh of satisfaction. Such is war. Thank God, they don't seem to realize the horrors as we do."

A despatch to the *Toronto Globe* under date of November 9, states that the honor of being the first Canadian unit to leave for the front has fallen to No. 2 Stationary Hospital and fifty Canadian nursing sisters. They left for France, November 9, Lieutenant-Colonel A. T. Shillington, Ottawa, in command. The staff includes nine officers and one hundred and fifty men.

The nursing sisters of the Canadian expeditionary force number about one hundred, and are in charge of Nursing Matrons M. C. Macdonald and H. Ridley.

Sister A. Karll of Germany has sent five hundred of her nurses to Austria. This is considered a very great compliment to the German trained nurses. One of Sister Karll's nurses received the Iron Cross.

Canadian nurses have very stunning dress uniforms of navy blue, with scarlet collars and cuffs and white facings. White kid gloves, which are worn on state occasions, combine to make the outfit a most attractive one.

Miss Daisy Mary Cox, a member of the Mountainside Hospital Alumnae Association, sailed on the "Finland" Saturday, November 21, to enlist in the Red Cross service in Serbia. The expense fund for Miss Cox's participation in the war relief is defrayed by a resident of Montclair, N. J., who makes the contribution through the State Committee of the Red Cross Society. Miss Cox has been head nurse in the Mountainside Hospital

operating room for some time, and was highly esteemed by all.

The nurses gave Miss Cox a farewell dance on Friday evening, which every one enjoyed.

Dr. Caroline Hedger, formerly in charge of the infant welfare work in Chicago, and her assistant, Miss Janet Hall, sailed on November 28 for Belgium to take charge of the work of caring for homeless children, under the Belgian Red Cross.

The Chicago Women's Club donated \$2,000 to Dr. Hedger and her assistant, to defray their expenses. They carried with them 10,000 doses of typhoid vaccine, prepared and donated by a Chicago woman physician at a cost of \$5,000 and 10,000 vaccine needles and \$700 worth of dressing given by the Red Cross.

Dr. Hedger is going to Belgium, it was announced, in response to an appeal from her friend, Mrs. Anne Fowler von Schelle, wife of the chief of the Red Cross workers in Brussels.

A very graceful tribute to the memory of a great pioneer of nursing service for the sick and wounded has been paid by the purchase of a motor ambulance out of the profits arising from the sale of Sir E. T. Cook's "Life of Florence Nightingale." The car, which is intended for immediate dispatch to the front, is being equipped by the British Red Cross Society.



Vermont

Miss Mary E. Schumacher, R.N., superintendent of the Brattleboro Memorial Hospital, Brattleboro, spent a few days of the week of November 15 at the Fanny Allen Hospital, Winooski, as guest of the reverend Sisters. During her stay at the hospital the nurses in training enjoyed the rare treat of a very interesting talk by Miss Schumacher on the various fields of activity open to the nurse of today as compared with that of the past. The more necessary qualifications of a successful nurse were brought out in clear and striking terms. Miss Schumacher laid particular emphasis on tact in various forms and loyalty to the alma mater and its teachers. A few numbers of instrumental and vocal music by the nurses brought to a close a very pleasant and interesting evening. The Vermont State League for Nursing Education, held its regular meeting at the Fanny Allen Hospital, Winooski, on November 10 at 7.30 p. m. In the absence of the president, the vice-president presided. After the regular routine of business a dainty luncheon was served by the sisters.

Reverend Sisters Coupal, Lefebvre and Dubuc, with Misses M. A. Bisson and Velma Wright, of the Fanny Allen Hospital, Winooski, took and successfully passed the State Board examinations for Vermont at its recent session.

Miss Eleanor Gero of the Fanny Allen Hospital has completed her affiliated course at the Harlem Hospital, New York City, and will be replaced by Miss Anna Sheridan.

Miss C. V. Costello has completed her course of training at the Fanny Allen Hospital and will return to her home in Middlebury, where she intends to take an extended vacation before assuming the duties of her profession.



Massachusetts

A series of interesting and instructive lectures are being given at the Suffolk County Nurses' Central Directory at 636 Beacon Street, Boston, and free to all members and other nurses. The first lecture was given by Dr. Arthur N. Broughton, on December 2, at 3.30 p. m. In January, Dr. Thomas F. Leen will be the speaker; on February 1, Dr. Richard C. Cabot; on March 3, Dr. Thomas M. Jackson, and on April 5, Dr. John T. Bottomley. Another speaker will be Miss Sara E. Parsons, superintendent of the Massachusetts General Hospital. Tea will be served on the second Friday of each month from 4 to 6 o'clock and all nurses are cordially invited.



Connecticut

The regular monthly meeting of the Alumnae Association of the Connecticut Training School for Nurses, New Haven, was held at the usual time and place, with the president in the chair, and other officers present. After routine business, it was voted to make the January meeting a social one, and to serve refreshments. Meeting adjourned.

The will of Mrs. Martha W. R. Wayland, widow of the late Dean Francis Wayland of the Yale Law School, has been filed in the probate court and by it is created a trust fund of \$15,000 to provide a woman missionary and trained nurse to care for the poor and sick of this city. The trust is established with Miss Susan E. Bradley and Mrs. Henry W. Farnam as trustees and, as the will reads, is "for the purpose of securing the services of a woman missionary who shall be a skillful trained nurse, to care for and minister to the

sick poor within the limits of the city of New Haven."

The regular November meeting of the Nurses' Alumnae Association of Grace Hospital, New Haven, was held at the dormitory with a very good attendance. In addition to the routine business the following were appointed to take charge of selling calendars for the nurses' relief fund: Miss Fenn, chairman; Miss Metzendorf and Miss Kuborec. After the meeting a pleasant social hour was spent with Miss Dick.



New York

The New York League for Nursing Education held a meeting at the nurses' residence, Bellevue Hospital, on November 4. The subject for discussion was "Some Modern Aspects of Efficiency in Its Relation to Hospital and Nursing Work." The speakers were Mr. E. J. Porter, ex-secretary of the Efficiency Society; Josephine Goldmark, of the Consumers' League, and Mr. R. N. Walker, secretary of the new Efficiency Society. The following were elected to act as chairmen of committees: Administration, Miss Murdock; Public Health and Social Service, Miss Tucker; Credentials, Miss Johnson; Program, Miss French.

The nurses of the Buffalo General Hospital Alumnae held a sale of fancy articles and baked goods for the benefit of the Alumnae and the Red Cross Fund, at the nurses' home of the Buffalo General Hospital, November 24. At nine o'clock in the evening Mr. Kenneth B. Lloyd and Miss Lorraine Fisher gave a demonstration of dancing.

The Clifton Springs Sanitarium Training School and Alumnae combined their efforts in holding a bazaar in the Sanitarium gymnasium on November 19 for the benefit of the Nurses' Home Fund. The affair was a wonderful success, about \$1,000 being realized.

The regular monthly meeting of the alumnae which was held in the lecture room, December 4, was attended by twenty graduates. A splendid paper was read by Dr. Loring T. Swann on "Posture in Relation to Visceral Ptoisis."

Miss Anna Smith and Miss Evelyn McClelland, graduates of Clifton Springs Sanitarium, will spend the winter private nursing in St. Augustine, Fla. Miss Edith Woodsworth has returned from three months' vacation and accepted a position as office nurse to Dr. M. S. Woodbury, physician in chief of the sanitarium staff. Miss Anna L. Mather has accepted a position as head operating-room nurse.

The graduating exercises of the class of 1914, St. Joseph's Hospital Training School for Nurses, Syracuse, were held at the nurses' home, Thanksgiving evening, November 26. Those who received diplomas are: Stella Catherine Alt, Martha Ester Barnston, Katherine Julia Bowes, Margaret Anna Donlon, Mary A. McGarry, Margaret Winnifred Morris, Mary Elizabeth Sheedy, Nina Mae Strife.



New Jersey

EXAMINATION QUESTIONS

Anatomy and Physiology—1. Name in order the divisions of the alimentary canal. 2. Into how many classes are bones divided? Give an example of each. 3. Name the organs contained in the thorax, abdomen, skull, pelvis. 4. Give a brief description of the heart. What vessels carry the blood to the heart? What vessels carry it from the heart? 5. Name the two classes into which muscles are divided. 6. What is understood by origin and insertion of muscles? Name the principal muscles of the back. 7. Name two openings in the stomach. 8. How is the waste of the body eliminated? 9. Define normal pulse. Name principal points to be observed in deviations from it. 10. Give average rate of pulse during infancy, youth, adult.

Hygiene—1. What are some of the sources of contamination of drinking water? 2. To what is much of the clogging of pipes of kitchen sinks due? How can it be prevented? 3. What is ventilation? 4. What is necessary to insure perfect ventilation? 5. What is the legal requirement in New Jersey concerning the public drinking cup? 6. Give the reasons for the crusade against the house-fly. 7. Why are cleanliness, rest and recreation essential to health? 8. How should milk be cared for and how should milk utensils be cleaned? 9. Why are flies, insects, rats, etc., a menace to health?

Bacteriology—1. What effect has prolonged sunlight on tubercle bacilli? 2. Name two conditions that favor the growth of all species of bacteria. 3. How do bacteria gain entrance to the body? 4. What is an infectious disease? 5. Name three methods by which germs may be destroyed. 6. Describe how flies may become carriers of disease. 7. Describe in detail the preparation of your hands before assisting at an abdominal operation. 8. Name two ways in which communicable diseases may be transmitted. 9. Why is a working knowledge of the principles of bacteriology necessary in the education of the trained nurse? 10. Define the following terms: incubation, asepsis, sterilization.

Medical Nursing—1. (a) What special points must be remembered in nursing a patient taking open-air treatment? (b) In cold weather how would you protect yourself and patient? 2. What are stupes used for and how would you administer them? (Give process in detail.) 3. What would you do to relieve a patient suffering from insomnia? 4. What measures can you take to encourage a patient to void urine before resorting to catheterization? 5. (a) What are the symptoms

of hemorrhage? (b) In case of pulmonary hemorrhage what would you do before the arrival of the physician? 6. What would you do to prevent bed-sores? 7. In charting perspiration as a symptom, what points should be noted? 8. How would you care for a paralytic case? 9. What precautions would you take in nursing a case of pulmonary tuberculosis, and what instructions would you give the family and the patient? 10. What is the general care of a pneumonia case?

Materia Medica—1. Mention the channels through which medicine is introduced into the circulation. 2. Write the tables of the apothecaries' weight and measure. 3. How much salt should be added to one quart of water to make a normal salt solution? How would you prepare it in a private house? 4. Name two preparations of nux vomica. Give the dose of each. 5. What precautions would you use in giving tr. ferri chloride, or other solutions containing iron? 6. What are the symptoms of an overdosage of arsenic? Morphine? Give treatment for same. 7. What are the symptoms of strychnine poisoning? What are the symptoms of opium poisoning? Give the antidotes for strychnine and opium poisoning. 8. If told to give gr. 1-150 of strychnine by hypodermic injection and only tablets gr. 1-30 were available, how would you prepare the dose? 9. Complete the following table: ? cc = 3. i. ? cc = 0. i. ? minims = cc. ? gr. = gm. ? oz. (Troy) = lb. What strength solution of creolin is usually prescribed for a vaginal douche?

Surgical Nursing—1. How would you sterilize scissors, dressing forceps, scalpels and needles? 2. What are the means used to control hemorrhage? 3. After operation, how long would you let a patient go without voiding urine before reporting it? 4. State in detail the care of a perineorrhaphy. 5. What are the symptoms of shock and how do they differ from those of hemorrhage? (b) How would you treat shock until physician arrives? 6. How would you prepare a room in a private house for an operation? 7. Outline briefly the care of a patient after an abdominal section. 8. Describe the Fowler's position and for what is its use. 9. Describe briefly the preparation for dressing a wound. 10. How would you sterilize silk wormgut and silk sutures?

Obstetric Nursing—1. State what care you would give an obstetrical patient the first forty-eight hours after delivery. 2. What are the complications to be watched for during the puerperal period? 3. What is the function of the amniotic fluid, and why should membranes be preserved intact during the first stage of labor? 4. What important points should the nurse note and report regarding the lochia? 5. What care would you give the breasts to prevent infection? (b) If a mother was not to nurse the baby? (c) A baby's breasts if swollen? 6. Name the articles to have at hand for patient, doctor and nurse during the progress of labor. 7. What is the placenta? (b) Why should it be carefully inspected after expulsion? 8. In case of post-partum hemorrhage, what should a nurse do until the arrival of the physician? 9. What is the pelvis and of what bones does it consist? 10. What are the three stages of labor?

Preventive Medicine and Food

As a practitioner of preventive medicine, you are naturally interested in pure, wholesome, appetizing food.

Baking powder is an essential constituent of many of the most appetizing and nourishing foods. It is therefore of much importance that the baking powder used in making these foods should be thoroughly pure and free from injurious ingredients found in alum baking powder.

The best and most healthful baking powders contain Cream of Tartar as their chief ingredient.

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contains no alum or other aluminum salts. It is made from pure, healthful grape cream of tartar and is backed by Government tests.

Practitioners of preventive medicine are therefore strongly advised to recommend **Royal Baking Powder**.

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NEW YORK

Diseases of Children—1. What points would you emphasize in teaching a mother the preparation of artificial food for a sick infant? 2. What should be done for a child in convulsions before the arrival of the physician? 3. State the capacity of a normal infant's stomach. 4. Define certified, pasteurized, sterilized milk. 5. Mention some of the causes of diarrhea in children and state briefly the care you would give such patients. 6. How would you give an enema to a very young child? (b) An aural douche? 7. When is a child who has had scarlet fever released from quarantine? 8. Describe the nurse's duties as to room, patient and herself in the care of a child ill with diphtheria. 9. Why is it beneficial for children suffering with adenoid growths to have them removed? 10. Give four causes of infant mortality.

Contagious Diseases—1. When would you isolate a case of erysipelas and for what reason? 2. Name five contagious diseases. 3. (a) What are the common complications of scarlet fever? (b) State nursing care you would give the same. 5. Define incubation, invasion, immunity, desquamation, quarantine. 6. In the care of a contagious disease, what are the duties of the nurse regarding herself and the sick-room? 7. How would you care for a case of typhoid fever to prevent the spread of the disease? 8. How would you prepare a room for fumigation? 9. Give symptoms of measles, chicken-pox.

Dietetics—1. Why are drinks made from fruit juices especially valuable for fever patients? 2. Describe the process of making beef tea. 3. Name four uses of water in the body and the value of milk as a food. 4. Name three diseases requiring special diet. Give proper menu for one meal in each disease. 5. Which is most easily digested, raw, soft, medium or hard-boiled eggs? 6. Describe the care of milk. 7. What disease is often caused by impure milk?



Pennsylvania

The regular monthly meeting of the alumnae Association of the Philadelphia Lying-In Charity Hospital was held at the hospital on Thursday afternoon, December 3, at two o'clock. The second vice-president, Mrs. Meehan, presided in the absence of the president. Twenty members were present. At the January meeting the alumnae election of officers will be held.

The Nurses' Alumnae Association of the Woman's Hospital of Philadelphia held its first annual meeting (after the summer vacation) October 14 at the hospital. In the absence of the president, Miss Guthrie, and vice-president, Miss Bratton, Miss Peters called the meeting to order. All the various committees gave good reports. It was decided that the alumnae join the classes in parliamentary law given by Mrs. John F. Lewis at the Graduate Nurses' Club.

The classes were well attended and we had the

pleasure of Mrs. Lewis as a guest at our December meeting. Eight new members have been elected this fall. The ballots for 1915 have been sent to every member of the alumnae and each nurse is asked to pledge a dollar towards the pension fund for nurses and return same with ballot at the January session. At present, the Woman's Hospital is adding two additional stories and a covered roof garden to the children's department, also a modernly equipped milk room for the preparation of formulae. We are glad to state our faithful treasurer, Miss Greaney, who had been ill most of the summer is recuperating and able to attend the monthly meetings of the alumnae.

Mrs. Entwisle was elected delegate to the State convention held in Pittsburgh in November and gave a very interesting report at the December meeting. The meetings have been well attended and we are hoping 1915 will bring still better results.

The following nurses were graduated from the Mt. Pleasant Memorial Hospital, Mt. Pleasant, in the class of 1914: Miss Cora Hohman, Miss Sarah Hood. The address to the nurses was made by Dr. Hartman, pastor of the Presbyterian Church. The pins and diplomas were presented by Dr. Mary L. Montgomery.

The annual meeting of the Alumnae Association was held the same day the new class was received. The following officers were elected for the ensuing year: President, Miss Pearl Thom; first vice-president, Florence Couch; second vice-president, Miss Pauline Mistlebaur; secretary, Miss Pearl Rodman; treasurer, Miss Eva Shram.

Laying aside for a brief time the cares of their calling, the nurses of the York Hospital and Dispensary with some invited friends enjoyed an entertainment of considerable beauty in the Nurses' Home on Thanksgiving night. All who could be spared from duty took part. There was music as well as dancing and, as a bit of variety, games were played. All was of the order that would fit in with the place and the time and cause no annoyance to any inmate of the hospital proper. The rooms were handsomely decorated for the occasion.

The Graduate Nurses' Alumnae Association of the Samaritan Hospital, Philadelphia, passed the following resolutions on the death of Mrs. Una B. Scott, a member of the Nurses' Alumnae Association, who died September 5, 1914.

WHEREAS, It has pleased our Heavenly Father

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makes cow's milk easy of digestion by the baby, because the curd, which many babies experience difficulty in digesting, is broken up so thoroughly by the Mellin's Food that the digestive juices readily act upon it. Thus, the inability of the baby to properly digest the curd of the milk is eliminated.

We will gladly send samples and literature to nurses.

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to call to rest our beloved sister nurse, Mrs. Una B. Scott, therefore let it be

RESOLVED, That the members of the Alumnae Association of the Samaritan Hospital regret the loss of one who has so faithfully filled her duties.

The Alumnae Association of the Dixmont Hospital Training School for Graduate Nurses was organized on the 30th of November, 1914. Those present included Mrs. E. B. Eberman, Miss M. E. Hetvick, Miss B. Teevans, Mrs. E. Cahill Pennycook, Miss M. Hudson, Miss C. W. Siegfeld, Miss D. Holbert, Miss R. A. Sloan. Letters were received from many of the graduates who were unable to be present, but they assured us of their cooperation. The officers for the year are as follows: Miss C. W. Siegfeld, Sewickley Valley Hospital, president; Miss M. E. Hetvick, Fairview Sanatorium, Pittsburgh, vice-president; Miss R. A. Sloan, Hydro-Therapist, Dixmont Hospital, corresponding secretary; Miss D. Holbert, Chief Nurse of the Receiving Ward, Dixmont Hospital, treasurer.



Ohio

The graduating exercises of the Canfield-White Training School for Nurses, Cleveland, took place Thursday evening, November 12, at the Euclid Ave. Christian Church. A large audience thoroughly enjoyed the fine musical program presented, two vocal solos by Mr. R. Wilson Derby, rendered in his masterly style, several beautiful violin solos by Miss Helen E. Allyn and a number of orchestral selections by the Cleveland Mandolin Club, led by Mr. J. G. Liddicoat. Mrs. Anna Moncure P. Tucker, principal of Tucker School of Expression, gave a delightful and forceful talk to the nurses which was listened to with marked attention. Prayer was offered and the benediction pronounced by Rev. E. A. Simons. The graduates, Miss Julia A. Terry, Miss Florence M. Reed, Miss Louise E. Aust, Miss Isabelle M. Radigan, received medals from Dr. Mary H. White and diplomas from Miss Florence Nightingale Maillue, principal of the Training School. Later a sumptuous banquet was served to the nurses and their friends at the hospital, where decorations of crimson and blue, the class colors, were much in evidence.



Arkansas

The Alumnae Association of St. Vincent's Training School for Nurses, Little Rock, gave their first annual reception and banquet in No-

vember, and it was a most enjoyable function. The spacious lecture room at St. Vincent's was beautifully and artistically decorated for the occasion, Southern smilax and roses being used in great profusion. The guests were welcomed by the president of the alumnae, assisted by the members. A musical program was rendered. At the conclusion of the program all repaired to the banquet hall where a most tempting seven-course spread was served. Here, too, the place was made attractive by the use of Southern smilax and many large yellow and white chrysanthemums. Rev. Father Saunders acted as toastmaster, and after a few well-chosen words in praise of the organization, he most tactfully introduced the speakers, Rt. Rev. Jno. B. Morris, Governor Hays, Hon. Chas. E. Taylor and Drs. W. B. Hughes and Carl Bentley. Ninety guests were seated.



Kansas

The second annual commencement of the Montgomery County Hospital Training School for Nurses, Independence, was held on the evening of October 30, 1914, at the First Baptist Church. The exercises opened with an organ voluntary, followed by the invocation by Rev. A. B. Appleby. The address to the graduates was given by Prof. S. M. Nees, and the presentation of diplomas by Dr. C. W. De Mott, president of the board. There were several musical numbers. The exercises closed with benediction by Rev. C. S. Burns. The graduates are: Eileen Josephine Cramer and Rose Cleveland Hailey.



Personal

Miss C. P. Vanderwater has resigned her position as principal of the Training School for Nurses of Grace Hospital, Detroit, after seven years of service in that institution. For a couple of years her health has been more or less impaired, until a serious breakdown occurred necessitating a rest of several months. For the present, mail may be addressed to her at her mother's home, 77 Jefferson Street, Muskegon, Mich.

Miss Harriet Leek, formerly principal of the General Hospital Training School for Nurses, Kansas City, Kan., succeeds Miss Vanderwater at Grace Hospital, Detroit, Mich.

Miss Elizabeth Donat, formerly directress of nurses at the Westmoreland Hospital, Greensburg, Pa., has been elected superintendent of the



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Mt. Pleasant Memorial Hospital, Mt. Pleasant, Pa.

Miss Jessie Harrod is starting a training school for nurses at the new hospital of the Ohio State University at Columbus.

Miss Elysian A. Thomas, superintendent of Lakeside Hospital, Milwaukee, Wis., was seriously injured in an automobile accident.

Miss Eleanor A. McI. Jones, superintendent of the city tuberculosis nurses, Baltimore, Md., recently underwent an operation for appendicitis.

Miss Laura Pair has been appointed school nurse by the Dallas (Tex.) Board of Education. Miss Pair taught four years in the public schools of Missouri, is a graduate of the Dallas Training School for Nurses, and has taken post-graduate work in nursing at Bellevue Hospital in New York. She is a registered trained nurse and has been engaged in that work for some years, having been supervisor of operating rooms in Indianapolis and Dallas. During the latter portion of the season she was in charge of the Dallas baby camp.

Miss Mary A. Smith, superintendent of the York Hospital, York, Pa., who was operated on recently for appendicitis, is improving rapidly and there is every indication of her speedy recovery.

Miss Katherine Hoffmann, formerly of Walla Walla, Wash., a graduate of the Ensworth Hospital, St. Joseph, Mo., also a graduate of the Pennsylvania Orthopaedic Institute, Philadelphia, Pa., has been placed in charge of the mechanical department of the Phipps Psychiatric Clinic of the Johns Hopkins Hospital, Baltimore, Md.

The Cortland Sanitarium, Cortland, N. Y., has engaged the services of Miss Bertha Bassett, R.N., Cortland, N. Y., a graduate of the Cortland Hospital, also a graduate of the Pennsylvania Orthopaedic Institute, Philadelphia, to take charge of its mechanical department.

The Methodist Episcopal Hospital, Brooklyn, N. Y., has engaged the services of Miss Anne Cheairs, Delaware City, Del., a graduate of the Episcopal Hospital, Philadelphia, also a graduate of the Pennsylvania Orthopaedic Institute, Philadelphia, to take charge of the mechanical department of that hospital.

Marriages

On December 24, 1914, at the home of her parents, Cambridge, Mass., Hulda Millet, R.N., graduate of Waltham Training School for Nurses, class of 1914, to Lieutenant William Harris Booth, U. S. N. Mrs. Booth will go to the Philippines with her husband. Her permanent address is care of Lieut. W. H. Booth, Navy Department, Washington, D. C.

On August 28, 1914, Miss M. A. Muller, R.N., superintendent of Mt. Pleasant Memorial Hospital, Mt. Pleasant, Pa., to Herman Hamel of Mt. Pleasant.

In August, 1914, Edna Lewis, R.N., class of 1913, Mt. Pleasant Memorial Hospital, Training School, Mt. Pleasant, Pa., to Cecil Loucks of Scottsdale, Pa.

On February 21, 1914, at Butler, Pa., Nora I. Muth, R.N. of Pittsburgh, to Otto J. Johnson of Anita, Pa. Mrs. Johnson graduated from the Adrian Hospital Training School, Punxsutawney, Pa., class of 1912, also from Magee Maternity Hospital, Pittsburgh. At the time of her marriage she was directress of nurses at the Ohio Valley Hospital, McKees Rocks, Pa. After their marriage Mrs. Johnson continued her nursing work in Pittsburgh and Mr. Johnson returned to Anita. Their marriage secret was a great surprise to their friends.

On November 25, 1914, at St. Thomas' Church, Waterbury, Conn., Mary F. Mays, graduate of Waterbury Hospital Training School, class of 1912, to Dr. William H. O'Neil.

On October 19, 1914, at St. Paul's Church, Bremerton, Washington, the Rev. Charles Holmes, brother of the bride officiating, Gertrude Holmes to Morris Russell Moon. Mrs. Moon was formerly nurse at St. Mary's School at Fairbault, Minn., and later of Good Samaritan Hospital, Valdez, Alaska. Mr. and Mrs. Moon will make their home at Sequim, Washington.

On October 26, 1914, at St. Mary's Church, Haledon, New Jersey, Harriett A. Gerold, graduate nurse of the Paterson General Hospital, class of 1912, to Ward H. Chadwick.

On September 7, 1914, Eva M. Shrum, R.N., class of 1910, Mt. Pleasant Memorial Hospital, Mt. Pleasant, Pa., to Jas. A. McMahon, of Tarr, Pa.

Metabolism

describes the process by which living cells incorporate the elements obtained from food into part of their own bodies.

In most healthy subjects this process is accomplished with little or no expenditure of excess energy, but in the sick and convalescing patients this ordinarily simple, natural phenomenon becomes an effort, unless the diet is in keeping with the existing conditions.

The sick need the strength which is usually imparted to the healthy by a variety of food, but it is obvious that they could not digest it. It, therefore, becomes necessary to select one food which contains the necessary ingredients required to easily establish bodily resistance.

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On November 10, 1914, Lillian Reckner, R.N., class of 1913, Mt. Pleasant Memorial Hospital, Mt. Pleasant, Pa., to Chas. Hough of Scottdale, Pa.

On November 25, 1914, at Portland, Oregon, Helen R. Sibel, graduate nurse of the Germantown (Pa.) Hospital, to Dr. Garrett Lee Hynson.

On November 26, 1914, at the residence of the bride's parents, Fort Edward, N. Y., Elizabeth Anne Henry, to Walter Arnstein of New York.

On November 26, 1914, at Ogdensburg, N. Y., by the Rev. J. S. Wilds, Phyllis Whitworth, to Clements Hyde, both members of the nurse training class of 1914 of the St. Lawrence State Hospital.

On November 25, 1914, at St. Anthony of Padua Church, Philadelphia, Pa., Lillian Frances Hopkins of the nursing staff of the Philadelphia Hospital, to Dr. Henry Joseph E. Newnam, chief visiting physician.

On November 21, 1914, at the Presbyterian Church, Ellicott City, Md., Edna Earle of the nursing staff of the Maryland General Hospital, to Thomas Gemmill.

On November 17, at Minneapolis, Minn., Lena Smidt, first graduate nurse of the Park Hospital, Mason City, Iowa, 1913, to Lawrence McNamee. Mr. and Mrs. McNamee will reside at 220 West Marna Street, Mason City.



Deaths

On November 14, 1914, at Gouverneur Hospital, New York, where she had been engaged during the past months, Laura Conrad, graduate of the Long Island Hospital, Boston Harbor, Mass., class of 1910, and post graduate of Infants' Hospital and Boston Lying-In Hospital. Miss Conrad succumbed from an infection following mumps despite faithful nursing and the heroic efforts made to save her. Interment at Lunenburg County, Nova Scotia.

On September 27, 1914, at Good Samaritan Hospital, Cincinnati, Ohio, Marguerite Gainey, a graduate nurse of the Good Samaritan Hospital, class of 1911. Miss Gainey's death followed an

operation for obstruction of the bowels. She was a member of the Alumnae Association, a faithful worker, and a most self-sacrificing nurse; was much loved and will be sadly missed by her many friends and associates.

On November 16, 1914, at Henrietta Hospital, East St. Louis, Doris Pruitt. Miss Pruitt's death followed an operation. She was a senior nurse at the Henrietta Hospital.

On November 11, 1914, at Mercy Hospital, Altoona, Pa., Maria B. Kleinsorgen, a student nurse of the hospital. Death was due to typhoid fever.

On August 5, 1914, at the home of her mother, Pleasant Grove, Belmont Co., Ohio, Mary Laura McMillian, class of 1895, Woman's Hospital, Philadelphia, Pa. Miss McMillian was a member of the Alumnae and State Associations. She spent most of her time in private work.

On November 28, 1914, at St. Mary's College, South Bend, Ind., Sister Mary Lydia (Mary Clifford). She was nearly eighty years of age, and was a famous war nurse.

During the Civil War she was in charge of the hospital camp at Moline, Ill., and during the Spanish-American War she directed the work in the camp at Lexington, Ky. Later she was sent to St. John's Hospital at Anderson, Ind., and in 1902 she was placed in charge of Our Saviour Hospital at Jacksonville, Ill. In 1910 poor health compelled her to abandon the work and she returned to St. Mary's.

On November 27, 1914, at St. Vincent's Hospital, Norfolk, Va., Mary A. Young. Miss Young was a native of Chicago, and had been at St. Vincent's Hospital as a trained nurse for twelve years.

On September 17, 1914, at Evansville, Ind., Lydia Metz, graduate of the Deaconess Hospital, Evansville, Ind., and district nurse of the same city for twelve years. She was a noble woman who had done much good among the poor. In her death, the city has lost an efficient nurse, whose example as a municipal worker and a Christian stands worthy of imitation by all. The Evansville Nurses' Association extended sympathy to her relatives, deeming her a sister worker and friend whose place could never be filled.

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contains valuable nutrients—phosphates of calcium, sodium, magnesium and iron. It is, therefore, far superior to Dilute Phosphoric or other acids.

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A teaspoonful in a glass of cold water
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Book Reviews

A Doctor's Viewpoint. By John Bessner Huber, A.M., M.D., Fellow of the American Medical Association and of the New York Academy of Medicine, and editor of the *Dietetic and Hygienic Gazette*.

Dr. Huber, who is a well-known contributor to medical and other journals, has brought together in this volume a number of papers dealing with medical topics of popular interest. Several of these have already been published in such periodicals as the *Scientific American*, *Harper's Weekly* and the *American Review of Reviews*, and all deal with live present-day problems. The first and longest chapter is entitled "A Twentieth Century Epic," and tells something of the dramatic battles and triumphs which have made the new century already notable in the history of medicine. The story of the rise of preventive medicine, the conquest of yellow fever, and Colonel Gorgas's renovation of the Canal Zone make very interesting reading. "The Elimination of Tuberculosis" is another chapter which will appeal to a wide audience. "Danger Signals" is a practical word of warning to those inclined to neglect the early signs of disease which, if not taken in time, may have the most serious results. "The Prevention of Cancer" is an especially timely paper. "Woman's Seven Ages," "after Shakespeare,—a long way after," says the writer, gives a physician's view of the gentler sex, from the time when the baby girl arrives, dowered with the good or bad inheritance forced upon her by those responsible for her being, to the day when "the justified mother of men rests in her armchair, . . . surrounded by her comforting children and her children's children, whilst the rays of the setting sun touch warmly her whitened hair." The chapter dealing with "Eugenics" preaches no cold and repellent doctrine of marriage on scientific principles only, but "would combine with love, if such a thing is possible, common sense and forethought." Other interesting chapters are "Let Us Get Out Into the Sunshine," "Sense Training," "Medical Research and Education," "Euthanasia," and "The Philosophy of Prayer." While making no pretense of exhaustive treatment of a subject, the papers are enlightening

and thought provoking, and their point of view is sane, wholesome and optimistic. Dr. Huber has the journalist's power of arresting and holding the attention, and this latest volume of his should add largely to the number of his readers.



The Psychic Uplift, or the New Mind Cure. By Mazetta Lairy. Price, \$2.50.

Mrs. Lairy's book has as its purpose the exposition, in simple language, of the leading principles of scientific psychotherapy, or mental treatment of physical, mental and moral disorders, with practical suggestions for their application in every-day life. The leading thought of the book is the curing of faulty habits of thought, which may lead to evil results of many kinds, by holding helpful thoughts resolutely in the focus of consciousness. This, in one form or another, is the keynote of every system of psychotherapy, though Mrs. Lairy scarcely gives sufficient credit to the excellent work which has been done along such lines. Her advice to the reader is that when an unhealthful thought, such as hate, or self-indulgence, arises in the mind, the attention should be deliberately fixed on the corresponding desirable thought, as love, or self-control. The book is simple and clear in style, and wholesome in tone.



A Medical Dictionary for Nurses. By Amy E. Pope. Giving the definition, pronunciation and derivation of terms used in medicine, together with supplementary tables of weights, measures, chemical symbols, etc. Arranged with special reference to use by nurses. Price, \$1.00.

The author of this work tells us that its purpose is to provide a medical dictionary containing a detailed definition of words and terms of special importance to nurses. Some words usually included in medical dictionaries, but which nurses are not likely to look for, have been omitted. In compiling the definitions, the latest books on bacteriology, chemistry, physics, physiology and medicine have been consulted.

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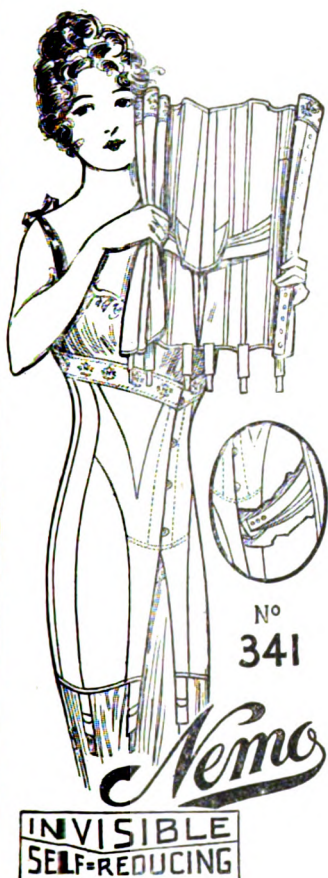
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A Monthly Magazine for Trained Nurses and Hospital Workers. Devoted to Trained Nursing in Private Practice and in the Hospitals of the Country

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ANNETTE SUMNER ROSE

Associate Editor
CHARLOTTE A. AIKENS

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Reprints Acknowledged

We beg to acknowledge with most cordial thanks the following reprints: *The Histological and Clinical Changes Induced by Radium in Carcinoma and Sarcoma*, by Dr. W. H. B. Aikins, Consulting Physician, Toronto General Hospital, and R. M. B. Simon, M.B., L.M.C.C., Pathologist to Grace Hospital, Toronto. Reprinted from *Dominion Medical Monthly*, September, 1914.

Personal Experiences with Radium, by Dr. W. H. B. Aikins, reprinted from the *Canadian Practitioner and Review*, September, 1914.



Ten Self Commandments for the New Year

- I WILL say a hearty "hello" at half a chance, and help everywhere.
- I WILL practise smiling until it becomes a fixed habit.
- I WILL cultivate my heart as well as fill my pocketbook.
- I WILL not forget to say "thank you" to God and man.
- I WILL swallow three times before talking when angry.
- I WILL not criticize but compliment folk, and that not gingerly.
- I WILL choke back complaints about aches, ills, and bad luck.
- I WILL take my head and heart to church quite regularly.
- I WILL say my prayers with a child's spirit and an adult's will.
- I WILL daily look myself over and make all possible improvements.

—C. F. Reisner.



We acknowledge with thanks the Report of The District Nurse Association of Scranton, Pa., for 1912-1913. The Report teems with interest, and shows the splendid work the association is doing.

The Trained Nurse and Hospital Review

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No. 2

Teaching Ethics in Hospital Schools

CHARLOTTE A. AIKENS

ARTICLE I

OF THE importance of the proper teaching of ethics in hospital schools there is little room for argument. Ask a company of a hundred or a thousand superintendents of hospitals and training schools whether they consider the teaching of ethics to pupil nurses—and head nurses, too—is an important thing to be included in their school plans for a year, and you would hear a perfect chorus of “We certainly do.” There would not likely be a dissenting voice. But when you came to the question of *how* they planned to teach it, the chances are that you would be tremendously disappointed in the answers you received. They would tell you, of course, that they always made a place for *ethics* in their curriculums. They would perhaps tell you that they combined the teaching of ethics with the history of nursing, though why this combination should ever be made is not clear to the average mind.

If we are going to combine ethics with any other subject, do let us combine it with the teaching of the *practice* of every-day nursing—do let us treat it as if it were of some real and practical use and value—as if it were an *essential* in a nurse's training—not something that could be left out without any serious loss to the pupil in training.

“How do you teach ethics in your training school?” is a question I have asked at different times and in different places. I am shown the printed curriculum with perhaps two or three talks on ethics at the beginning of the fall term—for the school as a whole. If I inquire a little more closely I find that in the first lecture the superintendent of the hospital explains the relation of the new pupils to the hospital, and in a general way tries to tell them what the hospital expects of them. If there is a second lecture, it probably dwells quite emphatically on loyalty to the doctor, the keeping of patients' affairs secret, and on the virtues of punctuality and obedience. So far so good. None of these ought to be omitted. It is when I begin to inquire further into “The How of Ethical Teaching in Hospital Schools” that I find myself getting into the realms of chaos, so far as this subject is concerned. Some superintendents will tell me that they always give “a little something” about Florence Nightingale in their lectures on ethics—but *just how* that “little something” is related to the ethics of every-day life as it concerns pupil nurses and head nurses, I am unable to learn. The one who does the teaching of the “little something” doesn't know how it relates to the life of her nurses,

but in a vague sort of way she feels that this sort of teaching is expected of her, and she tries feebly to measure up to general expectations.

And yet there is no subject which affects more vitally the training-school spirit and the highest training-school success than the matter of ethics and how it is handled in the school. We can add to our curriculum the finest course in laboratory instruction ever devised. We can add hours on hours of class work in anatomy and bacteriology and various other "ologies," but the reputation and character of our schools and of our pupils and graduates will not be influenced half so profoundly by all these additions or the lack of them as it will be influenced by our faithfulness in the ethical teaching of our pupil nurses. The spirit in which they do their work is tremendously important.

"I always give my new probationers a half-dozen talks on ethics when they first come into the school, but after that I am pumped clean dry, and I don't pretend to keep up teaching ethics beyond the probation period," said a superintendent, not so very long ago. And there are others—hundreds of them.

There is another type of superintendents who apparently labor faithfully on the teaching of ethics—their lectures resolving themselves into moral discourses on various virtues and sins—without tying the teaching up to anything particular in the life of the pupil nurse that will make the teaching stick. And the teaching rolls off the nurses like water off a certain bird.

There is nothing that the training schools of the United States and Canada need more than to get down to rock-bottom facts and principles in the teaching of ethics, and to evolve a practical system of dealing with this great fundamental matter in the development of character in nurses. And the failure to adequately meet this great need in our nursing education is affecting training

schools in a hundred practical ways. It is affecting the whole nursing structure.

A young graduate of a certain large and well-known school went to nurse a maternity patient in an apartment hotel. The family had a small suite of rooms and went to the general table in the basement for their meals. Arrangements had been made with the housekeeper for a tray to be sent to the patient. The nurse was to go to the general dining room for her meals. It seemed a perfectly simple and altogether admirable arrangement under the circumstances. How did it work out? The housemaids of the hotel had a regular schedule and routine of work which they were expected to follow in their cleaning. To hold their jobs they had to obey orders and attend to the rooms and halls in regular order. The nurse paid no attention to the maids' schedule. She was always bathing the baby or attending to the mother when the maid came to clean the room, and the nurse refused to be disturbed. There was a broom, dust-pan and dust-cloth in the closet off the bathroom, but the nurse considered herself above touching such common household appliances and in a few days the rooms became disgracefully dirty. The patient's husband complained at the hotel office of the supposed neglect of their apartment. The housekeeper called the maid to inquire. The maid blamed the nurse. The housekeeper and the proprietor blamed the nurse, and in three days she had stirred up the whole hotel family and incurred their ill-will—without apparently doing anything "unprofessional."

In this small apartment there was but one bathroom. This nurse believed in a rather elaborate *coiffure*—I think that is the proper term to apply to it. She also believed in the morning bath. The man of the house was accustomed to shave in the bathroom in the morning before going down for his breakfast, and when the nurse insisted, morning after morning, on shutting herself in the bathroom for nearly an hour, the

man of the house became irate and threatened to discharge her after the second experience of this kind. The tearful wife begged him to avoid having a fuss, and they endured the nurse for two weeks. When she left they vowed to all their friends that they would never have a — Hospital nurse inside their doors again. Not this nurse only but the other graduates of the school, and the school itself suffered from the failings described—yet the nurse had committed no real crime. What was the trouble? “A lack of common every-day sense,” you say. Perhaps so. And yet what is common-sense but wisdom that will guide us as to the best way to conduct ourselves and our work in the circumstances in which we find ourselves.

If we are to send out nurses properly fitted to give satisfactory service in homes after they leave our schools, we cannot neglect the practical teaching that touches the needs of different sorts of homes—whether those homes are in hotels or apartment houses or on boulevards or side streets or farms.

“But,” you say, “you cannot expect the training schools to anticipate all sorts of conditions and give the nurses rules of conduct to govern them in a thousand varying circumstances.” We can never hope to give *rules*, but we can give *guiding principles* to our nurses that will help them in the multitudinous perplexities they will have to meet. If we teach the Golden Rule in its practical application to families as a whole, to the maids and other servants we have to deal with, to the friends and others concerned, we will have gone a long way toward helping a young nurse to steer her course safely through the various conditions she has to meet. And the Golden Rule is just as important to be taught in its application to nursing in hotels or apartment houses, flats, cottages, etc., as are the rules for giving medicine, for applying bandages, for putting on stipes and a thousand other practical

rules which we try to make sure our nurses know before we sign their diplomas.

A certain Ohio city gained distinction for itself because it elected a mayor who was determined to meet his responsibilities with the Golden Rule always in view. He kept a copy of the Golden Rule in his office—and the world marveled—even as it marveled nineteen centuries ago, when the Golden Rule was given to men. It might not be an altogether bad plan to have a copy of the Golden Rule hung in our training school class rooms—for reference in teaching. Suppose we should try—earnestly try—to turn out none but “*Golden Rule Nurses*” from our schools—would the world marvel? Me-thinks it would.

A graduate nurse in a Michigan city got a call to a very seriously ill patient—a young man—who lived on a farm in the country. He died before the day was over, and when the father came in to the city to make the funeral arrangements the nurse returned with him. She boasted to a friend the next day that she had earned ten dollars the day before. The friend asked in surprise how she had done it. “Why,” the nurse replied, “I charged the family ten dollars for the day; you don’t suppose I’m going to go to the country for nothing. I charged them five dollars for the case and five *for going to the country.*”

Do you wonder, friend of mine, that the people in the neighborhood where that young man died have no use for trained nurses? Could the hospital have given no definite or positive teaching touching such circumstances? Has it nothing to give that will guide a nurse in managing her financial arrangements with fairness to herself and to others. In a certain Massachusetts town there is a society of young women who wear a little circle pin of gold, on which are inscribed the mystical letters “I. H. P.” If you inquire very closely, the wearer will probably hesitatingly tell you that the letters mean “*In His Place*”—that, after a

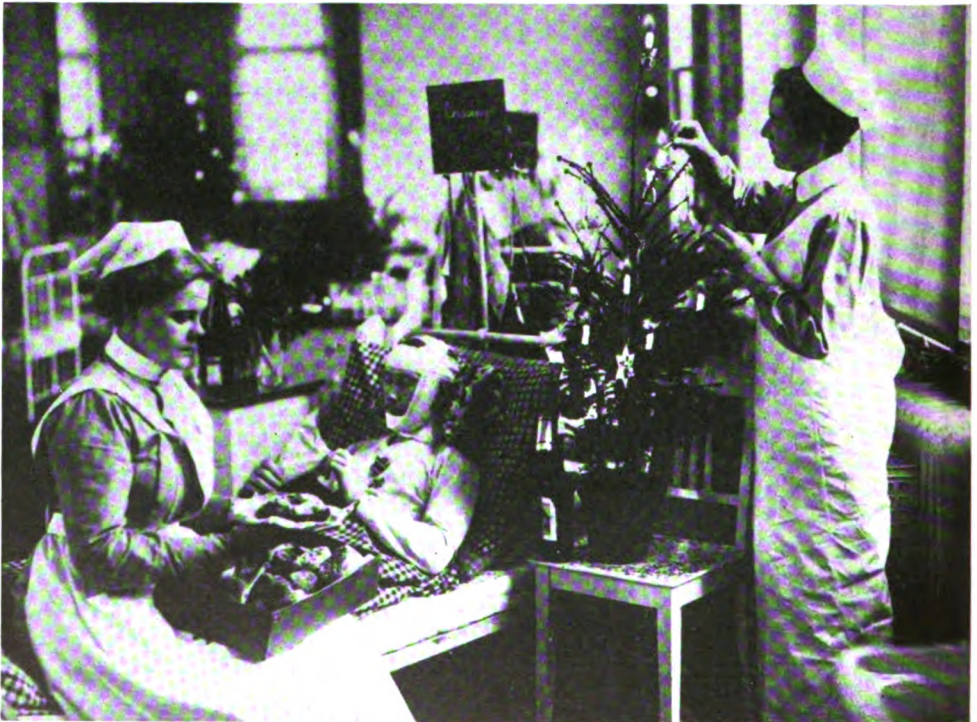
study of the Golden Rule, as given by the Great Teacher, they had decided to adopt it as their rule of life, and that the pin was just a quiet reminder that in all their dealings with others they were to pause long enough to consider what they would *do* if they were in his place, and what they would want others to do to them.

More than any other class of nurses, the private nurse is thrown on her own resources and forced to decide matters quickly and without consultation with others whose advice might be helpful. No class of nurses needs so much the clear, positive, unmistakable ethical teaching that will help her to manage herself and her patients so as to

secure the good-will rather than the ill-will of the families to which she is called.

It is seldom, indeed, that one hears a complaint regarding the technique of the private nurse or of her lack of technical skill in any way. Her failure is practically always an "ethical failure." We can do very well without adding an additional class in any medical subject to our curriculum in most schools. Indeed, we might wisely subtract a few in some schools and from some "prescribed courses," but we do need—sadly need—more faithful, more thorough, more practical and more systematic teaching of ethical principles as they apply to every-day nursing.

(To be continued)



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CHRISTMAS IN A GERMAN MILITARY HOSPITAL—ONE OF THE NURSES IS LIGHTING CANDLES ON A TREE, WHILE THE OTHER IS UNPACKING A CHRISTMAS BOX—THE WOUNDED MAN HAS BEEN HONORED FOR HIS BRAVERY WITH AN IRON CROSS, WHICH HE IS WEARING

Suppers for Night Nurses

AMY ARMOUR SMITH, R.N.

Former Superintendent New Rochelle Hospital, New York

THE problem of feeding the night staff is a difficult one, indeed, for three important reasons:

1. There is a possibility that some of the internes may require supper, and would like to eat with the nurses.

2. The orderlies, engineer, watchman and others may be so few in number that the management leaves the care of them to the nursing department, which is not the case in the daytime.

3. The appetites of all-night workers are more finicky than others and require special catering.

It is my purpose to deal with conditions as they actually exist, and to suggest some improvements.

There are two classes of hospitals to consider, the wealthy and the poor. Of the former, the service nearest to my ideal for the night staff was a large maternity hospital where an excellent night cook was employed, who prepared a regular dinner and set a long table at which each supervising nurse, pupil or interne had her or his place. The nurses *never* had any anxiety about getting to their meals on time, because the work was of such a nature that they could instantly relieve each other as all their work was routine and their treatments were given on time. There was no instance of any silly nonsense between the internes and nurses there, because they were given the freedom that grown-ups require, and governed themselves by an honor system, which permitted friendly companionship without foolishness. The other special feature of this service was the catering. Not only was the *quality* of the food supply excellent, but, also, special attention was paid to the selection of fruits, vegetables and meats of a juicy, pungent nature, to tempt the jaded

appetites of people living as if in a cellar, without sunshine or sunlit air. Celery, endives, pineapples, berries, chops, steaks and excellent bacon were among the foods bought, and *very, very* few canned goods were used.

Many people say they don't care about the quality of their food so long as it is nicely served, but gummy, meatless soups and canned vegetables served on gold plate with spotless linen will not sustain the strength of nurses with feet fatigued by tiled floors and stairways, which are one hundred per cent. more tiring at night than by day. I always claim that of the food presented to the night nurses, one kind at least should be of the sort that would make their mouths water. It will make the rest digest well, and maintain their strength. There should be one "*pièce de résistance*."

The other instance was in a small hospital where the night nurses were asked, since they were so few in number, compared with the day people, to come and tell what they had a hankering for. There is no reason why they should have lobster or plum pudding, but they could have honey or graham bread, grapefruit or onions, or any of the simple, wholesome things to be had in a private family, just as easily as not. Hospital cooks get into too much routine, and the person making the diet list *does not* take a live interest in that duty. The diet slip is a factor in the efficiency of the institution, just the same as the operating list. When I gave my night nurses permission to make out their own diet list, their imagination ran away with them at first, because they had not really been badly fed before, and they tried to recollect a menu card at some fashionable café rather than think of what they would really like. But after being refused

a few things, they became sensible. They also had to find the cost of the articles and keep the value of their suppers within a certain figure. We may always work towards an ideal in matters of this sort, not through love of any one class of nurses in the school, or any personal feelings, but rather to see a good system worked out, and to prove a theory. It is only following the Golden Rule to try to set good suppers for night nurses, and we must not be deterred by rebuffs—for example, to have fine chops wasted by a set of nurses who did not even know what kind of meat they were getting. It has positively been my experience in two hospitals where I had control of the food supply, that the nurses who were well fed had less illness and the number and type of probationers improved.

If the superintendent of nurses is youthful enough to have a good appetite, and if she makes it a rule to eat always in the hospital, so as to have no unfair comparison between her and the pupils; if, too, she eats with them or the food served at her table is the same as theirs, and if, finally, she is willing to fight for her pupils on this basis, she will secure their loyalty and the approval of the board. The argument must be presented to the finance committee that the nurses who live in an atmosphere of impurity and disease require special catering. Nowadays when there is such a dearth of nurses, the boards who pay for paid help can appreciate the advantage of a large class of pupils. Food is one of the factors, but the supervisors must keep struggling for those under them. It is no disgrace to say frankly that one enjoys good food. The supervisor who does not spend half an hour all told in a ward is apt to forget that one's appetite is taken away by its odors.

In the small hospital last quoted the nurses took turns in preparing the night supper, and put into practice what they had learned in dietetics. It seems incredible, but many girls who take up nursing cannot boil water

without burning it, and don't know that the egg which goes into the coffee pot must be broken. All these little points were collected by the night supervisor and listed for the teacher of dietetics, who pounced upon them and corrected the evil, till the nurses could make very good suppers, including hot biscuit and layer cakes on easy nights.

One cause for the reduction in their sick list was that they stopped buying foods outside, of an inferior kind. At first we had several cases of ptomaine poisoning from bad ice cream, exposed pickles from the delicatessen shops and things of that ilk. That all ceased.

The superintendent should be on hand for these night suppers and partake of them and frankly criticize them, too, or bring a friend in with her, and see the pupils improvise for the extra guest.

The night force should always be hospitable enough to take care of the interests of the surgeons who come to operate in night emergencies. Some excellent broth or good coffee goes a long way toward the *heart* of a man who digs himself out on a cold night to operate on some charity case.

There have been many systems tried. In one large, wealthy New York hospital, the diet kitchen is conducted by night just as by day, and the pupils taking the course prepare supper for the night force just as well as for the patient's night diets. Those whom I knew personally enjoyed the night service best, because they were thrown more upon their own resources, and would rather pay for what they spoiled, which was the rule, than be watched and corrected every moment.

In a large Southern hospital the nurses were doled out a very simple lunch of sandwiches and hard-boiled eggs, in a pasteboard box, and they never left their wards.

This is conducive to morbidness of soul, since they see few people by day, anyway. There is no use inuring nurses to a condition which will not obtain after they graduate.

These pupils were allowed only one glass of milk for themselves from the ward supply, and more could not be taken without detection.

In another hospital in New York City the night supervisor surveyed the total amount of food left out for her staff, and divided it among all the different wards, where supper was cooked by nurses in groups of three. She was one who was vulnerable to the shafts of Cupid, and if she had a few internes taking supper with her the junior nurses lost part of the fruit or steak, and dared not "kick." The hospital was so large that special nurses came sometimes after the suppers were set, and the calculations were so close that the amount was too scant. The night supervisor should be given the keys to all the supplies, so as to meet this emergency.

This problem of feeding night nurses is one which shows more than anywhere else the independence of spirit of the superintendent of nurses and her weight in the councils of the institution.

The diet should be varied and a little novel, and they should have a choice of dinner at six or tea at six, with tea at twelve or dinner at twelve. One night nurse who cannot eat dinner the minute she gets up at six should not have to suffer because the others can.

When these girls have late leave in the afternoon, they should have the privilege of coming to the last noon meal.

There is something comforting and substantial-looking about a set table for the

whole staff in the night, and whatever be the menu the nurses should eat in groups.

The night supervisor should be chosen with care. She is a most important official. She should be so fond of real nursing, getting next to the sickest patient and doing things for him, that she would do the ward work while a pupil gets the supper in places too small to afford a maid.

Where there is a large number of internes there should be supper prepared separately for them, and they will like it, because if they do eat with the nurses it is for the purpose of getting the food only.

The nurses should not see anywhere in the hospital, for the other nurses or the patients, any of the food which they will have for themselves later.

In making out their menus, one should not specify tea, coffee, bread or milk, potatoes or butter, which are staple foods, and are only padding for an otherwise very stingy menu.

There should be some sort of delicate rules of precedence in the arrangements made for the telephone operators, clerks and other persons who rank above the orderlies. Then, too, the engineers cannot eat with their oily clothing at the same table as the nurses, though they are professional, high-salaried men, and command our great respect. They should have their own dining-room.

It is to be hoped that these hints will be of some use to some person, or to set some one thinking, who has been slightly neglecting this part of her duty.



Some European Nurses

MINNIE GOODNOW, R.N.

A LOOK into some of the hospitals of the Old World is an interesting experience to an American. The better hospitals there are, after all, very like our own, the poorer ones ditto. In buildings we have done little but copy German, French and English models.

In the care of patients and the training of nurses it has been the other way. While trained nursing had its origin on the Continent, its real development has been in England and America. The Continental nursing leaders are now copying our methods, and they find it difficult because of conservatism and the many years of doing otherwise. Class distinctions make it difficult to get the right sort of material for the training schools.

Holland and Germany appear to be working out their nursing problems in a fairly satisfactory manner, doubtless because their nursing is largely in the hands of religious orders which attract superior women. France and Italy, for reasons not obvious, seem to lag behind.

In Germany very many of the best hospitals are carried on by nuns. In Holland, which is largely Protestant, much of the nursing is done by deaconess orders. Both nuns and deaconesses belong to the middle class and compare very favorably with the majority of our nurses at home. The French nurses, on the other hand, still belong distinctly to the servant class, though a good deal of effort is being put forth to bring up the standards.

In the new Psychiatric Hospital at Utrecht, Holland, the nurses belong to no religious order, though the graduates are, as in England, addressed and referred to as "Sisters." The head nurse who showed us about was a bright young woman who spoke considerable English; she carried with her a Dutch-English dictionary to which she

referred when she did not know the necessary word. There were also male nurses.

In connection with the Deaconess Hospital at Amsterdam, Holland, there is a large home for the deaconesses. These young women live here during their training in the hospital and remain afterward to be sent out on private or visiting duty. The nursing part of the course is much like ours; Bible study and subjects akin are added. The uniform dress was the regulation nurses' stripe, the apron made with a bib, and over it is worn a distinctive little gingham shoulder cape. The odd and rather ugly cap is of one piece, gathered into ripples at the back and tied with strings under the chin.

At the St. Georg Hospital, Hamburg, and the Neukoln, Berlin, there are training schools apparently very much like our own, and the nurses might easily have been mistaken for Americans had we not heard them speaking German. The nurses' homes at both places are quite as good as anything which we have in this country, being built with single rooms, beautiful living and dining rooms, all the comforts and some of the luxuries.

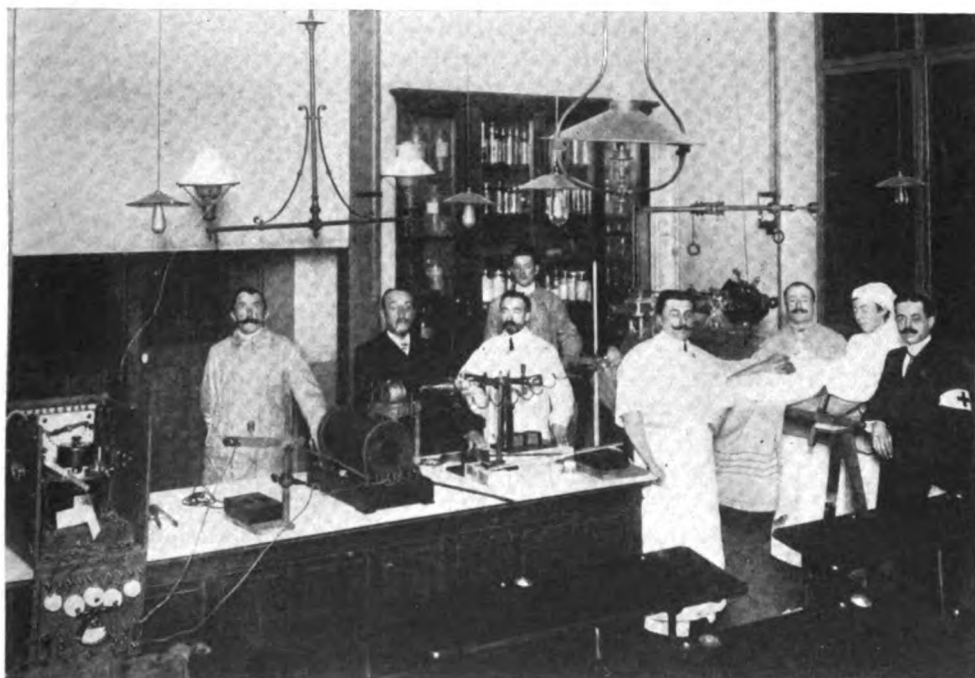
The nurses' uniform at the St. Georg was the usual one, but somehow did not look quite neat; upon catching sight of a nurse with her apron off we found that she wore no corset and that her dress was a Mother Hubbard, the apron disguising its ungracefulness.

At the Neukoln, in Berlin, we had a long talk with the matron, an English-German head nurse acting as interpreter. We found her problems much the same as our own. She complained of the shortage of nurses, the difficulty of getting good probationers, the problem of doing the work without over-tiring the nurses. It all sounded very familiar.



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MADAME PATTI, THE FAMOUS SINGER, VISITING THE WOUNDED BELGIANS IN THE PATTI
WARD, SWANSOO HOSPITAL



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A SCENE IN THE HALL OF RADIOGRAPHY IN THE JOHNSON DE SAILLY, SHOWING
DRS. BAZEROLL AND FROMENT MAKING A RADIO-PHOTOGRAPH OF A WOUND

At the Munich-Schwabing Hospital, whose buildings are considered the best in Europe, the nurses are nuns. They seemed high-class and capable. Their home is a marvel of beauty and comfort, though extremely simple. The bedrooms are very plain, and there is not a mirror in the place. Some of the bedrooms are double, and in these the beds are curtained, in accordance, we were told, with a law of the sisterhood.

German militarism was in evidence. Things which our patients would resent as "red tape" were taken as a matter of course. The nurses' submission to authority seemed absolute.

In Paris, the hospital of the Pasteur Institut, where all contagious diseases are cared for in one building, is under the charge of a nursing sisterhood. These sisters are educated women, with wonderfully sweet faces and manners. The place is immaculate, the care given quite in accordance with American ideas. These sisters remain in the same places year after year, and so become expert in the very exacting technic. The sister who conducted us about the building was plainly of Irish origin, though quite French in her vivacity. She showed us how the technic worked out, how by the use of methods which are no more than a reversal of operating-room practice they are enabled to keep each patient entirely isolated. They have practically no cross-infections, yet one nurse takes care of several different communicable diseases at the same time. "It is so simple," commented the little Irish sister, and smiled approval as we told her that a few of our American hospitals were waking up to their good results and were beginning to use their methods.

The new Pitie Hospital of Paris is considered the last word in hospital construction. It is a group of buildings housing one thousand patients, and has every modern appliance and convenience; but according to American or German ideals, it is neither

clean nor well-kept. The nurses we took at first to be kitchen maids, partly because of their easy-going, thriftless manner and partly because of their dress. The uniform is a Mother Hubbard of unbleached crash, with an apron of the same material cut in one straight piece and fastened only at the top of a low, pointed bib and at the back of the hips, a costume quite utilitarian but ungraceful and lacking in dignity; its finishing touch was a cap with strings dangling from the back.

In striking contrast is the American Hospital of Paris. This was, before the war broke out, a fifty-bed institution, remodeled and inconvenient, but ideally clean and beautifully kept. The site is that of an old chateau near the river Seine, with a charming garden. The place fairly bristled with home-made comforts and bright ideas for utilizing space. The nurses were American and have hitherto been all graduates. An attempt was being made to start a training school, with American girls as pupils.

Since the opening of the war, nearby buildings have been taken over and the place has suddenly become a two-hundred-bed hospital. It is caring for German, English and French soldiers. The surgeons have operated all night upon some occasions, but have been obliged to refuse more wounded men, owing to lack of accommodations for them and lack of help. The doctors on the staff are all Americans, but some of the best French talent come in for consultation.

The French government has recently turned over to the American Hospital a large high-school building, which will add eight hundred beds to the present number. Funds are being secured to hastily remodel it and to provide for its operation. Some of the most prominent Americans are interested, and it is expected that this institution, suddenly grown to twenty times its capacity of a few months ago, will be one of the best hospitals in Paris.

Therapeutics of Nature

HORACE MARKLEY

R: Oxygen—Ad lib.
Sunshine—Saturation, with discretion.
Regimen—Nourishing, sustaining.

DOSE: Nurse will administer in full dosage daily, amid cheerful surroundings.

A DISTINGUISHED physician once remarked to a class of nurses that a good nurse was half the success in any case, especially in a very difficult case. That was gallant. Then he added that fresh air and sunshine and good food were the other half. That was the modesty of greatness, to eliminate self.

A good nurse, while recognizing her power and responsibility, would admit with all graciousness that an able physician was also half the success in any case. In such examples it is not necessary that the fractions

have a common denominator. We know that each part is, perhaps, at some critical moment, the whole thing.

One of the strangest things in that most fascinating of all realms—discovery—is the manner in which trivial things have been ignored or overlooked.

Seemingly trivial it might be better to say, for once recognized, how tremendous an influence, often, do they wield. Such is true in science, medicine, chemistry, invention, in every line of endeavor.

Trifles which from their apparentness and



THE ROOF OF THE POST-GRADUATE IS A PARADISE



IN THE CONVALESCENT PAVILION

simplicity, when once they are known, it would seem should have been among the first to be recognized for their worth. It is the ability to see and avail of many such little details in their daily practice which gives to some nurses that superior skill which places them so far ahead of their sisters.

Consider the changed attitude of the modern physician toward the therapeutic value of fresh air and sunshine. Science has done much to relieve suffering humanity, but today all wise physicians recognize that that grand old nurse, Dame Nature, can do more than they, and without her aid all their efforts would be unavailing.

Given: A suitable environment, wholesome food, sunshine and pure air, and we have a prescription of great potency.

That the whole shall be compounded and administered with good judgment lies within the hands of the modern nurse.

How that once deep-rooted fear of fresh air is changing! Think of the almost universal custom of the past, by which the "night air" was barred from entrance in

any crack or crevice of the house with as much care as was taken to defend it from attack by probable human marauders who come under cover of darkness.

Crime statistics do not show that there has been any great increase of crime due to house ventilation by semi-opened windows. On the contrary, the modern burglar would be apt to think twice before entering such. The hygienic precaution is an indication of alert healthfulness and the probability of other precautions being taken. Those sleeping within are resting normally and are likely to be aroused by very slight sounds.

The house shut up to exclude the night air is an easy mark for the burglar. To pry open a shutter and jimmy a window is an easy and comparatively safe matter in the early hours of the morning, for then the inmates are likely to be sleeping heavily, half-stupefied by the poisons of their own exhalations.

Many a modern home is built with its sleeping porch, where the healthy or the invalid may revel in its luxuries.

Nowadays, no matter how ill or old a patient may be, an abundance of fresh air is the first care of physician and nurse. In many hospitals and sanitariums even operative cases are wheeled outdoors after the third or fourth day, and pneumonia patients are also treated by the fresh-air cure alone.

With such buildings in the country, the question of providing this up-to-date prescription is not a difficult one, but with city hospitals, where every cubic foot of space in the air is at a premium, how shall such be provided?

This, too, was one of those apparent things long overlooked—get out on the roof, next to the sky. One of the first experiments in this direction was that undertaken by the Presbyterian Hospital of New York. It was made possible by the generous donation of \$16,000 by Mrs. W. K. Vanderbilt, Sr. Today there are many such hospital gardens, where the miracle of healing goes on all the year round, and not even the diapason of a great city's traffic disturbs its peace.

The roof of the Presbyterian Hospital, which, fortunately, is high above its surroundings, has two pavilions, divided by a sun-parlor. The pavilions are wind-protected on all sides by glass, and are open to the full benefit of the southern exposure.

Awnings are stretched over the roof beyond the pavilions to control the light when necessary, and an orderly is always by to adjust them to the patient's needs and comfort.

Beyond the pavilion is a long promenade for wheel-chair patients and the convalescents. On one side is the pavilion for men, and on the other that for women and children. The palm garden or solarium in the center is the rendezvous for all who wish to bask in the sun's healing rays, or sometimes, when a sudden summer storm comes up, it is the retreat for all, until they can be taken below or the storm blows over.

In the summer there is rarely any time

when a refreshing breeze is lacking. In the winter it is steam-heated, and the patient can enjoy the somewhat weakened actinism of the sun in this sky parlor with as much comfort as on a summer's day.

In the morning on this roof garden it is often a wonderful scene that may be witnessed. First come the little folks in their white beds, until it looks as if it had rained babies and beds. Then the older children come, many on crutches or in wheel-chairs, and, last but not least, the adult bed patients, who spend the entire day on the roof. Many of them have never known what it is to receive the thoughtful attention and kindness which they now get from nurse, and the children, such as can, give themselves up to



"I DON'T WANT TO TAKE MY MEDICINE"

play and enjoyment that brings color to the wan cheeks and a sparkle to dull eyes. Were it not for splints and bandages and plaster casts, one might imagine the scene to be a happy throng in a day nursery rather than a hospital roof.

When the doctor makes his rounds, then it is noisier than ever, for he is hailed with delight, and there is only one thing they think more of than the doctor, and that is the ice cream at lunch-time. Even where there are painful dressings to be made it is not so bad, for as like as not some goody comes from the pocket, to make eyes open wide and forget the little pains. One interne is a special favorite, for with a handkerchief deftly rolled he can evolve such a wonderful lot of puppets, such as the ballet dancer, the frog and the jumping rabbit, that cause such shrieks of laughter and merriment that the surgical dressing that is to follow is a mere nothing compared with the memory of the fun during that few moments.

Many of the children are unable to stand on their feet, owing to burns or broken bones. They lie in their little white beds or reclining chairs, humming a bit of a song or playing with their toys. When they are in their ward they are often fretful and peevish, but here in the open air that soon vanishes. And just as that disappears and cheerfulness comes, so does the appetite, and there seems no giving them enough to eat at times, showing how important is the oxygen and the exercise in stimulating appetite and digestion.

Sometimes, when surgical treatment seems necessary, the open-air treatment is first tried and many times operations are avoided. Dr. W. B. Northrup, the pneumonia specialist, who is one of the pioneers in outdoor treatment, is an enthusiast about fresh air. He has had remarkable success at the Presbyterian Hospital in pneumonia cases. Fresh air, he says, is the first best medicine. Accordingly, he bundles all pneumonia cases off to the roof garden at



"'IS IS TURCH, 'IS IS TEEPLE,
OPEN DOOR, THERE'S PEOPLE!"

once. Right in the height of the fever, while the stimulating effect of pneumotoxin is on, and for six hours at least they breathe the cold air. This gives the nurses an opportunity to ventilate the wards thoroughly, and when the patient returns at night sleep is unbroken.

No matter what the weather, even in the dead of winter, with the winds howling and the snow drifting on the bed of the patient, it matters not so long as the following rules are observed:

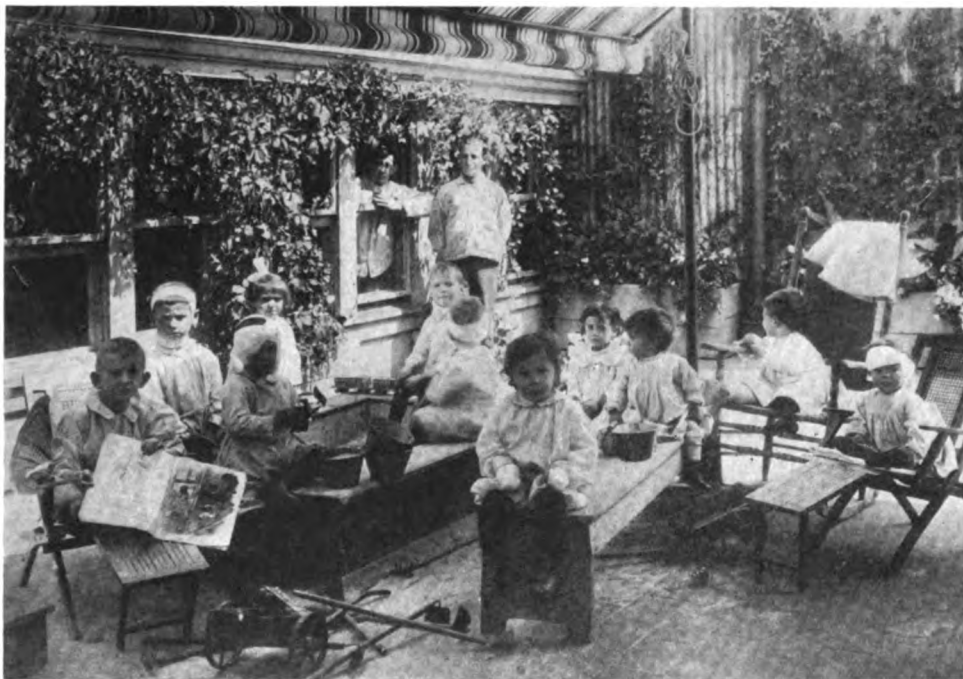
The feet must be kept warm, plenty of water must be given, in small quantities, cool and fresh, easily digested foods, and there must be a minimum of drugs until the temperature drops.

The patient must, of course, be protected from draughts, and if there is danger of snow or rain rubber blankets are used on the beds. Gray blanket coats with cowls protect the patient from wind and cold. But the breathing is never obstructed, and under the life-giving stimulus of pure, fresh air, the

heart is stimulated and the blood reddened, and the patient soon develops strength and vigor that medicines can never impart.

The Post-Graduate Hospital of New York was quick to follow the Presbyterian, and now has a roof equipped with vines and ferns

and palms, that make of the desert of a roof a perfect oasis, and to the children almost a paradise, where nature quickly mends under the stimulus of cheerful environment, good nursing and plenty of fresh air and sunshine.



A "CONEY ISLAND" CORNER OF THE POST-GRADUATE ROOF

IN THE MOUTHS OF BABES

Stanley, aged four, had been a patient in the hospital for some weeks, and had begun to acquire a medical vocabulary.

One day he was loitering about the medicine room and was sent away by the nurse.

In a few minutes he was back.

"Stanley, go right away. You know you are not allowed here. What do you want, anyway?"

"Why, nurse, I'm waiting for my p.c. medicine."

Nursing in Diseases of the Heart

MINNIE GENEVIEVE MORSE

VIII.—ARTERIOSCLEROSIS—*Continued*

AS ELDERLY people, and especially those suffering from any circulatory disorder, are apt to feel sudden changes in weather conditions and low temperatures very keenly, arteriosclerotics should be carefully protected from any sort of exposure, and in order to avoid sudden chilling of the body they should wear an appropriate weight of underwear of wool or of silk and wool. The wearing of very heavy and burdensome clothing should be avoided. In very cold weather, patients who are able to go out should have the ears protected, as the weakened surface circulation makes them more liable to frost-bite. With regard to bathing, the taking of any sort of cold bath is unwise, as cold bathing causes a constriction of the blood-vessels. Very hot baths also are risky, unless there is a vigorous heart action. Warm bathing, however, whether in the form of the tub, sponge or shower, has a decidedly beneficial effect; it both dilates the surface capillaries and so relieves congestion, and has a soothing influence on the nervous system, often aiding in inducing sleep. Old persons with mental failure are apt to dislike bathing, and some management may be needed in carrying out the physician's orders along this line. There must be special care taken that the patient is not chilled during or after a bath. The nurse should see that there are regular evacuations of the bowels and bladder; with regard to the former she should be on the watch for signs of intestinal fermentation, which may be shown by very offensive stools, in order that if necessary changes may be made in the diet, or intestinal antiseptics administered. If it is necessary to give enemas, they should be as small in quantity as possible, so as to avoid as far

as is practicable the raising of blood pressure by this means. Suppositories sometimes work well with elderly persons. An abundance of sleep is needed by these patients, and as far as possible it should be secured without the use of drugs, though these often become necessary; means that are useful in inducing sleep have already been discussed in an earlier section. Regular periods of rest, even without sleep, are important for a patient of this type, and he should be induced to rest as soon as either physical or mental fatigue shows itself.

The mental atmosphere about a patient with advanced arteriosclerosis has much to do with his well-being; alarmed at his own increasing disability, and haunted by dread of worse things to come, such a patient is often surrounded by relatives who do not understand the reasons for his altered disposition and symptoms of physical and mental incapacity, resent his irritability, childishness and unreasonable demands, or show such ill-concealed anxiety as to his condition that his danger is kept always before him, to his very great detriment. A nurse possessed of tact and understanding can do much to remedy such evils. While never lacking in sympathetic interest, and always on the watch for untoward symptoms, she should as far as possible draw her patient's thoughts away from himself, suggest new interests for him, preserve a resolutely serene and optimistic attitude, and persuade the family of the invalid to do the same. The patient should be assured that while his disease is not curable, in the ordinary sense, his condition may be much improved by strict obedience to orders, and that by leading a careful, well-regulated, abstemious life he

may have many years of comfort, usefulness and moderate activity.

With regard to the local symptoms which may arise in arteriosclerosis, the morning headache of the cerebral form can usually be relieved by a hot foot-bath, or, where a patient is confined to his bed, by hot-water bottles or an electric heating pad applied to the feet. Patients should on no account be allowed to take headache remedies which they may have been accustomed to keep in the house and use without a physician's orders; such preparations are usually very depressing to the heart, and may have exceedingly serious effects. Vertigo, if troublesome, will usually disappear if the patient inhales ammonia, or is given a small dose of the aromatic spirits of ammonia. Cramps in the muscles of the limbs are sometimes annoying, and occasionally very persistent; in most cases they disappear quickly upon the application of hot water or hot cloths, but sometimes it is necessary for the patient to wear woolen stockings during the night. The treatment of heart symptoms has already been considered under their proper heads, and the treatment of kidney complications cannot be gone into here. Pain in the digestive or generative tracts is usually relieved by heat. Many of the discomforts of the arteriosclerotic are lessened by massage, carbonic acid baths, and the exercises used in connection with the latter, all of which have already been fully described. High blood pressure is often very favorably influenced by the use of the high frequency electrical current, but this treatment is usually administered in the physician's office.

There are few diseases in which more terrifying emergencies may arise than in the final stages of arteriosclerosis. The treatments for angina pectoris and of acute heart failure have already been described. Apoplexy, however, is the great dread of the arteriosclerotic, and it cannot be denied that it is of such frequent occurrence that his

fear is often justified. An apoplectic stroke is the result of some cause which produces a sudden rise of blood pressure in the cerebral arteries, and at some point where the vessel wall is especially brittle a rupture takes place, there is hemorrhage, and the pressure upon the brain of the escaping blood results in greater or less disability, according to the location of the lesion. The exciting cause may be sudden physical overstrain, intense mental exertion or excitement, a fright, shock, or violent emotion of any kind, over-indulgence in alcohol or other stimulant, or even a too heavy meal. The frequency with which such seizures have followed over-eating is familiar to every one. Premonitory symptoms of any duration seldom occur, though in occasional cases there may be some impairment of the special senses, or a sensation of bodily heaviness, usually accompanied by mental depression. The prodromal stage is, as a rule, only momentary, the patient being seized with vertigo, a sensation of bodily weakness, numbness of the side which is affected, and a feeling of overwhelming terror. He usually tries to sit down, or lay hold upon some support, then falls and becomes insensible. This unconsciousness is in most cases complete. In a typical case the face is flushed or cyanosed, the breathing heavy and noisy, and the pulse slow and strong. The cheek on the paralyzed side may be blown out with each expiration. The sphincter muscles are usually relaxed.

Unless the patient is in a situation where he will suffer from exposure or be otherwise injured by remaining there, he would better not be moved before the arrival of the physician. Any considerable change in his position within half an hour, at the least, after an apoplectic seizure, is liable to cause a recurrence of the cerebral hemorrhage. The patient's head should be somewhat raised, to facilitate the flow of blood away from the brain, and for the same purpose ice may be applied to the head and heat to the

feet and limbs. No stimulants should be administered, as increase in the force of the heart action is not to be desired, on account of the danger of increasing the bleeding, unless heart failure and collapse are threatened,

in which case there will be pallor instead of flushing of the face, and a weak and rapid pulse. Any drugs that must be given should be administered hypodermically.

The Value of Discipline in the Care of the Sick Child*

T. WOOD CLARKE, M.D.

Utica, N. Y.

THE value of discipline in the care of the sick child is to my mind a matter of no small importance to the physician; of an importance, unfortunately, not sufficiently recognized, for upon the control of naughtiness not infrequently depends the success or failure of our efforts toward diagnosis and cure of the sick child.

We are all familiar with the hopeless feeling when, on entering the nursery, we are greeted by a howl of fury and a series of acrobatic and pugilistic activities. We all know that if such a state of affairs continues we are tempted to make a rash guess at the nature of the disease and prescribe the medicine which will allow us most quickly to get outside the front door and rest our aching ears. On the other hand, it is with a feeling of pleasure that we look back at the visit where the young patient has greeted us with a smile, be it ever so wan, has submitted willingly to being undressed and examined, has opened his mouth to let us look at his tongue, and has perhaps only winked hard when that trying weapon, the spoon handle, has produced an acute anxiety as to the safety of all he holds most dear. After examining such a child we may be in doubt as to the nature of the illness, but we

at least feel that we have done our duty and have given the child a fair chance. It is a very easy matter to overlook a soft heart murmur or some early sign of pneumonia or tuberculosis in an examination accompanied by a combination of outlandish shrieks as overpowering as a symphony by Richard Strauss.

When a child is sick, especially if he is in pain and the prospect is that the illness will last through weeks or months, the first thought of the fond parents is to make the little one as happy as possible during the days of suffering, and as it would seem that the way to accomplish this were to gratify his wishes, they vie with each other to supply every expressed desire and to satisfy every whim. The result is disastrous, for the autocrat, naturally the greatest egotist in the world, learning that whatever he wants will be given, immediately becomes dissatisfied with what he has, and turns his active mind to the discovery of new wants to be gratified.

If at the beginning of an illness, especially if it promises to be protracted, there could be explained to the parents the necessity of strict, almost military discipline and obedience, and if the parents could be persuaded to carry out this idea, the life of the family would be easier, the work of the doctor

*Read before the Academy of Medicine of Syracuse, and the Section on Pediatrics, Medical Society of the State of New York. Reprinted from *The Clifton Medical Bulletin*.

would be lighter and, most important of all, the days of suffering of the little patient would be happier.

Some years ago I had occasion to observe a striking comparison between two cases, in which the right and the wrong way of treating invalid children was exemplified. Two laddies, friends and neighbors, of the same age, were at about the same time afflicted with chronic tuberculous arthritis, one of the spine, the other of the hip. Both were confined to bed for months at a time, and both suffered severe paroxysms of pain. In one case the physician impressed upon the mother the necessity of absolute strictness in her dealings with her boy. She was told that she must be more strict than ever before, and she was. The child soon learned that what he was told he must do, he must, and that what he was told he could not have no amount of teasing would procure. He was allowed to cry from pain, but even this was discouraged, while crying from anger was promptly suppressed. The boy through years of illness was a ray of sunshine in the house. He accepted his hardship, was happy and contented himself, and a joy to the family.

The other child, at the onset of the illness, had fits of temper, and the physician told the parents that his wishes must not be crossed. The results were appalling, and the poor little sufferer, to the physical distress, had added discontent, unhappiness and an uncontrollable temper, which made him a pitiable object himself and kept a large household in a constant turmoil.

Those of us who have spent much time in children's hospitals or in the children's wards of general hospitals, are familiar with the remarkable change which often takes place in a child's disposition during the first few days of ward life. We can look back at the snarling, resisting, little fury who, on admission, refused to be undressed, and screamed and fought at every attempt to

handle it; we remember vividly the utter astonishment and rage in the face when the child was first confronted with the idea that he must do what he was told, not as he wished; and we recall with pleasure, as he gradually learned that the way to get affection and petting was to earn it by being good, the steady disappearance of the frowns and scowls, and the ever-increasing frequency of the smiles and laughs, and finally the incredibly short time required for the discontented little pessimist to merge into the crowd of laughing, happy youngsters who make the chronic wards of the children's hospitals perhaps the sunniest, happiest spots in the world.

The reason for this change is not hard to find. In the few days in the ward the child, naturally pliant and adaptable, has learned the meaning of authority and has gracefully submitted to it. He has discovered that naughtiness has availed him nothing. He has adopted a new scheme of existence, and has found it productive of a generous supply of happiness.

The production of such changes of character in the wards of hospitals are daily incidents, and are taken for granted. In the private house, however, to keep an ill child happy or to make an unhappy one cheerful is by no means an easy matter. In the hospital, except during the visiting hours, we have but one small rebel to train, while in the house we have the father, the mother, usually at least one grandmother, and if our luck is very bad, there may be a group of maiden aunts. In such cases the entire family must be taken into our confidence, and their confidence in us must be established. When this has been done, and not until then, the training may be extended to the child himself. He must be taught by one means or another that the word of the parents, the doctor and the nurse is even as the laws of the Medes and Persians, that teasing and yelling are useless wastes of time, and that a burst of temper will avail

nothing beyond some experience highly incompatible with bodily comfort.

I hope none of my hearers have gathered that I approve of being rough or cruel to a child. Such behavior on the part of a physician destroys its own ends. In a rather wide experience in the training of the spoiled child, in which I cannot recall an instance in which, having been given a free hand, I have failed to produce in the course of a few days a docile, obedient child, I do not think that in more than one or two cases have I caused the little one actual pain, even of the mild type produced by a spanking. The restraining hand, while of a confidence breeding firmness, must be absolutely gentle. Far more effectual than physical pain is the appreciation that you are stronger than he, that you have an indomitable will, that what you say must be done and you will see it carried out if it takes hours to accomplish, and that you never recede from an established position. The lesson may require ten minutes, it may take two hours. or it may be a matter of several seances, lasting two or three days in all. The point is that you must never give up until you have established your supremacy. There is no greater economy of time when dealing with chronic illness in a spoiled child than to devote even several hours to teaching the little patient that your will is unfaltering, and that you are and always will be the master.

Lack of discipline may be directly responsible for actual illness, as was well demonstrated in a case I saw some months ago, when asked by a physician of Utica to take charge of a small and very puzzling patient who, he feared, was coming down with tuberculous meningitis. For six weeks this two-year-old had been causing an incredible amount of trouble and anxiety. The history was of a progressive weakness, apparently partial paralysis of the legs and violent attacks of almost maniacal excitement, especially between ten and eleven o'clock at

night, when he would climb out of bed, run about the house, scream and raise trouble generally. As he had been a well-behaved baby earlier, the suspicion of approaching meningitis seemed justified, except for the protracted period of the prodromi. On examination, I found no signs of meningeal disease and few evidences of illness of any kind except anemia and a slight intestinal irregularity. The examination was conducted under difficulties, as the young man absolutely refused to be handled. The most important factors to my mind were that the patient was a first child, was the center of a world consisting of parents, a grandmother and at least four maiden aunts, all living under one roof, and had a decidedly calculating and appraising look in his eye. After explaining to the mother that I could see no signs of meningitis, I told her that except for the intestinal indigestion I could find nothing definitely wrong, but that before a diagnosis was possible the child must be taught to behave, as I could not tell how much was mental disease and how much spunk. With the mother's consent, after getting rid of the grandmother and the aunts, I proceeded to take steps to let the young man know who was the master. I started to examine him, but at every yell I stopped and firmly placed my hand over his nose and mouth, smothering the cry, the hand being loosened during inspiration, but firmly replaced during expiration at the first evidence of a cry. With the other hand I gently but firmly prevented kicking. For a few minutes the fight was fast and furious, but as I had considerable advantage in weight and from my position on top, in ten minutes the child gave me one long, comprehending look, relaxed, and submitted peaceably to whatever I wanted to do. A second insurrection a few minutes later was subdued in less than a minute. Instructing the mother to repeat the treatment whenever required, and insisting on bed and sleep at the proper times, I left, and

two days later was pleased to learn that the boy, to use the mother's own words, "had been as good as gold." The intestinal irregularity was soon corrected, the attacks of mania were promptly aborted by an exhibition of the palm of the hand steadily approaching the mouth, and a little simple treatment and a lot of fresh air brought back the power to the legs, and a child as disagreeable, snarling and troublesome as I ever saw, became in a few weeks a healthy, happy youngster. Incidentally, he seems not unfond of his doctor, and on several occasions since has allowed me to waken him from a sound sleep, put him on the kitchen table, undress him completely and give him a thorough overhauling without so much as whimpering.

I have given the account of this case in some detail, as it was one of the most extreme cases of illness produced by naughtiness due to pampering that I have ever seen. The conditions of the family and the fact that I was a total stranger made it seem a particularly unfavorable case for disciplinary measures. What appeared to be symptoms of grave cerebral disease disappeared as soon as the child was firmly impressed with his true relation to the rest of the universe. I want to emphasize the fact, however, that before beginning to train the patient I was thoroughly convinced that there were no signs of meningitis, a possibility always to be borne in mind when a naturally good child suddenly becomes naughty. Not only is discipline of value to the well child in preventing illness and in its immediate cure, but it is a factor of paramount importance in determining the character and health of the future man or woman. There is no more fruitful seed of adult neurasthenia, hysteria and uncontrollable temper than that which is implanted in the child's mind by lack of discipline during the illnesses of childhood. One is often tempted when dealing with a sick, spoiled child, especially if the illness is a matter of a few

days only, to save present trouble by pampering it. This may save worry for the time being, but it is probably starting the child on the downward path to a neurotic temperament, which will continue more precipitately after the illness is passed and the restraining influence of the physician is lost. As to how to enforce discipline with the younger child, there are many opinions. Occasionally bodily chastisement, calmly ignoring fits of temper, or with deprivation of pet privileges, is effective.

The method with which I have the most success is the one referred to earlier, that of suppression of the scream with the palm of the hand. In any trial of strength the adult has all the advantage on his side until the child begins to scream. In the ultimate analysis, the child's one thoroughly effective weapon is the voice. It is the one great resource when he wishes to accomplish his ends, and if used with enough of a will it usually obtains its way. Take a child's scream away from him and he is powerless to resist. It is for this reason that the suppression of the scream with the hand is so effectual. By holding the legs between one's knees, placing one hand firmly but not too lightly about his body and arms, and the other over his nose and mouth, his struggles are rendered useless. If the mouth is held loosely during inspiration and just tightly enough during expiration to allow the air simply to splutter through between the fingers, the child's satisfaction in the scream is lost, and the only result of his efforts is a sensation which though in no way painful is far from pleasurable. The child is convinced that he has met his master, a master of his body, of his voice and, if sufficient patience is exerted, of his obstinacy as well. If persisted in, this method is practically sure of success, provided it is continued until the child is thoroughly convinced that there is no limit to your patience. After two or three such seances, it is usually necessary only to raise the hand toward the child's

mouth to cause an immediate cessation of the scream.

The objection that the method is cruel or dangerous is unfounded. There is no pain associated with its application, except the soul-elevating one of anger suppressed, and as it only interferes with the expiratory sound and not with expiration itself it is without danger. I should not apply it or any other treatment liable to excite and anger the patient in cases of heart disease or pneumonia. Given a normal heart and lungs, however, no injury can be caused to any organ, unless it be that which is the seat of the infant spunk.

Do not imagine that I am advising, immediately on entering a household where there is a spoiled child, to resort to suppressing the crying without careful consideration of all surrounding conditions. Judgment is required in all things, and in nothing more than in dealing with the spoiled child of dotting parents. A self-willed child, when being restrained in any way, becomes so angry that the parents usually think he is being murdered. Before any method of disciplining a child is adopted, and especially such a

drastic one as that outlined above appears to the onlooker, it is imperative that you first win the confidence of the mother and convince her thoroughly that what you propose to do can neither hurt nor injure the child.

However, whatever method of discipline be indulged in, and to whatever extent circumstances make it possible in individual families to carry out any measures, remember always these three facts—a healthy child needs discipline; an ill child needs it more, and a nervous, spoiled one needs it most of all. By being strict with a child you increase his chance of recovery from an acute illness; you make the household more habitable; you make the child himself happier; you make his school life more profitable, and, most important of all, you destroy the cocoons which, if allowed to develop, will in later years hatch out into the devastating blights of neurasthenia, hysteria, and even insanity.

Above all things, let us do away once for all with that pernicious admonition to the parents: "Your child is nervous; he must not be crossed."

NOT AS THE WORLD GIVETH

If ye enter my service, if ye serve under me,
Not as the world giveth give I to thee.
If ye minister only for what the world pays,
For that which will wither, for that which decays,
Then as the world gives it will give unto you,
But what it will give will never ring true;
For you'll find that its promise of pleasure and joy
Will ever be dulled by the dross of alloy;
The world pays for service in silver and gold—
With me, ye will often be hungry and cold.
Will ye enter my service, march under my flag?

Then will ye be weary and footsore, and lag;
But the soul will grow strong as the body grows
weak,
And the service of *soul* is the service I seek.
Whate'er the world giveth it also retains,
What comes from the world in the world it re-
mains;
But that which *I* give is eternally thine;
And the soul that serves me is eternally mine.
Then not as the world gives give I unto thee,
My peace I give unto those who serve me.

—*Adelaide Mabie.*

Post-Operative Care of Tonsils and Adenoid Cases

CECIL CHARLES

THESE patients are usually brought into the hospital such a short time before the operation, that for the history of the case we must depend entirely on the information furnished by the surgeon who sends them in. If they have any family record of hemophilia, they have likely been treated with calcium lactate for a week or more previously. This point should be made clear to all the hospital force, in order to have every styptic ready. But nurses should regard all tonsil and adenoid cases as possible hemophiliacs, and never relinquish their vigilance. They require specialling night and day, till the danger point is past. Secondary hemorrhage has been known to occur as late as the end of a week, and one instance would be a severe lesson after twenty years of well-behaved cases.

Such patients really should be relegated to the hospital specialist in nose and throat work, though in small towns every general practitioner wishes to keep the work for his families in his own hands, with much other minor surgery. The method of enucleating with a blunt instrument, followed by the snare, is by all odds the safest and cleanest, and the man who does a tonsillotomy with a tonsillotome is frequently chagrined by a recurrence.

If the patient is carefully treated in the operating room, after the operation, he is not likely to have any hemorrhage. Lay him on his abdomen on the stretcher, with one arm under his head, his face turned to one side, in exactly the same attitude as the Schaefer method of resuscitating the drowned.

Reaching his room, he is laid in bed, in the same position, and held there between

blankets, soft, old, white ones, or gray flannelette bath blankets, fresh from the blanket warmer.

The table is set with:

1. Two pus basins.
2. Towels in ice-water.
3. Dry towels and gowns.
4. Cone-shaped black rubber spiral mouth-gag.
5. Sponge holders and sponges of gauze.
6. Wipes of old muslin, six inches square.

A paper bag is pinned to the side of the bed, to hold and save the sponges, and to calculate the amount of blood lost. The patient must be kept free from draughts and exposure, on account of the loss of blood and the opening of the pores under ether. If he lies on his face, the blood flows out of his nose and mouth. The nurse must constantly watch for hemorrhage, and if she needs to leave the room to cleanse the basins she must first ring for relief.

One should be able, also, to locate the following articles instantly:

1. Tonsil clamps.
2. Adrenalin.
3. Spray.
4. Glycerite of tannin.
5. The cautery.
6. The instruments and suture material necessary to ligate, suture, or pack.

There are two kinds of tonsil clamps, of which each surgeon has his favorite. These things need not be kept in the patient's room, but if his bell rings warningly every one on the corridor should guess what the nurse wants. Meanwhile she must not lose her head. She always has her finger with her, and after putting in the mouth-gag, she should wrap a piece of gauze around her finger and apply pressure over the bleeding

base, between the anterior and posterior pillars, where there is a space large enough to hold a lime. Failing the mouth-gag, one may use a spoon, bandage scissors, clothes-pin or a thimble to open the jaws and protect the finger. The pressure must be steadily maintained, even for half a day, while expert aid is coming. In all cases of hemorrhage, morphine is indicated, but an order for that can be left conditionally after operation, or given over the telephone.

On the surgeon's arrival, he may do one of four things:

1. Use the actual cautery on the bleeding area, or some powerful escharotic, such as silver nitrate grs. C. ad 3*r*, put up now in the Soloid tablets, and easily made into solutions.

2. Ligate the bleeding vessels with cat-gut, which, however, sloughs off, and may permit another hemorrhage later.

3. Suture the edges of the pillars in a continuous suture. This requires silk, needle holders, sponges, etc.

4. Pack, before suturing, with plain half-inch gauze packing in close, minute folds, between the pillars.

Continuous applications of ice can be made externally, all the while counterbalanced by heat to the feet.

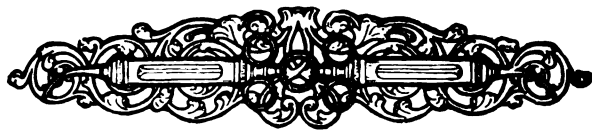
The diet of the tonsil cases is begun about four hours after operation, consisting of cracked ice, sherbet, ice cream, cold milk, or kumyss. Next day give cooled broths or cold consommé. To eliminate the nauseating blood that was swallowed, the patient

should get a generous dose of castor oil, about twenty-four hours after operation. On the third day give soft eggs, poached or coddled, jelly and custards, but no fruit or cereal with rough or sharp particles.

The temperature must be taken religiously; the ears, glands, nose and throat observed daily. A throat spray of some mild antiseptic, like Dobell's solution, relieves the soreness. These patients may be carrying germs of diphtheria or scarlet fever, which will break out rampant in this fertile field. The ears, particularly, are endangered by the heroic ice treatment. The glands sometimes swell, showing disturbance of the lymphatics.

The vomited matter should be carefully watched. Expert operators can always lay the tonsils and adenoids out in the specimen dish after removal, but if this is not the case, watch that they come up. Occasionally there is post-operative vomiting of large portions of undigested food, which might also choke the patient if he were alone at the time. Lift him up and give him a firm blow between the shoulders. If that does not dislodge the mass, hook your forefinger into the pharynx and pull out the piece.

We need to work with a wholesome though not morbid fear that something will happen, and we must not trust to luck that every case will go along uneventfully. But the least unpleasant side of tonsil work is enucleation, in an adult, by quinine and urea anesthesia, or some other local drug, where there is a clean pair of walls and no chance of hemorrhage.



Physical Training for Nurses

LEONHARD FELIX FULD, LL.M., PH.D.

Member American Academy of Physical Education

EXERCISE III

IN PREVIOUS chapters of this series we have explained in detail the benefits to be derived by nurses from performing in a scientifically correct manner the daily routine movements of arising and of putting on stockings. A well-supported and well-arched spine in place of a twisted and distorted backbone, a free chest in place of one which is cramped, and a properly supported abdomen are the rewards received by nurses who carry out these instructions. They may enjoy deep, full breathing, the circulation of their blood through their arteries is unimpeded by any pressure, and the stomach

relieved from all discomforting sensations is enabled to perform its functions in a normal manner. This proper support of vital organs and this freedom from cramping any of them may be obtained by the nurse who has followed the instructions outlined in this series of papers, without devoting a single moment of her precious time to exercising.

The movement of putting on shoes is ordinarily performed in a manner similar to that of putting on stockings. The double curve of the back is converted into an ugly, unhealthy outward curve, and the chest is cramped to such an extent that its very



FIGURE 5



FIGURE 6

existence seems to be threatened. This movement may, however, be made one of considerable value to the nurse. Balancing exercises are excellent for the development of the legs and for the maintenance of a proper and attractive carriage. Few nurses have an opportunity during the day to practise these exercises. While putting on your shoes stand in an upright position in your stocking feet on the carpet of your room. Raise the left foot, balancing your body on the right leg and slip the left shoe on your foot while in this position (Fig. 5). Repeat the movement with the right foot. Untrained women sometimes find balancing exercises somewhat difficult of execution. The skill required for their performance is quickly acquired by an intelligent young woman, however, and these balancing exercises then have a fascination which few other routine exercises possess.

The buttoning or lacing of the shoes presents additional opportunities for physical training and development. Ordinarily this movement is performed in the cramped position which is best described as the one in which the nurse, with legs crossed, seeks to bring her eyes as close to her toes as possible. For the performance of this movement it may be necessary to bring the eyes close to the feet, in order that the nurse may be enabled to observe the details of the buttoning or lacing. Most must exercise this close

supervision of the movement, although many perform it almost as a reflex movement, without conscious supervision.

Even if it must be consciously supervised, this supervision need not necessarily involve the usual cramping and distorting of the body. The crossing of the legs does not assist the movement or its supervision in any manner. It is a habit, the development of which should be avoided by nurses. It impedes circulation, causes muscle cramps and is frequently assumed during the day, when it causes unfavorable comment from superiors.

Physical benefit is derived from this movement of buttoning or lacing shoes when it is performed in the following manner: Take a standing position. Bend the knees and lower the trunk as if you intended to sit on your heels. Bend your knees until your body almost touches your heels, being careful not to disturb the normal position of the spine. Then move the right leg backward, kneel on the right knee and lace or button the left shoe (Fig. 6). Repeat the movement, kneeling on the left knee and lacing or buttoning the right shoe. This movement develops the muscles of the abdomen, the thighs and the calves, preserves the double curve of the spine, and substitutes a graceful and beneficial posture in your daily routine for one which is conceded by all observers to be ugly and harmful.

A LITTLE WAY TO GO

So many little faults we find;
We see them, for not blind
Is love. We see them; but if you and I
Perhaps remember them some by and by
They will not be
Faults then, grave faults to you and me;
But just odd ways, mistakes, or even less,

Remembrances to bless.
Days change so many things—yes, hours!
We see so differently in suns and showers!
Mistaken words tonight
May be so cherished by tomorrow's light!
Let us be patient, for we know
There's such a little way to go.—*Anon.*

Department of Public Welfare

THE SPIT NURSE

MARGARET CRAIG, R.N.

She really had a much more high-sounding title, but it takes the very young American of the public schools to truly christen you. There is never any sense in calling a spade anything but a spade in the estimation of these very young gentlemen. Consequently, the title of "The Spit Nurse" stuck as tight and fast as some of the much-chewed gum under the desk edges. Nor was this very realistic name restricted to the pupils of one school. It traveled, as bad news is supposed to travel—"fast." In fact, it became as frequent a means of designating this very small and inoffensive woman as the frequent finding of the very offensive matter itself.

She had entered the work of teaching these "least brethren" with the proper feeling of exaltation, as do all educational nurses. She was trying to feel and to live up to the reputation of such a person. Surely, if one tiny insignificant person could succeed in implanting in these young minds the primary facts of personal hygiene and prevention in regard to that particular spitty disease she would have given lasting service.

On school-days she could be seen starting out with suit-case, heavy with the weight of books, to preach her particular gospel of pure air and sunlight. Each day produced a new resolution. Each day she resolved to educate the child mind, not only in the proper disposal of "spit," but to use the more elegant word "sputum" for the matter, and the word "expectorate" for the act. These were the least of the difficulties. It

was a never-ending "**New** Year's resolution" party.

Truly the psychology of the child mind is a "fearful and wonderful thing," and, when you know very little psychology of any kind, much less of the child—it is an appalling thing. In that case one longs to be a double of Myra Kelly's "Constance Bailey."

The only means of escape is contained in the words of Isadore Applebaum's grandmother, interpreted by Isadore (Constance Bailey's Isadore) as follows: "She says you don't have to care what nobody says, or how you is smart or how you ain't smart. She says that don't makes nothing mit her the whiles you is lovin' mit childrens."

The being "lovin' mit childrens" theory seemed to work, but to make it work the small, dignified educational nurse must descend to common earth. When she was finally educated by these future voters to the point that she finally believed that spit was spit; that a partially consumed cigar found on the streets was a "butt"; that a not completely eaten apple is a "core" and in spite of the possible presence of Koch's bacillus is a luscious thing, then and then only was she taken into the utmost confidence of the student body.

The descent from the top of the ladder to the earth to help the tiniest climber to the very first round was hard, to say the least, but it paid. Day by day this little dark-blue figure stood on plain, good earth (or actually a wooden school-room floor), and

hour by hour drew from the little ones their version of the germ theory. Her adopted human family was as large and hard to deal with as the large germ family. The old woman who lived in a shoe had an easy job in comparison with this. Her solution of the problem was whipping them and putting them to bed. Germs or humans, mentally or bodily, they refused to stay put.

Discouragement frequently settled upon the "spit nurse," relieved occasionally by the honest effort of "a bunch of us fellows" "to quit smoking butts." They had reached the conclusion that all the talk must mean something, in their own words, "because you know, Missus Nurse, some fellow has spit on the butts before we smoke 'em."

Taking it on a whole—in spite of many bright places—the work seemed endless. "The school-child," her professor of economics had said, "is an index of community health." That point is true beyond dispute, but again and again did she discover that it was an index of the dump, the garbage can, ash barrel, street corner, the saloon and individual home. Her work must go deeper—into that home itself. Not her work alone, but the work of any one who undertakes a similar appointment.

You may have such a position in a city of disfigured hills, or in one whose pathways resemble the golden streets. Wherever it may be, or whatever you may be called, "spit nurse," educational nurse, school nurse, your problem remains fundamentally the same. To qualify for the work, you must acquire knowledge of home conditions, sympathy (even to the appreciation of the dangerous and doubtful joys of swapping

gum), all the knowledge you can obtain in teaching methods, a full knowledge of the subject to be taught, and as deep a love for little children as it is possible to gain. Without the last we may be indeed like those who "speak with the tongues of men and of angels, and have not charity."

So tomorrow and the next day the "spit nurse" will resume her visits to the numerous schools in the city of disfigured hills.

✦

Mental Hygiene Campaign

The State Hospital Commission, which is charged with the supervision and financial control of the hospitals for the insane, with a population of 33,000, is planning a campaign of preventive measures in an effort to lessen the number of fresh cases annually admitted. During the past year 6,061 patients were received at the State hospitals, of whom one in every four owed their mental breakdown to causes largely within their own control.

In conjunction with the general health campaign to be inaugurated by State Health Commissioner Hermann M. Biggs, the commission plans a series of short illustrated practical talks on mental hygiene, these to be delivered in different parts of the State. Carefully prepared statistics of the commission, covering many years, plainly indicate the immediate necessity of extraordinary efforts to stem the tide of insanity which, in this State, as well as in Massachusetts, has increased out of proportion with the growth of population. This necessity is now emphasized by the commission's inability to secure the deportation of the alien insane by reason of the European war.



Cleanings

Conditions Necessary for Success in "Twilight Sleep"

In the *Medical Record* (December 5, 1914) W. H. Knipe, M.D., New York, describes the technique of the scopolamine-morphine treatment, as used to secure painless childbirth. He emphasizes the following points:

CONDITIONS NECESSARY FOR SUCCESS

1. In the first place, the physician should have a thorough knowledge of obstetrical forces and conditions, so that he may know when interference is indicated.

2. After the first injection is given, he must give all his time to that patient until the child is delivered. This, of course, is impossible in a general practice unless a man is willing to sacrifice his general work for his obstetrical case.

3. A proper preparation of scopolamine must be used which will not decompose; and morphine, or one of the morphine derivatives, must be used with extreme caution.

4. The environment must be such that a reasonable quiet and the absence of bright light are obtainable. The ideal place for the conduction of twilight sleep, therefore, is a hospital. Gauss and Kroenig have laid so much stress on this that they have never delivered a patient in twilight sleep outside of the Frauenclinic.

Technique—After the first injection of scopolamine and morphine, the patient must be watched and her reaction to the pupillary, the motor-coordination, memory and Babinsky tests noted. Gauss lays great stress upon the memory tests, and maintains that a twilight sleep cannot be properly conducted and the proper doses given unless the memory tests are properly carried out. Soon after the first injection the patient will

show some drowsiness and will sleep between the pains, though awake during the pains. There is considerable dryness of the throat and mouth; there is extreme thirst at times, frequently marked flushing of the face, sometimes irregular movements of the hands, and at other times there is motor-restlessness of a more or less degree. . . .

Attention must be paid to many details, such as darkening the room, preserving quiet, stopping the ears, covering the eyes, and so forth, that may be difficult to accomplish in many places. The induction of twilight sleep requires not only a technical knowledge of the method for using scopolamine and morphine, but also good obstetrical judgment based on an adequate understanding of obstetrical forces and conditions; and the method is, therefore, best used by the obstetrician.

If the drugs have been improperly used, there is considerable danger from the direct effect upon the child itself and the effect of the drug upon the period of labor, prolonging the length of labor to such an extent that the child's life is in danger. . . . That deep asphyxia of the child may ensue after an unwarranted dose of scopolamine or too large a dose of morphine has been demonstrated.



Ingrowing Toe-Nail

Cleanse carefully and dust the affected part with a little powdered lead nitrate, is the advice of a floating paragraph. A white scab forms, which must be removed on the following day, otherwise pus is liable to collect underneath, the dusting being then repeated. The same treatment is followed from day to day, as long as necessary.

—*Medical Summary.*

Etiology of Colds

The infectious nature of common colds has been so frequently asserted that it would be well to consider them such, even if purely physical causes such as "chilling" cause a condition of the system in which the ever-present pathogenic organisms have a chance to grow. Several years ago colds were investigated by the Boston Chamber of Commerce Committee on the Prevention of Disease. The secretary, Dr. James A. Honeij, reported the following summary and conclusions in the *Boston Medical and Surgical Journal*, April 27, 1911. Surely it is time to do something to end these dangerous "minor ailments."

Summary—1. Over half the population have colds during the course of the six months.

2. One-fifth of the population are absent from work on account of colds.

3. The average loss of time of 568 individuals was 6+ days per six months.

4. The average loss of money was \$21+ per six months, not including individual expenditures for medical treatment, etc.

5. The total loss in six months' time was \$12,105.37 for 568 individuals.

6. In addition to this there is a loss of energy, equivalent to \$3+ per six months per person.

Other Data—1. The most common cold is the "head cold."

2. Most colds occur in the month of March.

3. Individuals from thirty to forty years of age suffer most from colds. Department store employees suffer most in proportion. Half of them lose time on account of colds.

Conclusions—1. Preventive methods are essential in dealing with common colds. Better working conditions, pure air, even temperature, proper ventilation and the proper amount of humidity are important factors. Nourishment, general hygiene and proper clothing are necessary precautions, as in guarding against all other diseases.

2. After the onset of a cold, proper diagnosis is essential to ascertain whether the cold is infectious.

3. Individuals suffering from infectious colds should be isolated.



Causes of Pellagra

In the *Archives of Internal Medicine* (September, 1914) the conclusions drawn from a statistical study of pellagra in its relation to the use of certain foods and to the location of domicile in six selected industrial communities, are stated by J. F. Siler, P. E. Garrison and W. J. MacNeal. These conclusions are summarized as follows:

1. Pellagra spread from a pre-existing case as a center in the six villages here studied.

2. It was transmitted to new victims only through very short distances and chiefly to those immediately associated in the home with a pre-existing case of the disease.

3. Frequent use of corn-meal as an article of diet was not a factor in the causation of pellagra in these villages.

4. There was discovered no evidence that canned goods have anything to do with the causation of pellagra.

5. Frequent use, even daily use of fresh meats and of eggs afforded no relative protection from pellagra in these villages.

6. The daily use of milk seemed to diminish to some extent the danger of contracting pellagra in these mill villages in 1912 and 1913, although its use did not fully insure against the development of the disease.



Relief for Ear-ache

In ear-ache drop one drop of tincture of aconite upon a piece of cotton and insert in the affected ear. When the pain is gone, remove the medicated cotton and replace it with a piece of warm unmedicated cotton.—*Medical Summary.*

Editorially Speaking

Well-Deserved Honors

An unusual honor has been accorded Mrs. Anna Meredith Lawson in being made superintendent emeritus of the General Memorial Hospital of New York City. So far as is known, this title has never before been conferred upon a woman.

Mrs. Lawson is a Southerner, widow of J. Herbert Lawson, a well-known Baltimore merchant. She was born at "Inglewood," Bath County, Maryland, her father's country seat, and up to the time of her husband's death resided in Baltimore. Reverses of fortune came almost immediately, and in 1890, through the friendly offices of Dr. William T. Bull, Mrs. Lawson was offered the superintendency of the New York Cancer Hospital. She was without previous training in hospital work, but was not long in proving that Dr. Bull's estimate of her ability was correct. She has been an example of what common-sense and sound business judgment can do, even in an unfamiliar and unusual position, when it is backed by real ability.

Mrs. Lawson had no precedents to guide her work. The hospital presented problems which other institutions did not have, and she was compelled to find their solutions without example or assistance. The hospital had but fifty beds, all in one building, at the time she took charge. During her first two years of office a new wing was built, which practically doubled the capacity, a beautiful memorial chapel was added, etc. Many of the memorial rooms in the new part were the result of Mrs. Lawson's personal efforts.

In 1893 a post-graduate course for nurses was established, and very soon became popular. The school shortly had a long



ANNA MEREDITH LAWSON

waiting list and was able to pick the very best nurses of the country to care for its patients. Presently there grew up in New York a demand for the graduates of this hospital, and many nurses came to take the course for the prestige it gave.

In 1899 the name of the hospital was changed to the General Memorial, and while still specializing in cancer, it became, also, a general surgical hospital. The staff of the institution has always included some of New York's best surgeons, with not a few of national reputation.

Mrs. Lawson's management has been notable in that she always had complete control of her institution. Very little went on

in it of which she was not personally cognizant, and the whole hospital was imbued with her personality. Those who were connected with the hospital during Mrs. Lawson's administration find themselves continually going back to it for methods. Everything in the place was systematized, every detail of the building and its equipment standardized. Every point was covered, every emergency provided for, so that neither doctor, nurse nor patient was at a loss. Things went almost literally like clockwork, and the motive power was always the superintendent.

This capacity for detail, coupled with a grasp of big things, is doubtless the greatest factor in Mrs. Lawson's success.

In 1912 the hospital board made an alliance with the research department of Cornell University, for the study of malignant disease. This led to a permanent affiliation with Cornell, and in 1914 there have been changes which amount to a practical reorganization.

Mrs. Lawson resigned her position in July, 1911 (which was not accepted), and again in May, 1914, but at the earnest solicitation of her board remained in charge until October.

Mrs. Lawson is an example to women who feel that an extended term of service entitles them to withdraw from active life. In her nearly twenty-five years' continuous service in a most exacting position she has not grown stale nor gotten into a rut, nor become less open-minded. She is still a young woman, alive to new conditions, full of energy. These qualities, coupled with the maturity of judgment which experience brings, mark her as one of the unusual women in the hospital world and one who richly deserves all honors which may be bestowed, as well as the future recognition of those interested in the advancement of women possessing executive force.

Hospital Overcrowding and the Training School

A great deal has been said and written in recent years about the impossibility of proper training in very small hospitals, where the patients are too few to give sufficient variety in experience. Much less has been said about the impossibility of proper training in large hospitals, where the patients are too many, when the wards are overcrowded, and the nurses too few to give the patients the care they should have. Every one who is more or less familiar with the nursing methods which prevail where, as one doctor expressed it, "one nurse is on duty where six would be busy if the patients had proper care."

The result of overcrowding on a hospital training school has been mildly described by the principal of a certain large training school in her report, in which she says: "The increased numbers of patients have made the wards seriously overcrowded, and thus hampered the efforts of the nurses in their behalf. Frequently the pressure of work has been so great that only the most essential duties could be performed, and the patients are by no means the only losers; probably the patient's loss is less than that of the pupil nurse, for while he may be temporarily uncomfortable, because the nurse has no time to rub his back or get him a fresh pillow, it is unlikely his recovery will be retarded thereby; but a nurse who is too rushed to cultivate an attitude of thoughtfulness toward her patients is establishing a bad habit that will be difficult to break, and which will interfere with her usefulness always. The efficiency of the hospital house-keeping is very much impaired in overcrowded wards, as humanity demands that we say 'attend to the patients first,' and after a little the state of the supplies, brought about by a few days' neglect, makes good work very difficult to attain. The too frequent attitude of carelessness in the use of public property is encouraged, and the

training in system, in attention to detail, and in responsibility for property, which we ought to give our nurses, and which it is their right to receive, becomes a dream instead of a reality."

There is just as much need of establishing a Grade B for schools of nursing as there is in regard to medical schools, which are now graded as Grade A plus, Grade A, Grade B and Grade C, and the school thus described belongs in the Grade B class, however many beds it may have.

Certainly it is unfair to class a finely organized and managed school, large or small, with the one wherein the careless, slipshod methods above mentioned are the rule. If we really want to improve training schools all down the line, we shall have to classify and standardize, as is nowhere done in America at the present time in regard to schools of nursing. Under present conditions a large school, when it is registered, may be doing excellent work. In a few years, through changes in management, through overcrowding and other causes, it may markedly deteriorate, and those in charge know it has deteriorated. Yet it remains registered as having "proper standards," while a small school that may be giving a thorough and systematic course of instruction, in which the *quality* of the nursing is high-grade in every way, is refused registration, because, perchance, it does not show fifty beds always occupied. The open and plain injustice of this system is bound to keep up unrest and discontent until it is corrected.

Medical schools that are doing superior work are given recognition by being ranked as Grade A plus. Those maintaining a fairly satisfactory standard rank as Grade A; those which are deficient along certain lines or which fail to maintain a *fully* satisfactory quality of training rank as Grade B, while the schools whose work seems hopelessly deficient rank as Grade C.

A proper system of classification acts as an incentive all down the line, and it would

do the same in schools of nursing. Let a large or small school be given one year to improve or be dropped from Grade A to Grade B, and you have given the principal of that school a weapon of no mean order to use in her struggle for better conditions.



Those Unpardonable Spots

In her article entitled "Our Noble Calling," published recently, Miss Helen E. Johnston makes the statement that a nurse will often be remembered much longer by a mark on the furniture than by weeks of faithful service. This may be an unfortunate condition, but it is only too true, and will remain true while human nature, especially feminine human nature, is as it is. Any nurse who thinks she can rise superior to damaged "household gods," wants to disabuse her mind of the idea at once.

When we read Miss Johnston's article, visions immediately arose before our mind's eye. One of a beautiful pair of spotless blankets hopelessly ruined because of medicine spilled by the nurse. Some choice linen towels, with spots which could not be removed because the nurse had anointed her own face before going to bed, with some toilet preparation, and had then wiped off the surplus with the finest linen she could find. An exquisite piece of old Roman glass in countless pieces, broken by a nurse, who had taken it from the curio cabinet in the drawing room without authority, because she thought it would be attractive to the invalid when medicine time came around. We could continue to swell the list if space would permit. Sad to relate, these are the things we remember more vividly than anything else regarding the nurses who committed these offenses.

There is, after all, a certain justice in this remembering, for most cases of the kind related are due to carelessness or ignorance, and the public has a right to expect something better from a trained woman who can

command a salary of from \$25 to \$30 a week. But the blame rests mainly on the training schools, which train nurses presumably to do private nursing, and yet give them no experience in dealing with conditions in private families. The superintendent of one of the largest registries for nurses in New York City once stated that if training schools would not allow their nurses to go out to private cases during their training, then hospitals should provide a suite of luxuriously furnished rooms, where nurses could be given object lessons in the care of fine belongings; for the complaints which came to her registry were seldom of lack of ability as a nurse, but for some shortcoming such as we have mentioned.



The Striking Nurse

Is a nurse ever justified in joining in the common, ordinary, garden variety of strike such as might be called by the Bottlers' Union or the Hotel Waiters' Association? If so, when and how? Is she justified in walking out of the operating room, leaving a patient under the anesthetic for an abdominal operation—to join her comrades in a "sympathy strike"?

Recently the following headlines were to be found in nearly every New York City newspaper: "Nurses Strike, Leaving Patient Under Knife."

Any nurse is justified in showing her disapproval of conditions or actions by resigning in a dignified way, and, sometimes, doing it on short notice, but the methods of this "sympathy strike" savor so strongly of labor-unionism that those who have retained the old-fashioned ideals of nursing taught by Florence Nightingale can hardly help gasping and exclaiming, "What next!" as one reads column after column in the New York dailies about the striking nurses in a suburban hospital.

It requires no special amount of skill to

work up a strike among pupil nurses. Given a daring leader of the group and a strike can be worked up without much difficulty; each one may think she is a martyr to a worthy cause, and feel as virtuous as a real heroine is supposed to feel. Pupil nurses and some nurses past pupil days never look very far ahead to see where their jump is going to land them. Like sheep jumping over a precipice, they "follow the leader."

This particular strike seems to have been called in sympathy with the superintendent of nurses, whose resignation had been asked for—though the story goes that the complaints which the nurses had made against the principal were the cause of her resignation being demanded—that the very nurses who went on the strike to show their sympathy were the ones who had made the complaints. The details of this case do not matter very much. The principle underlying the affair matters tremendously.

Disagreements and difficulties are certain to happen in institutions, but whether nurses are justified in resorting to a "strike" to express their sympathy or their disapproval is a tremendously important question. An institution may be temporarily embarrassed by "a nurses' strike" (the term has an awfully unpleasant sound), but the real harm is bound to come to the strikers. We fancy there are few things which nurses will be more ashamed of as they look back over their training career than the memory of that strike. Yet strikes among nurses grow more common every year.

Nearly always it is a head nurse or a senior who works up such strikes, and certainly she will suffer for it far more than the institution. There may be some few labor strikes which are justifiable, but when it comes to pupil nurses in a hospital walking off on a strike as timed by the leader—well, we do not like the idea, and we wish the nurses had not done it. Perhaps we are behind the times and all wrong. What do you think about it?

The Hospital Review

CONDUCTED BY CHARLOTTE A. AIKENS

Items of interest, annual reports, publicity literature, and material descriptive of newer methods and plans in any department of hospital work, should be sent to the editor of this department, at 722 Sheridan Ave., Detroit

NOISE—AN ARTICLE OF PROTEST

MAUD A. POWELL, R.N.

JUST what do we mean by noise? The *Encyclopedia Britannica* tells us that the derivation of the word is doubtful, it being held that it comes from the Latin root "nausea," meaning sickness, or from the word "noxia," meaning harm. Whichever may be correct the probable derivations are suggestive enough and need no further comment. Furthermore, it may be of interest to add here that according to the common law of England, "freedom from noise is essential to the full enjoyment of a dwelling house, and acts which affect that enjoyment may be actionable as nuisances."

Theodor Lessing has written a very interesting volume on the subject of noise, and it is stated that the philosopher, Schopenhauer, and the essayist, Carlyle, were very sensitive to the influence of various noises and suffered greatly thereby.

Generally speaking, noise is the product of activity of some kind, whether it be deliberate, as in the case of the blacksmith, or whether it be the result of chemical combination, as, for instance, in an explosion. Then again, noise depends upon degree, and it may be pleasing or displeasing, dependent upon that factor alone. To hear a military band on a parade ground is a delight; to listen to the same performance in a small hall is quite another matter. Quality, too, makes a difference, and whereas a mother's lullaby or the crackling of a log fire soothes,

the blaring of a trumpet or the booming of a cannon stirs.

But what chiefly interests us here is the effect of noise on the nervous system, and it may be stated at the outset that noise in this connection usually constitutes that which is loud, unusual, unexpected or unnecessary.

At the present time the gunners of the warring nations are suffering severely from the noise of the cannon, and this is so well recognized that the governments have taken various precautions against it. For instance, the soldiers have stuffed their ears with cotton, others have placed wooden wedges between the teeth to keep the mouth open and so diminish the shock, while some wear tightly fitting rubber caps over the ears. Doctors have discovered that a "noise neurosis" may exist in otherwise healthy persons, and there can be no doubt but that people differ widely as to their sensitiveness to sounds of whatever kind.

What, then, must the effect of noise be upon the sick?

In my own experience I have found that persons operated upon in hospitals invariably return home suffering from "nerves," and the complaint, "Oh, the dreadful noise in the hospital," is frequently heard. The outside street noises are bad enough, but why cannot the inside hospital noises be practically eliminated? In every corridor

there are signs requesting persons to be silent. But are they heeded? Among the noises patients complain of are loud talking, the clatter of dishes (cooking and other utensils), slamming of doors, telephone and call bells, elevators, rushing of stretchers, crying of babies, people recovering from ether, etc. Those in rooms or wards in the front of the building have to contend with milk wagons, business traffic, automobiles and so on. Those in the rear fare no better with the noises from engine rooms, kitchens, steam pipes, etc.

All these and similar noises tend to retard the patient's recovery. Sometimes he is in a worse nervous condition after than before the operation. This is one argument in favor of operations performed at home. At home the noises may be just as numerous, but at least they are familiar noises and so do not strike the ear as forcibly as do unfamiliar ones.

There exists a society for the suppression of unnecessary noise, and signs have been placed on all hospital streets requesting traffic to slow down and make as little noise as possible. For all the heed that is paid them, these signs might as well be scarlet, announcing unlimited speed to traffic and an exercise ground for street hucksters.

I know of a hospital where the city opened a fire station across the street and installed motor engines. When the doctors complained about the deafening noise all the satisfaction they obtained was that the safety of the city demanded the site chosen—just as if any district could be imperiled by the fire station being one block further away. Every day for weeks an expert taught the firemen how to run the motor engine, up and down, before the hospital, from 8.30 A.M. until 5.30 P.M. Thus the city observed the hospital street—and now, whenever an alarm is sent in the hospital patients and nurses have the honor of knowing it first, as evidenced by the ringing of loud gongs, the starting of the ponderous

engine, and everything that goes with it. Imagine this uproar bursting forth in the still of night! It's either up to the firehouse or the hospital to move, and as neither seems inclined to do so, the patients suffer.

I recall my training days, when I was on night duty and trying to sleep during the day in a corner room. They were building and constantly drilling in the lot adjoining; in front, they were laying pipes in the street; as the street had an incline, children used it for roller skating; and, as a fitting climax, hand organs were plentiful in the neighborhood.

During illness nerves are in an acute state and more susceptible to breakdown than ever. Need anything more be said? Let us have PEACE from NOISE!



The Hospital Dietitian

At the meeting of the National Home Economic Association held in Boston December, 1909, the first definite attention was given to the hospital dietitian.

A section of the general meeting was arranged by Mrs. Ellen H. Richards, president, with Miss E. Grace McCullough as chairman.

The Massachusetts General Hospital tendered its amphitheatre for the conference and extended an invitation to inspect its dietary department. Much to the surprise of those who stood as vouchers for the new departure, instead of the meeting being an informal round table exchange of experiences and conditions, there were present about one hundred (100) and the whole took on a most dignified character.

A paper at that meeting was presented by William F. Boos, M.D., Ph.D., of Boston, which gave a comprehensive, far-reaching and forceful outlook for the hospital dietitian. It was the first time the true note had ever been struck. He not only included the manifold duties of routine and the instruction of nurses, but there was no uncertain

sound as to the primary reason for her *being*, viz., the dieting of patients, whether special or general, emphasizing first that she should not only be trained in domestic science, but also in medicine sufficient to intelligently diet all and any patients who would be referred to her; that she should daily visit such patients either as part of the regular clinical rounds or alone; she should be equal for consultation and of the same rank as the medical house-officers; second, that there should be established a hospital course in dietetics open to domestic science college graduates with at least two years in a medical college, they to have the same length of term as the medical internes and known as the dietetic internes, with the same status; this post-graduate work should be required by all hospitals before accepting any applicant as resident dietitian. The closing remarks of the paper were so strong that they are quoted in full:

"The woman who studies to be a hospital dietitian has, in my opinion, entered upon a dignified profession of absorbing interest, and one which is eminently within her domain. Dietitians have come to be as necessary in a modern hospital as the visiting medical staff itself, and the demand for members of this profession must, therefore, be met in some way. At present it is woman's work, waiting for her, and offering fine inducements to her. This fact should be impressed upon young women in search of a professional career, for if there are no women available—and I fear there are not many—it will not be long, in these days of overcrowded professions, before men will add dietetics to the list of callings for men, and women may realize too late what an opportunity they have lost, in part, at least."

In June, 1912, at the institutional section of the Home Economic Association, held at Lake Placid, one entire session was devoted to several phases of dietitians at large. One paper by Miss E. Grace McCullough, upon

"The Cooperation of the Dietitian and Physician," dealt with her experiences, and presented the plea for additional training to meet the demands of the large hospital and the busy physician. She did not hesitate to state that 50 per cent. of those entering hospitals were failures, while 25 per cent. more did not meet the needs. The paper created a stir, with much harsh criticism.

The seed-sowing apparently is bringing forth fruit, for the same National Home Economic Association, in the last meeting, June, 1914, at Cleveland, decided to do something toward the efficient training of the dietitian. The first step has been the sending, to all institutions, a "Questionnaire," "which it is hoped will be a small contribution toward solving the problem of the dietitian in the institutional household." "The immediate purpose is to gain information regarding the teaching duties of the hospital dietitian in order (first) to aid the dietitian by suggesting courses and reference material, and (second) to work toward standardization of such instruction."

AGAIN THE FUNDAMENTALS ARE OVER-LOOKED

Why should the teaching of nurses take precedence when the patient for which the hospital stands has second place?

The "Questionnaire" is divided into three subjects:

1. General hospital duties.
2. The pupil dietitian, required preparation, possible salary, etc.
3. The details of course instruction for nurses, length of service, etc.

The hospitals should be thankful that at last something is being done to raise the status of the would-be hospital dietitian. The average youthful graduate who enters a hospital has no more idea of all that is expected of her than if she had never taken up domestic science work. Ask any applicant why she has elected to enter a hospital, then study the answer.—*Contributed.*

Nob Hill Lodge

Nob Hill Lodge is the attractive name of a private sanitarium for the tubercular sick at Colorado Springs, of which Miss Florence Standish, R.N., is proprietor and superintendent, with Miss Juliet A. Farr, R.N., as her assistant.

The buildings and cabins are arranged along modern lines of sanatorium construc-

A Point for Economy

A writer in an exchange makes the common-sense suggestion that charitable institutions and organizations, in this time of financial stringency, should study carefully and make a list of items which might be termed "unnecessary expenses." In this list she suggests, for most organizations, less printed matter, which also will mean less postage.



NOB HILL LODGE, SOUTH

tion. There are ten large sleeping-porches with dressing-rooms adjoining, in addition to the famous Gardiner cabins, which are constructed along scientific lines, having shingled roofs, with ventilators at the top, which may be operated from the bed, and wooden floors on brick foundations. Each cabin is equipped with electric light and electric call bell. There is accommodation for twenty-five patients. Miss Standish was for several years superintendent of Bethel Hospital, Colorado Springs.

She further suggests that many programs and statements could be mimeographed instead of printed, which in the course of the year would mean considerable saving.

She mentions as one important item of expense the annual report and, incidentally, intimates that many institutions and organizations which are very hard up for funds spend several hundreds of dollars every year on a lengthy annual report, which is promptly consigned to the waste basket by the majority who receive it. She recom-

mends very strongly that for this year, at least, institutions and organizations give up their time-honored custom of preparing a tedious lengthy report, and that instead they publish a brief statement of the purpose of the organization. The statistical record of work done, the treasurer's report and, perhaps, a brief paragraph or two concerning outstanding features or special needs. She asserts her belief that apart from the saving

matter, which few, if any, who get the report care to read—the point is one well worthy of consideration at the beginning of the year.

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The Purchase of Butter

The superintendent of a State hospital in Iowa which last year purchased butter to the amount of \$20,636, states that this article in his institution has in the past caused considerable grief to stewards and store-



"CHASING THE CURE"

of much time and labor and money, more will be accomplished by the tersely worded statement in leaflet form, than by the voluminous report, because people will read a short leaflet through when they wouldn't try to wade through a long report of a hundred pages, more or less.

Of course, hospitals and other institutions which are so well supported and managed that they have no deficit and never feel the "pinch of hard times," will continue their time-honored custom, but the point she raises as to the unnecessary expense of printing and mailing several thousand copies of a lengthy report containing pages on pages of

keepers. They had been in the habit of receiving it in sixty-pound tubs, which occasionally became broken in transit. The tubs had to be opened to examine them on arrival, to see if the quality was up to that in the order, and then had to be closed and wrapped.

"During the past seven or eight months," writes the superintendent, "we have been receiving butter in one-pound cartons. Each carton is nicely wrapped in paraffin paper and again wrapped and nicely labeled. These cartons are packed sixty in a box. The boxes are made strong with hand-holds at the ends. One or more packages may be

tested without taking a chance of spoiling the entire shipment. Of the twenty-five or thirty thousand pounds of butter received at our institution during the past summer, packed in the above manner, not one box was broken in transit nor did we have any complaint about receiving bad butter, as it comes through in nice condition and is taken to the cold storage, and being in boxes of uniform size packs nicely and occupies but little space. The packages being sealed, the butter does not become tainted. When the butter is issued to the different kitchens and dining-rooms, it is sent out in the one-pound cartons, sealed, and remains sealed until needed for use. I might add that this butter cost us no more than did that received in the sixty-pound tubs."

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The Boston City Hospital

The year book of the Boston City Hospital, a substantial volume of over two hundred pages, chronicles the outstanding events and points of general interest in the fiftieth year of that great charity.

Mention is made of the satisfactory progress of the effort started a couple of years ago to train male nurses. Several have completed the course and passed their State examinations.

The report states that about 4 per cent. of the house staff have suffered from contagious disease, and that one-third of the nurses have been laid off for that and other affections. The former have lost 203 days' service and the latter over sixteen months.

Preventive measures as follows are suggested:

1. Physical examination of the nurses before admission to the hospital, especially as to nose and throat disease and the correction of these conditions before admission to the school.

2. Less crowding in the wards and fewer patients per nurse. It is noticeable that less sickness occurs during the non-crowded periods, both among the nurses and house officers.

In the report of the training school it is stated that the majority of the graduates engage in private nursing. Graduate head nurses who prefer to remain in hospital work or return after a period of private nursing, are given post-graduate instruction in ward management, hospital housekeeping and minor administration, fitting them to fill positions of trust in hospitals or other institutions.

An interesting item relates to the number of special funds received by bequest. These special funds total \$86,950. Among the objects for which these special funds are to be used are the following:

For the benefit of patients leaving the hospital poor and destitute of proper clothing.

For replenishing the library of the hospital with books and pamphlets suitable for the reading of patients during convalescence.

For the purchase of artificial limbs for patients leaving the hospital.

For a money prize to be given to the house officer who administers ether or other anesthetic in the most skilful and humane manner.

For books for the benefit of the training school for nurses.

For the employment of special nurses.

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Barnes Hospital, St. Louis, Opened

The Barnes Hospital, St. Louis, long waited for, has been formally opened to the public. Nearly twenty years ago, Robert A. Barnes, a wealthy layman of St. Louis, left a bequest of a million dollars to establish a hospital which should be operated under the direction of the Methodist Episcopal Church, South. The money was invested in order to secure from it a fund for maintenance. The building, which has just been opened, cost \$1,200,000, and provides 300 beds. Two years were required to erect it.

A working agreement as to its operation has been arranged with Washington University. Its total resources amount to nearly five millions.

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

Invalid Occupation

To the Editor of *The Trained Nurse*:

I wish to call the attention of those who have charge of training schools to certain significant statements in Bulletin No. 4 of the Massachusetts State Board of Insanity (December, 1914). I will quote the items which seem to me to demand attention from those who hope to maintain the standard of training. (The italics are in each case my own.) In the report of the director of industries for the State board of insanity, we find that "since October 1, 1914, *seven hospitals have started* courses of handiwork in their training schools for nurses.* With one hospital having previously started this course, there are now a total of eight institutions giving industrial courses to nurses, which are to be a *part of their training.*

"At Worcester State Hospital, during the last month . . . simple games and drills have been participated in by patients of the so-called 'back wards,' being patients who do not usually take part in any form of diversion. At Taunton State Hospital, in addition to the work which has been done by the patients heretofore, a knitting class was started this last month, occupying *four mornings a week*, and mufflers, shawls, slippers, mittens and stockings have been made. This has proved of great interest to the patients well advanced in age. The number attending has ranged from nineteen to forty-five. At Westborough State Hospital in October a basement room was opened as a workroom for men. A new loom and a renovated one are in use for rug weaving, machinery for broom making is already installed and the making of cocoa-fibre mats has also been started.

"At the Warren Farm a beginning of a tailoring department has been established. A new electric iron has been purchased, and pressing and repairing can now be done. At Worcester State Asylum, during the past month, there has been started a regular morning period of one hour of work on five wards at the Grafton Colony. One ward is an open ward, consisting of infirm and

demented patients, two others are of the noisy, turbulent and destructive type, and the remaining two consist of milder cases of the same class. The patients are grouped together in their respective wards and under the care and direction of *nurses.* Their work at present consists of sandpapering boards, raveling and braiding teamatting, and raveling, tying and winding burlap, and in one ward some of the patients have *already extended their work* to mending and plain sewing. In one ward every patient has been occupied. This is a very creditable showing for *one month's work.*

"At Gardner State Colony, although this colony *has as yet no training school*, instruction in handiwork to *the nurses* was begun November 1, 1914, with rug making (hooked and woven), basketry and garment making. At Monson State Hospital, until November 1, at the Children's Colony, the teaching has been done *by nurses.* On November 1, Miss Francis Brainerd took the position of teacher to these children. She is a graduate of the North Adams Normal School, has attended a course in extension work at Teachers College, Columbia University, New York, and has had experience and special work with defective children. At Worcester State Hospital an exhibit and sale of fancy work, bead and stencil work, embroidery, lace, weaving, hand-painted cards, leather and brass work, pottery, reed and raffia baskets, moccasins, rugs, brooms, brushes and woodwork made by the patients was held at the Worcester State Hospital from December 3 to 19, 1914, inclusive."

Does this not look as if "invalid occupation" is very much alive? There is one feature to which I would call especial attention. That is the possibility of using occupational training as an inducement with which to attract the large group of young women who reject nursing in favor of other professions. The day of the "pretty cap" has gone (and we are all thankful); "rubbing up brass" is now too well understood by the prospective probationer for her to think that "nursing is a cinch," and we need more nurses, older nurses,

nurses with a broader education than many have who are now entering the profession. Numbers of young women are declining nursing as a life-work because they feel (rightly or wrongly) that it allows no, or not sufficient, scope for individual development, and who turn (rightly or wrongly) to public school teaching, etc. May not the nursing ranks be augmented from this class if an opportunity is offered to them to become not only nurses but *nurse teachers*, wherein not a less but a greater opportunity will be allowed for individual development and progress?

There are more and more indications every day that the hospital of the future will be an educational or a re-educational institution, and hospital teaching will naturally, rightly and inevitably become either a part of the nurse's regular duty or the duty of a new subdivision of the nursing profession. These schools which do not consider it now will be "out of date" in another generation, and the probationers will go or be sent to the schools wherein they can receive the most complete training. The above report shows that at Gardner "although with no training school," the *nurses* are being taught. How long will the directors of a hospital do that when they can get nurses already trained in occupational therapy? And how long will the girls continue to train in a school which does not put them on an equal footing with the graduates of other schools, which leaves them entirely ignorant of one entire branch of work?

Massachusetts, it seems, is in the lead in this respect, for I can find no other State wherein occupation is already so widely recognized. In New York it is included in the regular training at Ward's Island, and in the Clifton Springs Training School it is to be adopted with the present junior class, when a new and apparently admirable combination of school and clinical work will be tried (for other than mental cases) by Miss Sara Blanchard, the directress of industries. It is, of course, too soon to see what the difference in the number of probationers will be between the schools which do and those which do not include this new department. But it seems axiomatic that those who do not keep up will be left behind. At Consolation House we are constantly receiving requests for occupational nurses at salaries from \$50 to \$100 a month, with maintenance and laundry.

GEORGE EDWARD BARTON.



Therapeutic Value of Music

To the Editor of The Trained Nurse:

Each one of us has experienced at one time or another that elation of spirits and warm sense of

pleasure on hearing military music, or sensed something holy in the tones of a great, solemn organ. The dancer performs until physically exhausted with only the music of a weird little tom-tom as an incentive, any great physical or daring feat being more easily rendered when combined with music; and so we see that there must be a direct influence of music on health.

Although the action of music is psychological rather than physiological, yet there is a distinct influence upon the body. It has long been recognized that music at meals aids the healthy processes of digestion, while unpleasant conversation or a worried condition of the mind is a distinct detriment.

In the care and treatment of the insane, both in the lesser and more advanced instances, concerts given regularly are a part of the curriculum, and where there is exceptional adaptability the patients may take minor parts.

While much may be said of the value of music in illness, one must not forget the fine line drawn between its use and abuse, nor that its uses are still largely experimental. Perhaps it may be regularly prescribed in the near future. •

M. ELIZABETH PENNINGTON.



Votes for Nurses and the Hospital

To the Editor of The Trained Nurse:

It was with great interest that I read George Edward Barton's article in the September number. I have also read Emma Y. Patterson's reply to same. I, too, "have intimate knowledge" of many hospitals and have found that the ways of governing these vary greatly. In the private hospitals and in the "closed" hospitals (and I believe that most hospitals in the East are "closed") only too often a doctor can "break a nurse at will," to quote Mr. Barton, and I could cite instances. It may be a coincidence, but I have never known it to happen in an "open" general hospital. It seems a splendid idea to have a member of the trustees elected by the *alumnæ* association. The nurses do have a better "working knowledge" of the hospital than it is possible for any one else to gain, and often much money, time and annoyance could be saved if the trustees understood requirements and conditions more fully. A short time ago I visited the newly opened maternity wing in a general hospital which has at its head a very practical woman with post-graduate course in one of our best lying-in hospitals. I was rather surprised at finding part of the equipment expensive, and not well suited for the purpose, I thought, and asked her to please explain its particular advantages. She laughed

and said "it was bought by the board and we *have* to work with it as best we can." Her advice was not asked, but the advice of two of the doctors, who could not be expected to know, as they never have actually done the work of caring for patients. Most of us who are superintendents know of similar instances, and I am satisfied that boards of trustees, as a rule, make such mistakes through ignorance. Neither do I believe that a board composed, as this one was, of business men, would allow the following to continue, if they knew of it. In a 250-bed hospital in a large city the office force—druggist, internes, matron, etc.—had delicious meals, well served, delicacies—often out of season—and beer served with *every* dinner and supper. The nurses' meals were so poor that several had to give up their training for that reason, and the hospital had a number of graduates doing general duty on the floors. Breakfast consisted of cereal (which never was sufficiently cooked for first breakfast), bread, coffee and "steak." This was varied with "hot cakes" on Saturday, and bacon on Sunday, but *never* enough for each nurse to have one piece. Toast, I was told, was too expensive. The other meals were on the same level. Lettuce and radishes were not served, as they "could not spare any one to clean them." A. H.



The Special Nurse

To the Editor of The Trained Nurse:

There is one question I would like to ask, and that is why do so many graduate nurses become careless and lazy when on private duty? I am superintendent of a small country hospital, where we have a training school, and there are many times when I have to have graduate nurses come in to special a case, and I do it most unwillingly unless I know the nurse, for two reasons—the example for the pupils is bad and the patient suffers.

For my part, I cannot blame one for criticizing nurses if one has had the same experiences I have had; there are certainly some nurses who are a disgrace to the profession. Their whole ambition apparently is to look attractive and "slick" things over in a hospital, expecting the pupils to wait upon them. I have had several cases where, when the nurse has gone off for hours, leaving work undone, my pupils have had to fix the patient, bathing, combing hair and rubbing back,

both morning and evening. I am at a loss to know just where my authority over them begins and ends. I sometimes speak to the doctor on the case, after I have tried in a diplomatic way to make the nurse improve and have failed.

Is there anything more that one can do? I hesitate to dictate to a nurse who has been practising for years, and yet they are the ones who bring the profession under condemnation.

H. B. J., New Jersey.

[Where does the authority of a superintendent of a hospital, or of nurses, begin and end, in connection with special nurses in a hospital? What more can she do than she is doing? Why do some graduates on private duty become careless and lazy? These are two or three practical questions asked by this perplexed New Jersey superintendent. Many a superintendent has asked and is asking the same question. Does a printed slip with rules for nurses on special duty, given to the nurse when she begins with the case, help to correct the conditions of which she complains. What rules, printed or otherwise, have you in your hospital, relating to special nurses? Kindly reply, sending copies of such rules as you would suggest.—ED.]



Sleeping Out-of-doors

To the Editor of The Trained Nurse:

A friend of mine has recently moved into the outskirts of the city, with the intention of sleeping out-of-doors this winter. Her doctor seems to think she needs this outdoor regime, or she will develop tuberculosis. In our northern climate the problem of keeping comfortably warm in zero weather or often 10 to 15 degrees below zero is not easily disposed of. Because I am a nurse, she has appealed to me for suggestions as to what she must do in order to be comfortable in winter. She plans to use a back balcony, as yet unprotected from the elements—not even a roof. Her husband is planning to put up a canvas awning. They rent the property and, of course, the owner will not assume the cost of anything.

I have never had any experience with nursing patients out-of-doors in winter weather and do not know how to advise her. I would be so glad if some nurses who have had outdoor nursing in winter would write of their experience and give suggestions.

ANNA K. M.

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

Notes from the War Zone*

As a result of a protest from the national council of trained nurses of England that incompetent women are serving at the front and in hospitals, Lord Kitchener, the British war secretary, has called on the council for a detailed report. The press some time ago directed public attention to the fact that many eager young women, either wealthy or socially prominent, were clamoring for positions as nurses. While the motives of these young women are to be commended, it has been said that meagre training was hardly beneficial to the wounded.

A useful contrivance which was asked for by a nurse on duty in France was a wall pocket for each wounded soldier, to hold his smaller belongings. The size mentioned was 9 by 5 inches. Those received were divided into one large and two small pockets, having a flap to fold over. These held a pocket-comb, piece of soap, handkerchief, paper, pencil and envelopes.

Carrying 3,500 tons of flour and other food-stuffs, valued at \$400,000, the gift of the State of Kansas, the steamship "Hannah" left New York January 5 for Rotterdam, under charter to the commission for relief in Belgium. Charles F. Scott, the representative of the State of Kansas, will go to Belgium to witness the distribution of the supplies. The "Hannah" is of 2,323 tons, and has just been changed from British to American registry. Before the steamship left the Bush Terminal, a short ceremony took place. Assisted by John R. Rae, the master, Mrs. Lindon W. Bates, chairman of the woman's section of the commission, raised the State flag of Kansas over the ship. The "Hannah" also bore, in addition to her own ship flags, the special safety conduct flags of the commission and special banners telling her mission.

A letter has been received by Mr. and Mrs. Michael Dooley, of Avondale, Cincinnati, from their daughter, Miss Elizabeth, who resigned as night superintendent of nurses at the Jewish Hos-

pital and went to Europe in charge of the Cincinnati contingent of Red Cross war nurses. The letter was written at Vienna, and says that all who went with Miss Dooley from Cincinnati are well.

Miss Price, a Waltham graduate, who went abroad last year to spend the summer in Wales and Scotland, on the breaking out of the war volunteered for service in the American Hospital at Paignton, the regular nurses there having gone to the front. For a while she was the only American nurse there, but now others have arrived. She writes that the work is very interesting.

Miss Elizabeth Ross, a Waltham graduate, is in Oxford, England, with a patient; she is doing what she can to help the Belgian refugees. Some of the Waltham nurses are sending Miss Ross money to pay the Belgians for making lace for them.

A letter has been received by the family of Miss Grace Wilday, of Elizabeth, N. J., the local nurse who left last September on the Red Cross ship for Germany to assist in caring for the wounded. The hospital where Miss Wilday is stationed is at Kozel, a city between Breslau and Cracow, and is on the direct route over which supplies are taken to the front and the wounded brought back. Winter has set in, Miss Wilday writes, and the hospital is in an overcrowded condition. The nurses have to be on duty constantly. She is in good health, she says, and is gaining invaluable experience.

Of things needed for the wounded, a writer in a London exchange makes special mention of many-tailed bandages, to be made as follows: "The best material to use is unbleached calico at 2¼d. a yard. Take a piece of calico 6 inches wide by 2 yards long and five strips of 3 inches wide and 1½ yards long. Stitch the five strips of calico together edge to edge in the middle for 14 inches, leaving loose ends either side of 24 inches. Place the stitched strips on to one end

*War Notes continued in Advertising Department.



GROUP OF NURSES OF MT. SAN RAFAEL HOSPITAL, TRINIDAD, COLORADO

of the 6-inch strip, so as to form a letter T, and stitch either side of the 6-inch strip firmly to the bottom of the five strips."

An English nurse who had to give up active work to care for her father found an opportunity to help the soldiers when a thousand volunteers were sent to the quiet country spot where she lived. She paid special attention to instructing them in regard to the care of the feet, for which she had printed cards bearing the following directions:

"1. Feet that are simply soft and tender should be soaked ten minutes in a saturated solution of alum. (Nearly all the men firmly believe that washing the feet well will make them soft and susceptible.) After the soaking the man must go to bed, and he should either rub in a little methylated spirit or castor oil in the morning. Soaping the socks is also a good tip.

2. Feet that are red and rubbed should be powdered.

3. Feet with corns, bunions and blisters are best thoroughly soaked and treated with corn paints, the blisters being dressed with Thymolodyne or Foot-Eazer.

In all cases one must remember that remedies are useless unless the feet are kept healthy by well-fitting boots."

Navy Nurse Corps

APPOINTMENTS—Helena W. Diegnan, R.N., New York Hospital; Ruby E. Wood, R.N., Albany City Hospital, Albany, N. Y.; Ancon Hospital, C.Z., three years; Eva R. Dunlap, R.N., Lewis Crozer Hospital, Chester, Pa.; Mary H. Conlin, R.N., St. Peter's Hospital, Albany, N. Y.; Anna Lee Merritt, R.N., New York Post-Graduate Hospital, N. Y., operating-room nurse, Hospital for Ruptured and Crippled Children; Blanche Finger, R.N., Phoenixville Hospital, Pa., post-graduate Los Angeles Hospital, Cal.; Norma McEchron, R.N., Christ's Hospital, Topeka, Kan., and Santa Fe R.R. Hospital; Louisa Kurath, R.N., Woman's Hospital, Philadelphia, Pa., head nurse M. E. Hospital, Philadelphia; Mary L. Douglas, R.N., Malden Hospital, Malden, Mass., Colon Hospital, C.Z.

TRANSFERS—Louisa Kurath to Newport, R. I.; Mary L. Douglas to Newport, R. I.; Philena P. Cheetham to Mare Island, Cal.; Inez Donaldson to Mare Island, Cal.; Violet Gass to Mare Island, Cal.; Emily Smaling to Mare Island, Cal.; Anne M. V. Hctor to Mare Island, Cal.; Mary A. Long to Mare Island, Cal.; Mary P. Leeder to Mare Island, Cal.; Blanche Finger to Mare Island, Cal.; Norma McEchron to Mare Island, Cal.; Mary V. Hamlin to Washington, D. C.; Anna Lee Merritt to Washington, D. C.; Anna M. Fallamal to Washington, D. C.; Ruby E. Wood to Washington, D. C.; Eva R. Dunlap to New York, N. Y.; Mary H. Conlin to Philadelphia, Pa.; Helena W. Diegnan, to New York, N. Y.; Agnes M. Quinlan to Philadelphia, Pa.; Mary C. Chewning to Philadelphia, Pa.; Eva S. Knowlton to Annapolis, Md.; Eleanor Lawrence to Annapolis, Md.; Elizabeth Roller to Norfolk, Va.; Annie

Wayland to Chelsea, Mass.; Helen A. Russell to Norfolk, Va.

ASSIGNMENTS—Elisabeth Leonhardt to Norfolk, Va., as chief nurse; Philena P. Cheetham to Mare Island, Cal., as acting chief nurse.

HONORABLE DISCHARGE—Charlotte Page; J. Beatrice Bowman, chief nurse; Anna R. Longsdorf; Nell I. McCarthy; Margaret Seitz; Margaret Pierce.

RESIGNATIONS—Alice Ralston, Marie C. Glindeman, Mary Belle Strubble, Christine Dixon.

LENAH S. HIGBEE,
Superintendent, Nurse Corps, U.S.N.



Maine

At the quarterly meeting of the Maine State Nurses' Association, held in Augusta, the Association became an incorporated body and by-laws were adopted. The officers of the unincorporated association were re-elected. Following are the officers of the incorporated association: President, Miss Edith L. Soule, of Portland; first vice-president, Mrs. Sarah Hayden, of Augusta; second vice-president, Miss Caroline E. Kelley, of Augusta; treasurer, Miss Bernice Mansfield, of Bangor; secretary, Miss Mertie Taylor, of Lewiston; corresponding secretary, Miss Irish, of Portland. The legislative committee presented a draft of the bill for registration of nurses, which was discussed and accepted. A. J. Torsleff, of Bangor, secretary of the Anti-Tuberculosis Association, gave a very interesting talk upon "Anti-Tuberculosis Work."



Massachusetts

The Arlington Health Resort Training School for Nurses held its first public graduation on the evening of December 7 in the Ring Sanatorium Building, which is the non-mental department of the resort. Frederick A. Bisbee, D.D., presided. Dr. Edwin P. Stickney spoke as the representative of the Symmes Arlington Hospital, and Dr. Joel E. Goldthwait gave an address emphasizing the skill required in caring for chronic cases, and the need of a cheerful, optimistic atmosphere. The diplomas were presented by Rev. F. A. Bisbee, and the pins by Miss Brown, superintendent of Symmes Hospital. The graduates were Miss Mabel Hunter, Peabody, Mass.; Miss Frances M. Pattee, Caribou, Me., and Miss Ruth A. Salisbury, Bar Harbor, Me. After the exercises there was an informal reception and buffet lunch, and the institution was inspected by the guests, the treatment and the occupation rooms proving of much interest. Systematic occupation has come to be an important department in the treatment of many chronic affections, and this work offers an excellent opening for young women who pos-

sess tact and a mechanical trend. The young women trained in the old way in the acute hospital seldom know anything of the kind of nursing required by chronic invalids, and have proved to have little insight into the problems presented by nervous and mental patients. So difficult has it been to secure nurses trained in the care and treatment of nervous, mental and chronic diseases and in the application of physiological therapeutics, that a training school for nurses was established seven years ago, offering to young women of sufficient preparation a two and a half years' course, which is now extended to three years. During the formative periods, on account of the limited number of beds, on account of lay prejudice against mental nursing, and also on account of the feeling that psychic cases needed a maid, not a nurse, considerable difficulty was experienced in securing as great a number of desirable pupils as we required; in truth, many came but few were chosen. The small number of graduates is an index of the high standard striven for. During the past two years, although the numbers have grown from five to thirty-five pupils, there have been more qualified applicants than could be accepted. Obstacles were again encountered when affiliation was sought with a general hospital; but a change has come about, and now several hospitals are offering these nurses a third year's training. This is evidence of a growing appreciation by physicians and hospitals of the value of nervous and mental training in conjunction with acute medical and surgical training. The Symmes Hospital and the Marlboro Hospital have been selected as offering the best instruction, the regular course being extended to acute work in obstetrics, surgery, children's diseases, etc. Nervous disturbances enter into nearly every illness, and there is no doubt that young women trained in this way have a broader outlook and insight into their patients' needs.

The graduate nurses of the Addison Gilbert Hospital met at the hospital December 28 and organized an association to be known as the Nurses' Alumnae Association of the Addison Gilbert Hospital Training School. The following officers were elected: President, Mrs. Katherine M. McDonald; first vice-president, Miss M. Estell Shields; second vice-president, Miss Catherine C. Mealey; secretary, Miss Harriett T. Lufkin; treasurer, Miss Carrie W. Davis.

Mrs. Mary E. Johnson, widow of Luther S. Johnson, a wealthy shoe manufacturer, has given

\$100,000 to the Lynn Hospital Corporation, to be used for building and maintaining a nurses' home in connection with that institution.

The male nurses of the Boston City Hospital held a banquet at the Revere House December 31. This event is to be a start for the foundation of the Male Nurses' Home of Massachusetts. Thomas Gorham was the toastmaster.



Rhode Island

Graduate nurses of the Rhode Island Hospital presented Dr. John M. Peters, superintendent of the hospital, with a handsome silver coffee service in commemoration of his twenty-five years of service as head of the hospital. The presentation was made at a Christmas and New Year's party of the alumnæ, at which exercises of a musical and literary nature were held and gifts distributed from a Christmas tree. The presentation came as a surprise and Dr. Peters thanked the nurses in an appropriate manner for the remembrance.



Connecticut

On a stage banked with palms and cut flowers, against a background of green and gold, eighteen nurses, graduates of the Class of 1915, of the St. Francis Hospital Training School for Nurses, Hartford, knelt to receive their diplomas from Rt. Rev. John Joseph Nilan, bishop of the diocese, in the St. Thomas's Seminary Hall, on the evening of December 30, 1914. After the introductory concert by the orchestra, with Bishop Nilan presiding, the address of welcome was delivered by Miss Mary Teresa Walsh, of Springfield, Mass. The impressive singing of the graduation song followed, in which the class was aided by a selected chorus from the lower classes of the school. An address by Miss Margaret Mary McNamara, of Wethersfield, concluded the speaking by the members of the graduating class. The address to the graduates was by Dr. Charles E. Taft. Dr. Taft outlined in inspiring fashion the duties of a trained nurse and the various lines of specialized activity which she might take up. After Dr. Taft's hearty "Good luck go with you all!" to the graduates, Bishop Nilan presented the diplomas and sped the class with words of wisdom and advice. He spoke briefly in closing of the growth of the hospital due to the unfailing energy of the Mother Superior.

The exercises closed with the singing of "Peace," an adaptation of Rubinstein's "Melody in F." The graduates are: Elizabeth Anna Ryan, Mary Teresa Walsh, Lena Frances Bittner, Margaret Frances Tanguay, Anna Josephine

McGill, Margaret Mary McNamara, Marie Anna Brinkman, Katherine Elizabeth Nugent, Mary Honora Britt, Elizabeth Florence Flaherty, Catherine Teresa Devine, Mary Gertrude Holden, Margaret Mary Cooke, Annie Elizabeth Powers, Mary Agnes Kelly, Sadie May Gleason, Katherine Elizabeth Hartnett, Agnes Marie Wurth.

On December 1, 1914, at the Nurses' Dormitory of the Memorial Hospital, New London, Conn., a reception was given all graduate nurses of the hospital by Mrs. Nellie R. Burby, superintendent, assisted by the pupil nurses. A most enjoyable evening was spent by all. Dancing to music furnished by the hospital Victrola was the principal entertainment. Vocal selections by Miss La Rue, a pupil nurse, were received with much pleasure. After a good, old-fashioned Virginia reel, in which all classes of the school were represented, a dainty lunch was served. Good-night was said with regret and Mrs. Burby was given much thanks for her cordial hospitality.

The annual meeting of the Nurses' Alumnæ Association of Grace Hospital, New Haven, was held January 4 at the dormitory. The meeting was called to order with the president in the chair. The following officers were elected for the ensuing year: President, Sophia H. Belser, R.N.; vice-president, Mrs. F. H. Bradley, R.N.; recording secretary, Norma S. White, R.N.; corresponding secretary, Kathryn E. Sherman, R.N.; treasurer, Alice F. Smith, R.N. Miss Jennie Greely, R.N., was elected the sixth member of the executive board. After the meeting adjourned, a delightful luncheon was served and enjoyed by all present.



New York

Headquarters for the preparation and forwarding of surgical supplies have been established at 7 East 61st Street, by the Central Club for Nurses, with the cooperation of the following organizations: New York County Chapter of American Red Cross, New York City League of Nursing Education, New York County Registered Nurses' Association, Association of Graduate Nurses, Manhattan and Bronx, and Nurses' Alumnæ Associations of all the local hospitals. The headquarters will be open daily, except Sunday, from 9 A.M. to 5 P.M., Mondays and Thursdays, 9 A.M. to 10 P.M. All nurses in New York City are asked to assist in this additional effort to meet the recent pressing appeals from Europe for such supplies, and will be welcome for any length of time they are able to give to this work; while at headquarters can be reached by telephone.

The public is cordially invited to visit these headquarters and take part in this work, the opening and maintaining of which has been made possible through the generosity of Mrs. John T. Pratt, Mrs. Edward S. Harkness and Mrs. Nathaniel Bowditch Potter, who are active members of the building committee for the new Club House for Nurses which is to be erected in the near future on East 45th Street. The new building is one of a group to be built from the proceeds of the recent big campaign of the Young Women's and the Young Men's Christian Associations of New York.

CIVIL SERVICE EXAMINATION FOR FEMALE TRAINED NURSES

Applications—Applications for the position of female trained nurse in all branches of the nursing service of the city, with the exception of bedside nursing, were received by the New York Municipal Civil Service Commission from September 30, 1913, to October 15, 1913. They were received in the autumn of the year to give the examining bureau of the Commission ample time to hold the medical and written tests and have the eligible list ready for certification at the opening of the milk stations and at the beginning of the campaign for the reduction of infant mortality in June of the following year. Applications were received only from registered nurses of the State of New York, who were citizens of the United States and residents of the State of New York.

Subjects—The subjects of the examination for the position of female trained nurse were as follows: A qualifying physical examination; questions relating to the candidate's education and experience having a weight of four points out of ten; and a paper of questions on the duties of the position, to which each candidate was required to submit answers in writing on the day of the written examination, to which a weight of six points out of ten was attached and on which each candidate was required to obtain a minimum rating of 70 per cent. To obtain a place on the eligible list, a general average of 70 per cent. was required on all subjects of examination.

Experience—An experience blank was issued with each application, and was to be filed with the Commission at the time of filing the application. On this experience paper each candidate was required to give a detailed account of her education and her record of previous employment. The questions on this paper called for a statement of the candidate's age; a statement of the educational institutions attended by her, together with the dates of attendance, the course of study pursued and the degree or diploma received; a statement of the technical education received by the candidate, tending to qualify for a trade, vocation, calling or profession; a brief statement of the candidate's employment from the time she began to work up to five years ago; a detailed statement of the candidate's occupation during each of the last five years, naming the occupation, the name and the address of the employer, the business of the employer, the cause of the

candidate's leaving and a description of the nature of the duties and the hours of employment, and a statement of any other facts, not opinions, which would tend to qualify the candidate for the position of female trained nurse in the municipal service. The answers to all the questions on the experience paper were given by the candidate under oath.

The experience papers of all the candidates in the examination were rated independently by two examiners upon a competitive basis, and the average of these two ratings constituted the mark attached to the candidate's experience paper. Those elements of the candidate's training which were of most value in tending to fit her for the position of nurse in the public schools, or at milk stations, or in infant mortality reduction campaigns, as, for example, special training in the nursing of infants and children, were given the highest rating. The character of the training school from which each candidate was graduated, whether connected with a general hospital or a special hospital, the number of beds, the time devoted to study and to practical work, and the faculty of the school were all rated on a competitive scale by the examiners who marked these experience papers. Similarly, those elements of each candidate's record of previous employment which tended to fit her for the position were given the highest rating, as, for example, previous experience in district nursing or in social service work. The other elements of each candidate's education and record of previous employment were given such lower ratings by the examiners as their smaller relative value in tending to fit the applicant for the position of female trained nurse in the city service justified.

Physical Examination—The physical examination consisted of two parts—a medical physical examination and tests of strength and physical efficiency. In the medical physical examination, the candidates were given a test of vision, in which the use of glasses was allowed, and to pass which required the reading of Snellen 20/20 test types. The hearing of the candidates was tested. The heart of each candidate was examined with a stethoscope applied to the naked chest. The candidates were inspected for evidence of nervous diseases, defects of the circulatory apparatus, deformities, glandular swellings, stiff joints, skin diseases, contagious diseases, goitre and abnormalities of respiration. The bare legs and feet were examined for evidence of defective circulation, edema, varicose veins, ulcers, eczema, bunions, deformities of the toes, everted foot and atrophy of muscles. The candidates were required to walk about fifteen feet in their bare feet, and the feet were then examined for flat foot.

In the tests of physical efficiency the candidates lifted a twenty-five-pound dumbbell with the right hand and with the left hand successively. The lifting of a seventy-five-pound bell from the floor to the height of the waist was employed to test the candidates' ability to handle a helpless person, and to test the candidates, incidentally, for the presence of hernia. All the physical examinations were conducted with the assistance of a woman examiner.

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WRITTEN EXAMINATION

Only those candidates who succeeded in passing the physical examination were admitted to the written examination, which was held at a later date. The written examination, which had a weight of six points out of ten, consisted of two papers of questions. The morning paper containing ten questions, which was given out at 10 A.M., was to be finished at 1 P.M. There was a recess from 1 P.M. to 1.30 P.M. The afternoon paper containing five questions, which was given out at 1.30 P.M., was to be finished at 4 P.M. The following were the questions of the written examinations:

MORNING PAPER

1. Name the contagious skin diseases and give full description of any one named.
2. Discuss the human pulse, respiration and temperature in health and disease.
3. Under what circumstances would you consider a child mentally defective?
4. What causes bed-sores? How can they be prevented? How cured?
5. Give the cutaneous symptoms of the first day of eruption of (1) measles; (2) scarlet fever; (3) smallpox; (4) chicken-pox.
6. How would you determine that a baby was suffering from malnutrition?
7. Name the diseases of the eye which are contagious and give a full description of one named.
8. Write in full detail what instructions you would give a mother in regard to the care, etc., of a two-months-old artificially fed baby.
9. What is the source of contagion in (1) pulmonary tuberculosis; (2) diphtheria; (3) typhoid fever? What prophylactic measures would you advise in each case?
10. Give in full detail your method of examining a public school child.

AFTERNOON PAPER

11. At what age does the law require children to begin to attend school in New York City? At what age may children's working papers be secured? Where is an application for working papers made?
12. Give two reasons to show the importance of a birth certificate record.
13. How may a scarlet fever patient be transferred to a hospital? (a) Name of hospital? (b) Vehicle of transportation?
14. To whom may a man without friends or money be directed for temporary lodging?
15. Given a family in distress: Father an unemployed longshoreman; one child sick with pneumonia, the mother just given birth to another child, three well children in school, dirty and ragged, rent two months in arrears, neither food nor fuel in the house. Outline your procedure.

STATISTICS

Number of applications filed and candidates summoned for physical examination.....	220
Number who passed physical examination and were summoned for written examination.....	156
Number who passed written examination and were placed on eligible list.....	129
Number who have secured appointments from eligible list.....	66
Number who have declined appointment..	63

Date: December 14, 1914. To be finished at 2 P.M.

1. What are the symptoms of adenoids?
2. What treatment should a district nurse give and what instructions should she give to the family of a patient suffering from (1) typhoid fever; (2) diphtheria?
3. Describe the appearance of the skin in (1) chicken-pox; (2) measles; (3) scarlet fever.
4. How would you know that a patient had (1) scabies; (2) impetigo contagiosa?
5. Enumerate and describe the eye diseases which are contagious.
6. Define (1) hernia; (2) tetanus; (3) cutaneous; (4) asphyxia; (5) chorea; (6) alimentation.
7. How would you prepare a proper food for a bottle-fed five-months-old child?
8. Describe a compound fracture of the femur and state what emergency treatment you would give.
9. State in full detail what action you would take in the following case: You visit a twelve-months-old boy who is suffering from measles. You find that this boy got a little sister a week ago. The father is a plumber who has been out of work three months and the mother has had no medical attention during the last month.
10. State in detail what action you would take in the following case: You visit a boy of ten suffering from scarlet fever. You find that his eighteen-year-old brother, who is a blaster on subway construction work, is at home because, as you are informed, he has had a cough during the last year, caused by the dust inhaled by him in the subway, and a few days ago, while coughing, he strained his chest. He is feeling a little weak from loss of blood. The three other members of the family are in robust health, because, as the mother explains, they work in a dairy, and can get all the milk they wish, free of charge. The father, who is employed as an ironworker, injured his hand on a derrick a week ago.



Pennsylvania

The twelfth annual meeting of the Graduate Nurses' Association of the State of Pennsylvania was held at the Seventh Avenue Hotel, Pittsburgh, Pa., November 11, 12, 13, 1914. The meeting was called to order by the president, Miss Ida F. Giles. Address of welcome by Chancellor S. B. McCormick, of the University of Pittsburgh, was followed by an address by Dr. John W. Boyce. Several interesting papers were read on "The Care of the Tubercular Patient." A large part of another session was given up to the discussion of "Hospital Social Service Work." One full evening session was devoted to "The Red Cross," particularly to "The American Red Cross and the War in Europe." A unique and instructive demonstration in nursing methods by the student nurses of Pittsburgh hospitals was held at the Western Pennsylvania Hospital. This was followed by a tea. On November 11 a reception was given to the Association at the Nurses' Home of the Allegheny General Hospital. Miss

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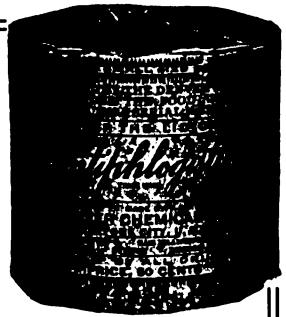
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in these conditions, as to make it an important factor in their regular treatment of Ovaritis, Dysmenorrhea, Incipient Appendicitis, Colitis, Enteritis, Hepatitis, Colic, etc.

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Susan C. Francis, the president-elect, was elected delegate to the convention of the American Nurses' Association in 1915, with the first vice-president, Miss Roberta M. West, as alternate. No semi-annual meeting will be held, as the date conflicts with this convention. The next annual meeting will be in Philadelphia in November, 1915. Forty-six new members were elected. The following officers were elected: President, Miss Susan C. Francis; first vice-president, Miss Roberta M. West; second vice-president, Miss Katherine Dempster; secretary-treasurer, Miss Williamina Duncan; directors, Miss Ida F. Giles and Miss N. E. Macafee.

The regular monthly meeting of the Alumnae Association of the Philadelphia General Hospital Training School for Nurses was held at two o'clock on December 7, 1914, at the Philadelphia County Nurses' Club. Several bills were ordered paid, no new business was transacted, and the meeting adjourned early to permit the members to attend Mrs. Lewis's Parliamentary Law Class. An adjourned meeting was held on December 14, 1914, and there were twenty-nine members present. The membership committee reported two delinquent members who wish to be reinstated. Motion adopted that the State ticket for nominations for the National Association be endorsed. The Alumnae Association endorsed an amendment to the Charter, adding a corresponding secretary and increasing the number of directors, making a board of eleven. The by-laws committee presented their final report, which was accepted, and a rising vote of thanks tendered them for their untiring and efficient work and excellent results. Christmas gifts were ordered to be sent to two nurses who are being treated in a sanatorium for tuberculosis. The following nominating committee was appointed: Mrs. E. D. Uhler, Misses Sarah Guthrie, Ida Liley, Irene Reed and Mary Nick. The regular monthly meeting for January, 1915, was held on the 4th, at the Philadelphia County Nurses' Club, with twenty-eight members present. The minutes were approved and the treasurer's report submitted to the auditing committee. Amendment to the Charter, as endorsed at the previous meeting, was adopted, and the by-laws committee authorized to employ an attorney to make the change. Miss Margaret B. Wise tendered her resignation as chairman of the scholarship committee, and Miss M. L. Eager elected to fill the vacancy. The following were elected as delegates to the National Convention: Miss Alma Wrigley, Alice O'Halloran, Bessie

Wright and Jane Davis. Greetings were sent Miss Sarah L. Clayton, who on January 1 assumed her duties as chief nurse of the Philadelphia General Hospital. On motion adjourned.

The annual meeting of the Nurses' Alumnae Association of Philadelphia Lying-In Hospital was held at the hospital on the afternoon of January 7, with the president in the chair. The following officers were elected to serve during 1915: President, Clara B. Steinmetz, R.N.; first vice-president, Christine Gunn, R.N.; second vice-president, Miss Rue, R.N.; treasurer, Frances Taylor, R.N.; corresponding secretary, Lillian Ernst, R.N.; recording secretary, Adele Miconi, R.N.

Miss Mary Joyce, night superintendent at the Pittston Hospital, has resigned her position. Her position has been filled by Miss Perry, 1914 graduate.

The first annual dance of the Pittston Hospital Alumnae was held at the Pittston State Armory on November 11, 1914. The decorations were on an elaborate scale, the class colors, blue and gold, being carried out. The dance was largely attended and was a success socially and financially. The proceeds are to go toward a fund for sick nurses.

The Pittston Hospital Alumnae held its regular meeting at the hospital January 7, 1915. Election of officers took place. President, Miss Mary Joyce; vice-president, Miss Becktold; secretary and treasurer, Miss Dora Beard. Four new members were taken into the Association—Miss Perry, Miss Whalen, Miss Loughney and Mrs. Ottman. A vote of thanks was tendered Miss Tinsley for her interest and assistance in the Alumnae meetings held at the hospital. At a meeting held in November, Mrs. Helen Castro, ex-superintendent, and Miss Tinsley, superintendent, were elected as honorary members of this Association.

A dinner and theatre party were given to the graduates of 1914 of the Pittston Hospital by Miss Tinsley, superintendent.



Iowa

At a called meeting of the Nurses' Association the following resolutions and vote of appreciation were adopted by the nurses of the Ottumwa Hospital:

We, the nurses of the Ottumwa Hospital, do resolve that in the death of our loved superintend-

Respiratory Diseases

can be promptly relieved of their principal dangers—embarrassment of the heart's action and general systemic depression—by the administration of

Gray's Glycerine Tonic Comp.

"This admirable reconstructive," as one physician describes it, "not only exerts a pronounced influence on the pulmonary circulation, thus lightening the heart's burden, but in addition raises the general vitality so substantially that local processes are rapidly controlled and convalescence quickly established."

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MAX J. WALTER, M.D., Supt.

ent, Miss Elizabeth Trotter, we do realize the loss of a dear friend, who was the inspiration and instigator of the highest ideals of our lives and our work. We realize in her death the breaking up of our hospital home, which has been so much appreciated by the returning nurse from her private work.

We do one and all, from those who were first associated with her up to those of the present time, feel to be better women for having been under her care and training.

We will always hold in grateful remembrance her life and work among us.

Resolved, That a copy of these resolutions and appreciation be spread upon our minutes and sent to the press and relatives.

(Signed) ESTELLA FOSTER,
ESTELLA AKERS,
MADGE BALDWIN,
FLORENCE RHOADES,
LOUISE REMY,

✦ *Committee.*

Minnesota

The Hennepin County Registered Nurses' Association held its regular monthly meeting on December 9, 1914, in the parlors of the Hampshire Arms. After the business of the Association was transacted, the nurses were entertained with a chalk talk given by C. L. Bartholomew, cartoonist for the Minneapolis *Journal*. Refreshments were served in the large dining-room to about sixty nurses. The Association has two hundred nurses, who register and receive private and hospital calls through their registry, conducted by Dr. Marion A. Mead, registrar.

The Alumnae Association of St. Mary's Hospital Training School held its annual meeting in the Home, December 12. The election of officers took place and nine new members were admitted.

✦

Montana

In the case of Miss Woolsey vs. the Montana State Board of Nurse Examiners, the District Court has rendered a verdict in favor of Miss Woolsey. The case is of extreme importance, not only to nurses and physicians of the State, but to members of all professions in which certificates from State examining boards are required to practise. While the judgment of the lower court is for Miss Woolsey, it is expected that the State Board will carry the matter to the State Supreme Court. Contributions from members of the Montana Association of Registered and Graduate Nurses are being solicited with that end in view by the Board.

Personal

Miss Anna McGurty, graduate nurse of the St. Vincent's Hospital, Bridgeport, Conn., Class of 1913, entered the novitiate of the New York Sisters of Charity, at Convent Station, New Jersey, on December 8. All her friends and classmates wish her much happiness in the life of self-sacrifice she has taken up.

Miss Ruby E. Prutsman, graduate nurse in the Class of 1914 of the Arnot-Ogden Hospital, Elmira, N. Y., has returned to that institution to accept the position of night superintendent.

Miss Kunz, of New York, has accepted the position of head nurse at the Anderson County Hospital, Anderson, S. C.

Miss Lena Bourdelaise, head nurse at the Municipal Hospital, Lawrence, Mass., has resigned her position and will take up private nursing.

Miss Irene Rickert, a graduate of the Ellis Hospital Training School, Schenectady, N. Y., in Class of 1913, who has been one of the nurses in the John Wells Memorial Hospital of New Brunswick, N. J., has been appointed superintendent of that hospital.

Miss Ruth Fagerli, for a year and a half an assistant head nurse at the Volga (Iowa) Hospital, has resigned her position and will return to her native country of Norway.

✦

Marriages

On December 26, 1914, at Wilkes-Barre, Pa., Grace Marjorie Lewis, of Dorranceton, graduate nurse of Elmira (N. Y.) Hospital, to Scott Stites Good, of Chicago, Ill.

On November 26, 1914, Mary E. Lynch, graduate nurse of St. Mary's Hospital, Saginaw, Mich., Class of 1911, to Arthur Flint, of Saginaw, Mich.

On December 15, 1914, at Greensboro, N. C., Mabel Catherine Haut, R.N., graduate nurse of Fennell Infirmary, Rock Hill, S. C., Class of 1911, to Horace D. Dupree, of Kinston, N. C. Mr. and Mrs. Dupree will reside at Kinston.

In December, 1914, at Belleville, Mo., Gladys Armstrong, a nurse in training at the St. Louis Baptist Hospital, to Wilfurd Stollberg.

Sleepless Nights

are usually the direct result of an overstimulated nervous system. The sufferers of either transitory or permanent insomnia present similar pathological conditions.

Many patients who complain of restless, wakeful nights are found to be coffee or tea drinkers upon whom the caffeine acts as an unnecessary and injurious stimulant. Thoughtful physicians will see there the necessity of interdicting coffee and tea, and an indication for use of the safe and nutritious drink

POSTUM

which will tranquilize the nervous system and satisfy the stomach.

Postum is made of selected whole wheat, including the bran-coat and a small per cent. of wholesome molasses. Skillful roasting and blending imparts a distinctive, snappy flavor quite similar to that of mild, high-grade coffee, but Postum is absolutely free from caffeine or any other stimulant.

Postum now comes in two forms:

Regular Postum—must be well boiled.

Instant Postum—is soluble—made in the cup with hot water—**instantly**.

Physicians who find it advisable to order “no tea or coffee” can rely on Postum as a safe, tasty beverage containing some genuine nourishment.

“There’s a Reason”

The *Clinical Record*, for Physician’s bedside use, together with samples of **Instant Postum**, **Grape-Nuts** and **Post Toasties** for personal and clinical examination, will be sent on request to any physician who has not yet received them.

Postum Cereal Co., Ltd., Battle Creek, Mich., U. S. A.

In December, 1914, at the Universalist Church, North Adams, Mass., Mildred Chapin Grant, graduate nurse of the Wesson Memorial Hospital, Springfield, and formerly head nurse at the North Adams Hospital, to Dr. Robert John Carpenter.

On January 1, 1915, Elizabeth Mason Dickisson, graduate nurse of the Memorial Hospital, Morristown, N. J., to Howard Alfred Wicks.

On January 6, 1915, at Berwick, Pa., Sue R. Steiner, R.N., graduate of Williamsport Hospital, superintendent of Berwick Hospital for the past six years, to Ralph M. Hosler, of Beach Haven, Pa.



Births

On December 31, 1914, at Jefferes, Mont., to Mr. and Mrs. J. Spencer Watkins, a daughter. Mrs. Watkins was, before her marriage, Miss Annie Lawrie, and a graduate nurse of the Boston City Hospital, Class of 1907.



Deaths

On January 1, 1915, at the home of her brother, Norfolk Va., Elizabeth Trotter, for twenty years superintendent of the Ottumwa Hospital, Iowa.

Elizabeth Trotter was born in Owen Sound, Ontario, Canada, where her girlhood life was spent, and where she was educated. She was graduated from Guelph General Hospital and Training School and followed her chosen profession in Guelph a short time. She was elected superintendent of Ottumwa Hospital and Training School for Nurses in July, 1894. For twenty years and five months she gave herself to the work she loved in most untiring devotion. Suffering from extreme nervous exhaustion, she left for a rest about the 1st of December, going to the home of a brother in Norfolk, Va. The change and rest failed to do what was hoped for, and on January 1 she entered into eternal rest.

In November, 1914, at Easton, Pa., Miss Mary Mahoney, Class 1895, Philadelphia General Hospital. Also Mrs. Minnie Hazen Mellor, Class 1893, Philadelphia General Hospital.

On December 3, 1914, from typhoid fever, Nora T. Daly, a pupil nurse of St. Vincent's Hospital Training School, Bridgeport, Conn.

On December 9, 1914, at Presbyterian Hospital, Chicago, Ill., Lena Mullins, of Natchez, Miss. Miss Mullins was a widely known and much beloved nurse, and her loss will be greatly felt.

In December, 1914, at St. Joseph's Infirmary, Hot Springs, Ark., Sister Mary Clare (Quinlan). Sister Mary had been a nurse at the Infirmary since its opening in 1888.

On December 22, 1914, at New York City, Amanda L. Swenson.

On December 14, 1914, at St. Luke's Hospital, N. Y., Helen Irene Jones, a pupil nurse of the institution. Miss Jones was but twenty years old, and had been in training but a few months.

On December 22, 1914, at St. Luke's Hospital, Little Rock, Ark., Mrs. Lillian Hill McFayden. Before her marriage Mrs. McFayden was Miss Lillian Hill, a member of the Pulaski County Graduate Nurses' Association and head nurse at St. Luke's Hospital.

In December, 1914, at the Tuberculosis Hospital, Yonkers, N. Y., Anna J. Hutchinson. Miss Hutchinson was a graduate of St. Joseph's Hospital, Yonkers, Class of 1898. After graduation she took up private nursing in Brooklyn. In 1912 she became head nurse at the institution in which she died. Death was due to heart disease.

On December 25, 1914, at Fabiola Hospital, Oakland, Cal., Jennie Jessen, superintendent of nurses of that institution. Miss Jessen had devoted her life to hospital work. She had been connected with Fabiola Hospital for the past twelve years and served as superintendent of nurses for about five years. She was loved by all her fellow-workers, by whom she was held in high esteem. In all the charitable movements of Oakland Miss Jessen manifested an interest. She was a director of the Alameda County Nurses' Association, and she was at one time its president.

On December 19, 1914, at Brockton Hospital, Mass., Mabelle F. Wishart. Mrs. Wishart, who was a nurse at the institution, was preparing for a slight operation, and died during the administration of ether.

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In ANY form of DEVITALIZATION
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ANEMIA of All Varieties:

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After LA GRIPPE, TYPHOID, Etc.

DOSE: One tablespoonful after each meal.
Children in proportion.

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A Nourishing and Cooling Drink for the Sick

In convalescence, for weakness, nervousness or feverish conditions, **Horsford's Acid Phosphate** is safer, more palatable and more beneficial than lemonade or lime juice.

HORSFORD'S ACID PHOSPHATE

contains valuable nutrients—phosphates of calcium, sodium, magnesium and iron. It is, therefore, far superior to Dilute Phosphoric or other acids.

It is recommended especially for promoting digestion, strengthening the nervous system and in wasting diseases.

A teaspoonful in a glass of cold water
makes a most grateful beverage.

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RUMFORD CHEMICAL WORKS,

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Book Reviews

Reducing Weight Comfortably; The Dietetic Treatment of Obesity. By Prof. Gustav Gaertner, M.D., of Vienna. Authorized translation in English. (J. B. Lippincott Company.) Price \$1.50 net.

Out of a very large experience in weight reduction, Professor Gaertner has written a full, clear and practical exposition of the subject. While intended primarily for the physician, the book is so free from technicalities that it can be read with profit by any one desiring information along this line. The writer holds that the only form of treatment which will reduce weight satisfactorily is a properly regulated diet, though various other procedures may be relied upon to render assistance in the cure. He does not believe in violent reduction measures, nor does he advocate a diet which makes life a burden to the patient because of its strictness or causes a constant sense of hunger. The principal restriction which he practises is in the use of breadstuffs, as he claims that overeating of bread is the most prolific cause of obesity. He gives his patients a sufficient quantity of food to produce a comfortable feeling of satiety, depending for this effect chiefly upon the bulky and not very nutritious vegetables and fruits. He believes in varying the diet as much as possible, and in allowing the patient, whenever it is practicable, a certain amount of the foods which he especially desires. No article of food is wholly forbidden under his regime. His method is purely empirical, each case being treated on its own merits. Every article of food eaten is carefully weighed, and the diet is changed in accordance with the difference between the effects produced and the effects desired. "No cure without scales." By his methods patients are able to "undergo the treatment at home. They pursue their usual tasks, undisturbed, even though these are such as to make unusual demands upon the intellect and the 'nerves.'" As a result of the treatment the general health is improved as well as the appearance, disorders of menstruation or incident to the climacteric are found to disappear as nutrition improves, and digestive and neurotic disturbances are lessened or cured. As Professor Gaertner practices in Vienna, his references to

weight are according to the metric system instead of in pounds and ounces, while European customs regarding meals differ somewhat from our own; otherwise, however, the book will be of as much practical assistance in this country as in Europe, and will unquestionably prove a valuable contribution to the literature of its subject.



Text-Book of Massage and Remedial Gymnastics.

By L. L. Despard, Member and Examiner Incorporated Society of Trained Masseuses. 413 pages, 201 illustrations. (Oxford University Press, American Branch, N. Y.) Price \$4.50.

This is the second edition of this very comprehensive and splendidly illustrated book. In the preface to the first edition the author tells us that her aim in writing the book was to embody in concise form such a knowledge of the theory of massage, as well as the principles of elementary anatomy and physiology, as is indispensable to all those desirous of taking up massage as a profession; at the same time, she puts great stress on the fact that no matter how clever and full descriptions may be, the practical work must be learned from a competent teacher.

In the present edition many amplifications and additions have been made. In Part I the chapter on Skeleton has been extensively amplified, and certain additions have been made to the chapters on the Articulations and the Nervous System. Some rearrangement of the Tables of the Muscles has been made, and an additional column, giving their action, has been inserted. An additional chapter on Remedial Gymnastics has been introduced and is arranged in tabular form. More space has been devoted to the Theory of Disease and to Applied Treatment, and tables of exercises for various conditions have been added.

The author states that "the practice of massage should be undertaken only by educated persons who, both by nature and training, are qualified for the work. The natural qualifications are health; soft, dry, well-covered, pliable hands; a sympathetic 'touch'; trustworthiness, refinement, kindness and tact. The training should

(Continued in Publisher's Desk)

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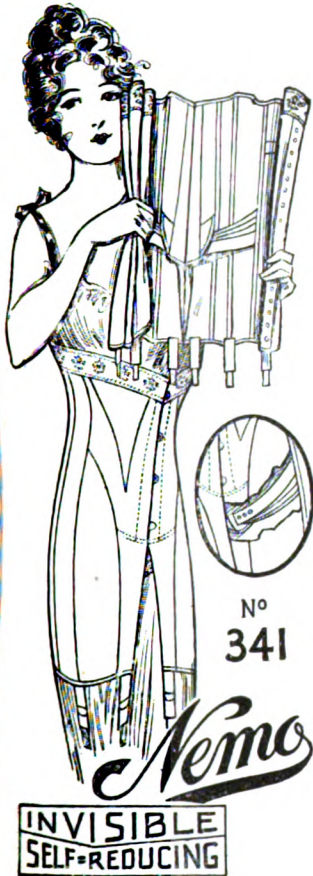
1. Women who want a supple corset that is durable and gives ample physical support, but is not too heavy.
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4. Women who imagine that the usual EXTERNAL Self-Reducing Straps add bulk to the figure—which, of course, is not true.

This Model is the first to produce the

New “Military” Shape

You don't see the new kind of Nemo Self-Reducing Straps; but they are there, and give the most comfortable support with wonderful figure-reduction.

The new “visible” Nemo “bridge” pivots at the highest point of the abdomen—corset goes in at the bottom and out at the top. That means plenty of room for breathing, no over-pressure on the digestive region—*SOUND HEALTH and SOLID COMFORT*. And—*PERFECT STYLE*.



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Liquid Peptonoids is especially valuable in the acute fevers, in pneumonia, rheumatism, sepsis, whooping-cough, scarlatina, measles, for auto- and post-operative feeding, in young children and aged people, in diarrheal diseases, nausea, vomiting, etc.

It is also a most valuable auxiliary nutrient tonic during convalescence, or in debilitated, cachectic or exhausted conditions of low vitality and systemic weakness.

Liquid Peptonoids should always be given chilled by pouring over cracked ice—or hot—never at ordinary room temperature.



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An efficient, trustworthy, non-poisonous antiseptic, peculiarly free from irritating properties, even when applied to the most delicate tissues. SaZel, in proper dilution, may be freely and continuously used, either by injection or spray, in all the natural cavities of the body, as a wash and dressing for wounds and ulcers, as a lotion in diseases of the skin, and as a gargle, mouth-wash, inhalant or douche; internally, a teaspoonful three or more times a day, either full strength, diluted with water or combined with other drugs, as directed by the physician.

SaZel mixes with water in any proportion without precipitation or separation of its constituents.

As a mouth-wash for daily use in the care and preservation of the teeth it is unexcelled.

Bad Breath

Formamint Tablets will be found a most pleasant and effective means to prevent or remove bad breath.

They are particularly useful wherever there are softened and bleeding gums, broken or decayed teeth, "gum boils," ulceration, or an unhealthy condition of the mouth, and are to be recommended for all persons regardless of age or business, in health or sickness, as their primary object and effect is to guard against disease by destroying the germs that cause it.



Glyco-Thymoline as a Mouth-Wash

A mouth-wash of Glyco-Thymoline is not only a pleasant method of sterilizing and maintaining an aseptic condition of the oral cavity, but it also tends to prevent the formation of lactic acid, which is a prominent factor in causing decay of the teeth. For these reasons the daily use of Glyco-Thymoline cannot be too strongly urged.



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Every trained nurse should be familiar with Tyree's Powder. Its uses are numerous and it is an invaluable antiseptic for every nurse to carry in her emergency kit. Send your name and address to J. S. Tyree, Washington, D. C., for a full-size box free of all expense to you.



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The cleaning properties of Wyandotte Detergent are in the water, not at the bottom of the pail. So with the water on the mop each time comes the Detergent, and you get the full benefit of its work. It is only when allowed to stand for some time that the Detergent slowly sinks to the bottom of the pail.

Every buyer and user of cleaning agents will at once recognize this property of Wyandotte Detergent to be one of the real live reasons for its superiority.

GLYCO-THYMOLINE

Is Indicated in the Treatment of

*Congestion and Inflammation of
Mucous Membranes in
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Saxonia Quality

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Bed-sores Healed by Comfort Powder

Catatonk, N. Y.: "I was recently called to the case of an old man eighty-four years old, ill for months, and the sores on his body were terrible, and nothing they had used seemed to heal them. I commenced to use Comfort Powder at once, and the sores were soon healed. No one need tell me of the merits of Comfort Powder."—Mrs. C. L. Frost, Nurse, Catatonk.

On account of its skilful medication, Comfort Powder subdues inflammation, counteracts poisonous secretions, destroys parasitic action and promotes skin health.

For all skin soreness of infants, children and adults, Comfort Powder cannot be excelled.

Be sure you get the genuine, with the signature of E. S. Sykes on the box.



Robinson's "Patent" Groats

Trained nurses who are familiar with Robinson's Barley will be well pleased with gruel made from Robinson's Groats, which takes the place of oatmeal and is most delicious. Gruel should always be made from the following recipe: Take of the "Patent" Groats one tablespoonful, mix with a wineglassful of water into a smooth paste free from lumps (this is most important). Pour this into a stewpan containing nearly a pint of milk just on the boil. Stir the gruel on the fire while it boils for ten minutes, and pour it into a basin, adding sugar to taste, or a pinch of salt and a little butter. If a double saucepan is used, it will naturally take longer to prepare.



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As a dressing for wounds, a popular dilution is one part Listerine to ten parts water, though frequently used one to twenty; when there is a tendency to suppuration, stronger solutions are indicated, one to four being generally employed.

Listerine in 10 per cent. solution is of suitable strength to apply to scalds and burns. It is also advantageously combined with bicarbonate of soda and linseed oil. In the suppurative stage, one part Listerine to four parts water may be employed.

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Send ten cents to Ernest Monnier, Boston Mass., for samples of Ingram's Nipples made from finest Para rubber. There are no nipples that last as long and give such perfect satisfaction. The "Agrippa" is an especially satisfactory nipple, and if you once use it you will use no other.



Nurses Interested

Thousands of nurses have requested a copy of the new catalogue on Nurses' Uniforms, recently issued by Henry A. Dix & Sons Company, to prove conclusively that the question of style and correctness has become uppermost in the minds of nurses in general.

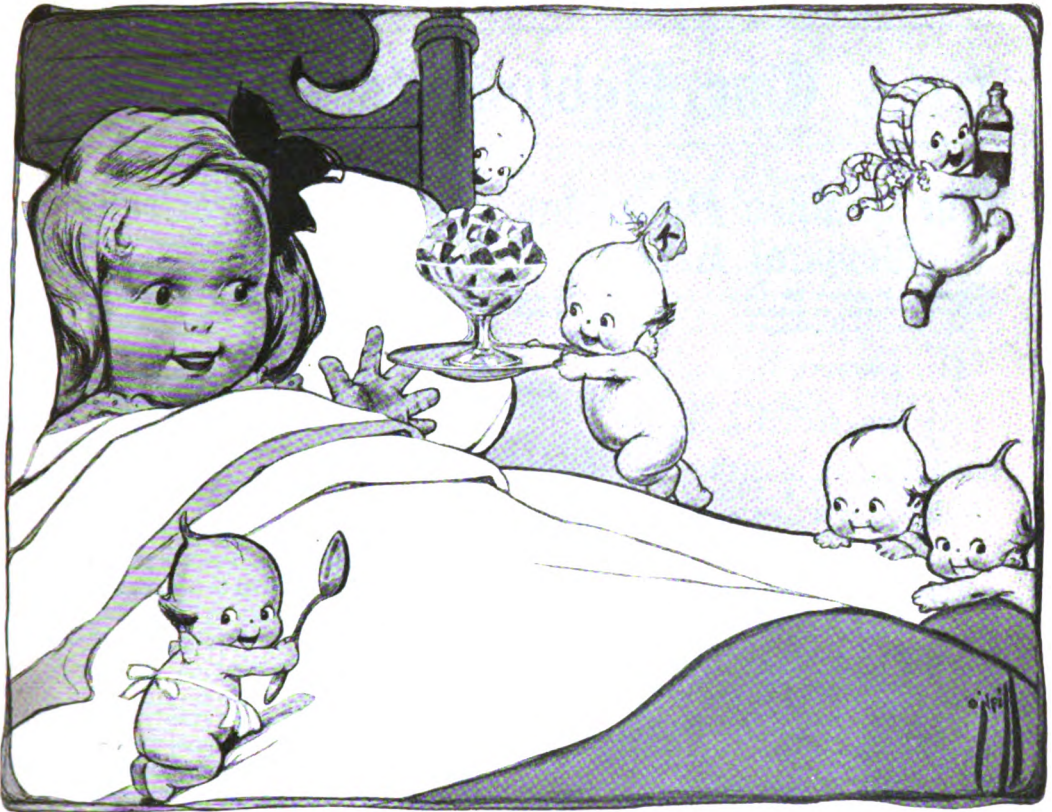
Correctness, perfect fit, good tailoring, good materials—all these features of highest satisfaction may now be gotten in ready-to-wear Uniforms, and within a moment's notice at leading department stores everywhere.

If you have not yet seen the new Dix-Make Uniform catalogue, the manufacturers, Henry A. Dix & Sons Company, 116 West 14th Street, New York, will gladly send one on request.



An Opportunity for Nurses

An effort that will actually bring results can only be obtained when sought in the proper field. Not only in recent years has it been recognized that a knowledge of physio-therapy is indispensable in medical and surgical cases, but it is known that it was used three thousand years ago. To-day you can avail yourself of an opportunity of acquiring this knowledge at the Pennsylvania Orthopedic Institute and School of Mechano-Therapy, Inc., 1709-1711 Green Street, Philadelphia. The aim of this school is to embody in a concise form a knowledge of theoretical and practical use of Swedish "Ling" system of massage, electro- and hydro-therapy, and covering a scope of anatomical details, as well as physiology, pathology, hygiene, medical and corrective gymnastics and bandaging, that deserves more than a passing mention. The completion of a new wing consisting of forty rooms added to the Bushhill Sanatorium, which is affiliated with the Institute, has every modern improvement and apparatus that are especially designed for the successful teaching of mechano-therapy. For interesting illustrated book of courses, address Max J. Walter, M.D., superintendent.



Dorothy's Getting Well

Dorothy, who is just getting over the measles, has no more than said, "My Goodness! Why don't they give me something good to eat?" when the wise Kewpies appear, one bearing a dish of delicious, sparkling Raspberry

JELL-O

another bringing a spoon, and one carrying from sight the hateful medicine.

Dorothy's happy face expresses her approval.

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The Trained Nurse and Hospital Review

A Monthly Magazine for Trained Nurses and Hospital Workers. Devoted to Trained Nursing in Private Practice and in the Hospitals of the Country

Editor

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THE TRAINED NURSE AND HOSPITAL REVIEW

is a magazine of practical nursing and progress—not an organ. It is the magazine for the nurse who desires open-minded, free discussion of all nursing questions, and who expects to keep abreast of the times in regard to practical methods in the nursing field. The magazine with the courage of its conviction, which numbers among its contributors the cleverest writers in the hospital and nursing world.

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(Continued from Book Reviews)

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✦

Inspiration for the New Year

THE TRAINED NURSE deserves a large patronage. It grows better and better with each number. I have found much of interest and I wish for you every success. DR. M. P. PUTNAM.

I have been a subscriber twenty years and in all that time I have never missed but one copy, that a July number which was probably lost in the mail. I could not think of doing without THE TRAINED NURSE. It grows better and better each year, and my husband reads it from cover to cover each month. I shall try to send two new subscribers soon. With my best wishes for your future success. L. F. CURRY.

Through the influence of our hospital superintendent and also that of a nurse with whom I have recently been nursing, it is my desire to subscribe to this splendid magazine. Several times it has been put in my hands, and I have derived such help from it that I feel that I cannot afford to be without it. C. H., MINNEAPOLIS.

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I enjoy the paper very much indeed, and find it both helpful and instructive. You certainly deserve great credit for making it such a splendid magazine for nurses, and I wish you all prosperity and every success for the coming year. M. L. B.

The Trained Nurse and Hospital Review

VOL. LIV

NEW YORK, MARCH, 1915

No. 3

In Defense of Our State Hospitals and the Mental Nurse

REBA G. CAMERON, R.N.

Superintendent of Training School and Occupational Teacher, Taunton State Hospital, Taunton, Mass.

INSANITY has existed as far back as we can recall, and at the present time it seems to be on the increase. This country has a whole army of these unfortunate patients, and the United States stands as high as any country in its method of caring for the insane.

Insanity is one of the most expensive diseases that we have, and our State institutions are supported at an enormous expense annually. Take as examples three of our Eastern States, viz., Massachusetts, New York and Pennsylvania. In Massachusetts there are thirteen thousand insane in our State hospitals alone, and this number does not include those in private sanatoriums or those cared for in their own homes. These hospitals are supported by the State at a cost of over three million dollars yearly. In Pennsylvania there are nearly eighteen thousand insane, and as the legislature meets every two years, it finds the insane population one thousand greater than at the previous session. In New York the insane population is even greater, and statistics, less than a year ago, stated that at least thirty-two thousand insane were cared for in the State of New York at a tremendous expense.

From time immemorial hospitals for the

insane have been supposed to be mysterious, grewsome places. Visitors were not admitted or sought after, and the public knew very little of affairs in the hospitals, except from the patients or from public reports. This, however, is not the case at present, for nowadays visitors are made welcome to every part of our institution, and if more would avail themselves of the opportunity to inspect there would be few unkind criticisms and more kind words said of the State hospitals.

A large proportion of people still think that the insane are cared for as they were years ago, with ropes, manacles, handcuffs, blows and rough treatment. Visitors are shown through the various wards, and when the visit is over they frequently say: "May we see the padded cells, the dungeons," etc., or "Do you permit visitors to see these cases?" When we explain that such things are of the past, they accept it with amazement, and they usually leave the institution with the feeling that a hospital for the insane is not such a terrible place after all.

The insane in our State hospitals today are well cared for, and while there will always be more or less complaint from both patients and friends about the treatment given these patients, we hear very little of

the good which is done and the humane treatment accorded them.

I would ask my readers not to forget the fact that the humanitarian age is quite recent. Consider the abuse that prevailed before State hospitals existed. The insane were, for the most part, committed to jails and poor-houses, and were treated worse than the vilest criminals instead of human beings who were deprived of reason. Manacled by heavy chains, sleeping on straw, their food often thrown to them, and all classes mingling together without any precaution taken to separate the various grades of insanity. The young and old, the violent and depressed, the physically sick and feeble, all herded together without distinction, and under these conditions the natural tendency of all *was* to become worse instead of better. We read with horror of "Old Bedlam," a famous hospital (?) in London, England, devoted to the care of the insane, where every manner of abuse existed, and where sight-seers would journey on a holiday and pay a small fee in order to see the lunatics. Yet we need not go as far as England, for in this fair country of ours, less than eighty-five years ago, equal horrors existed, and were only discontinued by the advent of State hospitals. We read of the case of an old man who was found in prison, who had been heavily chained for *twenty-five years*, and had the chains removed only *once* in that period of time. Another insane man was found in the same prison, where he had been confined for *nine years*. He was clothed in a wreath of rags around his neck and another around his body. He had no other clothing, neither had he a bed, chair or bench. A heap of filthy straw, like the nest of swine, was in one corner. Connected with this wretched apartment was a dark dungeon, having no light, heat or air, except by the iron door, two and a half feet square, opening into it from the prison. The room was not heated, and still the keeper said, "*He had not froze.*" As he was seen through the ori-

fice of the door, the first question was, "Is that a human being?" The hair was gone from one side of his head and his eyes were like balls of fire.

And all this, gentle reader, was less than one hundred years ago, and we must admit that even when State hospitals were in their infancy that the patients were cared for infinitely better than they were previously.

Today they have not reached perfection—far from it—but they have attained a degree of efficiency hitherto unknown in history, and yet a large number of people still think that our insane patients are being cruelly treated. They accept without question the horrible stories of "abuse in our State hospitals," appearing from time to time in our newspapers all over the country.

I do not make the statement that abuse never exists in our State hospitals. Once in a while a case of abuse will occur; yet, I ask you, does not the same thing occur once in a while in a general hospital? I will, however, make a *most decided* statement when I say that no irregularities or abuse are permitted in our State hospitals, and any harsh treatment of a patient by an attendant or nurse is treated by prompt dismissal if it comes to the attention of the authorities in charge.

Chronic fault-finders (and there are many) should look carefully into present conditions before they denounce and criticize our State hospitals. When we remember that less than twenty years ago a certain superintendent of a State institution hired a prize-fighter to keep the violent ward in order, we shudder at the thought. Nowadays the prize-fighter is supplanted, in certain hospitals, by women nurses who do the same work, but in a different way.

We hear complaints of the food from this quarter and that, yet the cost today per capita is, in most State hospitals, from \$4.50 to \$7.00 per week, and we cannot help but compare this with the report of a super-

intendent of a country hospital for the insane less than twenty-five years ago, who claimed with great pride that he supported the State insane patients at a cost of ninety cents a week, or less than thirteen cents a day.

THE GRADE OF PATIENTS IN OUR STATE HOSPITALS

Some may ask, "What class of patients are admitted to the State hospitals? Are they all charity patients, or is there a certain number who pay for their maintenance?" In answer I would say that all classes of patients, "except the very wealthy," are admitted to these institutions.

This country, especially the New England States and the extreme West, has ample accommodations for nervous and mental cases who are able to pay from \$50 to \$100 per week. The very poor, who cannot afford to pay anything can, of course, be provided for in our State hospitals, but at the present time there is no adequate provision for the large number of middle-class people who cannot afford to pay the above rates, and whose pride would forbid them entering any institution as a State charge. For example, here is a teacher earning perhaps eight hundred dollars a year and supporting herself and an aged mother. The mother is old and soon develops senile dementia, a form of insanity due to old age. She is not safe to leave alone, and the question comes up, "What shall I do with mother? She needs constant care and attention. I cannot send her to Dr. Smith's private sanatorium, for his charges are very high." No one wants to take care of mother for \$10 a week in her present condition, consequently she is sent to a State hospital, and the daughter pays from \$5 to \$7 per week for her board and nursing.

Here is a man with a family depending upon him. He perhaps reaches the age of forty, and quite insidiously the dreaded disease of general paralysis begins its work. As this disease is very common and at the

present time is incurable, the family realizes that they cannot keep the head of the family in their home, both from lack of money and because of the nature of the disease, so he is transferred to a State hospital, and the family pays \$5 a week to the State for his support.

These cases are typical, and I mention them merely to show that a large number of patients in our hospitals for the insane today are composed of the average middle-class people—men and women who have broken down mentally, either from hereditary causes, alcohol or disease, and who, for financial reasons, cannot be cared for in their own homes or in private sanatoriums.

THE NURSING STAFF IN OUR STATE HOSPITALS

Much has been said and written of the qualifications necessary for a prospective pupil to possess in order to be accepted in a general hospital, but until lately little attention has been paid to the qualifications necessary for entrance into our State hospitals. If a high degree of intelligence is necessary in caring for physical illness, how important it is that we should have a good type of nurse to care for one suffering from a diseased mind.

The training schools in connection with our State hospitals require as high a grade of nurse as those admitted to general hospitals, and in some of the State hospitals *this standard is being maintained*. The mental nurse must be tactful, patient, resourceful, firm yet gentle, and possess courage to an unlimited extent. The pupils who are being admitted to our State hospitals today are a much better grade than ever before. One reason for this is perhaps the pay a nurse receives while in training.

Take, for example, a young woman who is dependent on herself and, perhaps, has to help her family. She feels that she cannot afford to work for three years at \$5, \$8 or \$12 a month, which is the average wage of our large and small general hospitals, so she

enters a State institution and begins with \$20 per month, with increased remuneration at the expiration of six months' service.

Years ago, before training schools existed in our State hospitals, the poorer grade of attendants applied merely as a means of obtaining a living, but now the prospective pupil realizes that she can get a good training and a fair salary at the same time in certain State institutions, so for this reason some very excellent young women are being admitted to these schools. True it is that they do not get the surgical and maternity training, but, thanks to our large general hospitals, affiliations have been effected, and today when a nurse graduates from certain State institutions she has as good a knowledge of the various branches of work as her general hospital sister, besides having a splendid knowledge of mental diseases.

The course in a State institution where affiliations have been provided is usually two and one-half to three years, and this will include from three to six months spent in a general hospital and three months in a maternity hospital.

Some may ask, "If a mental training is so important, why does not the general hospital include this branch in its training?" And the question will not remain unanswered very long, for at the present time some very important general hospitals are making it compulsory for their pupils in training to serve a certain length of time in caring for mental cases. The need of this is obvious, and I predict the time when no general hospital graduate will have completed her training until a course in mental nursing has been included in her curriculum.

It is a well-known fact that very few general hospitals wish to admit an insane patient, and if by chance one is admitted the first thought is, "How soon can he be transferred?" Of late years a few of our general hospitals have opened up psychopathic wards, but this is the exception and not the rule. Now, why should insanity be shunned

by the general hospitals? As we all know, it affects the brain and entire nervous system, and when a man or a woman is insane the most important part of the body is diseased, yet this one important branch of nursing has not yet, to any extent, been included in the training of the average general hospital graduate.

Eight months ago the hospital with which the writer is connected offered a post-graduate course of four months in mental nursing to graduates of recognized general hospitals. During this short period we have had as large a class of post-graduates as we cared to accept, and at present there is a waiting list, which would go to show that at least a number of general hospital graduates feel that their training has not been completed.

The general hospital graduate has a great many advantages that do not come to the State hospital graduate, but when the training of both is completed, they stand side by side, the weak points of the one supported by the strong points of the other, and *vice versa*. Some might ask, "Wherein does the State hospital graduate excel?" and I might mention several lines of training, such as the *occupational work*; the *good housekeeping qualities* which they are always accredited with; the *patience* which is cultivated to a high degree during two or three years' care of the insane; the good care they give the *helpless, uninteresting, bedridden, chronic* cases, and many other qualities which are equally as important as being able to anticipate a surgeon's wants during an operation or being skilled in operating-room technique.

FAIR PLAY FOR THE STATE HOSPITAL

GRADUATE

Before I conclude this article I would impress my readers with the fact that there are two classes of State hospital training schools.

First, the hospitals where the training school is an essential feature, where affiliations have been provided, and much has

been done to improve the training and thereby prepare the pupil to take her place after graduation with the general hospital graduate. In these hospitals the probationers are selected with as much care as in general hospitals, and the undesirable ones are dismissed when it is found that they do not come up to the standard.

On the other hand, there are State institutions which have a training school but have no facilities for keeping it up. Take,

These latter nurses are the ones who are usually out of work, and who apply to directories and registries seeking employment and claiming to be graduates of State hospitals, and these are the nurses who hurt the entire State hospital training schools.

One word about the nurse who is graduated from a good State hospital training school. She passes her State Board with credit and is then ready for service, but she is not always given a square deal by the



INDUSTRIAL GROUP—BASKET CLASS

for instance, a hospital devoted solely to the care of epileptics, or take the asylum which admits only chronic cases transferred from other hospitals. Some of these schools have no affiliations, and the experience the pupil receives is limited indeed, yet they graduate pupils, both men and women, and send them out as qualified nurses. The average young man or woman does not care to go to a hospital of this kind, consequently these hospitals are extremely short of good material, and they are compelled to accept pupils that are no credit to the nursing profession.

"powers that be," and we hear them say, "She graduated from a special hospital. Is she eligible? Has she the training we have laid out for her? How many beds has her hospital? How much education did she have? Is her hospital recognized?"—and so on. I may be out of date, but to my mind the following questions are far more important: "Is she a good woman? Can she give good service? Is she conscientious, truthful and reliable?"—and, if so, she is eligible for any nursing order in the world, no matter if her hospital only had twenty beds

and she went only as far as the ninth grade in school.

After all, is it not service we want? Whether the nurse graduated from a State institution, a general or a small hospital, and if the nurse can give that service, why should she be barred out from any organization or from registration? After several years' experience as superintendent, both in a general and a State hospital, I have come to believe that there is too much red tape about nursing orders, too many political nurses, and too much useless talk on State registration.

In an address not long ago by a graduate nurse of several years' standing, a remark was made to the effect that a nurse with an R.N. to her name needed no introduction and no chaperon. The writer takes exception to that statement and believes that it takes more than an R.N. for such a guarantee. Good common-sense, reliability and service are better than any number of R.N.'s, and a good many registered nurses

are lacking in some of the above qualities, while a large number of good women who possess these qualities in the highest degree are not permitted to write R.N. after their names, but whose place in the nursing world cannot be disputed by any broad-minded man or woman.

In closing, I would add that most all institutions, whether they are colleges, universities or hospitals, at times graduate a few pupils who are bound sooner or later to bring discredit on the institution which granted them their diplomas. If you doubt this statement, just think a moment and you will remember that Mr. Lawyer was arrested for defrauding his client of a large sum of money. Mr. Clergyman eloped with Mr. Brown's wife, and Mr. Banker embezzled several thousand dollars from the bank with which he was connected; and I would remind our profession that the black sheep of the nursing world are not all graduates of State hospital training schools.

A PRAYER FOR PEACE

(Tune, National Anthem)

RICHARDS M. BRADLEY

God give the nations peace!
Grant us from war release;
God give us peace!

Guide thou the helm of state,
Still thou the blast of hate,
Bid waves of strife abate;
God give us peace!

Touch thou the human heart,
Bid hate and greed depart,
From fear release!

Bid men in every land
Stretch forth the helping hand;
Brother to brother stand,
Blest in thy peace.

Send Truth and Righteousness
Healing the world's distress,
Great God of peace!

For Him who died that we
Saved by thy love might be,
From war O set us free!
God give us peace!

—*The Survey.*

Teaching Ethics in Hospital Schools

CHARLOTTE A. AIKENS

ARTICLE II

IF WE make up our minds to get down to rock-bottom principles in our ethical teaching and cease playing with the subject or treating it as an abstract or theoretical matter in our schools, how and where shall we begin? That is a fair and a very important question.

First of all, we shall cease calling "mass meetings" of all the nurses in the hospital for a lecture on ethics. We ceased trying to call mass meetings for other class work long ago, and if we are to get anywhere in our teaching of ethics we will have to do it in graded classes—not in mass meetings.

Certainly the teaching of ethics, which the probationer and junior just entering on their careers need, differs widely from the teaching which the nurse in her final year needs. No sensible person with a fair knowledge of the nursing situation in America will question this—then why announce "mass meetings" for teaching ethics to pupil nurses.

When we get close enough to study beneath the surface we will probably discover that the subject of ethics in some respects resembles a tree with roots deep down and with branches out in several directions. If we do not notice the roots of the tree, we may expect to develop branches and fruit and have them flourish without roots, and we will be doomed to disappointment.

The roots of the tree we may designate as *RELIGION*, which some writer has said is "the relation which man fixes between himself and his God." The greatest teacher of ethics this old world has ever known or ever will know is the Great Physician, and His teachings are much more important for nurses to know, to have impressed on them, and brought to their remembrance at fre-

quent intervals, than the teachings of any human teacher or writer. Different hospitals may have different methods of cultivating the spiritual life of the pupils by means of morning or evening worship, week evening prayer services. Some have weekly Bible classes for one-half hour, led by some outside teacher or leader; but none of these things—important though they may be in their influence—exceeds in importance the simple method of seeing that as far as possible every new pupil is put in touch with the church of her choice nearest the hospital—this when she enters the hospital—that she is urged or forced by gentle compulsion to go to church as regularly as possible. No nurse can afford to miss the influence of public worship, and no one needs this influence more than do nurses.

All our efforts to teach ethics to nurses while neglecting this simple *fundamental* method of cultivating "the fruits of the spirit—love, joy, peace, long-suffering, gentleness, goodness, faith, meekness, temperance"—in their daily life, will be like trying to tie fruit on a tree that had no roots. There is plenty of room for detailed ethical teaching in addition, but let us see to it that our nurses get a chance to get some religious and ethical teaching from other sources—in the most simple and natural way—*by going to church*. Let us let them know that we expect them to go—the day we have the first interview with them in the hospital—and let us set the example by going to church ourselves.

Incidentally, let it be stated that no superintendent who wishes to deal faithfully in the teaching of ethics, so that her nurses will go out, not only with the technical knowledge they should have but with the right

spirit toward their associates and their fellow men, with the right outlook on life and its problems and the problems of others—no superintendent can afford to neglect the opportunity for a private interview with each probationer in the first day or two after her arrival. We forget many lessons that we get in the later days of our training, but the lessons and experiences that come to us the first day or two after we enter the hospital leave an impression on our memories not easily effaced.

In this first private interview with each pupil, many of the more important things expected of the nurse can be mentioned, and several of the things we do *not* expect or want may very properly be suggested. The opportunity to have such an interview with a pupil in this highly impressionable stage in her life, when she is leaving the old behind and entering on the new, is too important to be lightly disregarded.

If we put the right use of the natural means for cultivating the religious life of the pupil first in our teaching of ethics, what shall we put next—and how shall we grade the teaching of ethics? What does the pupil most need in the probationary period, in the junior year and in the senior year, so far as ethical teaching is concerned?

In the probationary period she needs to be helped to get her bearings in the new world she has entered; to know the functions of the different elements in this new world, and her relation to them. The hospital world is a complex world, with laws and customs differing widely from the world from which the pupil has come. First of all, she may wisely be admonished to accept meekly, as right and necessary, much that she cannot understand at the beginning of her nursing career.

This new world has a governing body—not greatly in evidence in the daily routine, except as its representative, the superintendent and executive head of the institutions, represents it. While not in evidence, this

governing body is in reality responsible for the proper care and treatment of every one connected with the hospital or having dealings with it. The governing body must bear the brunt of the defense if a nurse makes a serious blunder and the patient or friends care to go to the courts for redress. It is the final court of appeal in all matters involving serious disputes.

The work of the hospital in all but very small institutions is divided into departments, each with a separate executive head, who is responsible for the proper management of his department. The relation of the pupil to these varied departments needs to be explained. The house rules for nurses may wisely be given one whole lecture, the ward rules another. If the reason for these rules be explained, it will help much toward their proper observance. The attitude of the pupil nurse toward the varied collection of people making up the hospital world may be given a whole lecture—engineers, laundresses, ambulance men, porters, ward maids, cooks, head nurses, doctors, internes, druggists, patients. How she may make their work much heavier or upset the smooth running of departments remote from her own daily field of activity should be explained.

Her attitude toward the patient and patient's friends, the necessity for reticence, tact, discretion, in order that she may do no harm, is a subject not easily exhausted, and one which can be illustrated profusely.

The nurse herself—her health, carriage, tongue, voice, manner, friendships, habits and general deportment—is a broad subject that cannot be properly dealt with in an hour or two.

Later in the junior year may come lessons on her relation to hospital property—ethics as applied to her handling of supplies and appliances and the misuse of such things. Let her know that there is an ethical principle involved in what may seem a very small transaction, and that her conduct on appar-

ently unimportant occasions may be an index to her character.

A lesson or two may be wisely given on hospital accidents and unpleasant situations which were created by nurses or which might have been averted by a nurse. Every hospital has enough of these to make such a lecture of thrilling interest.

Ethics as it applies to night duty, how night duty tests a nurse's character as well as her general ability, should not be neglected.

In the nurse's second year, lectures or talks on ethics should include the relation of probationers and juniors; the responsibility of older nurses for the good tone and good reputation of the hospital, and what good tone includes; the things a nurse owes to a patient outside the regular orders; the tests of character and judgment which come in the special nursing of a private patient in the hospital and the things to avoid; the qualifications for head nurse work and the things that mar a head nurse's influence; the special responsibilities of the chief surgical nurse and her assistants; the necessity of a good conscience, as well as a good surgical technique; wise use of recreations and holiday seasons; the right use of the money a nurse earns—there is no lack of practical subjects which might be mentioned which are deserving of brief conferences with second-year pupils.

In the third year the nurse is looking forward to the broad field outside and wondering how or where she will find her place in it. This is a tremendously important period in ethical teaching. The private duty field is a prolific subject for ethical teaching. The ethics of response to calls; ethics as applied to the making of engagements with patients or with organizations; suggestions as to what and what not to do when nursing in hotels and public places; the different qualifications needed for the different lines of nurs-

ing; the nurse's duty to her alumnae association and to various organizations, all need to be discussed in turn.

By far the best method of dealing with different phases of institutional and private nursing is by the case method—giving the nurses a brief statement of a certain situation at one class period and the next class spending ten or fifteen minutes at the beginning of a lesson on general nursing or some other nursing subject, in informal discussion of that particular case—how a nurse may bring discredit or complaints in a dozen different ways in such a situation, and how she may conduct herself in such a situation so that the patient, the family or the institution will recommend her to others. Far more than they realize, nurses, especially private and institutional nurses, are dependent on *recommendations* from one source and another. They should be shown how by being disobliging or untactful or lazy they are bringing discredit not only on themselves but on all the graduates of their school. "We never want to have a nurse from that hospital again," is such a common saying because some one nurse has failed in her general management of some situation in private nursing.

Don't soar away up in the clouds in the teaching of ethics. Keep down on the earth and apply your ethical teaching to every-day things in the lives of your pupils and of the nurses you meet and know, and you will find ethics far from being a dry or shadowy abstract subject. You will find that it pays to weave your ethical teaching into the very warp and woof of your practical nursing instruction, and if you deal faithfully with the subject you should be able to send out nurses with the "right spirit within them" who will be prepared to steer clear of some of the difficulties of their predecessors who did not have such instruction.

Occupational Therapy*

GEORGE EDWARD BARTON, A.I.A.

Director of Consolation House

MANY people seem to have the idea that we at Consolation House have discovered a sort of panacea, and that we can at once describe one form of occupation which will immediately improve the mind, expand the chest and become a necessity in every household. That is not true.

I shall now introduce but one or two ideas, for the complete exposition of the Consolation House theory would require the disentanglement of a number of social problems and require an attention which at present you would hardly consider worth while.

In order, however, that you may have some insight into the method of our procedure, I will say that we are endeavoring to offset, to cancel one of what may be called "society's liabilities," not with an asset (as it seems is the accepted method), *not with an asset*, but with *another liability*. Not by making a strength of society pay for (support) a weakness, but by making one weakness *expend itself* by *overcoming another* weakness. Not by even "killing two birds with one stone," but by setting the birds at each other, letting *both* die in conflict, and thus saving not only the stone but the effort required to throw it. At the conclusion, I shall be glad of and benefited by any conversation or discussion, and if you desire it, will take up in detail any of the different propositions involved in the problem. Any with one exception. I am requested by the advisors of Consolation House (the name by which the little effort is known) *not* to discuss or explain at present the business, the purely "money-making," possibilities.

That large amounts of money can be made has been already proved, and the information will be given to the public at the proper

time, but not until we are certain of what the "back-wash" will be, that is, what the effect will be upon other institutions which should be left undisturbed.

Is there no limit? I would ask, Is there *no limit* to the amount of time, energy and money which can be drawn from a State or from an individual, however rich? Our civilization is demanding more and larger charitable institutions every year! But still more important, still more terrifying, is the indisputable *need for them*. How long can we keep it up?

What can we do for and with the convalescent, both before and after his discharge from the hospital?

Occupation—YES!

One occupation—NO!

That one health-giving occupation is the "will-o'-the-wisp" which has led so many astray, which has hindered invalid occupation. It has led to a too great consideration of detail before the problem was sufficiently analyzed.

Why should we seek for one occupation? Is there one drug in *materia medica* which has the same effect upon all people? To that question I have received often for answer, "Morphine." Yet idiosyncrasy, toleration and habit must be considered. Is there one book which has the same effect upon all people? "The Bible," I am answered. But the Bible is a collection of books, a very complicated prescription, and with all respect I submit that the Song of Solomon or the Book of Job produce quite different effects upon the aged philosopher and the nymphomaniac.

With twenty or thirty centuries of medical research, how many "specifics" have we? And did the science begin with the specifics?

Some one, some time in the far-distant

*Delivered by request before a conference of hospital workers called by the Massachusetts State Board of Insanity at Boston, Dec. 28, 1914. Contributed by the author to THE TRAINED NURSE AND HOSPITAL REVIEW.

past, weary of going over countless scrap books full of old wives' tales and witches' simples (devoted largely, probably, to love potions and the effects of ergot and rue), some one conceived the idea of separating, testing, proving and arranging that great mass of true and false statement and superstition concerning the action of drugs. That man, I take it, began the official pharmacopeia. I do not think the task we have set ourselves at Consolation House will prove any more difficult than his. I think it will not prove to be much easier.

Because a store has one or ten barrels or tons of morphine or strychnine or digitalis or any other drug, it is not, even with a skilled pharmacist in charge, qualified to open as a pharmacy. And why not? Because unless it is stocked with specifics for a specific clinic *it cannot fill prescriptions*.

So far, I (at least) know of no specific, no panacea, in occupational therapy.

OCCUPATIONAL THERAPY!

If there is an occupational disease, why not an occupational therapy?

That is one of the seven fundamentals, threads which we have sorted out of a tangle and are endeavoring to twist into a rope with which to draw our institutional system out of the mire into which it is sinking. Into the mire of pauperization.

One instance now: Drug therapy gives benzol as a leucotoxin. Occupational therapy will put the patient with leukemia to work in a canning factory, or where, exposed to the fumes of hot benzine, he or she can while doing the work necessary for self-support, be kept in good health by that work. Objections? Oh, yes, hundreds, thousands; it would shift the very foundations of society? As an architect, I know that if our foundations are not so placed as to carry the weight, they must either be shifted or the structure will collapse.

The first thing to be done, as we believe and are at work upon, is for occupational

therapy to provide an occupation which will produce *a similar therapeutic effect to that of every drug in materia medica*. An exercise for each separate organ, joint and muscle of the human body. An exercise? An occupation! An occupation? A useful occupation! Then it can fill the doctor's prescriptions, yes, even his prescriptions *written in the terms of materia medica*.

A simple instance:

Let us suppose that a pharmacist receives a doctor's prescription for morphine. The patient may have a sacroiliac displacement or the mumps; it requires no expert to know that sleep is wanted. With it comes a prescription for a laxative. Again it is easy. "Sleep without constipation."

Well, occupational therapy can already provide sleep, an opiate, and it can provide a laxative *by occupation*, and very shortly we hope to have a far-reaching antipyretic. Time and a sufficient number of cases will determine dosage, and then why cannot the doctor's prescription be filled?

Almost the only bright spot upon our horizon at Consolation House is the fact that, with them all, so few drugs are in common use. Of course the problem is difficult, especially so as the medical profession seems to have given so little consideration to the effects of the commonest human occupations. We find able researches into such questions as "the bends"—a disease which, aside from the subaqueous engineer, not one man or doctor in a thousand ever heard of, and fail to find any information upon the effect of the treadle upon the kidneys. Of course, it is difficult, and we should laugh at ourselves if we hoped to do more than make a feeble, perhaps futile, attempt at a beginning. But it seems to us worth trying and, as the slang of the day has it, "we'll be the goat," but we believe and are alive for no other purpose than to prove that we can use the hospital *not as an educational but as a re-educational institution* through which to

put the waste products of society back *and into the right place.*

Where we can *re-educate* our dependents, no longer upon the basis of *childish fancies for optional courses*, but upon what *time, experience and failure* have proved to be

the mental and physical *possibilities and limitations* of the individual and to return him not only with his fracture, his lesion, healed, but fitted for some work needed, required, by the society which has preserved him.



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A DETACHMENT OF THE JAPANESE RED CROSS WHICH PASSED THROUGH NEW YORK IN JANUARY, CONSISTING OF ONE CHIEF SURGEON, ONE SURGEON, TWO HEAD NURSES, TWENTY NURSES, ONE CLERK AND TWO INTERPRETERS, BOUND FOR ENGLAND. THE TRAINED PERSONNEL ARE DRS. SUZUKI AND OSHIMA; MRS. T. MURATA, MRS. M. HIROSO, AND THE MISSES KATSUTA, KEYOOKE, YAMAMOTO, MALSUZONO, HESAYASU, MIYABARA, HOSOYA, OGASAWARA, KONDO, MATSUDE, NISHIYAMA, NISAYASU, ONO, KASAI, AND KAMIJO



An American Nurse in the War Zone*

American Woman's War Hospital,
Oldway House, Paignton,
S. Devon, England.

MY DEAR ALUMNÆ ASSOCIATES:

There is so much to write about that I know would be interesting to all, but just where to begin or what to say seems the greatest puzzle to me. We have been combining a little pleasure along with our work, and have been able to see quite a little of English scenery while at Haslar. We are now located at Paignton, the country house of Paris Singer, which he turned over to the American women in London to be used as a war hospital, with the Duchess of Marlborough as chairman of the general committee, and Lady Randolph Churchill as chairman of the hospital committee. This place accommodates about 250 at present, and they are talking about fixing up the arera, or swimming pool, with a ward of about fifty or sixty beds. The gymnasium is a ward of sixty-seven beds—the Boston unit has had charge of that ward entirely. We came here from Haslar on the 12th of this month, just fifteen minutes after Queen Mary left the station, but we had the pleasure of seeing her, and waving our dearly beloved Stars and Stripes as her train passed us at Terro, where our train was being held for her to pass. We had orders from the Admiralty to be here at two o'clock on the 12th for inspection and to meet the Queen, but we were not able to leave Haslar in time, so missed her by fifteen minutes.

Our experience at Haslar was wonderful, every way, it being the Naval Base Hospital and the main one in England. Their methods and treatments were so different to anything any of us were accustomed to, but we all got quite used to the various terms, and could use the nautical terms as freely as if we were born to them, and understand what

they were talking about. The floors they call the deck. The windows are the port-holes, and when you have your time off you go ashore. The kitchen is the galley, and the small kitchens to the ward are the scullery. At first we were at a loss to know what they were talking about, but after asking all kinds of questions we were able to make each other understand. They were just as much in ignorance as to the meaning of our expressions, so we did not feel so badly about it.

There are ninety-nine wards at Haslar. In war time, by using all their superfluous space, they can accommodate 7,000 patients. In peace time they only accommodate 3,500, and average 500 patients a week. On October 14 and 15 they received 1,000 of the Belgian soldiers who fought at Antwerp, coming by way of Ostend. They were half-starved and muddy from the trenches, with only the first aid being done for them—nothing to eat for two days. We thought at first we should never be able to fill them up—such appetites I never saw—but they were so kind to them there and gave orders that they must have plenty to eat. A number of their wounds were quite serious, others not so bad, and many were crippled with rheumatism from exposure in the trenches. So many of the soldiers are invalided home for the same thing, and at present the weather along the firing line is severe, snow and rain and cold, raw winds. They are feeling it dreadfully.

The methods at Haslar for treating bullet wounds were hot saline baths and hot fomentations, four hourly. It was wonderful to see how those dirty wounds would clean up. Then they used iodine dressings. There were only about two hundred of them there when we left; the others had been discharged, most of them going to France to rejoin King Albert and army. Out of all

*Letter to the Nurses' Alumnae Association of the Woman's Hospital, Buffalo, N. Y.

that number they only lost one case. One officer went completely out of his mind, and tried to commit suicide by running a poker, heated to a white heat, through his body completely. The entrance in front was about one inch below his heart and through to the spine, just missing by about half an inch. At first they had no hope of saving him, but he seemed none the worse for the wound, as far as complications were concerned. He was doing very nicely when we left.

The work was exceedingly interesting all through, and we felt quite badly about leaving it all, but the work here at Oldway is just as interesting. If we had received your check of \$50 while at Haslar, we could have been able to use it personally, as there were hundreds of refugees there in Gosport. We were up several times to see some that were being cared for by a priest. He had thirty-five or forty families housed in a small hall connected with the church. They had nothing except what they had on, and the women had no night-clothes. There were several little ones expected and nothing for them when they arrived. Most all the nurses went up with some donation for them. Here we have no opportunity to do anything, as there are no refugees here. Would you be willing for us to send the check to the Belgian Relief Fund in London, or would you rather have us send it to some priest who is looking after them? We could get in communication with this priest at Gosport, and we would feel sure the real needy ones would be benefited by it. Let us know as soon as possible what you would like us to do with it, and let me thank all of the Alumnæ for the kind thought that prompted the sending of so generous a check and I assure you all the B. W. H. girls here are extremely proud of our little body of nurses in Buffalo and that we belong to them. But do not forget your own needy poor at home through your sympathy for the Belgians. The call for help here is being

met generously, and little Holland is beginning to feel the strain. She has been caring for so many all through.

The hospital here is rather quiet at present. A week ago yesterday, Sunday, November 22, a lot of eighty-five wounded arrived from Boulogne. They were all convalescing, and most of them will be gone by Thursday, when the place will fill up again. The treatments here are quite different. Dr. Beals is in charge of the hospital, and he is introducing Boston methods. I really do not know which I like best. He uses vaseline dressings altogether. He claims the wounds will clean up just as quickly, but from what I have seen I think the hot fomentations for the first couple of days would be my choice, although his method saves much work.

Paignton is a favorite winter resort in peace time, but at present it is quite dead. They billeted 1,000 British Territorials here last week, which has made the place a bit livelier. The hospital is situated upon a knoll facing Tor Bay, with Paignton to the right and Torquay to the left. The view is fine from the Terrace and the grounds are a source of surprises, one after another. With all the cold, raw winds and frost, the roses are still blooming, violets are coming up (gathered some yesterday), and the spring primroses are beginning to peep through, a number of shrubs are blooming, and the magnolia tree has two buds which will be open by Christmas. We have had a lot of rain this month. One never knows how to dress, as it is lovely and bright with sunshine when you go out, and by the time you get a yard or two the rain is coming down in sheets without a bit of warning, so I have decided upon wearing raincoat and rubbers and carrying an umbrella no matter what the prospect looks like, as I have found it the only safe outfit. Sister Irene Welch and Sister Frances Hennessey join with me in sending love and best wishes to all.

(Signed) SISTER MARGARET STRYCHER.

The Nurse's Station, Serving Kitchen and Sink-room of the General Hospital

EDWARD F. STEVENS
Hospital Architect

NURSE'S STATION *Charting and Chart-Cases*

JUST where the head nurse of the floor or section should be stationed is a question about which there is much discussion among many hospital administrators—whether in a room adjoining the ward, in the open corridor, at a semi-glazed observation station, or in the ward proper. Dr. Rowe, the dean of hospital superintendents, used to say that he believed the nurse on duty should be in sight of her patients as well as within hearing, and in large wards the center-of-the-ward station may work out with the best results.

Wherever this station may be, certain conditions and equipment should exist. The nurse should have a table or desk, with sufficient light for her work of charting and keeping her records. She should have facilities

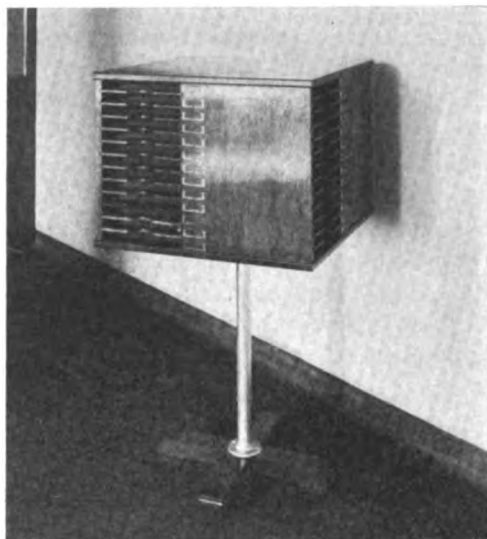


FIG. 2—REVOLVING CHART-CASE

ties for writing her records and holding them after they are written. At this point the nurse's call system should have its annunciator.

The writer believes that the charts, bedside notes and standing orders for each patient should be kept together and that, as far as possible, those sheets should be of uniform size.

The writer has found the most suitable chart-holder to be made of heavy manilla paper, with the tops folded so as to enclose the top ends of all the papers, all held in place by regular ring paper clips. If the charts are to be hung, each chart is punched in the right spot for hanging; if placed on shelves, the punching is not necessary. These chart-holders are light, serviceable and noiseless. A nurse in going through the wards with the doctor can take in her hands the charts for the whole ward, having them



FIG. 1—CHART-CASE, N.-E. DEACONESS HOSPITAL

ready as the patient is approached. In this way they are always kept away from the patient, whereas if the chart is left on the bed it is available to the inquiring mind of the visitor and of the patient himself.

Various methods for holding the charts in readiness for inspection are employed: One, the chart-case opening like a book with one leaf against the wall, which, when open, discloses all the charts to view at one time (Fig. 1); another, the desk with "pigeon-holes" for each chart-holder; a third, adopted by the writer for use where there are a large number on one service, built on the principle of revolving book-case, with the center of the case placed on a level with the nurse's desk, so that without rising the nurse can reach any chart (Fig. 2).

Where a room for the nurses can be provided, this should be central. The station shown (Fig. 3 and Fig. 4) illustrates an ideal nurse's station, for from this station the nurse controls not only the corridor, but the stair hall, the elevator, the patients' airing balcony and the serving kitchen entrance; with the use of the telephone, she is in touch with all departments.

NURSE'S CALL

I spoke of the nurse's call annunciator being at the nurse's station. There are many systems of the so-called "silent call" on the market. All of them have some merit.

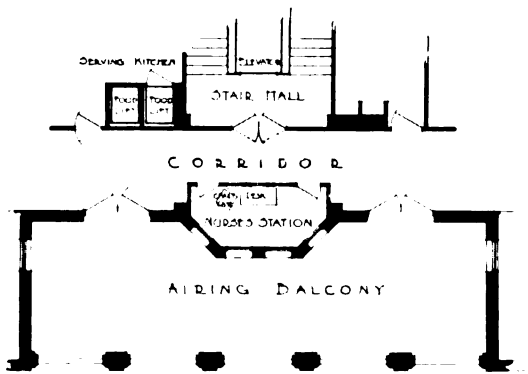


FIG. 3—NURSE'S STATION, OHIO VALLEY GENERAL HOSPITAL, WHEELING, W. VA.

There are, however, essential points which should be considered in selecting a system.

1. The system should be simple and as nearly "fool-proof" as possible.

2. The part made accessible to the patient should be of non-metallic substance, with smooth lines, non-detachable, and easy to operate.

3. The attachment to the wall should be of such a nature that if the connecting cable should be held by the bed-post and the bed suddenly moved, the entire system would not be disarranged; in other words, the "plug" to which the cord is attached should be readily removable, whether a straight or a side pull is exerted. This is a most important feature.

4. The resetting station should be within easy reach of the patient's bed; if on the wall, at such a height and location that the nurse can reset it without taking the time to go around the bed; if at the press-button itself, which is in the patient's hand, so much the better; but if the point of resetting is at the patient's hand, there should be some locking device so that the patient cannot easily cancel her own call.

5. The signal lights, if in a ward, should be shown over each bed, also at the entrance of the ward, at the nurse's station and at the grand annunciator in the superintendent of nurses' office. Together with the last mentioned, an elapsed time record can be kept, showing the elapsed time between any call and its cancellation. This is a device which always settles a dispute as to whether a call remained unanswered one minute (as the record might show) or ten (as the patient might claim).

THE SERVING KITCHEN

The serving kitchen has its place among the important rooms of a hospital, for in this room the trays for the food are prepared, and from this room the food is distributed; and if the serving kitchen is conveniently arranged, the food is more likely to be

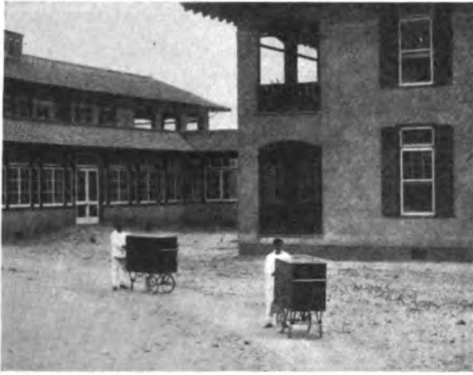


FIG. 4—FOOD CARRIER, ST. LUKE'S HOSPITAL, JACKSONVILLE, FLA.

brought in the best of condition to the patient. And what a difference even the appearance of a tray makes to a delicate patient!

How often one hears it said about this hospital or that: "The operating-room technique is perfect; the nursing is all that can be desired; but the food—and the service!"

Good food, properly served, goes a long way toward offsetting deficiencies in other departments.

The serving kitchen should not be too large; neither should it be too small. In one of the earlier hospitals designed by the writer, the planning of which was dominated largely by the building committee, their desire to make every inch available for patients made it necessary for the serving kitchen to be so reduced in size that it has always been a great drawback to the best serving of meals, while a little more space devoted to this room would have added greatly to the comfort of both nurse and patient.

What are the essentials and what are the luxuries of a serving kitchen? The essentials are:

First, Proper Location—Remember that a ward serving kitchen is a very busy place three times a day. Many utensils must be handled, washed and put away; food trucks are going and coming, so that this room

should be located remotely or in such a way that the sound from the room is cut off from the patients. This may be accomplished by having the serving kitchen entered from a side corridor, as in the Melrose Hospital; or through a vestibule, as at the Royal Victoria; or by having it decidedly removed, as at the Bridgeport Hospital.

Second, Room Enough to Lay Trays—There should be room enough, and the room should be so planned that no one will be crowded while preparing the meals. If the building is a multi-story building, special food lifts, large enough to carry a food car, should be provided, and space enough to bring the car into the room and discharge it.

In moving the food from the kitchen it should be handled as little as possible. To that end, the food truck loaded in the kitchen is not disturbed until it reaches the serving kitchen (Fig. 4). This food truck can be taken on the service elevator, or, better still, special food elevators may be provided, working automatically from the sending point on the kitchen level. These food trucks can be kept warm by electricity, hot water, or hot soapstone. The one shown in the illustration is heated by hot soapstone.

Third, Keeping Food Warm or Cold—The steam table is almost indispensable for keeping food hot, and should be provided with a gas plate and warming closet.

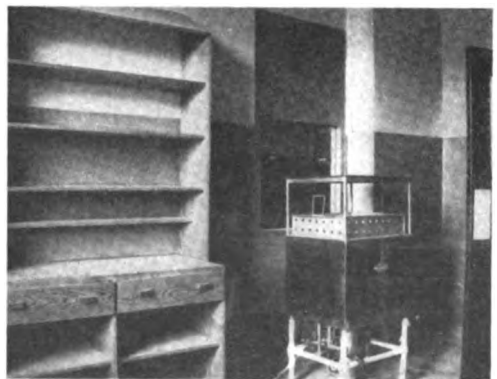


FIG. 6—STERILIZER, BRIDGEPORT (CONN.) HOSPITAL

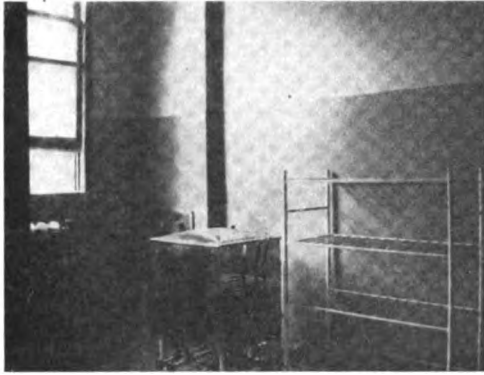


FIG. 7—LOCAL INCINERATOR

Tray racks of sufficient capacity for holding all trays should be provided. These racks should be movable on ball-bearing casters, so that if required the trays could be brought "en masse" to the ward door.

The use of the portable hot table is growing in popularity. For some classes of patients this makes the most satisfactory method of serving.

Refrigerators should be built or selected with care and with due regard for hygiene, should be either porcelain or tile lined, and properly wasted with trapped drain. If there is a refrigerating plant, by all means extend the pipes to these small serving-kitchen refrigerators.

Fourth, Cleaning of Utensils—Where the dishes from patients with infectious diseases are cared for, the dish sterilizer is absolutely essential. The illustration (Fig. 6) shows a sterilizer in the new Bridgeport Hospital which contains a small isolating department. The soiled dishes from this department are put directly into the sterilizer from the corridor connected with the isolation rooms. The basket is raised and lowered by hydraulic pressure and can be manipulated from either side of the partition.

Among the luxuries of the serving kitchen might be counted special egg boilers, coffee percolators, individual services for private patients, special china and glass, hot plates and more attractive trays and linen.

The location and size of the sink is important. There should be an ample drainboard and the sink set high. The tendency of the plumber is to place the sink at his standard height, making every one who uses it stoop, while placing it a few inches higher would mean the saving of many a backache.

The material for the sink is largely a matter of fancy. Iron, porcelain and soapstone (Alberene) are used.

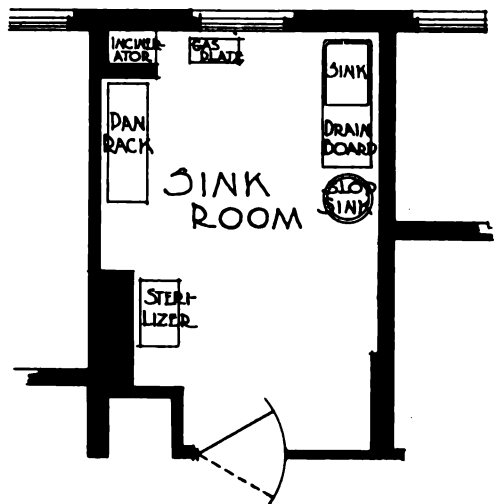
After the utensils are cleansed, a suitable receptacle should be provided. The cabinet should be hygienic in its construction, easily cleaned and removed, with slanting top to prevent the lodgment of dust. This case should contain sufficient drawers and cupboards to take care of the cutlery and silver needed in the section served by the ward kitchen.

In General—The room should be tiled to a height of four feet or, at any rate, at the back of all plumbing fixtures.

The floors should be of a non-porous substance, like magnesite, terrazzo, or tile; if of tile, a gray or buff is much easier to care for than white.

SINK-ROOMS

A call for a room where the dirty work of the ward unit can be done has developed

FIG. 8—SINK-ROOM, JACKSONVILLE (FLA.)
ISOLATION HOSPITAL

what is commonly termed a sink-room or dirty room. In the older hospitals one will find no such room, and the work now being done in this room was commonly done in the toilet room, with the bed-pans and urinals placed on the walls or wherever there was a few square inches of room.

The need of such a room is great. Here not only are the bed-pans discharged, washed and sterilized, but there should be room for the preservation of specimens in a

cool, ventilated space, opportunity for the boiling of catheters, making of poultices, etc.

There should be a local incinerator in this room for the destruction of all ward waste, faded flowers, etc. (Fig. 7). There should be a sink for the washing of rubber sheets and other utensils, an ice-box for crushed ice; in fact, this should be a room which can be the general work-room of the section.

If there is no local laboratory, this room will often serve that purpose.



FIG. 5—SERVING KITCHEN, JACKSONVILLE (FLA.) ISOLATION HOSPITAL

The Empyema Patient

AMY ARMOUR SMITH, R.N.

EMPYEMA—Purulent pleurisy, *For-scheimer*; pus in the pleura, *Sir William Osler*. This condition comes on very insidiously after pneumonia, often when one thinks the patient is favorably convalescing. Just as any germ disease may produce abscesses in parts remote from the organ in which it takes its rise, so various illnesses, namely, scarlet fever, typhoid fever, measles and whooping-cough, carry in their train this medico-surgical condition. The patient's opsonic index is low when this happens. There may also be a traumatic empyema, due to fracture of the rib or any penetrating wound of the pleura, as a gunshot wound or the stab of a dagger, also to tuberculous and other malignant diseases of the adjacent parts.

The nurse must early in her training be solemnly impressed with the necessity of saving all specimens. This is difficult, since the instinct is equally strong to clean away all filth. But the fluid withdrawn from a patient's chest *must be saved*, in part, if not the whole. The technique of aspirating must be aseptic, and as follows:

Tincture of iodine for the skin, sterile cotton, towels and aspirating set, and a *sterile glass graduate* for the specimen, a waste pail for the overplus, and cotton and collodion to seal the wound.

When the pathologist has made his examination, each pupil should read the findings.

(a) If the specimen is reported sterile, this would suggest tuberculous pleurisy.

(b) Pneumococci are commonest, and the prognosis is then favorable.

(c) Streptococci are very often found when the empyema results from some septic process.

Empyema causes a reduction in the working space of the lung, and consequently a diminution of the oxygenating power of the

lung. There is very little pain, almost no cough, and never any dyspnea unless the side is very full of pus. The temperature rises irregularly, the patient grows pale and weak, and the skin yellow, with a dull dark-red flush as the fever mounts. Sweats occur. The leucocytes are increased to as many as ten times the normal number, showing that Nature is aware that a big fight is on. In children the intercostal spaces are obliterated and even bulge.

This condition is neglected by some medical men who cannot operate, and who are reluctant to pass their cases up to a surgeon. They try to relieve the condition by frequently aspirating, but the repeated nerve-strain is more exhausting to the patient than one single anesthetic and resection, while the pleura also becomes greatly thickened. Aspirating is rarely effectual. The surgeon never needs to use the aspirating set. His diagnosis is made by the history and observation of the physical signs.

There are various degrees of work in the surgeon's procedure. In the case of an infant he simply makes an incision in the soft intercostal parts, as a rule. It is only in very severe cases that he resects in a young child. In an adult he always resects one or more ribs. If an empyema were left to itself it might perforate the chest wall somewhere between the third and sixth intercostal spaces, but the point taken for resection is governed by the position of the pus pocket and the adhesions of the pleura around it, whether anterior or posterior, so as to promote the best drainage.

In preparing such a case for operation, the affected half of the chest must be entirely shaved, and this may be also done repeatedly afterwards, since there is a great deal of adhesive plaster used on these cases. Formerly these wounds were irrigated twice

daily with sterile water, through an empyema button made of rubber and shaped like an empty spool, but this method is discontinued. The dressings would soon be soaked with foul, dangerous pus, and if they are sealed with rubber dam for external cleanliness, the edges of the wound quite naturally become red and irritated. But, in order to keep the patient comfortably clean, as well as to carry on sufficient drainage, a vacuum cleaning process has been devised, consisting of the following parts:

1. Rubber drainage tube in wound.
2. Glass connecting tube.
3. Long rubber tube to bottle on lower shelf of bedside table, similar to water bottle on oxygen tank, with rubber cork that has two holes, through which bent glass tubes pass, on one of which the tube is fitted.
4. Carbolic acid 1-20 or any other powerful disinfectant is kept in this bottle to dilute and disinfect the pus coming from the wound.
5. Long rubber tube connecting with second glass tube in the cork of the bottle, and running up to a Politzer bag on the upper shelf of the table. A vacuum is created in the bottle and tubes, and then the apparatus is connected with the wound. The collapsed bag is laid on the table, and as the nurses pass, when they see the bag rounded up to its normal shape, they should pinch the tube, disconnect and empty the bag and connect it again. This is highly successful in keeping up drainage. The patient, when up, can carry the apparatus around with him. The bottle must be washed and boiled daily.

These patients should be elevated to whatever point will cause free drainage, very early after operation, especially since there is very little shock connected with a resection, and the blood circulation at once shows relief. As soon as possible the patients should be dressed in warm clothing, hood, jacket, mittens, and the doors and windows opened to give them an airing.

Connected with this illness there is danger of collapse of the lung, though it is believed that the adhesions in the affected region save the patient. In order to inflate the lung to its normal size, the patient should take exercise in the form of blowing water from one bottle to another. The apparatus consists of two bottles, capacity one gallon each, fitted like the cork stoppers of a bottle on an oxygen tank. The patient should blow the water from one bottle to the other, up to the point of fatigue, twice a day, beginning very gradually with small amounts. The apparatus must be boiled daily and fresh water used.

The best place for convalescents is in a high altitude, where deep breathing is forced on them by circumstances. A special diet is necessary, modeled after that for tuberculous patients, consisting of milk, eggs, cornmeal, butter, emulsions, with vegetables and fruits in season. An excellent tonic for the stomach consists of the raw pressed out juices of all the fruits and vegetables to be found, twice daily, amount half an ounce. It is not disagreeable and has a fine effect on the appetite.

Regular tonics, such as compound syrup of hypophosphites or elixir of glycerophosphate, or various forms of iron, are always indicated.

Mild exercise in the sunshine is necessary, gradually increasing in strenuousness.

These patients do not remain in bed so long as other surgical cases, the condition simply being relief for a lung abscess. They are better as far as possible from a hospital, in purer air.

Every precaution must be taken by isolating and disinfecting utensils, burning dressings, boiling various kinds of apparatus, and boiling all the bed-linen used, since one never knows which one of these cases is positively not in the incipient stages of tuberculosis. In a hospital for tuberculosis one sees many scars from resection of a rib.

These patients are normal in their men-

tality much sooner than other cases, and this directs one's attention to the teaching of children of school age. Frequently they can resume their games and their instruction almost immediately under teachers provided by the hospital, this being one of the happiest forms of social service work which the most humane and ambitious hospitals are doing. When the child of poor parents is, however, taken home, it is a big field for the district nurse, the social service worker or the school nurse to keep the child happy in the consciousness that he may be promoted with his class in spite of his slow illness.

The aspirating set is, as a rule, the bugbear of the nurse's existence. She can make it work in water, milk or molasses, but the physicians seldom do. In most of these instruments there are two channels, one for air and one for fluid. These must be thoroughly worked out by experiment. Each terminates in a small nipple. It is a good scheme to file the nipple off the end of the air chamber, so that the two cannot be confused. There are also delicate ball-bearings which must be kept oiled and smooth, counted and not lost, and their chamber must be opened every time the instrument is cleaned. When a physician tries to do a phlebotomy with an aspirator and drops all the ball-bearings in the dressing pail among the blood clots, then swearing at the instrument, do not get flustered. That is merely to veil his chagrin. Some friendly attending

will perform another aspiration soon and say, "This instrument works finely. When it doesn't it's the fault of the man behind the gun." But the set must be taken apart with great caution at all times.

Just a few more facts. Pneumonia cases must be watched by the minute after the crisis for many days, since there may be an abscess forming that will perforate the lung spontaneously, causing immediate death unless relieved at once by resection. Again, this abscess may open into the bronchus, and suffocate the patient by the sudden gush of pus into his breathing apparatus. The chest wall has been known to be perforated, with a fistula remaining for years. Occasionally this finds vent through the esophagus, diaphragm, peritoneum or pericardium.

In double empyema it is wise to have the resections about a week apart, since there is plenty of relief afforded by one to keep up the patient's vigor temporarily.

In tuberculous empyema it is very difficult to decide whether to operate or not. In mild tuberculosis aspiration is safe.

Lastly, in the case of any patient who may develop empyema, do not turn him much, nor suddenly. When he finds the condition in which he breathes best, let him keep it; the fluctuation of a large body of fluid may cut off his heart beats or respirations at once, with fatal effect. His color must always be watched, when the bed is being made, or his gown changed, or a dressing being applied.



The Hygienic Diet

ROSAMOND LAMPMAN, R.N.

THE hygienic diet is, perhaps, not receiving the attention it should in sick-room cookery; a thorough scientific study of this system of eating is comparatively recent, and a diet that furnishes no meat and all grains, cereals, fruits and vegetables prepared and served without the slightest addition of seasonings or condiments in any form, even salt and sugar being prohibited, is looked upon by most people as a sort of starvation diet to be used only in rare instances. Yet this diet is not lacking in healthful variety and good flavor when properly prepared. When once the palate becomes adapted to the pure, natural flavors of foods it is as keenly relished as when served in the ordinary way, while its nutritive qualities are equal to a diet in which meat plays a prominent part.

It will be well to mention, before going farther, that there are certain principles which govern the proper combinations of foods that may be applied to any diet, and it is a neglect of this important feature in a hygienic diet that often discourages those who have attempted the "diet reform" without first considering them.

From the various food products there are many kinds so unlike in their natures as to disagree with one another when eaten together or if taken at the same meal. To get the very best results from food materials one must carefully consider those that make an agreeable combination.

Fresh fruits combine well together, while fresh or cooked fruits are always delicious with bread or grains, and with nuts or nut preparations (peanut butter, protose, nuttose, ideal nut food, etc.). Fruits and vegetables should not, as a rule, be eaten together or at the same meal, while fruits and grains are best suited for the morning and evening meals.

Tomatoes are better eaten with other vegetables or with grains; sweet potatoes and tomatoes make an excellent combination; the one is sweet and dry and the other acid and very juicy. Tomatoes should not, however, be eaten with fruits.

The Irish potato, almost entirely a farinaceous food, combines well with either vegetables or fruits, and goes very well with grains. In order to gain its highest food value, the potato should not be peeled before boiling; thus its valuable salts and mineral matters may not escape in the water in which it is cooked.

All ripe fruits should be eaten at the beginning of a meal, especially if warm foods are to follow. Grains, when thoroughly cooked, usually digest well with all foods.

In choosing vegetables for a meal, if there is to be more than one variety, do not select all those of a dry nature, as dried beans, dried peas, winter squash, sweet potatoes, etc.; nor all those that are of the watery sort; but blend the more nutritious with the less nourishing ones in a prudent manner. In arranging menus in which meat is not included, it is only necessary to remember that eggs, nuts, cheese and the legumes (lentils, peas and beans) contain the same food elements as meat, and can always be eaten in its place.

Grains—All grains require several hours to cook them thoroughly, as a long cooking changes their starches into glucose; thus they are made sweeter and more easily digested. Grains and fruit, as well as vegetables, should not, as a rule, be allowed to stand for any length of time in cold or lukewarm water, and their flavor will also be found more pronounced if served after they have cooled a little than when eaten hot.

Fruits—All fruits are best when eaten fresh, and these should be well ripened;

those intended for cooking, however, should not be too ripe or cooked too long. If unripe fruits are used they ought to be stewed very slowly and for a long time, that their starches may be changed to saccharine more completely. In cooking fruits, if care is taken to preserve their natural shape as much as possible their delicate flavors will be more fully retained.

So long as we can obtain perfectly ripened fruits they can be eaten without a particle of sugar, but owing to the climatic conditions and long distances from good markets this is often impossible, and even strict hygienists find it necessary to add a little sugar to the more tart varieties. In cases where sugar is completely eliminated from a diet, sweetina is often used in place of sugar. This is a refined product from coal tar; it comes in crystal form, and is made into a syrup by dissolving in cold water a twenty-five-cent bottle of crystals, making one pint of syrup, of which one teaspoonful is equal to one cupful of sugar. Some mix the sweet and sour fruits together, with very good results.

Vegetables—The hygienic way to cook vegetables is first to have them absolutely fresh whenever it is possible, then to cook them so as to waste as little of their salts and mineral matters as possible. In order to do this, they must be dropped into just enough boiling water to cook them, then allowed to boil rapidly until done, with no water left to drain off; thus most of their natural flavors and sweetness are saved.

The following are a few recipes in which fruits, grains and vegetables are prepared and served on strict hygienic principles—*i.e.*, with all valuable salts retained, and no salt, sugar or condiments added thereto.

Fruit Soup—Into one quart of boiling water sprinkle one-half cupful of sago, add

the grated rind of one lemon, and cook for thirty minutes; then add one quart of stewed cherries; bring to the boiling point, strain, and serve warm with nut wafers.

Baked Tomatoes—Wash and peel some perfectly smooth tomatoes, of medium size, slice off the stem end and scoop out a portion of the centres; fill the cavities with fine, whole-wheat bread crumbs, mixed with a little unsalted butter or cream; arrange in a pudding dish, cover and set in the oven. Bake twenty minutes, uncover and brown. Serve warm, not hot.

Hygienic Baked Beans—Look over and wash white beans, rubbing them well between the fingers, then drop them into boiling water (soft water being preferred for cooking all legumes), and cook until soft, not letting them cook to pieces; do not par-boil them unless they are old. If necessary, more boiling water may be added from time to time during the cooking, but only just enough to make them rather juicy. Turn into a baking dish, add a little sweet butter (unsalted) or cream, and bake slowly until they are nice and brown. No seasoning is used. Serve plain or with a dressing of minced onion and lemon juice.

Nut Wafers—Put one cupful of peanut butter with one-half teaspoonful of soda into a mixing bowl, and add one cupful of warm water; stir until the mixture is perfectly smooth and the soda dissolved; then mix in enough whole-wheat flour to form a dough easy to handle. Knead and roll out very thin, cut into squares or with a cookie cutter, and bake in a moderate oven until crisp and dry.

Fruit Sandwiches—Cut graham bread into thin slices and spread with a paste made from figs, almonds finely crushed and chopped apples.



A Nurse's Experience

BEING THE LETTERS OF JANE WILLIAMS TO MARGARET THOMPSON

DEAR TOMMY:

Do you remember the last night I stayed with you before coming to Millville? How tired we both were and I fell asleep while you were talking to me, and at last in desperation you said, "Answer me, damn you!" That "damn" wakened me with a jolt (I can feel it yet), for I never, in all our ups and downs together, had found you guilty of any expression even second cousin to "damn." Well, I sat up and took notice immediately, but I want to tell you that I have thought "damn" a million times in the last two months (as a matter of fact, I have said it only to Jane Williams), and it wouldn't be surprising if I occasionally slipped in a swear word when talking to some one else. I was so very tired of even thinking that I didn't do any more of it than was positively necessary. You remember the next day after the night I mentioned, when Dr. Brown asked me to go to Millville to special a typhoid case? It seemed to me that I could not possibly go, but when he stated that there wasn't a nurse to be had and the boy would probably die without the extra care needed, and that his parents were way out in Nebraska on a farm and too feeble, as well as too poor, to come East, I braced up (as we are trained to do), and went. Well, the boy lived by the skin of his teeth, but when he was practically out of danger, I made a fool of myself by fainting away in the diet kitchen, where I had gone for a glass of milk for my patient. As I struck a tray of dishes in falling there was some crash, which brought the floor nurse and the head nurse, who called the house doctor. He gave me a hypo. of strychnine and said I would be all right presently. Miss Pratt, the head nurse, looked at me sharply and ordered me to bed. I went very meekly, turned my face to the wall, and hoped no one would

speak to me; I didn't want to be troubled by answering them and I wouldn't have smiled if I'd been paid for it. Even when little Miss Gray, the floor nurse, slipped in to see if there wasn't something she could do for me, I pretended to be asleep—shameless hypocrite that I was. How good the chicken broth with rice that she brought me tasted. I slept most of the time for several days. Have only a hazy recollection of Dr. Snow coming in with Miss Pratt. "Complete nervous breakdown," I heard him say. "One of those high-strung people who haven't sense enough to go through life at a reasonable pace, but must burn the candle at both ends." I did not feel much interested in what he said. I was too tired. Was glad when he left and I could go to sleep again. Then one day, when I was not quite so drowsy, Dr. Snow came in alone and talked with me a long time, and, Tommy, what do you think he said? That in order to *live at all* I must give up all work for the present. That every organ in my body was tired (how well I knew that!). Also that unless I did take the best of care of myself I would not be here long. Well, as you know, with my mother a cripple from rheumatism and father having lost the insurance on his store by letting the policy lapse at the time we thought mother wouldn't live from one hour to the next, I didn't see how I could possibly die and add the expense of a funeral to our other expenses; so it seemed the only decent thing I could do was to get well. But how? I was perfectly willing to do as I was told as long as some one else would decide for me what was to be done, but to decide for myself was impossible. Above all, I disliked the thought of a strange hospital or sanatorium. It seemed to me that in a hospital every one was tired, that even the pleasant-faced nurses had a mechanical

smile. Strangely enough, the ones I was used to did not give me that impression, but whenever I pictured myself a patient anywhere else the nurses all looked so tired that their "noble expressions ached." I pictured the sanatorium as a place where all talked of their ailments, and that I thought I could not endure, for I might get into the same habit. Finally, Dr. Snow suggested sending me to a private boarding-house at Glenville-by-the-sea, where I could have baths, massage, etc., along with sea air and rest. How I loathed the thought of being rubbed and bathed, when all I wanted was just to be let alone and rest. But that shadow of a sanatorium loomed large on my horizon, and it seemed anything was preferable to that, so I hastily said "yes" to the private boarding-house plan.

Slowly I packed my belongings (a miniature drug store with the rest) and prepared to start. Dr. Snow himself came with me, as he had business in Glenville, he said. I have a secret suspicion that his business was to see me safely located. How I hated going! He rang the bell at Mrs. Lacey's vigorously. A very round-faced, very rosy-checked woman answered. "How do you do, Mrs. Bob?" said Dr. Snow. "I have brought Miss Williams to stay with you for a little sea air and rest." Mrs. Lacey extended a very plump hand. "How do you do, Miss Williams?" she said. I responded, "Very well, I thank you," and fainted dead away. When I came to I was lying in the

cleanest, coziest bedroom, with a window overlooking the sea, and the lap, lap of the waves in my ears. Dr. Snow and Mrs. Bob were standing beside me, and a man whom I at once guessed was Mr. Bob was by the door. He smiled at his wife and left the room and she soon followed, saying she would bring a cup of tea. "I hate to be waited on," I said to Dr. Snow, "or have them think I need to be." Dr. Snow came close to the bedside and, taking my hand, said: "You have put up a brave fight, little girl, but don't try to bluff yourself. That heart of yours must be kept quiet." My eyes smarted and I could scarcely keep the tears back. I could have stood a scolding better than sympathy. "Now I must go," the doctor continued, "but I will expect you to report to me occasionally. Don't forget that you are a patient and under orders." His kindly face beamed on me for a moment and he was gone. A wave of utter desolation and homesickness swept over me, and I should have dissolved in tears had not Mrs. Bob appeared at that moment with a dish of cream toast and a cup of tea. After dispatching this, I went to bed, although it was only 6 P.M. Through the open door I could hear Mrs. Bob bustling around, putting the evening meal on the table. Later the hum of voices, as she and Mr. Bob visited and ate, and still later her voice as she washed the dishes, rising and falling in "Onward, Christian Soldiers," and before I knew it I was asleep.

Hoping you are the same,

BILLY.

(To be continued)

Miss Katharine Lily, head nurse of the Department of Surgery of the Rockefeller Institute for Medical Research, sailed Saturday, February 20th, on the steamship

Rochambeau. She goes with a detachment of nurses being sent by the American Red Cross for service in the American Hospital at Yvetot.

Department of Public Welfare

The Midwife

MARCELLA MACDONELL, R.N.

Of all the evils contributing to the high infant death rate and chronic invalidism among the foreign-born element of our population, the uneducated midwife plays an important part. There are almost no laws regulating her work. She is often old and densely ignorant, and frequently allowed to practise without registration or to register without qualifications; she hastens unsupervised from one confinement case to another, spreading infection as she goes. According to statistics, she controls from 40 to 50 per cent. of all the childbirths in some localities. Her presence is a handicap to the work of the district nurse in the community, who must present a diploma from a recognized hospital and a registered nurse certificate from the State where registration is in force, and is also required to take a special course in the rudiments of public health nursing before being assigned to permanent duty. She is trained not to assume the responsibility undertaken by the midwife, and, therefore, cannot give the after care to the mother and child unless the patient has been delivered by a legal obstetrician. The custom is so deeply seated that often when a nurse has arranged for free maternity service, given prenatal instructions, provided clothing for the coming infant, and assisted in getting relief for the destitute family, she calls one day to find a midwife has been called and the case must be terminated.

The writer, at one time a district nurse, had a case reported to her by a clergyman in the Polish section of a large city. Upon calling at the tenement house, she located the patient in bed, in a small, dark, stuffy

room, which sheltered a family of seven all told. The window had been nailed down and stuffed to keep out the cold. The father had given up his work to care for the baby and other small children. There was no income. The woman had been delivered five months before by a midwife, and was still under her care. Her temperature was 101 degrees. She complained of severe pain in the pelvic region. A cleansing bath was given and a physician sent for from the nearest dispensary. The mother was immediately sent to a hospital for an operation, the baby referred to the infant welfare station. The other children were placed under the care of the Children's Aid Society. The father was found work and everything done that could be done.

Another instance is known where there were four deaths in two weeks from puerperal infection, all traceable to the one midwife. For penalty, Amelia was up before the court, reprimanded and forbidden to practise. In the course of a few months she was again at her post in the usual way. These are only two of the numerous instances that come under the observation of the nurse and settlement worker.

Ruskin says that "every child has a right to be well-born." Thus far in America we have failed to provide scientific care for the mothers of the poor. Our free lying-in hospitals and obstetric charities are far too few and inadequate to cope with the situation; their extension would necessitate endowments of thousands of dollars, which could never be realized in the smaller communities. It would seem proper and fitting, since the district nurse is already in the field, that she should be trained to meet this

demand. Abnormal obstetrics is major surgery, and of course would not be undertaken by any one but a doctor. In England the Queen's nurses are required to take a special course in midwifery. Bellevue Hospital, in New York City, is the only place where such a course is given in this country.

It is not the desire of the writer to cross the boundary line or to invade the field of medicine, but to offer a suggestion for the solution of a knotty problem.



How One Social Service Nurse Spent Christmas

EVELYN BRONELLE

As I read over the pages of *THE TRAINED NURSE AND HOSPITAL REVIEW*, which mean so much to me, I came across the editor's request for hospital and private nurses, as well as welfare workers, to share with others their Christmas experience.

I have the privilege of being employed (I say privilege, for it is) by one of the great mission societies of the city as social service nurse. One can never comprehend the opportunities this phase of welfare work involves without having had the experience. I am associated with four other women who are employed by the same society and whose work is to conduct various clubs and classes among women and children, and whose aim and goal is to bring every mother and child in every club or class to the ideals of our one great Teacher.

Our city is districted and laid out by our great organization. I find through these mothers and children, in homes where domestic relations are estranged, where the little ones are underfed and the dreadful white plague eating them, as it were, alive, where mothers have battled against hardships and difficulties until their bodies are physical wrecks. I find a father a drunkard, and because of the social evil that exists he is laid up in a hospital for repairs while the mother and children are at their wits' end how to keep body and soul together. Or it

may be a husband who has walked the streets of the city day after day to find work, but days and weeks and months go by; finally he breaks down from worry and insufficient nourishment.

These are but brief illustrations of the problems I find for charity organizations, hospitals and dispensaries to help solve. Thus my Christmas experience was only enlarged by locating homes where probably some child or mother would have no Christmas cheer—yes, and probably a very scanty meal on Christmas Day.

Could you, dear reader, have seen the furrows of anxiety and care becoming smooth and the sadness of the eye give way to a starry twinkle when I began unloading my pack (for I played "Santa" all day before Christmas), you, too, I believe, would say it is the social work that counts. I had clothes and food to share with the needy and destitute. This was not my only experience, though, for when Christmas Day was ushered in I found myself wakened by a duet, the melody and words at once becoming familiar, for it spoke of "Joy to the world, the Lord has come, let earth receive her King." Our home, though simple, was one bower of holiday attire, for we, too, had friends who were thinking of us and who said our Christmas must be a happy one. We were children then for a while; our stockings had been hung and filled by dear old "Santa" himself. Fairies had been making frequent visitations, slipping package after package of every description about the "tree." Finally there had to be a package opening and it seemed that all the heart could desire was there. We also had had the privilege to share our dinner with friends, bringing added joys when new tales are told and old ones retold. At last came the story hour and farewell greetings. Christmas of 1914 was not only implanted in memory, but the pages of a "diary" bear witness for future reference. "Lest we forget, lest we forget."

Coffee Bread

V. S. SIMMONDY

Much can be done by the visiting nurse in every district, but when working among Polish people it is brought home to us every day and all day that education is the fundamental basis of all public health work.

John came to the dispensary to get a bottle of milk for his little baby brother. Thinking that he looked very pale and pinched, he was asked what he had had to eat. He answered: "Coffee bread." On further questioning it was found that the whole family had lived on coffee and bread for two months, because the father was out of work, caused by the "shutting down" of some of the mills. John was offered a sandwich, but began to cry and said, "No, I'd vomit."

His digestion was in such a condition that he could not attempt to eat ordinary nourishing food. Bread dipped in coffee is the regular diet of a Polish family unless they have enough money to buy cabbage to make that evil-smelling stew that one immediately recognizes on entering one of these homes, or some other equally indigestible food. Of the value of cereals and the way to prepare them they know practically nothing, much preferring their own methods of choosing and preparing foods. Bologna sausage is a favorite diet for small children, who clasp their treasure in both hands, and although some part is conveyed to the mouth, much is wasted by traveling over the face and hair, not to mention the floor. Regular meals are not an established custom; when children are hungry they must be fed, therefore a large kettle of coffee must be kept on the stove and a loaf of bread handy, so that whenever a child cries, no matter for what cause, he may be soled with the remedy for all evils—"coffee bread."

To break down this extremely fixed habit requires unending energy and tact on the part of the nurse, who must not be easily discouraged if her efforts are not appreciated at first.

It is as great a superstition as the belief that fresh air will cause small children to take cold, so for that reason they must be kept in a hot, closed-up room during all the winter months, the baby having the choice position next to the stove, where he sleeps, continually rocked by a small sister or brother, wrapped in plenty of rags, covered with a feather tick and a bright-colored handkerchief tied round his head, making him resemble an old peasant woman, and developing a breathing apparatus that will prove in time a splendid soil for the reception of tubercle bacillus.

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A Practical Suggestion

RUTH E. WAY

Much unnecessary delay and anxiety is often given both physician and nurse, as well as friends and relatives of the family who live in an imperfectly lighted locality, when the emergency call is sent for helpers at night on account of illness. This is particularly the case when the number of the house is old and when the light from the house or street fails to illuminate such a number, even in the slightest degree. Much stumbling around in dark streets at night with a heavy suitcase would be avoided if the following hint were observed:

In the absence of light from the street or transom, cut the large numbers representing the house number from an old calendar. Place these in the front window against the pane, and behind them put a lighted lamp or candle. Thus much wasted time and labor will be saved all around and many a valuable life might thus be saved.

Cleanings

The Value of Skimmed Milk in Fever

Dr. L. Fischer believes that in pneumonia one should give no more than one-half of the quantity of milk formerly given. The frequency of feeding should also be reduced. Solid food should be prohibited during an acute febrile attack, regardless of the diagnosis, so that eggs, meat, vegetables and bread should be prohibited. On the other hand, gruels may be permitted in many diseases. Thus, a farina or oatmeal gruel, or a barley gruel made with diluted milk is well borne and may be ordered. Fruit juices, such as orange juice and pineapple juice, are grateful and quench thirst. One of the best remedies to give is water, for its antipyretic and laxative effects, and because it stimulates the kidneys. The tolerance for carbohydrates during fever is limited and in many cases they are contraindicated. Fat in the form of butter or cream is also contraindicated. Skimmed milk should be diluted with an equal quantity of water. By this method of feeding there is given a very low percentage of sugar and casein and practically no fat.—*New York Medical Journal*.



Novel Treatment for Ringworm

A writer in the London *Lancet* describes a novel treatment for ringworm—iodine and freezing—as follows:

The part, having first been washed with a strong solution of sodium bicarbonate, is next swabbed with a piece of lint moistened with spirit of ether—to remove any grease. When dry, it is painted with tincture of iodine, and immediately after an ethyl-chloride spray is applied. The author finds it best to work with a pair of ethyl-chloride

tubes in each hand, as he thus covers a larger area in quicker time. The deeper the disease-process penetrates, the longer the spray must be applied. He continues spraying until the integument becomes china-white.

It will be found that in from twenty-four to forty-eight hours the patch of ringworm has become quiescent. Next, little tiny spots should be looked for and these treated in a similar manner. They also will disappear in from a few days to a week. In ringworm of the scalp three or four applications of iodine and the spray are required, but on the face or smooth surfaces one application suffices.



Metastasis from Mumps

Whenever there is danger of metastasis from mumps, either to the mammary glands or to the testicles, apply a hot mustard poultice over the parotid gland and put the patient to bed for a few hours. The inflammation will be attracted to its original site and there remain, and will abate with proper treatment.—*Dr. Ellingwood, in American Medicine*.



Flat Stomach Tube

In the *Medical Record*, J. Fuhs, M.D., Brooklyn, calls attention to the value of the flat stomach tube in cases in which the use of the ordinary tube is beset with difficulties. It should not be used for lavage. It has special advantages in nervous cases and can be introduced more easily and quickly, conforming somewhat in shape to the esophagus and being more flexible. The flat tubes are made in various sizes.

Editorially Speaking

Which the Greater Service

An illustrated Sunday paper contained a short time ago the picture of Mrs. Jean Key, a Queen's Jubilee nurse, who for several years was connected with one of our district nursing associations. Accompanying the picture was a short article telling of Mrs. Key's patriotism in not only responding promptly to her country's call for nurses, but likewise in defraying all her expenses from this country to England. It told of her work in England in charge of the children of Belgian refugees, and of her experiences at the front, mentioning, also, that at one time she had been a district nurse in the employ of the local association in the city in which this particular Sunday paper was published.

One knowing Mrs. Key and her work in this country could not fail but smile at the strangeness of life and fate and realize that it requires the doing of something really spectacular to really count in the public mind. Mrs. Key never did any braver, finer work than she did as a district tuberculosis nurse with the local organization referred to in the newspaper article. Her work was in the poorest and meanest quarters of the city, where she cared day after day for the far advanced and highly infectious consumptives under the most unpromising and insanitary conditions. She was untiring in her duty and faithful to her trust to the last degree, and yet one never saw a mention of her name in this same illustrated Sunday paper which now sees fit to eulogize her. Nor did she expect or desire it. Mrs. Key is only one of many women who for years has answered without fame or comment to the war call. But the war Mrs. Key and many others have given and are still giving their services to in this country

is, to quote a certain secretary of a tuberculosis association, "an unpopular one," and so we hear comparatively little of those on the firing line. One reads of the work of the National Association for the Prevention of Tuberculosis, of the great sale of Red Cross seals each year by the local associations, but what does the public know of the nurse who each day goes out upon her route, always in and out, first of one home, then of another, the real ammunition in the world's great howitzer trained against tuberculosis. Is Mrs. Key a greater and braver woman today at the front with the allied armies than she was at the front in the allied forces against tuberculosis?

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The Care of Sick Children

Not every nurse is a successful nurse for sick children, and it is undoubtedly true that no class of cases is a more severe tax on the resourcefulness of the nurse than the care in the home of a much loved child seriously ill, surrounded by distracted parents and anxious relatives. When failures occur, it is more often on the ethical side than on the technical side of nursing, but failures there are, many and serious failures, each year.

"If you come to nurse my children, will you please remember *that the children are mine*, and that I have some rights concerning them," was the remark made by an anxious mother with two seriously ill children, and one who had had previous experience with nurses. The remark may well form the basis for a talk to nurses on the ethical side of the care of sick children in the home. "How would you manage a petted child in the home, who objected to taking

his medicine and often his food?" Such a question discussed in a practical manner may be a thousand times more valuable to a class of nurses about to graduate than a lecture on rare diseases which the nurse may never encounter.

Have you given the nursing of children the place in your curriculum to which its importance entitles it? Have you, graduate nurse, supplemented your perhaps meagre instruction with a careful study of the subject—the care of children in all its phases. In your study of infancy, how much time have you given to the run-about baby—the baby in its second perilous year?

How one nurse managed a tedious case is delightfully told in the following sketch, which appeared in the *Australasian Nurses' Journal*. Can we not have a number of short sketches or letters on the general subject of the management of sick children in the home.

"She was only a small girl of six years, with straight red hair, pale blue eyes and a freckled nose; but for her six years she had wondrous common-sense. When I explained that for six whole weeks we should have to live together in practically one room, she looked up and said: 'Well, I guess we'll just have to make the best of it, nurse!' And make the best of it we did; for all the time I was with her I never saw Myra shed a tear.

"There were reasons why the quarantine should be specially rigid. We were in a thickly populated neighborhood, and there were eight children in the family. I was immune, and so we settled down together.

"First of all, Santa Claus braved infection and did not forget to call. He fixed a lucky stocking to each cot post, and the contents of those stockings kept Myra employed for days. The box of paints produced the most marvelous pictures, and the clay pipes wonderful bubbles, while the paper booklets of Cinderella, Tom Thumb and Red Riding

Hood were read and re-read. Towser, a china dog of small dimensions, was quite happy tied with cotton to the leg of the cot, while the medicine bottles made excellent children in our school. Topsy was manufactured out of an old black stocking, and proved a most useful person all through the time of quarantine. Topsy contracted scarlet fever and various other illnesses, during which she was most devotedly nursed by 'Nurse Myra.' Later on, alas, Topsy became an ideal 'Aunt Sally,' and still later was turned into a hockey ball. There was tremendous enthusiasm over the hockey matches, the goals being the legs of the cot.

"Then came our picnic days, when, having packed our hampers, we set forth upon excursions to Lake Tub. With fishing rods made of sticks and string and hooks of hair-pins, we 'fished' for hours. The fish were made of corks, paper, cardboard, or anything else handy, and great was the excitement when we hooked them and brought them from the bath to solid land.

"Fires were frequent in the city just then, several large and small emporiums having been burnt to the ground. We could not be present in the midst of the public excitement, but we had fires of our own, when the fire brigade performed invaluable service, the syringes making splendid hose and reels.

"At last the six weeks' isolation ended. During the fifth week I turned my thoughts to the world again, and began to long for its freedom—the trams and trains, the shops and churches, the people and the music—and joyfully I said to Myra, 'Just think, Myra, next week we shall be outside again!' She looked at me a moment, then said: 'I'm not glad, Nurse, are you? Because we won't have each other then!'

"Who can say that those weeks were not spent in Fairyland? And what happier world could one inhabit?"

Our Beautiful Laws

Before us lies a letter from a nurse superintendent who is registered in New York and in two other States, yet who has been forced out of a position in a Western State because of a "beautiful" law, which, according to the way it was interpreted, made it obligatory on her to take an examination if she wished to hold a position in that State.

This nurse has been teaching and training nurses for fifteen years and more. She has certificates and licenses to burn. There is no possible doubt as to her ability or efficiency as a superintendent of nurses, yet she is arbitrarily forced out of her position as superintendent of a large school. The hospital and school are embarrassed and handicapped, the nurse is thrown out of a living, and all for what? What possible benefits are there in such a law which was presumably designed to be "a protection to the nurse"?

Surely there should come a time in a woman's life when she might consider herself through with writing examination papers, but evidently this security is not to be enjoyed. This is surely "protection of the nurse" with a vengeance. We are much inclined to agree with the editor of the *Review of Reviews* when he exclaims, in the words of the poet, "What fools we mortals be!" Then he goes on to explain what he has particularly in mind, as follows:

"Of all the fool things in which we mortals engage, perhaps the most laughable is our lawmaking, which we take so seriously. We do not laugh, because we are a part of it. If one wants to know the appearance of the sky-line of New York City he must get outside of the city. We are so closely interwoven with our customs that we are more or less obsessed with a sense of their wisdom, and it is utterly impossible for us to "see ourselves as others"—from Mars, for instance, would see us. But just as surely as the seventeenth-century customs and ideas appear crude and bizarre to us, so would our

customs and ideas appear crude, foolish, uncivilized, to a future generation.

"The old *Sonoma Democrat* had at its head the motto, 'The World Is Governed Too Much.' How cheap it is to put some freak bill into the legislature and under the excitement of the moment, and with the *vis a tergo* of an excited populace, to get it passed, and its originator into the limelight! And this, notwithstanding the fact that we would be as well off—or better—if nine-tenths of the bills were never passed. After all, the bill-killing committees of a legislature are not so bad an institution, though the man who has *his* pet bill killed is apt to think that the committee which smothered it is under the pay of the trusts or in league with the devil."

Good laws are good things, as we have remarked many times, but what seems to be badly needed just now is a little plain common-sense in interpreting laws.



Wanted—Sensible Women

The head worker of the social service department of a large hospital recently received a telephone call from a man in a smaller city of the State, asking her if she could put him in communication with a nurse of experience, good judgment, tact, with a proper regard for appearance, not easily discouraged, able to take the initiative in developing social service in that city, able to direct others, etc. He was not very particular whether she had social training or not, but he knew the personal qualifications he wanted her to have. The woman to whom he was talking smiled as she replied that she was looking for several workers for her own department such as he had described, and would be grateful to any one who would help her to find them.

Ask the head of any large business firm where many women are employed the kind of workers needed, and the list of qualifications will not be greatly different from those

specified for social service. The superintendent of a hospital might add a few more desirable qualities to the list if he were telling of the kind of workers he wanted for responsible positions, but he would be likely to include the same list of qualities for executive workers in hospitals. As a rule, one does not find such workers waiting to be picked up. They are at work somewhere, because they have the personal qualities that make them valuable.

We have been told so often that if we had higher educational qualifications for hospitals we would have no difficulty in securing in large numbers the type of workers wanted. But the facts are that in few, if any, lines of activity are there enough of such workers to fill all the places needing them. The college education is often brought forth as a desirable requirement, but no college seems to be able to give a woman common-sense, good judgment and the ability to work harmoniously with different varieties of people if she does not have a well-balanced character and disposition to start with.

Do we realize as we should the importance of laying special emphasis on the personal qualities which are indispensable to success in the most important positions? Do we do this with the pupil nurse at the beginning of her nursing career, at intervals along the way, and put it before her very seriously when she is leaving the training school? It is easily possible to unduly emphasize the newer opportunities for nurses and to fail wholly in emphasizing the qualities called for if a nurse desires to make the best use of such opportunities.

When we are through analyzing the needs as enumerated in the opening paragraph, we will admit that neither brilliancy nor superior education count half as much for real success, as does just plain, ordinary common-sense. Sensible women have a remarkable

capacity for rising equal to emergencies, and of adapting their theories, if they happen to have any, to the conditions in which they find themselves. The needs of today are not greatly different from those of fifty years ago, when Florence Nightingale began her educational work. We still need in large numbers practical, sensible women. In every nurse class there are splendid possibilities of developing such workers, given the right spirit in those who have charge of nurses in the formative period of their career.



Good Resolutions

If you have made good resolutions and failed to keep them—who has not?—try keeping this set for the balance of the year. They are practical and sensible enough to fit almost any of our lives:

“To pray more and to worry less; to pay more to advance the general good, and to complain less; to smile more and to scold less; to make Sunday the brightest day in all the week for somebody—somehow; to worry less than you have been doing about other people’s views; to go to heaven in your own way, the chances being that you will meet them there, if not before; to remember that a man’s or woman’s reputation is worth more to them than their money, and that therefore you ought to be as careful of robbing them of it as you would of putting your hand in their pockets; and, above all, do not forget that the good you hope to do sometime ought to be begun right now.”



Fanny Wilde McEvoy

It is with great regret we announce the serious illness of our aged Nightingale nurse, Mrs. Fanny Wilde McEvoy.

The Hospital Review

CONDUCTED BY CHARLOTTE A. AIKENS

Items of Interest, annual reports, publicity literature, and material descriptive of newer methods and plans in any department of hospital work, should be sent to the editor of this department, at 722 Sheridan Ave., Detroit

Hints for Prevention of Waste in Hospitals

A. A. S.

One naturally thinks first of the operating room, since its accessories are the most costly and must be kept in perfect condition. It is in the operating room that a nurse must, if ever, develop a sixth sense, a "tactility" that will prevent her from getting too near a sterile table cover or from bumping into an operator—a sort of sense that she is in the midst of a great coil of heavily charged electric wire. When she gets this she will not bang nor chip basins, or smash \$30 glass immersion tanks. But some do not acquire it with repeated reminders.

There is sure to be waste where inferior goods are bought, waste of time by the buyer, the bookkeepers, the porters and the final users, since it causes delay in the nursing and a trial of another grade of goods. Buy first-class goods.

I. ENAMEL—1. Do not let basins boil dry or chip. 2. Take rust off at once with oxalic acid solution. 3. Grease dark spots daily. 4. Paint floor basins with enamel, if possible. 5. Do not use bleaches to take off the gloss. 6. Soak basins as soon as used, and a very light rubbing with brown soap will cleanse and polish. For stains use sapolio.

II. GLASS—1. Melt ends of packing tubes, when chipped, over gas flame, till smooth. 2. Bend glass tubing as required, over gas flame. 3. Seal ends of tubes similarly. 4. Lay all glass goods on

a cloth when being boiled. 5. Do not expose suddenly to cold air or cold water. 6. Do not lay hot glass or enamel on cold glass table. 7. Use nickeloid furnishings where possible, and eliminate glass.

III. INSTRUMENTS—1. Put calcium lactate 3ii. in a saucer in each instrument cabinet, to absorb the moisture. 2. Lay bits of camphor on shelves to prevent oxygenation of silver probes, etc. 3. If needles are kept threaded, run them through woolly flannel or flannelette, then when needed boil in a similar strip of bandage. It is a fine thing for a doctor's bag, in general practice, to keep a set of needles for eye, lip or hand, threaded with graded silks, and run through little books of flannel. 4. Needles *not* to be kept threaded should be *carefully counted* before and after operation, and boiled in a small perforated nickel or aluminum box. 5. Knives—the blades should be loosely wound in soft cotton, then all knives and scissors and needles should be laid, one at a time, in the platings of a big, soft towel, and boiled, where the hospital technique requires it, or laid in carbolic acid and alcohol, so that the points and edges will not be touching anything. Again, one might urge that the American Hospital Association standardize a technique for these things. 6. Clamps and other jointed instruments should always be oiled around the joint, since that part is not exposed to

the light of the sun. Grease the corrugation slightly, also. These must be thoroughly cleansed in cold water to remove blood, and well scrubbed BEFORE boiling. 7. Gouges and chisels—in mastoid work. When sharpening these, the new edge should run on up into the old nickel at the same angle as when new. Re-nickel these often, and do not let the instrument repairer nickel the edge. There is no nickel on the edges. 8. Sounds should not be passed unless perfectly smooth. If allowed to rust deeply they might as well be thrown away. Keep dry and smooth, and re-nickel often. Keep separate in a flannel case, no two sounds touching each other.

✦

The Hospital Exhibit at San Francisco

The annual convention of the American Hospital Association, to be held in San Francisco late in June, will occur from two to three months earlier than usual. It leaves that much less time for those who have the work of preparing for the convention.

Miss Lydia Keller, who had charge of the Non-Commercial Exhibit at St. Paul, has again consented to organize the exhibit, assisted by her committee, composed as follows: Miss Mary E. Thrasher, superintendent Robert Brigham Hospital, Boston; Miss Elizabeth Miller, Flushing Hospital, New York; Mr. G. W. Olson, Swedish Hospital, Minneapolis; Miss A. A. Williamson, Los Angeles.

Miss Keller is resting this year at her home at Northfield, Minn. She asks for suggestions regarding the exhibit from any reader who is interested, to be sent to her at the address mentioned.

She asks that hospitals which prepare models of any kind, plan to leave them with the Association for a year or two at least, as the nucleus of a permanent exhibit, also that those who have contributed to previous conventions such models of any kind of

hospital appliance or device, arrange to send them to San Francisco, where the convention attendance is certain to be made up largely of members who have not attended previous conventions.

No one who has not had the task of planning and managing the details of such an exhibit can appreciate the time and labor it entails and the enormous correspondence necessary. Every hospital worker can help share this burden and assist in making the first Pacific Coast convention of hospital people a success by writing Miss Keller of some appliance or device invented or arranged by yourself, or which you have seen in some other hospital. This may seem a small service for you to render the Association, but in the aggregate it means a tremendous help.

Miss Keller is especially anxious to have a good exhibit of operating-room sheets, masks, gowns, aprons, bandages and home-made appliances for a permanent exhibit. These are best demonstrated on large dolls, but if you haven't time to arrange the exhibit in miniature, plan now to send the complete set, and write Miss Keller that you will do so. The set will be returned to you when the convention is over.

If you have devised a satisfactory uniform for summer wear, please send a doll with the sensible summer uniform and help on the effort to emancipate nurses from full-length sleeves and stiffly starched collars and cuffs in the hot weather.

Have you worked out a satisfactory device of any kind for keeping food hot? If so, please send a model or demonstrate the idea in some way.

Even as small a thing as the way you mark your linen—if demonstrated or shown—will help some one else.

If you are specially desirous of seeing some particular thing included in the exhibit, please write Miss Keller or her committee about it and an effort will be made to secure it.

Make a good-sized scrap-book of your hospital and training-school blanks, and contribute it to the Association. Hundreds of superintendents carry away new ideas from the exhibit of blanks and literature. Have you done your share to help on previous exhibits?

Take it upon yourself to do something to add to the success of this exhibit and to lighten the labors of the committee.



Inquiries Concerning Patients

The manner in which inquiries concerning patients' condition are answered from the hospital has a great deal more to do with the good reputation of the hospital than the person answering the inquiry often realizes. In a small hospital the superintendent may personally answer such inquiries, or they are answered under her direction by some assistant whom she has personally directed.

As the hospital grows larger, this personal touch with the friends of patients is gradually lost, and this task, among others, is committed to some one else. If an unsophisticated telephone operator or clerk is assigned this task, there will certainly be many complaints. "About the same" and "improving" are stock answers which may mean much or little.

"What did he die of?" a question directed to the family in regard to a patient who had died in a certain Western hospital, brought forth the response, "Evidently he died of *'improvement,'* for every time we called the hospital to inquire about his condition we were told he was *'improving.'*"

The necessity for guarded answers is appreciated, but it is sometimes possible to be too guarded, especially when dealing with near relatives who have a right to know.

When the superintendent or an experienced assistant cannot reply to such inquiries, the bulletin method is the only satisfactory way—the bulletins being prepared daily

by the head nurse of each department on printed forms, and, possibly, O.K.'d by the resident physician or senior interne.

Inquiries are likely to come any time after eight o'clock, and reports of freshly operated patients or those seriously or critically ill or not progressing favorably should be sent to the office as soon after eight in the morning as possible. This list is usually a short one and can be quickly prepared. In some large hospitals an emergency list is kept in the office and when a sudden change for the worse takes place in any patient his name is at once entered on the emergency list—the office being responsible for notifying the friends who should be notified.

The one blank may serve for the general list of patients whose condition is satisfactory or in which little change occurs from day to day, and for those in a serious condition, the seriously ill patients' names being underscored in red ink or marked by an asterisk.

Such a bulletin may wisely contain the patient's name and number, name of ward, date of admission, time of operation, general condition and a column for "remarks." The term "improving" when it is used should mean something. The phrase "about the same" may tell something to the inquirer and may not. It may wisely be dropped from the list of stock phrases used in answering inquiries. If the patient slept well and his condition is satisfactory, it should be so stated. "Condition satisfactory" or "unsatisfactory" is a positive reply which is better than "improving," unless the improvement is real and positive.

If the patient is doing fairly well but not yet "out of the woods," the one who answers the inquiries should know it, so that he does not give out assuring reports which are unwarranted.

Whether the person whose duty it is to reply to inquiries about the condition of patients be clerk, nurse, porter or telephone operator, he (or she) should certainly receive

definite instruction and suggestion in the "fine art of putting things" and be just as definitely told *what not to do*.



The Probationer's Course

An increasing number of training schools each year are finding it an advantage, not only to the probationer but to the smooth running of the hospital, to give a few weeks, at least, of preparatory training before the probationer is given nursing responsibility. At least one Michigan school is putting the whole of Miss Goodnow's booklet, "Ten Lessons in Chemistry for Nurses," into this preparatory course, the superintendent believing that it is a distinct aid to a clear understanding of much teaching and practice that must follow. Daily talks on ethics are given, and the pupils get such a good start on anatomy and materia medica that fewer classes are needed later on in the first year. The following outline of the probationer's course in the Boston City Hospital will be of interest to others who are planning such a preliminary course.

The first week the probation class meets in the practice room daily for practical instruction in the making of beds, including the use of bed-rests, cradles, etc.

The care of rooms, sweeping and dusting.

Care of set bowls, wall stands and utensils.

Care of linen rooms, the folding of linen.

The use of hot and cold applications, including the making of fomentations and poultices.

The care of rubber goods.

The making of surgical supplies, pads, sponges, tampons, etc.

The use of slings, binders and supports.

During this time the class is instructed in the use of antiseptics, disinfectants and deodorants, and the preparation of solutions.

Tables of weights and measures.

The use of abbreviations and symbols.

The principles of ventilation.

The temperature of the body. Heat production and radiation.

The use of the clinical thermometer and charts.

The giving of baths, care of the back, mouth, etc.

From the seventh (7th) to the tenth (10th) day allowed to go to the wards, make beds, sweep, dust and fold linen (hours from 7 to 10.30 A.M.).

The tenth (10th) day assigned to wards for regular duty, and during the remaining weeks of the probation course three hours each day will be devoted to class and practice-room work, with one additional hour for recreation.

TOTAL HOURS OF STUDY AND WARD WORK IN THREE MONTHS' PROBATION

	Hours
Anatomy, physiology and hygiene...	66
Practical nursing and practice room..	126
Materia medica and nursing ethics...	24
Lectures.....	12
Ward work.....	481
Elementary dietetics.....	8



A Device for Keeping Meals Hot

A subscriber sends the following item, which will be of particular interest to workers in smaller hospitals and especially to those with a small isolation department or cottage separate from the main building to which meals must be sent from the main kitchen. She says:

"The housekeeper of a small hospital, which I visited, showed me an invention of her own for keeping meals hot in sending them to the serving kitchens and to the isolation cottage. She had the tinsmith make two or three tin kettles a couple of sizes larger than the ordinary asparagus boiler. These were divided and fitted into a shallow pan, the kettle resting on a rim. These apparatuses were thoroughly heated before putting the food in. The shallow pan was

filled with boiling water and the whole was kept hot by setting the food carrier over a gas flame in the serving kitchen. Each food carrier had compartments for three hot articles of food.



New Maternity Building for Massachusetts Homeopathic Hospital

As a result of a gift of \$100,000 from an anonymous donor, a new maternity building will be added to the Massachusetts Homeopathic Hospital, Boston. The plans provide for one of the largest equipments of the kind in that city.

The new building will be erected on the site of the present out-patient building and will be a five-story fire-proof structure. The two lower floors will be used for the out-patient department, greatly increasing its rapidly growing service.

The maternity department will occupy the upper floors. The third floor will be devoted to ward patients, the fourth to semi-private patients, and the fifth to private patients. There will be a total of eighty-two beds for mothers. It is also planned to equip each of the maternity floors with large nurseries and to have a large solarium on the Stoughton Street end of the building.



De Graff Memorial Hospital

The De Graff Memorial Hospital, of Tonawanda, N. Y., was recently opened to the public. It was erected by James H. De Graff as a memorial to his father, Le Grand De Graff. The cost was about \$100,000, and it contains all the latest in electrical appliances, sanitary finishings and furnishing. No chronic or infectious cases will be accepted. It contains thirty beds. There is no training school.

Miss Mary E. Tuttle is in charge and has as her assistants Miss Mary T. Dean, Mrs. Katherine Johnson and Miss Irene Mulchi-



APPLICATION OF HEAT BY ELECTRIC PAD—BATTLE CREEK SANATORIUM EXHIBIT, HOSPITAL CONVENTION

neck. All are graduates of the Buffalo Hospital of the Sisters of Charity.



New Hospital at Millville, N. J.

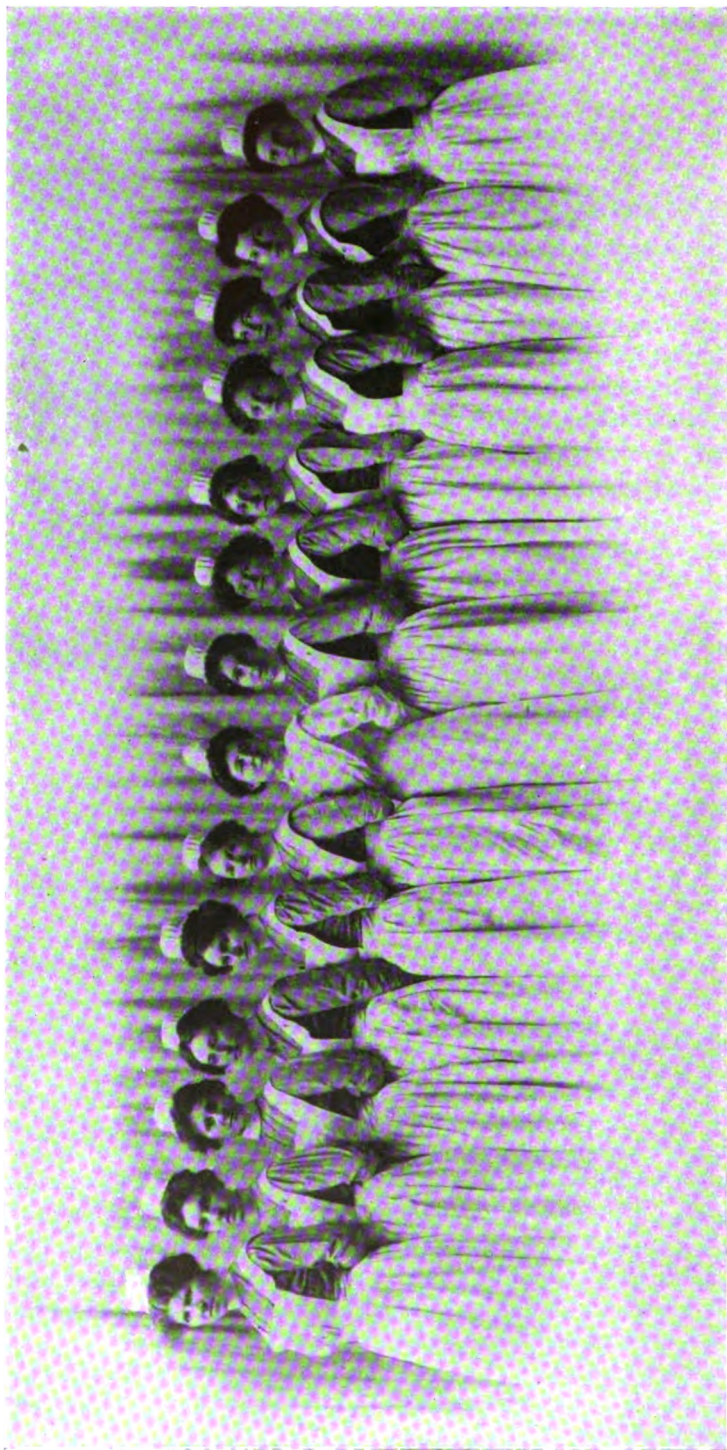
The cornerstone of a new hospital at Millville, N. J., was laid on January 17. This new institution was given birth through the personal efforts of Mr. Henry A. Dix, who donated \$10,000 with the understanding that the town of Millville was to raise \$20,000 in addition.

The movement, started by Mr. Dix, afterward received the cooperation and assistance of other well-known citizens of the town.

The hospital is planned along the most modern lines and will accommodate thirty-two patients. The equipment is of the most modern type.

Mr. Henry A. Dix, who made this new hospital possible, is head of the house of Henry A. Dix & Sons Co.

(Continued in Advertising Section)



GRADUATING CLASS, STATE INFIRMARY, TEWKESBURY, MASS.

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

The "Special" Nurse

To the Editor of the Trained Nurse:

In reading over the many interesting letters in the "Letter-Box" of THE TRAINED NURSE of February's issue, I was most interested in the letter signed by "H. B. J.," New Jersey, and entitled "The Special Nurse." I have a great deal of unusual experience with special nurses here, where a large percentage of our patients are private and surgical, and the community very much in the habit of employing special nurses, if for only a few days in the immediate post-operative stage. We do not restrict our outside specials to our own school graduates, although we do give them the preference when they are available. We also put our senior pupils on special, and reserve the exclusive right to do so in all cases, regardless of all considerations, if we should have the available pupil. Many times we are confronted with the claim that the patient has had such and such a nurse engaged for a week or two previous to her coming to the hospital, and many times the doctors will, without previous arrangements, send both patient and nurse to the hospital, evidently believing that any resistance will be overcome in that way, but their tactics fail if the nurse should happen to be an undesirable or if we should happen to have a spare pupil whom we wish to place on special. The hospital board has protected the hospital against the inroads of undesirable nurses, and maintained their right to the means of revenue derived from our own pupils' special nursing, by the following special resolution: "That no outside nurses be sent in to the hospital on 'special' unless the hospital is unable to provide 'special pupil nurses,' and that only with the consent and approval of the lady superintendent may outside nurses be sent in, such nurse to be subject to the approval and control of the lady superintendent." Typed rules have been prepared for the benefit of outside "specials," and are bulletined in the nurses' dressing room.

I find that in reserving this right for our own pupils, that we gain more than in revenue and protection; the experience given to the pupil is

invaluable in that it gives her time for planning and studying out the details which go toward finished nursing—catering to the patient, artistic arrangement of the room, careful arrangement of the tray, etc., and while not exactly private nursing, gives some of the poise necessary to private nursing. I am pleased to say that we do not experience much difficulty in dealing with outside "specials," and find that we have many times gained by interchange of ideas and methods. I hope this contribution may aid in some small way.

MARY A. CATTON,
Lady Superintendent,
General Protestant Hospital, Ottawa, Can.



To the Editor of The Trained Nurse:

Replying to "H. B. J., New Jersey," of the January issue of your journal, wish to state we have a book of rules governing graduates on special duty, which I find very satisfactory. Any violation of same calls for relief on duty with the case. The rules are read over and signed below by said nurse before assuming her duties.

MARY A. SMITH,
Supt., York Hospital.



The Gatch Bed

To the Editor of The Trained Nurse:

Will you please favor me with further information regarding the Gatch bed mentioned in the article, "What a Nurse Should Know When She Leaves the Operating Room," by Amy A. Armour?

L. B., Nebraska.

[The Gatch bed is to place the patient in the Fowler position. It may be purchased from any company making hospital beds. It is not necessary to get a bedstead. Only buy the Gatch frame. The cost is about \$12. It consists of a solid frame, the same size as the bed, which is placed on the spring. Then the mattress goes above all, on the Gatch frame. It is in three parts, so that the patient may be placed at whatever angle is suitable for drainage. But every hospital should

have a large number of these beds. They are ideal for heart cases and other similar conditions, as well as for drainage. Be warned in time about two things—a patient accustomed to the elevated position may die instantly if lowered carelessly. Also, when he has been lowered for a dressing, or for getting his bed made, the foot must be lifted first. It is almost impossible to handle it otherwise, since the whole weight of the patient is on the foot when the head is raised first. Any clever hospital engineer could make half a dozen of these frames out of stout pine, window screens and a few hinges in his leisure time in summer.—EDITOR.]



Sleeping Outdoors

To the Editor of The Trained Nurse:

Outdoor sleeping apparel must fit closely, whether in winter or summer. For cold weather pajamas of wool or part wool are preferable. If woolen clothing irritates the body, vest and drawers of gauze are worn under the wool. Many of our patients, however, do wear cotton without chilling. In extremely cold weather a heavy gown or bath-robe is worn over the closely fitting underwear. Heavy stockings are used, and if the feet are inclined to be cold bed shoes made of felt or any heavy, pliable material are worn. These shoes can be made by laying a stocking foot flat on the material and cut one inch larger around. This brings the seam from upper back along the bottom of the foot, and up the front, which leave open about three inches. They will need a slip tie to prevent losing in bed, if the patient is restless. A closely fitting hood with a neckpiece five inches wide is worn. The method of making the bed is even more important than the robing. For convenience, a cot is usually used. A rubber sheet or newspapers with edges overlapping to avoid separations are spread on the cot, then a mattress or thick pad is used. Use wool blankets, if possible. Cotton blankets are better than cotton sheets. Rubber sheeting on top secures against rain or dampness. Our sleeping porch is protected by a boarding about four feet high, which keeps wind from blowing under the beds. The remainder is glass in sashes as windows, which hook open. A balcony can be utilized by arranging in a similar way. Enclose with canvas four feet up from the floor. An awning above completes a good sleeping porch. The ideal sleeping porch is provided with doors sufficiently wide for the beds or cots to be drawn into the house and warmed, the patient being put to bed inside, then the bed rolled outside. The

primitive plan results the same, but is not so comfortable when retiring.

ADDIE N. COMPTON, R.N.

Nurse in Charge of Saint Johnland Infirmary,
Long Island.



How One Nurse Spent Christmas

To the Editor of The Trained Nurse:

In the December number you asked nurses to tell how they spent their Christmas. I do not know how many would find Christmas interesting under the conditions in which I spent the day, but I believe that whether things are interesting or not depends a lot on ourselves and the influence we have on those around us. On Christmas Day I was nursing in a family where I had previously nursed for a period of ten weeks. The family consisted of three sisters and three brothers, only one sister and one brother being married. My patient was the married sister; about a week before Christmas she gave birth to a baby girl. Christmas was indeed a sad day for the mother. True, she had two darling children, but about three months before her baby was born her husband was shot, and died a few hours after he reached the hospital. My patient's father, when he died, left a fortune to his wife and children. The mother died a few years later and left the care of the two younger girls to the eldest sister, who was then about twenty. The three boys have been a terrible burden to their sisters; they are just as bad as they can well manage to be; in fact, they were so bad that their evil reputation began to fall on the girls, though they are sweet and lovely. Their Christmas was pitiful; there was the young mother, only twenty-two, and her two fatherless children. The aunts trimmed a tree and arranged a very pretty Christmas for the little boy. At midnight, just as Christmas began, the mother and baby happened to be awake, so the girls slipped in and gave my patient her presents and surprised me with some very pretty remembrances. Early in the morning the girls went to church, and from there to their mother's grave. Soon after lunch they told me that they would sit with my patient for a few hours, and they had the chauffeur take me home to see what Santa Claus had left for me. I found a very different Christmas at home, as ours is a house full of gay, happy young people. Shortly after I returned to my patient we had a delicious Christmas dinner. One big proof of the goodness of these sisters was seen in the fact that in spite of the way their brothers had treated them they had

them all to dinner, and though at dinner the boys became rough and behaved as they should not have done, the girls were as sweet and patient as could be, and I could not help wondering how in a civilized and humane age people could in some instances be so unjust.

JENNIE McMASTERS, R.N.



The Hot-Water Bottle Accident

To the Editor of The Trained Nurse:

I, too, was greatly interested in the article in the September number on "The Financial Side of Hot-Water Bottle Accidents." In the hospital where I was trained the nurse was usually suspended for such carelessness. In one case she was expelled. This nurse suffered for the failures of several others. The superintendent had given the whole school fair warning that the next time a patient was burned with a hot-water bottle the nurse in charge would be expelled. It did seem a hard punishment, however.

I was strongly impressed with the justice of the remarks of "A. McC.," in November number on the subject, and wondered if in any hospital such a method had been adopted and how it worked out in actual practice.

I do not always think such accidents are due to carelessness, though it may appear so. Sometimes a nurse has far too much to do. She has more patients than she can properly keep on her mind, or she has, perhaps, one or two terribly sick ones who demand constant attention. The unconscious one who remains quiet is the one who may be forgotten. He may move, though unconsciously, and come in contact with a hot-water bottle.

The worst burn that I have seen that was caused by hot-water bottles was caused in this way. A lady doctor, a friend of the patient who was operated on, came to attend the operation and to stay the remainder of the day with the patient. When she came from the operating room, the lady doctor informed the corridor nurse that she would take entire charge of the patient. The hot-water bottles were in the bed when the patient was brought into the room. The corridor nurse in charge of that room started to remove them, but the lady doctor said she would attend to them. Between the two, the patient received a frightful burn, which, of course, the lady doctor blamed on the nurse. The patient also blamed

the nurse. A lawsuit was threatened but did not materialize.

There are so many stories of how such accidents happen and so many sides to each accident that it would take a Solomon to mete out justice in every case. I wish some superintendents would tell how they deal with such cases.

A YOUNG SUPERINTENDENT,
Kansas.



Lack of Employment

To the Editor of The Trained Nurse:

In looking through the several nursing journals we are constantly reminded of the many avenues of usefulness now open to the graduate nurse. In these days we are well trained and capable, else we would not receive our diplomas and R.N. certificates. Yet more often than not, when we make application for these various positions, we find that there are more applicants than there are positions. This is but the natural result of the increasing number of nurses graduating from hospital schools each year. But we spent three years in training for the purpose of nursing the sick in the years to come. Every nurse knows that the doctors for whom she nurses have more nurses who are asking them for work than they have cases to give. The directory often gives the nurse but one or two cases a year, because there are so many nurses on the list. Why take more nurses on the list than they can keep employed? Numbers of capable, worthy nurses are working but six months of the year. Think of the discouragement of waiting day after day in your boarding-house rooms, sister nurses, and if you can write a few letters telling us how to help ourselves they will be truly appreciated. Hoping to hear from the more successful nurses,

✦ M. B., R.N.

The Male Nurse

To the Editor of The Trained Nurse:

I would like to hear from some of the male nurses who are readers of THE TRAINED NURSE as to the conditions and opportunities for the male nurse in the Eastern States, and hope we shall get some articles pertaining to the male nurse and his work and standing in the profession.

Burkett, Neb. JAMES D. MARTIN, R.N.

(Continued in Advertising Section)

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

The National Organizations

The dates of the meetings of the three national organizations of nurses at San Francisco, Cal., have been changed from May 30-June 5 to June 20-26. This will bring the meetings at the same time as those of the American Medical Association and of the American Hospital Association.



State Registration

The nurses of Maine, Alabama and North Dakota are presenting bills for nurse registration. Nebraska, Wisconsin and Massachusetts are considering amendments. It is reported that there will be strong opposition to the amendment to the Massachusetts bill.



Canada

The annual Christmas tree, in connection with Grace Hospital, Toronto, was held Wednesday, December 23, 1914, in the Lyman ward of the hospital. For the past twenty years Mrs. R. B. Hamilton, sister of Sir Henry Pellatt, has provided the Christmas tree, assisted in this work by contributions from business men of the city and from the wholesale houses. This year's tree surpassed all others, in spite of the hard times that prevail. The outdoor patients, paper and messenger boys and every one connected in any way with the hospital were invited. A program, given gratis by talented performers, was rendered during the earlier part of the evening. About 9 P.M., to the tune of "Jingle Bells," Santa Claus made his appearance: All the patients, help, nurses, officers and doctors were remembered. The public ward patients each received a large bundle containing articles of apparel, as well as other things. Each member of his or her family was remembered—wife, mother, husband or child, as the case might be. Each of the help received not only one but several gifts. Santa Claus afterwards visited the wards and unloaded his pack to the patients unable to come to the tree. Never were such a number of happy faces seen among the patients than when next morning the wards were visited. One old man said, "It is the first time in my life I have ever seen Santa Claus."

Another man, whose parcel was still neatly wrapped, was asked if he had not opened it. He said, "Indeed, ma'am, I have had it opened eight times, but you can open it again if you like." On Christmas morning a church service was held at 6.30 A.M. in the hospital, for nurses, doctors, help and patients able to attend. One of the attending doctors had secured a good orchestra, which, under his direction, rendered sweet music for an hour after the service. At 9 A.M. Santa Claus again visited the wards, this time the part being taken by Mrs. Hamilton and the principal of nurses, leaving with each patient an orange, a box containing nuts, raisins and candy, and a bottle of perfume. The patients, although very tired, were happy, and I am sure were much benefited by the pleasurable excitement. The patients with one accord said that they had never slept better in their lives than they did the night of the Christmas tree.



Vermont

At a meeting of the Nurses' Alumnae Association of the Fanny Allen Hospital, the following resolutions on the death of Sister Sweeney:

WHEREAS, It has pleased Almighty God to send the Angel of Death to summon from our ranks our much beloved and esteemed acting treasurer, Reverend Sister Sweeney, whose life and works in our Association have ever been an inspiration and an assistance to each individual member, and whose memory shall ever be a guiding light in the future problems and welfare of our Association. Wherefore, be it

RESOLVED, That whilst humbly bowing in submission to the will of Divine Providence, and hearts filled with profound grief, the members of the Graduate Nurses' Association of the Fanny Allen Hospital Training School for Nurses tender to the Sisters of the Fanny Allen Hospital and the relatives of our dear deceased member our heartfelt sympathy in this hour of extreme sorrow and mutual loss; and be it further

RESOLVED, That a copy of these resolutions be sent to the Sisters of the Fanny Allen Hospital and the members of the bereaved family, spread on the records of our Association and published in THE TRAINED NURSE.

Massachusetts

Resolutions of regret for the recent resignation of Miss Jessie E. Catton from the superintendency of the Springfield Hospital were passed by the Springfield Hospital Nurses' Alumnae Association at a meeting in the nurses' house. The action was taken in the business session, during which new officers and committees were elected for this year. The new officers are: President, Miss Helen Hunt; vice-president, Miss Flora E. Bartlett; treasurer, Miss Jane White; secretary, Miss Knox.

Graduation exercises of the Franklin County Public Hospital Training School for Nurses, Greenfield, took place February 2, in Grinnell Hall. Eugene B. Blake, president of the hospital board of managers, gave an address following prayer by Rev. J. B. Whiteman, St. James' Episcopal Church. W. P. Abbott, superintendent of schools, was another speaker, and Frank J. Lawler, treasurer of the hospital corporation, spoke of the needs of the hospital, gave the oath and awarded diplomas. There was also a musical program. Graduates were: Mrs. Mary Ellen Walsh, Misses Grace Maud Belanger and Elizabeth Frances Delaney. After the exercises there was dancing, an informal public gathering and supper for the graduates.

Graduation exercises for the class of 1915 of the Massachusetts General Hospital Training School for Nurses, Boston, were held at the hospital January 15. Diplomas were given to fifty-four nurses. The principal address was by Miss Mabel T. Boardman, of the American Red Cross. Essays were read by Miss Marion Alice Fuller, of Melrose, on "Earning the Broad Black Band," and Miss Alida Winkelmann, of Lansingburgh, N. Y., on "What Makes a Nurse's Training Worth While." The superintendent of the school, Miss S. E. Parsons, delivered the annual report. The report of Miss Parsons contained the following: "The day is surely coming when the word 'nurse' must be protected by law as is the word 'physician' for the safety of the public. Nothing short of this will eliminate the correspondence and other pseudo-nursing schools, and the employment of women who have been dismissed from training schools."

Massachusetts State Infirmary Training School for Nurses held graduating exercises at the infirmary, Tewksbury, 1914 Class. Twelve nurses received diplomas. Dr. J. H. Nichols, superintendent of the infirmary, made an ex-

cellent address, and presented the diplomas. L. E. McEachern, R.N., superintendent of nurses, presented the school pins. A reception and dance followed.

The Waltham nurses have won their contention with the Massachusetts State Nurses' Association, and will now have the privilege of becoming members of the Association if they so desire.



Connecticut

The Connecticut State League of Nursing Education held its December meeting in the Nurses' residence of the Bridgeport Hospital, Bridgeport, the president, Miss Evelyn M. Wilson, in the chair. There were twenty-five members present and seven new members were admitted. The present officers were elected for the coming year. It was voted to hold the May meeting in Waterbury, May 5, 1915, the same day of the meeting of the Graduate Nurses' Association in Waterbury. Miss R. Inde Albaugh, as chairman of the legislative committee, brought before the meeting the advisability of an amendment to the State Bill of 1905. A lengthy discussion was held, resulting in a decision that the amendment was much needed and would be a help to the schools. Mrs. Hart gave an interesting talk on the dental work being done in the Bridgeport public schools. At the close of the meeting refreshments were served. Miss Oliver, superintendent of nurses, invited inspection of the new nurses' residence, which is a delightful home, the result of much thought for the comfort of the nurses. The new maternity building was also inspected, and everybody felt well repaid for the time spent.

The February meeting of the Nurses' Alumnae Association of Grace Hospital, New Haven, was an open meeting and no business was transacted. In spite of a severe storm the afternoon was enjoyed by many members and their guests. A delightful program of vocal and instrumental music and readings was arranged by the social committee. An interesting talk was given by Miss Dick, after which luncheon was served around the open fire.



New York

The Women's Auxiliary of the New York Polyclinic Hospital and Medical School, New York City, has taken possession of the building at 347 West Fiftieth Street, adjoining the hospital, and begun its conversion to a home for nurses. The

home will provide living quarters and instruction for eighty nurses of the Polyclinic Hospital. It will be ready for use April 1.

The Nurses' Alumnae Association of St. Mary's Hospital Training School at Rochester, N. Y., reorganized on January 31, 1915. Sister Mary Gertrude, the honorable president, gave an interesting address on the necessity of the Association. Officers were elected as follows: Honorable president, Sister Mary Gertrude; president, Miss Richardson; secretary, Miss M. Walsh; treasurer reelected, Miss A. Cahaley. Also an arrangement committee for a banquet to be held in the near future. About thirty members were present and an interesting afternoon spent by all.

The nurses in training of Har Moriah Hospital, New York, gave a masquerade and Valentine dance, on February 12, at St. Marks Mansion. Prizes were awarded to the most attractive masqueraders.

A joint meeting of the New York County Registered Nurses' Association with the League for Nursing Education was held at Osborne Hall, 426 East Twenty-sixth Street, New York City, Tuesday, January 5, 1915, at 8 P.M.

Mrs. F. F. Fehr presided at the meeting of the Nurses' Association of Buffalo February 2, when plans were discussed for the banquet held at the Hotel Statler, Monday evening, February 8, at 7:30 o'clock. Four letters were read from Buffalo nurses doing Red Cross work in England and Germany. Miss McKenna gave a talk on "Personal Experiences In and Around the War Zone, Leading to the Subject of Woman Suffrage." Tea was served after the program by Mrs. Bain and Miss Cronster.



New Jersey

At a meeting of the Nurses' Alumnae Association of the Cooper Hospital, Camden, the following resolutions were adopted:

WHEREAS, God in His own wise providence having seen fit to remove from this life our good friend, Emma Steelman,

BE IT RESOLVED, That we, the members of the Cooper Hospital Nurses' Alumnae Association, do hereby publicly announce with deep regret the loss of such a worthy, intelligent member of the profession, who was faithful and attentive to her duties at all times and in all places. A friend of all and greatly beloved by her fellow nurses and

patients, her death is certainly a great loss to us and to the profession.

BE IT FURTHER RESOLVED, that a copy of this resolution and statement be published in THE TRAINED NURSE and spread upon the minutes of the Association.

(Signed) ELLA S. MICHAELS,
MARY J. LENNOX.



Pennsylvania

The regular monthly meeting of the Alumnae Association of the Philadelphia General Hospital Training School was held at the County Nurses' Club, 1520 Arch Street, on February 1. In spite of the inclement weather twenty-eight members responded to roll call. The minutes of the previous meeting were read and approved and the treasurer's report referred to the auditing committee. A reception was held at the Philadelphia General Hospital on January 14, to meet the new chief nurse, Miss S. Lillian Clayton. The invitations were extended to senior physicians connected with the hospital, heads of training schools and graduate nurses of the Philadelphia General Hospital. Miss Roberta M. West, Miss Marion E. Smith and Miss Ella Phillips Crandall, with the officers of the Alumnae, received the guests. Coffee, cake and ice cream were served. The attendance was large and the affair thoroughly enjoyed by all. The arrangement committee received a vote of thanks for its management of the reception. The reports of the special and standing committees were received favorably. The Association voted to accept Miss Clayton's invitation to hold the future meetings at the Nurses' Home of the Hospital. It was decided to again join the Parliamentary Law Class, to be given at the Nurses' Club House this year. Several slight changes were made in the by-laws. Five new members were received. Refreshments were served. On motion adjourned.

The semi-annual meeting of the Adrian Hospital Nurses' Alumnae was held in the parlors of the Adrian Hospital, Punxsutawney, Wednesday afternoon, January 6, 1915. The meeting was called to order by the president. Ten members responded to the roll call. After the business session the following officers were elected for the ensuing year: President, Miss L. M. Clark; vice-president, Miss Stevenson; recording secretary, Miss Anna Hunger; treasurer, Miss Blanche Harding. After the adjournment of the meeting the nurses enjoyed a social time and later were served a delightful lunch by the superintendent

of nurses. In August, 1914, the Alumnae held a picnic—the object of which was to bring the nurses together and arouse their interest; while they are widely scattered, those of us who are near should at least make the effort to be present at these meetings, as your cooperation is needed. It is hoped that the year 1915 will show an increased interest.

The nurses of the Dixmont State Hospital gave a party and dance on January 28 for the affiliating nurses who left for Gouverneur Hospital, New York, January 30, 1915, to commence their nine months' course. The freshmen acted as ushers. The decorations were in green and pink, ferns and roses being used. Toerge Orchestra, of Pittsburgh, furnished the music.

The Alumnae Association of the Harrisburg Hospital held their monthly meeting February 4, with sixteen nurses in attendance. After a business session a progressive "Five Hundred" party was given, after which refreshments were served. The officers of this Association are greatly pleased with the interest manifested by the nurses.

The State Board examination for registration of nurses was held at the Warren State Hospital, Warren, Pa. Twelve graduate nurses from the Warren State Hospital were successful in passing the examination. The following graduates of the Warren State Hospital are taking post-graduate courses: Misses Maud Ward, Pauline Stannard, Helen Dasen, Grace Cornell, Bellevue Training School for Nurses, New York; Misses Sara Fausnaught, Gladys McQuisten, Dorcas Moore, Margaret McGlaughlin, Illinois Training School for Nurses, Chicago, Ill.

The Nurses' Alumnae Association of the York Hospital held its monthly meeting in the parlors of the Nurses' Home, Saturday, January 16, at 3 P.M. There was a full attendance. Miss Ethel Cox, of Harrisburg, and graduate of Bayonne Hospital and Dispensary, Bayonne, N. J., has accepted the position of head nurse of one of the wards of the York Hospital, and assumed her duties January 1, 1915.

The following rules for graduate nurses on special duty have been approved by the directors of the York Hospital:

Immediately upon entering the hospital, the nurse who has been called for a case will report to the superintendent.

Graduate nurses will wear uniforms when on duty in the hospital.

Graduate nurses will wear rubber heels in the hospital and will not be permitted to go on duty without them. Graduate nurses, when leaving the room of the patient at night, will be dressed sufficiently to appear in public.

The nurse will be required to carry meals from the serving kitchen to her patient, and to return the used tray promptly after the meal is over. She will be required to wash all dishes or utensils she has occasion to use, except for the regular meals, and to return them to their proper places on the shelves. The nurse will be expected to keep her patient's room in a clean and orderly condition. It is an important part of the duty of the graduate nurse to make her patient comfortable, mentally as well as physically, and to see that the patient's relatives and friends are pleased with the institution and its services. It is also her duty not to allow loud talking in her patient's room.

The graduate nurse is understood to enter the service of nursing in the hospital with a full knowledge of its rules in all departments, and of the technique of all nursing procedure, and to have accepted the responsibility of conforming to them. She will nurse her patient according to the methods of the institution in all its details, unless ordered otherwise by the attending physician.

The nurse will take orders for her patient from the attending physician in the case or, in case of emergency, from the interne on the service, whose orders are written in ink. If for any reason the orders cannot be carried out precisely as given, she will immediately communicate with the physician. If she cannot reach the physician, she will lay the difficulty before the superintendent or her assistant, and thus place responsibility where it belongs, whether on the physician or the nursing representatives of the hospital.

Graduate nurses on duty in the hospital are expressly forbidden to eat in their patient's room, or to order any food except for their patient's use.

Graduate nurses will not be permitted to visit in any part of the hospital, except where their duty lies, except with the explicit consent of the superintendent in each instance or in case of extreme emergency.

Graduate nurses will be expected to report all breakage and damage to the hospital property immediately on their occurrence, and to pay for the same unless payment is waived by the superintendent of the hospital in each case. Failure or refusal to pay for same on demand will subject the

offender to immediate dismissal from the institution, and she will not again be permitted to nurse in the hospital unless the amount has been paid. The hospital declines to collect fees for graduate nurses and will, under no circumstances, assume responsibility for same. The institution business office will at any time be pleased to give the special nurse any information in its possession, but declines to be held responsible for the correctness of said information.

The hospital, as an accommodation, provides board for the graduate special nurses on duty, then charging the cost of same against her patient, but the institution will, under no consideration, undertake to furnish special diet for nurses on duty.

Graduate nurses shall have use of the telephone only in conversing with the attending physician, unless otherwise permitted by the superintendent or her assistant.

Sleeping requirements and the place of sleep for the graduate nurses shall be prescribed by the superintendent or assistant, as may be required. No cots will be furnished nurses.

Graduate nurses are positively forbidden to enter the main diet kitchen, unless permission is granted by the superintendent or assistant. They are also forbidden to eat in the diet kitchen, or do any cooking there, unless same is for patient.

If a graduate nurse becomes disloyal to the management of this institution she renders herself liable to dismissal from the hospital by the superintendent.

Repeated or flagrant violations of these rules will subject the offender to dismissal and to refusal of further employment in this institution.



District of Columbia

The Nurses' Examining Board of the District of Columbia will hold an examination for registration of nurses, Wednesday, May 12, 1915. Applications must be made before April 28, 1915, to Helen W. Gardner, R.N., Secretary, 1337 K Street.



Virginia

STATE BOARD EXAMINATION

Anatomy—1. Name the covering of bone and state its function. 2. How do fractures in the young differ from fractures in the aged? 3. (a) Name the two classes into which muscles are divided. (b) How are muscles attached to the skeleton? 4. Name the organs in the (a) thoracic cavity; (b) abdominal cavity; (c) pelvic cavity. 5. By what name is the fifth cranial nerve known? Give a brief description of it.

Physiology—1. What is the special function of the lymphatic glands? 2. What is the source of bile, and what are two of its functions? 3. What action does oxygen have on the blood? 4. In how many and in what ways are the waste products eliminated from the body? 5. Why is the care of the teeth important? 6. Where would you make pressure on a lacerated limb if an artery were severed? Why? 7. (a) Where are mucous membranes found? (b) Serous? (c) Synovial? 8. Name the divisions of the alimentary tract. 9. Name two diseases that would indicate an inflamed condition of the intestinal tract. 10. What important openings does the stomach contain?

Hygiene—1. What is meant by (a) public hygiene; (b) personal hygiene? 2. Outline a plan, briefly, but not omitting any essential point, for the proper disposal of the excreta of a small general hospital. (Proper sewerage is assumed, and garbage or trash is not referred to, but all forms of bodily discharges and dressings, etc.) 3. What is the object of ventilation? (b) Describe some simple methods of ventilating a sick-room where patent appliances are not available. 4. Give a reliable disinfectant for each of the following, and state exactly how each is to be used: (a) typhoid stools; (b) bed clothing from a case of typhoid; (c) tuberculosis sputum. 5. What is the actual value of dishes of a germicidal solution placed about a sick-room? 6. Why should the room of a malarial patient be screened? 7. Is night air dangerous? Give one good reason for the view formerly held. 8. Give two diseases spread exclusively by insects and the names of the latter. 9. Give two diseases caused by (a) water; (b) milk; (c) flies. 10. What general and special hygienic precautions should be observed by nurses, during their training and while practising their profession, in order to preserve their own health?

Bacteriology—1. What are bacteria? Name and describe the three important groups into which they are divided according to shape. 2. In what branch of her work is a nurse's relation to bacteriology most emphasized, and why? 3. What is the difference between ordinary cleanliness and what is called "surgical cleanliness"? 4. Name three diseases caused by bacteria. 5. What is meant by (a) "a positive culture"? (b) "Culture media"? 6. (a) What are spores? (b) What bearing have they on sterilization? 7. Define: pathogenic; anerobic; pyogenic; saprophytic; pasteurization. 8. What is the cause of malaria?

Dietetics—1. (a) Name three foods we get our proteins from; (b) three carbohydrates; (c) three fats. 2. (a) What do the proteins supply our body with? (b) Carbohydrates? (c) Fats? (d) Mineral matter? (e) Water? 3. What is modified milk? (b) What utensils would you have and how would you proceed to modify milk? (c) How do you get "top milk"? 4. (a) Give some of the foods you would give a chronic diabetic patient. (b) Some you would avoid. 5. Give a typical light diet; (b) soft diet; (c) full diet. 6. (a) How do you make a cup of tea? (b) Coffee? (c) Cocoa? (d) Albumin? 7. Give recipe for making soft batter bread.

Medical Nursing—1. (a) Describe the appearance of a patient suffering from apoplexy. (b)

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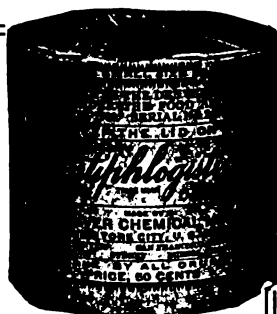
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Alcoholism. (c) **Convulsions.** 2. Describe in detail the preparation and giving of a bed bath and the changing of the linen. 3. State the most important point in nursing tuberculosis in regard to both patient and public. 4. Give two causes of abscess following hypodermic injection, and treatment to guard against them. 5. What immediate precautions against infection would you take in animal and insect bites? 6. In what stage of typhoid fever are hemorrhages likely to occur, and what should a nurse do until she can get a doctor? 7. Give treatment for packed rectum. 8. (a) What are frequent complications of diphtheria? (b) Typhoid fever? (c) Measles? 9. What relative proportions of oxygen and nitrogen is so-called "pure air"? 10. State simple means you would use to check vomiting.

Materia Medica—1. Define: (a) anodyne; (b) hypnotic; (c) physiological action. 2. What do the following abbreviations stand for: t.i.d., p.c., a.c., p.r.n., tr., ung., gtts., and q.s.? 3. Name two emetics easily procured in a household. 4. (a) How is a solution of corrosive sublimate 1-500 made? (b) A 5 per cent. solution of carbolic acid? 5. By what method would you get the quickest action of a drug? 6. Name and give usual dose of each of the following: (a) narcotic; (b) hypnotic; (c) heart stimulant. 7. Give common uses for the following: (a) oleum tigllii; (b) oleum terebinthina; (c) oleum ricini. 8. (a) Give dose of Croton oil, and how best to administer it. (b) Tincture of iron. 9. (a) Name a drug that causes dilation of the pupil of the eye. (b) Contraction of the pupil. 10. Name symptoms of opium poisoning.

Obstetrics—1. Give usual method of calculating date of labor. 2. What are the most common complications of pregnancy and their causes? 3. What are the symptoms of (a) toxemia? (b) eclampsia? (c) abortion? 4. Describe briefly the different stages of labor. 5. How should the nurse proceed when the doctor does not arrive in time for the delivery? 6. Describe the infant's first bath, including care of the eyes. 7. What do you consider the best method of caring for the cord? 8. Why is it so important to watch for any abnormal conditions of infant's stools? 9. (a) What is the name for the first intestinal discharge after birth? (b) How soon should the character of the stool change? (c) What should be the character of stool after that first intestinal discharge? 10. Define: embryo; fetus; parturition; colostrum; primipara.

Contagious and Infectious Diseases—1. In typhoid fever give the general rules for disinfection of: (a) Discharges and excreta; (b) linen; (c) utensils; (d) nurse's hands. 2. What disposition should be made of excreta in typhoid fever where there is no sewerage? 3. Differentiate between the throat in tonsilitis and diphtheria. 4. Give in detail the preparation of a patient prior to his release from quarantine. 5. (a) Name three contagious diseases most common among children. (b) What symptoms in each will you first see? (c) Give time of incubation. (d) At what stage of the disease is each most frequently communicated?

Surgical Nursing, Including Gynecology—1. Give in detail the post-operative care of perineorrhaphy. 2. (a) What unfavorable symptoms

would you watch for following an abdominal operation? (b) Give the significance of each. 3. (a) What are the symptoms of fracture? (b) Give five different forms of fracture, describing each. 4. When a doctor wishes to apply a Buck's extension, what appliances should the nurse have at the bedside for his use? 5. Describe the various positions for pelvic examination. 6. Define: dysmenorrhea; salpingitis; osteomyelitis; phlebitis; menopause.

Diseases of Children—1. What are the main points of difference in the nursing of children and the nursing of adults. 2. (a) What is the average normal weight at birth and the rate of increase for the first year? (b) How many milk teeth are there and at what age should they all have appeared? (c) The permanent teeth? (d) At about what age does childhood end? 3. What type of disease is most common during (a) the first three years of life? (b) Between the ages of three and twelve? 4. (a) What may convulsions in children indicate? (b) What treatment may a nurse give in the absence of a physician? 5. How should a nurse properly reply when told that it "is a good thing for children to have all the contagious diseases while they are young." 6. Give the correct names for the two diseases commonly called "true" and "false" croup. What is the now accepted treatment for the former? 7. What two diseases are frequently followed by suppurative otitis media? Why is this so dangerous? 8. What is pediculosis and how should it be treated? 9. What is the real cause of the bad symptoms so often ascribed to "teething"? What simple treatment may a nurse give? 10. (a) At what season of the year is infant mortality highest and why? (b) How may this be lessened or prevented? 11. Define: marasmus, incubation, congenital, tenesmus, pertussis, enterocolitis, chorea, parotitis, orthopedic, ophthalmia neonatorum.

Urinalysis—1. What particulars should be noticed in the examination of urine? 2. What is the average capacity of the adult bladder? 3. What is normal specific gravity of urine? 4. Give a test for albumin in the urine. 5. What is the condition of urine in an acute case of Bright's disease. 6. (a) Give a test for acid in urine. (b) Alkaline. 7. What causes cystitis? 8. Why is diet of special importance in diabetes mellitus? 9. What is the normal amount of urine voided in twenty-four hours? 10. What is urine?

Nursing Ethics—1. Why should you join your State Association? 2. Tell what you know about your State law on nursing. 3. Name two national nurses' organizations. 4. What qualities do you think a nurse should cultivate to become a successful head nurse? 5. If you were nursing a very unruly child, and the mother did not require the necessary discipline, what would you do? 6. If you were called on a case by the family and you knew the doctor did not care for you, what would you do? 7. If a patient took a dislike to you for some unknown reason, what would you do?



Florida

An organization of the graduate nurses of Tampa was formed recently under the name of

In Gastro-Intestinal Catarrh

—and other affections of the stomach and bowels characterized by muscular weakness and glandular insufficiency—there is no remedy more prompt and effective in its action than

Gray's Glycerine Tonic Comp.

Under its systematic administration the appetite is restored, the alimentary processes greatly improved, the nutrition promoted and every vital function throughout the body given a new and substantial impetus. As the digestive and assimilative functions are restored to their normal efficiency, a notable increase in the restorative and recuperative powers of the body naturally follow.

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Theoretical and practical instruction, Lectures, Quizzes, and Demonstrations on Anatomy, Physiology, Pathology, Hygiene, Theory of Massage and Gymnastics, Hydro- and Electro-Therapy, by members of the staff and invited physicians. Abundant clinical material. Students attend clinics at several city hospitals. Hospital positions secured after graduation. Separate male and female classes. Diploma. Particulars and illustrated prospectus upon request.

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MAX J. WALTER, M.D., Supt.

the Graduate Nurses' Association of Tampa, Florida, and it already has an enrollment of forty-one active members and five honorary members. The meetings, which are held on the first Monday of each month at the Gordon Kellar Hospital, have been well attended and great interest has been manifested in the work being done. While the organization is a young one, it has already considered a number of moves for the benefit of the nurses of the city, and has established a central registry in charge of Miss Margaret Snyder, a graduate of the J. H. S. H. Hospital, of Brantford, Ontario. Owing to the fact that Tampa has a large tourist population, this is a field for the transient nurses, and the Association is composed of members from various training schools throughout the United States and Canada. The officers of the Association are: President, Miss Lila Zinck; vice-president, Miss Nona Prewitt; second vice-president, Miss Martha Snyder; third vice-president, Miss Marcia Jones; treasurer, Miss Margaret Snyder; secretary, Miss Grace Ballard; press reporter, Miss Olive E. McMullen. The committees appointed are as follows: Credential, chairman, Olive E. McMullen; entertainment, chairman, Martha Snyder; program, chairman, Miss Ida M. Tracey. The Association anticipates many interesting and beneficial meetings.



Michigan

The annual meeting of the Nurses' Alumnae Association of Mercy Hospital, Cadillac, was held at the hospital on January 12, 1915. Officers were elected for the ensuing year as follows: Miss Margaret Barry was elected president; Mrs. John Knauf, vice-president; Miss Eva M. Carey, secretary; Miss Adele La Bourselier, treasurer. After the business meeting the annual banquet followed.



Minnesota

The Nurses' Alumnae Association of Northwestern Hospital, Moorhead, Minn., held its first annual meeting January 12, 1915, at the hospital. Miss Selma Johanson, president; Mrs. A. N. Axness, vice-president; Miss Mildred McCarthy, treasurer and secretary. The president appointed a ring committee, which will meet later. Refreshments were served in the hospital dining room after adjournment.



Nebraska

The Nebraska State Nurses' Association met in an all-day session at the Lincoln Hotel January 12, the morning session being devoted to busi-

ness, while the afternoon was given over to a program. There was a good attendance, about sixty nurses. The invitation coming from the State Hospital at Norfolk to hold the spring session on April 20 as the guests of the Norfolk nurses was accepted unanimously. Other invitations came from Fremont and Seward. A bill will be introduced in the legislature increasing the requirements of a graduate nurse, with the object of demanding higher efficiency and in order to keep in line with other States which have similar laws. Miss Gertrude Keating, of Omaha, has been engaged by the Association to remain in Lincoln and work for the bill. At the afternoon session the principal talk was given by Miss Renie B. Stern, of Chicago. She told of the work of nurses in the large cities, and especially along commercial and mental hygienic lines. Miss Stern is librarian of the School of Civics and Philosophy of Chicago. Dr. Ralph Knight, the school physician of Lincoln, had for his subject: "The Nature of Health Work in the Schools and the Extent to Which It Should Be Carried." He expressed the opinion that before many years the services of trained nurses would be used in inspection of social conditions in many small towns and throughout counties where they are now practically unknown. He devoted considerable time to explain how teachers and nurses could discover first symptoms of ailments and diseases in children. Miss Katherine Wollgast, who is engaged as a nurse in Lincoln under the direction of the city schools' physicians, told of her work among the people, how she is privileged to enter the homes and aid in nursing or instructing others how to care for the sick. The afternoon session was interspersed with musical selections by Mrs. Clarence Emerson, Miss Leota Furgason and Miss Frances Caldwell.



Washington

The fine new Pierce County Hospital was opened to the public in January. The County Nurses' Association has furnished one room, which is of sufficient dimensions to accommodate two beds. As a special favor the nurses were allowed to make the selection of the room, which is one of the most desirable; it has a balcony designed to be used as a sleeping porch. The Association is in a flourishing condition, with an increasing membership.

The regular monthly meeting of the Hospital Superintendents' Society was held January 13 at the Swedish Hospital, Seattle. Interesting reports from the various committees were received.

Food Values

Wheat and barley supply a very great proportion of the food elements necessary for the human body.

The only resistant factor to be considered in the digestive process is the starch element which they contain.

Starch in most foods causes the greatest amount of digestive disturbance, particularly where there is a tendency to, or an existence of, impaired digestive function.

It is self-evident that a convalescent, an anemic, or any under-nourished individual cannot exert sufficient digestive energy to vitalize ordinary food.

Given a cereal food in which the starch elements have been converted, in the manufacture, into dextrin and maltose, you have an ideal food—easily digestible and quickly assimilable.

Such an ideal cereal food is

Grape-Nuts

eaten with cream or good milk.

Grape-Nuts is made of wheat and barley—digests in about one hour, and supplies the food values required by the body. It is rich in phosphates, calcium, iron, etc., all of which are valuable for tissue repair, and furnish the health-giving and strengthening sinews to the human economy.

“There’s a Reason” for Grape-Nuts

The *Clinical Record*, for Physician’s bedside use, together with samples of Instant Postum, Grape-Nuts and Post Toasties for personal and clinical examination, will be sent on request to any physician who has not yet received them.

Postum Cereal Co., Ltd., Battle Creek, Mich., U. S. A.

Personal

The District Nursing Association of Westchester County has recently appointed Miss Perkins to the nursing staff for the winter months. Miss Perkins' territory is the northeastern section of the county. Mrs. Louise Cunningham is in charge of the work of the other section of the county.

Miss Blanche Jones, formerly of Johns Hopkins Hospital, is in charge of the obstetrical ward of Hartford Hospital, Hartford, Conn.

Miss Esther N. Lincoln, Reading, Pa., a graduate of the Pennsylvania Orthopedic Institute, Philadelphia, Pa., has been placed in charge of the mechanical department at the Methodist-Episcopal Hospital, Brooklyn, N. Y. This department was formerly in charge of Miss Charlotte P. Moodie, also a graduate of the Pennsylvania Orthopedic Institute.

Miss Annie Jones, Wichita, Kan., a graduate of the Pennsylvania Orthopedic Institute, Philadelphia, has been engaged to teach massage and hydrotherapy to the nurses in training at the Wichita Hospital, Wichita, Kan.

Miss Jennie M. Smith, a graduate of the Taunton State Hospital, Taunton, Mass.; post-graduate of the Bellevue Hospital, New York, N. Y.; also a graduate of the Pennsylvania Orthopedic Institute, Philadelphia, has been engaged to give a course in massage to the nurses in training at the Mt. Sinai Hospital, Philadelphia; while the theoretical instruction will be given by Max J. Walter, M.D., superintendent of the Pennsylvania Orthopedic Institute.



Marriages

The marriage is announced of Anna Shirley Desjardins, R.N., Class of 1912, St. Mary's Hospital, Rochester, N. Y., to Dr. Albert J. Bergeron, of Quebec, Canada.

On January 7, in Ireland, Anna Zita Lynn, graduate of St. Francis Hospital Training School, Hartford, Conn., to Michael Francis Kelly. Mr. and Mrs. Kelly will live in Ballycastle, Mayo, Ireland.

On December 25, 1914, at Chester, S. C., by the Rev. A. D. P. Gilmore, Miss Nancy Lee Walkup and James M. Walker, of Pensacola, Fla. The bride was a member of the senior class of the Magdalene Hospital Training School for Nurses. Mr. and Mrs. Walker will make their home in Chester, S. C.

On December 28, 1914, Bessie Grant, graduate of Rebekah Hospital of St. Louis, to William McCluskey, of Taylorville, Ill.

On January 21, 1914, Emma C. Peschke, graduate of Rebekah Hospital of St. Louis, to James G. Hunt, of Ramsey, Ill.

On December 17, 1914, Celia M. Perry, Class 1908, Mt. Sinai Hospital Training School, New York, to Olin Volney Shepard. Mr. and Mrs. Shepard will make their home in Oswego.

On November 24, 1914, at her home in London, Ontario, Eva Elliot, graduate nurse of Mt. Sinai Hospital, New York, Class of 1907, to J. B. Wentworth.

On November 30, 1914, Annie Gause, graduate nurse of Mt. Sinai Hospital, New York, to Curtis Leo Old.

In January, 1915, at St. Patrick's Church, Dubuque, Iowa, Mary Hamilton, a graduate nurse of Mercy Hospital, to Vincent Welsh.

In January, 1915, at St. Patrick's Church, Norwich, Conn., Mary Irene Beswick to John F. McCarthy.

In January, 1915, at St. Mary's Star of the Sea Church, Branchdale, Pa., Margaret E. Reilly, graduate nurse of the Medico-Chi Hospital, Class of 1908, to John J. Doyle.

On February 1, 1915, at St. Patrick's Church, Brockton, Mass., Edith J. Cosgrove, graduate nurse of Brockton Hospital, Class of 1912, to Dr. J. J. Condrick.

On December 31, 1914, at the English Lutheran Church, San Bernardino, California, Rosalie de

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Supplied in 11-ounce bottles
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Prescribe original bottle to avoid
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In ANY form of DEVITALIZATION
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Pepto-Mangan (Gude)

Especially useful in

ANEMIA of All Varieties:

CHLOROSIS: AMENORRHEA:

BRIGHT'S DISEASE: CHOREA:

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MALNUTRITION: CONVALESCENCE:

As a GENERAL SYSTEMIC TONIC

After LA GRIPPE, TYPHOID, Etc.

DOSE: One tablespoonful after each meal.
Children in proportion.

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Our Bacteriological Wall Chart or our Differential Diagnosis Chart will be sent to any Physician upon request.

A Nourishing and Cooling Drink for the Sick

In convalescence, for weakness, nervousness or feverish conditions, Horsford's Acid Phosphate is safer, more palatable and more beneficial than lemonade or lime juice.

HORSFORD'S ACID PHOSPHATE

contains valuable nutrients—phosphates of calcium, sodium, magnesium and iron. It is, therefore, far superior to Dilute Phosphoric or other acids.

It is recommended especially for promoting digestion, strengthening the nervous system and in wasting diseases.

A teaspoonful in a glass of cold water
makes a most grateful beverage.

NURSES AND PHYSICIANS PLEASE WRITE FOR FREE SAMPLE.
RUMFORD CHEMICAL WORKS,

Providence, R. I.

When you write Advertisers, please mention THE TRAINED NURSE

Armond, graduate nurse of Phoenixville (Pa.) Hospital, to John A. Larson.

On February 2, 1915, at St. Peter's Cathedral, Scranton, Pa., Hannah A. Tighe, graduate nurse of St. Agnes Hospital, Philadelphia, to Edward L. Earling, of Butte, Mont.

On December 25, 1914, in Mt. Zion Lutheran Church, N. S., Pittsburgh, Pa., the Rev. J. Howard Worth officiating, Clara Amanda Ott to Jeremiah Clark Davis, of Meadville, Pa. The bride is a graduate of St. John's General Hospital Training School for Nurses, N. S., Pittsburgh, Pa., and previous to her marriage was employed as visiting nurse, Bureau of Child Welfare, Pittsburgh, Pa. Mr. and Mrs. Davis will make their home in Meadville, Pa.

On February 4, 1915, at St. Mary's Church, Kingston, N. Y., by the Rev. John J. Hickey, Anna Catherine Bell, graduate of the City Hospital, Kingston, N. Y., to William C. Hussey.



Births

On October 21, 1914, to Mr. and Mrs. Ira Greenberg (Sophie Rafelowitz) a son.

On October 23, 1914, to Mr. and Mrs. William Galanter (Clara Fogel) a daughter.



Deaths

In the death of Mr. John Parsons, on January 16, the hospital world has lost a friend, a generous donor and a man ever ready to help the sick, the suffering and those who worked for such. No nurse or physician ever sought his aid in vain, and his charities were many. The Woman's Hospital knew him for its president; the Cooper Union likewise. He was the first president of the General Memorial Hospital, incorporated in 1884 under the title of the New York Cancer Hospital, and held office until November, 1914, when he resigned. He founded the Vacation Home at Lenox, Mass., and, indeed, if one listed all his charities there would be room for but little else in this issue. A great man, a truly noble soldier of Christ, ever ready to see good, always loath to

see evil. Those of us who knew him are sad at heart, sad for ourselves, not for him. "He has fought the good fight; he has kept the faith."

On January 24, at Chicago, Ill., Margaret E. Johnstone, superintendent of nurses of St. Luke's Hospital. Miss Johnstone was a most well-beloved nurse, and men and women in all walks of life were deeply grieved to receive the news of her death. She had devoted twenty-three years of her life to the healing of the sick, and for the past twelve years had held the position of superintendent of nurses at St. Luke's.

On January 2, at the home of her sister, Putnam, Conn., Elizabeth Mitchell, a graduate nurse of the Rhode Island Hospital, Class of 1895, and of the Sloan Maternity Hospital. Miss Mitchell was a member of the Spanish-American War Nurses' Association and had seen service both in this country and the Philippines. She was also a member of the Army Nurse Reserve Corps and of the Red Cross.

On January 13, at the General Hospital, Rochester, N. Y., Gertrude Montford, Class of 1884, Bellevue Hospital. Miss Montford had had a varied experience in hospital and nursing work. She had been connected with the opening of a number of hospitals in different parts of the country, and in pioneer days was one of the nurses sent to St. Paul's House, Rome. She had been for two years past registrar of the Nurses' Central Directory, Rochester.

On February 9, 1915, at Fanny Allen Hospital, Burlington, Vt., Rev. Sister Sweeney, R.N., graduate of the Fanny Allen Hospital, Class of 1902.

On January 4, 1915, after undergoing a very serious operation at the Mt. Holly Hospital, Mount Holly, N. J., Emma Steelman, graduate of the Cooper Hospital Training School, Camden, N. J., Class of 1892. Miss Steelman was at one time head operating room nurse, and then night supervisor at the Cooper Hospital, Camden, N. J. For eight (8) years prior to her death she was visiting nurse at Mount Holly, N. J., where she was much beloved and highly esteemed for her ability and kindness.

The Use of Synol Soap by The Trained Nurse in Confinement Cases Must Appeal to Every Nurse

The disinfectant and antiseptic qualities of **Synol**, together with the pure vegetable oils entering into its composition, produce an ideal preparation for cleansing the parts and bathing the patient.

All drug stores carry **Synol** in stock. Get yourself a package for use with your next case.

A sample on request to the manufacturers

Johnson & Johnson

NEW BRUNSWICK, N. J.

FINE UNIFORMS



Faultless in Form, Fit, Finish and Fashion

Complete Outfits

DRESSES
CAPS

APRONS
BIBS

COLLARS
CUFFS

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HATS

SEND FOR CATALOG AA

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When you write Advertisers, please mention THE TRAINED NURSE

Book Reviews

Mental Medicine and Nursing. For use in training schools for nurses and in medical classes. Also a ready reference for the general practitioner. By Robert Howland Chase, A.M., M.D., physician-in-chief, Friends' Asylum for the Insane, Philadelphia, Pa.; late resident physician, State Hospital, Norristown, Pa.; member of the American Medico-Psychological Association; member of the Neurological and Psychiatric Societies, Philadelphia. Seventy-eight illustrations. Cloth, net, \$1.50. J. B. Lippincott Company, Philadelphia and London.

Dr. Chase has given to the public a book which is the result of years of care and study of the insane. It should be well received, not only in hospitals for the insane, but also as a text-book in general hospitals where the actual experience in mental cases is limited. The book is well printed on good paper, and is written in such a clear and concise way that the nurse in training, as well as the general practitioner, can readily understand all that is set forth. Dr. Chase, first of all, takes up the central nervous system and compares it in relation to the rest of the body to a horse and rider. The man on the horse's back governs and controls the horse. In like manner, the nervous system governs and controls every part of the body.

He then takes up insanity, with its causes and, of course, brings out the important fact that "heredity" is undoubtedly the most potent and important of all the causes of insanity. Alcohol, syphilis, age, etc., are all dwelt on as important causes of mental diseases.

In the chapter on general symptomatology, Dr. Chase gives some very good definitions and examples of the most common symptoms of insanity, such as delusions, illusions, hallucinations, disorientation, retardation of thought, etc. He then gives the various forms of insanity, with an excellent classification table which takes in the different forms of mental diseases. The book then assumes a more cheerful tone and the patient is observed from the physician's and the nurse's viewpoint. The treatment prescribed by the physician is given at some length, but, for the most part, is included in hydrotherapy, massage

and rest. The successful mental nurse, according to Dr. Chase, must be an all-around excellent nurse with the additional quality of being a mental companion. Diversional occupation as treatment for the insane is dwelt on, and the fact brought out clearly that any nurse who cares for these cases should possess some knowledge of industries and amusements in order to be successful.

The book is well indexed and the illustrations are exceedingly valuable to all who are interested in the study of nervous diseases.



Obstetrical Nursing. A Manual for Nurses and Students and Practitioners of Medicine. By Charles Sumner Bacon, Ph.B., M.D., professor of obstetrics, University of Illinois and the Chicago Polyclinic; medical director, Chicago Lying-In Hospital and Dispensary; attending obstetrician, University Chicago Polyclinic, Hernotin, German and Evangelical Deaconess Hospitals. 12mo, 355 pages, illustrated with 123 engravings. Cloth, \$2.00 net. Lea & Febiger, publishers, Philadelphia and New York, 1915.

Dr. Bacon's great experience and unusual opportunities for observation in the handling of obstetrical cases have enabled him to present concisely and yet with most painstaking fullness all the information needed by the nurse to achieve the success in this important field that is conditioned on a full understanding and complete grasp of the minor niceties as well as the fundamentals.

Indeed, as stated in the preface, the needs of medical student and practitioner have been kept in mind as well as those of the nurse. This is due as much to the author's belief that satisfactory results can only be obtained when the physician is fully posted on the approved minutiae of obstetrical nursing as to a realization that the exigencies of obstetrical practice may compel the nurse to act in place of the physician instead of as his assistant. Hence the section devoted to the handling of labor is more complete and detailed than might be expected in a work of this class.

(Continued in Publisher's Desk)

Be a Wise Woman! Get the Nemo Habit



World's Standard Corsets

The Nemo is the only Corset that has held its own during the last six months of war's depression.

It has been advertised and sold—has been bought and worn—while extreme styles have hesitated, halted and fallen down.

The demand for Nemo Corsets is today greater than ever before. Sales exceed even our vast output.

Of course there are good reasons for the triumph of the Nemo over the commercial

debacle, now happily disappearing.

The Nemo is now, and for some time has been, the only really staple line of corsets in the market.

Its makers have adhered to sensible designing, avoiding extreme and freakish effects, producing *real corsets* that perform their *natural functions*.

The Nemo has seen the absurd "corsetless" mode pass into oblivion, and is the first to give you

The New Military Shape For "Tailor-Mades"

This is the new silhouette which we predicted months ago. It isn't *our* fashion, though we "saw it first."

Get ready for your Spring gowns by selecting the Nemo Corset that we have designed for *your* figure. It will pay you to take the time for right selection and correct adjustment.

A Nemo for All

Self-Reducing, \$3 Up KopService, \$5 Up

Fashion-Service, \$3 Up

By the way, keep watch for the new Nemo "Fashion-Service" Corsets now coming into the market. Dainty, durable and economical.

SOLD EVERYWHERE

Nemo Hygienic-Fashion Institute, N. Y.

When you write Advertisers, please mention THE TRAINED NURSE

New Remedies and Appliances

Acne

And similar forms of skin eruptions are speedily cured by using Rainier Natural Soap. This soap is useful as a general cleanser, and also as a medicinal treatment. It deodorizes, disinfects and aseptifies. It cleanses the pores of the skin, removes pus, keeps the parts affected clean, and exerts a powerful healing and curative effect. It is a natural complexion soap and makes and keeps the skin healthy.

Rainier Natural Soap should be applied to the face or other parts in a thick lather at night before retiring and allowed to remain. In the morning wash with this soap, rinsing thoroughly. Repeat the treatment and continue to use this soap frequently. Do not use ordinary toilet soap of any kind. Do not use a sponge, wash-cloth or brush; apply Rainier Natural Soap with the hands only.



Sanatogen

When the question of a patient's diet is left to you, what is your favorite vehicle for protein? Protein the patient must have, and broths, teas, etc., contain almost none, while the protein of gelatine will not nourish.

Sanatogen is about 95 per cent. pure effective protein; the other 5 per cent. is a quickly assimilated salt of phosphorus, essential to furnish the nerve force that the patient must have to complete his convalescence.

There are full details in a booklet we have had written especially for you. A free copy awaits your order, together with sample of Sanatogen. The Bauer Chemical Company, New York City.



Freshen Up Yourself

You probably have been using Daggett & Ramsdell's Perfect Cold Cream in improving the appearance of your patients and as a soothing lubricant in cases of bed-sores.

Have you ever thought to use this delightful cold cream for yourself after a long, hard day? A gentle massage with Daggett & Ramsdell's Cold Cream will relax the tension and will greatly refresh you.

▶ Send for free sample tube which they offer in their advertisement.

A Unique Little Brochure

A unique little brochure (twenty-four pages) on "Clinical Symptomatology" has already been distributed to the medical profession by the Purdue Frederick Company, who prepare the well-known Gray's Glycerine Tonic Comp. This consists of a number of tables or charts giving the common or usual "symptom-complex" of each of sixty different diseases, and will prove of exceptional value for reference purposes. If any physician did not receive a copy of "Clinical Symptomatology" he can easily obtain a copy by addressing the Purdue Frederick Company, 135 Christopher Street, New York City.



Always To Be Relied Upon

In instances where the menstrual discharge is membranous or clotty in character, Ergoapiol (Smith) can be relied on to increase its fluidity and thus facilitate its passage from the uterine cavity.

Results are ordinarily most satisfactory when the preparation is administered in doses of one capsule four times a day before and during the menstrual flux.



Dr. Storm's Binder

It is hardly a stretch of imagination to speak of Dr. Storm's binder as an "old reliable." It is certainly so regarded by a large number of physicians in the city in which she is best known.

Such physicians at a distance who might like to know more of Dr. Storm's ability along this line should send for her booklet, which will tell what she can do for their patients, and at the same time show how she is regarded by those physicians who know her best.



In the Sick-room

In this room, where cleanliness is of first importance, Sulpho-Naphthol is invaluable. It destroys all disease germs or unpleasant odors and keeps the whole room hygienically clean. All clothing, linen, vessels or utensils used, as well as floors and woodwork, should be washed in a Sulpho-Naphthol solution.

GLYCO-THYMOLINE

(TRADE MARK)

FOR THE TREATMENT OF

*Congestion and Inflammation of Mucous
Membrane in All Parts of the Body*

SPECIAL OFFER (T. N.)

To any Nurse sending us this advertisement with
her professional card we will send free of all cost
one of our special bottles of Glyco-Thymoline

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KRESS & OWEN CO., 361-363 Pearl St., New York



*Over five feet tall, made of finely woven stockinet.
Is durable, water-proof and sanitary. Has copper
reservoir which has three tubes leading into it, cor-
responding in location and size to the urethral, vaginal,
and rectal passages.*

SPECIAL SIZES: Superintendents now using the adult
size, as illustrated above, will be glad to know that several
small models are now perfected, corresponding to a two-
month, four-month, one-year and four-year-old baby.

Train Your Nurses

Nurses *must* be trained. The nurse who has
had PRACTICE added to THEORY feels
a confidence in her first year's training. You
have always at hand the means of teaching
practice if your hospital is equipped with the

Chase HOSPITAL DOLL

This doll is to the Hospital Training School
for Nurses what the Laboratory is to the
Medical Student. In other words, the theory
of teaching by its use is converted into the
practical knowledge and manual dexterity
obtainable only by actual work.

The value of this substitute for a living
model is found in the many practical lessons
which can be taught in the class room, such
as handling patients, administering enema,
douching, probing in the ear and nose cavities
—in short, the complete care of the patient.

Send for particulars

M. J. CHASE, Pawtucket, R. I.

When you write Advertisers, please mention THE TRAINED NURSE

The Pneumonia Convalescent

While the course and progress of acute lobar pneumonia is short, sharp and decisive, the impression made upon the general vitality is often profound, and apparently out of proportion to the duration of the disease. Even the robust, sthenic patient is likely to emerge from the convalescent period with an embarrassed heart and general prostration. In such cases the convalescent should be closely watched and the heart and general vitality should be strengthened and supported, and this is especially true as applied to the patient who was more or less devitalized before the invasion of the disease. For the purpose indicated, strychnia is a veritable prop upon which the embarrassed heart and circulation can lean for strength and support. As a general revitalizing agent is also needed at this time, it is an excellent plan to order Pepto-Mangan (Gude), to which should be added the appropriate dose of strychnia, according to age, condition and indications. As a general tonic and bracer to the circulation, nervous system and the organism generally, this combination is most excellent.



Glyco-Thymoline in Tonsillitis

A local remedy must fill two requirements—it must be a detergent antiseptic and produce a degree of permanency of effect.

Glyco-Thymoline as a gargle, or used in an atomizer, produces excellent results. It rapidly relieves the dry, congested condition of the mucous membrane by its exosmotic action, and its anodyne effect is immediate and lasting.

Glyco-Thymoline is harmless, and if any is swallowed will produce a beneficial effect by breaking up any mucous plugs that may have gained access to the stomach.



Boremetine—A New Emetine Preparation for Pyorrhea

Every doctor and dentist in the United States should know about this new preparation for the local treatment of pyorrhea alveolaris. Boremetine is a one-half per cent. solution of emetine hydrochloride, together with boric acid, zinc sulphocarbolate and aromatics.

The emetine is amebicidal, the boric acid bactericidal, and the zinc sulphocarbolate astringent. These three drugs meet the three essential factors necessary for the successful treatment of pyorrhea. Boremetine should be used in every case, either alone or (in some severe cases) in associa-

tion with the subcutaneous injection of emetine hydrochloride (Abbott).

A special free booklet on "Pyorrhea Alveolaris: How to treat it successfully with Emetine" will be sent on request. Send for it today. The Abbott Alkaloidal Company, Chicago.



Dimazon Ointment

Dr. C. Decker, of the surgical section of St. Vincent's Hospital, Cologne, writing in the *Medizinische Klinik*, gives the following testimony regarding Dimazon Ointment:

"About six months ago I had placed at my disposal for experimental purposes a quantity of the Dimazon Ointment. I had an opportunity to apply this ointment in a large number of granulating wounds. Aside from many small wounds, simple traumatic wounds, burns, ulcers of the leg, I used it repeatedly for the large wound surfaces after amputations of the breast. In one case I was very much surprised to see how quickly the surface, about the size of the palm of the hand, which, to be sure, had been covered with small skin grafts, showed epithelialization. After a few days the wound was completely healed up. In a similar case, the healing process took a little longer, but I could observe from day to day how by means of the treatment with Dimazon the surface became covered with skin from the edge of the wound toward the center."



A Happy Thought

A prominent New York physician, in treating the many skin diseases which came before him, found that there was objection to ointments, lotions, liniments, etc., and a happy thought came to him one day to combine special healing and antiseptic qualities in a powder so fine as to be held by the pores of the skin, and thus readily impart its medication.

Thus was Comfort Powder discovered and used by this physician with great success for many years. It has since been quite materially improved and given to the general public, with the fac-simile signature of E. S. Sykes on every box.



Marble, Tile and Mosaic Floors

For scouring marble, tile, mosaic and terrazzo, dampen the surface to be cleaned. Sprinkle Wyandotte Detergent lightly; scrub well with brush or mop. Rinse with clean water and dry with mop or rag. Once thoroughly scoured, subsequent washings with the mop should be sufficient to keep them clean and sanitary.



A MISTAKE

To quote from an authority:

"In convalescence, acid jellies (orange, lemon, etc.) are of service as a pleasant supplement to the ordinary diet." And the writer goes on to say that extra nutriment can be added by combining with the jellies eggs and milk, as in Snow Pudding, Charlottes of various kinds, and Spanish Creams, all of which are attractive forms of invalid diet. The writer is referring to jellies which require laborious preparation.

The writer's mistake lies in overlooking the fact that

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A Monthly Magazine for Trained Nurses and Hospital Workers. Devoted to Trained Nursing in Private Practice and in the Hospitals of the Country

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THE TRAINED NURSE AND HOSPITAL REVIEW

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EMMA C. SEHL.

The Trained Nurse and Hospital Review

VOL. LIV

NEW YORK, APRIL, 1915

No. 4

Common-sense in Contagion*

MINNIE GOODNOW, R.N.

HUMANITY has ever been inclined to make a mystery of illness. In the childhood of the race men attributed their ills to evil spirits. Later they felt them to be sure proof of the anger of the gods. The whole subject of sickness and death has been surrounded with superstitions of one sort or another.

A surprising number of these superstitions survive at the present time. It may not be so surprising when one considers that most of the sciences did not exist a century ago, and that only a few generations have permitted their scholars to make investigations of the truths of life.

The time seems to have arrived at last, however, when our scientists may make as thorough investigation as they choose, and do some real thinking in regard to what they find. They are even allowed to think aloud and to put into practice what they think.

Yet we cannot quite get away from our superstitious fear of diseases which are "catching." There is a fascination about a person or a thing which can "do things" to you. And if that person or thing be insignificant in appearance the fascination is heightened. After all, we rather like mysteries. A germ which you cannot see is

vastly more interesting than a dagger which is visible. We find a good deal of satisfaction in letting our imagination run riot in the realm of the invisible. "Man's Invisible Foes" is a theme too thrilling to abandon.

Science and Superstitions—The scientists have spoiled a lot of our fun. They have also made us do a lot of work. It is so much easier and more interesting to blame Providence or the devil than it is to plan a sewage disposal plant. Christian Science and New Thought are nice to think about, but scrubbing your hands and boiling dishes three times a day are uninteresting.

But isn't it about time that we stopped our childish plays and went at these matters of life and death, of illness, and of uselessness, in a grown-up and sensible fashion? Isn't it time that we knew the facts and acted upon them, instead of wandering among a lot of theories and superstitions?

Suppose we abandon our love of mystery and replace it by a real, practical love of humanity. Suppose we "get down to brass tacks," even if we miss some of our accustomed entertainment in the clouds of fancy.

What Contagion Is—What are the things we have to deal with? Germs, otherwise plants so small that we must have a good microscope to see them. Parasites, otherwise animals equally small. Nothing more.

*This article was written at the suggestion of Mr. Edward F. Stevens, hospital architect, of Boston, who believes that we can apply in the home some of the hygienic precautions to avoid contagion that are applied in the modern hospital for communicable diseases.

Perfectly definite things, but troublesomely alive.

Each disease is due to a special germ, from which it grows, just as surely as turnips grow from turnip seed, or nasturtiums from nasturtium seed.

How Germs Grow—Right here let us pause and consider. Disease germs are mostly plants, and their conditions of growth and activity are almost exactly the same as those for larger plants. The seed must be sown in a suitable soil, must have warmth and moisture. Air is usually a secondary consideration with a germ.

How Diseases Thrive—To begin at the end, the human body, viewed as a residence for germs, is always warm and moist, presenting, therefore, proper conditions for them to thrive if once they get a start. It is not, luckily for us, always a good soil. Germs are rather particular about the place they live, and some of them prefer potato to flesh. Also, Mother Nature prefers us to be well, and has had arrangements made for attending to objectionable outsiders. If unwelcome germs come into her domain, she literally eats them alive. If she happens to be having internal dissensions at the time they come, or lacks a sufficient standing army, they may gain a foothold. In other words, healthy tissue is not a good soil for germs to grow in, the white blood corpuscles are continually killing them, and it is usually when we are a bit down in health, or we get too many germs at once, that they get a chance at us.

New and Startling Methods—The scientists are telling us some startling things these days about transmissible diseases. They tell us that some of the precautions which we take to avoid infection are good common-sense, but that others are more like a witch's incantation. How, then, are we to distinguish between the important and the useless?

A Visit to a Contagious Hospital—The up-to-date contagious hospital is a most en-

lightening place, since there you may see the new principles put into practice. Unfortunately, most of our contagious hospitals are old-fashioned and are not getting the results which the newer ones do.

Come with me to the Pasteur Institute of Paris, or to the City Hospital of Providence, R. I. Immediately I hear you say: "Go into a contagious hospital! Not on your life! They won't let you in, anyway."

But they do let you in, superstitions and all. They invite you in, and they guarantee your safety. The superintendent tells you: "My five-year-old boy has played for three years on a balcony fifteen feet from the diphtheria ward, yet has been perfectly well." We go about with him as if we were visiting an ordinary hospital. We see doctors coming and going in the usual way. We see nurses and servants working apparently as they do in other hospitals. We step into a room or ward containing a sick patient. Most startling of all, we observe a mother visiting her child and are told that she has other children at home. When we leave, we are sent to the station in the extremely good-looking, closed motor car which transports most of the patients from their homes to the hospital.

New Principles—Are all these people tempting Providence? Not at all. They are having fewer infections and altogether less trouble than the hospitals which carry out the elaborate precautions of a day that is past and which scare you into staying a mile from them.

The explanation is that these new style institutions have found out what the essentials are and are giving attention to them, having freed themselves from the burden of the non-essential.

What is the principle upon which they work? Simply that the sick person himself is the real source of danger, and that *infection occurs chiefly by contact*. Contact may be direct or indirect, but it is the direct which is most important.

What Contact Is—With this simple fact in mind, look about you again. The nurses and doctors touch the patients and their utensils as rarely as possible. The servants do not touch them at all. The visitors who are permitted are under supervision every moment, and may sit in a chair and talk with the patient, but never touch him. We ourselves are handling nothing.

This is a fundamental principle, to let things alone. It is our hands which most frequently get us into trouble. If a man remembers to keep his hands in his pockets, he runs very little risk of contracting a contagious disease while in the house with it. If a woman wears white gloves and refuses to soil them, she is pretty safe.

How the Thing Is Done—The doctors and nurses must handle these cases a good deal at times. When they do, they work as in a surgical operating room, making the handling as little as possible, and after it thoroughly scrubbing their hands. Merely washing them will not do. There must be a thorough removal of all the germs which may have been picked up. Plenty of soap, plenty of running water (for the germs must be washed off and stay off), and a clean, good brush for getting into the corners and under the nails must be used. They turn the water off and on with the foot or upper arm, because they must not handle the faucets and thereby infect them. (Observe closely and you will see that doors are usually left ajar, so that one need not touch the knob in going in and out.) Disinfection will not do. The scientists have condemned it as practically useless, besides giving a false sense of security. Mechanical removal of dirt of all sorts gives far better results and has no uncertainty about it provided it is thoroughly done.

Watch this nurse go into a patient's room. She comes in with medicine or food. She places it so that the patient may get it, watches him take it, but she does not touch the table nor him. She does not infect her-

self; therefore, she goes out without ceremony.

She comes in again. This time she must handle him. She puts on a gown which protects the front of her dress and her sleeves, does the work, scrubs her hands, takes off her gown and hangs it up in a certain way, so that the inside shall be clean though the outside is infected, scrubs her hands again, and leaves the room. She is not infected. She is clean, and she may go to any other patient with any other disease, or to her meals, or down-town, and be safe herself, nor run the risk of infecting others. Why not? She has done the things which she ought to have done and has left undone the things she ought not to have done. Whatever infection she got by contact with the patient she removed before she left his room.

The technique is very simple, much simpler than in the days of disinfection. It needs practice, to be sure, and there are details to be worked out in order to make it effective.

Now, how does this apply to us, the outsiders? In this way, that it is going to show us how to get away from our elaborate and, as we know, frequently useless precautions against contagion, and enable us to do the few simple essential things which we need to protect ourselves.

Doctors and Nurses—It is a well-known fact that doctors and nurses escape contagion more easily than the rest of us; yet they live and work in the midst of it, get tired out and run-down as well as the rest of us. Wherein lies the magic? Merely in the simple, uninteresting fact that they keep their hands away from things which contain germs, or if they are compelled to handle infection they remove it as promptly as possible.

Where the Germs Really Are—The thing which puzzles the layman is to know where the infectious material is. It is his bewilderment which makes him do the curious and elaborate things which he does to avoid infection, and then fall victim to it.

Let us try to reduce the matter to a few simple rules. In scarlet fever, diphtheria, measles, whooping-cough, mumps, pneumonia, grippe, tuberculosis, common cold, syphilis, avoid contact with any discharge which comes from the nose or mouth. Do not touch the patient's hands if he has had them about his mouth until he has thoroughly washed them. If you have touched any of these things, scrub your hands very thoroughly with soap and water, paying especial attention to the nails. All discharges should be received in something which can be burned promptly.

It is as well to take the same care about typhoid, as there may be some germs about the mouth. In chicken-pox, smallpox, erysipelas, the itch, do not handle the patient's skin or clothing and do not get against his bed or clothing. If you cannot avoid it, scrub your hands thoroughly. In typhoid, dysentery, gonorrhea, avoid the discharges from the patient's bowels or bladder, or any utensils which contain or have contained them. If you must handle them, scrub your hands well.

That is pretty nearly the whole story, except what common-sense will tell you in addition, that the above-mentioned things which are infected should be cleaned or destroyed before they are safe to use.

The Fallacy of Fumigation—Now comes simplicity again. We have for years heard about disinfecting and fumigating, and we have pinned our faith upon it. We have burned tons of sulphur, we have spent much

good money for elaborate devices for fumigating with formaldehyde gas. We have used carbolic, corrosive sublimate and all sorts of expensive and ill-smelling drugs, so as to be sure.

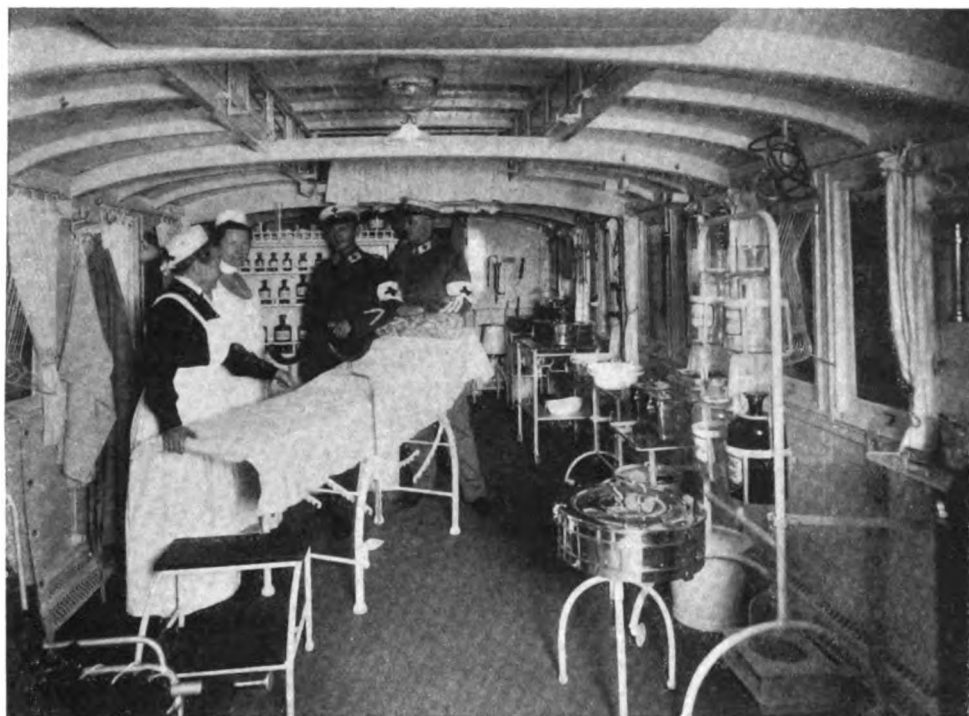
And now the wise men tell us that all these things are but so much incense burnt in superstition to the god of contagion, and are as useless as any other incense, nay, more useless, since they are not even symbolic any more. Our grandmothers used soap, water, sunshine and elbow-grease, and these are still the most effective things we have. The Mosaic law gives washing and a little lapse of time as the safeguards, and we are not yet in a position to dispute their efficacy.

Elaborate and Useless Precautions—In our exaggerated fear of germs, we have gone to foolish extremes, and have sometimes omitted the vital matters. Our boards of health, instead of telling us what to avoid in each case, have put us through an elaborate system of isolation and disinfection. And the worst of it is that the system has not worked out well. We continue to catch all sorts of diseases despite our precautions, a rather conclusive proof that there is something the matter with the precautions.

The matter is this: We have kept away from harmless things and taken into our bosom the dangerous ones. We have pinned our faith to fumigation, and neglected to wash our hands. We have blindly followed out a few meaningless precautions, and have not used our brains and common-sense.

(To be continued)





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THE PICTURE SHOWS THE OPERATING CAR OF A GERMAN HOSPITAL TRAIN—THE EQUIPMENT OF THESE TRAINS IS COMPLETE IN EVERY RESPECT AND THEY HAVE PRACTICALLY EVERY APPLIANCE OF WHICH MODERN SURGERY KNOWS

Medical Work in the War Zone

AS WAS announced in our March issue, Miss Katharine Lilly, head nurse of the department of surgery of the Rockefeller Institute for Medical Research, went with a detachment of nurses sent by the American Red Cross to the American Hospital at Yvetot.

Miss Lilly went to France for the especial purpose of assisting Dr. Alexis Carrel, of the Rockefeller Institute for Medical Research. Dr. Carrel now has been detached from work at the Lyons Hospital and placed by the French Government in charge of a hospital at Compiègne, which is near the northern line of battle.

For the use of the patients in charge of Dr. Carrel and his assistants, the Government has requisitioned a hotel which has

been converted into a hospital with accommodations for about one hundred persons. The Government will provide administrative officers as well as competent surgeons suggested by Dr. Carrel to carry on the regular work, thus leaving Dr. Carrel free to perform his characteristic operations, especially in the line of transplanting tissues, blood-vessels and nerves, and blood transfusion, and to conduct the laboratory studies which are about to be undertaken.

In order that the work under Dr. Carrel may not only be of the greatest effectiveness at the moment, but may be made permanently available to the world of science, the Rockefeller Institute is equipping Dr. Carrel's hospital with complete apparatus for research in the bacteriological, pathological,

chemical and surgical conditions which may arise.

Dr. Carrel, who was spending his vacation in France at the outbreak of the war, immediately offered his services to the French Government, which were accepted. He was detailed to the military hospital at Lyons, at which there were referred to him especially the wounded with injured blood-vessels and nerves, in view of the research work which he had done in these classes of injuries. From the application of the method which he discovered for suturing and transplanting blood-vessels and tissue, it was possible to save limbs which otherwise would have inevitably been lost. Dr. Carrel has now been given special facilities as near as possible to the line of battle, because of the unusual conditions which have developed in this conflict incident to trench warfare.

It had been supposed that all future wars would yield small numbers of infected wounds. The facts, however, are that no previous war has yielded such a large number of infected wounds as the present one.

The reasons for this under the old conditions are developed to be as follows: Poor hygienic facilities, infection of the wounds caused by the surgeons who carried the infecting germs on the operating instruments, dressings, etc., the introduction of infected material from without at the time of injury, were the sources of infection. In the present case the infections occur because the injured in trenches receive their injuries from missiles which carry dirt and soiled clothing into wounds, and also because in many cases it is days before the injured can be removed. The infections have also been of an unusual character. Formerly they were usually suppuration and pus formation. Now they are commonly due to the development of gas in the tissues and to tetanus or lockjaw.

This gas infection is very serious in form. It originates in bacteria of the soil, particularly soil which has been under a high state

of cultivation for a long period of years. The technological term applied to the condition is gaseous phlegmon. The bacteria which cause it do not grow except in the absence of atmospheric air, which the injured tissues provide. In their growth they break up the constituents of the tissues and impart a gas in which hydrogen forms a large part. This gas penetrates the tissues and carries the infected material further and further, and may penetrate into the blood, when it soon causes rapid death.

Hitherto this class of infection has been so rare that adequate means for its prevention and cure have hardly been worked out. It is in order that he might have access to this class of cases, now, unfortunately, so numerous, that Dr. Carrel has been transferred to the northern field of war. It is in order that, in addition to the regular routine work of the care of the wounded, he may study these infections especially, he is being provided by the Rockefeller Institute for Medical Research with the medical equipment requisite for this work.

In carrying out the enormous work incidental to military operations, one government alone could hardly undertake at this critical period to organize hospitals and laboratories for conducting research work. They must be quite content to deal with conditions as they arise. It is just there that Dr. Carrel's peculiar qualifications come in, and in that respect that the contribution of the Rockefeller Institute is largely made.

Hence it is that he is to have a staff consisting of bacteriologists, chemists and technicians, forming a laboratory unit in addition to the regular surgical unit of the hospital. He is fortunate in being joined by Dr. H. D. Dakin, who has been for many years in this country and has a distinguished reputation as a chemist. He has been assigned to take charge of the chemical part of this humane work of investigation.

The Rockefeller Foundation has just



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THE HOSPITAL TRAINS ARE EQUIPPED WITH CARS FOR THE COMFORT OF THE NURSES—HERE THEY CAN ATTEND TO THEIR PERSONAL MATTERS—THE PICTURE SHOWS GERMAN RED CROSS NURSES IN THE HOSPITAL CAR

voted an appropriation of \$20,000, to be used under the direction of the Rockefeller Institute, in furthering medical research work under war conditions.

The Institute has had many appeals made to it for serum for use in the treatment of meningitis and dysentery, and these serums have been distributed freely.

Members of the Mountainside Hospital Alumnæ Association, Montclair, N. J., at their regular meeting listened with eager interest to the reading of a letter from one of their members, Miss Mary D. Cox, who is now serving as a Red Cross nurse in Servia. The letter was addressed to Miss Mary M. Willer, president of the Association, and was undated, though evidently written after Christmas. Miss Cox, before leaving in November to enter the Red Cross service, was head nurse in the operating de-

partment of Mountainside Hospital. Miss Cox's letter is as follows:

"Servia is a country we of America know very little about. It is small—agricultural, chiefly—and the people a slow, law-abiding race, professing the orthodox Catholic faith, but harassed so by the other Balkan States that today, at the height of the third war in five years, it is at its worst. The Government is without money, and the soldiers, in consequence, wear shabby and insufficient clothing, the officers no shoes, and thousands are fighting in the suits they owned when they worked on their small farms. The soldiers are brave and good fighters—generous and humane.

"We arrived here three weeks ago, and began our duties at once. Two weeks before we reached this place an American doctor with his nurse-wife arrived from Chicago and took over the care of 2,000 wounded.

A factory run by the Sultan of Turkey, but abandoned after Servia's victory over the Turks two years ago, had been cleaned and converted into a hospital, or rather a shelter for the men who were suffering from exposure, hunger and neglect. The big battle in Belgrade had been won and every public building was full of wounded.

"Try to picture 2,000 lying on beds of straw on the floors of a dark, damp old shed. Half of the wounded were Austrians. The horrors you must wait to be told!

"We have worked hard, and will in another week move to a better building, properly cleaned and whitewashed, with a stool here and there, kerosene lamps, with orderlies (plenty of prisoners for that post) and beds for 250 of the acutely ill and seriously wounded. We expect no smallpox or cholera until the arrival of warm weather. We have sterilizers, a laboratory and X-ray machine, and will be prepared to do a great deal after the style of camp nursing, which differs greatly from that of Mountainside Hospital, which you can easily realize.

"Personally, the hardships are not easy to bear. I am selfish and feel keenly the loss of heat, light and other comforts. Water is as precious as alcohol is to the average hospital. We get enough to eat, and have now an army cot and tiny wood stove in our shelter in one of the sheds used by the Sultan as a storeroom for the special looms on which

silk was made for his harem. All about us are mulberry trees for the silkworms, silk-growing being one of the chief industries of the district. Snow-covered mountains close us in from all civilization, and we are totally ignorant of the doings of the great world. I have had no news yet from the United States, though, I suppose, letters have been sent. The letters just don't get through. You may notice that I have directed my letters to be sent 'care of American Consul at Salonique, Greece,' which may aid in their dispatch. The mail and news I really pine for—all the rest is what I expected, and even better, for we are safe and get food. The uncertainty was once a bit thrilling; you know the terrors we anticipate are often worse than the realities.

"To my dear friends I owe the sweetest memories for the interest, kindness and love shown before sailing. The affection displayed touched me more than you can know, and I cannot explain how good is the feeling as I often sit and rehearse in my mind all that was crowded into the few exciting hours before I sailed. I saved one orange from your basket for my Christmas. Besides the luxury of an orange I had the thought of a taste from home.

"On board ship we fared sumptuously and as far as possible we had every comfort; now, instead, we have the appreciation of these poor, miserable men, and the scenes are often very pathetic."



Eye Nursing

HENRY GLOVER LANGWORTHY, M.D.

Lecturer on Diseases of the Eye in St. Joseph's Mercy Hospital Training
School for Nurses, Dubuque, Iowa

The following articles, continued from time to time, cover the writer's lectures, quizzes and demonstrations given in the St. Joseph's Mercy Hospital Training School for Nurses, Dubuque, Iowa. The subject, as presented, is intended as a course of study for nurses in private work, as well as enabling those still in training to competently pass a hospital or State board examination. All material that is unnecessary and from a nurse's standpoint of little practical use has been eliminated. It has come to be so generally recognized that the favorable outcome or shortened duration of acute eye diseases or of operative cases so frequently depends upon an intelligent

carrying out of the doctor's orders that skilled specialty nursing is being rightfully placed upon a higher and higher plane.

The general synopsis of the course of study is as follows:

1. Handling of eyes in the hospital ward or private sick-room.
2. Principles of treatment in ocular therapeutics.
3. Common acute and chronic eye diseases (considered from a nurse's standpoint).
4. Eye operative nursing (preparation and care of operative cases).
5. Working (dioptric) system of eye.

PART I

HANDLING OF EYES IN THE HOSPITAL WARD OR PRIVATE SICK-ROOM

Practical Method for Examination of Lower Lid—Place thumb gently but firmly near the margin of the lower lid and pull the lid down, asking the patient at the same time to look upward toward the ceiling (Fig. 1). This will expose the inner or so-called conjunctival surface, which may be examined for undue redness, granular formations (follicular conjunctivitis and trachoma) and excessive secretion or discharge. In dropping eye solutions into the eye, also, the lower lid is pulled down in the same way and one drop of the medicated solution placed on the inside of the lid, where it is quickly dispersed about the eyeball by winking. (See, also, "Correct Method of Instilling Drops or Flushing Eye," as outlined farther on in the paper.)

Practical Method for Examination of Upper Lid—This is a little more difficult and will probably have to be practised several times before one can become at all proficient. While the nurse is hardly expected to evert or turn over the upper lid as a



FIG. 1—EXAMINATION OF LOWER LID

routine, she nevertheless should know something about it. The proper method of procedure is as follows: Direct the patient first to look down toward the floor, take hold of the eyelashes of the upper lid near the center, draw the lid gently downward, place the blunt end of a match or toothpick at a point on the middle of the broad lid surface (Fig. 2) and turn the lid back over it (Fig. 3). Cin-



FIG. 2—EXAMINATION OF THE UPPER LID: FIRST STAGE, SHOWING LID DRAWN DOWNWARD AND TOOTHPICK IN POSITION READY TO TURN

ders, sand, small bugs, etc., are the most frequent foreign bodies encountered lying out of sight beneath the upper lid.

Examination of Cornea and Anterior Surface of Eyeball—The cornea, the clear, transparent front coat of the eyeball which projects outward from the surrounding globe



FIG. 3—EXAMINATION OF UPPER LID: SECOND STAGE, SHOWING LID EVERTED OR TURNED OVER SO THAT THE UNDER (CONJUNCTIVAL SURFACE) IS EASILY SEEN

like a watch crystal from a watch, together with the surrounding white sclera, may be examined by merely separating the upper and lower lids with the fingers. When the eyeball is inflamed this procedure has to be done rather carefully, as the eye is sensitive to light and touch, and the patient's lids unconsciously rebel. In inflammation the usual white scleral coat surrounding the cornea is of varying degrees of redness (due to inflammation of the conjunctival vessels, invisible except where inflamed) and the cornea itself may be hazy or cloudy. A good light (as in front of a window) is essential for the first examination of the physician. Very frequently a small hand

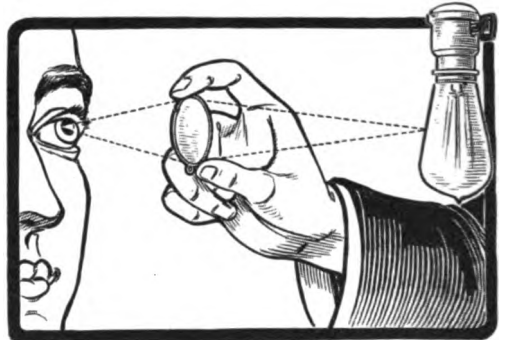


FIG. 4—PHYSICIAN'S SMALL LENS (CONDENSING LENS) FOR THROWING A BEAM OF LIGHT ON THE CORNEA TO SECURE BETTER ILLUMINATION

These glass "condensing" lenses (usually with 2-inch diameter and $2\frac{1}{4}$ -inch focus) are made either with a rubber ring to protect the surface of the glass as it lies on the treatment table or are deeply notched in two places for easy holding with the thumb and finger.

lens (Fig. 4) is used by the physician to throw a beam of light (oblique illumination) on the cornea in order to study not only the cornea but also the iris and pupil inside the eyeball. As a rule the nurse has little occasion to examine the anterior surface of the eye, except in the handling of pus cases, as most of the work will be confined to instilling drops of medicine as ordered. In actual cleansing or irrigating pus from the eyes, however, the lids are handled quite freely, as the pus must be washed out from underneath. (See also "Examination of Eyes in Infants.")



FIG. 5—PROPER METHOD FOR INSTILLING EYE DROPS OR FLUSHING EYE FREE FROM DISCHARGE

In instilling a single drop of a strong medicated solution of atropine sulphate one per cent., it is a good point to remember that if a pledget of cotton is held firmly against the inner angle of the eye at its junction with the nose for three or four minutes the drug solution will be prevented from making its way into the nasal cavity or naso-pharynx through the tear ducts and producing a dry mouth.

Correct Method of Instilling Drops or Flushing Eye—In instilling a drop of a medicated solution in the eye, such as, for instance, a cocaine 4 per cent. solution, atropine sulphate 1 per cent. solution, etc., never drop it directly on the cornea or eyeball from a distance, but pull down the lower lid, asking the patient at the same time to look upward toward the ceiling while the drop is being placed upon the inside of the lower lid (Fig. 5). By applying the drop in this manner it will not be attended with any discomfort or pain and will, moreover, prevent the patient from jumping unexpectedly. The medicated solution is quickly dispersed over the entire surface of the front of the eyeball by winking. A careful routine of this kind

will further prevent the possibility of strong medicines (such as atropine sulphate) from accidentally running down the cheek into the mouth. In flushing or irrigating a distinct or profuse discharge from the eye, the procedure is the same, also, as the foregoing, with the difference that a considerable quantity of fluid (such as saturated solution of boric acid, normal salt solution or clean warm water) is used and repeated as often as seems necessary to thoroughly cleanse the eyeball. By using a well-filled dropper of good size and allowing the fluid to run from the inner angle of the eye outward along the inner surface of the lower lid toward the temple (or vice versa) the surface of the globe may be systematically flushed clean. The overflow should be collected on a piece of dry absorbent cotton held at one corner of the eye. In "pus eyes" it is always wise to flush away from the nose toward the temple in order to avoid any chance of the discharge getting into the good eye and infecting it. Ordinarily it is more convenient, especially if the patient is sitting up, to allow the fluid to run naturally toward the nose. Frequently in difficult cases the nurse will find that better cleansing can be performed if the patient is lying flat on his back. Lid retractors (Fig. 6), where the lids are badly swollen, are used by the physician and the nurse to gently draw back the lids and inspect the globe.

Examination of Eyes in Infants—Lay the child upon its back in another nurse's lap, with the head toward the one who is to examine or treat the eyes. Its hands are to be held by an assistant nurse and its head steadied between the knees of the examiner (Fig. 7). By pulling the lids apart they

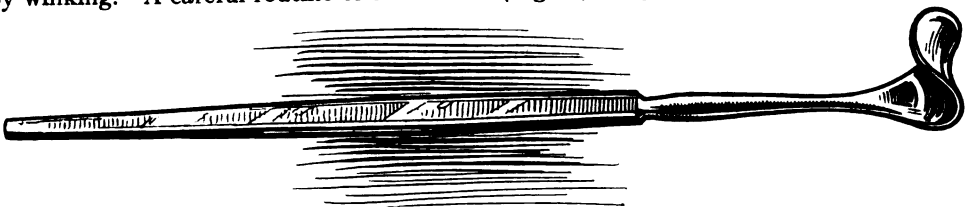


FIG. 6—LID RETRACTOR

may be washed out and inspected. Here, again, small lid retractors (Fig. 6) are usually necessary for examination, but should be used with caution, in order to avoid undue pressure on the eyeball. In examining a baby with "pus eyes," great care should be taken to avoid getting any of the infected material into one's own eyes. One should also bear in mind the possibilities of contaminated water or pus unexpectedly splashing or spurting upwards into the eyes at treatment time. A bowl of warm water, cotton wads or balls, eye-dropper and whatever medicines to be used should be conveniently at hand within easy reach. The best way to learn many of these special methods of examination and treatment in eye diseases is to watch the technic of the attending ophthalmologist or head nurse of the isolation (gonorrheal or ophthalmic) ward. (See also general consideration of "Purulent Conjunctivitis" to be considered in a later paper.)

Instruments and Materials Required by the Physician for Ordinary External Eye Examination and Treatment—1. Small bowl of either warm sterile salt solution, boric acid, or clean warm water. 2. Few cotton balls or jar of cotton, for wiping away secretions. 3. Two clean eye-droppers. 4. Small bottle



FIG. 7—EXAMINATION OF EYES IN INFANTS

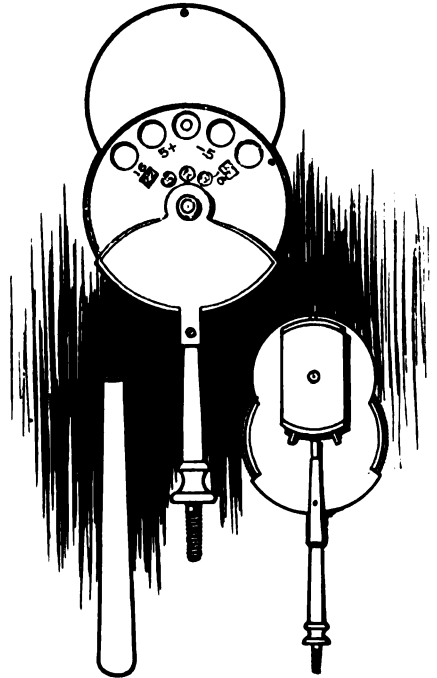


Fig. 8—OPHTHALMOSCOPE (Loring)

argyrol 15 per cent. or 25 per cent. solution. 5. Small bottle cocaine hydrochlorate 4 per cent. solution. 6. Small convex lens (Fig. 4) often used to throw a beam of light on the cornea to secure a better source of illumination in examining for small embedded foreign bodies. 7. Two clean towels. 8. Few toothpicks sometimes used by the physician in turning over the upper lid in order to examine the under surface for foreign bodies or inflammation of the conjunctiva. 9. Tube sterile white vaseline or jar of bichloride ointment 1-3000. 10. Small pan for collecting waste material.

In external eye inflammations the eye is usually treated by either dropping in eye medicines or placing an eye ointment underneath the lids. The nurse should aim to have most of the materials at hand ready for use when the oculist arrives. Special instruments and medicines will, of course, be brought by the physician himself. An external eye examination is usually performed by daylight, as, for instance, in front of a

window, with the patient seated in a chair, the materials to be used on a table close at hand. A chair or stool should also be provided for the attending physician. With a little previous thought the nurse, after reading the above instructions, should have no difficulty in supplying the average wants of the physician in treating his cases.

Instruments, Materials and Room Arrangement Necessary for Examination of the Interior of the Eye (Lens, Retina and Optic Nerve)

—1. Examination made by the physician in a darkened room under artificial illumination from an electric drop-light, large candle or good lamp. The light should be held at one side of the patient's head, a little behind and at about the level of the ear.

2. *Ophthalmoscope*—This instrument (Fig. 3) invented by Helmholtz, in 1851, consists of a small perforated mirror and a disc, containing a number of lenses (convex and concave) of different strengths, so arranged that the various lenses may be rotated over the sight-hole during the examination. The mirror reflects the light into the patient's

eye, while the aperture allows the returning rays to enter the eye of the examiner, and in this way renders the interior of the patient's eye clearly visible; indirect method of examination (Fig. 9); direct method of examination (Fig. 10). As an ophthalmoscope is one of the common instruments used in eye work the nurse should be able to



FIG. 10—DIRECT METHOD OF EXAMINATION OF THE INTERIOR OR FUNDUS OF THE EYE—PHYSICIAN APPROACHING AS CLOSE AS POSSIBLE AND LOOKING DIRECTLY INTO THE EYE THROUGH A DILATED PUPIL WITHOUT THE USE OF THE "OBJECT LENS"—THE EXAMINATION IS CARRIED OUT IN THE "DARK ROOM."

By this method—*direct method*—the various parts of the interior of the eye are seen in their natural position.



FIG. 9—POSITION OF PATIENT AND LIGHT IN A DARKENED ROOM FOR PHYSICIAN'S INDIRECT METHOD OF EXAMINATION OF THE INTERIOR OF THE EYE

In the *indirect* method, the ophthalmoscope is held at a considerable distance from the eye, necessitating the use of an additional convex glass or condensing lens to facilitate the examination. In this method details of the background of the eyeball are seen inverted.

recognize one by sight. The oculist usually carries the ophthalmoscope with him.

3. *Small Convex Lens*—A small hand lens of sixteen or eighteen diopters (Fig. 4) is also used with the ophthalmoscope for examining the interior of the eye, as well as being used for other purposes, *i.e.*, to throw a beam of light on the cornea for clearer illuminating purposes. A lens of this description is frequently alluded to as an "object" glass or lens to go with the ophthalmoscope.

4. Very often, in these cases, in order to see the fundus or background of the eye distinctly, the pupil must be widely dilated, for which the physician orders one drop of a 1 per cent. solution of homatropine hydro-

bromate dropped into the eye every five minutes for three doses. Homatropine dilates the pupil and paralyzes the muscle of accommodation so that the patient cannot read for two days. The pupils may also be dilated, but not quite so well, by using a 4 per cent. solution of cocaine every five minutes for four instillations. Cocaine, although dilating the pupil, does not paralyze the muscle of accommodation, and its effect (dilatation) lasts but an hour or two, and so is most often preferred. Atropine in any form should never be used in the eye except on direct order from the physician, and never in the disease glaucoma.

Eye Bandaging—This is an important subject and should be understood in a practical way, so that the nurse may be of the greatest service possible. While a bandage should not be applied to an eye without a direct order from the physician, when it is ordered it should be intelligently put on so that it will present a neat appearance and stay securely without unnecessary discomfort. As a general rule eyes are not banded in acute eye diseases, but in operative cases and in other instances where thought necessary a so-called pad and bandage is constantly used. The dressings usually con-



FIG. 12—DOUBLE EYE BANDAGE

sist of a pad of absorbent cotton between two thin pieces of sterile gauze placed over the affected eye, sufficient material being used to fill out the depression between the nose and supra-orbital bony margin. As a rule a simple ointment, such as sterile white vaseline or bichloride ointment 1-3000 (bichloride ointment always being specially prepared by the druggist), is placed along the lid margin to prevent the bandage from sticking to the skin. A roller gauze bandage, usually an inch and a half in width, is the one commonly used. We speak of eye bandages as single or double eye bandages, according to whether one or both eyes are covered.

Single Eye Bandage (Fig. 11)—A single eye bandage is applied as follows, and should be practised by the nurse several times, so that she may become proficient in the art: With the dressing applied on the right eye, let us say, the nurse begins by placing the free end of the roller bandage over the temple of the affected side (requesting the patient at the same time to hold the end in place on the temple with his finger), takes a turn across the forehead, around the head,



FIG. 11—SINGLE EYE BANDAGE

above the opposite or left ear, behind the back of the head, below the right ear, and coming forward again obliquely across the pad on the right eye to the forehead. The bandage is now steadied for a moment with the finger at the center of the forehead, so that it will not slip down, and again turns are taken about the head, this time, however, evenly around the head above both ears and across the forehead, alternating in this way first below the right ear and over the bandaged eye and next at an even level about the head above the ears, until the eye has been sufficiently covered. When finished, the bandage is cut where needed and the loose end pinned with a safety-pin at the center of the forehead, so as to support the oblique and horizontal turns which cross at this point.

Double Eye Bandage (Fig. 12)—In the double eye bandage the nurse begins in the same way, starting at the temple, over the right eye to the forehead (where the bandage is steadied with the finger), across the forehead, making a turn around the left side of head above the left ear, across the back of the head or occiput, below the right ear,

obliquely upwards across the right eye, over the forehead and around the head, over the right ear, this time, however, forward to the forehead and downward for the first time over the left eye, below the left ear, across the back of the head, below the right ear, upward again over the right eye, alternating in this way over both eyes several times, finally ending up with one complete turn around the head at the level of the forehead, pinning the bandage in front in the middle of the forehead. While it is a little difficult to secure a real good idea from a word description, a glance at the illustration, together with some practice, will result in a good deal of proficiency for the nurse in a remarkably short space of time. It is worth repeating, finally, that as a safety-pin or two and scissors for cutting the bandage are almost invariably required before the task is completed, the nurse should have foreseen these simple wants in some way or other, and not try and hunt them up when badly needed, leaving the patient to clumsily hold what is very apt to become a wobbly bandage.

(To be continued)

AWAKENING

Never yet was a springtime—
 Late though lingered the snow—
 That the sap stirred not at the whisper
 Of the south wind, sweet and low;
 Never yet was a springtime
 When the buds forgot to blow.

Ever the wings of the summer
 Are folded under the mould;
 Life, that has known no dying,
 Is love's, to have and to hold,
 Till, sudden, the burgeoning Easter!
 The song! the green and the gold!
 —MARGARET E. SANGSTER.

Practical Points in Maternity Nursing

AMY ARMOUR SMITH, R.N.

"We must look to the mothers of a country for that country's welfare."—FROEBEL.

IN MOST instances, when a pupil nurse finishes her term on the maternity ward she is not well equipped to meet the odd contingencies which arise on private duty, with the result that she makes a failure of her first outside case, and promptly turns down obstetrical nursing forever. Can you account in any better way for the unpopularity of maternity work among the rank and file of nurses?

Those things which go to make the mother, the baby and the relatives comfortable and serene can be learned on a ward just as well as not, but this demands good teaching and constant supervision. Given equally valuable facilities for doing good nursing, the nurse who gives an infant such care that he starts well in life is a greater asset to the community than one who assists in mending a physical or mental wreck.

Assuming that the pupil receives the requisite demonstrations from her supervisor in setting up for delivery, application of binders, etc., and the lecturer's instruction in the theory of obstetrics, there is one more kind of help which neither of these persons usually gives, because, on one hand, the head nurse has never had a private case, or so long ago that institutional life has obliterated all memory of its pleasant, comfort-giving details; while, on the other hand, the lecturer, if a physician, could not be expected to know them, nor can either of them ever get the nurse's viewpoint. In a well-ordered institution some of the following points are non-essential, since the physician, the interne, the supervisor, the ward maid, the laundress, etc., are all there to take their share of the burden. But eliminate them suddenly and you explain the awful sinking

sensation with which a nurse goes out on her first "mat." case.

There are many homes with more complete hospital facilities than she ever saw. There are others with dainty luxuries of bath and toilet for the infant which it seems almost sacrilege to touch. There are mothers so intelligently informed about feedings that they can "put it all over" a nurse who is not armed with accurate information. The pupil, therefore, must be guided to familiarize herself with all the needs of mother and child from the time the physician is first called in until she is honorably discharged herself.

I.—ENGAGEMENT

If the nurse is chosen by the physician, she will call on the patient particularly well groomed, for a woman patient approaching such a climax is rather finicky in her tastes about everything. There is a divine gift of adaptation which some nurses possess, and all should cultivate, which helps one in such a call to sound the depths of the patient's nature and take on the manner, voice and trend of thought that will best answer to her mood. If the patient chooses the nurse, the nurse should call on the doctor to receive instructions. In either case there is an appointment made for the call.

The nurse and physician can determine by the patient's co-operation just what each shall provide. Things which "bend to the hand," or become easy to use through their familiar touch, the nurse should always carry, viz.: hypo, catheter, razor, cord tape, and especially a long pair of uterine dressing forceps, which can be boiled and left standing in lysol 1 per cent., to serve satisfactorily

as a "scrubbed nurse," for passing sponges, opening towels, etc.

The nurse should visit all parts of the home where she may need to go during the confinement, to see how she can expedite her work. She must make a study of the stairs, plumbing, bath room, kitchen, refrigerator, disposal of garbage, furnace, her own room and bed, and the patient's room. She should find out whether there is assistance in serving the patient's food, who is to care for the remainder of the family, and whether the laundry can be done daily, and by whom. One principle must be emphatically enunciated. The nurse who wades in and does the family washing and cooking where her patient is poor can be a great deal happier than some others who must dawdle and wait on the whims of a pampered doll.

The nurse must always assume the attitude of a learner, from the grandmother, or the mother who has borne other children, or even from the cook. She must know that every patient is due for at least one weeping fit, probably on account of relaxed nerves, and she must not give her any further cause by whispered conversation near her room or by appearing to find any special diversion in the husband's companionship. When the baby arrives, she must be the first to comment tactfully on all its pretty features and cunning ways—a safe subject, inexhaustible! She must do her own room up, and keep it neat, since the baby will be there, and its few quiet, silent visitors will drop in there for a moment. She must frankly discuss, on her first call, the weekly salary, the hours, the question of relief, the amount to be paid while waiting for the event, the arrangements about board, before coming to the house; who will occupy the patient's room, if any one, with her, and how the dressings will be made. She should look for oilcloth, newspapers, old linen, pins, and a second mattress to raise the bed, or, preferably, a set of shock-blocks to elevate it to the hospital height. This forethought saves the

backs of physician and nurse, so that they can work better. The mother is told to make the dressing covers two thicknesses, and to bury the pins at one insertion to the head. Particularly hard to find are basins of the correct size and shape for speedy boiling of obstetrical forceps. The clever nurse carries a pocket-light at night, and has a small portable electric buzzer which she installs between her room and the patient's. She must have suitable garments for cool nights, pajamas and straight-coat kimono, plain boudoir cap and moccasins lined with wool. She must investigate the verandah, fire-escapes, supply of cots and steamer chairs, electric fans or other conveniences, so as to have this arranged while the mother is yet able to be about. She should never let relatives, children or servants see the diapers, placenta or bloody clots. She must make up her mind to use as few supplies as possible while consistently caring for her two charges. She should know the current rates for public laundry or private laundress and frankly consult with the family about these topics. She must be saving of electric light and gas, and keep in mind all the expenses the family are incurring to give such as herself a profession and a *raison d'être*. It is quite plausible that the great expenses attendant on the birth of a child are responsible for much race suicide.

II.—LINEN AND APPARATUS

Diapers are best made of cotton birdseye, half 22 inches wide and half 26 inches wide. The child needs four dozen altogether, the smaller ones next to him, while he is very young. The goods must be well shrunk and washed before making up. They must be cut twice as long as wide, adding about three-quarters inch for the two end hems. Linen, when wet, chills the child. Very few people can diaper a baby properly. Small squares of old lint are laid on the center of the diaper to catch the bulk of the stool. The diaper is folded into a square, then

again into the triangle, and a fold laid on its longest edge, so that the two loose points hang between the thighs. Bring up one loose point over the genitals, then the two long ends, then the balance of the lower part. This prevents the long ends from being covered with stool, which the nurse would throw back over her own lap.

The nurse should never take the baby on her knee without first donning a rubber and a flannelette apron. Each side of the diaper is pinned above the knee, to avoid bowing the legs. The second diaper is folded diagonally and the ends pinned across, but not the point; it hangs like a pad or train, to protect the petticoat. Keep a whisk-broom for the purpose of whisking the stool off the diaper under running water, if possible. Then the diapers are collected for twenty-four hours in an enamel pail, or a ewer in carbolic acid 1-40, in a hospital; in plain water in a home where no other child uses them. They are washed and boiled daily, early, so as to dry and bleach in the sun. No ammonia or bluing should be used. Never be seen carrying a diaper. Never lay one on the floor or rugs. Make paper bags of newspapers for this purpose, as well as for the mother's soiled dressings.

The mother needs binders which should be made by the nurse, like a tight, plain corset-cover for the breasts, and on the scultetus or many-tailed pattern for the abdomen. She also requires nightingales or short kimonos, which can be easily laundered when the

milk oozes. For the delivery she should provide a pair of leggings of canton flannel or flannelette, which can be made over, later, into other useful articles. There is a continuous sleeve, much used in the West, which finds favor with all who adopt it, preventing the arms from flinging about. A simple breast-binder used by one obstetrician consists of two bibs, like a child's, joined on one shoulder by a seam and on the other by pins. From the bottom of the back extend two long tails horizontally, meeting in the front and crossing under the breasts, to hold them up. It is of double unbleached muslin and is very easily handled at the nursings. The first binder mentioned should be open only on the shoulder of the side from which the child nurses, not down the center of the front, undoing all the work for which it is designed, since the feedings come so often. A Kelly pad may be improvised by rolling two soft old gray blankets into one long cylinder, over which an oilcloth is rolled once to cover the flannel by one long edge. Then this is divided into three equal parts, the middle part being kept for the Kelly pad, the two ends being folded along it at right angles, then the surplus being rolled under till it forms the apron to hang over the pail for waste. It is secured by two clamps, safety-pins or adhesive. The leaf from an extension table or the ironing board should be laid across the bed, under the springs, to make it firm under the buttocks, particularly if the patient is drawn across the bed.

(To be continued)



The Day Before Easter

EMILY HARRISON BANCE, R.N.

IT HAD been a very dull and cloudy week but Saturday morning dawned bright, clear and sparkling, a favorable forerunner of Easter Day. It had been a very busy one for me in my work among the tenements, and, with the approach of spring, the houses seemed dirtier, the hallways and areas more offensively odorous, the people more sordid and bedraggled. Little babies, who had come into existence during the winter months were being aired on door-steps, often held in the dirty, loving arms of a small elder sister, while the older babies of two years toddled on the sidewalks or sat on the curb.

That morning, before I left home, one of my friends rang me up to say "good-by." She was just starting for Atlantic City to spend the Easter holidays. She wanted me to go with her, but that was impossible, and, as I picked my way along the streets and noted the many signs of spring, the vision of Atlantic City, the boardwalk, the glorious ocean, fresh air and bright blue sky came between me and my duties. How I wished that I could leave my work for a few days and go to Atlantic City. "Visiting nursing may be very noble and elevating," I grumbled to myself, "but it sure has its drawbacks."

I had quite a number of calls to make, and things did not seem to go at all smoothly. It often happens that way in district work. My first call was made in one of the most congested parts of the city. As I climbed the three flights of stairs, stumbled over a woman who was scrubbing and ran into a man carrying a pail of beer, I wondered to myself what these people had to live for and what they had to look forward to. My little patient was suffering from valvular heart disease and the day before I had found her

lying in a dark, ill-ventilated inner room, opening off the kitchen. I had spent considerable time in transferring her to the front room and making her clean and comfortable on an improvised bed made of two chairs, by the window. I had told the family how necessary it was for the child to have sunlight and air.

Imagine my chagrin when, on entering the little flat, I found the child back again in the close inner room. Words of protest rose to my lips, when I caught the mother's expression. "Oh, Miss," she said, "she were that lonesome away off there, so I had to bring her back near the kitchen where I am working." I lit the gas so I could see and there, gasping, lay my little patient, and I knew, then, that it would not be necessary to make any more changes, for the great and wonderful change was taking place. The flickering light lit up the dingy walls and the humble bed. The mother, in rude imitation of my instruction, had the clothes neatly but clumsily arranged. The baby of the family lay in a placid bundle at the foot of the bed, fast asleep, and three children home from school stood curiously in the doorway.

"She seems so much better," said the mother, as the little girl clutched my hand with her little hot one. I sat beside her for a while, till she fell asleep, and I could slip away, but I knew that on Easter morning another little tenement child would be where air is fresh and sunlight is free.

In the Polish district I visited Feliska Bodjewski, a Polish mother with a family of six children. I had discovered them a week before on the verge of starvation. Food and fuel were provided, but Feliska, the mother, was found to be suffering from tuberculosis, and preparations were in progress to remove her to a sanitarium. After

Easter the six children were to be placed in a home. I found Feliska sitting by the window in an attitude of despondency, but her mournful brown eyes brightened as I entered. She could not understand my language, but the woman across the hall always came in and acted as interpreter. She did so on this occasion and, through her, I made Feliska understand that soon she and her children would have the best of care, and I told her: "When you are well again you shall have your children back and have a home once more." But I knew that the chances of Feliska's recovery were very, very slight. I wonder if she knew it, too, for as I said good-by she caught my hand impulsively and kissed it and I felt a hot tear on my palm. You see, she was nothing but a poor Polish tenement woman who did not know anything about germs.

I made several calls in the Italian quarter. Catrina Bavassa had given birth to her fifth boy and was feeling disappointed because it wasn't a girl. The little thing was well swaddled in bandages, but the beautiful earrings which Catrina had bought from a peddler the week before lay on the bureau, practically useless. "And the way I prayed to the Virgin for a girl," whined Catrina. The baby's crib was placed under a little shrine dedicated to St. Joseph, for whom the bambino was named. As I emerged from the Bavassa house, a troop of six little girls passed by in fresh white dresses, all muslin and lace, their bright black heads festooned with garlands of smilax. They were on their way to their first communion, a vision of purity and cleanliness in chaste contrast to their homes and surroundings. And as I made one call after another, I remembered Atlantic City, the salt air and the ocean, and the good time my friend was having.

My last call that day was on Mr. Jones, on Railroad Avenue. Have you ever been on Railroad Avenue? There are streets like it in nearly every large city. The whole street is dark because the elevated railroad

takes up the thoroughfare and cuts off all the sunlight from the lower floors of the tenements. On foggy days there is always a damp drip, drip from the railroad, and the rumble of the trains is incessant and very annoying to one who is ill. Mr. Jones lived on Railroad Avenue on a lower floor, and, although his bed was in the front room, he rarely saw any sunlight. His disease, tuberculosis, had made him very cross and irritable and he refused to go to a sanitarium. Before becoming so ill he had been a heavy drinker, and on some days when he felt well enough to get up and go out he generally visited the corner saloon and often had to be carried home. His wife tried hard to keep the little home comfortable and the three little children clean, but was greatly handicapped by this invalid husband. On this day I knocked on the kitchen door at the end of the hall and his wife admitted me. "He is asleep," she told me, and as he had been awake all night with his cough, I decided not to disturb him. I sat on the kitchen chair for a little rest, when some one said "Good morning." There by the window sat a stranger, a very neat little old woman, darning the stockings. Her eyes were bright and shining, and her dress immaculately clean. Across her shoulders she wore a little checked shawl, crossed surplice fashion, and tucked in at the waist. "Why, who are you?" I asked, as I had never seen her before on my many previous visits.

"Well," she said, "I'm Mrs. Black, and I've come here on a little visit from the almshouse, just a little Easter holiday, you know." I looked at her in amazement, and then she went on to tell me about her home, the almshouse, which was two miles out of town. She had been an inmate there for six years and this was the third vacation she had had. "Yes," she said, "you do get tired of the almshouse, and a little trip to the city does one good. Mrs. Jones has always been a good friend to me and she likes me to visit her, although she has so much trouble with

her husband, poor thing. Of course," she added, proudly, "I paid my own way out here with my own money."

I asked her how she managed that, and she told me, in confidence, how many of the inmates had "rich" friends and relatives who gave them money, but she had no such wealthy relatives and friends. However, she helped these more fortunate inmates with sewing and often made their beds for them, and they paid her for her help.

"Some, you know, can't see, poor things, and there's others as have lost the use of their hands from rheumatiz. And many never gets a vacation because they would be brought back drunk. But I never take a drop and they can trust me to come back straight, so here I be." I smiled at her and told her how glad I was that she was having such a nice time, and somehow or other, as she spoke, Atlantic City didn't seem so very desirable, after all, for here was this poor old woman, spending an Easter vacation on Railroad Avenue, in the crowded home of a consumptive, with people on the verge of

poverty, and yet she was happy and contented because she could pay her way to and from the almshouse and was trusted because she didn't drink.

Easter Sunday was a gloriously beautiful day, and in the morning I attended the service in my church. I wore a new pair of gloves, but my suit was last year's and my hat a made-over one, but what difference did it make? The altar was a mass of flowers and the choir music inspiring. The day before my mind had been full of Atlantic City, the boardwalk and the ocean, but here, in the church, listening to the Easter music, all that seemed far off, like a remote dream. And as the sacred strains of the organ filled the church, I thought of the people of the tenements, of the little old woman enjoying her Easter holiday on Railroad Avenue; once again I felt the Polish woman's kiss and remembered six children soon to be motherless and placed in a home; once again I felt the clasp of a child's hot hand and thought of a little tenement child who had fallen asleep.

AN EASTER CAROL

Spring bursts today,
For Christ is risen and all the earth's at play.

Flash forth, thou sun,
The rain is over and gone, its work is done.

Winter is past.
Sweet Spring is come at last, is come at last.

Bud, fig and vine,
Bud, olive, fat with fruit and oil and wine.

Break forth this morn
In roses, thou but yesterday a thorn.

Uplift thy head,
O pure white lily, through the winter dead.

Sing, creatures, sing,
Angels and men and birds and everything.

—CHRISTINA G. ROSSETTI.

A Child of the Middle Kingdom

A GLIMPSE INTO A HOSPITAL IN CHINA

IRENE K. SUMNER*

THE Square Thing, her mother and baby brother arrived at the hospital.

It was the Square Thing who was sick, but in China you take the family with you if you consent to enter the hospital at all. It is true the Outside Kingdom folk are queer people, but sometimes their medicines give peace to the body when the quarts of stuff ordered by the medicine man of the village leave it as distressed as ever.

That was how the Square Thing came to the House of Healing—also, her mother had no money, and she had heard that the *kunions* were good and sometimes allowed you to eat their rice if your string of cash was empty.

But the Square Thing understood nothing of this; in fact, she did not want any rice at all, but there was a great thirst on her, and her cry was "Tea—tea—tea!" Her head was hot, her tongue was dry, and she found it hard to get her breath. This made her feel very queer, and she bitterly resented coming to this strange house, and more than anything else she hated the foreigners with their white faces, particularly one who came and took hold of her wrist, and put a thing with long tubes attached to it against her chest. Yes, she would fight and kick as long as her breath held out, and if she could get hold of that odious, interfering hand she would bite it. She had a perfect set of little sharp teeth, and it cost less to bite than to scream. She did not get so out of breath.

Her real name was Li Goi, but the Outside Kingdom folk were stupid about Middle Kingdom names, and so, because she had a little square head on a very square body, she became known by her appellation.

Everybody knew her. She seemed to fill the house. For one thing she was a very temper some small person, and she made her wants known in an imperative manner; for another, she was very sick indeed, and the foreign people were always coming to look at her.

They gave her queer white stuff to drink, that she learned was condensed milk—not so bad, after all, when you got used to it. They gave her medicine, too, that was quite good—she nearly gulped down the china spoon when she took it.

As the days went by she felt better, and was able to run about. She also found out that the white people were not as terrible as she had thought. One *kuniong* gave her candied plums and sugar; she liked *her* best.

The Square Thing had one cherished possession—it was her smile. It was not often exhibited. Sometimes it lurked in the depths of her bottomless eyes, or twitched at the corners of her mouth, and now and then it hid in a dimple—but when it did come in all its brief sweetness it was the most adorable thing in the world—a thing to watch and wait for.

It was very cold. It was four or five coats cold, which is the way you measure cold in the Middle Kingdom.

Her mother, like every one else, had a fire basket filled with red-hot charcoal covered with wood-ashes. She would take an arm out of the sleeve of her blue coat, and hold the fire-basket underneath, where it made her look a very odd shape; or she would put her tiny bound feet on it when she was nursing the baby. Sometimes the Square Thing had it and, like her mother, she shook an

*It will be remembered that in our October, 1914, issue we made the announcement that Miss Irene K. Sumner had joined the Belgian Red Cross and had been ordered for duty. Miss Sumner had just returned from China when the war broke out, and at once offered her services, which were accepted. She was on active duty throughout the bombardment of Antwerp.

arm out of the sleeve of her coat and held the fire-basket underneath, so that the warmth could go right up her little body. It was so comforting to feel the hot air.

How it happened nobody knew. Perhaps the blue trousers were too long, for the small feet stumbled and down went the Square Thing, measuring her tiny length on the floor. The terrible hot ashes shot up inside her coat—on her chest, her arms, her hands. Her mother was so used to hearing her cry

lady, who was a doctor, looked serious, and took the Square Thing on her knee, and very gently removed her coat. Then she scolded the mother for not calling her at once. "Yes, the *kunions* was very angry, and it was such a little thing!" thought Li Goi's mother. "These foreigners are strange people."

The little doctor picked up the Square Thing and took her down to the dispensary, and put on large pieces of lint spread with



THE "SQUARE THING" AND HER FAMILY

that she did not hurry to pick her up, and was not very much concerned that the fire-basket upset—it was a thing that happened every day. Perhaps Li Goi was a little burnt, but that did not matter much. So she slapped her and told her not to cry, and said if she did not stop she would slap her harder. When the *kunions* came with the medicine she would ask for some stuff to be put on; you could get any sort of medicine here for the asking.

The *kunions* came, and she told them how stupid Li Goi had been. The foreign

ointment, and fixed it on with bandages. The Square Thing did not mind much; she was feeling very queer and faint, and only wanted to be left alone. This was the only time she did not fight the doctor, but she was not quite sure where the doctor was; everything was swimming round so.

Then she was carried up-stairs again and put on the tressel bed, on the straw mattress, and the doctor told her mother to keep her covered with the *ming puoi*; she had to go away then, for she was very busy.

Li Goi's mother could see that the doctor-

lady was still very much annoyed, not with the child but with *her*, so she sat and sulked by the bed. When the *kuniongs* came round again she would tell them she did not want any more foreign medicine—she would go home. It was very stupid of her to have kept this girl-baby, she had been ill so often, too. Why, the woman with the sick baby in the big ward had thrown away five baby girls, and it was only because the foreign ladies had heard of her leaving this one outside the house on a heap of rubbish that she had been made to take it in and nurse it; far better if it had died. Of what use was a girl? She could not help in the ancestor-worship, and you did not get much money if you sold her as a *simo-giang*—a child-wife for somebody else's boy. But at least she would be brought up in their family, and *she* would not have the trouble of her. Yes, she could sell her, though she would get very little for a girl who was always ill. And she shook the Square Thing, who was asking for a drink of tea. Even the Mandarins were getting foreign ideas into their heads, and she had heard that there was a notice up by the lake outside the big city, "Girl-babies must not be drowned here." It was very stupid, she thought.

But before the *kuniongs* came again she remembered that she had no cash and that it was very nice to have plenty of rice every day, and tea, and even *poi* to eat with the rice. So she thought she would stay a little longer; besides Li Goi was more trouble at home when she was ill than here.

She did not know that the foreign doctor had heard that she stole *poi* from the richer people in the hospital and that it was only for the sake of the Square Thing that she was allowed to stay. She only thought that the foreigners got vexed about nothing at all and did not understand Middle Kingdom ways.

Now the Square Thing had to go down every day to have her burns dressed. She hated it, even though her own *kuniong* did

it, and she knew there were sugar-plums in the drawer. "Don't cry, don't cry!" the *kuniong* would say, and the Square Thing repeated in her high, petulant little voice, "Don't cry, don't cry!" sometimes adding, "It does not matter, it does not matter!" with furious courage, till her voice broke into a loud wail. It did not take very long, and afterwards she had her medicine, which was good, and she was jealous when her baby brother had any. Then the *kuniong* would put powder on her hand, and she would blow it off—that was fun to have a white hand and see the powder fly. "*Chieu*, laugh," her mother would say, and then the flickering smile came and lit up her face, and a little laugh bubbled out.

That was the time when her *kuniong* was most happy.

The doctor came to look at her several times, but the Square Thing was not pleased to see her, and stamped with rage. The doctor and her *kuniong* were talking together and the doctor said: "It is very nice, she is nearly well now—she will soon be able to go home." When the dressing was done her *kuniong* opened her arms, and the Square Thing ran to her and buried her face in her lap. It was not often that she was affectionate. When the white lady got up she had a lump in her throat and her eyes were a little bit misty. She went over to the doctor and said: "Keep her in a little longer. She has such a wretched home and she's so delicate." The doctor's mouth gave a little twitch. "We can't keep her much longer," she said. "We're so dreadfully full."

So the Square Thing got quite happy running about the hospital and playing with the other children. She even looked for her *kuniong* to see if she had an orange for her, and she would leave the others and run to meet her if she saw her at the other end of the corridor.

One day it came to pass. The Square Thing lifted her eyes and smiled, then overcome with shyness buried her head in her

kuniong's lap, and took tight hold of her arm with two small hands. The doctor came out of the next ward and stood still, looking at the little square figure, then she said, huskily: "She really must go; I haven't a bed anywhere—and her mother is such a thief. Besides, today is a lucky day, and we shall have a crowd in."

The Square Thing sat on the steps with her mother. They said she might go home, but, strange to say, she did not want to. She bit her lips furiously and put on her most uncompromising expression. "*Chieu*," said her mother, but she did not feel like smiling.

"*Chiang ang*, invite peace," her mother said, but there was no peace in the Square

Thing's heart. She was being sent home.

Her mother gathered up her bundles and hobbled down the path, Li Goi clutching at her coat.

"Good-by, Square Thing, good-by. May God bless you, dear little one!" *Su Kuniong* was speaking a language the Square Thing did not understand, but she caught at the English word and, turning round, said in her high little voice, "*Su Kuniong*, goo'-by!"

Su Kuniong turned away; her eyes were brimming. A little child was taking away a bit of her very heart, and she had only the treasured memory of her smile.

A Nurse's Experience

BEING THE LETTERS OF JANE WILLIAMS TO MARGARET THOMPSON

DEAR TOMMY—I was wakened next morning by voices in the street and discovered it was broad daylight and the hands of my watch pointed to 9 A.M. I felt no desire to rise, but lay there thinking (something I haven't wanted to do for a long time), when Mrs. Bob's smiling face once more appeared in the doorway, with a breakfast tray. I was hungry and the cereal, toast and cantaloupe disappeared very rapidly. Still I felt no inclination to rise, but lay back on the pillows with closed eyes. A feeling of general content settled over me. "Just think," I said to myself, "there's not an earthly thing that you are obliged to do." I don't know when this condition ever existed for me before. I felt much like the little boy only eleven years old and employed in one of the cotton mills in the South. He was literally pulled out of bed every morning before light to eat a hurried breakfast and get to work on time. He was

too young for the work given him and after a time he became ill. His mother called him in vain one morning. He simply rolled over in bed and dozed again, with a feeling that the heavens might fall for all he cared if he could only sleep, and sleep he did. I know just how that boy felt. After so many years of doing, doing, doing, because I felt that I must, I at last felt that though the heavens fell in consequence I could do no more. Well, you know, that not until a person with nerves (and most of us have them) reaches the don't-care stage can anything be done for him. Previous to this he overestimates his own strength so greatly that he doesn't believe it possible for him to break, and not until the crash actually comes can he comprehend that it could possibly come to him. You see, Tommy, I have time to think of these things now, as I lie here with nothing else to do. Oh, it seems to me that I could map out a beautiful schedule

for a nurse's day's work! But what patient ever existed that wouldn't break all schedules to smithereens. Well, about my treatment. At 10 A.M., on alternate days, comes the osteopath to "adjust my vertebræ, liver, lights, etc.," as Mark Twain said. Then in the afternoon a woman whose name I can never remember, but whom I call Mrs. Muldoon (on account of her treatment resembling in severity the famous Muldoon's), comes to give me a salt bath and massage. After this I feel quite refreshed and am rather glad I am living. Mrs. Bob told me tonight that she expects a couple more boarders tomorrow. I wish they would stay away! I am selfish enough to want a corner on this place myself.

Yours as ever,

BILLY.

DEAR TOMMY:

Since I last wrote you things have been happening. First, the new boarders came, an elderly lady, Mrs. Covey, with her niece, Mathilda, and believe me, poor Mathilda has my sympathy. It's no wonder she has a worried expression all the time, for Mrs. Covey keeps her jumping from morning till night, and I'm not sure but a good part of the night, as well. The other boarder was a doctor who had been injured in an auto accident, and came here to recover from the shock to his nervous system. He was the glumest-looking individual you ever saw. Never smiled and talked no more than to answer questions, and acted as though he hated to do that much. You see, by this time I was going to the table for meals, and that's the only time I saw the other boarders. I suppose the doctor's expression was about what mine was when I came here. Thanks to Mrs. Muldoon and the others, I had once more learned to smile and to take some interest in things. About a week after this Mrs. Covey had a bad spell one night

and got Mathilda up, but all Mathilda's ministrations failed to pacify her, and at last in desperation the poor girl came to my door and asked if I could suggest anything to do for her aunt. Two weeks before I would have said "No," and gone to sleep again, but I got up, put on a kimona and started for the old lady's room, when what did Mathilda do but make a misstep, which sent her head first to the bottom of the stairs, where she lay, with a big gash in her head, having struck a piece of the tumbler she was carrying. I forgot Mrs. Covey, I forgot that I was a patient, I forgot everything save that I was a nurse, and I flew to the doctor's door and pounded it with a vengeance, in the meantime calling to him that Mathilda was killed. He quickly appeared and at the same time the Laceys also appeared. Mrs. Bob and the doctor carried Mathilda to the kitchen, where we improvised an operating table, and were diligently at work sewing up her scalp when Mrs. Covey appeared and immediately went into hysterics. As no one had time to attend to her she finally subsided and retired to her bed. Strangely enough, Mathilda had no broken bones, only a sprained ankle and the lacerated scalp, but Mrs. Covey had to do without her for the next fortnight, and here is where the surprising thing happened. I got to running in to look after Mathilda and, incidentally, doing things for Mrs. Covey, and I found that I actually *liked* to be at work again. The doctor lost his glum expression when he called and really seemed so human that I wondered that I had thought of him as the "disagreeable man." Before we knew it, we were both laughing heartily over our experience. The doctor is going back to his practice in another fortnight, and, Tommy, you may look for me about that time, for I am coming back, Dr. Snow says, "as good as new."

Heaps of love to you.

BILLY.

Department of Public Welfare

The Fakers

E. O. A.

One learns with interest and approbation of a decree of the German authorities forbidding all newspapers and magazines in Germany to publish during the war any advertisement offering "cures" for venereal diseases or their consequences. But why should the decree be in effect only during time of war? Must peace bring with it special privileges to the unscrupulous purveyors of drugs who fill their coffers with life-money by holding out false hopes to the unfortunate uninformed?

If every country might issue such a decree with an unlimited period of enforcement, including not only the "cures" just referred to but all the other harmful and misrepresented preparations with which the drug "fakers" flood the market, what a tremendous amount of misery might be averted.

Possibly few appreciate this fact more than does the public welfare nurse in her various lines of endeavor. She comes in such close touch with the families she visits that she learns the little, intimate details which bring to her knowledge facts which they would hesitate to tell others.

The Pure Food Law and the various exposures in popular magazines of fake drugs have done a good deal to remedy this evil, but they have not by any means destroyed it, as statistics show that \$15,000,000 was made in New York City alone during the year 1913 from the sale of patent medicines. But as there is also a decrease in the death rate, the manufacturers of these preparations take advantage of this and argue that, in comparing the decreased death rate with the growing increase in the sale of patent

medicines, there is but one conclusion to draw—that the lowered death rate is due to the increased use of the patent drugs. In drawing this conclusion and presenting it to the public, they fail, however, to present the economic side of the question, making no mention of the tremendous amount of money constantly being expended to undo the harm done by these same preparations from which the manufacturers draw such fabulous incomes. Neither do they present the public with any facts regarding the vast number of lives that are being saved today by science, prevention, better living conditions, purer water and all the numerous efforts in public health work that really have accomplished the important and telling effects upon the decreased death rate.

Strange to say, it is not alone the poor who are the dupes of the exploiters of patent medicines. A fancy and apparently convincing advertisement is apt to draw into its net many a person whose pocketbook is amply filled, but whose time being limited sees a convenient way of avoiding awaiting one's turn in a physician's office by purchasing a bottle of the promising preparation from the nearest druggist or slipping a check into an envelope and having one's "medicine" arrive by post without any further inconvenience. The result is twofold—the injury the drug does to the system and the harmful period elapsing while taking the drug, when the individual should be under the care of a reputable physician.

But it is the poor who suffer the most from the "fakers," for in addition to the harmful results from taking the drug and the lack of proper medical care is the tremendous financial loss. If statistics might be ob-

tained from ten active, keen, intelligent district nurses on their findings among patients addicted to the use of patent drugs, the results would be anything but favorable to the manufacturers. Many harmful results of the use of the fake "cures" must certainly present themselves to a district nurse's mind when questioned regarding this matter, and the following instances are but examples of many more that could be recounted:

A district tuberculosis nurse, upon her first visit to a bedridden, far-advanced consumptive woman, questioned the husband as to why he had delayed so long in sending for a physician and nurse to care for his wife. His reply was of such an incoherent nature that the nurse concluded it had been due to the usual dislike of calling in the city physician and the lack of money to pay any other. Matters had been let drift along until the patient had become so ill that medical care was imperative and pride was set aside and the city physician called; he in turn had sent for the nurse. This was apparently the situation, but before leaving the house the nurse unearthed the real reason why there had been no funds to pay the physician. Behind a screen in one corner of the patient's room stood two barrels filled to overflowing with empty bottles, bearing the label of one of the most widely advertised and flagrantly misrepresenting consumptive "cures," each bottle representing an expenditure of five dollars. What was the result? A dying woman, a burdensome debt and later a grave in the potter's field—sorrow, unhappiness and blighted young lives.

Into a tuberculosis dispensary there dragged herself one day a tall, large-boned but deathly pale woman. Dropping into the seat for which she groped, she straightway fainted. When questioned after recovering consciousness, it was found that she had been unable to retain any food for weeks and her fainting had been caused from over-exhaustion in her weakened condition. A

few days later the nurse discovered in this woman's house the cause of her disordered stomach. Not only empty bottles but letters from the unscrupulous firm making the preparation, asking for affidavits and testimonials, offering all kinds of inducements to obtain them. This "cure" had cost one dollar a bottle, and for many weeks and months there had been a new bottle each week. The patient was a widow with a small boy dependent upon her, and although there was no debt there had practically been no food for several days, and the extent of the injury the drugs had wrought upon her stomach was so extensive that it took weeks of carefully supervised and prepared diet, as well as of rest and care, before it could be said the patient's life was no longer in danger, while two years elapsed before she and her boy ceased to be objects of charity.

During a frightful epidemic of measles in a great city five children died in one family because a drug store controlled by a large patent medicine corporation permitted to be prescribed over its counter a preparation warranted to "cure stomach troubles which caused blotches on the skin."

A great deal has been done to prevent the sale of these so-called "cures," and yet the market is still flooded with them. Scarcely a day passes that one does not find men going through the streets distributing drug-baiting literature containing pages of testimonials from people claiming all manner of wonderful "cures" from the use of the preparation.

There is a splendid opportunity for nurses, thrown as they are intimately in all forms of nursing work with their patients, to fight this evil. All of us who are progressive and interested in prevention must realize that an extremely good preventive course to adopt is assisting in the campaign against the fake "cures." People, no matter of what class, are usually quite willing to listen to their nurse's opinion, particularly in all matters pertaining to their health.

Nurses in sanatoriums, constantly among their patients and free from many of the routine duties of general hospital life, realize, of course, the opportunity to carry on educational work of various kinds, the knowledge gained from which the patient carries into his home when he returns. To educate any group of people against the evils of the fake "cures" would be indeed a task worth accomplishing.

In private and district work the nurse's opportunities in this line are even greater, for she has the advantage of coming in touch with the details of family life which patients away from home do not always reveal.

But, above all things, nurses should set a shining and effective example in this matter by refraining from the use of these fake "cures" themselves. Have nurses ever been guilty of using these fake "cures"? I regret to say they have.

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Traveling Exhibit in the Philippines

A correspondent to the *Medical Record* (December, 1914) sends the following interesting note regarding a public health exhibit in the Philippines:

"The bureau of health gospel of hygiene railroad car and traveling sanitary exhibit is now ready to enter in its work, and was thrown open to inspection by the public recently. Refreshments were served by pretty Filipina nurses from the General Hospital and a large number of visitors were in attendance. The exhibit is very complete and includes a moving picture outfit, and will prove very interesting and do a great deal of good. The bureau of education is to assist in the work of publicity by having all its pupils attend the demonstrations and lectures while the car is in their town, and by sending out notices regarding the latter through the children and by teachers, post-

ers, etc. The health officials will, of course, cooperate, and the governors and other officials have been asked to assist in every possible way while the car is in their provinces or municipalities. The railroad towns for about 150 miles north of Manila will first be visited."

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New Bedford District Nurses

That the New Bedford District Nursing Association ranks among the best in the country is indicated by a letter received recently by Mrs. Jessie M. Smith, the superintendent, from the National Organization of Public Health Nursing, with which the local society is affiliated. The letter reads as follows:

"My dear Mrs. Smith:

"The National Organization for Public Health Nursing is most happy to inform you that the eligibility of your association is 100 per cent., a standard attained by only two or three associations in the United States that are corporate members of this body.

"Allow us to congratulate you on your high standard of service.

"Sincerely yours,

"ELLA PHILLIPS CRANDALL,
"Executive Secretary."

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Disinfection of Subway and Elevated Cars

In the *Bulletin* of the New York City Health Department, a letter is printed from the general manager of the Interborough Rapid Transit Company, announcing that the company has decided to discontinue the use of disinfectants in its cars, relying rather upon frequent airing and thorough mechanical cleansing of the floors and all points of contact.

Gleanings

Chronic Catarrhal Otitis Media

This very practical subject was discussed by Dr. Stephen H. Lutz (Brooklyn) in the *Annals of Otology, Rhinology and Laryngology* (June, 1914). He states that among the causes of the deafness which we call chronic catarrhal otitis media, may be placed abnormal conditions of the nose or sinuses, with consequent poor drainage, extension of inflammatory processes from these to the tube mouth, and obstruction by the presence of adenoid masses or enlarged posterior ends. The effort to dislodge a mass of mucus in order to clear the breathing passage is often the beginning of the ear trouble for which the patient sought help.

Careful, well-done nasal surgery will often stop the progress of the ear involvement by providing a fairly natural open-air channel with a fair return of muscular control of ventilation of the tympanic cavity. *The following points should be remembered:*

Carefully instruct your patient how to blow the nose. This seems like a simple thing to dwell upon, but it will be found by careful practice to be the best means of helping the patient to help himself and retain whatever improvement he may have gained by treatment.

Instruct the patient to blow gently both nostrils at once into a handkerchief held about an inch away from the nose. The fingers must not compress the nose at any place over the yielding soft parts of the nose; in fact, they must not touch the nose at all.

Instruct the patients to place the thumb on one side and the forefinger on the other side, at least an inch away from the side walls of the nose, thus supporting the handkerchief like a bag instead of crumpling it in

a wad and pressing firmly up against the nose, as the average person does. When a clear passage of air can be had, stop blowing. There may be some mucus left in the nose, but not enough to block the nose and interfere with ventilation.

Some persons do better holding the handkerchief in two hands, one on either side, resting against the cheeks.

Whatever way is used, do not allow the least pressure on the nose to interfere with both nostrils being cleared at one and the same time. If the mouth can be slightly opened while blowing there cannot be any amount of back pressure toward the Eustachian tubes.

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Lead Poisoning

Linenthal (*Journal American Medical Association*) calls attention to the importance of the early diagnosis of occupational diseases, more especially to lead poisoning. An early diagnosis is essential to protect workers and to gather information as to the prevalence of the conditions. He finds that there is a tendency among physicians to attribute too much diagnostic importance to the blue lead-line on the gums, and the presence of basophilic granules. Lead poisoning presents itself in a great many ways. Its early manifestations are not always clear, but the physician who fails to recognize them very often loses the chance he has of arresting the disease in season. Among the early symptoms the author mentions especially the skin pallor entirely out of proportion to the actual anemia, the wasting of the fat in the face, general muscular weakness, with rheumatic pains in the joints, nausea

and attacks of constipation or constipation alternating with diarrhea. General nervousness, persistent headache and dull mentality are also among the earlier manifestations, and with the characteristic colic are often the precursors of the more serious nervous lesions. The history of exposure is an all-important aid to the diagnosis.



The Treatment of Burns in Children

In the *American Journal of Surgery* (February, 1915) S. V. Haas, M.D., describes the methods used in Lebanon Hospital, N. Y., in treating the burns of children by exposure to the atmospheric air. Occasionally a wet dressing or carron oil has been applied for twenty-four hours. This, he says, does not interfere with the subsequent treatment, and has the advantage, sometimes, of rendering the wound cleaner.

The patients are placed in bed upon a clean sheet and the burned parts are left uncovered; the other parts of the body are well covered in cool weather. In warm weather it is necessary to keep the entire bed well covered with mosquito netting to keep flies from the wound. Opium in some form is usually necessary during the first twenty-four or forty-eight hours, after that rarely. The bowels are freely moved, and as soon as the patient is hungry a full diet is given. The wound, after a short time, takes on a very characteristic appearance. Those portions that have suffered only a first degree burn assume a normal appearance, excepting for the redness. Those portions that are the seat of second and third degree burns crust over and, according to the depth, discharge purulent fluid under these crusts, which are lifted up and take on the appearance of rupia. When the exudate beneath the crust is not great, the crust remains until it falls off, leaving a reddened, healthy surface without scar.

Where the deeper burn produces a large

exudation the scab is lifted until it is loose in nearly all its parts, and a granulating surface bathed in purulent fluid is seen beneath. These crusts should be left as long as possible, but it frequently becomes necessary to remove them and clean the granulating surface thus exposed by gently mopping with cotton moistened in boracic or other solution. The crusts form again immediately, but each time smaller, as healing from the edges proceeds very rapidly. The granulations by this method do not bleed, as when a dressing is applied, except where the crust is forcibly separated, or from mechanical injury from some other source. The granulations are constantly bathed in the purulent fluid held beneath the crusts.



Borax Kills Flies' Eggs

Borax kills fly eggs, and about two ounces per garbage can will prevent flies from breeding. This is the statement of the National Department of Agriculture. Propagation in stables, garbage piles, rubbish heaps and in fertilizer can be prevented cheaply without lessening the value of the decaying matter. Borax, to the amount of 0.62 pound, was found by experiment to eliminate breeding of flies in eight bushels of fertilizer. It is believed and hoped that this discovery will assist in the campaign against the typhoid fly.



Thyroid Enlargement

The thyroid gland is enlarged at times in infections in different organs of the body, noticeably in syphilis, scarlet fever, tonsillitis and tuberculosis. This does not mean that the enlargement is due to a specific organism, but may indicate that the increased activity of the gland is due to its effort to eliminate toxic materials.—*The Therapeutic Gazette*.

Editorially Speaking

A "Help One Another" League

We hear much of social service in these days—not too much, however. Nurses have become prominent factors in this social service movement—devising ways and means of helping the invalid, the aged, infirm, and handicapped, in a hundred different ways.

The very essence of social service is *personal service*; without the personal element all such service becomes mechanical—a lifeless thing, devoid of the warmth of interest and the spark of human sympathy. We have been so busy looking after the great masses of people in distress that we sometimes forget that there are those of our own household—our own nurse sisterhood—who need our help. They do not ask for charity. They do not necessarily always need the sick-benefit fund we have been striving to accumulate. Sometimes they ask simply for *work*—tasks which nurses with frail bodies can do to earn something as long as they are able.

Is there not a danger then in our zeal for organization and system that we may pass by opportunities for helping one another that we should heed, while some poor soul is pinched for the real necessities of life or for the bit of sympathy or heart interest we should give? Is there not a danger that we will turn over to some committee things which *we ourselves* should do—responsibilities which we ourselves should personally assume? If you are in need, dear nurse, pin your faith every time to some *individual* rather than to some committee if you expect prompt assistance. Committees are all right for some things, but when "hard times are knocking at the door" committees are rather uncertain sources on which to depend. "*He took it upon Himself.*" A whole sermon

could be preached from those five words. Do not wait for a committee of nurses or other people to meet a definite concrete opportunity for helpfulness that is staring you in the face.

There is real danger that you card catalogue, index and refer to some committee a definite case of distress or sorrow, that you, gentle nurse reader, should take upon yourself to work out. This is especially true where old or handicapped nurses are concerned.

As the years go by we are going to come face to face with more and more definite cases of infirm or handicapped nurses who need a helping hand—not always charity—not always a doled-out pittance from a fund—not the hand of a committee officially appointed, but *YOUR HAND* of helpfulness—*your personal* service to a sister nurse who needs *your* personal interest, in your own community or State.

We need a "help one another" league with each member pledged to lend a helping hand as far as she can to any nurse who has proven herself worthy of help.



Nurse Legislation

The report of the mid-winter meeting of the Massachusetts State Nurses' Association, which will be found in the Nursing World Department of this issue, is interesting and suggestive in its discussion of the new nurse registration bill. Of all the objections that might be brought against the bill, Miss Riddle spoke only of four—one specific and one general. To the first objection that too much power is put in the hands of the board of registration, she replied, simply, "Get another board." This proposed remedy is

hardly logical, as getting another board would neither increase the size of the board nor lessen the amount of power. It is not the present board that is necessarily open to objection, but the power vested in the board. There is a very strong public sentiment to the effect that hospitals and training schools, to say nothing of the public which furnishes the money to support these, should have some say in the matter.

The next two objections, as to hardships accruing to schools and hospitals, are both answered by "the best good should be considered." But here again comes the question: Who is to judge of that "best good"? The five members of the board alone? Doubtless if the hospitals and training schools considered that the regulations were for the best good they would be willing to submit to them. But will they be convinced? Have they not some right to judge for themselves what is for the best good? Finally, the hardship to the individual was considered. Here an interesting point comes to light.

Though not mentioned in the bill, it seems to be taken for granted that hardship to the individual will come through higher educational requirements for entrance to the training school. It is then already understood among those favoring the bill that one result of its passage will be the requirement of one or two years in high school. Why else Miss Parsons' statement that any young woman who wishes to become a nurse can give one or two years to the high school first? That point is evidently already arranged. Besides, does not Dr. Hughes contend that the bill should come up before the committee on education rather than that of public health, for its aim, she says, is "to regulate or standardize the education of nurses." To protect the public from incompetent nurses is not, then, what the framers of the bill are striving for, but the institution of certain fixed methods of education which they favor.

That the framers of the bill seem to feel

that they are going too fast is evinced by the proposed withdrawal of the paragraph on compulsory registration; the defeat of the bill is evidently feared if this is left in. But if this is withdrawn of what use is the bill? The suggestion that "registered attendant" be substituted for "household nurse" is rather confusing, in view of such phrases in the bill as "as nothing in this act shall be construed from preventing a *nurse* registered under the title *household nurse*," or, again, "the certificate of a *nurse* of either class," etc., though where possible the expression "care for" is used in place of the verb "to nurse."

One is surprised to find that in the discussion of the bill, the most important point—the point which might affect adversely the graduate nurse—was quite overlooked and not touched upon. The bill requires that graduates who apply for registration shall have "received a certificate of graduation from a training school *considered efficient by the board*." Thus, the bill makes no definite stipulation as to length of course or conditions of training, but allows the board to set any standards it sees fit, and to pass on each individual school and discriminate as it so pleases. This absolute power in the hands of a board has been tried out in other States, and has worked to the disadvantage of many hospitals, schools and graduates. But even in these States, the graduates of the schools discriminated against, though barred from some institutional positions, the State Nurses' Association, Army and Navy, and Red Cross nursing, are yet free to practise their profession in other lines. This would not be so in Massachusetts, for should the bill be passed in its present form the graduates of any school not considered efficient by the board could be barred from practising as trained nurses. If they wished to engage in nursing they would have to do so as attendants or household nurses. It can be readily seen that such a condition would not be tolerated.

At the hearing on the proposed amendment held in Boston on March 9 before the Committee on Public Health, Dr. Bowers spoke for the bill on behalf of the board of registration that proposed it. Miss Parsons, of Massachusetts General Hospital; Miss Riddle, of Newton Hospital, Mrs. Henry Ehrlich and Mr. H. S. Stone also spoke for the bill. The arguments of Senator Tufts, of Waltham; Dr. Goss, of Taunton, and Dr. Palmer, of Framingham, were strong and convincing. The clauses in the bill which were most strongly objected to were those relating to compulsory registration, the inspector of training schools and the power vested in the board. In matters of legislation it is hard to predict what will happen, but it seems hardly likely that the bill will pass in its present form.

An act to amend the public health law in relation to the practice of nursing has been introduced in the New York State Legislature. The bill was prepared by some of the regents of the university, and is intended to be a compromise between the views of Miss Goodrich, as expressed in the bill of last year, and the views of the hospitals. While the contention for the monopoly of the term nurse has been abandoned, there is much of the text which will be objectionable to the hospitals, and it is safe to say will be opposed by them in its present form.

The bill makes a hard drive at the short term and correspondence course schools; for, should it pass, they will not be allowed to give their pupils a "diploma, certificate or any credential indicating that such person has received qualifying training and education for the practice of nursing." The important features of the bill will be found in the Nursing World Department.



The Inventive Nurse

An American physician, after spending several months in European hospitals, the

latter part of the time in the hospitals of London, remarked on his return that the English nurse was far ahead of her sister nurses on this side the Atlantic in her ability to improvise and devise and invent and improve on hospital appliances and furnishings for use in sick-rooms. We wondered if this were true or if the facts were that England, being much smaller in area, it was easier for the inventions of nurses to become generally known. Go into any hospital, however small, and if you are there for a day or two you will observe or have shown you some device that has been worked out in that hospital to meet some necessity which presented itself. Yet the average visiting physician or surgeon from abroad would never hear of one in a hundred of the useful devices that necessity has prompted some one to bring into existence. No one outside of those connected with the hospital knows about most of them.

Why not let your fellow workers know of them. Send us a photo—small, clear kodak will do—or a drawing, with a short description, or send the description alone if it cannot be easily photographed.

If you are a private or visiting nurse, what have you been able to improvise, or have seen others improvise, that has taken the place of some hospital utensil or appliance you could not get? Tell us about some of your makeshifts. Everybody is interested in "makeshifts."

What improvements have you made in your training-school plans or methods that you feel has been helpful and that you would commend to others? Tell your comrades in the cause about it. Remember that hundreds will read a short description of a practical device or plan who would not read through a long article of several pages. What have you to suggest in the way of labor saving in the care of the sick in hospital or home of any class?

Favoritism—A Hospital Vice

Traced back to its smallest beginnings, the cause of much of the petty discord and the undercurrent of complaint which exists in many hospitals and training schools will be found to be favoritism, or a feeling that justice is not being meted out equally to all. In the training school the vice of favoritism creeps in almost unconsciously—unless the head nurse or the principal has been warned of its insidious dangers and resolves to have none of it in her administration. It seems to be a failing which women are more likely to yield to than men, but whether in men or women, it is fatal to successful administration. Wherever favoritism exists it is a sign of weakness of character—a character not sufficiently developed to do justice to all.

None of us can help liking and enjoying some of our associates or subordinates better than others, but our personal likes or dislikes should never be allowed to obscure our duty to those who are under our authority, nor take the keen edge off our sense of justice.

The habit of favoritism is so insidious and the dangers of it so little appreciated, that it needs a good deal more attention on the part of superintendents than it has ever received. Nothing does more to clear the air and disarm suspicion than a frank discussion of this subject. It is such a very human failing and so many are liable to it that it need not be aimed at any individual but rather suggested "to all whom it may concern."

The young head nurse may easily be thrown off her guard by a little flattery from some of the nurses in her department, and thus the way is paved for her to begin to have favorite nurses and to show favoritism.

Pupil nurses are very prone to cherish a grudge in regard to some one who is in authority because of some fancied slight,

and they, too, need to be warned of the dangers of ill-founded and causeless prejudice, and of how much unhappiness both prejudice and favoritism cause.

Very often the busy superintendent is too overburdened with other details to notice that the vice of favoritism in her hospital is flourishing unchecked. In some cases the vice has become such a source of discontent and ill-will that otherwise capable head nurses have been asked to resign because of this one failing. It might be well for superintendents and head nurses to do a little self-examination and a little careful investigation of their own establishment—to make sure that unnecessary unhappiness and discontent is not being created by the yielding on the part of some executive to this human failing.



What Are Dispensaries For?

"I don't believe in dispensaries. Do you? I just hate to see people sitting in rows, waiting. *I think dispensaries ought to be abolished.*" This remark was made recently to one of the editors of this magazine. If it had been made by a frivolous society woman one would not have been surprised. But it was not made by that type of woman. It was made by a social worker—in charge of a "welfare bureau" designed solely for the needs of the dependent class, and that worker had taken a course in a well-known school of philanthropy and social service.

The remark set us to thinking of how many other people there were who did not believe in dispensaries, and of why they should believe in them. The result of our thinking will appear in two articles on dispensary work, especially as it applies to smaller communities, written by one of the foremost authorities on dispensary work in this country.

The Hospital Review

CONDUCTED BY CHARLOTTE A. AIKENS

Items of Interest, annual reports, publicity literature, and material descriptive of newer methods and plans in any department of hospital work, should be sent to the editor of this department, at 722 Sheridan Ave., Detroit

Hints for Prevention of Waste in Hospitals*

A. A. S.

IV. RUBBER—I. Should be kept in the basement in bulk and doled out often in small amounts, rather than seldom in large amounts. 2. Keep in lycopodium powder. 3. When used in operating room, it should be washed and laid to drain in a wire tray over the hopper. 4. Do not boil hard black rubber goods.

V. GLOVES—I. Glove bills are generally enormous. But dry sterilization is the principal cause. If the doctors insist on dry gloves, either persuade them to provide their own or charge the price of them to the patients. One pair, boiled and dried and powdered carefully each time could last an ordinary man in general practice for six months. These methods have been successfully tried. 2. Do not dry the gloves over a warm place.

VI. CATGUT—I. The surgeons in one center run to mainly one method of suturing, and one can determine in what lengths best to buy catgut. Ends should not be used on another case. Accident work is clean work in one sense, that it does not proceed from disease, and it should have the benefit of clean material.

VII. CYSTOSCOPIC APPARATUS—I. As specified by the attending, should be soaked in carbolic acid 1-40. 2. Many parts must be simply washed in cold water and dried and fumigated dry in an air-tight formaldehyde closet.

VIII. SAFETY-PINS—I. At best these are cheap, much cheaper than a worried nurse or an uncomfortably bound patient. 2. Send the pupils to the laundry to hunt for safety-pins and cease giving any out for a week or two once in a while.

IX. ALCOHOL—I. An account must be kept of the amounts used. The alcohol in which instruments lie before the final polishing is the same that counteracted the carbolic acid for disinfection. It can be used over and over, and when Bon Ami sediment collects it must be strained through cotton. 2. The pupils should be taught that it is pilfering to take this alcohol for their personal use. Lock it up from the orderlies, who dilute and sweeten it to make white whiskey.

X. COCAINE—I. Under the Boylan law every particle must be accounted for. It is very expensive and should be made up in the smallest possible quantities. For this use the tablets. A solution that stands is costly and a fungus may appear in it.

XI. GAUZE—I. Each hospital has a standard size for its dressings. One kind of gauze is preferable, but the web may be cut to much greater advantage one way than another. 2. The folds, at the edges, make quite a pile of fluffy material for perineal or obstetrical pads. 3. Do not advocate washing and re-using the gauze. Here, again, is the question of economy versus efficiency. The nurses' time is too valuable.

*Continued from March.

XII. COTTON—1. Keep at least four kinds on hand—waste, two of absorbent and one non-absorbent. 2. Send all the odd bits to the babies' ward, to cleanse their buttocks with olive oil every time the diaper is changed after the morning bath, instead of with water.

XIII. GOWNS—1. Should be patched or have the buttons sewed on after every laundering. 2. Use no bleaches. 3. When old, keep for visitors or for special dressings on the wards or for isolated nurses.

XIV. DRESSINGS—1. The operating-room nurse should make a raid on the ward closets to see if they are opening and spoiling dressings or collecting too many packages. Better have many covers and only a very few in each cover.

XV. BURNS—1. All old soft linen begged from outsiders or discarded in the hospital, should be cut, not torn, in squares of 6 to 10 inches and put up in packages of four, to be sterilized for burns. 2. All old mended linen or linen unavoidably stained should be kept for burns, also blankets. 3. This applies equally to patients who have very dirty dressings, *e.g.*, ichthyol.



Noise in Hospitals

From time to time this department has called attention to the crying need for a closer study of the prevention of noise in hospitals. Miss Powell's article in the February number adds emphasis to the need for study of this problem, and, incidentally, to the futility of expecting to suppress noise in the vicinity of a hospital by the posting of a notice, "Quiet Zone." In the *Hospital World* for January, Miss Elizabeth Mills, head nurse of the Rockwood Hospital, Kingston, Ont., contributes an important practical article on the effects of noise in hospitals for the insane, and of the importance of its prevention.

Among other splendidly practical things she says: "Of all individuals connected with

the hospital none can do more to disturb its peace than the nurses. . . . The whole secret of the success of non-restraint methods in the management of the class with which we are dealing consists in preventing or avoiding situations where restraint may be necessary. Those who fear that the insane will take advantage of the milder methods of treatment little appreciate the power, well-poised, properly taught, expert nurses can exercise by mental suggestion, calm persuasion and innocent artifice. Ward disorders can be more easily prevented by the judicious, quiet words of a quiet, self-possessed, gentle-toned nurse than by the threats and stormy commands of a ferocious keeper. . . .

"It cannot be too deeply impressed on our nurses that noisiness in an institution for the insane is as infectious as measles; they should be taught to handle keys, dishes, doors and furniture gently and quietly; they should wear rubber heels and cultivate a noiseless tread; they should understand the necessity of promptly answering the telephone, door and waiter bells; . . . shouting commands to patients or fellow nurses is inexcusable—therefore, nurses should early form the habit of speaking lowly and distinctly. Example is more important than precept, so if the head nurse is negligent she need not wonder if her pupil nurses regard this form of 'voice culture' lightly."

The whole article is well worthy of careful reading.

One superintendent who has had excellent results in securing a quiet hospital makes a practice of asking nurses to send in to her as a part of their studies written essays on the sources or causes of hospital noise which they have observed in their own hospital, and how such may be avoided.

When we begin to attack such a problem as a *subject for study* we have taken a step which will carry us far beyond and help us to reach results which can never be attained by the posting of "Silence" signs or

occasional admonitions. Study the causes of noise carefully and constantly, and try to remove or correct them one by one. You may be surprised at the amount of noise that can be eliminated when the human voice is subdued. *

The Accomplishment Card for Nurses

Most industrial workers, whether they belong to the nursing staff or not, will agree with me when I say that cooperation on the part of the nurse is most important in the occupational department of each hospital, as occupation has proved to be a most powerful therapeutic agent in the treatment and cure of nervous and mental diseases. We who are superintendents are very careful to find out certain qualifications the prospective pupil possesses before we admit her as a part of the training school, but the occupational qualifications we have in the past overlooked. Providing the probationer is the right age, is of proper height and has the required educational and moral qualifications, the average superintendent does not inquire whether the prospective pupil can knit, sew, do basketry, sing, dance or play cards.

The time is here when we should consider the occupational qualifications of the nurse as well as the others, and by so doing aid the occupational teachers in their work, and increase the efficiency of the nursing staff, for nowadays a nurse who is versed in occupational work is, without a doubt, of more value than one who knows absolutely nothing of industries.

In order to find out what lines of work the nurse may already possess, an accomplishment card might be given to each nurse on admission, with instructions to fill in and hand to the superintendent of nurses before a stated time. When these are handed in, the physicians, the superintendent of nurses and the industrial workers will know at a glance that Miss Jones can knit and do plain sewing, Miss Brown plays the

piano, and Miss Smith understands raffia work.

Now, of what advantage is this knowledge to us when we have found it out? Let me illustrate, using the present war as an example. A number of hospitals are doing relief work, and the question comes up, "Who understands knitting?" Instead of asking each one individually whether or not she can knit, we consult our information cards to find out that Misses Jones, Brown and Smith know how to knit, so these nurses can be assigned classes in this old-fashioned but useful art, which has revived considerably since the present war broke out.

Again, the industrial teacher may arrange some little entertainment for an evening's enjoyment, and by consulting the cards can find who can recite, sing and do fancy dances, and all needless questioning is avoided.

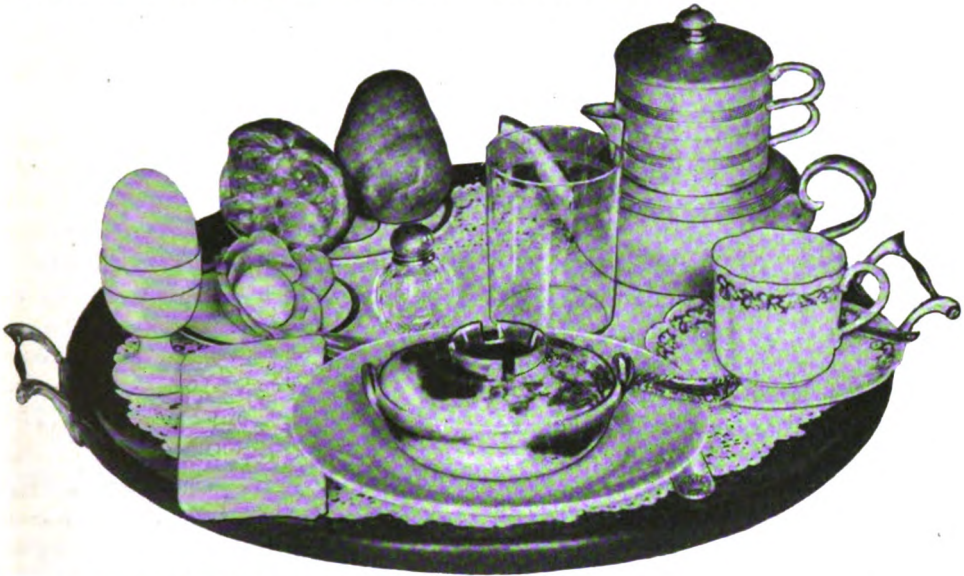
One more illustration to show the advantage of the accomplishment card to individual patients. Mr. Jones, an artist, is admitted in a much depressed condition. It is very difficult to interest this patient in the industrial pursuits on his ward. Caning chairs, basketry or weaving does not appeal to him, and the industrial instructors in a large institution cannot spend very much time with individual patients, so we consult our cards and we find that Miss A knows something of drawing and painting; thus Miss A's services are brought into play. She is placed on this ward as nurse and given instructions to interest herself in this patient. Before long we find Mr. Jones helping Miss A illuminate Christmas cards and calendars. Interest takes the place of apathy and his fancied grievances are on a fair way to be forgotten.

This card system is well worth trying, and superintendents who introduce it in the training school will do so to their own advantage, as well as to the advantage of the patients, and to the occupational department of the hospital.—*R. G. C. in Maryland Psychiatric Quarterly.*

The Food Laboratory of the Hospital

Two-thirds of the complaints made by patients regarding hospitals center in the food question. What the patient gets to eat and how it is served are matters of much greater importance to him than how the sutures in his wound are prepared, or how the skin is disinfected. Yet, somehow, though we are supposed to be approaching perfection in the details of surgical technique, we make slow progress in improve-

A woman who had gone with a patient to a hospital and remained a day or two as a guest related her experience to the writer, with the question as to why such conditions in regard to food were allowed to exist. Her meal was served on a tray at the same time the patients' meals were. She had stated that she never tasted either coffee or oatmeal if she could help it, yet both were religiously served to her each morning of her stay—both of them lukewarm.



THROUGH COURTESY OF WOMAN'S HOME COMPANION

DOES NOT THIS BREAKFAST TRAY LOOK TEMPTING? ITS SPECIAL FEATURES ARE THE INDIVIDUAL SILVER COFFEE POT, CREAMER AND SUGAR BOWL COMBINATION; COVERED CEREAL DISH; BUTTER BALL SURROUNDED WITH ROSE PETALS

ment in regard to hospital dietaries in most general hospitals. The difficulties in the way of managing a scientific dietary in general hospitals are numerous and difficult to overcome. The difficulty is first of all a difficulty in securing capable managers for the dietary department of a small hospital, in which the duties of a housekeeper are almost of necessity combined with those of the dietitian. The average graduate of a school of domestic science without experience in hospital needs and conditions is a poor prop on which to lean if one wants to really improve dietary conditions.

A friend of the writer, recovering from an operation, was served with liver for breakfast twice in one week, and she has never gotten over talking about that liver being served to private patients in her condition.

Thus complaints, *just* complaints, continue to be made, and one wonders what the solution of it all is. Where an experienced dietitian is in charge one finds the dietetic department more free from such gross blunders as those cited above, but the smaller hospitals are the most numerous and few are able to afford a high-priced woman who can

give her closest attention to the satisfactory management of dietary problems.

As a rule, there are fewer complaints regarding the common diets in small hospitals than in large hospitals. The difficulty comes when a rigidly restricted diet, free, or almost, from certain elements of food, needs to be carried out for a protracted period. The changing of nurses, the failure of the one in charge of the kitchen to comprehend the needs of such individual patients, and the failure of the physician to give positive help in outlining such diets, combine to make the problem a most difficult one.

It is easy for a physician to say, "No starches or sugars," but when you ask that physician to state what he wants the patient to have, you find in five cases out of six that he begins to move toward the outside door and makes as graceful an exit as he can. To devise a system that will result in getting for every patient in the hospital who needs a special diet the exact diet that he needs, and just as the physician orders, who has made a study of scientific dietaries, and to continue it in the changes that take place in an average hospital, is what we are looking for. We have a strong feeling that the position of hospital dietitian, in charge of the food laboratory of the hospital, should appeal to many nurses, and that when nurses begin to specialize in this department a better day will dawn for hospitals in general. Such a position pays as well or better than many of the other lines of nursing. It is free from night calls, as a rule, and the nurse who specializes in this line may be sure she is entering a field far from crowded and with wonderful opportunities for a successful career.



Hospital Consolidation

Owing to lack of funds, St. Luke's Hospital, Baltimore, has been forced to close. On

February 1 it was officially consolidated with the Hahnemann General Hospital. All patients at St. Luke's were moved January 30. Drs. William Dew and L. C. Clarke will be the chief resident physicians of the merged institutions, with Miss Louzetta E. Cornish as day superintendent and Miss Theresa Boose as night superintendent. To pay off the debt of St. Luke's Hospital a theater party was held at Ford's Opera House February 9.

Now that the merger of the two hospitals has been completed, the board of directors announces that the present quarters of the Hahnemann Hospital, on North Mount Street, will be rebuilt at a cost of \$250,000. Plans for the new building and remodeling of the old ones have been completed. The funds to accomplish the purpose of the board will be supplied, it is said, by the national organization of homeopaths. It is not known just when the rebuilding of the institution will be started.



Another Three-Million-Dollar Hospital

Not many cities of the size of Houston, Texas, have the prospect of a three-million-dollar bequest for hospital buildings and endowment.

"Having from personal experience and observation become acquainted with the suffering and deprivation of the unfortunate, indigent, infirm and sick, and having great sympathy for them, I desire that they shall receive the full benefit of the devise mentioned in this paragraph."

Thus did George H. Hermann close the paragraph in his will in which he provided for the construction and maintenance of a hospital with the residue of his estate, valued at from \$3,000,000 to \$5,000,000. The hospital will be known as the Hermann Hospital.

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

The Special Nurse

To the Editor of The Trained Nurse:

In reply to the question concerning the duties and conduct of the special nurse in hospitals, I should like to say that the superintendent should certainly be able to control a situation of this sort. Why does she countenance such laxity and indifference, and allow her pupil nurses to perform the duties for which the special is being well paid? The article reads that the patient suffers in consequence of the inattention on the part of the nurse. Why should she be retained on the case, or spoken to in a "diplomatic" way, when it is a clear case of shirking her duty? The superintendent's authority entails complete control of her institution and every one in it, and if she fails in this she lacks executive force and is not qualified for her position.

I should think she would make regular rounds, and investigate any complaint from the patient, or, if there is any evidence of neglect or carelessness, speak of it without the slightest hesitancy, and have it corrected. If necessary a change of nurses should be made.

Every reputable hospital has certain requirements to which the special nurse must conform: regular meal hours, time off duty, etc.; but, if she requires set rules for the actual care of her patient she should go back to her probationary period or, better still, qualify herself for some other line of work, for she surely is out of her sphere as a nurse.

I believe other nurses will agree with me that surely any superintendent should be able to adjust a matter of this kind through her own resources.

S. R. CLARK, R.N.

Knapp Memorial Eye Hospital,
New York City.

To the Editor of The Trained Nurse:

In response to your request in the February number under "Special Nurse," permit me to say that it is a well-known and, I suppose, undisputed fact, that a hospital is responsible for the nursing care of the patients. (This opinion has been held by courts in damage suits brought

against hospitals.) Then special nurses, as well as pupils, **MUST** be responsible to the superintendent or superintendent of nurses and submit to their authority. Without this you will have confusion, difficulty in maintaining discipline and standard in the training school, and in the end the patients will suffer. On the other hand, the superintendent should see that the special nurse gets proper food and sufficient time off while on the case. When a nurse has proven herself careless and lazy, then why not speak to her about it, and if she does not do better bar her from coming there. That is your (disagreeable) duty to your patients and institution. I would *never* complain to the doctors of a nurse unless I was forced to refuse to allow her on cases in the hospital. But let us remember, in dealing with graduates from other schools, that not only does the technic vary greatly in the schools of today, but treatments used universally in one section of the country are *unheard of* in another. Rules for specials serve as a guide for the new nurse and every hospital has to work out its own.

Why do some nurses become lazy? Because some superintendent graduated the wrong women, and we have some nurses that require as many rules and as much supervision as pupil nurses.

A. H., R.N.

To the Editor of The Trained Nurse:

H. B. J.'s letter in February magazine is most interesting, and I hope will bring rules and advice from many superintendents. We all seem to have similar troubles with special nurses. I think the superintendent should be allowed to make rules governing all nurses on duty in the institution where she is responsible, and where she must bear the embarrassment from a careless graduate nurse. The charges against our graduates are too often true.

I have found graduates lacking in courtesy to the superintendent and the hospital. For instance—I have been notified by the doctor that a patient is coming in for immediate operation. My ward nurses are already overworked, and could not possibly give another seriously ill

patient good care. I make requisition to the superintendent of nurses that another nurse be sent me, which is done with no little inconvenience to some other ward. In a little while the patient arrives with a graduate nurse. Why has not this nurse notified the superintendent that she is coming, or, rather, asked if she might come. The graduate has been a pupil and has seen the same mistake made which gave her extra work. Yet she graduates and does no better herself.

Where lies the fault? With that nurse's superintendent in training days? Perhaps—but even so, having witnessed the results of the mistake, should she need such a point shown her? I think we should hear from the other side. We would be glad to hear from some of the graduates doing special duty in regard to the courtesy they receive at institutions. Our nursing ethics need many rules enforced.

One thing more—will nurses who have taken post-graduate courses in institutional management tell us something about them?

AN INTERESTED SUBSCRIBER.



Ethics

To the Editor of The Trained Nurse:

I want to express my appreciation of Miss Aiken's articles, "Teaching Ethics in Hospital Schools." I believe if we spent a little more time discussing ethical questions, instead of nursing politics, it would be better for us. If the editor will be kind enough to allow me space I would like to present some ethical questions for discussion, to which I have given a great deal of thought the past few months.

1. What is the ethical position of the doctor who gives his support and influence to the correspondence school for nurses and its interests?
2. How would this be considered by the American Medical Association?
3. What is the position of the doctor connected with a hospital training school who lectures to the hospital pupils, and at the same time gives his support and influence to the correspondence school for nurses?
4. How should the training school and hospital authorities regard his action?
5. What would be the attitude of the doctor to the graduate nurse who gave her support to the doctor who had gained his medical knowledge in a correspondence course?
6. If the graduate nurse is expected to give her loyalty to the doctor, does not the nurse deserve a little loyalty in return?
7. What is the ethical position of the R.N. who

gives her support and influence to the correspondence school for nurses and its interests?

8. How would this be considered by the board of nurse registration in any State?

I should like to have a full discussion of these questions, for it has been a shock to me to find presumably reputable physicians and supposedly R.N. nurses giving their support to the correspondence school.

IDA FLETCHER, R.N.



Comments on Various Letters

To the Editor of The Trained Nurse:

I am glad that I am a subscriber to your magazine. I profit so much by it. I read it carefully from cover to cover, but I believe I enjoy the "Letter Box" best of all. I think it such a practical way of exchanging ideas upon the many puzzling problems that face every member of our profession from time to time.

I take great interest in all articles and letters dealing with the problem of nursing the middle or working class. I think all suggestions about a nurse working for less than \$25 per week are unfair. Nursing is hard, especially the night work, and while the cut in the price would give a nurse more calls, and she would be enabled thereby to average the same amount at the end of a month or year, the work is too hard to keep at constantly. When I am kept constantly on duty for several months I become completely worn out, and other nurses say the same thing.

I think a better plan would be to organize the men and women making less than \$100 per month into an organization or "nursing benefit." Have them pay so much per month or year and let that organization furnish them with nurses upon a doctor's order. That plan seems to work very well in the lodges. They furnish the doctors. The "nursing benefit" would have to be a higher rate per capita, as I understand that the Lodges pay only one doctor and him by the year. This plan looks practical to me, and I would love to see it tried. I would like very much to know what my sister nurses think of the plan.

Quite a lot of time, valuable time, I think, has been wasted by nurses in some sections of the country in trying to monopolize the name "nurse." In this part of the country any and every old thing is called nurse, old negro mammies and little black nurse-girls that push the baby-cart up and down in the sunshine. We are satisfied here to be known and spoken of as "a trained nurse."

I agree heartily with "A Hospital Superintendent" in the January issue of *THE TRAINED NURSE*. I, too, do not think it right to let a patient know that a mistake has been made or an unavoidable accident has happened to retard his recovery. It seems disloyal to the profession, a reflection on the institution, and can do the patient no good whatever to possess the knowledge. I agree with the superintendent of nurses in the January number of *THE TRAINED NURSE* that a nurse without a liking and an aptitude for operating-room work should be excused from that service. There is nothing to be gained and very much, sometimes, to lose, by inflicting such scrubbed nurses upon surgeons. I gave particular thought to the puzzling questions of M. C. L., in the January issue. I am of her opinion that much more can be accomplished in handling girls by justice, fair-mindedness and trust. I have known real small children to keep silence for an hour in a class room when they were left upon their honor when they would not have done so if some one had been placed to watch them. As far as the question of young girls autoing at night with men goes, I think a good many things would have to be taken into consideration, the foremost being the custom of the town or State in which a hospital is located. For instance, here in the South no young lady with self-respect or a care for her reputation would go autoing at night with men; that practice is looked upon here as one of loose women and "joy riders." Thus, you see, a superintendent would most likely have her institution closed by the mayor of the city if she permitted such. I think, too, that even in localities where such things are customary, that the superintendent should know what kind of men her girls are keeping company with, as the editor suggests. Married men, ex-patients, are very often too ready to repay the kindness extended them by a nurse in ways that are not always very honorable. As to the question regarding the mistake made by a girl of fifteen, would say that the position of a superintendent in this instance is a difficult one. Girls are so mean—I'm sorry to say it of my own sex—but they are much meaner than boys. Were this young lady of the unfortunate past allowed to remain in the school, the two who were in possession of her past history would impart their knowledge to their companions and the whole school would demand her removal or else ostracize her there by making her stay in the training school very unpleasant. I believe I would endeavor to place her in a school in another State, where there would be less likelihood of any one learning of her past.

I am afraid that my letter is so long that it will form acquaintance with the trash basket rather than "The Editor's Letter Box." Before I close I wish to make inquiries about "school nursing." Will any school nurse give me a few pointers upon that branch of nursing? I'm very much interested and would like to undertake work of that kind. I have been fortunate enough to capture the knowledge of a handy trick of the profession and for the benefit of those who like myself have all these years been blacking spoons, burning fingers with matches or else cumbering themselves with alcohol lamps, etc., will say that all of this can be discarded and a urotropin tablet used instead; a ~~u~~ ^u grain tablet will last for a long time. It gives a smokeless flame, lights and extinguishes easily and can be used with double spoon or an ordinary teaspoon.

A. L. S., R.N.



To Be Personally Applied

An Open Letter to the Readers of The Trained Nurse:

May I tell our readers of a splendid opportunity to help a sister nurse in a variety of ways which will suggest themselves, if they think hard about it, now and then. No money, thank you, but *your personal interest wanted*.

Over in Philadelphia lives a nurse, not so old as some others, but too infirm because of rheumatism to do active nursing or to take an institutional position. She is quite an expert at doing all kinds of crochet and knitted work, at which she is now earning a little by making up samples for a yarn manufacturing concern. A nurse who visited her says that she also "makes very beautiful trays of mahogany with glass surfaces, under which are specimens of natural history, butterflies, feathers, shells, etc."

Thirty years ago she graduated from the Long Island Hospital, Brooklyn, N. Y. She was a nurse in the Spanish-American War (S.-A. War nurses please take notice.) Was also for a number of years a member of St. Barnabas Guild for Nurses, but allowed her membership to lapse because of being in institutional positions where there was no branch of the Guild. She greatly desires orders for caps, leggings or knitted or crocheted articles—makes wool "cosy coats" to wear under a suit coat or for a little extra warmth on cool days. Also makes "knee-warmers"—knitted wool caps for people who have sensitive knee-joints. Please remember this, and see if you do not often have patients whose knee-joints would be better with such a woollen cap on. You

can help greatly by suggesting it to your patients and sending the orders.

Perhaps if you are a busy private or institutional nurse in Philadelphia and "hate mending," you would like to help her and yourself by having her keep your clothes in order. Send her a post-card if you wish such work done. She or a friend will call. Try to have a good-sized package of mending. If you can think of any other light occupation she might try, mention it to her. The parcel post will carry knitted or crocheted articles anywhere in the United States. She has another old nurse friend who will help her with such work. Write her about any special thing you have in mind which she might be able to make for you. Address Mrs. E. M. Swainson, 1529 North Tenth Street, Philadelphia. Please, gentle reader, don't lay the magazine aside and say that is meant for some one else to work at or think about. It really is meant for you.

CHARLOTTE A. AIKENS.



Sleeping Out-of-Doors

To the Editor of The Trained Nurse:

I have had a great deal of experience with tuberculosis, where my patients have slept out-of-doors, and am sleeping out-of-doors myself this winter, therefore feel able to give a few useful suggestions:

Sleeping Porch or Tent—Most people use porches, as they are less expensive. These porches have one side closed and usually a roof. In case they do not have a roof, an awning should be put up, to be lowered in case of snow or rain. Always select a porch as high up as possible.

Patient's Bed—This should be a single iron bed. Good mattress, six wool blankets, rubber sheets to cover bed in case of rain, a Henderson foot-warmer, as they stay hot twenty-four hours.

Sleeping Garments—A sleeping garment I find comfortable is in one piece, feet and hood attached, made of eider-down, leaving only eyes, nose and mouth exposed. If you follow these few suggestions I am sure you will enjoy outdoor sleeping and good health. E. F. A.

To the Editor of The Trained Nurse:

Having nursed at Saranac Lake, where sleeping out-of-doors is quite common among the tubercular patients, permit me to relate these experi-

ences to Anna K. M., whose letter on "Sleeping Out-of-Doors" in the February issue of *THE TRAINED NURSE* asked for such advice. In order to protect the patient from draughts, place thick pads of newspaper between the spring and the mattress and then proceed to make the bed after the usual fashion. Have the patient wear a flannel nightdress, and sleep between blankets. The bed is warmed with hot water bags about an hour before retiring. During the day the bed is covered with a rubber blanket. As an extra protection against draughts, the head and foot of the bed are covered with thick canvas, although in case of a wooden bed this precaution is not necessary. Many patients complain of the light at sunrise. To avoid this inconvenience a piece of black lining is placed at the patient's bedside, and upon being awakened early she can bandage her eyes and so not be disturbed. Some patients shield their eyes with umbrellas.

KATHRYNE CARTMANN.



Casting the First Stone

To the Editor of The Trained Nurse:

I should like to reply to M. C. L.'s letter regarding probationer who at the age of fifteen was betrayed and the two pupil nurses saying their fathers would not permit them to stay in the hospital if he knew they were under the same roof with this girl. What is to be done with this probationer? Do you think, dear sisters, that the mistake of a girl at the tender age of fifteen should be held against her, especially when she has lived right since? Don't you think she is deserving of help and encouragement from us all. To me it seems a blessed opportunity to do good. I fear to think what might happen to her were she dismissed for this reason. I can only think of a little saying that says something about having "the game as well as the name," and if the worst should happen, would you not feel that you had part in it if you do not hold out a helping hand now. Just stop to think how easily one is influenced at that age. What right have we to be scornful? Perhaps we have never had temptations, or I wonder were we in her place would we have done otherwise. I think as women and more as nurses we should help to uplift, especially when we are supposed to be so good and have opportunities for doing so much good. Why not make use of some of them?

B. L. A., R.N.

Continued in Advertising Section

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

The National Organizations

The dates of the meetings of the three National organizations of nurses has been changed from May 30 to June 20. This will bring the meetings at the same time as those of the American Medical Association and of the American Hospital Association. Full particulars of transportation, etc., can be had from Mrs. C. V. Twiss, R.N., 419 West 144th Street, New York City. It seems now positive that there will be no foreign visitors at the Convention. Writing in her department of the *American Journal of Nursing*, Miss Dock states: "With the word that Mrs. Fenwick cannot leave England and that Japan cannot send any colleague to San Francisco because of the war nursing, disappears the last probability of any foreign visitors to the San Francisco meeting."



Massachusetts

The midwinter meeting of the Massachusetts State Nurses' Association was held in Boston at 585 Boylston Street on Saturday, February 20, at 3 P.M., the president, Miss Riddle, in the chair. The meeting was opened with prayer, after which the minutes of the last meeting and the treasurer's report for the interval from June 1 to February 1 were read and approved. Miss Riddle then addressed the meeting to this effect: "Why should we have all this agitation about registration and education? That we may have better nurses and have them more abundantly. It was declared at the first meeting of the Association that it was desirable to have a law for the regulation of nursing, and we are still working at it. Standards have been raised throughout the State by the desire of graduates to join the State Association. Progress in the schools, as shown in the census reports, is astonishing. The registration law has also done pretty well; witness the number of applicants for registration. The board has concluded that practically all graduates of all the schools must come before it soon after graduation. It follows that the schools must have spent considerable time and teaching in preparation. And now we are asking more. We are especially interested in obtaining through legislation an in-

spector of training schools, because without it nurses are exploited and do not get a proper return for the time spent. These wrongs can only be corrected by having some one study them up and report. The present bill calls for an inspector to be appointed by the board of registration. There are objections that can and will be made to the bill: 1. It will be said that too much power is put in the hands of the board. Get another board. 2. It will be hard on some schools. All of us might be criticized by an impartial judge, but we are all ready to be criticized if it is for the best good. 3. Some one may object that the hospitals need to accomplish their work and cannot be bothered by an inspector, that they cannot have their reputation injured and the number of applicants lowered in consequence. But the best good should be considered. 4. Individuals would be put to hardship. High requirements for entrance should not be demanded lest hardship come to some. People quote the past and say Lincoln studied law by the light of a pine-knot. But conditions have changed. Twenty-five years ago applicants were older and knew their own minds; now they are young and unformed. Twenty-five years ago one kind of work was taught in the training schools, private nursing. Now many are taught. So times and requirements have changed, and now a nurse must not only be a good all-round nurse, but a specialist. Competition, too, is great now. The schools used to be in good, straight hospitals; now they are in every place—for example, the correspondence schools. Therefore, something should be done to standardize nursing, and we believe that if the amendment to the law is carried a long step will have been taken in that direction. The Hon. Mr. Joseph Belcher will tell us how to proceed with matters legislative at the State House. Then we hope the legislative committee will have all your assistance. Whether or not we are now successful, it is only a matter of time. It must come as a matter of evolution, if in no other way."

Mr. Belcher, representative in the ninth Norfolk district, then spoke at some length. He ended with a brief eulogy of district nursing, in the course of which he said it was really the



GRADUATE NURSES AND SUPERINTENDENT OF CANFIELD WHITE HOSPITAL AND SANITARIUM, CLEVELAND, OHIO

nurse who cured, obeying orders with a little common-sense.

Dr. Laura Hughes next referred to the fact that the bills had always come up before the public health committee, though regulating education, and said it should come before the committee on education, as the aim is to regulate or standardize the education of nurses. To this Mr. Belcher did not agree, maintaining that the bill more properly went to the public health committee, as the work of nursing is more aligned to health than education, and the main achievement they were after was health.

After a few questions of little moment, Miss Riddle called for a report from the legislative committee, which was given by Mrs. Homer. The main point in the report was an expression of the desirability of omitting from the bill the paragraph making registration compulsory, on the ground that they were not yet ready for that. (Mr. Belcher said he had felt this would be their Charybdis.) The committee also approved substituting the words "registered attendant" for "household nurse." Mrs. Homer then urged the nurses to see the representatives about the bill and gave them a list of their names. She was glad to hear Mr. Belcher say the nurse is left in charge of the case; it was the doctors who oppose them; and she urged the nurses to attend the hearing, as their presence was important.

Dr. Hughes then spoke of the bill being presented by the board of registration, not the State Association. She spoke especially of the need of safeguarding the word "nurse," saying that a woman is only a nurse if she has had training for two years in a hospital, that you cannot make a nurse without the laboratory of the hospital. She referred to the existence of correspondence schools and asked if their graduates were to be called nurse. She also spoke of the courses in household nursing offered by the Red Cross.

Miss Parsons said it was a mistake to think hospitals could not attract young women to train as attendants, for the Eye and Ear Infirmary and the Robert B. Brigham Hospital were getting a good class of young women for that work. She spoke of the danger coming from dismissed pupils calling themselves trained nurses. She also said any young woman who really wished to become a nurse could give a year or two to high-school work before coming. Asked what an attendant would be taught, she said that was yet to be decided; it rested with the individual hospital at present.

Dr. Hughes then read a letter from Miss Mary Cary Nelson, who was sailing for Europe as a

Red Cross nurse, and the announcement was made of various sums of money raised by different nursing organizations for the Red Cross. The meeting closed with an exhortation from Miss Riddle that the nurses see the legislators of their district, the members of the public health committee, and leave no stone unturned.

Tea and a social hour followed.

The following extracts are quoted from the bill:*

"Applicants for registration under this section, who shall furnish the board with satisfactory proof that they are twenty-one years of age or over, of good moral character, and that they have received a certificate of graduation from a training school for nurses, *considered efficient by the board*, shall, upon the payment of a fee of five dollars, be examined, and if found qualified shall be registered and authorized to use the title registered nurse. . . .

"Applicants for limited registration under this act who shall furnish the board with satisfactory proof that they are eighteen years of age or over, of good moral character, but who cannot qualify as graduates of *approved training schools* for nurses, shall, upon the payment of a fee of three dollars, be examined by said board, and if found competent to care for cases which do not require expert services shall be registered with a right to use the title household nurse. . . . Nurses registered with the title household nurse shall not care for major surgical cases nor make internal obstetric examinations. . . .

"After January 1 in the year nineteen hundred and sixteen no person shall engage in the work of nursing for hire in this commonwealth unless he or she has become registered in accordance with the provisions of this act. . . .

"The board shall have authority under this section to investigate at any time the training schools for nurses in this commonwealth for the purpose of determining their fitness and efficiency as shown by their general equipment, by the character, the methods and the extent of instruction given. For the purpose of conducting this investigation as aforesaid, the board may employ a person legally entitled to registered nurse. . . ."

At the hearing held in Boston, March 9, before the committee on public health, Dr. Bowers opened the support of the bill by reading it paragraph by paragraph, and commenting by the way. He said the object of the first paragraph was to oblige those registering to be graduates of training schools. The expression "household nurse" had been changed to "registered attendant," on account of objections. The compulsory

*As we go to press we learn that the bill has been reported adversely by the committee.

registration clause had been strongly objected to, and he said the board was not particular if this was not adopted for a year or two, so long as it came eventually. He felt that the objection to an inspector of training schools was due to the feeling that the purpose was antagonistic to some of the training schools of the State; this he denied and, mentioning Waltham as the chief opponent, went on to praise the course highly and say it could not possibly be interfered with. The paragraph on penalties was to remedy the present inability to prevent nurses guilty of crimes or maltreatment of patients or those dismissed from schools for cause from nursing again. Then there was a discussion of the effect of the law on practical nurses, Dr. Bowers contending that not more than 1 per cent. would be eliminated by examinations, as the examinations would be made easy. Miss Mary Riddle wished to reiterate what Dr. Bowers had said, called the present law inadequate, especially emphasized the desirability of having an inspector of training schools, as it would be for the benefit of the schools. Mrs. Henry Ehrlich, as a manager of a district nursing association, thought that the public should be protected. To which the chairman of the committee said that unfortunately the public did not want to be protected. Miss Sara Parsons felt the bill would help, for in other States with such a bill the public had become interested. There had been cooperation in establishing standards. Hardship to small schools could be done away with through affiliation. The question of expense being brought up, she said the poor could have a district nurse and get a trained attendant under supervision from the household nursing headquarters. The chairman suggested that he get together with the opposition and draw up a bill, which Dr. Bowers expressed himself ready to do. Mr. Stone spoke for the executive committee of the Anti-Tuberculosis Association in favor of the bill, and some twenty women went on record as approving it.

Senator Tufts, of Waltham, spoke for the opposition. He said the act of 1910 purposely gave little power to the board of registration. There were three things to be considered regarding a bill: (1) Demand, (2) necessity, (3) results. Neither the public nor the medical profession were demanding this bill, but only certain nurses and the board of registration. The bill was aimed at the Waltham School, one of the best in the country. The course is different from that in the other schools. The service you get is the thing, not the nurse's title. Waltham welcomed inspection. Dr. Palmer, of South Framingham,

represented Dr. Cook, of Natick. He thought that the compulsory registration clause was from twenty to forty years ahead of the times. District nurses did not exist in many places, and in any event could not give continuous care. The fact that schools must be approved by the board on information given by the inspector might work a great hardship. He read letters from Dr. Gay and Dr. Hugh Cabot. Mr. Samuel Elder said the aim of legislation had always been to protect the public against fraudulent representations while allowing the public to employ whom it pleased, but this bill would alter the whole policy of the State. Miss Annette Fiske spoke of the need of more than two classes of nurses. She said the bill put too much power into the hands of a few people. She showed how the supporters of the bill put the emphasis on education rather than competent nursing. She pointed out the unrepresentative character of the State Nurses' Association, which has only a few over six hundred members, while the Waltham school alone has three hundred and fifty graduates. She spoke of Waltham being barred from registration in New York and the likelihood of a similar course here if the bill went through, as members of the State Association were already speaking of one or two years of high school as a preliminary requirement. She concluded that it took one Waltham graduate eight months to get into the State Association, though admitted to be eligible.

Dr. Goss, of Taunton, spoke of the great power put in the hands of the board, their chance to exclude any school they saw fit, and the fact that they were given the power to choose the inspector and to exact penalties for infractions of the law made them judge, jury and all combined. Miss Cameron, of Taunton, Miss Louise Fielder and Dr. C. B. Fuller went on record as opposed to the bill.



Connecticut

The Meriden Hospital Nurses' Alumnae Association held its annual meeting at the Hotel Winthrop on Tuesday, January 11. Officers for the coming year were elected as follows: President, Mrs. E. H. Marcham, R.N.; vice-president, Miss Jennie Pratt, R.N.; secretary, Miss Mabelle Penfield; treasurer, Miss Mary Rahaley; press committee, Mrs. C. W. King, R.N. After the meeting the members present were guests of Miss J. Riecke at a dinner at the hotel.

The regular monthly meeting of the Alumnae Association of Connecticut Training School for

The Food of Your Patient

must be appetizing, easy of digestion, nutritious, and without harmful after-effects—in short, it must be *wholesome*.

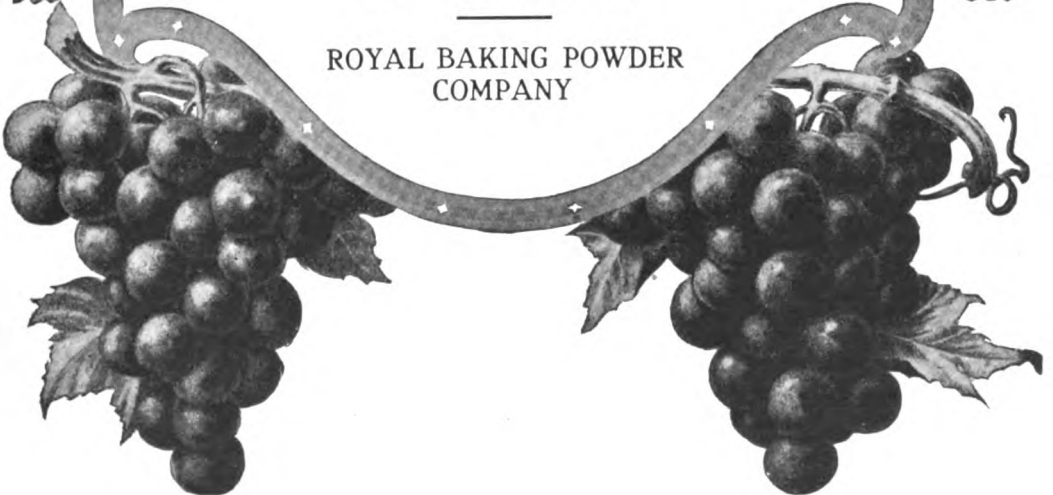
Many delicacies, both nutritive and appetizing, can be prepared from simple ingredients, obtainable in every household, through the use of a *pure* baking powder.

But in order to insure such food to be tempting to the palate, as well as acceptable to delicate stomachs, only such baking powder as is made from pure cream of tartar should be used.

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Nurses was held on March 4 at the usual time and place, with a large attendance and all the officers present. Routine business was attended to, a nominating committee for officers being appointed. Miss Hasson, a former graduate, was welcomed, and Miss McDonough, secretary of the local Society of Mental Hygiene, gave a very instructive talk on her work. After adjournment, coffee was served and conversation enjoyed.



New York

An amendment to the nurse registration act was introduced in the Assembly on March 3, and contains the following special features:

"Definition of the practice of nursing: In the contemplation of this article, the practice of nursing means the care of the sick and of the injured by a person recognized and registered, as hereinafter provided, as a properly trained and educated nurse, and none other shall, in this State, practice or hold himself or herself out, or be by any one in any way held out, to do so, as a trained, certified, graduate or registered nurse, or under any designation indicating that such person has received qualifying training and education for such professional occupation; nor shall any school or institution which is not registered by the regents of the university as a training school for nurses and as maintaining proper standards issue to any person a diploma, certificate or other credential attesting or indicating that such person has received qualifying training and education for the practice of nursing. Nothing herein contained shall, however, be deemed to prohibit others from caring for the sick and for the injured, as nursing attendants who may be known by such name or may be called simply nurses, but shall not use therewith any prefix, letters or designation indicating that they have received qualifying training and education for such services."

Nineteen young women received their diplomas at the twenty-sixth annual commencement exercises of the Methodist Episcopal Hospital, Brooklyn, on March 4. The Rev. J. M. Buckley, president of the hospital board, presided. Dr. A. S. Kavanagh, superintendent of the hospital, was not present, on account of illness. Addresses were made by Rev. Dr. H. H. Beattys and Dr. Russell Fowler. Dr. A. Ross Matheson presented the diplomas. The valedictorian of the class was Anna Stewart Haldeman.

In her report to the New York City League of Nursing Education, Miss Aida E. Sonderstrom,

who has been making a study of the nursing outlook, stated that less than 5 per cent. of high-school girls, being graduated, care to become nurses. Out of the 1,235 questioned Miss Soderstrom has received 565 replies, of which 26 answered "yes" and 539 answered "no." That nationality was not a consideration in the negative answers was evidenced by the fact that 504 of the girls were born in this country and only 35 were foreign-born.



Pennsylvania

The Nurses' Alumnae Association of the Woman's Hospital of Philadelphia elected the following officers for the year 1915: President, Miss Nellie W. Guthrie, R.N.; first vice-president, Miss Mabel Ewart, R.N.; second vice-president, Miss Anna Peters, R.N.; third vice-president, Miss Lillian Tucker, R.N.; recording secretary, Miss B. M. Seldomridge, R.N.; corresponding secretary, Mrs. E. P. Vollers; treasurer, Miss Helen F. Greaney, R.N.

All members of the Alumnae will be glad to learn that the board of managers of the hospital rescinded the rule at the December meeting of sending out pupil nurses while in training, which makes us eligible to become members of the American Nurses' Association, and our application blank has been filled. Also the curriculum of the training school sent to Miss Katharine DeWitt, secretary of the Association. The Alumnae has started its campaign for both old and new members. All graduate nurses from the hospital are requested to join, as the Alumnae needs the support of all. For application blanks and other information apply to Mrs. E. P. Vollers, corresponding secretary, 221 South Forty-seventh Street, West Philadelphia. We trust this will be one of the best years the Alumnae has known, and a cordial welcome awaits every one at the monthly meetings.

The regular monthly meeting of the Alumnae Association of the Philadelphia General Hospital Training School for Nurses was held on March 1, in the Nurses' Home. The president, Alice O'Halloran, was absent, having been sent to the Panama Exposition to supervise the tuberculosis exhibit of Pennsylvania. The vice-president, Frances Hess Lewis, presided, and there were forty-three members present. The minutes of the previous meeting were read by the secretary and approved. The treasurer's report was accepted and referred to the auditing committee. The visiting committee reported two members ill.

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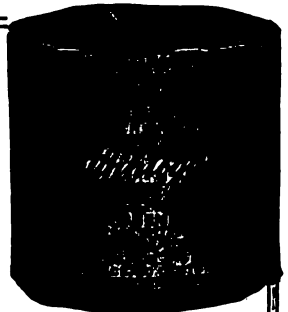
makes cow's milk easy of digestion by the baby, because the curd, which many babies experience difficulty in digesting, is broken up so thoroughly by the Mellin's Food that the digestive juices readily act upon it. Thus the inability of the baby to properly digest the curd of the milk is eliminated.

We will gladly send samples and literature to nurses.

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is applicable in every instance where there is congestion, inflammation, tension, pain—and in all wounds (septic, especially), indolent ulcers, gangrene, etc.

Clinical reports of Physicians are authoritative:

Antiphlogistine on the gangrenous foot of an aged woman so stimulated the circulation as to result in saving the foot.

Carbuncle treated with Antiphlogistine shows few, if any failures, in the practice of one physician.

Another says he saved his own leg—septic phlebitis—by the regular, persistent application of Antiphlogistine; also relieved rheumatic iritis in three days.

Such evidence, from professional colleagues, is submitted, through professional mediums, to the profession only.

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Therefore, Physicians should always WRITE "Antiphlogistine" to AVOID "substitutes"

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On motion of the arrangement committee it was decided to revive the custom of holding a memorial service at the grave of Alice Fisher on Easter Sunday afternoon. Roberta M. West accepted the chairmanship of the special committee for the arrangement for the celebration of the thirtieth anniversary of the training school. This will take place some time during the fall, the date to be selected by the committee. Cecelia Kennedy was elected an alternate to the annual convention. Four new members were received. The ballot of the nominating committee was accepted. The changes in the by-laws, as accepted at the last meeting, were finally adopted. Motion adopted that the secretary send notices to all members that the Alice Fisher Memorial Scholarship, to be given at Teachers College, Columbia University, was available for the fall term of this year. This scholarship is to be awarded to a member of the Association in good standing and having the endorsements of the Alumnae. It was voted to donate \$10.00 for gauze to the Red Cross Division of the Emergency Aid Committee. On motion adjourned.

The regular monthly meeting of the Nurses' Alumnae Association of the Philadelphia Lying-In Charity Hospital was held at the hospital on Thursday afternoon, March 4, at three o'clock. The vice-president, Miss Christine Gunn, presiding. Twenty-two members were present.

Twenty-seven young women qualified in examinations of the Civil Service Commission, Philadelphia, held recently, for the position of city nurse in the bureau of health, at a salary of \$900 a year. Sixty-one nurses took the examination. The averages ranged from 91.4 to 70.48. Mary E. Boteler received the highest average.

At a regular meeting of the Alumnae Association of Chester Hospital Training School, Chester, Pa., Tuesday evening, February 2, 1915, the following resolutions were unanimously adopted:

WHEREAS, The Alumnae Association has learned with sincere regret of the death of Mrs. Harry Oliver, one of its active members of the district of Pennsylvania,

WHEREAS, We recognize in her a nurse of long standing, to whom we have for years been indebted for faithful service, and whose influence in the nurses' fraternity has always been of high honor, one in whom we have recognized an upright, conscientious and honorable woman,

AND WHEREAS, The Great Master of human destiny has seen fit to remove this respected woman from our midst, therefore be it

RESOLVED, that in her death this fraternity has lost one of its most loyal and valued members.

RESOLVED, These resolutions be spread upon the minutes of this meeting and a copy be sent to her husband, thus attesting our sincere sorrow in the irreparable loss we have sustained.

OLIVE E. ROWE,

President.

LINNIE E. LAIRD,

ELIZABETH L. KEELEY,
Committee.

The annual masquerade ball of the Dixmont Hospital took place on February 13, 1915. Prizes were given for the most original as well as the most beautiful costumes.



District of Columbia

The Nurses' Examining Board of the District of Columbia will hold an examination for registration of nurses on Saturday, May 1, 1915. Applications must be made before April 28 to Helen W. Gardner 1337 K Street, Washington, D. C.



Georgia

The State Board of Examiners of Nurses for Georgia will hold its annual examinations for the registration of nurses in Atlanta, Savannah and Augusta on April 6, 7 and 8. Applications must be filed fifteen days prior to this date. For information and application blanks address the secretary, Mary A. Owens, R.N., P. O. Box 436, Savannah, Ga.



Kentucky

The Kentucky State Board of Nurse Examiners will hold an examination for State registration at Speers Memorial Hospital, Dayton, on May 17 and 18, 1915, beginning at 10 A.M. For further information apply to secretary, Flora E. Keen, R.N., Somerset, Ky.



Louisiana

The annual meeting of the Louisiana State Nurses' Association was held in the lecture room of the Touro Nurses' Home. Changes in the official staff and the reading of committee reports

In Functional Nervous Diseases

derangement of the bodily nutrition is so prominent a factor that the first consideration in the logical treatment of these affections is a restoration of the nutritional balance. To accomplish this

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Spring Class Opens April 7, 1915

Summer Class Opens July 6, 1915

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MAX J. WALTER, M.D., Supt.

constituted the chief business. The reports indicate that the organization is in a flourishing condition, and that the Central Directory is being enthusiastically supported by nurses throughout the State. Miss Jerome Landry succeeds Miss Corinne Lehman on the directorate. The latter's term expired. Mrs. J. E. Hayel was elected to the post of treasurer, to succeed Miss Alma Achlegel, who resigned. Miss Rena Williamson will go to the national convention in San Francisco.



Michigan

The Michigan State Board of Registration of Nurses will hold an examination for State registration at the U. B. A. Hospital in the city of Grand Rapids, on June 1, 2 and 3, 1915, and at the Grace Hospital on June 8, 9 and 10, 1915, in the city of Detroit.



Minnesota

On Friday, February 12, 1915, St. Raphael's Training School for Nurses, St. Cloud, was agreeably surprised by a visit from Miss H. Wadsworth, R.N., field secretary of the Minnesota State Association. On the following day the graduates of the school held a meeting and organized an alumnae, Miss H. Wadsworth acting as temporary chairman.



Montana

On Tuesday evening, January 26, at eight o'clock, the Assembly Hall of St. Vincent's Academy, Helena, was the scene of a pretty event when the Class of 1915 of the training school of St. John's Hospital received their diplomas as graduate nurses. The program consisted of vocal selections by Mrs. T. F. Martin and Mrs. W. L. Mason, and orchestral selections by the St. Vincent's Orchestra. The hall was crowded with relatives and friends of the graduating class—Miss Teresa M. Flanagan, Ahsarokee, Mont.; Miss Fannie M. Larsen, Barnard, Minn.; Miss Irene M. Thomson, of Spokane, Wash. The speaker of the evening was the Right Rev. J. P. Carroll, D.D., who also presented the diplomas. His words of kindly, fatherly advice were most appropriate to the occasion. The Rev. J. J. Treacy, chaplain of the hospital, presented the pins to the class, and in a masterly manner exhorted the young ladies to ever remember and to put into practice the teachings of their Alma Mater. Preceding the exercises of graduation a banquet was held at St. John's, at which the

Rt. Rev. J. P. Carroll and members of his clergy, the members of the graduating class, together with several relatives and friends, were present. The tables were beautifully decorated with carnations and jonquils—the class colors, white and gold, predominating.



Personal

Miss Sara A. Bowen, for the past ten years superintendent of the Lowell General Hospital, has resigned her position to accept the superintendency of the Springfield Hospital, of Springfield, Mass., one of the leading institutions of its kind in the State. Her resignation was regretfully accepted by the trustees. The trustees would have liked to retain the services of Miss Bowen, but they realized that they could not compete with the offer of the Springfield institution. In a letter acquainting her with the acceptance of her resignation the trustees expressed their deep regret at her departure and best wishes for her future success, and they emphasized the fact that during her incumbency at the local institution she has contributed no small share toward the successful results obtained.

Miss Helen A. Parks resigned her position as assistant superintendent of the Burbank Hospital, Fitchburg, Mass., and left for France, March 17, as a volunteer nurse with the American Ambulance Service, being a member of the Harvard contingent chosen for three months' work at the base hospital just outside of Paris. Miss Parks is one of three nurses (all graduates of the Massachusetts General Hospital) chosen to go with the body of sixteen representing Harvard out of nearly one thousand applicants anxious to assist in the work of caring for the wounded fighters. Two banquets were given in Miss Parks' honor before her departure, one by the pupil nurses of the institution, the other by the graduate nurses.

Miss Helen M. Spalding, a graduate of the Long Island College Hospital, Brooklyn, and Miss Frances F. Van Ingen, graduate of the City Hospital, Brooklyn, have gone to care for the wounded soldiers of the European War. Both of the young women will be stationed at the Alliance Hospital, in Yvette, in the Department of the Seine.

Miss Mary McPharon, operating-room supervisor at the Bayonne Hospital, N. J., has resigned. Ill health was given as the reason.

“Nervous” Children—

The kind that “fly to pieces” at small provocation; that respond over-quickly to ordinary external stimuli which pass unnoticed by the well-poised child—then relapse into a morose or lethargic state.

Such children are often found to be coffee users.

This unnecessary and easily avoidable stimulation in early life is allowed at a tremendous cost of nerve stability, and doubtless “cripples” the child to a greater or less degree as to mental poise in later years.

Many family doctors, realizing the deleterious action of caffen-bearing beverages upon the general health and resisting power when attacked by disease, are speaking out plainly to parents against coffee for children.

Generally this is not a difficult matter to arrange, even where children have already formed the coffee habit. The suggestion to parents that

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—be used instead of coffee is usually followed, and beneficial results begin at once.

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On the occasion of the departure of Miss Elsie Rankin, for two years acting superintendent of Merritt Hospital Training School for Nurses, Oakland, Cal., she was surprised at a reception given by the student nurses. Various gifts from student and graduate nurses were made, and a set of engrossed resolutions from the staff of physicians of the hospital was presented.

Miss Ida J. Anstead, of New York, has been appointed superintendent of the nurses' training school at the St. Lawrence State Hospital, Ogdensburg, N. Y.

After serving eleven years, first as superintendent of the training school of the Springfield Hospital and later as superintendent of the hospital, Miss Jessie E. Catton has resigned from the important position she holds in the institution and will take a much desired rest from hospital work. Her resignation will take effect April 1. Miss Catton came to Springfield in 1903 from Boston and took entire charge of the training school for nurses, conducting the courses with unusual success and compiling a noteworthy text-book for nurses to study. At the annual meeting of the trustees, December 29, Col. Stanhope E. Blunt, president, paid a marked tribute to the energy, ability and skill with which Miss Catton managed affairs at the hospital. A number of social functions have been given in Miss Catton's honor.

Miss Lillian F. Finnegan, Fitchburg, Mass., a graduate of the Burbank Hospital, Fitchburg, Mass., and of the Pennsylvania Orthopedic Institute, Philadelphia, Pa., has been engaged to teach massage to the nurses in training at the Burbank Hospital.

The following nurses comprised part of the first field unit from the French Hospital, New York City, which is to be installed in a new hospital at Chateau de Passeq, France. The nurses are Miss Eugenie H. Lyons, Miss Cathryn O'Hanlon, Miss Ellen O'Hanlon, Miss Florence Gordon, Miss Mollie McGrath, Miss Alma Marie McCormick, Miss Nellie Burdette Parsons, Miss Victoria Francfort, Miss Dorothy O'Connell and Miss Beda Laurentia Pederson.

They sailed from New York on *La Touraine*. When off the Irish coast a fire broke out on the ship, but was kept under control till she was safely docked at Havre. The officers of the ship

are loud in their praise of the nurses throughout the very trying ordeal.

Sister Julie Rigard, a nun, who was acting as nurse in a military hospital in France, has received the Legion of Honor for her valor under fire. She prevented a village from burning, and secured food for wounded men who were isolated under heavy fire.



Marriages

On November 4, 1914, at the home of Surgeon and Mrs. Neilson, Agana, Elizabeth Reed, of the Navy Nurse Corps, to George Perry, of the Cable Station. Mrs. Perry is a graduate of Blockley Training School for Nurses, Philadelphia, Pa., Class of 1904, and had endeared herself to many during her stay on the island. The wedding, which was a very beautiful one, was largely attended. Mr. and Mrs. Perry will make their home in Sumay.

On February 16, 1915, at St. Joseph's Church, Newport, R. I., Mary R. Nahan, a graduate nurse of the Rhode Island Hospital, Providence, to Lawrence P. Sullivan.

On March 1, 1915, at Providence, R. I., Lena R. Handmore, a nurse in training at St. Luke's Hospital, New Bedford, Mass., to Dr. J. N. Tessier, a member of the hospital staff.

On February 23, 1915, at Kansas City, Mo., Lillian V. Townsend, graduate nurse of St. Luke's Hospital, Kansas City, Class of 1911, to Dr. Harry F. Mather.



Deaths

On January 6, 1915, Mrs. Mollie Agin, a recent graduate of the nurse school of the City Hospital, Parkersburg, W. Va.

On December 20, 1914, at the home of her aunt in Collingwood, Ont., Canada, Minnie I. Currie.

On February 20, 1915, at St. Joseph's Hospital, Norwich, Conn., Rosaline Marie Davis, graduate nurse of the institution in which she died.

On February 4, 1915, at her home in Atlantic City, N. J., Ada Cromwell, graduate nurse of the Woman's Hospital, Philadelphia, Pa., class of 1889.

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Book Reviews

Scopolamine-Morphine Anesthesia. By Bertha Van Hoosen, M.A., M.D., Attending Gynecologist in Cook County Hospital, Chicago; and *A Psychological Study of "Twilight Sleep."* By Elisabeth Ross Shaw, Consulting Psychologist, Chicago.

This work is unique. It is written by two women, all the data were collected by women, and the hospitals were in some cases for women only, many of the patients in the gynecological wing being nuns. In one respect, therefore, it is open to the criticism of being biased. However, as the reviewer is personally acquainted with the excellent results obtained in gynecology by Dr. Herman St. John Soldt as early as 1905, when he used these drugs in combination with ether for the sake of a quieter period during returning consciousness, one should enter upon the study of this work without prejudice.

The origin, chemistry, toxicology and advantages of this drug are very fully discussed by Dr. Van Hoosen. She also gives rules for overcoming cyanosis or any of the other complications from which no anesthetic is free, but especially those of respiration, since that is most feared, owing to its action on the respiratory system. There are several excellent plates showing the apparatus, positions and dress assumed by the patient. One thing to be learned by the general practitioner or nurse on reading this work is "Hands off! Don't undertake it without long and careful work and observation under an expert."

The studies in the various stages of consciousness made by Professor Shaw are extremely interesting, she herself having been anesthetized in this way and forced to talk for several hours, notes being taken by a stenographer—a rather heroic step, indeed. Dr. Van Hoosen, it is stated, uses a different dosage from that prescribed in Freiburg, just as each set of students will form some variation from the outlines of the preceding era.

Professor Shaw is guarded in her conclusions, and we may go further and state that since no woman ever has the same preliminary conditions before the births of her family or at confinement, and as no two women have exactly the same temperament, or, therefore, the same attitude of approach to such a novel drug; since, too, many

others of moderate means will not lend themselves for experiment in a charity ward, while there is a strong personal tie between others and their family physician, who is so situated that he cannot devote the time and attention to them that its use absolutely demands (special room, nurses, etc., considered, too), it will probably remain only in the hands of the few.

A determined effort should be made by both friends and foes of this newly revived drug to prevent any physician from deceiving his patients into thinking they are getting "twilight sleep" by giving them such combinations as pituitrin and chloroform.

It is an added strain to an already overbusied nurse to watch all the vital signs as closely as this anesthetic demands, when, too, more nurses are required than formerly by its use. Many nurses avoid heart cases on account of their easily recognized handicaps in caring for that tricky class of disease; but add to this surgery, plus a new-born child, and the burden is a little too great.

The drug has not been long enough handled to get proper data about lacerations. Dr. Van Hoosen reports about one-third of the cases as having suffered this. What would this lead to in less inexperienced hands than hers?

Dr. Van Hoosen is very enthusiastic about this twentieth-century anesthetic, but its use is only adding to what has chiefly caused the decrease in the American family of today—the high cost of living, *not* the fear of travail, which is soon forgotten, a natural function not having its origin in disease; the price paid for a child held dear, the just claim on her husband's sympathy—all of which would of *necessity* fade under the new conditions.



Medical Nursing. By A. S. Woodward, M.D., B.S. (London), M.R.C.P. (London), Lecturer on Medical Nursing and Physician to the Royal Waterloo Hospital, Southeast London. 324 pages, 314 illustrations, price \$1.25 net. Longmans, Green & Co., New York.

This book contains a large amount of valuable instruction for the nurse, from the time she begins her probationary period until she finishes her

(Continued in Publisher's Desk)

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If you were the patient and knew just what you now know about it, would you ask your doctor for "twilight sleep"?

If your doctor thought just as you now think of the Gauss method of using morphine-scopolamine, what would he say?

Even so—yes or no—you surely have read longer and may have read even less interesting things than our little booklet on "twilight sleep" that is waiting for you at Baltimore. When and where shall we send it? Sharp & Dohme, the hypodermic tablet people since 1882.



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The National Biscuit Company bakes many varieties of biscuit. You should see the selected materials which are used—flour, sugar, butter, eggs, nuts, spices, fruits and flavors. Also, the large, airy bakeries, with their new apparatus for mixing, their evenly heated ovens and their white-clad attendants. These, together with ceaseless care and newest methods, make each variety of National Biscuit Company biscuit—sweetened or unsweetened—whether known as crackers or cookies, wafers or snaps—the best of its kind. You will find the attractive packages in the grocery near you, always oven-fresh.



Poisonous Fly-paper

From the first of July to October 15 the press of a few States reported forty-five cases of poisoning of children from the use of fly-poisons, nine resulting fatally within a few hours. In a number of cases the child at the time the report was made was still very sick. Certainly, in our propaganda for health conservation, child betterment and educational movements, this peril should be recognized and a warning be issued so that the coming summer does not witness a repetition of these fatalities and accidents that are wholly preventable. There are other ways of killing flies than by the use of poisonous materials.



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An instance of the obstacles to be overcome in the prosecution of this important matter of the health of the infant is outlined in a sentence culled from the editorial of the *Journal of the American Medical Association*, November 28, 1914, page 1954:

"Rare, indeed, is the person at the present time who has any idea whatever of the make-up of rubber."

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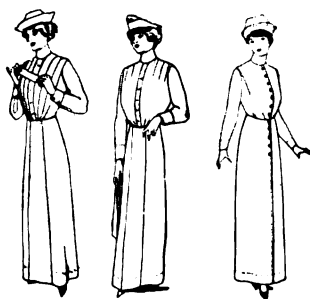
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Announcement

The Pennsylvania Orthopedic Institute and School of Mechano-Therapy, Inc., 1709-1711 Green Street, Philadelphia, Pa., wishes to announce the opening of the spring class on April 7. The work of this school has increased greatly in volume and is able to offer unsurpassed opportunities to nurses wishing to further develop their professional work. The instruction in the Swedish (Ling) system of massage, medical and corrective gymnastics, electro- and hydrotherapy is theoretical and practical. In the past year almost 17,000 treatments were given at this institute, besides the practical experience which is obtained by students attending several large hospital clinics in Philadelphia. The summer class opens on July 6 and the fall class on September 22. Further information and illustrated prospectus can be obtained by addressing Max J. Walter, M.D., superintendent.



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(Continued from Book Reviews)

course. It is divided into the following chapters: Preliminary Considerations; General Rules for Nurses; The Administration and Action of Medicines; Poisoning and Its Treatment; External Applications and Baths; Bacteriology; Acute Specific Fevers or Infectious Diseases; Diseases of the Alimentary Canal, Liver and Kidneys; Diseases of the Respiratory System; Diseases of the Heart, Blood-Vessels and Blood; Diseases of the Ductless Glands and Constitutional Diseases; Diseases of the Nervous System; Nursing of the Insane; The Nursing of Sick Children; Affections of the Skin; The Care of the Dead; Dying Declaration and Will Making; Massage; Invalid Cookery; Appendix Emergencies; Index—which gives some idea of the scope of the book.

✦

The Modern Hospital Purchases The International Hospital Record

The *International Hospital Record*, which has been published for eighteen years by the Sutton Publishing Company, Detroit, has been purchased by The Modern Hospital Publishing Company of St. Louis and Chicago, and will be merged with *The Modern Hospital* beginning with the March issue. We deeply regret the discontinuance of *The Record*.

The following books have been received and will be reviewed at an early date:

The Cancer Problem. By William Seaman Bainbridge, A.M., M.D. 534 pages, 38 plates. Price \$4.00. Macmillan, New York.

Nursing and Care of the Nervous and the Insane. By Charles R. Mills, M.D. Third edition, revised by author, assisted by N. S. Yawger, M.D. Illustrated. Price \$1.25. J. B. Lippincott Company, Philadelphia, Pa.

Cancer, Its Cause and Treatment. By L. Duncan Bulkley, A.M., M.D., Senior Physician the New York Skin and Cancer Hospital, New York. Price \$1.50. Paul B. Hoeber, New York.

Sick-room Cookery Simplified. By Mabel Baker. Price 50 cents. G. Bell and Sons, Ltd. London, England.

Psychology and Mental Disease. By C. B. Burr, M.D. Fourth edition, revised and enlarged. With illustrations. Price \$1.50. F. A. Davis Company, Philadelphia, Pa.

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A Year of "Organized Neighborliness"

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Superintendent Detroit Home Nursing Association

ABOUT the beginning of the year 1914 the Detroit Home Nursing Association opened its office and announced through the press that it intended to devote itself to providing home care to the sick of moderate means—especially to those who needed continuous care in the home and yet were unable to meet the expense of a graduate nurse.

The work was begun in a most modest way by renting two furnished rooms in a refined home, centrally located. The office was on the ground floor in the front parlor. The telephone was in this room and an extension was carried to a room on the second floor, which was the sleeping room of the superintendent, thereby providing day and night service for the sick requiring household nurses.

Three months previous a representative board had been organized, composed of men and women—physicians, clergymen, nurses and other public-spirited citizens. Preceding the organization, two or three public meetings had been held to discuss the need of home nursing in families of moderate means in a fast-growing city like Detroit, and to decide upon the ways and means of meeting the need.

As the citizens of moderate means are very self-respecting—willing to pay for service, and not wishing charity or even the

semblance of it—it was decided not to attach this work to any other society, but to make it a separate organization or bureau of public service, cooperating with all philanthropic organizations in its service, but not governed by any except its own special board.

Because of the many inquiries that have come to the Association during the past year as to the *how* of the work, this article of a year's experience is written. The social, financial and medical statistics are not given, but are available to any one who desires them. The plan of work to be followed until a better one was found was based on the simple social service principle of trying to give the family in every case the kind of nursing or other help it needed to successfully tide it over the sickness. This was to be done with a few conditions which, though kept in the background, were never to be lost sight of.

The service to be supplied was designed to provide chiefly for *independent* people of moderate means—those who were not asking for free nursing nor free service of any kind. Emergencies might be met without charge if necessary, calls were to be responded to where churches, lodges or other organizations paid the bills, but the Association itself *was not advertising free nursing* to any one.

The charity done was to be done quietly and unostentatiously as requests came from different sources.

A graduate nurse is in charge of the office and in charge of all those who are sent out from it. No one is employed who is not willing to work under graduate supervision. All business arrangements are made with families by the superintendent or her assistant, and all bills are paid through the office. This controls the matter of overcharges by practical nurses, which is so frequently complained of by graduate nurses. These arrangements also place on the superintendent the responsibility of deciding as to what kind of cases the practical or household nurse shall care for. If the patient is very seriously ill and should need a more skilled nurse constantly in charge, it is her business to see that a graduate is called to the case.

Another important point is that the graduate, while on the case, is not asked to lower her price, but is paid the current rates. There must be no cutting of graduate nurse rates. She comes back to the office when her work is concluded, and presents her bill and is paid promptly, just as is every other worker—even if the Association has to wait months to collect the bill, as it often has, and if it has to borrow money temporarily.

There are a few other details in the plan, such as that the office must be open night and day; there was to be no red tape about its service. The household or practical nurses were to be given instruction by class work and at the bedside, but no certificates of any kind are allowed to be issued to them.

Neither are the household nurses permitted to wear caps while on duty. With a view to the eternal fitness of things, the workers are advised when buying new working dresses to buy material of a uniform color, but this is not obligatory. Their dresses must be of washable material and, besides their white aprons, they are expected to provide themselves with large, dark work aprons for household duties.

Efforts are devoted to *building up* for the city of Detroit a reliable corps of household nurses who will remain under instruction and supervision year after year. They are never to be *graduated*. It is an easy thing to plan a course of instruction in the rudiments of bedside nursing—it is a widely different thing to establish and maintain a household nursing corps suitable to varying grades of middle-class homes; to discipline and drill the workers to a fair degree of efficiency; to supplement their work with that of a graduate nurse who stands back of the family and the nurse ready to respond in any emergency; to meet the workers as they come back to the center day after day or telephone for advice about their problems; to meet the full needs of the family in sickness as far as an association can; to help the family to maintain its independence by extending credit, and to assume the entire responsibility of the business end of a growing benevolent enterprise. This, in brief, was the task assumed and the plans which have guided the Association in working out the problem.

The plan lacks *red tape* deliberately. The office is open night and day, and workers are sent to city, country or adjacent towns, where the distance is not too great for adequate supervision.

Weekly classes and conferences with groups of the household nurses are held, but the largest part of the instruction is given informally to individual workers. Not infrequently the class work planned has been set aside and the hour devoted to a discussion of some practical problem that has arisen with one of the workers. For example: A household nurse is in charge of a woman patient, moderately ill with some gynecological ailment which required her to be in bed. A man who has a room in the home develops erysipelas. The family are anxious to help tide him over his trouble, and ask the nurse to take charge of him in addition to the other patient. She telephones to the

center, asking what she shall do about it. The occasion furnishes an excellent opportunity for a talk on "contact infection" to the next class that meets and the lesson that was planned is set aside.

It has been a year of beginnings. Every detail, from the bottom up, has had to be worked out in view of local conditions and needs. The first task was to organize a small corps of workers; to investigate their previous history, and to give such practical instruction as was possible in a brief period before trying them out in actual practice. This sounds simple, but it meant that different sets of blanks had to be prepared and printed, and that weary hours had to be spent in interviewing many wholly impossible women as well as many splendid workers. In all, during the year, almost three hundred women have applied to the Association, offering to work under the supervision of a graduate nurse.

At first the idea was considered of trying to arrange to place a certain number of the selected workers at a time with some of the maternity homes, such as the Crittenton or the Salvation Army Home, or some of the numerous small hospitals of the city, but after full consideration of different phases of the situation, it was decided to *train them in the homes for service in homes—to train them under the conditions under which they would have to work*. It is mighty easy to spoil a good household or home nurse by a smattering of hospital training—to lead her to think she knows a great deal more than she really does. It is putting a tremendous temptation before a working woman in her struggle for a living to place her for a few months in a hospital for training and then forbid her to say she has had hospital training.

In the mind of the public at large there is a fairly clear distinction between the so-called practical or household nurse or attendant nurse and the hospital graduate. It is less easy for the public to differentiate between one who has had two or three years in

a hospital and one who has had three or four months. If advice were being offered by the Detroit Association, one bit of advice would be—develop your workers in the homes and through classes arranged and taught by your superintendent and the supervising nurses under whose direction the women are to work.

It was not really in the plans of the Association to undertake to care for contagious-disease patients, at least until the work was well established and definite methods for this class of work could be formulated. However, calls for assistance in contagious work came and were too insistent to be refused. It is one thing to theorize, but your theories are often upset when an urgent call comes. The doctors frequently make the simple request for some one to assist the mother, who is in quarantine with her children, and who is worn out with night and day nursing, in most cases, and the need had to be met. The difficulty came in the matter of supervision, where careful supervision was urgently needed. This difficulty has been removed since a second graduate nurse has been employed, and the Board of Health has given the superintendent permission to don a large apron and go into such homes to give instruction and supervision to the household nurse and the mother. As the work grows it is hoped to employ a supervising nurse wholly for contagious nursing.

It would be easy to write pages regarding the difficulties that have been encountered here and are likely to be encountered to a greater or less degree in other places. There has been no difficulty in regard to cooperation with other organizations devoted to or related to the care of the sick. Every organization has seemed interested in the success of the work and many calls have come from graduate nurses; many, also, from the organized charities and philanthropies, for household nurses to be sent, the bills to be sent to their organization.

The financial end of work of this kind is

more difficult in some ways than where charity is offered, though the sums needed may be very much smaller. The work must be kept free from the tinge of charity, so far as the general public is concerned, if self-respecting, independent people are to be made to feel that the service exists for *them*, and not for the submerged tenth. Charity balls, bazaars, tag days and public appeals for funds are not to be considered by an organization of this kind. Pictures of nurses down in the slums cannot be played up to arouse the sympathy of possible givers, while at the same time the administrative expenses have to be met. In Detroit this problem may in time be met by an insurance system. A plan for such insurance is now under consideration and may be tried out in a limited way this coming year, though this is by no means certain. However, ultimately, this or some other insurance system is likely to be evolved.

One local difficulty which was entirely unexpected was the fact that when the infant enterprise was only about three months old the landlady from whom the office was rented decided to move out of the city, necessitating another long search for a suitable location. A large house, capable of accommodating from fifteen to twenty people, was leased for a headquarters, and here the superintendent and her associates have their home. A dozen or more of the picked household nurses who were rooming elsewhere were given the privilege of having rooms there. This helps to reduce the rental of the headquarters, and at the same time provides them with much more attractive living conditions than they could secure elsewhere at much greater cost. It adds to the efficiency of the service in many ways and makes possible a better discipline of all the workers.

One difficulty which is likely to be encountered anywhere in doing this sort of work is that every little while you have a case where the household nurse is over-

worked because there is no one to relieve her in the home or because of some unusual burden. One advantage of having some of the household nurses in residence is that it is frequently possible to at once send a relief nurse when the need becomes known. Very often the Association has to pay the relief nurse, and for this and various other reasons an emergency fund is necessary, though you cannot make public appeal for such funds.

Not infrequently the family *thoughtlessly* overworks the nurse to the breaking point. In other cases the overwork is apparently intentional. In one or two cases the married daughter or sister of the woman who was ill decided that they might as well get the housecleaning done while the nurse was there, in addition to the care of the patient and the needed housework. The superintendent in those cases is obliged to have a serious interview with the family and interrupt the housecleaning plans. *Necessary routine housework* is done, and in many cases this is by no means light. In the first maternity case booked by the Association the expected baby was the seventh child, and the nurse was expected to manage the entire household and care for the patient. She did it. The man was a letter-carrier and could pay only ten dollars a week for the entire service, including the graduate supervisor's assistance.

Meeting the needs of the family to whom sickness has come, or is threatened, may mean transporting a cot, mattress, pillows, blankets, etc., to provide a place for the nurse to sleep and enable her to see the case through in comfort. It has meant in numerous cases providing her with money to buy food of a different sort for herself when she was nursing in a foreigner's home, or letting her go out entirely for her meals. If the patient is to be cared for, the worker must be given food such as she can eat—and these extra items all count in the daily expense. Most of the calls, however, come from modest American homes with fair liv-

ing conditions. There has been no disposition on the part of the wealthier class to ask for this service, and graduate nurses are learning that there is nothing to be feared and much to be gained by having an organization devoted to this work with a graduate nurse in control of the details of the situation—backed by a general board of citizens who will find the money to develop the work. The burden is not one which nurses alone should ever be expected or should try to carry. Their best work will be done in promoting the right kind of a citizen's organization and in working with the organization to the end that the practical utilitarian, all-around service rendered by household nurses which the world is going to continue to demand may be supplemented and directed by the graduate's skill.

In all such work the maternity nursing, if rightly handled in the beginning, is likely to constitute a large part of the demand, since in these cases continuous care is *always* needed, and the mother is the patient. When the Detroit Association was six months old a second graduate nurse was employed—one who had specialized in maternity nursing—to have the responsibility of the management of the maternity service. About one-third of the cases served by the Association have been maternity patients and the proportion is likely to grow larger. This means that as rapidly as possible any association attempting this kind of work should plan to place at the service of the public as soon as possible a maternity supervisor, since the superintendent obviously cannot give such service the attention it needs.

Those who expect such work to grow by leaps and bounds and to reform conditions in a few months are bound to be disappointed. All enduring movements of this character are of slow growth. It has taken the tuberculosis movement, with all the study and publicity possible, long years to get under way so that practical results were

readily apparent. And the same is true of other lines of philanthropy. Spectacular results are not to be achieved in a short time. There are practical difficulties to be met, too numerous to be mentioned in a paper of this kind.

We have frequently been asked: Cannot such work be done by visiting nursing associations? Why cannot these associations send out household nurses and other helpers? The sending out of household nurses and other helpers is done by a score of different sorts of organizations at the present time, and experience has proven that the needs of the public are not met when that is done.

The greatest danger that besets the efforts of those who are devoting money and brains and time to working out this problem is that people will seize on one or two features of a comprehensive plan, tie it on to an organization devoted to a different purpose and catering to the needs of a different class of people, and fail utterly to grasp the essential features of the whole plan which is the result of years of study and practical experiment. The close association of the visiting nursing with the slums and with charity in the large city makes it practically impossible to develop on any adequate scale a service for the great two-thirds of the population who are not asking for charity.

In smaller cities the proportion of charity nursing required is much less than in larger centers, and it is possible and desirable to have the household nursing, visiting nursing and school nursing managed from a common center, all under the superintendency of one capable graduate nurse.

In larger cities this work unquestionably needs the undivided attention and care of a representative organization and an independent center. If it is to meet the needs that exist in a large city it should never be considered a side-line to some other enterprise. A common mistake when such work is first considered is to appeal to the associated

charities to start the service. The farther such work can be kept from associated charities and organizations chiefly devoted to charity the better. Independent, self-respecting, bill-paying people are not in the habit of going to the associated charities for help, and it is not desirable that they should get the habit. They do not want *charity*. They want their needs met in a businesslike way, free from red tape, and our experience has been that four-fifths of them are ready to pay their bills promptly when the service is completed. The other fifth may be divided into two classes—those needing a loan to tide them over and those needing to have the expense provided by churches or other organizations or individuals.

If it is necessary to tie such work on to an existing organization in a small city or town, a hospital may be willing to inaugurate a home-nursing department. Hospitals are usually regarded as places where people expect to pay their bills, and work of this kind can be started at comparatively small expense. No such work of this kind, however, should ever be undertaken by a hospital without a capable, experienced graduate nurse appointed to give her full time to this outside work. The service, if rightly managed, should be to a large degree self-supporting.

So many theories have been brought forward in the last twenty years for meeting this need, without any systematic or concerted attempt to try out *thoroughly* any of the plans, to study how they might be improved, or to find out where there were dangers to be avoided, that efforts in the future may wisely be directed to trying to make some of the theories work out in actual life, and to *standardizing* such efforts so that others may avoid some of the dangers that threaten all such work.

It is well to remember that the field in which the work for families of moderate means is to be done is not an entirely uncultivated field. It is an *unorganized* field, occupied to a greater or less extent by a miscellaneous, nondescript group of workers without standards or definite knowledge of nursing of people who are struggling for a living, even as you and I. Our business is not to crowd out these workers—unless they are unfit, and for the safety of the sick should be put out of business. Our business is to take the best of them, teach and improve and assist them to do better work, to secure recruits, to organize and develop an all-around service for the sick in middle-class homes and serve the public in the most efficient way possible—free from red tape or from unnecessary rules that will lessen the efficiency of the service.

This work is going to be done by somebody. There may be better ways than the Detroit Home Nursing Association has yet discovered. If there are, the Detroit workers will try to adopt the better ways. They have many unsettled questions before them, but *they are learning by doing the work, according to a definite plan*, the principles of which may be applied to any community.

If we are going to make any headway in combating the work of correspondence schools and low-class registries, we have got to organize a service in our different communities to carefully select and direct workers, to supply a practical nursing service at rates varying from one dollar a day up to two or two and a half dollars—in short, to meet the practical, every-day needs of the families at prices which they can pay, and do it better than it has been or is being done by other agencies. This is "*organized neighborliness*," as it relates to the sick of moderate means.

Eye Nursing

HENRY GLOVER LANGWORTHY, M.D.

PART II

PRINCIPLES OF TREATMENT IN OCULAR THERAPEUTICS

IN DEALING with this subject it may be said that there are a few fundamentals in treatment which are especially applicable to ophthalmic cases, and which should be understood by any one taking up eye nursing. This has been shown quite clearly in the preceding chapter relating to the actual Handling of Eyes in the Hospital Ward or Private Sick-room, where special instruction was necessary along the lines of proper technique. As standard principles, also, of drug action and the handling of drugs change but little, the nurse is expected to become acquainted with the chief and important points relating to the following solutions, not only for immediate use in training, but also to successfully pass a later class or State board examination. The making and keeping of additional notes with reference to medicines will be found of great value for future reference and save looking up these subjects when they are encountered again and again in other courses. For instance, considering the matter of a normal salt or a boric acid solution, the nurse should read over carefully the paragraph on this subject, and also a page of her *materia medica* volume relating to same as well, and learn once and for all the practical information presented about the drug and how to use it. Such knowledge is absolutely essential, as sooner or later the nurse finds herself stationed in a private home away from the hospital and its advantages and has to stand on her own feet.

Collyria or Eye-Washes—The various solutions used in the treatment of affections of

the eye are known as eye-washes or collyria. The nurse should avoid using medicated solutions in the eye above the strength ordinarily specified. Simple inflamed eyes, due to obvious causes, may be washed with clean water, normal salt solution or a saturated solution of boric acid, but stronger medicinal solutions, such as atropine sulphate 1 per cent., cocaine hydrochlorate 4 per cent., etc., should never be used except on a direct written order from the physician in charge.* As the eye, further, is an extremely sensitive and delicate organ and easily irritated, all liquids used as eye-washes or eye-drops should be clean and free from dust or musty sediment. Frequent filtering may be necessary to keep these solutions clear. It is often of advantage to preserve some eye-solutions, such as adrenalin chloride 1-1000 or silver nitrate 2 per cent. solution, in tinted bottles out of the chemical action of the light.

Proper Care of Bottles Containing Eye Medicines—In some hospitals poisons or strong caustic solutions are put up in special bottles with distinctive labels, so as not to be easily mistaken even in the dark. Always look at a label on the bottle before using it in the eye. Many unfortunate accidents have been recorded by undue haste and failure to follow this simple rule. Medicines should be kept in places well out of the way of children and parents cautioned in this respect. Never use or allow to be used solutions out of bottles standing unlabeled on the shelves. Bottles containing

*The effect of the new Harrison "habit-forming drug" law of March 1, 1915, requires that for every dose of opium or coca leaves in any form—opium, morphine, laudanum, heroin, cocaine, etc.—a full line of the physician's or hospital record sheet as to date, name of patient, quantity given, under whose direction administered and by whom, be filled out. Failure to do so is punishable under the law by both fine and imprisonment.

medicines not properly labeled should be thrown away. Eye-droppers should be carefully cleaned before being used a second time.

EYE CLEANSING AND IRRIGATING SOLUTIONS

A saturated solution of boric acid is the most frequent solution used for eye irrigating, and is a very good one. Normal salt solution, clean boiled (sterile) water, mercuric chloride 1-10,000, etc., are also in common use.

Irrigation means the actual use of a considerable quantity of fluid in some form of an irrigating apparatus, such as an extra large-sized eye-dropper (Fig. 13), bulb syringe (Fig. 14), or in a continuous flow from a fountain douche bag with suitable nozzle (Fig. 15) or some similar mechanical device. These cleansing and antiseptic solutions, used lukewarm, may be prepared as follows:

Boric Acid (*Acidum Boricum*)—A saturated solution, or 4 per cent., is the strongest solution which can be made, owing to the fact that water will hold in solution only a certain amount (4 per cent.) of boric acid. Amounts over this strength will merely fall to the bottom of the vessel and need scarcely be considered. Boric acid solutions are usually made up by the nurse on the hospital floor with sterile water and weighing the powdered crystals before being used. When weighing is inconvenient half an ounce of boric acid powder to a pint of water will give the strength desired. If a larger quantity of solution than this is required, two handfuls roughly of boric powder may be placed in a clean pitcher and a gallon of boiling water added to it. When cooled any excess of boric over the 4 per cent. as mentioned will sink to the bottom of the vessel. All of the clear solution may then be poured (decanted) into a gallon bottle, labeled and thus preserved for constant use. Boric acid gauze dressings are also quite popular in many hospitals.

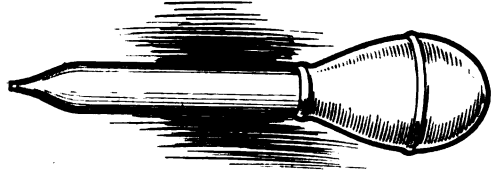


FIG. 13—LARGE SIZE EYE DROPPER HOLDING A CONSIDERABLE AMOUNT OF FLUID FOR EYE FLUSHING

Normal Salt Solution—Sodium chloride or pure common salt in a so-called physiological strength of 0.6 per cent. or, roughly, a teaspoonful to a pint of water, will make this solution. Pure table salt is added to water as directed and then boiled. The operating room nurse is the one ordinarily required to prepare this solution on the hospital floor. Usually in the hospital a sufficient amount of weighed chemically pure sodium chloride is taken for making up five pints of solution, using distilled water and sterilizing at once in the autoclave. If this is not handy, the

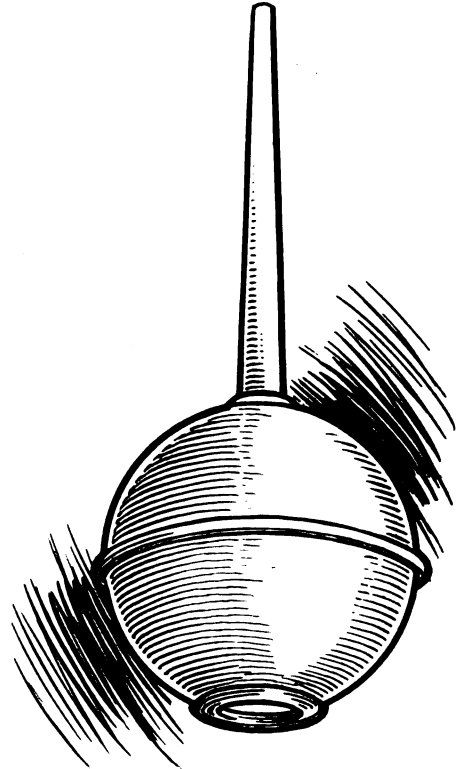


FIG. 14—BULB SYRINGE WITH SMALL RUBBER TIP

prepared normal salt solution is boiled one hour each day for three successive days, when it is ready for intravenous or subcutaneous injection.

Sterile Water—Boiled water, free from sediment, makes an excellent and safe irrigating solution at any and all times. Hot sterile water may be readily obtained from the teakettle, both dipper and kettle having been thoroughly cleaned by boiling water beforehand. In infirmaries sterile water is prepared by first filtering and boiling under a high pressure of steam in the large steam sterilizers. In the home boiled (sterilized) water is used for making up such solutions as may be required.

Bichloride of Mercury—Mercuric chloride or corrosive sublimate solution 1-10,000 or 1-5,000 are the usual strengths employed in eye work. The desired strength of solution may be quickly made up from the use of standard corrosive sublimate tablets, which are put up with precise printed directions as to the amount of water to be used. All stock poison solutions from which weaker solutions are made should be colored, so as to avoid any possibility of being mistaken for harmless water. It is important to remember that instruments are corroded by solutions of bichloride of mercury. In hospitals the bichloride of mercury solutions are given to the floors already made up, with directions printed on the bottle.

Eye Ointments—Eye ointments are usually applied by pulling down the lower lid and placing a small quantity of the eye salve on the inner surface of the lid next to the eyeball. The ointment quickly melts from the heat of the eye and spreads over the globe. Ointments are put up by the druggist in collapsible tin tubes, with a special point for easy application (Fig. 16). The common ointments employed in eye nursing are as follows: Sterile white vaseline, bichloride ointment 1-3,000 (bichloride in vaseline of a strength of 1-3,000 and specially prepared), yellow oxide of mercury

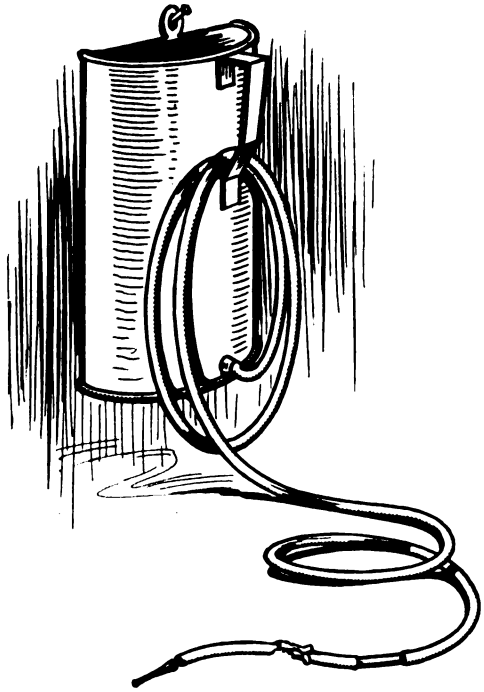


FIG. 15—IRRIGATING APPARATUS FOR PROVIDING CONTINUOUS FLOW

ointment, two or five grains to an ounce of petrolatum, atropine sulphate ointment 1 per cent. in vaseline, argyrol ointment cocaine or holocain ointment 1 per cent., copper sulphate ointment and dionin ointment.

Cold—Cold compresses are much used for lid swelling and inflammation. Method of application: Cut a number of small square pads of cloth (double or more thickness), moisten and lay on a block of ice. Transfer bits of cloth from ice block to lids, changing frequently (Fig. 17). Cold compresses wrung out of ice-water may also be used. Every nurse should have a good working idea of the therapeutics in general of cold applications. An ice-pack should never be applied directly to the eyeball.

Heat (Fomentations)—Hot water baths and hot eye-compresses are constantly prescribed in inflammations of the cornea, iris and ciliary body. Heat is applied to the eye by means of flannel cloths wrung out of

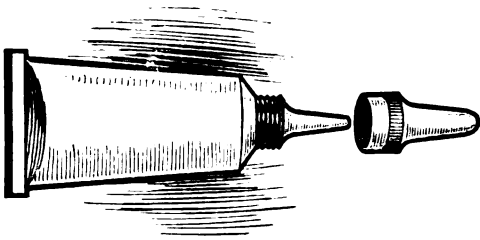


FIG. 16—EYE OINTMENT TUBE MADE UP OF PURE BLOCK TIN WITH ELONGATED TIP FOR EASY APPLICATION

hot water and used as hot as can be borne without burning. The most practical method of applying fomentations is to place three or four wads of cotton rolled up like a torpedo in a bowl of hot water and then pick up the hot saturated cotton on the end of a wooden stick, transferring direct from bowl to eye. By bending over the bowl the patient's clothes will not be soiled and the hands need not come in contact with the water (Fig. 18). If the water is too hot, the dripping cotton may be held a moment in the air to cool. Fomentations should be used from ten to twenty minutes at a time and often several times daily. Fifteen minutes by the watch is a good average.



FIG. 17—COLD EYE COMPRESSES OR PADS ON BLOCK OF ICE READY FOR USE

These pads consist usually of several thicknesses of cotton cloth cut in a somewhat circular shape so as to fit better over the eye. They must be frequently changed in order to maintain the effects of the cold. The shape of the ones on the ice block in the illustration are after those used in the Manhattan Eye, Ear, Nose and Throat Hospital.

Another method is to place the patient in bed flat on his back, with the hot water in a chafing-dish set over an alcohol lamp on a convenient stand near-by (Fig. 19). The hot applications, *i.e.*, hot wads of cotton with the excess of water squeezed out, can then be easily transferred by the nurse from the pan to the eye. The cotton used should be clean but need not be specially sterilized.



FIG. 18—METHOD OF APPLYING FOMENTATIONS (MOIST HEAT) TO THE EYE IN PATIENTS ABLE TO BE UP AND ABOUT THE WARD

Cycloplegics—Cycloplegics are agents which cause paralysis of the ciliary muscle. A cycloplegic always produces dilatation of the pupil, as well as placing the muscle of accommodation at rest. Atropine sulphate 1 per cent. and homatropine hydrobromate 1 per cent. are the best examples.

Atropine sulphate 1 per cent., the alkaloid of belladonna, is the most commonly employed mydriatic and cycloplegic. The effect lasts for fully a week to ten days. This drug is commonly used in examining eyes for glasses (1 per cent. for adults and one-half of 1 per cent. for children), as well as in the treatment of ulcer of the cornea, scleritis, iritis, etc. Atropine should never be used in the disease of glaucoma. Dark glasses are worn during and for some days after the use of atropine in the eye. As

atropine is used in ophthalmology almost more than any other drug (with the possible exception of cocaine) the nurse should have a good working acquaintance with it. (See Correct Method of Instilling Drops or Flushing Eye, Part I.)

Atropine Poisoning—In using atropine sulphate 1 per cent. care should be taken to drop only one drop in the eye at a time, and not allow any excess of the drug solution to flow down over the cheek into the mouth. In children and in susceptible individuals quick absorption of overdoses of atropine often takes place through the mucous membranes of the nose, mouth or throat, producing the characteristic toxic symptoms of very dry throat, flushed face and skin, rapid pulse, excitability and even delirium. It is always wise, therefore, in using atropine to observe the above caution and, in addition, instruct the patient to hold a bit of cotton pressed against the inner angle of the eye, at the junction with the nose (over the lacrymal sac region), to prevent the drug from passing into the nose through the tear duct, along with the tears. Solutions of atropine should be labeled "poison." A red label on the bottle is also preferable, so as not to be easily mistaken.

Homatropine Hydrobromate 1 per cent. solution resembles atropine in its action (cycloplegic) but is not as strong. It is the one preparation used most extensively during examination for errors of refraction in all adults under forty years of age. The effects of homatropine last from thirty-six to forty-eight hours, so that the patient cannot read during that period. The same care should be taken with homatropine as with atropine. As solutions of homatropine 1 per cent. are quite costly, small amounts only, as a rule, are kept on hand. An easily recognized red label on the bottle is also a good precaution.

Myotics—Myotics diminish the size of the pupil, as well as lower intra-ocular tension. Myotics are used especially in the treatment of the disease glaucoma. The



FIG. 19—APPLICATION OF MOIST HEAT (EYE FOMENTATIONS) TO BED PATIENTS, UTILIZING CHAFING DISH WITH ALCOHOL BURNER FOR CONVENIENT HEATING OF WATER

common myotics are eserine sulphate one-half of 1 per cent., and pilocarpine hydrochlorate 1 per cent. solution. Eserine sulphate is the stronger in action. These two drugs are used mainly in the disease glaucoma. A drop of the solution is instilled in the eye, as ordered on the treatment chart in the service room.

Suprarenal Gland Preparations—Preparation of the suprarenal glands of sheep, called epinephrin or adrenalin chloride, is a valuable astringent and hemostatic. One drop of a 1-3,000 or 1-5,000 solution will very quickly blanch or whiten the conjunctival membrane of the eye by contracting the blood-vessels. Preparations of the suprarenal gland stop capillary bleeding very quickly. The nurse should have a solution of adrenalin chloride or epinephrin at hand in the operating room. At present the drug is preferably kept in tinted bottles, as solutions turn pink on standing when exposed to the light.

Local Anesthetics—The great majority of eye operations are performed under local cocaine anesthesia.

Cocaine—A 4 per cent. solution of co-

caine hydrochlorate is dropped into the eye with an eye-dropper, one drop every two or three minutes for three or four doses. An additional drop of cocaine may be repeated at any time during the operation if the part is not insensible to pain. Stronger solutions than the above are rarely necessary. Often the request is made that the cocaine solution be previously sterilized. Cocaine, besides being a local anesthetic, is also a mydriatic, as it dilates the pupil but does not paralyze the muscle of accommodation. As a rule no danger of toxic symptoms from absorption need be feared from the use of cocaine in the eye. Bottles of cocaine should have a distinctive—preferably yellow—label, so as to be easily recognized on the treatment table or in the medicine closet.

Holocain—Holocain 1 per cent. is also used for local anesthesia in the eye, as well as eucain and stovain. Its action is similar to cocaine.

Silver Nitrate—Silver nitrate dissolved in distilled water is used in ocular therapeutics in the strength of usually 2 per cent. Solutions of silver will stain the skin and conjunctiva slightly. The 2 per cent. silver nitrate solution is a mild caustic and for that reason must be used with caution, as it often causes considerable pain and burning. The most frequent use of this drug in a 2 per cent. solution is for prophylaxis against ophthalmia neonatorum (Crede's method of prophylaxis), which method should be familiar to every nurse. As mentioned previously, solutions of silver nitrate should be kept in tinted bottles, out of the chemical action of the light, and labeled distinctly, so as not to be mistaken for anything else.

Argyrol—Argyrol, a blackish solution (silver vitelline) is employed in the common strengths of 15 to 25 per cent. It is often used as a substitute for silver nitrate, because of its being non-irritating. In using argyrol care should be taken to avoid soiling clothes, pillow slips or bed sheets, as the solution stains such things badly. Argyrol



FIG. 20—HYPODERMIC INJECTION

is used as a routine in all purulent eye cases, a drop or two of the solution being instilled after the eye has been cleansed free from discharge with boric acid or a normal salt solution.

Protargol—Protargol in a 2 per cent. solution is another substitute for silver nitrate, but is a little more irritating than argyrol. Frequent instillations of a drop or two at a time after the eye has been flushed free from discharge is the usual method of application in purulent conjunctivitis.

Copper Sulphate—Solution of copper sulphate (bluestone) may be employed in the eye in the strength of one grain of copper sulphate to the ounce of distilled water. Copper sulphate is an astringent commonly used in the infectious disease trachoma, or true granulated eyelids, and is most helpful in this condition as the patient's home remedy.

Zinc Sulphate—Zinc sulphate solution, one grain to the ounce of distilled water, either with or without boracic acid, is another astringent with much the same uses in the eye as copper sulphate.

EYE SEDATIVES

Eye sedatives or anodynes are used to allay severe eye pain. The principle eye sedatives often left by the physician as an emergency night order in case of trouble are as follows: Fomentations, instillation of a drop or two of a 4 per cent. solution of

cocaine, drop in the eye of 5 per cent. solution of dionin, and internally (by mouth) aspirin, heroin, codeine and morphine sulphate. Occasionally, in cases of obstinate pain unrelieved by other measures, the application of a leech to the temple may be ordered.

Dionin—A 5 per cent. solution of dionin (a derivative of morphine) is useful for severe eye pain, as in iritis, and, furthermore, promotes absorption of inflammatory products. When instilled in the eye the solution is at first mildly irritating, but quickly produces a cooling sensation and local anesthesia. Dionin, as mentioned, is frequently ordered as an emergency drug for severe pain during the night hours.

Aspirin—Aspirin (acetyl salicylic acid), a white, crystalline powder, is usually given internally, by the mouth, in five-grain capsules for two or three doses, for the relief of pain or headache. It is especially useful in cases of iritis of rheumatic origin, one capsule often being given every two or three hours.

Morphine Sulphate—Morphine sulphate, an alkaloid of opium, is usually given hypodermatically in a 1-6 to 1-4 grain dose. One dose only is permissible, except by very special order. Morphine is a dangerous drug, to be used only on written order from the physician.

Hypodermic Injection—A subcutaneous injection of morphine sulphate grain 1-6 or grain 1-4 is frequently ordered for various purposes in eye work, as well as being given to adults some thirty minutes before operations, to control pain on recovery from the anesthetic, to minimize mucous secretion in the throat during throat operations and in a general way to lessen the wear and tear incident to any severe surgical procedure. The most convenient place for an injection is in the fleshy part of the arm, on the outside.

The syringe and needle are sterilized by drawing boiling water through both barrel and needle of syringe, followed by alcohol. Care should be taken to make sure that the needle is securely screwed on the syringe, so that none of the medicinal solution to be injected is lost by leaking. A small hypodermic tablet of the drug desired dissolved in just enough boiled water in a sterile glass dish or teaspoon as will fill the syringe comfortably is then drawn up and the syringe is ready for use. The skin over the area to be injected is cleansed with soap and water and rinsed clean with either alcohol or ether. By picking up the skin between the thumb and finger the needle is quickly inserted (slantingly, Fig. 20) and the fluid injected under the skin. Puncture wounds from a small hypodermic needle do not need dressings. After the injection the syringe and needle should be thoroughly cleansed by drawing either carbolic acid solution, hot water and, finally, alcohol through it. This will prevent gumming of the piston in the barrel of the syringe and blocking of needle. Failure to observe this simple rule or to keep a thin wire in the needle itself is very likely to result in a useless article just at a time when it may be badly needed.

Mercurial Inunction—Mercurial inunctions are frequently applied to the temple on the same side as an inflamed eye, for various purposes. A bit of blue ointment about the size of a pea is rubbed into the skin with the tips of the fingers until absorbed. This drug is quite useful in protracted cases of iritis, indo-cyclitis, as well as in syphilis.

Poultices—While poultices are not often used on the eye, they are occasionally required in deep-seated inflammations of the cellular tissue of the orbit. A flaxseed-meal poultice is the one in common use and should be made up and changed frequently in order to keep them hot.

Common-sense in Contagion*

MINNIE GOODNOW, R.N.

RATIONAL ROUTINE—What is the rational thing to do when we have a case of transmissible disease develop in our own home? Send the patient to a hospital for contagious cases? Not necessarily, though it may be cheaper or more convenient. Some one must nurse the patient, either the mother or a nurse from outside. The patient should be put into a room which no one need enter for ordinary purposes. The mother or nurse should wear a gown while caring for the patient, leave it inside the room, and always scrub her hands thoroughly after she has handled the patient. The rest of the family may speak to the patient from the door of the room, or even come in if they do not touch things or the patient. They may go about their accustomed work or play if they have not come into contact with the patient nor the things which he has used.

There is no danger whatever to other children in a family where one is ill with scarlet fever or diphtheria, provided they keep away from the patient, the nurse, and the things which have been used in his care. It should not be necessary to keep away from the nurse, but if she is the mother, or has not been trained in the care of contagious cases, she might omit some of the important small things and so become dangerous.

The simplicity of the whole thing has been our stumbling block. We have been confused by a multiplicity of useless precautions, and have, therefore, overlooked the important items in our protection.

Example—For example, a few years ago, when the maid in a certain man's family contracted scarlet fever, because there was no contagious hospital in the town and because the man's wife had done a few things for the sick girl before the disease was recog-

nized, the wife remained in the house to care for her maid while the man and his children moved out of the house. In this day, with our more exact and thorough knowledge of the subject, we have come to see that if the mistress of the house had scrubbed her hands and had boiled any utensils which had been used about the patient, washed her face and changed her dress, she might have engaged a nurse, let her remain up-stairs with the patient, and the whole family gone on as before, except that they would have had to advertise for another maid. What a saving of trouble and expense to do the simpler, effective thing. What a saving of worry to know that it is so simple.

A well-known magazine calmly states that a certain epidemic of trachoma (granulated eyelids, a contagious trouble) which occurred among a group of foreign laborers was due to "unsanitary lodging houses, twelve men occupying a room, no water supply for washing except a bucket in the yard, and no health officer except a layman without funds." In this instance, the only thing necessary to prevent the spread of the disease was that the men should not wipe their faces upon the same towel. If the health officer, without funds, had explained to the men what to do and spent a little time in seeing that they did it, the epidemic could have been stopped without any expense worth mentioning. The unsanitary lodging houses were deplorable, to be sure, but they were not responsible for a man's transferring the germs from another man's eyes to his own.

The Non-Essentials—Some one is interrupting this calm disposal of non-essentials. "But, we know very well that scarlet fever, measles and all sorts of things are carried in clothing, in books and such things; that we get tuberculosis, gripe, pneumonia, from

*Continued from April number.

the dust of the street; that malaria comes from swamps," etc.

Hush a minute and listen to the modern scientist. He explains that we have gone a long way around to blame disease to such modes of transmission, while we have neglected the more direct modes of transmission which were under our noses.

What Science Has Disproved—Do you remember the days when it was proven (!) that yellow fever was carried in clothing and that malaria was due to the damp exhalations from low-lying ground? Now we know, as surely as we know that we are alive, that yellow fever comes only through being bitten by a certain kind of mosquito, and that malaria comes only through being bitten by a certain other kind of mosquito. Cuba, New Orleans and Panama have proven these things over and over again in thousands of cases.

We have learned very recently that scarlet fever and measles are not carried by the dried scales of skin which we were formerly taught were so deadly. These are harmless, while the real infection is in the nose and throat. If we had kept away from the secretions which came from the noses and throats of these patients we need not have feared a bit of dust from his clothing.

Again some one begins to cite the cases of diseases acquired by handling clothing which had been put away for years. The scientists tell us that these are mere coincidences, that if we had carefully examined the other things which were done about the same time that these old clothes were handled we should have found in them a simpler and more rational explanation.

Children's Habits Spread Contagion—Watch a crowd of even well-bred children at school recess and you will no longer find infections mysterious, nor be under the necessity of going back twenty years for an explanation. All of them cough or sneeze with hardly a pretense of precaution for their fellows; some may half shield their

faces with their hands for a moment. Think about the habits of grown persons and see how freely they distribute their nasal and throat secretions. Do you wonder that your child and another come down with scarlet fever a few days apart? The other child has the germs in its nose and throat. Its mother thought it a slight cold. Watch the two children. They give each other bites of their apple or candy, they kiss each other, use their infected handkerchiefs for all sorts of services to each other, exchange pencils which have been in their mouths, drink out of the same cup with perhaps a cursory rinsing, put their fingers into their mouths or about their noses, and take hold of the next one's hands, etc. By all these means, and more, they transfer to their fellows any germs which they may happen to have in any quantity.

There is no mystery about it. It is a mass of disgusting facts. These worst diseases are due almost entirely to the free distribution of nasal and throat secretions. Yet we worry over a thousand details of minor importance, and let the distribution go on.

Dust and Virulence—And the dust. What about the dust? Did you ever observe a dead leaf or a faded flower blowing about in the wind? What do you think were its chances of growing? Would you fear encounter more with a half-dead dog or a live and healthy one? Remember, germs are plants, and they must have good soil, warmth and moisture to thrive. The wings of the wind present none of these conditions, and the germs do a good deal the same as plants and animals do under similar conditions. They, to put it mildly and scientifically, "become inert." Some of them die pretty promptly, and few of them are half as long-lived as we have been led to believe.

Germs are much shorter-lived than we have thought, that is, outside their native habitat. They begin to lose their vitality when out of proper soil, and the few which

survive are exceptions. These few, which have long been tossed and tumbled about, are not going to do much damage; but the many fresh ones which we take from our neighbor's hand, after he has had it upon his face or in his handkerchief, are capable of giving us a serious illness.

Essentials and Non-Essentials—It is easy enough to keep away from a sick person. It is harder, because of our careless habits, to keep away from his secretions. We keep our children away from a yard where there is a scarlet fever sign, but we kiss them when we have a cold and promptly and surely infect them. We fear the house of our tuberculous friend, but we watch him cough into his hand, and immediately thereafter shake hands with him in farewell, and within a minute or two we pass our hand, infected from his, across our own mouth. We shudder at the danger encountered in a public toilet, and are extremely careful in our use of it; but we handle with great recklessness the public door-knob and put our fingers into our mouths immediately thereafter.

Hands Again—It is our hands and our children's hands which very largely get us into trouble. We have learned the danger of the public drinking cup and the public towel (and very real dangers they are, because they bring us into *contact* with the diseased person who has preceded us), but we still continue to collect disease germs from all sorts of objects and transfer them to our faces, mouths, eyes, etc., until it is very

evident that had not Nature so well protected us against them we should be constantly ill with some communicable disease.

Personal Habits—Our part, the part which we can and must do if we are to protect ourselves efficiently, is just the part we have been neglecting. We must stop being afraid of the air and become more careful about our hands. We need not be afraid to look at a person if we but keep our hands off him. We need not fear his house if we avoid his expectoration. We need not shrink from our neighbor's half-dead germs which come to us on the wind, but we should run to cover when he sneezes over our shoulder or coughs on our hands.

Let us look carefully into our personal habits and observe and avoid those of our neighbor. Let us teach our children to keep their hands off things and people at the same time that we are teaching them to control their tongues and their tempers.

Then, let us stop fearing the wind, some old clothes, or a germ up-stairs.

Keep your eyes open for the germs which your neighbor is handing you today and you will not need to be afraid of the worn-out ones which he discarded last year.

If you think you have picked up some infection, use soap and water and a scrubbing brush. Leave incense and other superstitions to the benighted savage of the South Seas, and face in a sensible, simple fashion these small but deadly enemies which you have been so often taking into your bosom.

As far back as 1888 Dr. Worcester, founder of the Waltham Training School for Nurses, said: "Trained nurses on leaving hospitals have shown an inability to adapt themselves to the circumstances of private practice. This fault is evidently due to the present methods of training."

Times seem not to have changed very much since 1888. Where, then, is our progress?



DAILY MIRROR

MILITARY FUNERAL OF MARY MACGILL, ACTING MATRON, ISOLATION HOSPITAL,
ALDERSHOT, ENGLAND

Medical Work in the War Zone

A NEW form of strategy in the treatment or, rather, the preventing of the septic dangers associated with the wounds of war, is suggested by Sir W. Watson Cheyne, in his recent Hunterian Oration (*Lancet*, February 27, 1915). The plan of campaign is not simply the application of antiseptics to the wound, according to the Listerian method, as soon after the infliction of the wound as possible, but is an effort to apply the antiseptic agent in such manner that it will have a continuous action on the bacterial invaders, and by its diffusion will follow these into the surrounding tissues and destroy them or inhibit their growth. Ordinary syringing of the wound is not sufficient to disinfect it; the antiseptic must be introduced into the wound and left there to dif-

fuse into the tissues. Watson Cheyne and his associates devised a method of estimating the diffusibility of antiseptics in blood clot and their action on the bacteria contained in it. The antiseptics were incorporated in a base consisting of six parts of lanoline to one part of white wax. The antiseptic base to be tested was placed on the bottom of a Petri dish underneath a slab of nutrient agar, the upper surface of which was painted with an emulsion of bacteria. The diffusibility and activity of the bacteria were judged by observing the growth or absence of growth of the bacteria planted.

The above method of investigation revealed a number of interesting and a few surprising facts. Thus, with a paste containing 6 per cent. iodine no diffusion of this

substance occurred, for the bacterial growth was not inhibited on the agar directly over the iodine paste. This finding apparently contradicts the current conception of iodine as an efficient antiseptic and particularly valuable for its penetrating power. Similarly, alcohol had but slight diffusibility. A 10 per cent. paste of the double cyanide of mercury and zinc had no action; oil of turpentine did not inhibit the growth of bacteria; colloidal mercury, selenium, copper and silver were also devoid of inhibitory effects. In contrast to the above a 20 per cent. paste of carbolic acid or of tricresol diffused rapidly into the nutrient medium and checked the growth of bacteria before they had formed colonies visible under the low power of the microscope.

Similar results were obtained in a series of experiments in which blood clot was used instead of agar. The findings were also confirmed in animal experiments. The method has produced happy results in the few instances in which it was tried in human beings. The present war provides an un-



DAILY MIRROR

MARY MACGILL

usual opportunity of testing this method of antisepsis on a large scale. It is suggested that tricresol or carbolic acid pastes should be tried first in the strength of 20 per cent. The important object is to find some means of averting sepsis in a wound for some hours, or at most a day or two, until thorough disinfection can be carried out.—*Medical Record*.



NURSING TIMES, LONDON

ROSA VECHT

The latest reports from Serbia indicate that to the distress and widespread destitution caused by the war have been added the ravages of serious epidemics of typhus fever and typhoid fever among combatants and non-combatants, together with the imminent peril of an outbreak of cholera, which has already made its appearance in different parts of southern Europe. Typhus fever has already killed over sixty thousand people.

The Red Cross, acting upon the invitation of the Serbian Government, and with assurance of its official support, is sending to Serbia a sanitary commission, headed by Dr. Richard P. Strong, to take active charge

of measures for the control of the epidemics. The functions of this Commission will be to assist the Governmental authorities in the formulation and execution of necessary sanitary regulations, the strict enforcement of which by the military and civil authorities will be indispensable if the epidemics are to be checked. Dr. Strong is qualified for the task assigned him by studies of tropical diseases in the Philippines, by work in connection with the last outbreak of pneumonic plague in Manchuria, and by subsequent experience as director of the School of Tropical Medicine of Harvard University.

Nurse Rosa Vecht, a Dutch nurse, died on January 23. Nurse Vecht was struck by a shell dropped from a German aeroplane, and was so injured that her leg had to be amputated from the hip. She died from the

shock and loss of blood. Everything possible was done to save her life. Eight expert surgeons were present at the operation.

Nurse Vecht was buried at Ardenkerke with military honors. The coffin was covered by the Dutch flag and was followed by soldiers of all ranks.

Mary Macgill, acting matron of the Military Isolation Hospital at Aldershot, England, died March 10 of cerebrospinal meningitis. Ever since the war broke out Miss Macgill had worked heroically and had so overtaxed her strength that it could not resist the disease. She was accorded a military funeral with full military honors. The coffin, draped with the Union Jack, was borne on a gun-carriage, and in the funeral procession walked a large number of nurses. The funeral service was most impressive.



NURSING TIMES, LONDON

MILITARY FUNERAL OF ROSA VECHT

Practical Points in Maternity Nursing

AMY ARMOUR SMITH, R.N.

III.—DELIVERY

CATHETERS, hypodermic syringe and high forceps must be boiled on every occasion. Then they will not be needed, likely. A sterile auscultation cloth is required for the abdomen. The most convenient form of draping a patient is with two draw sheets, the long way. Then the surgeon is not annoyed by the excessive weight of a lot of linen on his hand. The nurse must do a great deal to encourage the mother to push with her pains, as if the bowels were moving in a very constipated stool, and to relax, open her mouth and breathe shallowly when necessary. **THE MOMENT THE HEAD IS BORN, THE NURSE MUST GRASP THE FUNDUS** and hold it, noting the time. A stretcher can be made by laying two chairs face down on the floor and splicing their legs together. Some patients can be delivered only on their left side, thus necessitating a different arrangement of supplies. The doctor should always state if he is left-handed, also. The nurse must provide a plain, firm chair for him. There is no kind of work where a nurse has to attend to so many things at once, at a time over which she has no control.

IV.—THE PHYSICIAN

The pupil nurse should learn from packing the ambulance bag, with its medical, surgical and obstetrical needs, how to pack a physician's obstetrical bag, whether she is his office nurse or his private special. She should instantly list mentally all he brings and see that he gets it all again—instruments, towels, dressing covers, apparatus. She should provide materials and table for him to get the data necessary for the birth certificate. She should prepare gloves, drape, lubricant, etc., for all vaginal exami-

nations. She must never forget her hospital manners or her hospital charting. If the patient has means, she may be asked to supply the best chart paper; if not, ruled foolscap will do.

V.—SOLUTIONS

Where lysol is used, do not let it be mistaken for argyrol. Any articles used in measuring lysol should be at once thoroughly doused and boiled. Boric acid can quickly be made by boiling and then cooling. If bichloride of mercury is used, only a weak solution should be applied when the patient has been delivered, 1-6,000 or 1-10,000 at the most. The symptoms of bichloride poisoning must be watched for. When cleansing the patient's vulva, never pour or squeeze bichloride solution into the vagina, over the fourchette. Different strengths of lysol should be used for gloves, the hands and the periods before and after delivery. The physician should have the technique for delivery prearranged with his nurses. It is nothing short of murder for a nurse to guess at strengths of solutions. She must show temperatures and strengths accurately by the requisite utensils.

VI.—THE INFANT

The Board of Health now puts up silver nitrate in small wooden containers, in a soft waxy substance resembling Old Brown Windsor, which when squeezed emits two drops, and can then be thrown away. For a reception blanket use the oldest, softest, closest woollen blanket in the house, and pin it snugly under the baby's chin. Most nurses leave the whole chest of the infant exposed, as they would themselves wear a tulle scarf. Inside the blanket keep a diaper folded, with its pins in readiness, and a soft cotton towel. Find a place for the basket or

bassinet that is wide, low and free from draughts. Never leave any child alone on any high place. Keep separate soaps for the face and the genitals. Wash the buttocks only once a day with water, but at all other times for cleansing use sweet oil, cotton and a plain, unscented, reliable powder, for fear of some form of dermatitis. Compound stearate of zinc, dusted into the crevices, and then pasted in, acts like a paint, impervious to urine. Give sponge baths on the knee till the cord comes off. Give tub baths then, not immersing the stump. After it is thoroughly healed, the baby can enjoy a good sousing. If hurried by many other duties, the mother can then heat up her porcelain bath-tub and give the baby his bath by kneeling beside it. This saves carrying water to and fro. The proper and uniform time for weighing an infant is after undressing him for his daily morning bath at 9.45. At night change his band, rub his back and put on a loose nightgown, which he will enjoy just as much as grown folks do. When the cord comes off the stump should be wiped out every four hours with a tiny applicator made of cotton on a toothpick, till it is permanently dry, also keeping a sterile cotton square over it, which is daintily replaced by being drawn down over a fresh sterile one, pushed up without removing the flannel binder, every four hours. Do not allow any visitors to talk or hang over the baby's crib. If money is scarce it is a good idea to buy the crib at once which the child may use for years. Keep the weight chart as religiously as the others, dividing it horizontally into days and vertically into pounds, subdivided into ounces, making ascending and descending lines, as with temperatures. Watch for the effect on the infant from cathartics taken by its mother. An enema daily for her is much easier to handle than a pill, all told. The infant's dresses must be plain and fine, with nothing more than very soft narrow lace at the neck. Wrinkles of fat must be

kept clean, dry and lightly dusted with powder, in neck and axillæ, otherwise disastrous conditions may arise.

The Gabrielle pattern is best for petticoats, open at the back, not on the shoulders, and fastened with fine silk or linen tape. The skirt flares swiftly, and the child can easily be cleansed or examined by turning it up over the arms. Put no hose on the baby. Take him up once or twice a day and hold him. Make love to him, so that he will know what it feels like to associate with other human beings.

Never under any consideration use the barracoat. When applying the band, begin at the axilla, so that it really serves as a breast binder. A small dart in one groin will keep it firm. The band should be rolled very tightly before applying, and must be pinked, not hemmed, and sewed, not pinned. Dress him from the feet, pulling dress and petticoat on together, over the feet first.

VII.—THE MOTHER

An ungainly form such as hers cannot be expected to climb easily into a bath-tub. Sponge baths are preferable preparatory for delivery. Never leave the mother alone before delivery, and do not let her use the toilet after her pains commence. If she is to be catheterized use only rubber, on account of pressure from the oncoming head. She should have a good stool or enema twice every day and should urinate every two hours, so that we may detect eclamptic conditions while she relieves the pressure. When she is in labor the nurse's eyes must be on her constantly. In a private house one person may be within call, to come to the bedroom door, taking and bringing. Another, the husband or grandmother, may be stationed by the patient if the nurse must leave the room. She must think beforehand of how she will get or discard everything, always keeping the room surgically neat. The nurse who had her maternity work a year or two before she graduated

is embarrassed on her first few cases by having lost familiarity with its dicta. One pet rule she must always have, the four signs of the second stage!

1. Regular bearing-down pains from back to pubes.
2. Show.
3. Rupture of the membranes.
4. Bulging of the perineum.

But if the nurse gets a hurry call and the birth could be with advantage delayed a few minutes, she should take a towel and press back on the vulva with all her might, making the patient open her mouth and breathe shallowly. Where labor is long the legs grow cramped and a humane nurse will rub them till comfortable. It is cruel to put the patient to bed before the membranes rupture on a normal case. Where there is any sign of hemorrhage or other abnormal condition she must lie flat. The mother should wear gowns open in front all the way and quite short, so as to be free from contamination. The nurse should have a stout high chair with a footstool, so that when holding the fundus after delivery for the usual hour she can be over the patient and get some purchase.

VIII.—DIETS AND FEEDINGS

If the baby requires castor oil, give it with an equal amount of glycerine in a warm

spoon containing a little warm water, off which it floats easily. The feedings which may be necessary must be made with utmost accuracy. Tests may be made from mother's milk, the baby's stools, the bottled milk, etc., and there must be no flaw in technique. Nowadays, when there is only one child and his mother cannot nurse him, a good feeding accurately made is priceless. But the nurse does not need any great praise for it if she does her duty with her whole heart. A Chapin dipper is necessary to remove the cream by the ounce. The bottles should be at first small, only two ounces, and can be used for drinking water, which is boiled and *aerated* and cooled. One must have an Arnold sterilizer or other equally satisfactory kind, green soap, bottle-brushes, glass graduate and a milk thermometer that indicates about 260°. When barley water is made so much to the pint, part of the water is vaporized, and that amount must be added before using. The mother must be watched like a furnace. She needs coal and water. Put her on soft diet early, so as to avoid engorgement of the breasts. When they grow full cut down fluids. If the milk grows scant, give her large quantities of water, broth and cacao. It is a constant adjustment for about a week. Grapes, figs, dates, honey, prunes, apple sauce and oranges are conducive to a good milk supply and a correct bowel condition.

(To be continued)

Forget evil imagination. Forget the slander you have heard. Forget the meanness of small souls. Forget the faults of your friends. Forget the misunderstanding of yesterday. Forget all malice, all fault-finding, all injuries, all hardness, all unlovely and distressful things. Start out every day with a clean sheet. Be lovely, by loving. See how much sunshine you can produce.

Nursing a Tetanus Case*

HULDA MILLET BOOTH

I MUST confess that when I was sent to the hospital to "special" a case of tetanus, my heart sank promptly to the soles of my feet. This anatomical deformity increased all the way up the hospital hill, being perhaps aggravated by the fact that I had a heavy suitcase to carry and had just spent a strenuous graduation week. On learning that the patient was a little girl of six years and that she had nearly died in her last convulsion, my courage, which had also sought the soles of my feet in company with my heart, gave a last feeble struggle, then left me entirely! However, never say die.

The minute I saw my little patient, I made up my mind that if good doctors and faithful nurses and tetanus antitoxin could save her, saved she would be, and here, at the risk of anticipating, I must say that she is now on the sure road to recovery. The night "special," like myself, was very fond of children, and I firmly believe that practically all children react, particularly when ill, to the sympathetic or the unsympathetic influence of their nurses.

The case was an unusual one, from the nature of the disease and the fact that though statistics vary there is no doubt of the very high mortality, even when the antitoxin is given. The previous history of the case was difficult to obtain as the child's parents were poor, ignorant and confused. Briefly, what happened was as follows:

Sixteen days before admission to the hospital she stayed home from school and complained of feeling "sick," a description which, particularly with children, covers a multitude of ills. The family very naturally thought the illness a slight one, but

when she grew gradually worse and complained of severe pain in the nape of her neck and the small of her back, they finally called in a doctor. Before he saw her she had two convulsions and he at once made a diagnosis of probable cerebrospinal meningitis. However, on the child's admission to the hospital the next day, typical tetanus signs had developed, *i.e.*, spasms of the jaw muscles, general contraction of all the body muscles on slight stimulus, and moderate fever.

When I went on the case, about twenty-four hours after the child entered the hospital, she had had two severe convulsions. These each lasted about three minutes, and from all accounts differed from a cerebrospinal meningitis convulsion in that the opisthotonos was not very severe, while the rigidity of the jaw muscles was so marked that they relaxed only under full anesthesia.

Soon after admission, before the first convulsion at the hospital, she was etherized and 1,500 units of tetanus antitoxin were injected under each breast. Thus she did not receive her first dose of antitoxin until after she had had two tetanus convulsions at home. As soon as she was fully out of ether she began to grow very restless. She had paregoric m. x. p. o., repeated in two hours, yet in spite of that she had a severe convulsion at 5.15 A.M., sixteen hours after admission to the hospital and seven hours after her first dose of antitoxin. Ether was immediately given, artificial respiration resorted to, a wooden spatula placed between her teeth, and she came out of it well in about two minutes, with a good pulse and fairly good color. However, she very soon started in to get restless once more, and in less than an hour she had a second convulsion very

*Thanks are due to Dr. C. Benjamin Fuller, of Waltham, without whose permission and help this article could not have been written.

similar to the first. As soon as she came out of that the doctors, to avert, if possible, a third convulsion, ordered chloral hydrate grs. xv and paregoric $\overline{3}$ $\overline{11}$ p. o., which she got at 6 A.M. They had the desired effect. At 6.15 she was sleeping, though even when fully asleep her entire body was absolutely rigid. Her pulse was 140, good quality, temperature per rectum 100.4° , color fairly good, respiration 36 and labored, because of the rigidity of her jaws. Her jaws relaxed slightly when sound asleep, just enough to let the little wooden spatula fall out were there not some one there to hold it in. For a whole week—to anticipate again—this spatula was never taken out of her mouth except when we fed her liquids, a few teaspoonfuls at a time, or when we changed it. I called it her “medicine stick,” and told her that she must always keep it in her mouth because it was making her poor sore tongue better. Upholders of all the truth at all times will say I should have told her that if she took it out when going to sleep and then awoke with a start, she would undoubtedly bite her tongue, which would possibly bring on a heart spasm in which she might die! If they would have said all, or even a part of this, we will have to agree to differ, pleasantly but firmly! The medicine stick was changed several times daily because when startled or whenever she awoke she snapped so hard that her teeth—and poor ones at that—sank fairly deeply into the soft wood,

From the time of her first convulsion at the hospital her muscles began to stiffen, and when I first saw her her entire body was absolutely rigid. She could move her eyes, her lips and her fingers, but that was all. Her second dose of antitoxin was given the next day, intravenously, 3,000 units, the incision sewed up with horsehair. She was under ether about half an hour, and stood it fairly well. I gave her grs. v chloral hydrate s. c. as soon as she was fully out of ether, to prevent, if possible, a convulsion, and she slept quietly for several hours. She

took nourishment well in small quantities for several days, even though it invariably gave her a spasm, commencing with the throat muscles and extending to her very toes, and always accompanied by pain. Her only relief was in being gently rubbed, sometimes with alcohol, sometimes with powder, according to the degree of her fever. This was only 101.4° per rectum, at the highest, and dropped to 99° on the tenth day of hospital treatment. She had in all six doses of the antitoxin, six days in succession, the last three doses being given into the skin on her leg and covered by a sterile cocoon dressing. This change was made because to give it intravenously meant full ether anesthesia, and the strain was too great a one for her to stand daily. By giving her chloral hydrate grs. x half an hour before the antitoxin was given, we were able to save her pain and to ensure sleep for some time afterwards.

She had been in the hospital four days, and we were just beginning to think that instead of having no chance at all we might possibly pull her through, when she suddenly had a bad convulsion and came about as near dying as any one could and still survive!

She awoke out of an apparently peaceful sleep, and with absolutely no warning she stiffened, turned cyanotic, ceased breathing, and became pulseless at both wrists. She was apparently dead. I put on a cone soaked with chloroform, which had always been close at hand, and notified the house doctor, who at once used artificial respiration, while I kept on the chloroform until she began to relax. It must have been fully four minutes before she took her first breath, yet in only a few more minutes she was peacefully sleeping, with fairly good pulse and color. We gave her her antitoxin and chloral hydrate grs. x s. c. before she was conscious.

She had been in the hospital a whole week before her muscles started to relax. All that time she refused to be moved or turned, but

lay flat on her back, her toes stretched so tight that they were curved slightly backward, and the normal curve of her spine greatly exaggerated. Then, after two days of intense pain in her legs, neck, head, abdomen and back, and two nights of both pain and delirium, the muscles began to relax. Contrary to my expectations, her spine was the last to relax, and she could use both arms, flex both knees and chew bread before the spine and neck resumed their normal curves. She never allowed any one to turn her on her side, nor did she try to chew, until several days after we felt fairly sure that she could do both. But I think this delay on her part was due to fear of being hurt. She would not try to chew because one night, when she was asleep, the spatula fell out of her mouth, and quick as a flash, before the nurse could slip it in again her jaws snapped down on her tongue. It took the combined efforts of nurse and house doctor to pry the jaws open and push in the poor sore tongue, and she never forgot the incident! Chewing might mean biting her tongue again! In the same way, having two sore arms, which had both been opened for an intravenous injection, and two legs which had also been punctured, she was hardly to be blamed for not wanting to be turned!

However, when she learned that she could not get up in wheel-chairs unless she first learned to turn in bed, and when she discovered that the other children, who had also been very ill, were able to chew and have their tongues behave themselves, the coast was clear.

From the tenth day in the hospital her recovery was steady and rapid, and as far as I know at the present time of writing there are no complications or after effects. Instead of having to be coaxed to eat, she began to constantly call for food. The pain and spasms ceased, she slept well, and at the period of writing, three weeks since she entered the hospital, she is a rapidly convalescing little girl, up in a wheel-chair, and on careful house diet. Her mind was keenly overstimulated at first, so much so that the slightest unexpected sound, such as a cough or a loud footstep, would send her into a spasm. Now it is quiet and normal.

The interest of nursing such a case was tremendous. One of the doctors said to me in speaking of how the tetanus antitoxin probably saved her life: "Isn't she worth a few guinea-pigs and rabbits?" And I answered: "One human life saved seems to me worth hundreds and hundreds of animal lives lost."

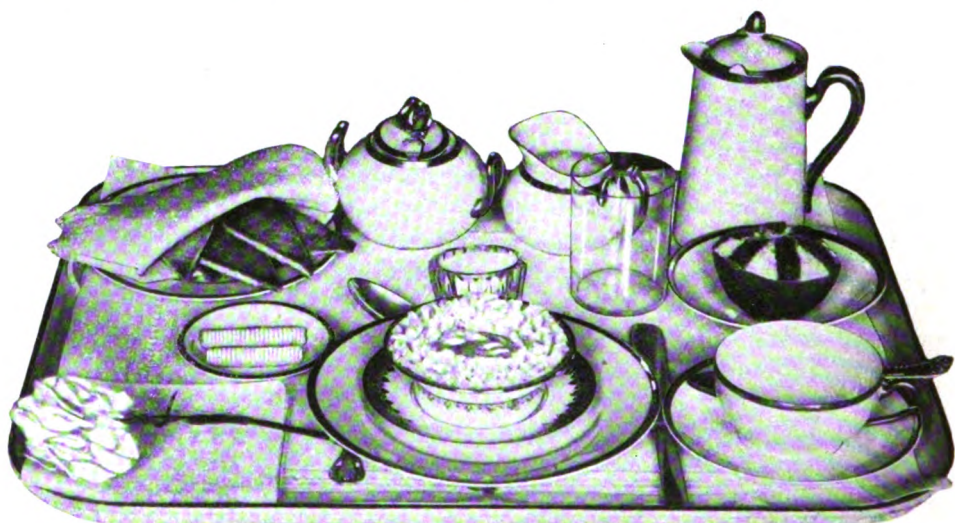
The unfavorable impression created by the ill-advised actions of some few trained nurses is shown in the following comment which appeared in the *McKeesport (Pa.) News*: "The latest White Cap movement in the North," it says, "is the effort of the Trained Nurse Union to monopolize by law the wage-earning care of the sick at \$25 or \$30 per week per union nurse. It might be argued that if all the poor nurse their own sick, loving care substituted for mechanics will give the sick a better chance of recovery. Monopoly will have to recognize its limitations."

Setting and Serving the Tray

HELEN G. HARLAN

THE setting and serving of a tray to a patient is the final demonstration of the dietitian's work, and the degree of its excellence in every detail is an accurate index of her ability in her profession. Since this is true, it behooves every wide-awake dietitian

will be found more satisfactory than the oval one, because it can be set to so much better advantage. The enamel trays are easily kept clean, look very nice and are extremely durable, but are very heavy to carry; while the japanned trays are light



THROUGH COURTESY WOMAN'S HOME COMPANION

CREAMED CODFISH WITH POTATO BORDER, TOASTED TRIANGLES AND ORANGE BASKET

to do her utmost to make the tray and its contents "a thing of beauty and a joy forever," as well as an important aid in the patient's ultimate recovery.

At first thought, perhaps, it may seem that too much stress is laid upon the importance of proper tray service, but when one considers that the natural stimulants to appetite, such as fresh air, exercise and enlivening companionship, are necessarily lacking, the realization comes that the taking of food is the chief event of the day, and, consequently, that too much care cannot be bestowed upon its preparation and service.

As regards the tray itself, the oblong tray

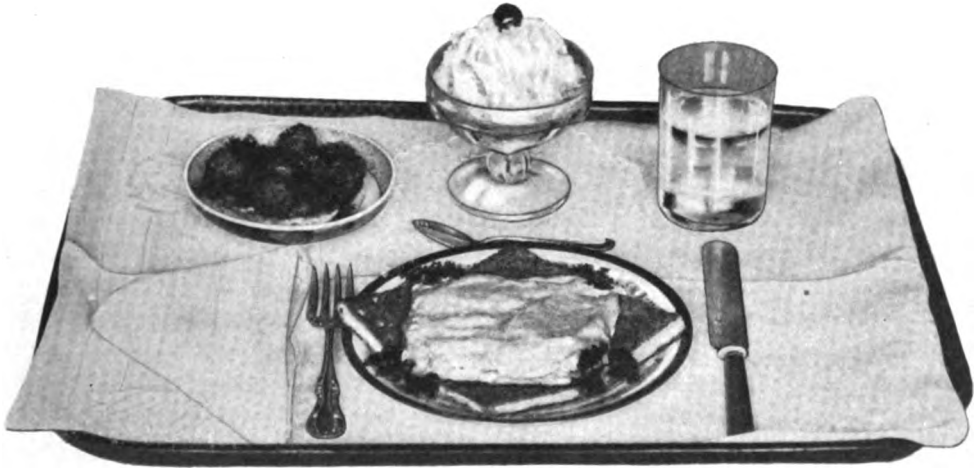
weight and present a good appearance, but are less easily kept clean and are not nearly so durable. The varying conditions in different institutions will naturally decide which of the above is better for their especial needs. And, after all, the appearance of the actual tray itself makes no very great difference, because it should always be covered with a snowy tray cloth, which should have at least the virtue of being whole. Linen of good quality is, of course, always to be preferred, but if the cost of this is too great, Indian Head linene—a cotton product—and various other cheap materials will make very satisfactory substitutes, and if laun-

dered properly will remain very white until worn out. What has been said in regard to tray cloths applies equally well to napkins. And in regard to the quantity allowed will say that an abundance of the cheaper quality is preferable to a limited number of the linen, for plenty of tray cloths and napkins are an absolute necessity for the most efficient service of a diet kitchen.

Next in order in setting the trays come the dishes themselves. A light-weight, good grade porcelain, with rolled edges and of the

and sugar bowls, while costing more at first than either glass or china, will be found far more economical in the end, as the latter are so easily broken and, consequently, must frequently be replaced.

In silver use the plated ware and procure the small-sized knives and forks rather than the dinner size, not only because a patient can handle the former to better advantage, but also because they occupy less space on the tray. A cereal spoon will be found in most cases to be more satisfactory for



THROUGH COURTESY WOMAN'S HOME COMPANION

CHEESE TOAST, BEEF BALLS AND ICE CREAM FURNISH A LUNCHEON RICH IN PROTEIN

kind which has undergone the so-called vitrified process, will wear far longer than even the heaviest of common white dishes, and will not chip so easily, either. A standard pattern of some plain design, with the monogram of the institution to lend distinction, and one which is always kept in stock, so that such dishes as are broken can easily be replaced, is to be preferred. Also, if possible, procure metal covers for the plates, so that the food will keep hot longer. The nickel-plated covers will be found the most satisfactory in the long run, as they require practically no care in keeping them bright and are almost indestructible. For the same reasons, nickel-plated cream pitchers

soup than the ordinary full-sized soup spoon.

In setting the tray place the fork at the left of the middle of the lower part of the tray, the knife with the sharp edge turned toward the fork at the right, with space for the plate between them. At the right of the knife place two teaspoons, then a soup spoon. These are placed, it will readily be seen, in the order in which they will be used. When soup is served, place the bowl between the knife and fork, and set the plate covered with a hot metal cover over it. At the left of the plate set the bread-and-butter plate, containing a slice of bread and one of fresh *hot* toast, with the individual butter knife

laid across one side of the plate. It is better to serve the butter itself on an individual butter plate for the reason that in carrying the tray the bread and toast, also the knife, frequently slip out of place, and if the butter is on this plate it is apt to look pretty messy by the time the tray reaches the patient. Put the small butter plate a little to the left, above the large plate. At the right of the plate set the cup, covered with the saucer to keep its contents hot. Immediately above

the cup place the sugar bowl and cream pitcher, and just at their left a glass of milk. It is a wise plan to always serve a glass of *cold* milk with each tray, unless positively known that the patient does not care for it. Above the plate set the vegetable dish, and at the left above the plate a glass of water. Above the bread plate set the dish of dessert. If a salad is served, it should be placed above the bread plate, in which case the dessert is then set above the salad.

(To be continued)

The Cyclamen's Message

FLORENCE E. MCKEE

A LITTLE girl had been ill for a long time. She lay in a large up-stairs bedroom, one of the windows of which looked out upon the stone wall of an old church. When the little girl first took to her bed she had watched the snowflakes dancing against the dark background, then an ivy had put out long, snaky fingers and pulled itself over the gray stones, and now they were covered with tender green leaves, among which the sparrows sometimes hid.

It was Easter morning and the window had been opened, that the child might hear the music from the church. She had lain motionless on the bed, her little face tense with interest while the organ thundered and the children's voices rang out the joyful Easter hymns.

Loving friends had filled her room with spring flowers. A tall vase of lilies stood at the foot of the bed. The little girl thought they looked like a group of sweet "sisters" in their white bands, with heads devoutly bowed. And while she looked at them one left the group and stood beside her. She felt her sweet breath on her face and her lips on her forehead. The little girl put up her hot hand and grasped the cool stem.

"Oh, Lily," she said, "I am so tired. The

days are so long. The things they must do to me 'to make me well' hurt so much. But, Oh, the nights! Horrid creeping things come out of the shadows and they chase me round and round in the darkness, and only when the lights peep in can I get back in my bed. Oh, why does not the angel that comes for the souls of little children come for me?"

A little pink-veined cyclamen on a stand by the bedside had been nodding eagerly. "Little girl," she said, "there is a baby bud under this green leaf by my side. Surely, today, the angel that opens the buds will come to it. Shall I tell him to tell he angel that comes for the souls of little children to come for you?"

Through the long, quiet hours of the day the child slept. In the early twilight she stirred and her eager little voice rang out: "Mother, has the cyclamen bud opened?" The mother brought the plant to the bedside. There stood the baby cyclamen, its white petals sprawling wide. The little girl touched the flowers caressingly with her thin little hand. Then, smiling sweetly into the wondering face of her mother, she turned toward the darkening shadows and patiently awaited another night.

Cleaning Up Sandy Creek

CHARLOTTE GARRISON, R.N.

Hospital Sanatorium, Kalamazoo, Mich.

THE doctor stood in the door of our tent. "Your sister, young man, is too good a thing for you to monopolize," he began, speaking to my tall sixteen-year-old brother in the reclining chair. "You obey orders and your mother and give the young lady a chance to 'clean up' on Sandy Creek. The place," he continued, turning to me, "is not fit for human habitation. I certainly dislike to place a friend in such a position, but some one must pull them through." I thought a moment. I had been called home from my hospital position to care for my young brother. This would be my first case in my home town for our own good doctor. My brother was much improved. The country paid well for contagious cases, I was told, and to tell the truth, I needed the money. Besides, I was interested at once. "I'll come when you need me," I responded, and shortly we drove off.

Together, in the doctor's office, we made out a list of supplies needed. Among them were included some new cooking utensils, canned soups, dishes, old linen, newspapers. While thus occupied, an emergency call took the doctor away, and I was left to wend my way down Sandy Creek. My patient's home was a one-story shanty, near the railroad track; on either side, at some distance apart, were small huts, occupied by negroes, I was told. With quaking heart I knocked. A tall, black-bearded man opened the door on a dingy, unkept kitchen, then led me into the sick-room, where lay the son of the house, his frame wasted by his long siege of fever. In the living room, on a huge bed, lay the little feeble-minded mother. The destitution and lack of sanitation was appalling to meet in my own clean country town. No information was forthcoming from the

delirious John or his dazed little mother; the big, black-bearded man, who was the father, was slightly intoxicated, and bade me make free with the house. Absolutely no linen was to be found, so I hastily scribbled a note to our supervisor for a bolt of linen, and awaited a chance to send it. The grocer wagon would come every other day and the milkman daily, they told me.

Since the whole house was already infected, the thing to do was to wall off a clean part. I put my clean utensils and dishes on clean newspapers on the kitchen table and kept them covered. After the patient's sponges were given and beds made as comfortable as possible without clean linen, I made a dishpanful of 5 per cent. carbolic. After dipping in my broom and sprinkling the dust-laden floor, I swept and wiped up the rooms with dampened cloth. A small foot-bath was procured, filled with carbolic and, when not in use, the bed-pan was submerged in the solution. A note to the Ladies' Aid Society brought offers to make sheets and old linen. The next day the doctor came in, sniffing appreciatively. "I positively wouldn't know the place," he declared. Since his orders for both patients specified liquid diet and mostly milk, the nourishments were easy. The son was sick enough to appreciate the unaccustomed care, but the little mother knew not what to think of the assuming young stranger in cap and starched uniform who had taken possession of her home and completely upset their tenor. Daily she gave orders to have "meat hog" for dinner, or what to put in John's dinner-pail, or worried about her poor little garden. Then, when the sheets came, the problem of washing must be solved. One tub did not leak, so this was filled with water

and yellow soap shaved fine, and put on the top of the stove to boil. As linen was changed it was dropped into the hot water and boiled twenty minutes. As I washed every morning the laundry was not my least problem. With a young nurse's intensity to have everything perfect at once, I had begun to neglect the nurse. I had been vaccinated for typhoid a year and a half ago and was reasonably safe, but was very fearful of infection. After scrubbing my hands almost raw, I felt it safe to eat, though I used my fork rather than my fingers for eating, even bread and butter. Now, with two very sick patients, the laundry to attend to and two coal fires to keep up, I decided to save time on my own cooking. "Raw eggs," I mused, "must contain the elements of a good breakfast," and to save time, for there was so much to do, I decided to swallow two strictly fresh ones. The adjective was misapplied, however, and one gulp satisfied my appetite until noon.

As the son began his convalescence, the mother's fever was at its height. No medication was indicated, but sponges for 101° fevers given. For the mouth I applied swabs of glycerine and lemon juice, alternating with glyco-thymolin. About this time a grandson, aged three years, became ill, and was brought to my hospital. The physician, at this point, turned the cases over to the county doctor, though in consultation about the child. On this case the first doctor diagnosed typhoid, and the county physician believed it to be pneumonia. Their relations were not cordial, and I became the confidante for both of their grievances. The new physician's treatment was radically different. A very liberal diet was prescribed for the grandmother. Sponges, camphorated oil to chest, with pneumonia jacket, were ordered for the child. One night at

about one o'clock the child became restless, crying as though in pain. The abdomen was greatly extended. After searching in vain for turpentine, I dressed, walled in the child's cot with chairs and locked the grandmother in her room. With a glance backward at the bright light I stumbled out into the dark night. A dim light glowed in a cabin a quarter of a mile up the road. Breathless and, it must be confessed, a little bit frightened, I knocked on the door. Through the window I could see a great, tall negro; on the table before him was a wicked-looking bottle; in his hands a banjo. Would he go to the drug store for turpentine? He was the only one I knew to ask. "Why, most suttinly, Miss; glad to obleege you," shuffled the gentleman, somewhat embarrassed. In twenty-five minutes I was applying stupes, and soon the child went into comfortable slumber.

The married son of the family living across the town became ill with typhoid shortly after my cases developed. The interesting thing in connection with this was the detail of the treatment prescribed by his Chiropractic physician. Disconcerting, but true, the patient seemed to make an uninterrupted recovery, sans doctor, sans nurse. We believe the infection must have been very slight in this case.

After four eventful weeks I left my patients safe on recovery's road. "After all," remarked the county physician, jokingly, "you came out best. The first doctor called gets his payment in a 'meat hog,' mine comes in the day's work, and you are now independently rich."

"Yes, rich in the experience of nursing typhoid without the bare necessities of life," I retorted. At all events I made firm friends on Sandy Creek, though I cannot say I cleaned it up.

Cleanings

The Abuse of Quinine

Quinine is usually looked upon as a harmless drug. So common a household remedy is it that the laity take it *ad libitum* for colds and nearly everything else. The use of quinine in large doses, and especially for a continued length of time, disturbs the auditory mechanism and often produces marked deafness; it also upsets the nervous system and affects unfavorably the corpuscular elements of the blood. Its tendency to produce hemorrhage is well recognized. Aside from malaria and just a few conditions bordering on sepsis, we see no special indications for quinine. The majority of colds and acute conditions for which quinine is taken are aggravated, the secretions perverted, the stomach and nervous systems deranged. Quinine is valuable as a tonic only when administered in small or medium doses.—*Medical Summary.*



Rapid Relief in Lumbago

Nurses who suffer from lumbago will be interested in a method described by William Haig in the *British Medical Journal*. The method consists of (1) deep thumbing of the lumbar muscles, in process of which a painful area is usually found either in the middle line or to one or other side; (2) fixing the part of the vertebral column below this painful region by firm pressure of the thumb on each side of the spine, and (3) making the patient perform movements of flexion, acute dorsi-flexion, lateral flexion and rotation. The result is cure of the attack of lumbago, inasmuch as the patient is able to at once return to his work, and in no case have I

had to repeat the process, says the writer.

Among the cases described is that of a ploughman: "I made him (1) bend forward as far as possible, then back as far as possible half a dozen times; (2) sit straight up and fall first to one side and then to the other half a dozen times; (3) still erect, turn his head and shoulders round as far as possible (until he could see with his left eye over his right shoulder and with his right eye over his left shoulder, I told him) half a dozen times in each direction, my thumbs all the while deeply pressed against his spine and my fingers spread out over the buttocks to keep the lower part of the body as rigid as possible. We finished with a few more antero-posterior flexions and extensions. The man returned to his work in the harvest field the same afternoon, and I had no occasion to see him again."



Radium in Cancer

Radium will gradually take its proper place. It is going through the period of enthusiasm that Roentgen-ray therapy experienced ten years ago. We really know now the extent of its possibilities. It is useful in numerous dermatoses and it is indisputable that it can be used successfully to destroy certain localized malignant growths, that is, growths on the surface whose entire extent can be sufficiently exposed to its energy. Extensive growths involving deep structures and disseminated growths are beyond its control, and there is no reason to believe that they will ever be brought within its control, even if the supply is largely increased.—*J. A. M. A.*

Observation on Milk Station Infants

A paper by Mark S. Reuben in *Arch. of Pediatrics* covers a series of 1,500 feeding cases and contains very many valuable suggestions regarding the feeding of infants. Reuben's summary of the value of caloric estimation is especially interesting:

1. "In beginning to feed a healthy infant with the bottle we have a definite way of ascertaining about how much food the infant needs.

2. "In feeding atrophic babies and puny babies we know that they require more calories than do healthy infants of normal birth weight.

3. "In infants who are not thriving and where there is no apparent cause for failure to gain, estimation of the calories at times reveals that they are getting a food that is too high or too low in calories.

"The caloric estimation of the food is of value, therefore, only at the beginning of a feeding case. After that the food should be regulated as the weight and symptoms indicate. In the cases that did well and in which the food was increased according to the weight and symptoms, it is surprising how unconsciously we followed the general caloric requirements which were ascertained in the later study. Still it is much safer to feed each baby separately than to follow any general rules."



The Subcutaneous Injection of Oxygen as a Therapeutic Measure

In the *American Journal of the Medical Sciences* (December, 1914), John McCrae, M.D., states that having personally seen one life apparently saved by this procedure, he recommends it because of its simplicity and apparent harmlessness, especially as a last resort. The technique is as follows: The ordinary oxygen cylinder is used, with the usual valve and wheel by which the escape of gas is regulated. To the tank is attached sufficient length of rubber tubing, 1 cm. in

diameter, to the end of which is attached a small hollow needle. The rate of flow is observed by letting the gas bubble through alcohol or sterile water; it should be just short of a continuous stream of bubbles. The selected portion of skin is sterilized by iodine. Any portion where the skin is lax will do. The needle is then introduced and the gas allowed to raise a lump half the size of a football. After withdrawing the needle the orifice is closed with adhesive. Most of the gas is absorbed in a few minutes, though some crepitation remains much longer.

McCrae considers the following conditions amenable to this treatment:

1. Accidents from anesthesia.
2. Edema of the lungs, edema of the glottis, and accidental interference with respiration by disease of the upper part of the respiratory tract.
3. Marked dyspnea with defective oxygenation, as in cardiac and renal disease.
4. Asphyxia of infants at birth.
5. Syncope.
6. Electrocutation.



Hard Water

According to the *Lancet*, it is safer to drink hard water (*i.e.*, water with lime in it) than distilled water. It is probable, says the writer of the article, that the amount of lime salts taken through food easily exceeds the quantity present in gallons of hard water; that when distilled water is drunk, the surface layers of the epithelium of the stomach undergo considerable swelling, and the salts also may pass out and the cells die and be cast off. "Such a process may well resolve itself into a catarrh of the stomach." . . . The conclusion arrived at is that "it is doubtful whether hard waters are unwholesome, but the inconvenience caused by the furring of domestic services and kitchen apparatus by the deposit of chalk from such waters is very real, and affords a just cause of complaint."

Editorially Speaking

A Memorial to Civil War Nurses

It should be a matter of sincere rejoicing throughout our country that the women who served the cause of humanity and bravely endured great suffering during the days of the Civil War are soon to have a splendid memorial erected in their honor.

On March 27 the cornerstone of the building was laid with appropriate ceremonies, President Wilson and ex-President Taft officiating. The building will be used as a permanent home for the American Red Cross. It will cost \$800,000, \$400,000 of which was appropriated by Congress, and an equal amount made up as follows: James A. Scrymser, \$100,000; Mrs. Russell Sage, \$150,000; Mrs. Edward H. Harriman, \$50,000; the Rockefeller Foundation, \$100,000.



In Memory of Florence Nightingale

The statue of Florence Nightingale, which represents the national memorial, has been placed on the left of the Crimean monument at the foot of Waterloo Place, Pall Mall, London. No ceremonies attended the unveiling, but in the week following the slipping off of the wrappings of the statue many tokens of affectionate remembrance have been quietly dropped at her feet. *The Nursing Times*, of England, says:

"On the first day a lady drove up in a car and watched the nurse who had accompanied her place at the base of the statue a spray of lilac with one red rose, to which were attached the words: 'With homage and love.' As the week went on the number of floral tokens slowly multiplied. By far the most important was a large green-leaved chaplet decorated with a crimson bow, and



MRS. REBECCA PRICE, PRESIDENT OF THE CIVIL WAR NURSES—ONE OF THE WOMEN IN WHOSE HONOR THE SPLENDID MEMORIAL IS BEING ERECTED

suspended from the statue itself. The whole of the lower portion was composed of deep red rosebuds nestling amid asparagus and other ferns. The card bore the following inscription: 'St. Thomas's Hospital. With love from her Nightingale Nurses and Probationers.' The Catholic Women's Suffrage Society forwarded 'A Tribute,' consisting of a wreath of laurel leaves tied with white, blue and pale yellow ribbons. Another circle of laurel leaves with a group of upstanding white flowers bore the inscription 'From a Grateful New Zealander,' and there were many tokens of a less striking character—a

bunch of flowers tied with simple ribbon; a few white tulips; a sheaf of daffodils; a cluster of ivy and other leaves, all testifying alike to the desire on the part of her many admirers to show their love for the woman to whom our soldiers owe so much."



Organized Neighborliness

The article on the above subject in this issue by Miss Carson, well known for many years as the superintendent of nurses in the New York Polyclinic Hospital, is certain to be read with interest by all our subscribers, and with thoughtful consideration by many who are earnestly seeking to find the best means of serving the great two-thirds of the population in sickness.

There are many points on which we would like to comment, but we desire to call special attention to that part in which Miss Carson states that the greatest dangers that beset this movement, which has in it such great promise of practical good, is the danger of considering a bureau for home nursing simply as a registry for practical nurses and charwomen, and of thinking that by tacking those features on to some other organization you are doing the same work advocated and done by the household or home-nursing association. There is the danger of snap diagnosis of the conditions and the means of meeting them—the danger of failing to grasp the essential features of a comprehensive plan for providing public service, and the unwillingness to give the whole plan a fair trial. The country is dotted with schools and registries for providing practical nurses yet only a few of these have seemed to command the full confidence of the public.

The financial features of the home-nursing plan which assures to every worker her money when she is through with a case, yet prevents her from making overcharges; the being able to extend credit or to make a loan to a family to tide it over a sickness without asking for charity, are to our mind among the

important phases of the work. The daily or weekly conferences over case problems with the workers which enables a superintendent to really *know* the household nurses that she sends into the homes; and because she does know them she is able to place them where they will fit and to supplement their needs accordingly—this is another helpful feature not usually found in connection with registries.

To take care of the *worker* as well as the family and protect her from imposition, while still caring for the needs of the situation—the placing back of her always the resourcefulness and skill of experienced graduates and a well-organized office ready for emergencies, these features are not provided without effort.

It is gratifying to note that graduate nurses, wherever such work has had a fair trial, have heartily cooperated. This plan of meeting the prevailing needs certainly safeguards the graduate nurse's interests and avoids the danger points as no other plan of which we have knowledge has done in this country. If the movement can be kept from growing too fast till the problems are more fully studied, and if enthusiastic workers will only carefully study the *whole plan* and not seize on a few features to tack on to some other plan—it surely seems to have in it enough practical common-sense and vitality to make its way.



The Forty-Eight-Hour-a-Week Law

The Association of California Hospitals has been making a determined effort to have the troublesome forty-eight-hour-a-week law for pupil nurses amended, and before this issue reaches its readers its fate will probably have been decided.

Copies of correspondence received from forty-six hospitals in that State show a marked unanimity of opinion as to the hardships and general iniquity of the law.

The fact that a pupil nurse can never dur-

ing her training feel that she has the full nursing responsibility of a case; that she rarely sees an obstetrical patient through from the onset till the completion of labor; that knowing that she cannot be kept on duty to finish her work leads to carelessness and slackness and makes proper discipline out of the question; that the nurses are in no better physical condition than before the law was enacted; that the course should be extended to four or five years if the law stands; that a change must be made if efficient, responsible nurses instead of mechanical, time-serving attendants are to be graduated—these are some of the comments contained in the correspondence.

The changes proposed are: Fifty-six hours of practical duty per week instead of forty-eight, and an allowance of four months during the year for experience in special nursing when the eight-hour limit will not apply.

The secretary of the Union Labor Hospital in Eureka, Cal., announces his institution as favoring the arrangement which will allow for special nursing experience, but as opposed to any change from the forty-eight-hour-a-week limit.

The San Francisco County Nurses' Association voted in favor of the fifty-six-hour amendment, but against any provision that would permit pupil nurses to have special nursing experience before graduation.



The Overworked Nurse

In one of the discussions at the St. Paul convention of the American Hospital Association, Dr. Ancker expressed himself with no uncertain sound regarding the complaint of the overworking of nurses so often heard. "I want," he said, "to add my song of protest against the reiteration of the story of the underfed and the overworked nurse. I don't believe there is such a thing. Go into any well-regulated hospital in any State of the Union and look at these women. I defy

anybody to say that they don't present the picture of health and well-being that you rarely see in any body of men or women in any vocation.

"Look at them on the street! Look at them when they are going away from their work! They are cheerful and happy and enjoy it. I don't believe any normal man in any rational work was ever killed or injured by work. Let's quit this story about the overworked and underfed nurse. She isn't there. In most of them there is a transformation. The majority of our nurses come from the country. At the end of a year look at them. They have rosy cheeks; they have every appearance of being well fed. We rarely have a record of a nurse who hasn't gained in weight—some ten, fifteen or even twenty pounds. She looks better and she is better. She is a more normal and rational person then when she came in. She lives regular hours. She has regular and good food, and that makes for the benefit of any human being."

Is it not true that the nurse who claims to have broken down in health during her training will usually be found to be the nurse who entered for training either with physical defects which she either did not know of or was careful to conceal, or with a predisposition toward certain ailments which would, sooner or later, have caused trouble whatever line of work the girl might have chosen? It is nothing unusual to find a girl who has sent in a blank form duly signed that she was free from physical defects to admit the presence of such defects before the probation period was over. Hernia, goitre, chronic digestive trouble, menstrual difficulties and irregularities—these are suggestive of some of the difficulties which appear in a few weeks or months in girls who have stated when applying that they were in good health and free from physical defects.

"I've had stomach trouble all my life and I'm glad now that I've got into a place where I can get it attended to"—this was a remark

made by one such nurse in the first week after her admission to a certain school.

Is it or is it not true that few girls who were really fitted to enter on a nursing career—physically and mentally fit—and who “like their job”—break down while in training?

The University Hospital, San Francisco, has inaugurated a practice of weighing all nurses on entrance to the school and thereafter every four months. The weights are recorded. Any nurse showing a loss in weight is obliged to undergo a physical examination and to be kept under observation in regard to health. Two nurses have been dropped for health reasons since this regime was introduced.



How Many Subjects?

How many studies can a nurse on regular duty in a hospital carry at one time and do justice to them? This is a question that has been thrust at the editor recently. It is a question which ought to be asked and answered by every training school. In multiplying subjects unduly may it not be possible that we are hindering good work with the best intentions in the world. In other words, is it better to have two or three classes a week on one subject till the course is finished—say, in *materia medica*—and finish up in a short time the work outlined for a year in that subject, or is it better to try to teach *materia medica*, anatomy and bacteriology all at the same time, stringing the classes out over a longer period, burdening the nurse with the study of three widely differing lines?

By careful study and planning as to the best way to manage such work with the least strain, may we not find a way by which better work can be done? It is so easy to give a smattering, to think we are doing efficient work, because we are holding so many classes, and yet be deceived as to what the nurse has really learned.

The noted William Rainey Harper, one of the greatest educators of his generation, is quoted as stating his opinion that “no student can *really master* from four to six studies at a time. Two at a time is the limit of human capacity *for efficient and thorough work.*”

If this be true of students, is it not doubly true of nurses who are absorbed with the daily work and the human needs for which they are held responsible.

If our ambition is to hold so many classes regardless of the efficiency of our work, it makes little difference whether we consider this subject or not. But a little study as to how to attain greater efficiency in our teaching might be beneficial in many schools.



Hospital Association Train

In order to insure a more comfortable and pleasant trip for the personnel of the American Hospital Association, attending the twelfth annual convention at San Francisco, Cal., June 21 to 25, 1915, very complete arrangements have been made for an American Hospital Association special train. For full information address Asa Bacon, chairman of transportation, Presbyterian Hospital, Chicago, Ill.



Dr. William O. Mann

Dr. William O. Mann, superintendent of the Homeopathic Hospital of Boston for the past sixteen years, died at the hospital April 9, after a short illness of bronchial pneumonia. Dr. Mann was operated on recently for abdominal trouble and was on the way to recovery when the attack of bronchial pneumonia set in.

Dr. Mann was one of the best known hospital executives of this country. Last year he was elected to the presidency of The American Hospital Association. The news of his death will come as a great shock and his loss will be keenly felt in the hospital world.

The Hospital Review

CONDUCTED BY CHARLOTTE A. AIKENS

Items of interest, annual reports, publicity literature, and material descriptive of newer methods and plans in any department of hospital work, should be sent to the editor of this department, at 722 Sheridan Ave., Detroit

Technique of First Aid in Pulmonary Hemorrhage for Hospital and Sanatorium Use*

HELEN B. FREER, R.N.

Director of Nurses, Cook County Tuberculosis Hospital, Oak Forest, Ill.

In pulmonary tuberculosis one of the most frequent complications is hemorrhage. The complication comes usually in the form of a surprise to the patient, often when he is feeling perfectly well.

The sensation the patient experiences at the onset of hemorrhage is manifested by his anxious expression and inevitable excitability. He looks for help and "first aid" must be promptly given; the sight of blood is convincing enough to him that his condition is a grave one.

In a tuberculosis hospital the nursing staff must have a uniform and definite method instituted whereby the complication of hemorrhage can be properly treated until the physician arrives. To avert any possible misunderstanding between the medical and nursing staff in giving first aid, a standing order prescribed by the head physician is of immense value. The standing order should be posted in the medicine room, nurses' station, and incorporated in the rules for nurses of the institution, so that a nurse new in the service is not "left in the dark" should hemorrhage occur while on duty alone, as is sometimes the case. A standing order will do much toward prompt administration, but to depend upon ward supplies to fit into emergency work is haphazard, to say the least.

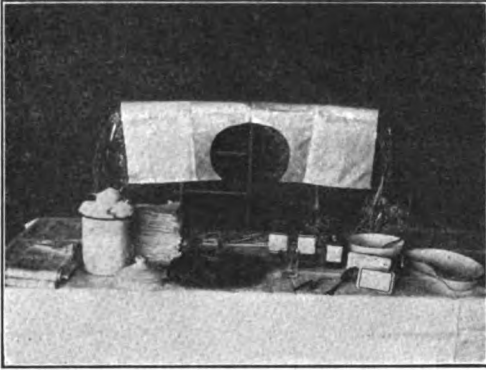
It is my pleasure in this article to describe a basket fully equipped to give first aid in hemorrhage, and which is in use at this institution. The basket is about 20 x 27 inches in size and 6 inches deep. The compartments are so arranged that every article is plainly seen and easily reached. A card is attached, giving on one side the physician's standing order, and on the other side a list of articles contained in the basket arranged according to their use. The list is as follows:

One rubber bib; two towels; two pus-basins†; one ice-cap; one bowl, for chipped ice; one teaspoon, for chipped ice; one ice-pick; one jar cotton pledgets; one bottle alcohol, 4 oz.; one bottle sterile water; one hypodermic syringe; three hypodermic needles (aseptic); wires for hypodermic needles; nitroglycerine tabs., gr. 1-100; atropine sulphate, gr. 1-150; morphine sulphate, gr. $\frac{1}{4}$; pituitrin; box amyl nitrite perles; 36 gauze squares, 3 x 6; sol. magnesium sulphate; glass drinking tube; one 6-lb. paper bag.

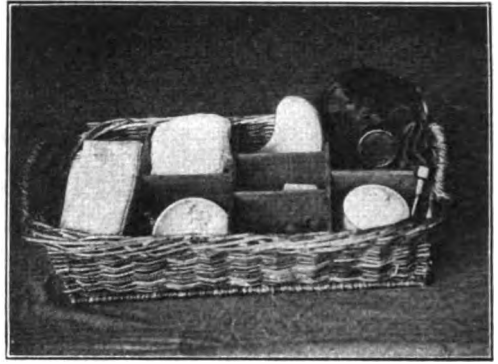
Treatment—The nurse who discovers the patient having hemorrhage attends the case, places the patient in the recumbent position, with assurance that rest and quiet are of the greatest importance. A second nurse is pressed into service. She notifies the physician in charge and returns to the bedside as quickly as may be possible with the hemorrhage basket. The assistant now takes the ice-bag and bowl from the basket and proceeds to fill them with chipped ice. The ice-bag is placed over the heart of the

† Two basins are provided, furnishing ample containers should the patient lose a great amount of blood. The blood when congealed is placed in paper and burned.

* Reprinted from *Journal of Outdoor Life*.



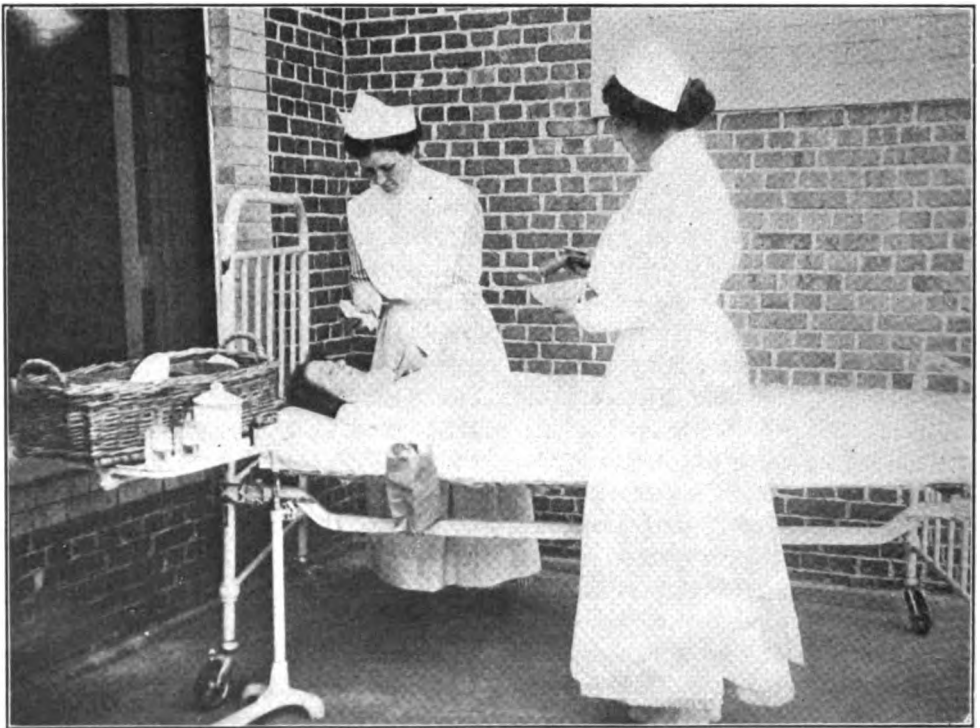
HEMORRHAGE BASKET WITH EQUIPMENT



HEMORRHAGE BASKET FILLED

patient and chips of ice placed in the patient's mouth as the bleeding diminishes. If for some reason the physician is detained and the hemorrhage is profuse, the nurse proceeds to carry out the standing order by giving nitroglycerine gr. 1-100, hypodermatically. It is necessary, perhaps, that the

nurse proceed further by breaking, in a piece of gauze, a three minim amyl nitrite perle, which is given the patient to inhale, with a word about its effect, as the sensation sometimes frightens the patient exceedingly. All patients receive as soon as possible one ounce or more of the saturated solution of



HEMORRHAGE BASKET IN USE AT TUBERCULOSIS HOSPITAL, OAK FOREST, ILL.

magnesium sulphate, repeated as the physician may order. The patient is not permitted to leave his bed under any circumstances. The nurse in attendance upon the hemorrhage is responsible for the record of the case.

With a bed capacity of about six hundred it is necessary to have a number of baskets placed throughout the institution, with their location familiar to all the nurses. After being in use the baskets are replenished and the utensils sterilized by the surgical nurse who is held responsible for the condition of all the baskets.

The hemorrhage basket has now been a part of the regular equipment of the tuberculosis hospital at Oak Forest for some time. In our experience it offers the advantage of supplying in one container all of the supplies ordinarily necessary in the treatment of hemorrhage. A technique is established and the psychic effect upon the hemorrhaging patient as the nurse appears with the basket is good, to say the least. The basket is inexpensive, the one in the photograph being made from willows gathered on our own grounds and woven into a basket by a county infirmary inmate.



Hints for Prevention of Waste in Hospitals*

A. A. S.

GENERAL WARD HINTS

1. Old muslin coming in, in the exchange can be torn up for small squares to put inside the diapers of infants to receive the bulk of the stool.

2. Newspapers can be very cleverly made into bags by the patients, with two straight pins.

3. Rags go to the window-cleaner and to the maids and orderlies for polishing.

4. Old blankets make pads for the ironing boards.

5. All white or Balbriggan hose (even

what the nurses cast off) may be used to place on a leg or an arm under a plaster cast, and then turned back out over the edge to render less rough.

6. It pays to put up special holders for toilet paper where only one sheet comes down at a time. The patients destroy these rolls in short order, and it is just such things as that which make them poor.

7. Nurses must not have a dozen rolls on the go in a ward, on every bedside table. Besides, when a patient hides it in his bed, the orderly, perforce, is slow and careless.

8. Ward brooms should hang, broom end up, bound with a piece of stockinet or stocking.

9. Watch the plates come in after a meal and find out how much bread is consumed and whether the nurses are serving too lavishly.

10. Collect the butter off the patients' trays and weigh it, and when it is out of proportion, charge it to the nurses on the floor. Use it for soap fat, and sell with all the other fat.

11. Count the number of patients and determine how many slices of bread are needed, and then send a little more, but follow it up and see that the margin is there, or find out why.

12. Do not allow lemons and oranges to accumulate.

13. Examine each ward's garbage can.

14. Tax the floor for the disappearance of tumblers, etc., unconfessed. Count goods often.

15. Send back to the main kitchen all foods unused from ward pantries, but send nothing back to be used as food if it has been in the wards.

16. The head nurse must order very exactly, not in a hurry at the last minute, on a well-drawn-out diet slip.

17. Keep two crocks for butter, one that is fresh, the other cuttings that are clean but slightly mussy, for toast.

*Continued from April.

HINTS FOR THE MAIN KITCHEN

1. Coffee and tea should be taken right off the grounds and leaves when made.
2. They should be made in small quantities, but for each relay of nurses.
3. Bread crumbs are saved for dressing and puddings (fig pudding is made almost entirely of them).
4. Sell the fat for soap, or make soap yourself.
5. When buying soap, remove the wrappers and pile in spaced pyramid to dry and harden.
6. Potatoes should be counted. Quick rounds by the housekeeper who knows her business will determine how much waste there has been.
7. Keep all strangers and others out of the kitchen.
8. Make all servants pass out via the office, and allow no bundles. Do not let colored laundresses do outside work.
9. Daily diet slip for the staff and the help will require discussion about how many portions are needed of each food.
10. It is an advantage when the housekeeper is a nurse and an officer of the training school, responsible to the directress of nurses. She can check the pupils.
11. Keep chickens to use up leftovers.
12. Do not try to use left-over foods to such an extent that it costs more to disguise them than new food would cost. Do not have any leftovers.
13. Weigh all foods and keep check on butcher *especially*.
14. Use bread one day old and keep it divided so as to be easily distinguished. Some bakeries will sell at a lower rate for the day-before's baking. It is more conducive to good health. *Nobody loves* fresh bread so much that he will go out and buy it. It cuts to much better advantage, also, for sandwiches, etc.
15. Do not aim at bare cupboards, but have all food in good, wholesome condition.
16. Wrap lettuce, etc., in a clean, damp

towel, and never put paper in the ice-box.

17. Bottled milk is cheaper in the long run than milk in the bulk. Bulk milk of the *second grade* can be bought in bottles. Milk in cans is unwieldy and not easily dipped, and does not keep so well.

18. Keep vigilant watch that the ice-box is always closed. Use a self-registering thermometer to indicate whether it was left open too long or not.

19. See that ice-box is not situated anywhere near a hot flue. But do not let any of the board of governors rattle you by a complaint about the size of your ice bill. Remember, your ice goes for sponge baths, packs, ice-caps and ice-coils, far more than for preservation of food.

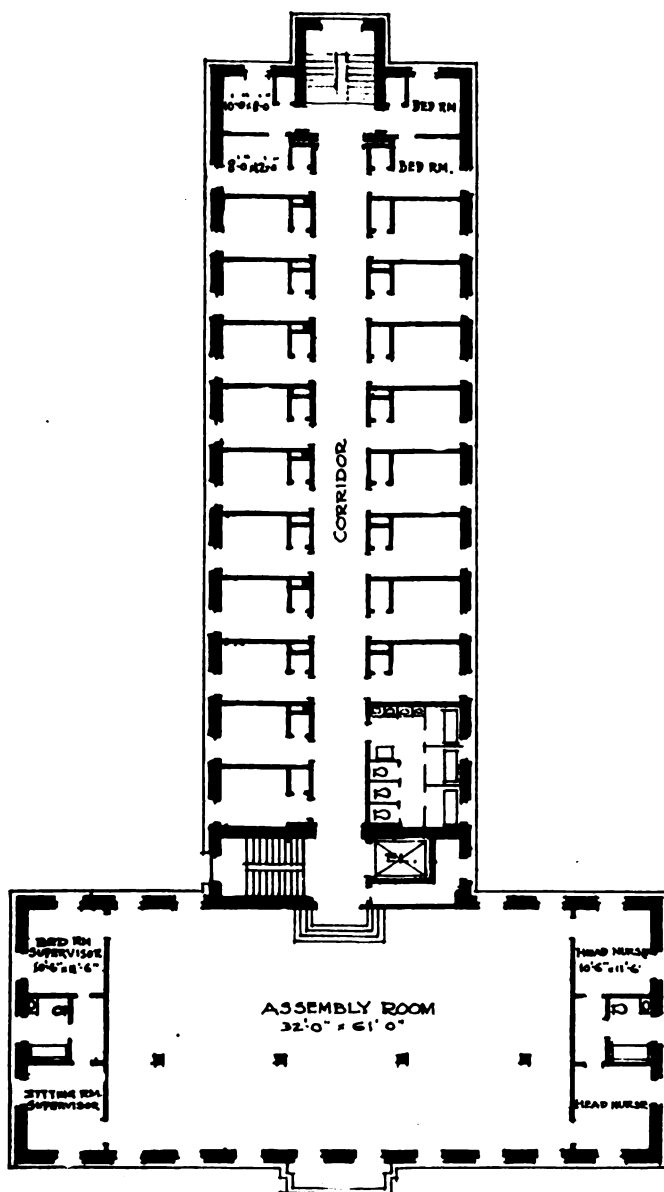


A Nurses' Home and Its Planning

While the erection of nurses' homes does not always keep pace with the building of hospitals, owing to lack of funds, yet it is matter for satisfying consideration that each year sees a goodly number of hospitals engaged in the delightful task of working out plans for beautiful and capacious nurses' homes. As an example of what appears to be a very satisfactory plan for a nurses' home of fairly large dimensions, we present this month one of the floor plans of the new nurses' home now under construction in connection with the Methodist Episcopal Hospital, Brooklyn, N. Y.

The plans provide for 136 bedrooms, with the idea of but one nurse occupying each room. There are, besides, six additional beds in an infirmary for sick nurses—in two wards. Each ward is 20 x 11 feet, with its own pantry, bath rooms, etc., so that when necessary each ward may be completely isolated from the other and from the main building. The infirmary opens off the roof garden and is so planned that sick or invalid nurses may enjoy their own private balcony or garden on the roof. ■ ■ ■

The building is of Philadelphia pressed



PLAN OF FIRST STORY—NURSES' HOME, METHODIST-EPISCOPAL HOSPITAL, BROOKLYN, N. Y.

brick, with a frontage of 86 feet and a depth of 161 feet. On the ground floor are two class rooms, one of which is a demonstration room with a storeroom adjoining for demonstration supplies. There is on this floor a trunk room and a kitchenette, where there will be a gas range, sink and laundry tubs for any bit of special laundry work which the nurses may wish to use it for.

The first floor contains in the front of the building a large and imposing assembly hall, 61 x 32 feet. Here receptions, entertainments, the graduating exercises, etc., will be held. When not so used it may be broken up into music or reception rooms by means of curtains or screens. At one end of the assembly hall will be a suite of rooms for the supervisor of nurses, consisting of a sitting room, a bedroom and a bath room. At the other end will be two rooms and a bath room. This suite will accommodate two head nurses. In the stem of the "T" there are twenty-four single bedrooms, each 12 x 8 feet, with a clothes closet.

The floor of the assembly hall will be maple. It has not been determined whether maple or battle-ship linoleum will be used in the bedrooms.

On the second floor bedrooms take the place of the assembly hall, and are of the same dimensions as the rooms on the first floor. There are two rooms especially intended for head nurses, with a bath room connection. In all, there are thirty-seven rooms on this floor.

The third floor is the same as the second, with one exception; two rooms are joined together in order to make an upstairs sitting room. This floor contains thirty-five rooms.

The fourth floor is the same as the second, and contains thirty-seven rooms.

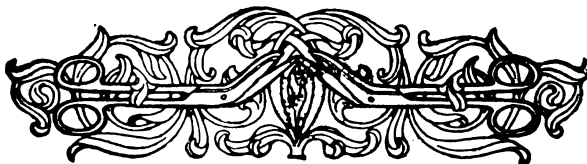
The cost of the building is expected to be about \$150,000, not including furnishings.



Plans for Improvement at Boston City Hospital

In view of criticisms that have been made that the general management of the Boston City Hospital was not quite up to the high standards of former years, and that the trustees had no general guiding plan by which to proceed in improving the hospital service, committees are now at work making a general study of the whole plant, with a view to improvements. Sub-committees have been assigned the following subjects:

1. Hospital administration.
2. Buildings.
3. Library and museum.
4. Departments of the hospital.
5. Advisability of organizing an obstetrical department, which does not now exist.
6. Question of having a department of physical therapeutics and orthopedics.
7. Private rooms and private wards.
8. House staff, housing, etc.
9. Social service and convalescent home, the two being required to work together.
10. Reform of hospital records. These are now bound in volumes in such a way that they are not readily available for desirable study.
11. Patients' diets, including the appointment of a trained dietitian to supervise the preparation of the special foods required in different diseases.
12. Ambulance service.
13. Training school for nurses; greater supply of nurses needed.
14. Additional relief stations.



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 South Carolina Experience

To the Editor of The Trained Nurse:

Perhaps some of your readers will be interested in my experiences while on a case in the country districts of South Carolina.

I was called to nurse a typhoid case some distance in the country. Leaving at 5 A.M., I traveled the first part of the way on a train, and was met at the station by a man with a buggy, driving a very poor and slow old horse. It was one of the coldest days I ever felt, but after joggling along for some time, my escort drew up in front of a two-room log-house. As it proved, this was to be my home for the next six weeks. On going in, I asked how many there were in the family and who was the patient. I found that the family consisted of the father, mother and seven children, the mother six months pregnant. The father and three children had typhoid fever.

In a short while the doctor came in, and frightened me almost to death by saying: "Our patients' only salvation will be good nursing, for the father is desperately ill." Of course he gave me very special orders for him, but these were the orders for the children: "Give them a dose of this turpentine mixture and take their temperatures whenever you can catch them." Their temperatures were from 102° to 103°, but they were playing around all day, ate fresh pork, sweet potatoes and whatever else they could find about the house. They never got a bath, except one day when I saw the mother giving them a partial bath. They certainly needed it. They all had colds in their heads, but never used a handkerchief. This partial bath was given in a tin pan, on the side porch, though the weather was freezing cold.

To my horror, I then found that I had been eating bread made in the same pan that the children were bathed in. Of course, I ate no more bread after that, but confined my diet to sweet potatoes, which they had in plenty, almost the only kind of potatoes used in this State. I knew that these were baked in their skins.

My hours off duty in the day, which were about two out of twenty-four, I slept in a little

room occupied by the children, and in the very same bed that those with the fever slept in at night. There was one little window in the room, and no sash or curtains. So I pressed my apron into service for various purposes, such as curtains, pillow-cases and sheets, since the linen on my bed (and the children's) was not changed during the six weeks that I was there. Part of the time I had no wood to burn, as there was no man at hand to cut it, and one night I came very near freezing. Unable to bear it any longer, I went out to the woodyard, raked up some chips and sap, and made a big fire in my patient's room. Such a shower of sparks flew up the chimney that the roof caught fire, and here was more trouble for me. I called to a boy who happened to be passing, and he came to help me. There was no ladder with which to climb on the roof, but I told the boy to put a fence-rail across from a tree that was near the house, and crawl upon that while I got up on a shelf on the side of the house and handed water in a tin bucket for him to pour on the blaze. It was so cold that the water froze as it ran off the house, and there were long icicles where it dripped from the eaves. My patient was very much alarmed by the commotion, and called to me that some drunken man was killing his wife and children. I told him that I supposed that his children were scrapping on the outside. This satisfied him for the time. Then the water began pouring into his room, by his bed, and he began to shake with a nervous chill. I applied hot-water bottles to his extremities, gave some whiskey, and begged him to be quiet, since it was only raining and the roof had sprung a leak. The poor fellow believed everything I told him. Finally we succeeded in putting out the fire. In my efforts as a member of the fire brigade I tore my skirt. I had no needles or thread with me, so I asked the wife to lend me one. But she had nothing of the sort. Can you imagine a household without needle or thread? After a siege of six weeks all the patients were well, and I returned home, only to go to bed with typhoid myself, where I remained for another six weeks. An amusing ending to this experience came when one of the little girls said to her father, as I was

leaving: "Papa, Miss B—— likes potatoes so much, let's give her a bagful to take home with her."

SOUTH CAROLINA.



Sleeping Out of Doors

To the Editor of The Trained Nurse:

In the February number of your magazine "Anna K. M." asks for "suggestions for those who wish to sleep out of doors in our New England climate during the winter." The trouble is in keeping the bed warm. If there is a heavy piece of paper next the spring or a heavy "puff" or, better still, a feather bed (feather beds have been doomed, I know, but they still have a place), then the mattress, the cold does not get through so easily. One gentleman I heard of had a steam coil fitted to his bedstead and turned the heat on at night, thus keeping the mattress warm. I helped to fit out a bed for a child ten years old. He had a canvas cot in a corner of the piazza, his bedding was taken in the house during the day, thus it was warm when the bed was made at night. He had a hot soapstone at the foot of the bed, slept in all-wool blankets, was rolled up in a long, quilted, old-fashioned cape, and with a woolen cap was, as he said, "as warm as toast," To break the sharp wind or snow from his face a bamboo piazza curtain was dropped at night. He slept out all the winter of 1912. I know another boy who has slept out every winter (all the year round) for a number of years; two sides of his balcony are the house, two screens with canvas curtains to drop when the weather is bad. He has the "sleeping bag and cap" and the bed is protected on top from dampness by a rubber sheet. To keep the cold from the bed underneath is as necessary as coverings enough on top. Perhaps these suggestions will be a help.

A. E. B.

To the Editor of The Trained Nurse:

The inquiry in *THE TRAINED NURSE* for February interested me greatly, as I have recently fitted up a sleeping porch for a patient of mine. She was advised last fall by her physician to sleep out of doors, and as there was no upstairs porch or balcony we had a small one built on the shed roof on the south side of the house. The property is rented and, as the owner would not assume any of the cost, we had the porch made detachable. Two carpenters built it in two and a half days and their labor and the lumber cost \$35. The floor is of matched boards and around the sides is

built an enclosure of boards two and a half feet high. In order to save expense the roof frame was covered with heavy canvas, then given two coats of paint, making it perfectly weatherproof. For the curtains we purchased 15-ounce canvas. It required ten yards for our 6 by 8 feet porch—two small curtains on each of the long sides and one on the front. We were given plenty of advice as to the hanging of these, but finally evolved a way of our own which is effective and simple. The canvas, starting from the bottom, is fastened by cleat to the under side of top of enclosure, then along the top of the curtain we fastened a stout stick, in this put a screw eye and attached heavy window cord run through small pulleys, which were screwed into the porch frame at the top. This makes it easy for the patient to pull the curtains up from the bottom as she lies in bed. A wire screening tacked on the outside keeps out snow and wind in the winter and flies and mosquitoes in the summer. Now cover the floor all over with carpet or rug.

To make the bed first place a heavy quilt or clean piece of carpet between the spring and the mattress. Then make up the bed warmly with blankets—no cotton sheets—then two or three pairs of woolen blankets, according to the weather, and outside a down puff, well tucked in. As the nights grow colder the patient should wear two union suits and a heavy "polar bear" suit of Shaker flannel, made after pattern No. 6652 published by the Standard Fashion Company. A half hour or so before the early bedtime I place hot-water bottles between the blankets to make it comfortable and warm for my patient.

Of all the benefits derived I need not write. The only way to be convinced is to try it yourself and, sick or well, you will never again enjoy sleeping indoors. My patient has now been following this regime for three months, and that, with careful diet and plenty of rest, has worked wonders. Much credit is due the faithful physician and friend whose kindly interest and help have been the means of starting her on the road to health.

FRESH AIR NURSE.



The Term "Nurse"

To the Editor of The Trained Nurse:

In sympathy with those who have, for some time, been discussing the vexed question of the graduate nurses' monopoly of the term "nurse," I want to give it as my fixed opinion that it is a "hopeless case." No amount or kind of serums, mental science, radium, scientific feeding or the old reliable rest cure could produce the least flush

indicating a return from the chronic condition into which "nurse" has fallen! How often do we read in the female want ads of the daily papers an advertisement like this: "Wanted—A white nurse for a child six months old. Apply mornings to Mrs. B. Anxious, 23 Bottle Avenue."

Let us sum up the many ways that we are always hearing the term, or word, "nurse" applied: The "undergraduate nurse," "practical nurse," "wet nurse" (horror!), the "correspondence nurse." "She is nursing." To whom are you referring? The professional trained nurse (the R.N.) or to the infant at the mother's breast? "Nurse, is it time for the baby to nurse?" "Has she sufficient nurse for her baby?" "No, her milk had to be dried up."

I know a nurse (I mean a graduate nurse, of course) who would not allow her patient to call her "nurse." Who can blame her? I certainly do not. I am sure that each one of us, down deep in our hearts, has often felt a resentment closely akin to that just mentioned, especially when we stopped a moment to reflect that two or three of the best years of our lives were given to earn this exclusive (?) and honorary title! In face of the hopelessness of ever inveigling the laity into indulging our idiosyncrasies to the extent of a "monopoly," let us look for a new title.

SAN ANTONIO.



Answers to Various Letters

To the Editor of The Trained Nurse:

Your magazine certainly is fine, so interesting and practical. Referring to the editorial, "Where We Differ," I believe the character of a nurse and the spirit she puts into the work of great importance, but certainly intelligence, cleanliness and tact are equally important. One can be intelligent without a college education. The better education one has the better nurse she can be in many ways, especially in private nursing. When we demand three or four dollars per day we should aim to give our best; it is none too good. A true nurse is willing to adapt herself to the ways of the average home. The middle-class people are those who suffer most for want of trained and skilful nursing, as they are mostly too proud to go to our city hospitals and too poor to pay three or four dollars a day. I suggest for the present every town of any size employ a visiting or district nurse. Then when a nurse is called to a case of this kind, say confinement, for instance, let her charge the standard price for one day in a normal case, then arrange for the visiting nurse to come once a day to care for mother and

babe for, say, fifty cents per hour, and usually the hired girl can do the rest. I have arranged in this way several times and been the visiting nurse myself where the city did not employ one. I have stayed five and six days at a surgical case, charged the three dollars for three or four days, then cared for the patient free a day or two, as necessary. Don't cut the price; but don't be above acting the "good Samaritan" part, as Christ would have us do when necessary. This is an important subject and I would like to hear the opinions of others. It is wrong to refuse a case because the patient is too poor to pay. A nurse should not be above cooking a meal, sweeping the house and caring for little children in the home, if necessary. I have done this more than once, and the appreciation and praise one receives is well worth the extra work.

To the question, should pupil nurses be allowed or prohibited from autoing at night with a young man, I say they should *not* be allowed to go at all, except with members of their own family. When I first entered the training school I inwardly rebelled at such restrictions, but before I had been in school two years I saw the *wisdom* of it, and believe it is the only way; in fact, I would not allow a pupil to keep gentlemen company at all. One cannot give her best to the school unless her whole mind is on her training. I am glad my superintendent made that rule in our school, because I know, since I have been married especially, that a beau takes the *best* part of a girl's thoughts, and to have the *best* nurses we must give our *best attention* to what our superintendent and instructors are trying to teach us.

In reply to the question about the probationer who was led astray at fifteen, I say by all means give the girl a chance, prove her yourself, do not be prejudiced by other women who would down her. Do you think for one minute those boys who coaxed her to go to the woods are being held down in life, handicapped for their childish curiosity? I say NO. Many a girl and boy have gone astray, not with a wrong intent, but from curiosity and ignorance, mainly the parents' fault. Parents bring their children up in ignorance of things they have a right to know; they want them to be so innocent, and all the time nature is calling forth their curiosity and they will find out for themselves those things if parents will keep them in ignorance. So I say if a girl is trying to lead a straight life, help her all you can and forget the past, and help her to make a noble woman of herself, as no doubt she will with wise and kind training.

E. MARY TATE.



CLASS OF 1914, ST. RAPHAEL'S HOSPITAL TRAINING SCHOOL FOR NURSES,
ST. CLOUD, MINN.

Book Reviews

Cancer: Its Cause and Treatment. By L. Duncan Bulkley, A.M., M.D., Senior Physician New York Skin and Cancer Hospital. Cloth, 224 pages. Price, \$1.50 net. Paul B. Hoeber, New York.

Cancer is a very live subject at the present day, as the disease is steadily increasing, has a mortality of fully 90 per cent. of those once affected, and causes so many deaths that there is an average of twelve daily in New York City alone. Dr. Bulkley's book, therefore, is most timely and should appeal to a large audience. It consists of a series of lectures given to physicians, but, though intended for the medical reader, will be welcomed by many outside the profession, and any nurse who desires to be well informed on this subject will do well to become acquainted with it.

Dr. Bulkley holds that cancer is a constitutional disease, depending largely on diet and mode of life—an aberrant action of originally normal body cells. It is his opinion that wherever there is an excess of nutritive material capable of being utilized for growth by the cells of a part, as may result from overindulgence along certain lines of eating and drinking, there malignant disease may develop; and this contention is borne out by the fact that while the ravages of tuberculosis decrease as conditions of living improve, deaths from cancer increase under exactly under the same circumstances. "The augmentation in the consumption of meat, coffee and alcoholic beverages," says the writer, "appears to be coincident with a very great and proportionately greater augmentation of the mortality from cancer. The nerve strain of modern life seems also to be an element of importance, both through disturbance of metabolism and by direct action on morbidly deranged cells." It is his view, therefore, that "the prevention of cancer, or the checking of its increasing occurrence, depends largely upon the early enough adoption of such measures as will limit the agencies which induce a derangement of the body juices which tend to bad metabolism and derangement of the body cells." Such measures he outlines, and he also describes the most up-to-date methods of treating the developed cancer, stating what success may be expected from their use. A wide knowledge of the facts

and suggestions presented in this book should certainly do much to decrease the number of those who fall victims to the most dreaded disease of modern times. ✚

The Tuberculosis Nurse—Her Functions and Qualifications. A handbook for practical workers in the tuberculosis campaign, by Ellen N. La Motte, R.N., graduate of Johns Hopkins Hospital, former Nurse-in-Chief of the Tuberculosis Division, Health Department of Baltimore. Introduction by Louis Hamman, M.D., Physician-in-Charge Phipps Tuberculosis Dispensary, Johns Hopkins Hospital. Two illustrations. Cloth. Net, \$1.50. G. P. Putnam's Sons, New York.

Miss La Motte's book, though dealing largely with local conditions in Baltimore, where for the last ten years she has so earnestly and enthusiastically labored for the cause with which her book deals, yet contains so much of general importance to tuberculosis workers that it would be well for all engaged in this and other social service activities to add it to their libraries.

Dr. Hamman's introduction is well worthy of careful reading, presenting in a concise and comprehensive manner the tuberculosis situation, from the view-point of a physician, as it exists and has existed of late years.

The substance of the book deals in an elaborated form with much that has already been written upon the subject of the tuberculosis nurse, which is naturally the tuberculosis situation generally.

Some of the important conclusions, which the author as well as other tuberculosis and economic experts have reached, are the lack of importance of the sanatoriums in comparison to the great need and usefulness of the tuberculosis hospitals for the care of the advanced patient; the change of opinion regarding the extensive use of the milk and egg diet in the treatment of the tuberculous; the ineffectiveness of fumigation and disinfection of premises which have been occupied by a consumptive and, what is of greatest importance, the futility of "home treatment" for the advanced and the need for sufficient and adequate means of segregating.

In the author's exhaustive treatment of the subject there are several points upon which she touches with which many of her readers will undoubtedly be at variance. The statement that a nurse beginning special tuberculosis work with an established visiting nursing association does not require previous training in social work is to be condemned. Such training would seem most essential. On the other hand, her argument for fully trained graduate nurses for this special work and not women trained in sanatoriums and small, special hospitals, is excellent. As to whether it comes within a nurse's province to tell the patient the nature of his disease, as the author states, would, it seems, be also a disputable point.

The report sheets, filing cards, charts, etc., which the book contains, should be of much interest to those organizing both municipal and private divisions of tuberculosis.

The tables of statistical figures relative to the degree of "carefulness" of a given number of patients in a given period makes an effective showing of the inadequacy of home treatment for the advanced patient and the emphatic need for segregation and hospital care, already referred to.

Careful reading shows practically no phase of the work has been omitted from the "statement of the case," in the first chapter, a clear defining of the tuberculosis situation that confronts physicians, nurses, social workers and organizers of tuberculosis movements, through detailed descriptions of the nurse, her characteristics, requirements, health, salary, her work, its organization, the development of the work from all standpoints; the relative position of nurse and physician; the preventive care of the patient, of the family; inspection of houses and disinfection; the tuberculosis dispensary and the nurse's relative position to it; hospital care; relief; home occupation and, finally, in the last chapter, the "Municipal Control of Tuberculosis," the author outlines very effectively the unfortunate results of the influence politics may have upon this work if the municipal administration is in turn under "political control."

The book is well written, though slightly ponderous in style, but it shows an intimate knowledge of the subject, only a "field worker," who has come in personal touch with the patients and

their homes and lives could comprehensively write about.

The book is well indexed and each chapter arranged in such a manner as to make it an easy and satisfactory reference book.

✱

Chemistry and Toxicology for Nurses. By Philip Asher, Ph.G., M.D., Dean and Professor of Chemistry at the New Orleans College of Pharmacy, New Orleans, La. 12mo. 190 pages. W. B. Saunders Co., Philadelphia, publishers. Cloth. \$1.25 net.

Dr. Asher's work supplies a real need in the nurse's reference library, in providing a book of moderate size which contains all the chemistry which a nurse has any occasion to use. He apologizes in the preface for the "elementary character" of the book, but it is exactly this feature which makes it so valuable. Nurses have no time for and do not need long treatises upon chemistry, but they do need the fundamental principles clearly and simply stated, and they require that the subject be connected up with their other studies.

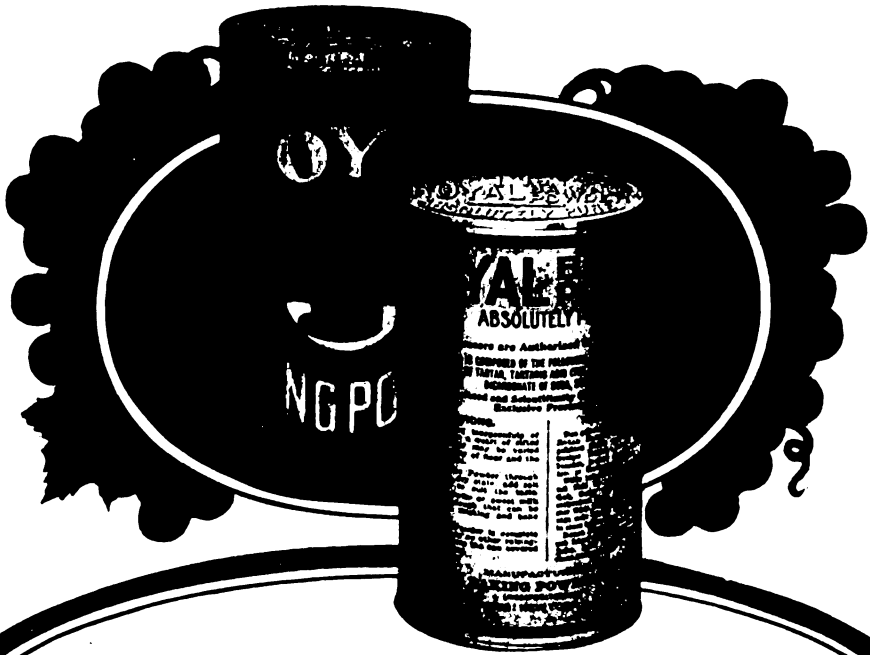
Dr. Asher has very wisely kept his work down to a manageable size, giving essential facts and endeavoring to avoid a confusing mass of detail. He has arranged the matter in logical order, and has made headings and paragraphs so clear that it is easy to find the subject for which one is searching. This point alone gives the work a decided value.

The toxicology is extremely well worked out, and its connection with chemistry made plain. It simplifies and elucidates a subject which is usually only a thing to be committed to memory without any definite understanding.

Throughout the whole book he has systematically and clearly shown the connection between chemistry and the other subjects in the nurse's curriculum: physiology, materia medica, urinalysis, dietetics, etc. This is perhaps the most valuable feature of the work.

The book is one which every training school should have in its reference library and encourage its nurses to use. It might even be possible to select portions which could be used as a text for teaching chemistry to nurses.





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—PRACTICAL DIETETICS, W. Gilman Thompson, M. D., Third Edition, Page 143.

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In the Nursing World

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The National Organizations

The date of the meetings of the three National organizations of nurses has been changed from May 30 to June 20. This will bring the meetings at the same time as those of the American Medical Association and of the American Hospital Association. Full particulars of transportation, etc., can be had from Mrs. C. V. Twiss, R.N., 419 West 144th Street, New York City.



In Mission Fields

The Yale Foreign Missionary Society (Yale-in-China) desires to get in communication with one or two highly trained women nurses, competent to share supervision of the Nursing School at Changsha (now numbering thirty Chinese pupils); also to assist in hospital and new medical school activities. It is likely that an emergency appointment may be made this spring. Candidates should be sympathetic with the earnest spirit of "Ya-li" and purpose a career in China, to begin with the study of the language. Address Yale-in-China, 5 White Hall, New Haven, Conn.



United States Navy Nurse Corps

APPOINTMENTS—Edna C. Ewing, R.N., New York City Hospital Training School, Blackwell's Island, N. Y.; Frances B. Liggett, R.N., Memorial Hospital, Richmond, Va.; Frances L. Long, R.N., John Norton Memorial Training School, Louisville, Ky.; operating nurse, Eve's Infirmary, Nashville, Tenn.; Julia T. Nicholls, R.N., Columbia and Children's Hospital, Washington, D. C.; assistant superintendent, Columbia Hospital, Washington, D. C.; superintendent University Hospital, Ann Arbor, Mich.; superintendent, Flower Hospital, New York City; Kinda Ruth Sheley, R.N., Middletown State Homeopathic Hospital, Middletown, N. Y.; post-graduate Bellevue and Allied Hospitals, New York City; Margaret Pierce, R.N., re-appointed, St. Louis Protestant Hospital, St. Louis, Mo.; Carrie H. Lappin, R.N., J. Lewis Crozer Hospital, Chester, Pa.; Frances L. Winkler, R.N., J. Lewis Crozer Hospital, Chester, Pa.; Ethel L. McVey, R.N., Columbus Hospital, Great Falls, Mont., and St. Patrick's Hospital, Missoula, Mont., assistant surgical nurse, Northern Pacific Hospital, Missoula, Mont.; Harriet K. Kavanagh, R.N., Buffalo State Hospital, Buffalo, N. Y.; post-graduate Bellevue and Allied Hospitals, New York City.

TRANSFERS—Mary Frances Lowery to New York City; Mary H. Bethel to New York City; Margaret A. Lytton to New York City; Margaret Pierce to Philadelphia, Pa.; Kinda Ruth Sheley to Philadelphia, Pa.; Frances Liggett to Norfolk, Va.; Edna C. Ewing to Washington, D. C.; Julia A. Nicholls to Mare Island, Cal.; Violet Gass to Samoa; Emily M. Smaling to Samoa; Carrie H. Lappin to Philadelphia, Pa.; Mary A. Long to Guam; Anne M. V. Huctor to Guam; Frances L. Winkler to Philadelphia, Pa.; Ethel McVey to Mare Island, Cal.; Harriet K. Kavanagh to Annapolis, Md.; Louisa Kurath to Norfolk, Va.; Frances L. Long to Norfolk, Va.; Mary M. Robinson to Philadelphia, Pa.; Anna I. Cole to Canacao, P. I.; Blanche Brown to Canacao, P. I.; Alice M. Gillette to Newport, R. I.

HONORABLE DISCHARGES—Mrs. Florence T. Milburn, chief nurse; Elizabeth Reed; Martha T. Bergman; Herma LaRoche Moyer; Mary A. Sheehan.

RESIGNATIONS—Maud Alverson, Nellie K. Campbell, Edith A. Murry, Eva Knowlton.

LENAH S. HIGBEE,
Superintendent Nurse Corps.



War Nurses

Miss A. Condit and Miss N. Steel, of Columbus, Ohio, and Miss E. Everard, of New York, who have been in the Red Cross service in Belgrade, Serbia, have returned to the United States.

Other nurses who have returned are Lillian Halliday, Louise Siegel, Hattie Moore and Sara McCarron, who have been in Casel, Germany, and Caroline Bell, Claudia O'Neill, Dorothea Mann and Alice B. Weston, who have been in Dreinitz, Germany.

Miss Clara Schofield, an Ohio trained nurse serving with the Red Cross contingent in Budapest, Austria-Hungary, will return to this country in June.

Miss Maria Maynard, of Biddeford, Me., and Miss Cora Decormier have gone to Canada, to prepare for Red Cross work in Europe.

Miss Margaret Lehmann and Miss Anna C. Lefving, both of Philadelphia, Pa., who were attending the wounded French at Pau, have been assigned to help fight typhus among the stricken Serbians.

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Rules for Special Nurses, General Protestant Hospital, Ottawa, Canada

Special nurses are expected to:

Report at the lady superintendent's office when called to a case and when off a case. If there should be no one in the office at the time, a slip may be left by the nurse, stating that she has arrived, and a slip will have been left on the desk advising her as to the whereabouts of her patient.

To observe silence and order while in the nurses' cloak room.

To make themselves familiar with the hospital rules by asking questions of the nurse in charge of the floor.

To carry out orders as they are written in the order book, but on no account to carry out verbal orders unless in case of immediate treatment in case of emergency and administered in the presence of the doctor, who will write the order as soon as conveniently possible.

To report to the nurse in charge of the floor should anything be required and not in supply, but on no account visit other floors for borrowing or other purpose.

To remember that eating in hospital kitchens is forbidden.

To report to the head nurse on and off duty promptly each day.

To be in complete uniform, cap and rubber heels.

To observe economy and careful use of linen and appliances.

To be subject to the day head nurse in charge of the floor and the night supervisor at night.

To remain in the room of their patient as much as possible, excepting when preparing treatments.

To keep in mind that the desk is for the exclusive use of the head nurse and doctors and nurse in charge of the floor at night.

To use the cupboards when charting.

To not use the phone in the main office without special permission of the medical superintendent.

To avoid loud talking and laughing while in the dining room and elsewhere.

To collect their own accounts, excepting when through the courtesy of the clerk they may be collected with the hospital account.

Hours for night nurse (if only one nurse is on the case) from 6.30 P.M. to 10 A.M. If two nurses are on the case the hours for outside nurses are from 8 to 8.

The wearing of rings, wedding rings or otherwise, while on duty is strictly forbidden.

Maine

The Maine bill for the State Registration of Nurses passed both houses of the Legislature and has been signed by the Governor.

The quarterly meeting of the Maine Nurses' Association was held at the Memorial parlors, Bangor, March 26, at 2.30 o'clock, the president, Miss Edith L. Soule, superintendent of the Children's Hospital at Portland, in the chair. Reports were given by the treasurer, Miss Bernice Mansfield, superintendent of nurses at the Eastern Maine General Hospital, and Miss Myrtle E. Taylor, of Lewiston, secretary. As chairman of the legislative committee, Mrs. Sarah Hayden, of Augusta, of the Augusta General Hospital, reported that the bill for State registration of nurses has been passed by both houses and signed by the Governor, with practically no opposition.

A class of twenty-one nurses was graduated from the Eastern Maine General Hospital at Bangor, March 15, with appropriate exercises. Trustee Donald F. Snow made the address to the class.



New Hampshire

The quarterly meeting of the Graduate Nurses' Association was held at the State Hospital, Concord, March 10. The meeting opened at 2.30 o'clock. Two applications for membership were accepted, and it was voted not to increase the registration fee from \$5 to \$10, as had been suggested. Miss Annie Lockerby, superintendent of the Laconia Hospital, and Miss O'Donahue, superintendent of the New Hampshire Memorial Hospital for Women and Children at Concord, were chosen as candidates, to be referred to the regent of the State Board of Medical Examiners to fill the vacancies on the nurses' executive board. Mrs. Eva Crosby, of Concord, was elected as delegate to attend the meetings of the American Nurses' Association, to be held in San Francisco, Cal., June 20-26.

Following the business the nurses had the privilege of listening to a helpful address given by Mrs. Ella Phillips Crandell, of New York, on the subject of "Public Health Nursing."



Massachusetts

The amendment to the Nurse Registration Bill which was reported in our April issue has been withdrawn and a substitute bill submitted.

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is especially adapted to effecting proper hepatic stimulation, and can be relied upon to correct "bilioousness" and similar affections. Best of all, its influence is physiological, and its benefits are accomplished solely through promoting and reinforcing natural functions.

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Connecticut

The Alumnae Association of the Connecticut Training School was held April 1 at usual time and place. There was a large attendance and all the officers were present. Routine business was transacted. A letter from Miss Bartram, of Waterbury, who has been doing Red Cross work in Russia, was heard with absorbing interest. Miss Hasson, a former superintendent of the Navy Nurse Corps, gave a most instructive talk on the work for nurses both in Army and Navy, and mentioned her delightful traveling while working for the Government, also paying a high compliment to Miss McCloud, also a C. T. S. After adjournment refreshments were served.

The Alumnae Association of Grace Hospital held its regular meeting on March 1 at the dormitory, with ten members present. An informal discussion followed the routine business.



New York

"Why should any one go insane?" was the keynote of the first State Conference and Exhibit on Mental Hygiene which was held in the auditorium of the Education Building at Albany on March 23, 24 and 25, under the auspices of the Mental Hygiene Committee of the State Charities Aid Association. Facts about the extent, causes, treatment and prevention of mental disorders were explained in popular addresses by physicians, alienists and educators of wide reputation. A public mass meeting was held each of the three evenings at eight o'clock. Every afternoon at 4.30 o'clock motion pictures and stereopticon views were shown. How the State of New York cares for more than 33,000 insane patients in fourteen State hospitals was pictured and explained. Watching the movies of the State hospitals was as interesting as a trip through the institutions. How the insane people live, how such large numbers are fed, what work they do and what their amusements are were shown in pictures. The methods of care and cure were described. The whole subject was treated in a popular manner, but with the scientific and medical facts given by men of unquestioned authority. Not a conglomeration of cut-and-dried statistics about the insane, but a live, graphic and interesting presentation of the striking and important facts about a tremendously important question—mental health.

The graduating exercises of the Bulkley Training School for Nurses in connection with the New York Skin and Cancer Hospital, New York City,

were held at the hospital on Friday evening, March 26, at 8.15 o'clock.

A public hearing was given the Jones-Tallett Nurse Bill, in the Senate Chamber, Albany, March 25. Those representing the opposition were practically the same as last year, and those supporting the bill likewise. While the impression was given that the Health Department was backing the bill, it has since been stated that such is not the case, and that the department is not giving its unqualified support to it. The bill failed to pass the Assembly.

The 109th annual meeting of the Medical Society of the State of New York will be held in Buffalo, April 26-29. In connection with the meeting there will be a conference of school medical inspectors, nurses and clinicians, held under the direction of the State Medical Inspector of Schools. The conference will be held at the Fifty-sixth Infantry Armory. There will also be a course of public lectures on the following subjects: Public Health, Children's Bureaus, Infant Mortality, The Subnormal Child, Welfare Work in Industry, Prevention of Blindness, Conservation of Vision. The lectures will be held at the Sixty-fifth Regiment Armory.

The exercises in connection with the laying of the cornerstone of the Nurses' Home of the Methodist-Episcopal Hospital, Brooklyn, N. Y., took place Saturday afternoon, April 17, at two-thirty o'clock. The Rev. J. M. Buckley, D.D., LL.D., presided. Brief addresses were delivered by the Rev. Luther B. Wilson, D.D., LL.D., Resident Bishop of New York; Rev. William Burt, D.D., LL.D., Resident Bishop of Buffalo; Hon. Lewis S. Pounds; Rev. A. S. Kavanagh, D.D.; A. Ross Matheson, M.D.; Glentworth R. Butler, M.D., LL.D., and the Rev. J. M. Farrar, D.D., LL.D.

On Thursday evening, April 8, the largest class in the history of the Training School for Nurses of the Jewish Hospital was graduated. Twenty-two young women received their diplomas.

John A. Kingsbury, Commissioner of Charities, delivered the main address. Others who spoke were Edward C. Blum, president of the Jewish Hospital of Brooklyn; Isidore Isaacsen, president of the training school for nurses, and the Rev. Dr. John F. Carson, who gave the benediction.

Joseph J. Baker, of the training school for nurses board of directors, presented the prizes

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are so closely allied that one cannot progress without the aid of the other. It would seem, therefore, the height of folly to burden a convalescent's stomach with foods which require more than minimum energy to render them assimilable.

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awarded by the board to the graduating nurses, and Dr. John O. Polak presented the special prizes, of which there were twelve in number.

The Nurses' Association of Buffalo met April 5 at its home in Hodge Avenue. Miss Kate Kennedy, Mrs. Boehm and Mrs. Gertrude Boyd were appointed a nominating committee. Miss Sylvia Nye was made an honorary member of the Association.



New Jersey

The thirteenth annual meeting of the New Jersey State Nurses' Association was held at the Public Library, Elizabeth, April 6. The sessions were at 10 A.M. and 2 P.M. Dr. Victor Mravlag, mayor of Elizabeth, made the address of welcome, to which Mary J. Stone, superintendent of the Hackensack Hospital, responded. The reports of officers and standing committees showed that the Association has been doing good work during the year past and plans were discussed for even greater success in the future.

The election of officers resulted as follows: President, Arabella R. Creech, of Elizabeth; first vice-president, Elizabeth Higbid, Passaic General Hospital; second vice-president, Mrs. d'Arcy Stephen, Orange Memorial Hospital; secretary, Miss Ingeborg Prætorius, Overlook Hospital, Summit; treasurer, Mrs. H. W. Churchill, Elizabeth General Hospital; trustee, Miss Agnes T. Considine, Passaic General Hospital.



Pennsylvania

The regular quarterly business meeting of St. Vincent's Hospital Nurses' Alumnae, Erie, was held at the hospital March 11. Twelve faithful members responded to roll call. After the regular routine business was transacted, arrangements were made for an educational meeting, to be held in April.



Arkansas

The annual meeting of the St. Vincent's Hospital Nurses' Alumnae Association, of Little Rock, Ark., was held on February 4, 1915. The meeting was called to order at three o'clock, with the president, Miss Frankie Hutchinson, in the chair. After the routine business the following officers were elected. President, Miss Carrie Craig; vice-president, Miss Celest Campbell; recording secretary, Mrs. C. A. Roth; corresponding secretary, Miss G. T. Groben.

Wisconsin

Examinations are announced by the board of examiners for registered nurses for State registration of nurses. They will be held at La Crosse, May 27 and 28, in the city hall; and at Milwaukee, June 1 and 2 in the city library. Applications must be made before May 26. Miss Anna J. Haswell, of the State Board of Health, is in charge of arrangements.



Iowa

The regular monthly meeting of the Alumnae Association of the German Lutheran Hospital Training School for Nurses, Sioux City, was held in the parlors of the Hospital, February 2, two officers being present and a large attendance. After routine business a discussion on "Standardizing the Nursing Profession" took place.

Red Cross work was also discussed in its different phases. The following are officers of the Association: Miss Gabriel, president; Mrs. Brinhan, vice-president; Miss Leverenz, second vice-president; Miss Borge, treasurer; Miss Sweeley, secretary.



North Dakota

The bill for the State registration of nurses passed both houses of the Legislature and was signed by the Governor March 9. It takes effect July 1.



California

The San Francisco County Nurses' Association has adopted the following new schedule of fees, which, it is stated, are "not obligatory."

1. For ordinary cases: Women patients, \$25 per week, \$4 per day for a fraction of a week. Men patients, \$30 per week, \$5 per day for a fraction of a week.
2. One-day, two-day or three-day cases, \$5 per day.
3. Contagious and nervous cases, \$30 per week, \$5 per day.
4. Insane, alcoholic and quarantine cases, \$5 per day.
5. Assisting at operations, \$5 to \$10.
6. Obstetrical cases, \$30 per week, payable from date of engagement.
7. When one nurse has two patients, \$5 per week extra.
8. Visiting nurses, \$1.50 for one hour or less, \$2 an hour after 6 P.M.
9. Agreement for charges in special cases should

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be made before the nurse takes charge of the case. Board included in all cases except visiting nursing.

10. Male nurses: Ordinary cases, \$5 per day for twelve hours' duty, \$6 for twenty-four hours' duty.



Marriages

On March 6, 1915, at Philadelphia, Pa., Minnie I. Raub, graduate nurse of St. Luke's Hospital South Bethlehem, Pa., and of Manhattan Maternity, New York City, Class of 1913, to Albert J. Kaye, both of Easton, Pa. Mr. and Mrs. Kaye will reside at Easton.

On February 23, 1915, at her home in Grand Rapids, Mich., Clara B. Ruoff, graduate nurse of the Hackley Hospital Training School, Muskegon, Mich., Class of 1914, to Dr. Jacob T. Cramer, of Muskegon.

On March 16, 1915, at the Presbyterian Church, Sharon, Pa., Gertrude Ward, graduate nurse of the Buhl Hospital, Sharon, to N. W. Ayers, of Erie, Pa.

On February 20, Katherine Lang, graduate nurse of the Presbyterian Hospital, Philadelphia, Class of 1908, to Robert W. Pierce. Mr. and Mrs. Pierce will make their home at Franklinville, N. J.

On March 31, 1915, at Seymour, Conn., Ada L. Daniels, of New York, to J. Williard Austin, of Spencer, Mass. Mr. and Mrs. Austin will reside in Worcester, Mass.

On January 23, 1915, at Annapolis, Md., Eva St. Clair Knowlton, of Perryburg, N. Y., graduate nurse of the Buffalo Homeopathic Hospital, Class of 1914, and late of the Navy Nurse Corps, to Harry W. Kohn, of Silver Creek, N. Y. Mr. and Mrs. Kohn have built a new home in Silver Creek.



Personal

Mr. and Mrs. Pennycook have opened their new home at Pennsboro, W. Va. Mrs. Pennycook was Ellein Cahill, graduate nurse of Dixmont (Pa.) Hospital, Class of 1913.

The friends of Ethel Grove, R.N., graduate of Dixmont (Pa.) Hospital, Class of 1910, who underwent an operation recently at the Rochester General Hospital, will be glad to know that she is on the road to recovery.

Miss Anna Lee, Minneapolis, Minn., a graduate of the Southwestern Hospital, Minneapolis, Minn., also a graduate of the Pennsylvania Orthopedic Institute, Philadelphia, Pa., has been engaged to take charge of the bath department of the Hotel Homestead, Hot Springs, Va.

Miss De. Anna Sloan, Titusville, Pa., a graduate of the Lee Private Hospital, Rochester, N. Y., and also a graduate of the Pennsylvania Orthopedic Institute, Philadelphia, Pa., has been engaged by the mechanical department of the Scarlet Oaks Sanitarium, Cincinnati, Ohio.



Deaths

On April 3, 1915, at her home in Brockville, Ontario, Canada, Ethel Marie Bacon. Death followed a long illness borne with quiet Christian fortitude, which was always a source of inspiration and help to the sorrowing relatives and friends. Miss Bacon was born and brought up in Brockville, and her kindly Christian character won her many friends, who will ever treasure in pleasant memory the beautiful character which blossomed in girlhood and developed in young womanhood in a nature singularly illumined with unselfishness and a desire to be helpful and kindly in all her relations with others. She was an earnest Christian, a consistent member of St. Peter's Anglican Church and Sabbath school.

Adopting as her life work the profession of caring for the sick, she entered Hahnemann Hospital at Rochester, N. Y., as probationer, and graduated as a trained nurse from that institution, afterwards continuing her profession in that city until illness compelled her to return home for treatment.

Suddenly on Sunday, April 11, 1915, at Washington, D. C., Alberta G. Helm, graduate nurse of the Kingston Hospital. At the time of her death Miss Helm was a member of the nursing staff of the Gallinger Hospital for Tuberculosis at Washington. Before coming to that institution, about a year ago, she had seen service at the Jefferson Hospital, Roanoke, Va., and the Frye Sanitarium, Baltimore, Md.

Miss Helm met her death while out walking, being struck by an automobile, which killed her instantly. Her death came as a great shock to her fellow workers at the hospital, where she was very popular, both with the staff and the patients.

Continued in Advertising Section

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It is a commercial and sociological axiom that no one ever gets—

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The Nemo Self-Reducing Corset No. 403, selling at \$4, has a special feature known as "Nemo Relief Bands." Omit this feature, and No. 403 would still be a great value at \$4. The service rendered by the Relief Bands, in the way of improving the figure and giving ease

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Probably this fact has never occurred to you. Now that we have mentioned it, do you not think all "wise women" should seek a good store where Nemo Corsets are intelligently handled, and solve their corset-problems by the Nemo method?

Don't think of Nemos as "just corsets." They are in a class alone, secure from competition.

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New Remedies and Appliances

Electric Devices for Nurses

In her admirable article in the April number, entitled "Practical Points in Maternity Nursing," Amy Armour Smith says: "The clever nurse carries a pocket-light at night." Probably no single item of a trained nurse's equipment will give her more solid comfort and satisfaction than a flashlight.

With it she has a brilliant stream of light at her command, and a light that can be directed on the instant just where it is wanted and nowhere else. She no longer needs to grope in the darkness, feel her way down unfamiliar halls and stairs, and



FIG. 1



FIG. 2

avoid unseen furniture by instinct; nor does she need to disturb the patient and family by striking matches, lighting gas lights, or flaring up incandescents. She discovers that it is a positive luxury for finding things in corners, closets, trunks, bureau drawers and under beds.

Furthermore, the light is absolutely safe. There is always danger with matches, candles and oil lamps, but the flashlight can't start a fire even in the most inflammable materials.

Flashlights are made in a large variety of styles and sizes, those of reliable makes varying in price from 75 cents to \$3.50. Several styles that are especially suitable for nurses' use are illustrated here.

Figure 1 shows a "Vest Pocket" light, a very convenient and popular type. It is only three inches high and weighs but an ounce or two, so that it is easily carried in the bag or pocket and placed under the pillow at night. It gives a brilliant light and the battery, though small, will

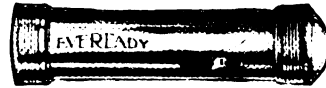


FIG. 3

last several weeks in ordinary service. The light can be either flashed or burned continuously, so that the flashlight can be laid down, leaving both hands free to work. The price of this light is 75 cents.

Figure 2 is a tubular light with a larger battery than the light shown in Figure 1. Hence it gives a stronger light and lasts longer. This type is made in several sizes, namely, 5, 6½ and 8½ inches long, costing respectively \$1.25, \$1.50 and \$1.75. The smallest size is the most suitable for the average nurse's use.

Figure 3 is an electric lantern, which, although light and compact, gives an extremely powerful, penetrating light. It will be found very useful for all purposes and especially where a large volume of light is needed. Two sizes are made—small size \$2, large size \$3.50.



Protection for Hospital Patients

Along with the remarkable advances in medicine in recent years has grown the correlated science of sanitation. Today sanitary engineers and experts are in ever-increasing demand. As late as ten years ago the sanitary engineer was a specialist in a profession which few followed. But now popular opinion recognizes that an ounce of prevention is indeed worth a pound of cure.

In the hospitals, no effort should be spared to make cleanliness paramount. Special care should be taken to keep the floors absolutely clean. Dirty floors are known breeders of disease germs. For this reason many of the better hospitals use Standard Floor Dressing on their wooden floors. This dressing not only cleans the floor but it lays the dust. Standard Floor Dressing is easy to apply and costs little. Besides its cleansing qualities, it preserves the wood and keeps it from drying out. In many hospitals Standard Floor Dressing is considered an absolute necessity for insuring cleanliness and safety from the spreading of disease germs.

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To any Nurse sending us this advertisement with
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Quaker Oats as Related to Good Health

That the doctors of the land shall look a little beneath the surface of Quaker Oats advertising as it has ordinarily appeared, is the purpose of the manufacturers, who have recently increased their use of medical journals in order to tell the physicians the facts about Puffed Grains and Quaker Oats that the general public don't always appreciate.

The company's advertising is emphasizing the importance of its products as health foods. Quaker Oats are shown to possess, in addition to the ordinary nutritive value of oats, a special excellence due to care in picking out only big, plump grains. The rolling process then partly prepares the oats for easy digestion.

The puffed grains—Puffed Rice, Puffed Wheat and Corn Puffs—have three qualities which will recommend them to physicians in prescribing diets for delicate stomachs. They are made of whole grains with none of the vitamins removed; they are cooked and toasted through and through by the peculiar exploding process and rendered easily digestible at the same time, and, finally, they have a taste that will tempt even the most reluctant appetite.



Free Recipe Book and Sample

The Charles B. Knox Company, of Johnstown, N. Y., are offering to nurses a free full-size (two-quart) package of Knox Gelatine and a recipe book of desserts, jellies, puddings, salads, etc. Do not fail to avail yourself of this offer. When your patient is capricious and you are almost at your wits' end for something to tempt her appetite, this little book may prove a veritable nerve saver and "a friend in need." Gelatine has a double advantage, as it is not only nutritious, but there are so many ways in which it can be made "a thing of beauty" and consequently a joy to the patient.



What Every Nurse Should Know

Dame Fashion influences the uniform of today as well as the highest priced gown.

To be correctly uniformed, the uniforms must be correct in design, perfect fit, strictly tailored and standard quality material.

S.E.B.-Make Uniforms possess all these requirements, and their additional merits are that the uniforms wash and wear well and retain their shape until worn out.

Our long experience results not only in the best

methods of manufacturing, but enables us to give you these unexcelled values. You get a uniform of quality, regardless of low price.

If you have not yet made a wearing acquaintance, it is to your advantage to ask your dealer for the S.E.B.-Make Uniform. If he cannot supply you, write to us direct.

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No Shortage at Abbott's

Emetine hydrochloride, from being an almost unknown and little-used drug, has become one of the most popular. Recent discoveries as to its unquestionable therapeutic values in amebic dysentery, hemoptysis and other hemorrhages, as well as in pyorrhea, have caused an enormous demand for this remarkable remedy, so that it is not to be wondered at that manufacturers are reporting a shortage.

The Abbott Alkaloidal Company is prepared to fill all orders for this alkaloid, which they supply in hypodermic tablets, in ampule form for hypodermic use, in tablets for oral administration, and in a standard antiseptic solution (Boremetine) for use by dentists and physicians in the local treatment of pyorrhea and other affections as above.

If you want emetine, if you want it in a hurry, if you want it right and when you need it ask for Abbott's, of the trade, or order direct. Complete literature sent free on request to the Abbott Alkaloidal Company, Chicago.



Sanatogen

Where the question of diet is left in the hands of the capable nurse, as is the growing custom, she will find Sanatogen unequaled in convalescence, gestation, lactation, preparation for operation and subsequently and frequently in the acute fevers, while in chronic cases, anemia, tuberculosis, gout, rheumatism, it will prove an admirable method of introducing the invaluable protein into the system without any of the drawbacks which formerly attended such feeding. Sanatogen is a combination of pure, specially prepared albumen, 95 per cent., with 5 per cent. of sodium glycerophosphate, obviously a preparation that will promptly repair waste and furnish the nervous system with the assimilable fuel without which vital action is impossible. Nurses who have not familiarized themselves with the manifold uses of Sanatogen in depressed conditions are urged to send for valuable free literature and sample on the subject.



A NURSE "gets on her patient's nerves" more often in the making of the toilet than in any other way, and nearly always it is the care of the hair that causes the irritation. Experienced nurses have found the "Ideal" way of caring for the woman patient's hair in

**Hughes
Ideal**

The Brush That Combs Your Hair

Made of strong, resilient East India boar bristles, Hughes Ideal not only passes quickly and smoothly through the worst snarls and tangles, but because of the springy action of its clever rubber cushion construction it reaches the scalp and gives to it a beneficial, nerve-soothing massage.

Keep your patient's hair smooth and satiny, and make the arranging of her hair refreshing instead of an irritant, by using Hughes Ideal.

Costs no more than the ordinary hair brush and gives twice the service.

None genuine without the name "Ideal" on handle. Be SURE you see the name "Ideal" before you buy.

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If you have a stubborn case of infant scalding, chafing, or a bed-sore case that is troubling you, let us send you free a box of

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We want you to try this wonderful skin-healing powder at our expense, as we can prove to you, with one trial, that Sykes Comfort Powder is truly what it is called, "the nurse's best friend."

There are thousands of nurses that never go without a box of Comfort Powder because it saves suffering of infants, children and bedridden people, and brings comfort and peace to the nurse.

Your name and address sent us on a postal card mentioning THE TRAINED NURSE will bring to you the free trial box by return mail.



THE COMFORT POWDER CO., Boston, Mass.

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ERGOAPIOL (Smith) is a singularly potent utero-ovarian anodyne, sedative and tonic.

It exerts a direct influence on the generative system and proves unusually efficacious in the various anomalies of menstruation arising from constitutional disturbances, atonicity of the reproductive organs, inflammatory conditions of the uterus or its appendages, mental emotions or exposure to inclement weather.

As an analgesic in gynecological cases, Ergoapiol (Smith) is superior to opium or coal-tar derivatives in that, besides relieving pain without exposing the patient to the danger of drug addiction, it also offers a tonic and restorative action upon the pelvic viscera.

It is a uterine and ovarian sedative of unsurpassed value and is especially serviceable in the treatment of congestive and inflammatory conditions of these organs.

The anodyne action of the preparation on the reproductive organs is evidenced by the promptness with which it relieves pain attending the catamenial flow, and its antispasmodic influence is manifested by the uniformity with which it allays nervous excitement due to ovarian irritability or other local causes.

Ergoapiol (Smith) proves notably efficacious in amenorrhea, dysmenorrhea and menorrhagia.



ERGOAPIOL (Smith)

For
**AMENORRHEA
 DYSMENORRHEA
 MENORRHAGIA
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 ETC.**

ERGOAPIOL (Smith) is supplied only in packages containing twenty capsules.

DOSE: One to two capsules three or four times a day. < < <

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Food for Typhoid Patients

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FOR INVALIDS and those recovering from influenza, typhoid fever and other illness. Made into gruel or barley water is a food constantly recommended by Physicians.

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"Patent" Groats made into milk-gruel or porridge, can be taken three or four times a day, is very nourishing and easily digested.

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When you write Advertisers, please mention THE TRAINED NURSE

Nursing World—Continued

OKLAHOMA

STATE BOARD EXAMINATION QUESTIONS

Surgical Nursing—1. (a) Give preparation of patient twenty-four hours before any major operation. (b) Give some of the necessary precautions to be taken just before patient goes on the operating table. 2. (a) Give method of preparing room in private home twelve to twenty-four hours before major operation. (b) Give method of preparing same in an emergency. 3. Give symptoms of hemorrhage. 4. Name three varieties of hemorrhage and how to distinguish each. 5. How would you cleanse your hands before doing a surgical dressing? 6. What symptoms following an abdominal operation would indicate peritonitis? 7. (a) Give reasons for examining the patient's urine before operation. (b) Give reasons for examining the urine after operation. 8. Why is Fowler's position (or upright) sometimes ordered? 9. What is hypodermoclysis and what precautions would you employ in administering the same? 10. What do you understand by sterilization and how would you prepare sterile dressings in a private home?

Bacteriology and Hygiene—1. How may infection reach a wound? 2. How are disease germs thrown off in the following diseases: (a) Diphtheria; (b) typhoid fever; (c) tetanus; (d) tuberculosis; (e) yellow fever? 3. What are the most effective means of destroying germs? 4. What is the difference between contagion and infection? 5. How would you isolate and disinfect in contagious diseases, under the following heads: (a) the physician; (b) the patient; (c) the nurse; (d) excreta; (e) dishes used by patient. 6. Why is deep breathing important? 7. Why is bathing so important to health? 8. Outline hygienic care of tuberculosis. 9. At what temperature would you keep a sick-room? 10. What are the beneficial effects of sunlight?

Gynecology—1. Describe the preparation of patient for an abdominal section. 2. Name organs contained in a female pelvic cavity. 3. Define: (a) salpingitis; (b) curetage; (c) ovariectomy; (d) hysterectomy. 4. Of what use are douches? Name several solutions used in giving douches. 5. What is ectopic gestation? Why is it so dangerous? 6. What is meant by a digital examination and how would you prepare for it? 7. What is meant by puberty and menopause? 8. When nursing gonorrheal patients, what personal care should a nurse take? 9. Name positions used in operating on gynecological patients. 10. Name solutions used when irrigating the bladder. 11. Define: amenorrhea, dysmenorrhea.

Obstetrics—1. Define: (a) meconium; (b) colostrum; (c) Wharton's jelly; (d) amniotic fluid; (e) vernix caseosa. 2. Describe: (a) placenta—its use. (b) How should the uterus appear and feel after delivery? 3. Define: puerperal sepsis; give causes and symptoms of sepsis. 4. Describe care of patient before and after labor. 5. Give the cause and care of eclampsia. 6. What would you do should your patient have a post-partum hem-

orrhage and you were alone with her? 7. Give treatment of infant's eyes, swollen breasts, care of cord. 8. What care would you give premature infants? What care is given an infant the first week of its life? 9. How often would you put an infant to the breast during the first week? 10. How long should it nurse? 11. What is the difference between the terms abortion, miscarriage, premature labor?

Ethics—1. What do you understand by nursing ethics? 2. What obligation do you consider you owe to the school which made it possible for you to become a graduate or registered nurse? 3. If the family become dissatisfied with the attending physician on a case and another being employed, what would you consider to be your duty in the case? 4. What do you understand by loyalty to your physician? 5. Name one rule which, if followed in every instance, would simplify nursing ethics.

Dietetics—1. Name the different classes into which foods may be divided. 2. Classify: (a) sugar; (b) butter; (c) milk; (d) eggs. 3. What would you include in a (a) liquid diet; (b) soft diet? 4. What are the chief ingredients in fruits? 5. Give list of tissue-building foods. 6. What disease is usually given a carbohydrate free diet? 7. How would you make beef tea? 8. What would you include in a diet for a patient suffering from Bright's disease? 9. Give one method of predigesting milk. 10. How ought beef, chicken and fish to appear when in a healthy condition?

Medical Nursing and Urinalysis—1. Define: (a) edema; (b) coma; (c) emesis; (d) epistaxis; (e) rigor. 2. What are objective symptoms? Subjective? 3. Give three examples, stating when each is used: (a) enemata; (b) baths. 4. How would you make a fracture bed? 5. What are frequent complications of: (a) typhoid fever; (b) pneumonia; (c) tuberculosis; (d) give nursing care in detail in case of erysipelas. 6. What particulars should be noticed in examination of urine? 7. Give test for (a) albumen; (b) sugar. 8. What is the average capacity of the adult bladder? 9. Define: nephritis, polyuria, dysuria, anuria, hematuria. 10. What is a urinometer?

Contagious and Children's Diseases—1. What are the most common complications of scarlet fever and diphtheria? 2. Name the most common contagious diseases. 3. When releasing a scarlet fever patient from quarantine, how would you proceed with the (a) patient; (b) yourself; (c) room. 4. How are the following diseases transmitted: diphtheria, measles, whooping-cough, chicken-pox? 5. What is the period of incubation in: (a) mumps; (b) measles; (c) chicken-pox; (d) scarlet-fever; (e) diphtheria? 6. State in detail how you would give a baby a bath. 7. What are the general causes of adenoids, symptoms? 8. What do you understand by pediatrics? 9. How would you care for a baby with diarrhea, pneumonia? 10. How would you give a child from two to five years of age an enema?

The Trained Nurse and Hospital Review

VOL. LIV

NEW YORK, JUNE, 1915

No. 6

Dispensaries for the Smaller Hospitals: Why We Need Them

MICHAEL M. DAVIS, JR., PH.D.
Director of the Boston Dispensary

THE growth of dispensaries has been one of the outstanding features in the recent development of medical institutions in this country. In 1800 there were three dispensaries in the United States. In 1900 there were about 100; at the present time there are at least 800. A certain number of these are dispensaries separate from hospitals, but a large proportion of the dispensaries treating general diseases are out-patient departments of hospitals.

Of the four hundred and more general dispensaries and out-patient departments, *i.e.*, dispensaries treating general diseases as distinguished from those limiting themselves to specialties, the majority are in the larger cities, but it is very interesting that in recent years many have been started in smaller communities, so that in 1910 as many as 25 per cent. were in cities of less than one hundred thousand population, and 10 per cent. were in towns of ten thousand and under. These proportions are undoubtedly larger today than they were in 1910.

What are the reasons for this phenomenal growth? Why have dispensaries or out-patient departments been established? One might say that there are four benefits from an out-patient department.

1. To the poor of the district.

2. To the public health of the community as a whole.

3. To the medical profession through increased clinical opportunities.

4. To the hospital itself, as will be shown.

Why is a dispensary worth while to a community of moderate size and to the hospital in that community? *Is it worth while?* Doctors in some cities would smile ironically at the suggestion that a dispensary should be established in their town for the *benefit* of the medical profession therein! "It is hard enough now to build up a practice," they would say. "Why should we have a dispensary which would take away cases that ought to pay a physician's fee?" It may be taken for granted that a hospital has not the right to establish an out-patient department as part of the work of a charitable institution, run this out-patient department as a charity, and then allow patients to come to it who can properly afford to pay for the medical or surgical treatment which they need. In other words, it may be taken for granted that the dispensary which announces itself as a charity should be maintained as a charity and be maintained properly. It should learn enough about its patients before it admits them to know that they really need medical treat-

ment and that they cannot pay for adequate treatment on a private basis. To find out this information about patients requires the employment of a trained person, with a soft heart, but a cool, rather hard head.

The two practical questions which a hospital superintendent wants to know are, first, is a dispensary really needed by the people of my town? Second, if we establish a dispensary in connection with our hospital, will it be of practical service to our hospital work? The first question must be answered by the superintendent's general knowledge of the needs of his community. Sometimes he may find workers in local charitable organizations who have a great deal of information about conditions and whose opinion will be of value. The real question to consider is whether there are many people who are not able to pay for medical treatment; not merely for *any* medical treatment, or for a little medical treatment, but for good medical treatment and enough of it to get results! There are families that can afford to pay for a doctor occasionally for minor illnesses, who would be completely upset by a serious illness to the chief wage earner. Under such circumstances they would be unable to meet even ordinary obligations and for a long period would be compelled to get medical service for nominal prices or free, or else do without it entirely. It must be remembered, also, that medical service to the poor must not be estimated on the basis of acute and serious illness merely. Any physician will follow the splendid traditions of the medical profession and answer a call to the bed of one who is critically ill, whether or not remuneration is possible. But when sickness has not progressed so far that it is a matter of life or death, or when an illness is not one that threatens life immediately, but only diminishes comfort and working efficiency, so that the economic future of the parents and their little children is at stake—these are the cases in which a self-respecting

but poor family do not readily seek medical aid from a private physician, because they have the natural embarrassment of going to a medical man whom they do not know and asking him for a personal favor. For such cases a properly conducted dispensary can perform a great service, preventing suffering, keeping wage earners at work, and often obviating an onset of serious disease due to diminished resistive power.

A woman entered a dispensary complaining of certain troublesome pelvic symptoms which, though not by any means serious, had been increasing sufficiently to disturb her usual routine. She might have dosed herself with patent medicines and waited some months before she was really "sick." It was fortunate she did not wait, for gynecological examination indicated, what operation proved to be cancer. On referring the patient to the hospital, a little bit of malignant tissue, no bigger than one's little finger, was excised. A hospital without a dispensary would have received that woman, if at all, when it was too late to save her life, at least without a dangerous and certainly mutilating operation.

Then, again, to the dispensary come the so-called minor diseases, which modern medicine realizes more and more to be important: For example, many skin diseases, very troublesome, and in some instances infectious; the common cold and its sequels; nervous disturbances; digestive disorders; septic processes of hands and feet, together with minor surgical injuries among working people; and a large proportion of the diseases and defects of special organs, particularly the throat, nose, ears, eyes and teeth. Those who are not well-to-do generally neglect such troubles, or treat them inadequately by home medicines.

While it is indeed true that a hospital is for the service of the community, it must also consider its own immediate interests. What, asks the superintendent, will an outpatient department do for the hospital



It Feeds the Wards

It Follows-up discharged Patients

(Preventing recurrence of disease and promoting Hospital Efficiency)

It Forestalls Serious Disease by treating it in early stages

(Promoting Economy of Hospital Service)

itself? The little diagram above, reproduced from a chart exhibited by the Boston Dispensary at the last conference of the American Hospital Association, answers this question graphically.

A hospital treats serious disease; an out-patient department "only ambulatory cases." But many "serious" diseases are ambulatory—cardiac disease in many of its forms, cancer, syphilis, gonorrhea, tuberculosis. Many other diseases that are responsible for great suffering and high mortality do not confine the patient to bed through a large part of their course. An out-patient department feeds a hospital ward with cases of persons suffering from these disorders, for though such patients often would not seek admission to a hospital bed (not appreciating what is the matter with them) they do come to a dispensary where a diagnosis is made and the necessary hospital care then supplied. The out-patient department receives many cases of serious disease among little children brought in in their mothers' arms—children who need hospital care.

Thus the dispensary feeds the hospital with cases requiring hospital care, drawing to the institution patients who otherwise would not come, and who would suffer without the care which only the hospital can provide. In this sense the out-patient department is a feeler which the hospital extends into the community, enlarging its power of public service.

Take another illustration: Many cities and towns have established medical inspection of school children, so that all children attending public schools are examined from time to time by a physician employed by the public authorities. A host of defects as well as functional diseases are thus revealed—questionable eyesight, bad teeth, defective hearing, enlarged tonsils, malformations, or deformities. It is very little use for the school physician to discover these defects unless the children are able to secure treatment for them, and many parents cannot afford to pay for what is needed. Here the out-patient department of a hospital can do a great service to the community by curing the defects, or caring for the diseases discov-

ered among the children of the poorer parents. There is great need for doing a vast deal of medical work for which the parents of a considerable proportion of the children cannot possibly pay. Much of such work requires the aid of specialists in eyes, throats and orthopedics, and even self-supporting working families cannot afford the fees charged for such work at private offices. The hospital, however, has on its staff the picked medical men of the community, who can perform the needed services skilfully.

Finally, a great proportion of the patients who are discharged from the hospital either after surgical operation or after a course of medical treatment, need further supervision by a physician. There is very often a gap between ability to walk and ability to work, between the time when a man can leave the hospital and the time when he can safely be left without further medical supervision to pursue his regular occupation. A well-managed out-patient department receives a considerable proportion of its cases from the hospital wards, taking the discharged patients and thus often enabling them to be sent from the ward earlier than would otherwise be practical. Thus economy of hospital service is promoted. This is particularly true if a social service department or visiting nurse service is conjoined with the out-patient department so that when a patient is discharged from the ward the patient shall be supervised in the home as well as brought from time to time to the clinic. Unfavorable home conditions which retard convalescence or tend toward the recurrence of disease will thus be largely obviated. The benefit to discharged patients and the greater efficiency and economy of hospital service which result are proved by actual experience. Is there any hospital which has established an out-patient department, where formerly none existed, and which would willingly return to the state in which its discharged patients had no opportunity for after-care?

In a still larger way an out-patient department saves a hospital money. Serious diseases among poorer families are allowed to run their course until they become acute when the patient is incapacitated and when hospital care is a necessity. Tuberculosis, the greatest scourge of adult life, is curable in its earlier stages. Hence the establishment of dispensary clinics has been made a chief item in the national anti-tuberculosis campaign. The tuberculosis case which is diagnosed in the dispensary and placed under care, will probably save the community the expense of giving sanitarium treatment to that patient and to the members of his family whom he would infect if allowed to remain at home in the later stages of the disease. Gynecological operations which follow gonorrhea would be saved in great measure to our hospitals, if the disease were treated in its earlier stages in the dispensary. Syphilis is barred out of many hospitals when in its earlier and infectious stages, but admitted under other names in its tertiary manifestations. Diseased hearts, joints and brains would be fewer in hospital wards if there were more dispensary treatment of syphilis. A case already cited suggests the same opportunity in relation to cancer.

In ordinary acute diseases among children and adults, either infectious diarrhea or typhoid, it is also true that the dispensary saves the hospital money, because patients with these diseases come, or in the case of babies are brought to the dispensary in the earlier stages. If, then, a diagnosis is made and the patient admitted to the wards, the mortality rates will be lower than if they had come to the wards at a later period of the disease. Thus an out-patient department enables the hospital to reach out into the community, broaden its service and enlarge the field from which it may draw financial support.

The managers of a hospital will wish to ask what the management of an out-patient department will cost, and how it is to be

paid for. An out-patient department cannot be run for nothing, and a good out-patient department cannot be run for next to nothing! The best unit of cost is the average cost per visit, obtained by dividing the total expense of the out-patient department by the whole number of visits paid by all patients. If the hospital keeps proper accounts and charges to the out-patient department its fair share of the general hospital expenses, as well as the special expenses for the dispensary, the cost per visit should not be expected to be less than 25 cents. Something can be done for less, but adequate service can hardly be maintained. As for raising money to meet the expense, something is said in an article to follow on the fees that may properly be charged, which should be a not inconsiderable part of the income, though they should not exceed from 30 to 40 per cent., at a dispensary doing primarily charitable work.

In raising funds, success depends on doing

good work and telling the public about it intelligently and persistently. Dispensary work has a strong appeal, because it is concrete, because it deals with large numbers, because it relieves suffering in very obvious ways, and because it is preventive and can be put before men who give not only because their hearts are touched, but because their heads approve. A well-managed out-patient service ought to promote the efficiency of the hospital by improving its medical results; the efficiency of the wage earner by helping to keep him well; the economy of the hospital service by reducing the amount of care necessary, and economy for those who are called upon to support hospitals by reducing the amount of serious disease in the community as a whole. Therefore a well-managed out-patient service, properly kept before the public, should be an asset, not a burden upon the hospital which maintains it.



SINK ROOM, ISOLATION HOSPITAL, JACKSONVILLE, FLORIDA, SHOWING FOOT AND UPPER ARM ATTACHMENTS

A New Scheme for Choosing Probationers

CECIL CHARLES

IT WAS a great source of regret to me during my tenure of office as superintendent that I had to refuse admission to certain young women who were really much more desirable material out of which to make nurses than many who met the Regents' requirements. Every one who has had charge of nurses is forced to admit that occasionally some high school graduate comes along who has not common horse sense, and yet we all know that a real *education* is greatly to be desired. But a cramming with facts is not an education, and if we had our choice we would PREFER intelligence to a pseudo-education.

There are hundreds of girls today with the real fundamentals of a good nurse's character, who could not pursue their studies because of an illness, the death of a parent or financial reverses. In most of such cases that come before my notice the very cause of the young woman's check was the making of her, because she had to shoulder responsibility, control younger children, learn domestic economy and, if having had an illness of her own, acquire a patience and a knowledge of what the sick require, all of which are very hard to implant in a class busy with "preps," tired with night duty or anxious about unstudied text-books as class day comes around.

However, there are certain things which lead girls to apply for admission to the training schools that ought not to enter into the serious choice of any vocation, let alone the most trying of all, nursing.

It is a fact that there is a large number of applicants in the spring, due, no doubt, to the restlessness which every one feels after the shut-in winter, and which Tennyson so aptly describes in "Locksley Hall":

"In the spring the wanton lapwing gets himself another crest."

If any applicant is questioned as to why she wishes to nurse, the first answer will be, invariably:

"I think I would like it."

"How can you decide, when you don't know anything about it?"

It would be amusing to read the candid, unsigned answers in any large nursing association to the question, "Why did you take up nursing?"

Here is a scheme that perhaps would make for solidarity in the hospital world, and check the irregularity of applications, as well as the flightiness of some.

Choose about thirty centers in a State like New York, large towns, each with an adequate supply of hospitals, where the people are familiar with the needs of such institutions and the essentials of good nursing.

In each of these towns form a committee, under the Regents, if necessary, consisting of the superintendents of nurses of all the local hospitals, members of the board of directors, preferably their representative training school committees, which therefore include physicians and a limited number of business men and women. This committee would comprise all those factors that control a pupil's life.

Let this committee meet on fixed dates, a certain number of times a year, about three times, each meeting being preceded by active preparation on the part of each member to make himself a thorough examiner.

One month before the date of meeting notices should be printed in every little country newspaper, as well as in all the city dailies, announcing that young women wish-

ing to take up nursing should come up for examination on the date appointed.

Then when the candidates are all assembled, the duty of the committee naturally falls into five parts—(1) social, (2) business, (3) physical, (4) professional, (5) domestic.

Under *social*, the women examiners from the board of directors or the training-school committee should award the applicants, examined singly, of course, marks for appearance, voice, manner, care and taste in dress, and all the other things for which they criticize a graduate and blame her hospital if not correct.

This affair would act like a two-edged sword, because it would be a very thorough demonstration to some critics, that a girl cannot be made over in three years, and the more repression during training the bigger the explosion afterwards.

For business, each girl should give intelligent answers to such questions as:

1. What does your father pay each year for water, gas, coal, electricity, meat, etc.?
2. How is your town governed?
3. Who owns the street railways?
4. Name the last four presidents.
5. What is the present cost, approximately, of milk, sugar, bread, butter, eggs?
6. Name a well-known college for each of the following professions—law, medicine, divinity, electric engineering.
7. What large public works have been done in your vicinity in the last five years?
8. How would you go from London to Bombay and what places would you pass?
9. Name five imported fruits and the countries they come from.
10. What are the chief exports of the United States?

Such questions as these would give the *intelligent* girl who has been keeping house for her father or in business a splendid opportunity to declare herself, while an unseeing, unhearing, unobservant high-school graduate would at once show her unsuitabil-

ity to be a nurse, since a nurse should know *all* those things.

The physical examination should be especially the palate, tonsils, nose, eyes, arches, muscles, *lungs* and heart.

Under *professional* the doctors and superintendents together could ask such questions as these:

1. If an insane patient paused a moment on the window sill, before leaping out, what would you do, if you came upon him suddenly?
2. What would you do, if you were bathing an infant on a high table, and heard another child cry in great distress in the adjoining room?
3. If a large number of pupils in your future school were ill and you yet escaped the epidemic and had to do extra duty, how would you act?
4. Suppose you were on a difficult case a long time, where you knew the routine treatments very well, and you got a sudden notice of an approaching wedding in your family what would you do?

The doctors and superintendents can make a very long list of such things, which are really a tax on the innate qualities of the girl and, therefore, beyond hospital control.

If the applicant gets rattled and gives foolish answers, at a time when she has no fatigue, no strain, no care, how would she act in a *ward*, or in a *home*, when dominated by rush, jealousy, fatigue, greed, or the various other factors that make the sum total of popular criticism?

Under *domestic*, again, the women members of the committee, preferably housewives, should ask such questions as bear on all the terrible misdeeds of all the nurses they ever heard about.

1. How would you know how much of any drug or disinfectant to buy?
2. If your patient's room was furnished in mahogany, how would you protect it?
3. If you chanced to break some fine china in a home, what would you do?

4. If a mother were invalided and you were caring for her baby and she asked you to wheel the baby in the park, what would you do?

5. Can you prepare yourself a meal? How do you make coffee? Broil steak? Make a soup? Prepare eggs? Make and serve toast? Boil potatoes? Make tea?

It would be a good idea to take each candidate into the hospital diet kitchen and there have her prepare these things.

These examinations over and the marks awarded the committee should meet and assign each girl a standing, under each heading, as belonging to Class A, B, C, D or E. These papers, mailed to the applicant after due deliberation, are kept by her, and presented when she wishes to enter a hospital.

Furthermore, she should state in what hospital she wishes to be prepared, and its superintendent could be sent her exact marking in full in each section confidentially, with the names of the most reliable business and professional people of her town, so that

her record can be looked up at any time before she enters.

The candidates in D and E should have to come up again for examination and those not reaching B or A should be assigned to non-registered schools.

From the lists thus supplied to the office of the superintendents of nurses, notices could be sent, a month ahead, to prepare for entrance to the April, June or August classes. It is well understood that pupils in one class must not all enter at once and then leave at once, leaving the school decapitated for six months at least.

By such a system many a girl would be saved the expense of a long journey to the hospital and of the preparation for probation, besides the chagrin of defeat. It would also prevent aliens from Jamaica, Bermuda and elsewhere from sudden changes of place. There are many after-thoughts to this system, such as a frank letter from the parents, stating their attitude toward this move of their daughter, with their reasons.

At any rate, it is a suggestion. Take it for what it is worth.

WADER STOCKINGS

The British War Office has adopted a new device which promises to add much to the comfort and health of the troops in wet or flooded trenches. This winter the presence of great quantities of water in the cold trenches was responsible for greatest discomfort and not a little serious illness to the troops, who were compelled for hours to lie in the trenches with water-soaked clothing. It is cheering news to hear that a new wader stocking has been invented which, it is claimed, will keep the men's feet warm and dry, even in the worst conditions. The "waders" are somewhat similar to those used by fishermen, but are both lighter and

stronger. They are lined with wool and take the place of the regular sock or stocking being worn next the skin and inside the boot. If punctured they can be mended easily, like the ordinary bicycle tire. In the trials they were worn continuously for periods as long as 118 hours, during which time the men were in the almost ice-cold water for a total of about 23½ hours. The tests are said to have been so satisfactory that the War Department was fully convinced of the merits of the invention, and will now supply the men in the trenches with the new "waders" as rapidly as they can be manufactured.



BAIN NEWS SERVICE
GROUP OF RED CROSS NURSES SAILING FOR FOREIGN SERVICE, APRIL 17. NAMES OF THE NURSES WILL BE FOUND IN THE NURSING WORLD DEPARTMENT

In the War Zone

THE Rockefeller Foundation War Relief Commission has issued the following report regarding the typhus fever epidemic in Serbia:

The information is based on official reports made to the commission by the Serbian authorities, who assert that the Austrian Army of invasion not only brought the typhus but also other diseases.

The commission says that it is safe to say that typhoid, typhus and recurrent fever are epidemic throughout Serbia. In every community, in every large hospital visited, the diseases named were found.

"In a number of cases," the report says, "it is probable that recurrent fever is first, typhus second and typhoid third. In mortality typhus is far in the lead. Serbia knows from experience the terror of these diseases, but with all her energies concen-

trated on a war for her existence, with her physicians and her men of strength and influence in the Army, with her resources exhausted, she is little able to cope with the vast and vital problem which confronts her people."

Of the extent of the epidemic the report says that the estimate of foreign physicians in Serbia and the members of foreign medical commissions sent to the country are greater than those of the Serbian authorities.

Under the heading, "How Typhus Started," the report says:

"The presence of typhus and recurrent fever in Serbia is explained by the Serbian authorities as follows:

"When the Austrian Army invaded Serbian territory it brought with it these diseases. Many of its soldiers died of typhus,

while with the army of occupation, and in this way Serbian houses, in which Austrians were quartered, became infected.

"The Serbians have captured about 60,000 Austrian prisoners. The burden of maintaining and guarding these prisoners was so heavy that the Serbian Government found it necessary to distribute the load. Accordingly, detachments of prisoners were sent to all the important cities and towns in the country, where they were quartered in public buildings. In this way, it is said, the seeds of typhus were widely scattered. Then the Serbian soldiers who guarded the prisoners and the civilian employees about the prison camps contracted the disease, and through them it spread into both homes and barracks.

"In Bulgaria a smaller outbreak of typhus is similarly traced to Macedonian ex-soldiers in the Serbian Army, held prisoners by the Austrians and infected while among them, and later escaping into Bulgaria at the time of the Austrian rout.

"In Nish an English physician stated that it was his belief that a hundred patients were dying of typhus daily. One day, during the visit of this commission, it was reported that the cemetery at Nish contained 250 unburied bodies. The force of grave-diggers was entirely unable to keep up with the work. Nish, with its congestion of population, its unsanitary conditions—such as lack of water and drainage imply—and with an almost total lack of physicians outside those attached to the Army, offers a rich field for the spread of infectious disease.

"In Belgrade, whose normal population is near 100,000, but whose present population is estimated at 15,000, are to be found all the facilities for cleanliness. As is to be expected, the epidemics have been least destructive here. Yet in one hospital were 165 cases of typhus, with a larger aggregate number in several other hospitals.

"The city of Skopje, with a normal population of 50,000, now is estimated to have

probably 70,000, including refugees and soldiers. An English physician who has had previous experience in treating typhus and who has been in Skopje several months with a British medical mission, estimated the number of typhus cases in Skopje on February 24 at 2,000.

"At the time of our visit the Sanitary Committee in Skopje, of which this British doctor is the active member, had just been given the use of a group of buildings on high ground near the city for use as an isolation hospital. The buildings to be occupied have been used as a military school for the training of officers and non-commissioned officers. The commission visited the place with the doctor on the day before the young officers were to depart. Several hundred good-looking students were about the buildings and grounds, apparently in good health and spirits; but we were informed that typhus had broken out among them.

"We were then conducted into the basement of one of the buildings, where we saw, lying on the floor, the bodies of eight young men who had died in the school on the preceding day. This is told as illustrating the fact that death from the epidemic, because of its frequency, already had become a commonplace.

"Every community on main lines of travel is infected with typhus. Into the mountain places and the villages distant from the railroads the disease is being carried by the moving troops and bullock drivers and by the straw-lined carts in which the sick and well are transported, and it is said to be prevalent in most of them already."

The Serbian National Committee on Sanitation estimates that the military hospitals are caring for about 33,000 patients, and that of these about 11,000 are victims of the epidemics. These estimates do not include the sick in non-combatant hospitals, in private houses or in the camps where are kept the Austrian prisoners. In all Serbia the commission estimates the number of



UNDERWOOD & UNDERWOOD

WOUNDED NON-COMMISSIONED OFFICERS AND MEN ARE BEING NURSED BACK TO HEALTH AT BLENHEIM, THE RESIDENCE OF THE DUKE OF MARLBOROUGH. ALL THAT THE MAGNIFICENT ROOMS AND GROUNDS AFFORD IS AT THE DISPOSAL OF THE MEN. THE PICTURE SHOWS A FAVORITE LOUNGE IN THE LONG LIBRARY, CALLED BY THE SOLDIERS "THE TRENCHES." THE MATRON, MISS AMY MUNN, MAY BE SEEN ON THE RIGHT.

typhus victims at from 25,000 to 30,000.

Referring to the cholera situation, the report says that an outbreak is expected with the coming of warm weather, but the commission could not discover that any precautions had been taken. The report then tells of the means that must be adopted to arrest the epidemics and of the organization of the American Sanitary Commission, which is financed jointly by the Rockefeller Foundation and the American Red Cross.

One part of the report deals with destitution. It tells of emaciated babies with mothers too weak to nurse them and of "whimpering children too feeble to crawl about." The commission believes that much need exists among many thousand Serbians—probably 300,000 or more.

"One now sees," says the report, "plenty

of people going about covered with nothing but the raggedest rags. The Serbian reservists are without uniforms and can be distinguished from other peasants only by their weapons, or sometimes by a military cap."

The following letter was received by Miss DeVeber, superintendent of the Waltham (Mass.) Training School, from a graduate at the front:

"Hospital St. Hugues,
Pau, B. P., 1915.

"Dear Miss DeVeber—We received with a great deal of pleasure on Monday your splendid present of dressings from our friends at the Training School. They will be indeed a treasure-trove to us, as material is at a premium in France today.

"I wish with all my heart that you might

see our wee hospital. It is, to my mind, a most ideal emergency one, as the villa proved most adaptable. We have twenty beds. On the first floor there are two salles with nine beds, a large dining-room (as many wounded are able to be up), a kitchen and scullery. On the second floor are three salles with eleven beds, an ideal small operating and dressing room that was originally a sun room, and also adjoining it a tiny scrap of a room with the great luxury of running hot water.

"We have on service a very charming French doctor who speaks English very fluently, which is fortunate for us, as my knowledge of French is not marvellously medical. The soldiers are very interesting; their courage and morale is superb. One never hears a word of complaint about their wounds, no matter how severe they may be. We have discharged quite a few this week and are daily expecting a fresh convoy of wounded. It gives one quite a few pangs to get them well and send them back to the front again, perhaps to be killed. When they arrive they certainly are the saddest looking men possible; usually clay up to their knees, dead tired, their wounds merely having had the primary dressing before they were put on the train. Warm water to wash their faces and hands and feet is the first thing needed, and it is a luxury to the poor things, as often they have not washed for months. Their feet are in a wretched condition.

"The wounds are most interesting. They always have a tiny wound of entrance and a large, ripping one of exit. They are dirty upon arrival, but we have very little sepsis, and it is astonishing the slight pain.

"I must write you more in the future. All

our military inspectors are pleased with the hospital, and a general who visited us with the medical chief pronounced everything '*Parfaitment.*'

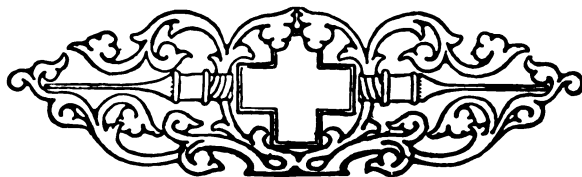
"Miss Severance and Miss Ross join me in thanks and good wishes.

"Yours most sincerely,

"AGNES TURNER."

Dogs will evidently not be outdone by their soldier masters in acts of heroism, and once again we are given an instance of how a dog saved his master's life on the battlefield. The story, which appears in the *Daily News*, relates how a Russian surgeon befriended a starving dog, which became very attached to him. During a recent engagement, however, they were both missing, but on the following day the dog arrived at the ambulance station in a state of great excitement and began to tug at the clothing of the soldiers and then to run toward the battlefield. A soldier who followed the dog found the surgeon lying on the field injured. He said that a shell had fallen close to him and had buried him in a big hole in the ground.

"When I recovered consciousness," he added, "I was scarcely able to breathe, owing to the weight of earth upon my body and face. I felt somebody trying to move the earth from my face. It was the dog. Throughout the night it scraped incessantly at the earth which covered my head, and by the morning had succeeded in uncovering my face. Then the dog made demonstrations of joy, licking my face, and afterwards ran away. I remained tranquil, assured that my mascot had gone for assistance. Then help arrived and saved me from death."



Occupational Nursing*

GEORGE EDWARD BARTON, A.I.A.

Director of Consolation House

IT IS written, that when Adam was cast forth from the garden of Eden he was told that by the sweat of his brow he should earn his bread.

We are in the habit of considering that in the light of a command. Perhaps it was also a prescription! At all events, ever since that day, man has found solace for his miseries in labor. And that is true not only of the individual sufferer, but also of his family. Ever since the first boy had the first case of mumps, father, mother and sister have rushed madly up and down-stairs, collapsed in the rocking chair, and exclaimed: "Oh, if he only had *something to do!*"

This need, so general, so widespread, was, of course, noted, and from time to time there have appeared many people who have devoted more or less of their time to amusing or to formulating amusements for the sick. And there the matter seems to have rested, in "killing time" for the sick man, until within a few years. So far as I can find out, the first attempts to develop this amusement idea into anything more serious were made in the State Hospitals or for mental cases.

That was quite natural, for the common absence of physical disability, combined with the extra need of training in concentration coordination in *re-education* makes occupation particularly desirable for cases of central disturbance.

For the beneficial effects of occupation are very far from being confined to mental cases.

There are the long days, weeks, months of convalescence during which the patients' conditions and improvement depend often so largely upon what?

Medicine? No.

Treatments? No.

Idleness? No.

Food? No.

Upon the assimilation of food and rest.

I do not have to point out to this audience that feeding and the assimilation of food are not the same. I hope that it is not necessary for me to point out that "*the mere lack of occupation is not rest.*"

We all know how impossible it is to tell what a doctor really thinks, but I believe that I am correct in saying that the simplest needs of the convalescent—sleep, rest and the assimilation of food, cause the medical profession more trouble than a gastro-enterostomy, an exploratory "lap" or anyotomy or ectomy. For there are many patients who cannot assimilate food without exercise, who cannot sleep or rest unless their minds are occupied, many who cannot sleep or rest unless their minds are occupied with something "*worth while.*"

And what does "worth while" mean to the great majority of patients. *It means money!*

I do not mean to depreciate the spiritual side of man, but I will not dwell upon it to you who have walked the wards. Walked the wards full of men who, weakened by sickness, anxious for the welfare of loved ones, troubled by the loss of their job are terrified at the thought of returning maimed to a world which even before demanded more strength and ability than they possessed.

You have all heard such a man told to "just lie still and rest." Have you not, each one of you, had him seize you with a grip that hurt, have you not heard him say, "In God's name, tell me what I'm going to do!"

*Address delivered before Boston Nurses' Club, April 7, 1915

It is a part of the Consolation House theory (for as yet I can call it hardly more than that) that by studying and considering the patient's past life and social as well as medical history, his education, training, experience, his successes and his failures, and by considering them in relation to the condition he must presumably or inevitably be in for the remainder of his life, that we *can* find some form of occupation for which he will be fitted, or at least for which he will not be incapacitated.

And not only that, but also one in which his interest awakened, with the prospect of "a better job" or a job done better, will lead him to *desire* to study, to learn, to *take exercise* toward that end.

And not only that—we believe, furthermore, that by and by we shall be able to provide such instruction and training that the interest will not only make toward the better job by and by, but also be of therapeutic value during convalescence.

For instance: Suppose a letter carrier must lose both his legs from, say, diabetic gangrene or anything else. I can see no possible chance for him to return to his old job of walking from door to door. If we can find that he has a gift, a tendency, a leaning toward mathematics, mechanics or even painting spots on rocking horses, though ignorant of the fact himself (for the man is often as unable to analyze his own abilities as the patient is to diagnose his own symptoms)—if we can find something for which he will be qualified after his stumps have healed, and present the idea to him in such a way that he will realize for himself that his stay in the hospital means a brighter, better life than he had before—will he not take his anesthetic better? Won't he make less trouble for you the night before operation? Will not such a condition of mind help more than bromides during the fits of hysterical whimpering when he first sees his bandages? Won't such a condition of mind—the desire for a better job, a job done bet-

ter, urging him *to try* (to paint spots on rocking horses or what not), help his appetite as much as nux and gentian?

Is he not apt to sleep better with the prospect of a possible future? Is not the realization that he can at least give joy to his small son apt to be as efficacious as veronal gr. ii?

And—can we not turn him back to the world better prepared for the struggle of life than by giving him a license to sell papers or pencils from a little cart, which must necessarily interfere with the city's traffic?

That case we should call an "alterative" in the sense the word is used in *Materia Medica*—of producing a structural change. That would be an extreme case (though heaven knows there are enough of them), but all cases would not demand a change of occupation; in fact, comparatively few do so.

A young lawyer, instead of revolting at the few months of rest and food required to make him entirely well was led to interest himself in mechanical drawing, not with any idea of making him a draughtsman, but to enable him to read mechanical drawings and so be better fitted for the practice of patent law.

Not always a different job, a "better job or a job done better." Society needs almost everything *done better*.

You see, I hope, that occupation is to amuse, to quiet, and to instruct the patient in doing something which he could not do before or in doing something better than he did it before. In doing something worth while, something that society needs and will pay for, and something which by the very doing involves motions, actions, exercises, processes which will in themselves have a beneficial therapeutic effect and so shorten convalescence.

You see all this involves the study of occupational diseases "inversely as" (as the geometrician would term it) and the consideration of the physical effect of every single form of human activity. That is one

of the little problems which we have been simple enough to undertake.

As things are now the doctor who casually says "Let him go to the industrial room for an hour" is in nine cases out of ten guilty of incompatibility in his prescription writing. For what effect will a small dose of a light hypnotic have on a patient who has been at work upon something which to him is highly exciting and stimulating?

How important a part this theory is destined to play in the hospital life of the future may be surmised from the fact that since the first day of October last (six months), industrial training has been introduced into seven training schools for nurses in Massachusetts alone.

Now, if you will consider for a moment, you will see that herein lies a very important point for you graduate nurses.

It means that classes of nurses will be graduated, are being graduated, who have a knowledge of a subject of which you or most of you are entirely ignorant.

Your active professional life is short now; it is going to be even shorter, because the new nurses are not only younger and more "up to date," but are inevitably better equipped than you are.

Of course, I will admit that this developed theory of the use of occupation is as yet hardly born. It is still in labor; it may be still-born. But, if it is proved that the patients, the hundreds of thousands of patients in our hospitals or even a small percentage of them can be wholly or partially re-educated for the life they must lead after leaving the hospital, why, then, not only *will* the hospitals include such re-education as a regular treatment, but they will *have to do so*!

For the moment it is proved that such a work can be done, then society and the taxpayer will demand that it *shall* be done!

Who is going to do it?

I wish to insist here that I speak thus, not at all with the idea of depreciating the work

which the nurse now does. Very far from it: and not so much to forward this "pet theory" of my own, but to lay before you a fact, a condition which already exists and which you cannot overlook with impunity.

Whether the Consolation House theories and work grow or disappear has nothing to do with what I wish you to consider; for nursing will not disappear in a year or a century, if ever.

I have insisted for a year that I had something to tell the nursing profession, and the nursing world has graciously inclined its head and, as if all coming from Missouri, has murmured, "Show me!"

Now I realize from the letters I receive from nurses in Maine, in California, in Canada and Mexico that you all think I shall advise you to learn basketry or weaving, or, to use my former example, to paint spots on rocking horses. *Not at all!* To be sure, I shall advise you to know more than "nursing." But those are merely the capsules, not the medicine, and in themselves they are, in most cases, about as efficacious as an empty capsule—as a placida.

Consolation House is striving to get down to the very foundations of our social difficulties.

We need more, older and better educated women than are many who are now entering the profession.

Isn't it possible to use this wider influence as an inducement with which to attract such? Will it not fit in with the growing tendency toward specialization.

The nursing profession has been complaining for a long time at the lack of opportunity granted for the individual development of its members.

"I feel that I can and should and I want to do more with my life." So many of you nurses write that to me! We have all heard the "probe" say: "Is this training? I could have cleaned the door knobs at home." Some of us have even heard so magnificent a person as a superintendent say: "I've got

a good job, seven uniforms a week and all that, but I'm still young, I'm not worn out, and now that I am a superintendent is there nothing to look forward to but these endless sheets of requisitions?"

If re-education is introduced into the hospitals, there is nothing good which any nurse can do, or know, or be, or stand for, which cannot be utilized to its fullest extent and as individual work.

But there are many young women who are now declining nursing as a life work just because they do feel (rightly or wrongly) that nursing does not now allow of individual development, that it does not go far enough.

A new opportunity for social service of this kind will appeal to them. And, one of two things will happen:

Either the nursing profession will give them the opportunity they crave and absorb them, or, the schools and colleges will open courses in hospital re-education, turn out a new order of social workers and *leave the nurse with the crescent basin!*

Do you nurses want to be put on the shelf

with the crescent basin? Do you want to withdraw as soon as the blinds are raised, salute another girl who won't even be a nurse, go out and wash up and leave the other girl to lead the patient through convalescence back to health and to a better job or a job better done, better than he had before entering the hospital, before knowing her?

Think of the opportunity granted by being in the position where you can not only give a bath or do a dressing, but where you can by your own individual effort help the patient to go out able to lead a more useful, a more remunerative, a better life than he did before he was sick!

Think of making the patient cease lamenting "the waste of time" lost in the hospital, of seeing him realize that the hospital and his sickness and *you* have been the remaking of him!

Would that not be satisfying and worth while?

Is it not worthy, just and true and right?
Is it not nursing?

The London correspondent of the *Medical Record*, in discussing antiseptics and aseptics, says: "The question of antiseptics has been a good deal talked about in reference to the present war. One meets now and again a person who is imbued with the notion that asepsis can be carried out in military surgery, but those who have served in a clearance station are not among them, but will tell you that aseptic gauze and sterilized water are not to be trusted against wounds contaminated with soil reeking with organisms. Sir R. J. Godlee calls them broken

reeds compared with a true antiseptic like carbolic acid, preferably pure, for the first dressing of a wound probably infected with tetanus or spreading gangrene, besides other organisms. He calls to mind Lister's early compound fracture cases in which undiluted carbolic acid was freely used and no ill effect took place, and adds that diluted with blood or serum it is less potent than with water, as also is bichloride. The wound should therefore be as dry as possible for disinfection. In a suspicious case he favors a prophylactic dose of anti-tetanic serum."

Eye Nursing

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PART III

COMMON ACUTE AND CHRONIC EYE DISEASES

IN CONSIDERING this topic few introductory remarks are necessary, as the scheduled outline speaks for itself. Only such material as has actually been given in the school course in the hospital is here included. The principal reason for considering eye diseases lies in the fact that as more and more exact knowledge is yearly required of the well-trained nurse, some familiarity with such conditions must be obtained if she is to be considered either well educated or properly qualified to fill her position. Indeed, no matter how high the standard of preliminary education may be or how great the nurse's general experience, she can always be reminded of many useful things in connection with eye nursing, by reviewing a page or two of her hospital lectures before going on duty in an actual case.

In taking up common acute and chronic eye diseases, the order of study of each disease is very briefly discussed as follows: Definition, etiology, symptoms and practical management from a nurse's standpoint.

BLEPHARITIS

Definition—Blepharitis is an inflammation of the lid margins and may be either acute or chronic.

Etiology—The condition is usually due to infection following in the train of dirty and unhygienic surroundings, debilitated conditions of the general system and most frequently of all uncorrected errors of refraction (want of glasses).

Symptoms—The margins of the lids are either acutely swollen and reddened or present merely, as in the chronic form, much scaling about the base of the eyelashes. In

acute blepharitis, so common in children, crusts and small yellow ulcerations (the seat of minute abscesses) combined with a little discharge glue the lids together in the mornings. If ulceration is bad the lashes may fall out in areas.

Practical Management from a Nurse's Standpoint—As the condition may be the result of a variety of circumstances, the real cause must first be ascertained by the ophthalmologist* and removed in order to successfully institute a permanent cure. For the acute cases the physician will probably leave an order for the thorough cleaning of the swollen lid margins with a warm antiseptic solution, such as boric acid or 1-10,000 bichloride solution and instructions to keep the edges of the lids smeared with an eye ointment three times daily. Simple ointments, such as sterile vaseline or bichloride ointment 1-3,000 (the bichloride or White's ointment being specially prepared by the druggist) are necessary at night to prevent sticking of the lids together mornings. In many acute infectious diseases, such as measles or small-pox, the lid margins and conjunctivæ become inflamed, requiring the above intelligent nursing attention of frequent cleaning, protection from strong light and an ointment to the edges of the lids at night. (For proper ophthalmic nursing technique see Part I.—Handling of Eyes in the Hospital Ward or Private Sick Room, and Part II.—Principles of Treatment in Ocular Therapeutics).

STYE

A stye is an acute circumscribed inflammation of the tissue about the follicle of an eyelash or, in other words, a small boil.

Etiology—It is usually due to infection rubbed in about the follicle of an eyelash, and especially liable to occur if the patient

*Ophthalmologist—specialist on diseases of the eye (oculist).

is a little below par in general health or needs glasses.

Symptoms—A small boil in this situation, with its attendant symptoms of localized lid redness, swelling and burning sensation is usually very uncomfortable for the patient. Frequently styes appear in crops.

Ocular Nursing—As soon as the oculist has made the diagnosis the following treatment is usually ordered and either carried out by the patient or left in the hands of the nurse. Fomentations (hot eye compresses) over the affected eyelid every two or three hours during the day to hasten suppurations (pointing of the abscess) and the application of an ointment of yellow oxide of mercury at the same time. As soon as a yellow spot is seen on the summit of the boil the pus is evacuated by the physician by incising with a small knife needle sterilized by dipping in boiling water or 95 per cent. alcohol. A tray, therefore, containing a few bits of cotton, two or three toothpicks, a small bottle of alcohol, cocaine solution 4 per cent., two eye droppers, small bowl of warm boric acid solution, ointment tube of yellow oxide of mercury or a special eye bichloride ointment 1-3,000 and a small sharp-pointed knife should be provided by the nurse, especially if the case is treated at some distance from the regular clinic treatment-room.

MEIBOMIAN CYST (TARSAL TUMOR OR CHALAZION)

A chalazion, a very common affection, is an enlargement or distention of one of the glands in the cartilage (middle) layer of the lid in consequence of stoppage of the excretory duct of a meibomian gland with which the lid abounds.

Symptoms—The onset of the small lid tumor is very gradual. Practically the only symptom noted for weeks may be a slowly developing tiny tumor in either upper or lower lid which feels hard. These cysts are somewhat annoying in a number of ways, as well as on account of the disfigurement which they present.

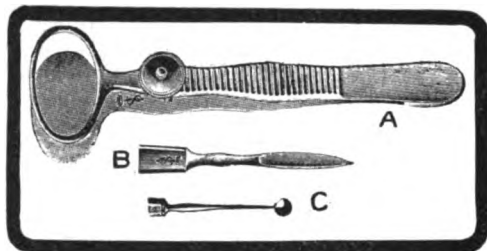


FIG. 21. INSTRUMENTS FOR CHALAZION (LID TUMOR) OPERATION

(A) Chalazion ring forceps (Desmarres') with protecting metal back. (B) Small scalpel for incising lid tumor. (C) Small chalazion curette (Moyhoover's) for removal of viscid contents of cyst and sac wall. The above instruments may be picked out of the instrument cabinet by the nurse and boiled. The operation of incising a Meibomian lid cyst is performed by the eye surgeon under four per cent. cocaine solution usually as a simple out-patient clinic or office operation.

Treatment—The treatment lies entirely in the hands of the specialist and almost always a slight but skillful lid operation becomes necessary in order to obtain proper relief. The tumor is usually opened by the surgeon with a sharp knife (the lid being held in a specially devised clamp) and its gelatinous contents curetted out with a small chalazion curette. As the preparation for this kind of an operation is in the nurse's province, the general directions necessary should be borne in mind as follows:

Nurses' Preparations for Chalazion or Lid Tumor Operation—The operation is performed with the patient either lying down on the operating table, lounge or occasionally even sitting erect in a stiff-backed chair in front of a window. A bowl of warm water, two eye droppers, small cotton wads or balls for sponging, and two or three clean towels will all be required. When the patient is operated upon lying down, as is usually the case, many operators cut a hole in a large piece of gauze previously dipped in a 1-5,000 bichloride of mercury solution and lay it over the entire face, leaving only the eye which is to be operated exposed. Local anestheisa is obtained by dropping a solution of cocaine 4 per cent. on the inner surface of the lower lid every three minutes for three or four doses. In performing this operation the lid is usually everted (turned over) with

a special pair of ring chalazion forceps (Fig. 21A) which completely surrounds the tumor, rendering the operation more or less bloodless. The instrument is so made that when clamped on the lid the metallic back also protects the eye-ball from possible injury. The other instruments required are a small scalpel (Fig. 21B), and a chalazion curette or tiny scoop (Fig. 21C). The cotton sponges used for wiping away blood or secretion should be moistened in warm boracic acid or normal salt solution, and squeezed fairly dry before being applied to the eye. It is worth while repeating that the nurse should not press down unnecessarily hard when sponging (assisting), as it will cause pain and is, moreover, apt to bruise and injure the eye-ball underneath. Following a lid operation of this kind sterile vaseline or the usual bichloride ointment 1-3,000, is usually applied, and a bandage worn for twenty four hours, although a bandage is not always necessary. From this description the nurse doing special ophthalmic nursing should have little difficulty in providing such articles as are accessible and even pick out the instruments for the doctor from the instrument cabinet. The instruments used are sterilized by placing in 5 per cent. carbolic acid solution and then into 80 or 95 per cent. alcohol, or by boiling for from eight to ten minutes.

BLACK EYE (ECCHYMOYSIS)

Black eye, or ecchymosis, is an extravasation of blood into the subcutaneous tissues, the result usually of trauma, such as a blow on the eye. This is usually of no serious consequence, except for the temporary few days' disfigurement. If seen immediately the doctor usually orders cold compresses, and if after the lapse of a day or two, hot compresses. Any simple ointment and very gentle massage helps to promote absorption of the extravasated blood. Discoloration due to unabsorbed blood pigment beneath the skin often remains for some time and

may run through the various colors of the rainbow. If the eyeball itself is in any way injured or the blow seems unusually severe, the nurse should insist that the oculist be consulted. In the handling of any eye case what may be termed approved ophthalmic nursing technique should always be followed as closely as possible. Ignorant or careless handling of eyes is to be condemned.

CARE OF THE EYES IN ACUTE INFECTIOUS DISEASES, SUCH AS MEASLES AND SMALLPOX

Measles—The first stage of measles is almost always associated with suffusion of the eyes (acute catarrhal conjunctivitis) and dread of light. In severe cases the measles eruption about the face, lids and mucous membranes of the mouth produces a good deal of temporary lid swelling, eye irritation and discharge, which tends to stick the lids together in the morning. As a rule, however, all signs of inflammation disappear within ten days without any permanent bad consequences.

Practical Management from a Nurse's Standpoint—The general line of special nursing to be carried out by the nurse in such a case consists in darkening the room, frequent use of a cleansing boracic acid solution and a bit of white vaseline to the edges of the lids, especially at night, which tends to prevent them from being stuck together in the morning. During convalescence and, indeed, for a few weeks following, as little work (reading and close work) should be done with the eyes as possible.

Smallpox (Variola)—Occasionally a smallpox pustule may develop on the lid, conjunctiva or cornea, which because of its location requires particular care and is often a most serious complication. Considerable attention is necessary in order to keep the eye clean and well lubricated with sterile vaseline. Pustules on the cornea with iritis either during or toward the latter stages of the disease require the immediate attend-

ance of the oculist and the exhibition of intelligent ocular nursing in carrying out the doctor's directions. Frequently disastrous results in the way of corneal scarring and injury to the sight follow in the wake of these smallpox ulcers.

DISEASES OF THE CONJUNCTIVA— CONJUNCTIVITIS

The conjunctiva is a very thin layer of mucous membrane lining the under surface of the lids and also the front of the eyeball with the exception of the cornea. The conjunctiva lining the eye globe (over the white sclera) is transparent, except when inflamed.

Inflammation of the conjunctiva is known as conjunctivitis, sometimes called ophthalmia.

Etiology—The condition is caused by head colds, foreign bodies in the eye, dust, measles, scarlet fever and, in fact, by any infectious bacteria lodging beneath the lids and causing inflammation.

Symptoms—In acute catarrhal inflammation of the conjunctiva a slight mucous or muco-purulent discharge develops according to the severity of the case. In chronic catarrhal conjunctivitis there are only very slight changes in the quantity of secretion and but little redness of the conjunctiva or eyeball. Very frequently in scrofulous children a circumscribed inflammation of the conjunctiva is encountered, resulting in the formation of small single or multiple reddened elevations called phlyctenules (*phlyctenular conjunctivitis*). A phlyctenule soon breaks at its summit, forming a small ulcer. Phlyctenules occur not only on the conjunctiva, but are even more frequent on the cornea. When occurring on the cornea the disease is called *phlyctenular keratitis*.

The differentiation between ocular redness due to acute conjunctivitis and that due to acute iritis requires the services of the skilled ophthalmologist and should not be

attempted by any one else. The reason for this lies in the fact that the treatment is so radically different that any kind of a mistake is sure to prove costly to the patient.

PINK EYE (ACUTE EPIDEMIC CONJUNCTIVITIS)

Pink Eye is an acute catarrhal inflammation of the conjunctiva accompanied by a muco-purulent discharge, occurring most frequently in the spring and fall in an epidemic form.

Etiology—The contagious element is infection with a definite bacteria (Koch-Weeks bacillus).

Symptoms—Within a short time after infection the eyeball becomes bright red (pink) with dread of light, burning and itching of the lids and a slight eye discharge. The symptoms gradually subside in a week or ten days.

Ocular Nursing—The proper technique of applying cold eye compresses to the lids several times daily to allay the inflammation and swelling, eye flushing with boric acid solution and the instillation of such medicines as a drop of Protargol 2 per cent. or Argyrol 15 per cent. solution should be well understood in order to carry out the orders on the treatment chart. Eye ointments, such as sterile vaseline and others (as ordered by the physician) applied to the edges of the lids at night will prevent them from becoming glued together during sleep. In institutions and schools cases of acute epidemic conjunctivitis are separated (isolated) from the other children. The contagiousness lies chiefly in the eye discharge. Owing to the fact that the above is a more severe and highly contagious form of acute catarrhal conjunctivitis than ordinarily encountered, the cases should be seen by the oculist and an expert opinion secured as to the necessity for strict isolation and as to whether it is likely to be carried about from one person to another.

(To be continued)

Practical Points in Maternity Nursing

AMY ARMOUR SMITH, R.N.

IX. SURGICAL CARE OF THE INFANT

AT THE delivery, blow-outs should be provided, consisting of a yard of gauze in half-yard widths, folded in three and rolled.

These the nurse unrolls, over the infant's mouth, so that the doctor may blow into its air passages and dislodge any foreign body, such as mucus, which may be cutting off its air.

To obtain a specimen of urine from a girl baby, lay a fluff of sterile cotton in gauze in the diaper, and watch closely till wet, then squeeze. For a boy, slit the end of a finger cot, and draw a fine rubber tube through it, then fasten them with adhesive. Lay the bottle in the crib, and elevate the baby's body. Then draw the finger cot up and fasten in place with adhesive.

► The stump of the cord must be watched for moisture, redness and pus. Smell it every day. Tetanus is possible. A newborn infant is laid on his right side at first, and may have a warm water bottle, not to burn his soles, but to warm the air circulating around under the covers, and for not more than three days. There must be tubs of hot and cold water, the cold about 90° like tap water, the hot about 105°, for use when the child breathes badly. The cord tape may be *any* white string boiled, but it ought to be linen bobbinette, not so fine as to cut the cord.

X. SURGICAL CARE OF THE MOTHER

The breasts must be cleansed with castile soap and boric acid, then thoroughly dried, and the sterile lead nipple shields referred to in a previous issue applied by the nurse's sterile hands. When a nurse uses bichloride she must rinse it off, on account of the baby's nursing. The patient should promise to

warn the nurse immediately upon feeling any pain from engorgement, for which she already has an order to massage the breasts. There is no use applying the breast pump first. The technique of massage is as follows:

1. Sterile albolene, gauze wipes, cotton, towel pump, container for milk (if to be saved), lead shields and glass breast shield.
2. Basin for waste cotton, etc.
3. Boric acid solution.
4. The nurse scrubs her hands and disinfects them. Then, with the patient well over the edge of the bed on the right side, she stands on the right and *very lightly* begins with oiled hands to press on the base of the breast, in a rotary direction, toward the nipple. The nurse can, by standing with her left side to the patient's right, go all the way around the breast with her left hand. The hand which is acting as a stay can hold a gauze sponge on the nipple, to keep it clean and absorb the milk. The massage must be *very light and slow at first*, since those glands are used now for the first time, and the pain is intense. I know of no greater satisfaction a nurse can have than to manage two belligerent breasts well. The breast must hang low over the edge of the bed, if pumped. To massage the left breast the patient must be drawn to the left side of the bed. The nurse disinfects her hands thoroughly between breasts. One might infect the other.

When a specimen of urine is to be obtained, plug the vagina with counted cotton sponges, after irrigating thoroughly, massaging the fundus and cleansing the vulva. Then leave the patient alone.

When doing a perineal dressing always *wash downwards, especially* after a stool. Do not carry the colon bacillus or common filth

from the rectum to the vagina. Do not let the mother tamper with her perineal dressings. Watch for retention, with overflow, bichloride poisoning, chills of sepsis, phlebitis and "nerves," eclampsia, retained secundines, odor to lochia, secondary hemorrhage, and everything else you ever heard anybody had.

When the perineum is torn and sutured, use a droplight and peer closely at every suture. Dry with softest gauze, toward the line of sutures. Saline solution poured gently at about 105° from a sterile enamel pint graduate, kept in weak bichloride and used for no other purpose, is a safe healing agent. Put the soiled dressings into a paper bag, pinned open wide at the foot, to one's right hand, before scrubbing the hands. The nurse should give a very intelligent account of the healing of that wound, every day, and should also have her patient draped and ready for examination by the doctor about every three days. Not enough attention is paid to the care of perineorrhaphies in any hospital.

If the breast binder is used it comes off on the tenth day, the abdominal on the fifth. The mother uses one pillow only for the first two days, then only two. On the fifth day she may go down on her knees to the foot of the bed to straighten and secure the covers. To do this daily as a knee chest exercise prevents retroversion. Never leave gauze on the nipples; cotton flannel is best. When a glass nipple shield is used, it must be filled with warm sterile water, to establish a flow of milk at once, and to prevent the baby from getting air. The mother's mattress may be turned by drawing her to one side of the spring on pillows, or it may be exchanged. This ought to be done as often as twice a week. But she does not require rubbing, like a surgical case, when she is normal, because she may roll around and her tissues are not diseased. The nurse must find facilities for giving a hot, sterile water douche in a very short

time, so as not to burn or shock or infect the patient. The placenta must be kept for the doctor to examine. When a convulsion occurs everything necessary for a hot pack should be right at hand, even to the ice in a small, portable ice chest, and water put on to boil promptly in a small kettle, to pour over the inner blankets, which are then tested to the nurse's cheek. A clothespin or spoon wrapped in gauze makes a good mouth gag. Many patients would not deem it necessary to go to a hospital to have labor induced. But most nurses have a fear of their first case of "Barnes bags." The physician brings the instruments:

Voorhees bags, 3.

Metal syringe, 1.

Long uterine dressing forceps, 1.

Bivalve speculum, 1.

Weighted speculum, 1.

Vulsellum forceps, 1.

Sponge holders, 2.

Scissors, medium straight, 1.

Thumb forceps, 1.

Artery clamps, 2.

The nurse tests the bags for leaks before boiling, by filling and squeezing. She must provide a sterile basin of water and tape, to fill and fasten them. She does not need to scrub up to assist him, having sterile forceps to handle articles with, but the doctor provides towels, gown, gloves and cap, with dressings, etc., just as for delivery.

If the patient suffers from hemorrhoids, the nurse may have to make an ice poultice, with crushed ice covered with bran or sawdust, then laid in a cloth folded so as to make an envelope, then covered with oiled silk, or rubber tissue, also in envelope style. Red-hot compresses afford some relief, also poultices of tea, boiled to get the tannin. There are special ice bags made for the rectum, resembling a finger cot, with a wired rim and a cork.

If a maternity case has a hemorrhage, the nurse should grasp the fundus, massage it till it is low in the pelvis and keep it there

then, without moving, instruct others to bandage the limbs, elevate the foot of the bed, or hand over the fundus to a competent person and prepare morphine and a douche herself.

XI. NURSERY HINTS

Lay the baby on the bed to kick, free of all clothing but shirt band and diaper, with the temperature at 70° to make his limbs strong. Let him sleep in only shirt and band in midsummer heat. Keep pins in Ivory soap, so that they will slide easily. Wash flannels in ammonia and borax 5 i aa to oii of water—in tepid water, rinsing twice, stretching evenly and drying on forms. Use only pure soaps. Give the baby no “comfort” and no “sugar teat.” When weighing him, keep one hand and arm over the scales. Use a bath thermometer as a defense against busybodies. Wash the baby with tufts of absorbent cotton. Saw the legs off an old kitchen chair, for nursery use. Keep needle, thread and thimble always ready. Keep a screen to “draw” the heat of radiator or stove during the bath behind you. Have towels of cotton birds-eye, marked with red thread and different in shape from the diapers.

To feed an infant with a spoon weans him somewhat. His bottle should have a nipple as nearly like his mother’s as can be procured. To make a small hole in the rubber nipple prick it with a red hot cambric needle. The milk should slowly drop but never stream through. When cleaning rubber nipples, turn them inside out, over the tip of the small finger, then boil them, and afterwards keep dry. Do not “dope” the child with peppermint water, nor give him a big drink just before he nurses. But when he is big enough to stay out in his carriage, if it is windy and he cannot be entirely sheltered, he will be very much pleased to get a small dose of peppermint when he comes in.

Visit the shops for children’s supplies, when off duty between cases, and post yourself thoroughly on prices, measures, patterns

and textures. Look up and save all advertisements and illustrations of maternity dresses, corsets, binders, suspenders and other needs for the patient. Many patients have a nurse almost from the time a physician is first called in, and she must enter into counsel with the patient in everything.

XII. PREPARATION OF THE ROOM

The poorest room can be washed down or hung with clean sheets. Rugs must be removed. Furniture must not be stained with water or heat. The windows must be made opaque with Bon Ami, where there is any remote possibility that any one high up and far away can see in. The floor must be kept clean and neatly picked up. No linen should be dropped anywhere. All closets, chiffoniers, etc., belonging to the husband should be molested as little as possible. Thick pads of papers and oilcloth will protect almost anything.

XIII. THINGS TO WATCH FOR IN AN INFANT

A frenum under the tongue, preventing free sucking, hemorrhage from the cord, hemorrhagic conditions elsewhere, tight prepuce, asphyxiation, mucus, deformities, burns, jaundice, atalectasis and “witches’ milk” in the breasts, which is rather funny in a boy. It must be instantly reported, and probably a tight binder will be ordered. On no account squeeze it to see what you can get.

When a baby gets a forceps mark on the temple, the nurse should build a cunning little forcep cap of gauze to keep the aristol applied. If he has a little inguinal hernia a splendid truss is made of a skein of yarn passed through itself and around the thigh, so that the knot presses into the groin on the hernia. A baby must not be allowed to cry too lustily or too long, lest he get an umbilical hernia. A clean finger tip on the tongue will tell if he is thirsty, but he must never be allowed to suck any finger, not even his own.

If any one of these little observations serves as a reminder for one person only, the labor of compiling it will have a great result.

Physical Training for Nurses

LEONHARD FELIX FULD, LL.M., PH.D.

Member, American Academy Physical Education

EXERCISE IV

HHEADACHES are pre-eminently a disease of civilized women. Normal men and uncivilized women seldom suffer from headaches, because they take sufficient physical exercise to avoid them. Headaches are the penalty which women are required to pay for violating persistently some law of health. A few of the most common types of headaches will be briefly considered in this paper.

A dull pain in the forehead is one of the most common forms. This is generally the result of eye strain. The remedy is simple. An oculist should be consulted and proper glasses obtained to correct the defect of vision. Incidentally the nurse should pay careful attention to the details of her personal hygiene. A simple diet of coarse food, plenty of fresh air and exercise and the sparing of her eyes as much as possible from the strain of reading will aid the oculist very much in banishing this type of headache.

A feeling of dull weight in the head, ac-

companied by a coated tongue, cold fingers and aching eyes constitutes a second common type of headache. This form is experienced by the male orderly upon his return to the hospital after a few days of absence following pay day, and by the trained nurse who eats little for breakfast and believes that she can obtain her nourishment from candy, pastry and meat. To cure headaches of this kind the nurse must realize that from a physiological point of view there is not very much difference between excessive indulgence in alcoholic liquor and gross intemperance in the matter of candy and pastry. Each results in a serious disturbance of the digestive functions and in the attendant headache of indigestion. Fresh air, physical exercise and a rational diet are the weapons with which this form of headache may be conquered by all trained nurses.

A heavy pain in the temples, accompanied by an offensive breath, cold, moist hands and feet and a sense of fullness are the symptoms



FIG. 7

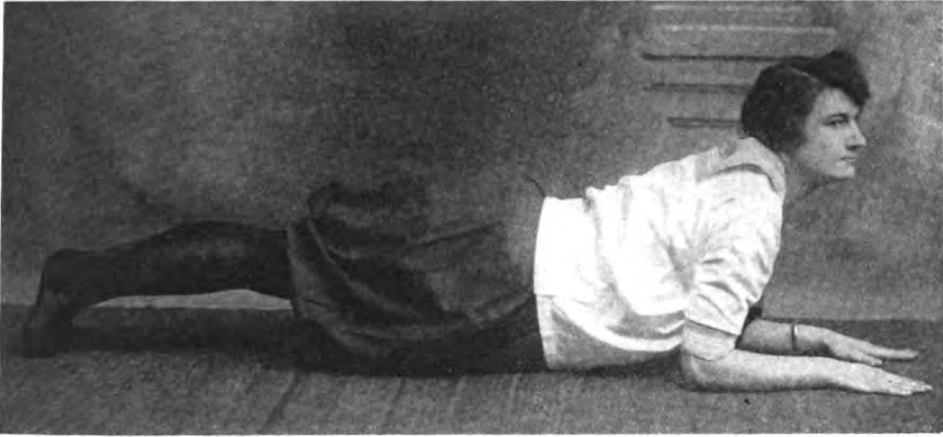


FIG. 8

of the sick headache which so frequently impels a nurse to report herself unfit for duty. A gentle emetic will give relief and abstaining from food for a short time will make the cure permanent. If the nurse is interested in learning the cause of her sick headache, let her ask herself whether she has violated the laws of health by worrying, by too much reading, by irregular eating, by an improper or insufficient clothing of the feet, or by becoming overheated and then hurrying into the cold air of the street. By committing one or more of these offenses against good health any nurse can readily acquire a sick headache and by carefully avoiding these indiscretions, particularly at times when she does not feel perfectly well, she can protect herself from these headaches.

Brain workers frequently suffer from headaches which are due to an insufficient blood supply in the brain. Nurses in training who complain of headaches frequently

find this to be the principal cause of their trouble. In most cases of headache an increase in the efficiency of the blood supply of the brain will aid in overcoming the distressing symptoms. Those suffering frequently from headaches, should perform this exercise in bed before arising. Lying on your back in bed, raise your head until you can see your toes. The movement should be confined to the muscles at the front of the neck; there should be no movement of the back (Fig. 7). Next turn over and support the weight of your body on your toes and your elbows. Raise the head and lower it until the muscles at the back of the head are fatigued (Fig. 8). Confine the movement to the muscles of the neck. This exercise increases the blood supply of the brain, makes the neck full and round and will reduce a double chin. If you should become dizzy while performing it discontinue the exercise and resume it on the following morning.

Mme. Marie Depage, wife of Dr. Antoine Depage, Chief of the Red Cross of Belgium, who lost her life on the *Lusitania*, had been in this country on a mission for the Belgian Red Cross and had made countless friendships among Americans of all classes. With her was lost over \$100,000 which she had collected for the Red Cross needs in her country.

One Method of Administering Salvarsan

FLORENCE STRUTHERS, R.N.

GIVE cathartic the night before, as physician orders. The morning of treatment give soap-and-water bath. One cup of coffee for breakfast. Sweep and damp-dust room.

Two trays are required for treatment. First tray contains: Iodine, alcohol 95 per cent., applicators, tourniquet (rubber tubing, 18 inches long), 1 specimen basin, adhesive plaster, scissors, 1 package sterile sponges, 1 vial of salvarsan, two fluid drachms of sodium hydroxid, 15 per cent.

Second tray contains: Two flasks of sterile normal saline, 1 hot, 1 cold; 2 sterile flasks, size 200-250 C.C.; 1 sterile graduated glass bottle with stopper, size 500 C.C.; 1 sterile medicine glass, 30 C.C.; 1 sterile medicine dropper; 1 sterile glass funnel; 1 sterile graduate, 500 C.C.; 1 pair sterile dressing forceps; 1 package sterile sponges; 1 package sterile towels (4).

Have sterilized in dressing pan one "record salvarsan syringe," size 20 C.C. Metal attachment (a two-way stop-cock and rubber tubing come with this syringe).

File neck of salvarsan vial and empty contents into graduated bottle. Add 30 C.C. of sterile water measuring from graduate, place stopper in bottle and shake until dissolved. (Salvarsan is a powder.)

Then add, drop by drop, 5 to 6 drops of 15 per cent. sodium hydroxid solution, which must be mixed thoroughly to clarify the solution. Add sterile water qs. ad. to make 100 C.C.

With the dressing forceps place the glass funnel in one of the empty flasks. Put one or two sterile sponges in the funnel and strain the solution. This may have to be repeated one or more times until there are no particles of powder in your graduate which have not dissolved. The solution

must be clear before being introduced into the system.

Rinse graduated bottle with sterile water and pour the clear, strained salvarsan back into it.

Draw the patient to one side of the bed as the doctor may direct, and put the near arm on the bedside table, which has been moved into position for the work. The table will contain a flask of normal saline and the salvarsan which has been prepared. The temperature of flasks should be at blood heat. The arm is in a supine position on a sterile towel. Paint an area of four square inches with iodine over the median cephalic vein. Put the tourniquet two or three inches above the elbow with enough constriction to throw the vein into prominence.

The syringe is then filled with saline and inserted into the vein. Constriction is removed. A strip of adhesive is put across the "butt" of the needle and on the arm to hold the needle firmly in place. Change from saline to salvarsan is made by means of the rubber tubing and the stop-cock regulates its flow, which is slow. Saline follows the prescribed dose of salvarsan. Place sterile sponges over the field of operation. Slight pressure is made over the puncture as the needle is removed, lest air be introduced into the vein.

These sponges are held in place by strips of adhesive (two are sufficient). Following the treatment the patient is kept quiet until no phenomena are noted. Rise of temperature, nausea, vomiting, headache, diarrhea, frequency of micturition, or exanthematous disturbances may be noted, or there may be no reaction. Initial and post treatment as ordered by the doctor in charge.

The nurse assisting the doctor need not "scrub up," as the sterile forceps enable her

to assist without a break in the "surgical technique" which prevails during the entire treatment.

If you are going to administer salvarsan immediately to another patient, have the doctor place the syringe and its attachments

in a sterile towel, after the needle used has been removed. A sterile needle is substituted in its stead. The solution is placed in a basin of water, temperature a little above blood heat, until the arm has been prepared as in previous case.

Complications in Scarlet Fever

MARY BAKER FENTON

AN uncomplicated case of scarlet fever may be tedious, long-drawn-out and unexciting, but when one has had the other kind, the kind with one or more complications, one learns to be thankful for the cases which run an even course toward "an uneventful recovery." To be sure, there is always the heightened joy in helping such patients fight a winning battle, but, preceding the final triumphant return to health, there may be long, tedious days and nights for the nurse and patient when the discouragements may often seem more numerous than the encouraging things.

Probably the most common complication is nephritis, often mild, but frequently serious. Be on the watch for albumen or blood in the urine. Be suspicious if the patient complains of headache or nausea. When this complication assumes a grave form one may expect drowsiness, deepening into coma with decrease in the amount of urine—sometimes complete suppression, sometimes convulsions.

Throat symptoms are nearly always prevalent to a greater or less extent. The glands around the jaw become enlarged, frequently are very painful and often suppurate. The inflammation may extend through the Eustachian tubes and result in inflammation of the middle ear. Perforation of the ear

drum, as the result of middle ear disease and, occasionally, mastoiditis, follow. Many cases of deafness can be traced to this cause.

Sloughing of the tissues surrounding the swollen glands may involve large blood vessels in the neck and cause fatal hemorrhage.

Swelling of the joints, often termed, "scarlatinal rheumatism," may occur, with cardiac involvement, as in acute articular rheumatism.

In the malignant form the patient from the outset seems overwhelmed with the poison and death may occur in a few days—even less time.

In mild cases the fever may never be above 101° F. or 102° F., and may quickly subside. These cases are apt to throw a family off guard, and nurses who have not had much experience with this class of cases, may easily be led to neglect some precaution that would be scrupulously attended to were the case more serious. One mild case may easily cause a dozen very serious cases.

Even when a patient is convalescent, pleurisy with effusion, pneumonia or pericarditis may occur. To be entrusted with the care of such cases is no slight responsibility, and in this disease a nurse needs to have her eyes always wide open for the first sign of an unfavorable development. Eternal vigilance is surely the price of safety.

Setting and Serving the Tray*

HELEN G. HARLAN

IN THE previous article we dealt with the actual setting of the tray. In serving strive for delicacy, neatness and attractiveness. Of course the above applies more to institutional work than to

tine, fruit or cranberry, into fancy shapes, and garnish with sprigs of parsley. Cones of cranberry jelly, made by inserting the tip of a teaspoon into the jelly and turning in the hand, garnished with sprigs of dark-



THROUGH COURTESY OF WOMAN'S HOME COMPANION

THE LUNCHEON TRAY MADE ATTRACTIVE BY A SINGLE ROSE

that in private homes, for in the latter naturally more and careful attention can be given to the service of one tray. Also, many attractive little details, such as flowers with each meal, etc., can be supplied here, while in most institutions such extravagances are utterly out of the question. However, with a little thought and ingenuity, very attractive as well as artistic trays can be served. Always use a garnish of some sort, either parsley, lettuce, cress or something of that nature. A little will go a long way when it is a matter of garnishing. For instance, serve snowy mashed potatoes on a leaf of lettuce, and note how refreshing is its appearance. Mould jellies, either gela-

green parsley, are exceedingly attractive. Mint jelly, colored with green vegetable paste, cut into cubes or moulded in some fancy shape, makes a desirable as well as appetizing addition to roast lamb or lamb chops.

With a French vegetable cutter, which can be procured at a cost of from ten to fifteen cents, many attractive forms of vegetables can be made. For example, potato balls the size of ordinary marbles, boiled and served with a thick cream sauce, through which chopped parsley has been sprinkled, are very appetizing. Again, spring carrots may be cut into cubes or stars, creamed, then served in a border, with a mound of peas in

*Continued from May number.

the center. White asparagus, served either with cream or plain butter sauce on toast, is always a welcome dish. Brussels sprouts, boiled and creamed, make a very pretty garnish for steak. Salads offer a large field for the display of one's ingenuity. Waldorf salad, that is, apple, celery and nut, served in red apple shells, is very pretty; orange, pineapple and banana salad, served in orange cups, is also very attractive. The so-called lily salad is one of the very prettiest made. On a lettuce leaf place in a circle strips of the whites of hard-cooked eggs, cut lengthwise to simulate the petals of a water lily. In the center place the yellow ball of the yolk, spread a spoonful of salad dressing over the yolk, and serve. This is an especially cool-looking and appetizing salad for warm weather.

Desserts also offer a big opportunity for variety in serving. Frozen desserts moulded in fancy shapes, or cut with different-shaped cutters and served with fresh fruit, are among the most pleasing. Halves of muskmelon or canteloupe served with a cone of ice-cream in the hollow appeal very pleasantly to most people. Watermelon is a fruit rarely served because of its clumsiness, but it is a useful fruit and should be utilized more than it is. If served in sherbet glasses, the pulp cut into small cubes or cones, etc.,

with shaved ice mixed through it, it is very refreshing, indeed, and is thus also in a form easily handled by most patients. Grapefruit is another valuable addition to most menus. It should be prepared, however, by removing all seeds, then by cutting each section of pulp free from the adhering tough fiber, and cutting through the core at the base, lifting out the entire mass of core and fibrous material. Sprinkle with powdered sugar, adding a teaspoonful or two of honey, or a bit of jelly, grape juice, etc., to add variety, then chill and serve.

Pineapple cut into crosswise slices, pared, then cut into wedge-shaped pieces and served on a plate with the pointed ends toward the center, where there is a mound of powdered sugar, is very attractive. Served in this way, each piece is supposed to be lifted with the fingers, dipped into the sugar and eaten.

These, then, are but a few of the many ways for pleasing and appetizing service, but they will illustrate in a small way to the inexperienced just how to obtain desirable results. The main points to remember, however, are neatness to an extreme degree and delicacy. With these two characteristics on which to build, no worker in dietetics can go very far wrong, and she will have had a considerable start on her way to success.

TESTED RECIPES

ORANGE PUDDING.—Grate rind of orange, put it into stew pan with 1 cup water, $\frac{1}{2}$ cup sugar, bring to boil. Beat 1 yolk of egg, squeeze into it the juice of 1 large orange, 1 tablespoonful lemon juice, 1 $\frac{1}{2}$ tablespoonful cornstarch, add to rind and water, and let boil thoroughly and then cool. Beat white of 1 egg stiff, add pinch of salt, tablespoonful of sugar, flavor with

lemon extract, stir lightly into cooled pudding (not beating), pour over diced oranges.

BANANA SALAD.—Cut a banana, without peeling, in half, lengthwise. Loosen the meat from the skin, divide into small sections and put it back into it, sprinkle with chopped walnuts and serve on a lettuce leaf with French dressing.

Cleanings

Efficiency in State Sanatoria

In the *Boston Medical and Surgical Journal* (September 3, 1914) W. C. Bailey and C. C. MacCorison give their experience in promoting the effectiveness of the treatment by a unique classification of patients and a careful tabulating of the results in the two classes into which the patients were divided. It was found in one State sanatorium, which was carefully studied, that "not only was there almost no cooperation on the part of the patients, but an actual systematized antagonism against the efforts of the physician was found to exist. To put an end to this condition of affairs a fundamental working scheme was evolved. The patients were to divide themselves into two voluntary classes. The first was to be called the "sanatorium class," and here would group themselves those patients who really wished to get well, who would cooperate with and aid the sanatorium management in every way, who would help others in the institution and who, when they left, would still keep up the fight and would get their societies and unions to study the problem and help to solve it. In the other class, to be called the "hospital class," were those who did not care particularly about their own health or that of others, who did not care to obey rules, who did not want to cooperate, but simply used the sanatorium as a boarding-house. They were told that the regime for the sanatorium class was to be a strict one, but that the results would prove that it was for their benefit, and that from time to time the gain of those in the sanatorium class over those in the hospital class would be tabulated and furnished to

the patients. The immediate results noted following the inauguration of this plan were a decrease in hemorrhages, pleurisies and fevers, with an attendant falling off in orders for medicine, special diets and raw eggs. There was also a marked decrease in the number of needless complaints and fault-findings; in short, there was established an *esprit de corps*. There followed week by week a marked increase in amount of weight gained, until the record for all the years has been surpassed by many hundred pounds."



"Dummy" Teats and Rubber Toys

The "dummy" teat has often been condemned as one of the alleged causes of adenoids, but this article, which is so familiar in households where there are babies, has now been adversely criticized from another point of view. The United States Government has issued an official publication of the Department of Hygiene, in which are recorded the results of the examination of a number of rubber teats, teething-rings and rubber toys, and it is evident that many of these articles which are on the market consist of rubber of decidedly objectionable character. Of thirteen varieties of rubber teats examined all contained iron and aluminum in appreciable quantities, while in nine of them antimony was found. The presence of antimony suggests that rubber scrap or recovered rubber is used in compounding the rubber from which the teats are made. Obviously the use of antimony rubber for the manufacture of rubber teats is highly undesirable, and it is not surprising that the Department of Hygiene condemns its use for this purpose,

and points out that these teats should be made of a good grade of black rubber, free from rubber scrap and recovered rubber. The same recommendation applies to rubber teething-rings and rubber toys.—*Exchange*.



Rules for Preventing Typhoid Fever

1. Keep away from all known or suspected cases of typhoid.
2. Wash hands thoroughly before meals. Do not use roller towels.
3. Use drinking water only from sources known to be pure, or if this is not possible, use water that has been purified by municipal filtration or by hypochlorite treatment or by boiling in the household.
4. Avoid bathing in polluted water.
5. Use pasteurized or boiled instead of raw milk.
6. Select and clean vegetables and berries that are to be eaten raw with the greatest care.
7. Avoid eating "fat" raw oysters and, in general, oysters and other shell-fish whose origin is not known.
8. Be vaccinated against typhoid in all cases in which any special exposure is known or feared.

For the community:

1. Insist on the hearty co-operation of all persons with an efficient health officer.
2. Require notification and a reasonable degree of isolation of every known or suspected typhoid case.
3. Exercise strict control over the disinfection of known typhoid excreta.
4. Insist on pure or purified water supplies.
5. Require pasteurization of milk supplies.
6. Regard all human excreta as possibly dangerous, and control their disposition in such a way as to prevent contamination of food or drink.—*E. O. Jordan, in Journal A. M. A.*

Prevention of Flat Foot

Gerson thinks that persons whose occupation compels them to stand much should take special pains to ward off flatfoot, and a simple and effectual means for this is to throw the weight of the foot more on the outer side of the foot. This relieves the tendons, ligaments and bones of the inner side, so that they retain their shape and elasticity, although the person may have to be on his feet all the time. The excessive use of the feet makes them perspire besides, and shoes or sandals should be worn which permit circulation of air. To keep the feet in slight supination he has an insole worn which is three-quarters of a centimeter high on the inner side, from the toes to the heel, and it slopes gradually toward the outside, where it is only an eighth of a centimeter. This slope answers the purpose, sparing the complicated mechanism of the arch of the foot and throwing the weight on the stout outer edge. The insoles cause no annoyance, but he advises to wear them only while at work and take them off at other times. They have been found a great help by clerks, bakers, waiters, porters, women in laundries, and hospital and other nurses; in short, for all obliged to be much on their feet. An actual support for the arch does harm rather than good when the foot is normal. It is merely a question of preventing overstraining of the arch.—*Berlin Notes in Journal American Medical Association*.



Antidotes for Carbolic Acid

A common antidote for carbolic acid is alcohol, but common cider vinegar is equally good and often more handy. Externally in full strength it restores the functions of the skin and removes soreness; internally, diluted one-half or two-thirds, it is to be slowly administered in teacup doses.—*Exchange*.

Editorially Speaking

Preparation for Private Nursing

The private nursing field is the field to which the great majority of graduate nurses expect to turn for employment when they leave the hospital. They will probably remain in this field at least till they acquire some experience, get their bearings and decide whether they wish to remain in this kind of work or to enter some other line of nursing. The private field has its compensations, its advantages and disadvantages. It affords a variety of experience. It leaves a nurse comparatively free to take a holiday between cases, at any time of the year, and *if* the nurse can keep busy the remuneration is fairly good.

The big word in the last sentence is *If*. The past year has been a hard one for many nurses and numerous letters of deep discouragement have come to us. It seems fitting at this time that we look fairly at the trend of sentiment and of general conditions as they affect the private nursing situation.

Is the average nurse as well fitted for work of a private duty nurse as she was fifteen or twenty years ago. Technically, she has had better training, but the gains in this direction are fairly over-balanced by losses in other ways.

Twenty years ago, or fifteen, the average patient counted on a period of convalescence *in* the hospital. Three weeks was an ordinary period for a clean laparotomy case, and these often extended beyond a month. After the exciting or critical stage was past, a nurse had her patient for a week or two during convalescence, when she had a chance to practise the art of companionship, and to learn how to keep her patients con-

tented and comfortable while they were regaining strength. Now we find similar cases hurried out of the hospital in a week, as soon as the critical stage has passed, to make room for another, who has again to be tidied over the operation and, when the exciting stage of the illness is over, sent home.

At the hospital convention in St. Paul last year Dr. Charles H. Mayo stated that of the approximately one thousand operations on the appendix and allied organs in the past year, the period in the hospital with which he is connected was barely one week. He comments on the saving thus effected for hospital and patient. Its effect on the training of nurses is another sort of problem which certainly calls for serious attention, and for some readjustments from the cast-iron standards which now exist in many States. How can such an experience properly fit a nurse for private duty?

When we consider that our hospitals are becoming to a large extent surgical hospitals; that in many hospitals little or no experience in special nursing is provided for pupil nurses; that graduates are called in for special cases; that the pupil nurse spends three years in dealing with acute cases, rarely carrying one through to complete convalescence, and that her calls to do surgical nursing in private homes are likely to be few in number after graduation—we cannot wonder that after graduation we find many nurses who do not fit well into private homes; who grow impatient with unexciting cases, and who have few resources in themselves to meet the demands of a protracted convalescence.

To offset in part these disadvantages of

training under the high-pressure system which now exists in hospitals, we find, here and there, schools sending out probationers to accompany visiting nurses; that they may get some idea of home conditions among the poor; or sending out pupil-nurses to assist at births in homes of dispensary patients. All this is good. It should be made a part of the training of every nurse, but it does not sufficiently prepare a nurse for private duty and we know it. To visit a poor patient in his humble home is an entirely different proposition from catering to the needs and desires of a well-to-do patient at \$25 to \$35 a week and upwards, surrounded by anxious relatives and friends.

To assist a poor mother through the perils of childbirth for charity is good experience for a nurse, but to share the life of a family for two or three weeks or longer, living with it day and night, is a different experience. To say that the one adequately fits for the other is to dodge responsibility.

HOW CAN WE BETTER PREPARE NURSES FOR PRIVATE DUTY?

We have stated the problem as it exists, especially in larger cities, but it is easier to state the problem than to find a workable solution. The biggest part of the problem is that comparatively few private duty nurses will admit that they are not well prepared for private duty. If they are idle they will lay the blame on the hospitals for the number of nurses they are sending out, or on some other reason, but they are ready to oppose any effort the hospitals might make toward giving them the experience in homes—the *training* under the conditions which they will have to meet. They see one side of the problem—they refuse to see both sides.

Not one nurse in twenty expects to become an operating-room nurse, yet we religiously, yes, even fanatically, adhere to the notion that every nurse ought to be trained for a couple of months in an operat-

ing room. Fifteen out of twenty nurses will turn at once to the private nursing field to find employment after graduation—most of them to remain in it indefinitely; yet we refuse to allow them to have one week's experience and training in private nursing before graduation.

How far should a hospital be expected to prepare nurses for special lines of work, is a question well worth discussing. May we reasonably ask a hospital school to afford some experience in the three great divisions of the nursing field—institutional work (including operating room training), visiting nursing and private nursing?

We leave this question with our readers. We hope there may be a good many expressions of opinion in the "Letter-Box" regarding the matter of how we may better prepare our nurses for private duty.



The Tuberculosis Nurse

Writing in the *Journal of the Outdoor Life* on the subject of publicity, Mr. Walter D. Thurber, executive secretary of the Indiana Society for the Prevention of Tuberculosis, mentions the visiting nurse as one of the greatest publicity agents in the field. He says: "Newspaper publicity, while the most powerful, is only one of many publicity agencies used in Indiana. The visiting nurse, as found now in nearly a score of Indiana communities, is a publicity agent and, therefore, an educational medium. As she makes her visits, she preaches '*Prevention*.' She teaches the patient how to live; the patient teaches the family; the family teaches the neighbors, and the neighbors teach their friends. Very often the nurse, as a part of her work and through the cooperation of school authorities, teaches the prevention of tuberculosis in the schools of her community—another channel for good publicity."

In the same journal Dr. George Thomas Palmer, president of the Illinois Association

for the Prevention of Tuberculosis, calls attention to the fact that "manifold agencies engaged in anti-tuberculosis education are working at cross-purposes, and not infrequently they are firing volleys that cripple their own allies. There is an immense amount of incoordination and lost motion. There is lack of concentration with loss of labor, loss of money and loss of time. What are we going to do about it? Before our educational campaign can reach the limit of its effectiveness, we must agree among ourselves what things are undeniably true about tuberculosis and what things it is essential for the public to know.

"As we look back," he continues, "we recognize that our greatest and most serious errors have been errors in education.

"It is unnecessary to remind practical tuberculosis workers of these mistakes—of the unreasoning phthisispholia created by our too lurid teaching of the infectiousness of the disease; of disappointment and discouragement born of our excessive optimism; of the mistakes in our overstuffing with milk and eggs. The battle-field in our war against tuberculosis is dotted with the mangled remains of commonly taught notions which could not stand up against the machine guns of experience and truth. It must be borne in mind, incidentally, that when we abandon a once-popularized idea the people lose faith."

Of the truth of these remarks, and the need of sounding the note of caution, and the necessity of a general agreement on what shall be taught, there is little room for doubt.

Dr. Palmer has touched on a tremendously important point when he says: "The embarrassing and very important question which now arises is: What are the 'accepted truths' about tuberculosis? Are the various agencies now engaged in the work teaching a uniform doctrine, or is the public mind being confused by contradictory or seemingly contradictory instructions?"

We would greatly appreciate having our

readers' opinions on the questions raised in the last paragraph.



The Program of the Hospital Convention

Before the lamented death of Dr. William O. Mann the program for the convention at San Francisco, which will be found in the hospital section of this number, was practically complete. It will make a notable volume when the papers promised come to be added to hospital literature.

Every phase of hospital work, apparently, has been considered and given its due place in the making of the program. Papers which promise to be of special interest are indicated by the following: "Method of Rating Professional Men for Hospital Appointments, for Promotion and for Hospital Reports," by Dr. R. L. Dickinson, of Brooklyn, N. Y.; "The Need of Pay Clinics for Persons with Incomes from \$900 to \$3,000," by Dr. Richard Cabot, of Boston. "Little Things Which Are Big Things in Hospital Management," by Dr. Robert J. Wilson, New York. "The Effect of Legislation Upon the Schools for Nurses in California," by Miss Anne C. Jamme, Sacramento. "Progress in Nursing," by Miss Harriet Leck, principal of Grace Hospital Training School, Detroit. "Correlation of Hospital Diet," by Miss Grace McCulloch, Boston. "High Ideals in Nursing," Mrs. Alice H. Flash, Boston. "Interdependence Between Hospital and Outside Work," by Richards M. Bradley, Boston.

The committee on non-commercial exhibits is actively at work endeavoring to make the exhibit one of the best the association has ever been able to assemble. Those who have in their institutions anything which is not likely to be in general use which they would be willing to contribute are requested to communicate with the chairman of this committee, Miss Lydia Keller, Northfield, Minn.

The Hospital Review

CONDUCTED BY CHARLOTTE A. AIKENS

Items of interest, annual reports, publicity literature, and material descriptive of newer methods and plans in any department of hospital work, should be sent to the editor of this department, at 722 Sheridan Ave., Detroit

Purchasing, Storing and Distribution of Hospital Supplies

ALBERT H. WILKINSON, M.D.

Assistant Superintendent of the House of Relief
(Branch of the New York Hospital)

Successful purchasing of supplies implies far more than the mere buying at the lowest price. The majority of supplies today are standardized, both in regard to quality and price. The definite and thorough knowledge of the uses to which the article purchased is to be put, and then the buying of a suitable article to fulfill them, requires more skill with better knowledge and judgment, and presents a wider and better field for economy, than the mere bargaining over prices. For instance, in the buying of vegetables the purchaser should be thoroughly conversant with market prices, so as to be able to buy advantageously the things that are in season and are therefore cheap. Far more can be saved by buying at the proper time, knowing that the article purchased is then cheapest, not in purchase price especially, but in amount of "work done," coupled with careful distribution and use, than in the small amounts gained by buying at under-standard prices, with the danger of receiving sub-standard goods.

Over-stocking is a greater evil than under-stocking. Over-stocking tends to create a liberality in use which in itself over-balances the discount obtained through large purchases. The supply should be moderate, that is, sufficient to meet all ordinary demands. The purchases should be made in sufficient quantities, as far as possible, to

secure wholesale prices, but never to the point of over-stocking to secure a special price. This is usually of small importance compared with the waste created by the subsequent liberality of use, or the discontinuance of use of this particular article before the supply has been exhausted—the shelves of hospital store-rooms are littered with articles which have become antiquated. Quality should never be sacrificed for mere cheapness, as the cheaper article is almost invariably more expensive in the end, due either to waste in its use or a shortened period of usefulness. The other extreme, the buying of fancy, over-priced products, is to be as carefully avoided. It is better to deal with a few reliable dealers than many, as competition is maintained and at the same time your trade is of sufficient amount to be sought for, and the dealers take a pride in serving you well. Much also can be learned from salesmen, as they are specialists in their line.

Everything purchased should be recorded with price, name of dealer, amount and date. All orders should be made out in triplicate form—one white, one yellow and one pink slip—and sent to the superintendent for approval. The white slip goes to the dealer through the purchaser and is his (dealer's) order for delivery of the goods. The pink slip is sent to the storekeeper, with which to check the goods on their arrival, while the yellow slip remains in the superintendent's office. When the bill arrives it is sent to the storekeeper to O. K., as regards quantity and quality. Prices and terms are then

approved by the purchasing agent, and the bill is now sent to the superintendent, provided some one else did the purchasing, for his approval for payment. A record of each purchase is kept in the superintendent's office, usually by a card system, showing amount purchased, date, dealer's name, date of the arrival of the goods, and the payment of the bill. This should be cross indexed, so one can readily ascertain the amount of a certain article purchased and also where purchased. Substantial savings can usually be made by discounting bills.

The supplies are now in the hospital, checked as to quality, quantity, terms and price. They should be kept in a store-room centrally located and with an honest, competent man in charge, unless the hospital is small and does not require the services of a storekeeper. This store-room should be equipped with refrigerators for the keeping of meats, etc., and be kept in a clean and sanitary manner. The storekeeper should have a knowledge of stock on hand, so as to be able to advise purchases, and, above all, he should be honest, thoroughly awake and active, for he is one of the vital centers in hospital economy.

All supplies are delivered only on requisition, properly made out and approved, and, where possible, the worn-out article should be returned for exchange; this will act as a curb on the dishonesty or generosity of employees. These requisitions should be made in book form—a plain, cheap memorandum book answers the purpose. The requisitions should be signed by the superintendent and, by having them in book form, he can readily refer to the previous requisitions and thus check extravagances and keep the heads of the different departments informed as to their economy or *vice versa*, as the case may be. Everything possible should be marked so it cannot be taken from the department to which it has been issued. The date of issue stamped on the article is also useful in determining the durability of the same. In-

ventory can be taken at any time, as the amounts distributed are shown by the requisition books and the amount purchased by the main office records, and the difference would give the amount in the store-room.

To summarize: Greater economies can be accomplished by:

1. Careful and skillful use of supplies.
 2. The purchasing of the cheapest article with reference to "work done" not to purchase price.
 3. Checking of extravagances and waste.
 4. Discounting bills,
- rather than the purchasing merely at an under-price, which ordinarily implies a sacrifice of quality.

✦

Fire Drills in Hospitals

That the question of fire drills in hospitals—their value, and the points to be emphasized—is one of real interest to hospital workers, is shown by its frequent appearance in question-box sessions at hospital conferences.

In England the National Fire Brigades Union has given some special study to the subject of fire drills in hospitals and has worked out a plan for such drills. They make two specific recommendations: "At large hospitals, it would be an advantage if a brigade were organized among the staff, and a resident member of the medical staff could be found able and willing to undertake the duties of chief officer. . . ." And ". . . In order to encourage the staff, competitions for smart handling of fire appliances should be held annually and small prizes awarded. The system would ensure a desire for constant drill in order to maintain efficiency." The Union's scheme provides examiners and awards certificates and badges to those candidates who pass the examination.

In the first hospital examined the matron, twelve nurses and six servants stood well the tests made by an officer in the National Fire

Brigades Union. Emphasis is placed on the necessity for periodical examinations by a central, outside, but recognized expert body, if the drills are to be serious and the efficiency maintained.

At a round table conference of superintendents and hospital workers of the Hospital Conference of New York, held at the New York Skin and Cancer Hospital in March, the question of methods of fire drill was discussed at some length.

Mr. Oliver Bartine, superintendent of the Hospital for Ruptured and Crippled, gave his experience as follows:

"At our hospital we have sets of rules printed and framed and hung in prominent places in the building. One set shows the different duties of each employee should the alarm be sounded. I urge the necessity of fire drills and that each employee should be coached as to what to do should the alarm be sounded. The last fire drill I gave was two weeks ago. A general alarm was sent in from one of the floors. It was received in the office, from the office it was sent to the basement, first and second floors, but not to any of the floors occupied by patients, and in forty-five seconds after the alarm had been sounded the hose was playing on the third floor. At one time Commissioner Ross, a friend of mine, and chief of the fire instruction department, asked me to come with him when they were going to sound several alarms. We started out at 8.30, and selected a room in the Hotel Astor for operation. An alarm was sent in and in forty-eight seconds after, they had the extinguisher playing on the room. Instructions should be specific and general talks should be given to employees, information regarding the whereabouts of fire apparatus should be conspicuous so that nurses and employees should know them. Our staff responds readily to fire drills. Fire extinguishers are very good. At the Children's Hospital an alarm of fire was sent in at two o'clock in the morning. A fire had broken

out in the laundry of the old building. A blaze was playing entirely up one side of the building, and, through the aid of extinguishers before the fire department had reached the place, the fire was out. I should like to hear of the personal experiences of others on this subject."

The question was asked Mr. Bartine: "Do fire drills disturb the patients and how often should they be called?" Answer—Twice a week. Often patients are moved on banana carts all over the building and some institutions that have fire drills even go so far as to move the patients on these carts. If the fire alarm is sounded in one part of the building the patients are moved to another. At one time at a fire a woman patient crouched up in a corner and it was almost impossible to move her out of it. A fire drill should be called at odd times on an average of twice a month, but sometimes I have called them twice in one week. On one occasion I went so far as to have a barrel filled with old rags and soaked with an inflammable substance, set it afire and sent in an alarm. It did its work well; two of the most valuable employees I thought I had, fell down. It was a practical way of demonstrating where our weak points were and who needed coaching. In answer to the question, "How do you avoid panic?" Mr. Bartine replied: "By being careful, having careful employees, and having them so instructed. My nurses are taught to keep patients away from windows, doors, etc., when an alarm of fire is sent in. The great thing is that all should play their parts, but the superintendent must shoulder a great deal of the responsibility. The engineer is of great assistance. About eight or ten weeks ago, on sending in an alarm, it was my matron who came to the front on account of her experience in other fires. Many engineers understand the importance of fire drills and that everybody must play his part. But each must have specific rules and responsibility and all instructions must be conspicuously placed on cards. Another

card must have the location of fire apparatus. Use extinguishers wherever possible."

Another speaker cited an experience when at the Bushwick Hospital in Brooklyn, several years ago, they had a fire at the time a surgeon was operating on a patient. An alarm was sent in, and even though no fire drills had been held the nurses and two orderlies came to the front and only three patients knew that there was a fire in the house.



The Twilight Sleep

The so-called twilight sleep continues to be the subject of much discussion in medical circles and also in hospitals in larger cities, and most contradictory reports are given regarding it. At a clinical congress, held under the auspices of the Chicago Medical Society in January, 1915, Drs. John Osborn Polak, of Brooklyn, and Dr. W. Francis Wakefield gave most favorable accounts of its use in a series of selected cases, under carefully arranged conditions and with a thoroughly trained staff of assistants. Dr. J. B. De Lee was opposed to broadening its use for general practice.

Dr. Lester E. Frankenthal and Dr. Joseph L. Baer related their experience with the method in thirty-nine cases at the Michael Reese Hospital, and from the standpoint of interpretation as given by Kronig and Gauss there was no success in 4 primiparæ and 9 multiparæ; very little success in 4 multiparæ and 1 multipara; partial success in 4 primiparæ and 3 multiparæ; fair success in 4 primiparæ and no multiparæ; good success in 5 primiparæ and 2 multiparæ, and complete success in 1 primipara and 2 multiparæ.

It is stated that the Michael Reese Hospital, as a result of over forty tests under conditions exactly as prescribed in the Freiburg method, has announced that hereafter, only on condition of a written statement from the mother absolving the hospital from all responsibility for injury to herself and

child will the "twilight sleep" method be permitted.



Information Asked For

Mr. J. H. Parke, superintendent of Montreal General Hospital, is very anxious to secure information in regard to nursing arrangements in the following particulars. We would be glad to have a number of letters in reply to these questions. Especially, please reply to the question in regard to the number of nurses and patients in wards—large or small—also in private rooms.

How many nurses do you allot to your

	Nurses	Patients
Medical wards, day duty?		
Medical wards, night duty?		
Surgical wards, day duty?		
Surgical wards, night duty?		
Operating room?		

How many graduate nurses have you in your operating room?

Average operations per diem?

How many graduate nurses have you in charge of wards?

Have you any undergraduate nurses taking individual care of private patients; also do you charge the private patients for this attendance and at what rate?

N. B.—It is not necessary to give the number allotted to all your wards, but a standard ward of, say, 25 to 30 beds, or whatever your standard ward is.



The Hospital Convention

Dr. H. A. Boyce, secretary American Hospital Association, sends the following word to members and friends of the Association in regard to the coming convention in San Francisco. There are great opportunities for benefits to the superintendent who attends this meeting.

First—To himself:

1. Meeting other men (exchanging experiences in similar lines).

2. Hearing and meeting big men (comprehensive reports on big topics).
3. Inspiration and fresh energy (getting out of the rut).
4. Learning relations of results to efforts
 - (a) How to analyze and improve methods.
 - (b) Value and use of records.
5. Getting himself known (has a chance to speak if he desires).

Second—To his hospital:

Getting

- (a) Information about other hospitals.
- (b) Information about relation of costs to work done.
- (c) Inside information as to the best methods of promotion of economy and efficiency in hospital management.
- (d) Establishing connections with sources of further information through correspondence to solve old and new problems.
- (e) Getting chance to vote on matters for the benefit of his hospital.

Third—To his profession:

1. Raising the standard of profession.
2. Increasing personal efficiency.
3. Helping the weaker brother by giving information.
4. Educating public to hospital standards.

In view of the fact that these opportunities come but seldom, it is plainly the duty and privilege of every hospital superintendent to attend the San Francisco Convention.

In view of the fact that the hospitals will benefit by the superintendent's attendance at the convention, it is the duty of the hospital to pay his expenses.

The following preliminary program is the result of the efforts of the late Dr. William O. Mann. It is doubtless the best that has been prepared for this Association. In fact, so important are the subjects discussed that no hospital worker can afford to miss this meeting.

PROGRAM

Tuesday, June 22, 1915—Morning Session, 9.30 A.M.—Invocation, Address of Welcome. President's Address, Dr. A. B. Ancker, first vice-president, superintendent City and County Hospital, St. Paul, Minn. Report of Committee on Inspection, Classification and Standardization of Hospitals, Dr. John A. Hornsby, editor *Modern Hospital*. Report of Committee on Medical Organization and Medical Education, Dr. Joseph B. Howland, assistant administrator, Massachusetts General Hospital. List and Nomenclature of Diseases and System of Filing in Use at California Hospital, James L. Whitney, M.D., University of California Hospital, San Francisco, Cal.

Tuesday, June 22—Afternoon Session, 2.30 P.M.—The Effect of Legislation upon the Schools for Nurses in California, Miss Anna C. Jamme, secretary Board of Registration of Nurses, Sacramento, Cal. The Eight-Hour Law, Its Present and Its Future, Miss Anne A. Williamson, R.N., superintendent of nurses, California Hospital, Los Angeles, Cal. High Ideals in Nursing, Mrs. Alice H. Flash, superintendent of nurses, Massachusetts Homœopathic Hospital, Boston, Mass. Progress in Nursing, Miss Harriet Leck, principal Grace Hospital Training School for Nurses, Detroit, Mich. Report of the Committee to Consider the Grading and Classification of Nurses, Miss Charlotte A. Aikens, chairman, editor *TRAINED NURSE AND HOSPITAL REVIEW*, Detroit, Mich. Report of Committee on Hospital Finance and Cost Accounting, Miss Lucia L. Jaquith, superintendent Memorial Hospital, Worcester, Mass. Correlation of Hospital Diet, Miss Grace McCulloch, dietitian, Peter Bent Brigham Hospital, Boston, Mass.

Wednesday, June 23—Morning Session, 10 A.M.—Method of Rating Professional Men for Hospital Appointments, for Promotion and for Hospital Reports, Robert L. Dickinson, M.D., Brooklyn, N. Y. Little

Things That Are Big Things in Hospital Management, Robert J. Wilson, director Health Department Hospital, New York City. The Hospital Superintendent and the Architect, Mr. Warren C. Hill, Architect, Kendall, Taylor Company, Boston, Mass. Some Apparently Accepted Hospital Units, Henry M. Pollock, M.D., superintendent, Norwich State Hospital, Norwich, Conn. Question Box.

Wednesday, June 23—Afternoon Session, 2.30 P.M.—Joint meeting of American Hospital Association, with American Nurses' Association at Greek Theatre, Berkeley, Cal.

Wednesday, June 23—Evening Session, 8 P.M.—Modern Hospital Illumination, David Crownfield, Pettingill, Andrews Co., Boston, Mass. The Possibilities of Future Development in the Service Rendered by a Hospital to the Community, A. R. Warner, M.D., superintendent Lakeside Hospital, Cleveland, Ohio. State Aid to Private Charitable Institutions, W. H. Walsh, M.D., medical superintendent, the Children's Hospital, Philadelphia, Pa. Where Should the Housekeeper for the Small Hospital Be Taught and Where Trained, Emma A. Anderson, superintendent New England Baptist Hospital, Boston. Where Should Hospital Dietitians or Dietitian Housekeepers Be Taught and How Trained, Laura E. Coleman, superintendent, Homœopathic Hospital, Buffalo, N. Y. The Relation of a Children's Department in a Teaching Hospital to Children's Institutions of the City or State, William P. Lucas, M.D., professor of pediatrics, University of California, San Francisco, Cal.

Thursday, June 24. Morning Session, 10 A.M.—The Question of Efficiency and Simplicity in Hospital Records, Edward Martin, M.D., Professor of Surgery, University of Pennsylvania, Philadelphia, Pa. Clinical Records in Relation to Teaching and Research: A New Plan to Promote Con-

servation and Utilization of Material. Eugene S. Kilgore, M.D., Instructor of Medicine, University of California Hospital, San Francisco, Cal. Heating, Ventilating and Power Plants of Hospitals, Mr. Dwight D. Kimball, consulting engineer; president, American Society of Heating and Ventilating Engineers; Member of New York State Commission on Ventilation, New York City. Discussion by Mr. O. H. Bartine, superintendent Hospital for Ruptured and Crippled, New York City. For the Greater Success of the Hospital, George L. Perusse, M.D., superintendent Michael Reese Hospital, Chicago, Ill. Efficiency and Progress in Hospitals, Mr. Howell Wright, superintendent City Hospital, Cleveland, Ohio. Report of Committee on Hospital Information, Dr. Winford H. Smith, superintendent Johns Hopkins Hospital, Baltimore, Md.

Thursday, June 24—Afternoon Session, 2 P.M.—The Building of the Hospital; Construction. Mr. Oliver H. Bartine, superintendent Hospital for Ruptured and Crippled, New York City. Discussion by Mr. Dwight W. Kimball, consulting engineer; president American Society of Heating and Ventilating Engineers; member of New York State Commission of Ventilation, New York City. Medical and Surgical Efficiency in General Hospitals, Frederic A. Washburn, M.D., administrator, Massachusetts General Hospital, Boston, Mass. Engine-Room Economics, Thomas Howell, superintendent New York Hospital, New York City. Mr. Phillip Murray, engineer, New York Hospital, New York City. Contemporary Mistakes in Hospital Construction, John A. Hornsby, M.D., editor *Modern Hospital*, Chicago, Ill. Report of Committee on Constitution and By-Laws, Mr. Richard P. Borden, chairman, Fall River, Mass. The Company Hospital, R. W. Corwin, M.D., Minnequa Hospital, Pueblo, Col.

(Continued in Advertising Section)

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

The Visiting Nurse

To the Editor of The Trained Nurse:

I wish to reply to Carrie Ball's letter about the visiting nurse in a small town. Having engaged in both private and district nursing in small communities, I feel I can look at the question from both sides. Whether doing private, visiting or hospital nursing, our attitude toward each other should be that of loyalty, and helpfulness, for are we not all working for the one and same end? Nurses in these three branches of the profession must cooperate. It is not unusual for a visiting nurse to advise a family to obtain a graduate nurse; if it is within its means and the patient's condition demands constant care. In other cases it may seem best to urge the patient to go to a hospital.

Having had the privilege of attending local and State medical meetings, I cannot conceive that any broad-minded physician could say that a visiting nurse, no matter how poor the nurse might be, could be a detriment to the community. The physician who made the remark must have been thinking of medicine and nursing as mercenary occupations. He certainly could not have been looking at the work from a humanitarian standpoint.

Has not a family, regardless of its circumstances, the right to employ the district nurse, if by her making one or two calls a day it is able to manage the rest of the time, with such help as relatives or friends can give? The district nurse is not for the poor alone; she is for the whole community and would be better called a public health nurse. Let us look at the family from the social standpoint. How many nurses take this viewpoint when they enter a home? Suppose the family consists of father, mother and three children. The husband earns \$100 a month. This must cover rent, food, shoes, clothing, insurance, dentistry, etc. How can this man, with the economic situation as it is today, hire a graduate nurse? Of course he will find a way, if it means life or death to his loved ones. This is a family which all district nursing associations wish to reach, and it can be done by hourly nursing.

There is in Brattleboro, Vt., an organization which supplies the people, in times of sickness, with exactly what they need. Through this organization one may obtain a graduate nurse, an attendant under the supervision of a graduate nurse, a visiting nurse, school nurse or social worker. Cannot other communities have such an organization? If such an association could be had in each city or town the long gap between the visiting nurse and the graduate nurse doing private nursing would be filled. The rules and regulations of visiting nursing associations are similar, and since they are too long to quote here I will be very glad to send copies of the rules of this organization to any one wishing them.

Getting the patient well is only half of the visiting nurse's work; she must teach him how to keep well. She must not only consider the sick individual, but remembering that he belongs to the family, she must deal with the whole family.

This nurse referred to in Miss Ball's letter was spoken of as a *young* graduate. It is unfortunate that a visiting nurse be young (I take young as meaning under twenty-five), as the work demands the judgment and experience of an older person. This is especially necessary if she is starting the work in a community. This young graduate may know how to give a bath, as well as a nurse well trained in social work and visiting nursing, but district nursing no longer consists of just the actual bedside care. The community at the mercy of a nurse inexperienced in other phases of the work, except actual bedside care, has my sympathy. Experience gained at this cost to others is not necessary, for there are, to my knowledge, four associations giving post-graduate courses in social work and visiting nursing; some of which grant free scholarships, and if this is not within reach of any nurse who wishes to do district work, she may usually find the opportunity of gaining experience by substituting on a large staff of visiting nurses for a few months. In this particular case the nurse is no more at fault than the organization which hired her. They could have obtained help from the National Organization of Public Health Nursing, in the form of

literature, personal advice and assistance, if so desired.

The visiting nurse in any town may take care of a few cases of slight illness which, if she had not been available, would have gone to the graduate nurse; but how many obstetrical cases of the poor people has the graduate nurse, doing private duty work, attended? These were never thought of. The average district nurse's work in a small community will be probably six-tenths of the poor class, three and one-half tenths middle class and one-half of a tenth of well-to-do. Remembering that our high purpose is the same, let us, whether visiting, hospital or private-duty nurse, work shoulder to shoulder for the betterment of the community.

M. B. S., R.N.



Male Nursing in the East

To the Editor of The Trained Nurse:

In answer to a request in the March issue of *THE TRAINED NURSE*, I shall try to give an exposition of "Male Nursing in the East," as experience and study has shown me.

When the desire to study nursing entered my mind, I naturally sought out information as to a place where such training could be secured. I addressed letters of inquiry, not of application, to the superintendents of several hospitals in my native State of Massachusetts. In the answers to my letters little direct information could I receive and no hospital management would commit itself, and particularly for training for a male nurse. In no hospital would I receive the appellation of male nurse; ward tender, attendant or orderly would be the name. However, after re-reading the applications of the various hospitals which accompanied the replies to my letters, I found a clause in the application of the Boston City Hospital, which said it would give a diploma as "male nurse" to an "orderly" who completed two years' satisfactory work, both practical and class work, in that institution.

I entered its training school for orderlies and have found it a training in all respects equal to that of the female nurses—the only exceptions being obstetrics, gynecology and contagious disease nursing. A regular course in medical and surgical nursing is given, also anatomy, physiology, materia medica, dietetics, sanitation and hygiene, lectures on special diseases and their care, "Ethics," "Urinalysis," "Bacteriology," "Care of Babies," "Instruments and Their Use" and "Splints and Their Use."

All work is marked and graded, and the seniority system is used in this hospital. The older the

orderly in his training the more responsible his position. He is expected not only to take the prescribed classes and ward experience, but also to take a State Board preparatory course and present himself for registration. This he does in his senior year. The result has been a large per cent. of our graduates are registered. After the two years' course of study is finished and the orderly has shown a satisfactory rank and record a diploma as "male nurse" is given. Many of the graduates remain at a salary of fifty dollars per month and living, which is, I believe, the highest salary paid any graduates, outside of especial positions, in any State in this country. Those graduates who do not care to remain at institutional work may go into private nursing and most of them go into male nurse clubs and are kept constantly busy. They also conduct their own registries at these clubs, as the Massachusetts registries for nurses do not quite fully appreciate the economic value of male nurses.

Our own graduates are employed by the hospital for "special" private or especial cases in the hospital. No female nurses, either graduate or under-graduate, care for male patients in the Boston City Hospital, except to make beds, give medicines, register pulse, respiration and temperature records and write orders. These duties, however, are performed by the orderlies, also.

The free time of the orderly is limited. Most all Eastern hospitals have a twelve-hour day, and the free time allowed is one afternoon a week, possibly one to one hour and a half on one evening a week, also some free time on Sunday.

Recently in Boston there has been organized a Guild of Male Nurses, and a Young Men's Christian Association Nurses' Club, both of which include in their membership graduates and under-graduates of hospitals throughout this State, which conduct training schools. These, however, are not many and the recognized list for Massachusetts is the Boston City Hospital, which is the largest; the Carney Hospital, the McLean Hospital, the Worcester City Hospital, the St. Vincent's Hospital, Worcester and the Taunton State Hospital. These associations are for the benefit of mutual help and social service. Other States in New England have representative hospitals and some graduate and undergraduate male nurses, but their number is so small it is impossible to give any information regarding them or the work accomplished by their graduates. An idea is often conveyed that the male nurse is called only upon such cases as alcoholism, genito-urinary diseases, mental diseases and for the care of drug users. This, too, is a mistaken idea; our

graduates and all others in the male nurses' clubs here find the majority of their cases general ones. The standard wage for a male nurse in this State is thirty-five dollars per week.

Yesterday saw the male nurse in very few numbers and the profession, one at which many a man would look askance, so severe its criticism. Today sees it an honorable one, an economic necessity, a value to the outcasts of society and State, a monument of self-sacrifice, struggle and persistence. Today in Massachusetts we stand respected, both by the public and its officials, and that world of which we are a unit and in which we are a factor.

DAVID H. GIBSON, R.N.,
Boston City Hospital.



The Correspondence School Nurse

To the Editor of The Trained Nurse:

From time to time letters appear in the magazine complaining of the menace of the correspondence school nurse. We hear that thousands of them have been graduated, we see the alluring advertisements before us, and we presume that such advertising must be bringing results or it would not be continued. We hear and see a lot about the correspondence school nurse, yet how many do we actually know personally?

In the eight years or more that I have lived in this city I have never met one. I have asked different doctors if any had ever applied to them for work. They said none ever had.

One home nursing association in about a year and a half has received applications from about three hundred women, yet among the three hundred there were but two correspondence school nurses. The superintendent told me that these knew nothing practical, and could not even read a thermometer.

In the South last winter I questioned nurses in two different States; none of them had ever met one. I recently talked with a nurse who has spent some years in California, and who has worked, also, in Pennsylvania and Ohio; she, too, thought they were a terrible problem, but had never seen one. I do not say that they do not exist. Having seen their pictures in the *Ladies' Home Journal* and other magazines, I am willing to admit their existence. But if they are graduated in such quantities as pictured, then they must either sail under false colors after they receive their diplomas, deny their school and assume to be regular graduate nurses, or else they find themselves so incapable that they do not

attempt to practise, for otherwise we should certainly come across them more frequently. May it not be that we are allowing the correspondence nurse to absorb our thoughts to a degree entirely out of proportion to the real menace of the case, and failing to put forth efforts in our own localities, so that there will be no need of women paying high fees for a correspondence course?

ONE WHO WANTS TO BE SHOWN.



The Correspondence School

To the Editor of The Trained Nurse:

May I have space to answer the letter of Ida Fletcher, R.N., which appeared in April "Letter-Box," regarding physicians and registered nurses giving their support to the correspondence school and its interests. I would say to Miss Fletcher that I do not believe that any reputable physician or any registered nurse would *knowingly* give their support to such schools. If they seem to do so, it is because they are deceived. "For ways that are dark and for tricks that are vain" the correspondence school is a close second to the "Heathen Chinee," and one may become involved with its interests without knowing it. I speak feelingly on this subject, as I am one of those who have been deceived. In my opinion the hospital graduate nurse has handled the matter of the correspondence school very badly. She has talked too much, and done too little. Recently I have been disgusted to see graduate nurses getting into newspaper controversy with the correspondence school, for that is just playing into its hands and giving it the thing it lives on—advertising.

A VICTIM.



Practical Suggestions

To the Editor of The Trained Nurse:

In private practice we know the nurse's ingenuity is often taxed to use available material in lieu of hospital equipment. The following very simple hints might be useful:

A washboard proves an excellent and easily adjustable back-rest, and that it can be readily removed is another advantage. A pillow placed perpendicularly against the head of the bed prevents marring the bedstead and also slipping of the washboard, which is placed against the pillow at any desired angle. Pillows are arranged against the board for the patient's comfort.

A fairly comfortable douche-pan can be improvised with a number of magazines or newspapers

and a basin or other vessel rightly arranged under the patient.

To give an inhalation, take a paper bag large enough to cover the pitcher used. Turn inward about an inch of its edge and tear an opening in one end of the bottom of the bag, which opening is at the mouth of the pitcher when the bag is applied. By wrapping a towel around the base no steam escapes, except through the vent at the top.

A soap box with the sides knocked out makes a bed-table.

Puddings can be baked on top of the stove or gas range, and custards are equally satisfactory, with the exception of the "golden brown" top. Place the *covered* bowl of pudding or custard into a saucepan of boiling water upon a rest to raise it an inch or two, and cover the saucepan. I was fortunate to find an old flatiron rest about an inch high to elevate the bowl; the "rest" will suggest itself with the material in view. The saucepan should be about four or five inches greater in diameter than the bowl; the sides and bottom of the bowl are then surrounded by boiling water.

ELIZABETH HUDSON.



Can You Help This Sister-Nurse

To the Editor of The Trained Nurse:

It is with great approval that I have read your remarks on "Wanted—Sensible Women." They are surely needed and yet there is such a thing as overlooking them, because as a rule they go

about their work without much fussing and just do what comes to them as a matter of fact. You ask to be put in touch with them; well, here I am. Will you take notice of me? I have been trained in Germany, have been actively engaged in nursing work for the better part of thirty years, and I would be glad to get in touch with some kind of responsible position, so that I can again feel I am really and truly doing some real work. With a little money that I had earned I began a small hospital in a North Dakota town, which was needed and for which people greatly clamored before they had it. But when it was there it was a different matter. After three years of hard work it had to be given up and I lost everything. Private work here is not a paying proposition; one nurse can hardly make her living, and when the little that is here has to be divided between two, why it simply cannot be done. I have formerly filled positions of trust, have worked as a missionary nurse in the foreign field and have done school as well as social work in my early days in Germany. I would be so thankful if by any chance some one could put me in touch with some form of social work. The doctors here in town can give references and also the business men and clergymen. You cannot imagine what the last ten months since closing the hospital have been to me. God has given me good health and therefore I ought to be able to find some corner which He wishes me to fill.

LYDIA K. SCHWARZE,
Casselton, N. D.



NURSES AND AMBULANCE MEN FOR THE WAR ZONE

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

American Nurses' Association

The eighteenth annual meeting of the American Nurses' Association will be held in San Francisco, June 20 to 26, 1915. Headquarters, Hotel Clift. For information in regard to direct trip, apply to chairman of the transportation committee, Mrs. C. V. Twiss, 419 West 144th Street, New York City.

The ticket for nomination of officers as officially announced is as follows: President, Anne W. Goodrich, New York City; second nomination from the floor. First vice-president, Adda Eldredge, Chicago, Ill.; Elizabeth P. Cocke, Bon Air, Va.; second vice-president, Agnes G. Deans, Detroit, Mich.; Retta Johnson, Brenham, Texas; secretary, Katharine De Witt, Rochester, N. Y.; Mary S. Sims, Bryn Mawr, Pa.; treasurer, Mrs. C. V. Twiss, New York City; second nomination from the floor.



War Nurses

Helen B. Cook left Atlantic City, N. J., on April 12 for Canada, where she had enlisted to serve with the next contingent of Government Nurses, to sail for Europe. Miss Cook is a graduate of the Atlantic City Hospital Training School for Nurses of the Class of 1913. She has done private nursing in Atlantic City since her graduation and was very popular. She is a Canadian by birth. Miss Cook was given a reception by the Nurses' Alumnae on the Sunday afternoon previous to her leaving and was presented with a cameo pin.

The American Red Cross sent to Belgium April 17, the following group of nurses: Dorothy M. Ferree, Hannah P. Guthrie, Lillian E. Wilsey, Helen Barclay, Lydia D. Shrope, Margaret H. Haggerty and M. Elizabeth Long, of Philadelphia; Miss Ruth Sherman Bentley, of Brooklyn; Misses Agnes M. Ward, Eva Emmons and Laura Wood Coons, of Manhattan; Miss Augusta Morse of Syracuse; Miss Florence E. Fisher, of Ann Arbor, Mich.; Miss Sarah L. Halsey and Miss Johanna Ericson, of Detroit; Miss Viola M. Visel,

of Hartford, Conn.; Miss Eva Isabel Johnson, of New Haven, Conn.; Misses Mary B. Gorman and Nellie Manning, of Clarksburg, W. Va.; Miss Luella Ross, of Wheeling, W. Va.; Miss Anna C. Robinson, of St. Louis; Miss Alotta May Lentell, of Newton Lower Falls, Mass.; Miss Eliza Orvis, of Taunton, Mass., and Miss M. Elsie Druggan, of Columbus, Ohio.

Another group sailing later in the month was as follows; To Austria-Hungary, Sarah Woodward and Mrs. Mabel Knudson, of the New York Hospital Training School; Norma L. White and Louise Emma Warnecke, graduates of Grace Hospital, Hartford, Conn.; Florence A. Hunt, Ethel Louise Jones and Margaret B. Cowling, Baltimore, and Martha Emerson, Providence, R. I.

The nurses for Germany, to serve at Kosel and Gleiwitz, are Anne Bauer and Katherine Kumke, New York, and Nathalia H. Schoettle and Olga Schoettle, Philadelphia.

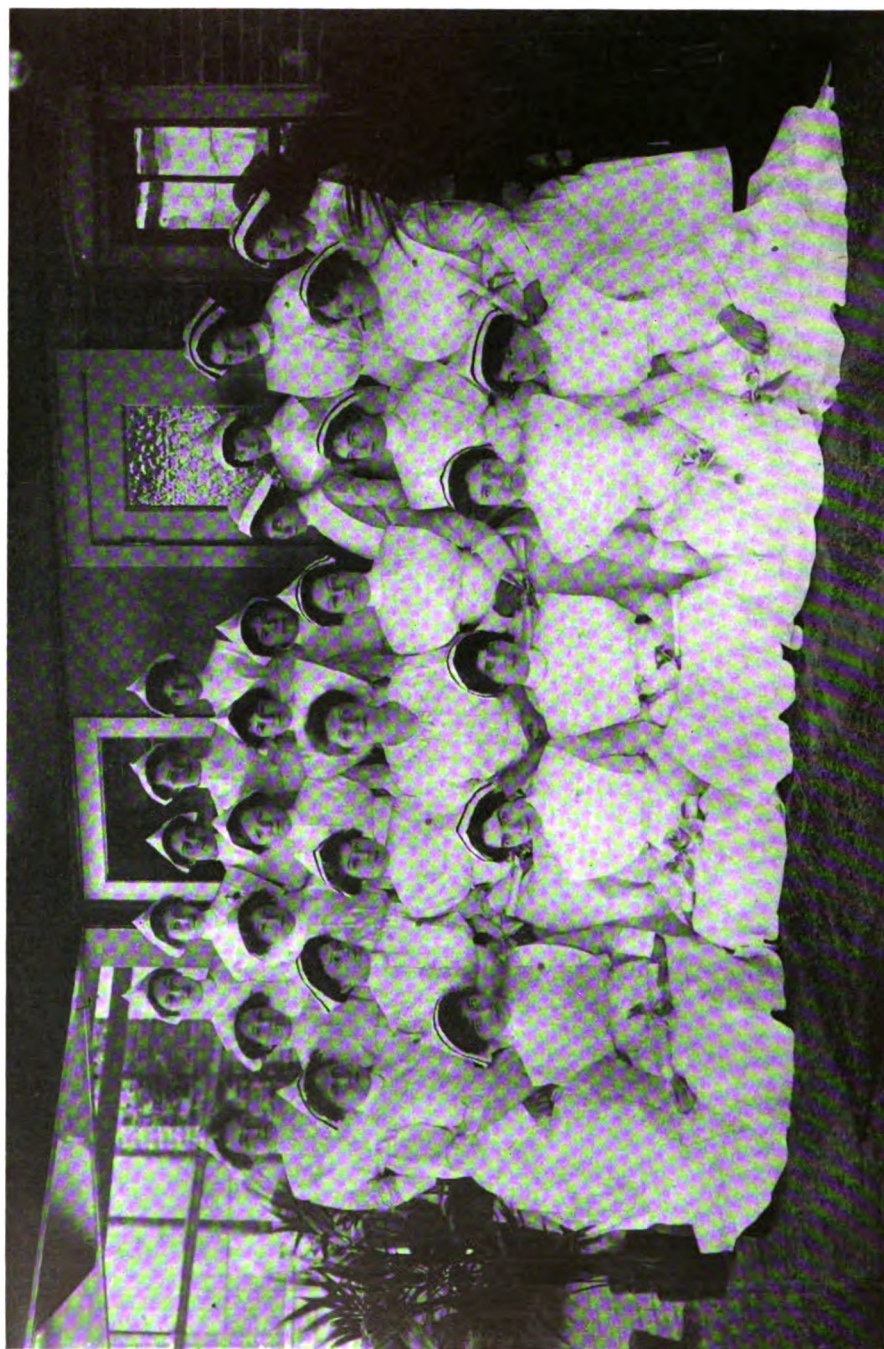
The nurses for Serbia, to be assigned to duty in Belgrade, are Lillian Navarro, Boston; Josephine Valentine, Columbus, Ohio; Isabel A. Robb, Akron, Ohio, and Mrs. Hattie Biddle and Sophie M. Weber, Denver, Colo.

To England, to be assigned at the Paignton Hospital, Anna G. Griffin, of Boston.

Beatrice Bowman, Henrietta Koechlin and Mabel Welsh have returned from six months in the Army Hospital, at Paignton, South Devonshire, England.

The nurses who sailed on board the steamship "Duca d'Aosta" of the Italian Line, May 15, will join the Red Cross units in Austria. They are Alice J. Philipp, of New York; Matilda M. Sturtzer and Caroline E. Bill, of Buffalo, N. Y.; Anna Baggerly Davis, of Utica, N. Y.; C. Adelaide Madsen, of Minneapolis, Minn.; Clodia E. Johnson and Mary M. Bowen, of Indianapolis, Ind.; Clifford Geffchen, of Savannah, Ga., and W. Louise Kochert, of Wheeling, W. Va.

Miss Elizabeth Hunter, a graduate nurse, sailed for England on the S. S. "New York" May 1, to take up active work at the front. She took with



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her letters of introduction from the British War Relief Association to many persons in London and France.



Massachusetts

A convention of public health officials of the Commonwealth of Massachusetts and the Massachusetts Association of Boards of Health was held at Ford Hall, Boston, April 29, 1915. There were two sessions. Dr. Allan J. McLaughlin, State Commissioner of Health, presided at the morning session, and Prof. M. J. Rosenau, president of the Massachusetts Association of Boards of Health at the afternoon session. The convention was a most remarkable one, the papers of unusual excellence.

Dr. Charles W. Eliot's subject was "The Main Points of Attack in the Campaign for Public Health." Dr. Eliot gave as the chief points of attack in public health work—tuberculosis, alcoholism and venereal disease. His paper was very fine, scholarly and practical.

Prof. Irving Fisher presented a paper on "Conservation of Life at Middle Life." Dr. Fisher's paper was epoch-making. He called our attention to the fact that more people and more *men* die between the ages of forty and fifty than they did a generation ago, and feels it to be not only tragic but economically tragic. He urged the study and dissemination of information concerning what he called "wear-and-tear" diseases, heart troubles, arterio-sclerosis, kidney troubles, etc.

"Scope of the Nurse in Public Health Work" was presented by Ella P. Crandall. Miss Crandall spoke well and forcefully, especially emphasizing the fact that the nurses' work is important, because she is the connecting link between the health department and the people, and that without her the legislation, instruction, etc., are apt to be nearly useless. She is the interpreter of the law and of the doctor, as she not only teaches but shows how things are to be done.

Hardly a speaker on the whole program failed to emphasize the importance of the public health nurse. They unanimously decreed that she is the most important factor in the solution of the problems of health. They all spoke of the need of special training for her for that sort of work, insisting that ordinary bedside nursing was far from sufficient, but that she must have the special knowledge of tuberculosis, infant mortality and communicable disease, and of public and private sanitation, with the teaching power and a knowledge of methods.

"The Health of the Farmer," by Dr. John S. Hitchcock. Dr. Hitchcock pronounced the farmer the most unhealthy and unsanitary member of society, but spoke of the marked improvements going on and was hopeful for the future.

Dr. Edward Reynolds spoke on "The Control of Cancer." Dr. Reynolds' talk was also hopeful. He urged the vital necessity of a nation-wide campaign, and told how his Society was already working with every sort of organization which was interested (60 or more) and of what they were prepared to do. He emphasized the value of publicity of every sort and of the work of the nurse in the direction of teaching the facts and curability of cancer.

The male nurses at the Boston City Hospital on April 21 organized themselves into a society, to be known as the Boston City Hospital Male Nurses' Association. The following officers were elected: President, Paul A. Rogers; secretary, David H. Gibson and executive committee Charles F. Pettipas, Carl R. Hogan and Thomas F. Nolan.



Connecticut

The regular meeting of the Connecticut Training School Alumnae Association was held at the usual time and place, with the vice-president, Miss Bigelow, in the chair, on account of unavoidable absence of Miss Barron, the president. The routine work was carried on, a committee appointed to prepare for the annual meeting in June and new members admitted. After adjournment a very interesting talk by Miss M. Grace Hills, on the work of the local Visiting Nurse Association, was enjoyed by all. Refreshments and a social hour followed.

The Alumnae Association of St. Mary's Hospital Training School for Nurses, Waterbury, held its annual meeting at the hospital April 1, with twenty-two members present, including several from other cities. Election of officers for the year resulted as follows: Anna Moriarty, Waterbury, president; Mary Aldrich, Thomaston, vice-president; Rose Murphy, Danbury, secretary; Catherine Cavanaugh, Waterbury, treasurer. An informal discussion followed the routine business, after which a dainty lunch was served.

The Alumnae Association of St. Francis Hospital, Hartford, held its annual meeting in the lecture hall of the hospital May 1, at 4 P.M. The president, Miss E. Riley; secretary, Miss E.

Marshall; treasurer Miss R. T. Moore, were absent on account of illness. Vice-president Miss E. Toomey presided, assisted by Miss M. Ahern, member of the executive committee. Fifty-two members were present. Eighteen new members were received. Routine business was transacted. Report of the annual whist was read, showing receipts of \$939.80. It was voted to give the \$1,000 to the free bed fund, making it now \$5,000. Refreshments were served.



New York

Forty-one nurses received their diplomas at the graduating exercises of Bellevue Hospital April 21. The graduates included representatives of Canada, Denmark, Italy, England and many States. The Rev. Charles P. Tinker delivered the invocation and there were addresses by Dr. John W. Brannan, president of the Board of Trustees; Dr. Simon Flexner, of the Rockefeller Institute, and Dr. George O'Hanlon, president of Bellevue and Allied Hospitals.

The commencement exercises of the Metropolitan Hospital Training School for Nurses will be held on Thursday, May 27, at 8.30 P.M., at the Metropolitan Training School, Blackwell's Island.

STATE BOARD EXAMINATION

Medical Nursing and Nursing of Children—

1. What is the preventive treatment of bedsores?
2. Give nursing measures for the relief of vomiting.
3. If you found a person unconscious, what particulars would you note and what would you do pending the arrival of the physician?
4. Define the following terms: (a) lysis, (b) crisis, (c) arterio-sclerosis, (d) myxedema, (e) hemophilia.
5. Why should a nurse not rub a limb in which there is phlebitis?
6. What are the symptoms of pleurisy?
7. With reference to the heart, what is meant by the term "compensation"?
8. Give nursing measures for the relief of (a) singultus, (b) insomnia.
9. Have you been taught to wash an infant's mouth? If not, why not?
10. At what season of the year is infant mortality the highest? How may this be lessened or prevented?
11. What are the most frequent sites of tuberculous disease in children?
12. What is the nursing care of whooping cough?
13. Mention three points to be observed in nursing a case of pulmonary tuberculosis.
14. Describe your method of applying stupes.
15. What is meant by blood pressure?

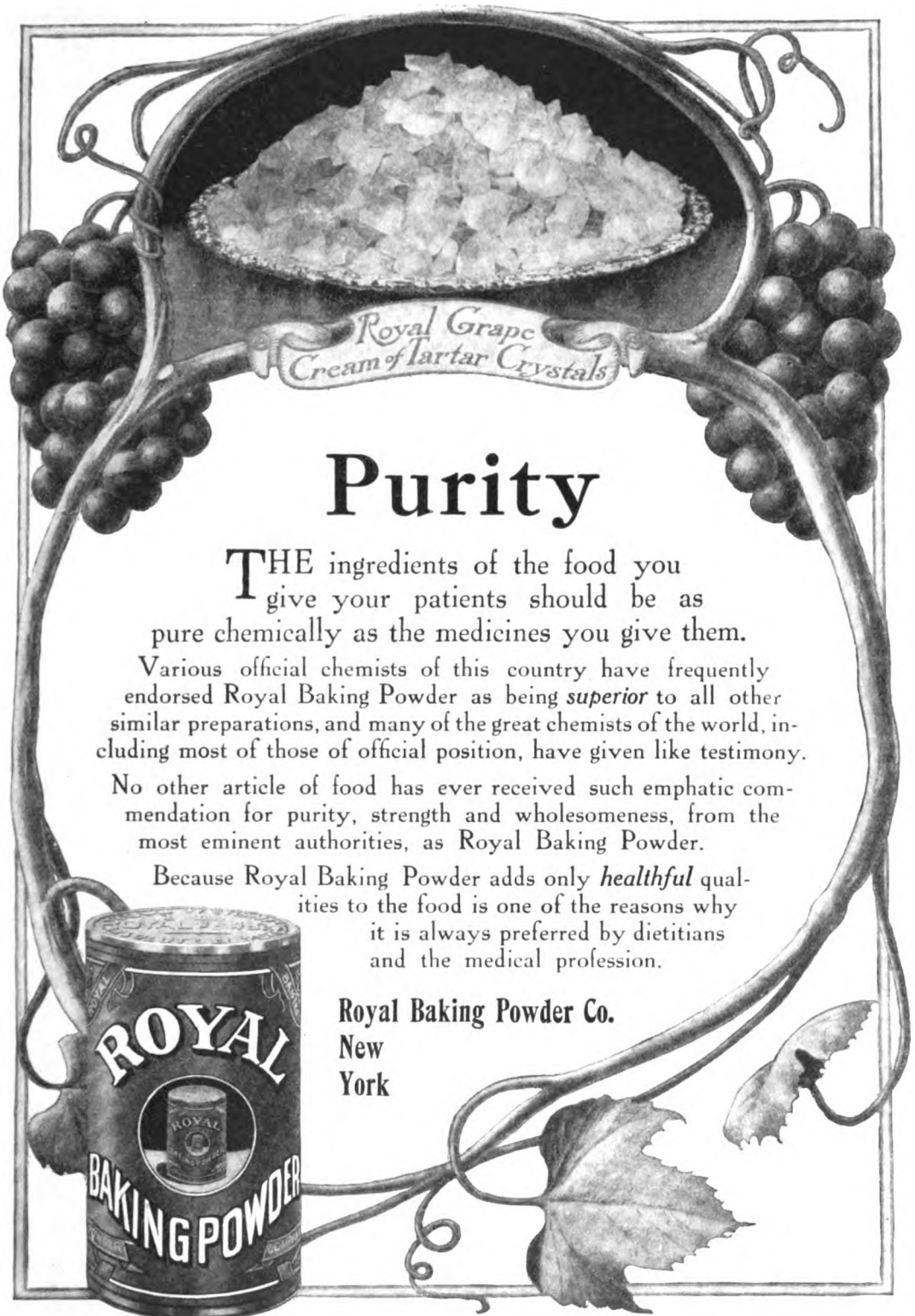
Anatomy and Physiology. 1. Name the bones surrounding the mouth or buccal cavity. 2. Describe the periosteum. 3. What are the normal stimuli that cause the contraction of muscles? 4. What is the name of the muscle that covers the shoulder? 5. Describe the diaphragm. 6. Name two ductless glands. 7. What are the four chambers of the heart and how are they separated from one another? 8. What is meant by the por-

tal circulation? 9. State one function of (a) the red blood corpuscles, (b) the white blood corpuscles. 10. Give the position of the gall bladder and state its use. 11. How many teeth are there in the permanent set of the adult? 12. Compare afferent nerves with efferent nerves. 13. Mention two functions of the skin. 14. What are the sebaceous glands and where are they found? 15. What are the functions of a lymph node or lymph gland?

Obstetric Nursing—1. Define labor and explain how a nurse may know when to call the physician. 2. Name three complications that may arise during labor. 3. Name three complications that may arise in the puerperium. 4. What is simple engorgement of the breasts and what nursing measure should be employed on its first appearance? 5. Outline a suitable diet for the mother on the second day of the puerperium. 6. Give three essentials in the nursing care of the mother during the first week of the puerperium. 7. If the patient complains of headache, either before or after delivery, what should the nurse do? 8. Name the internal female organs of reproduction. 9. Briefly explain the difference in meaning of the terms embryo and fetus. 10. Define viability, involution, pregnancy. 11. Name three parts of the new-born child that are extremely susceptible to infection. 12. What is the most important attention that the mother should receive immediately after the completion of the third stage of labor? 13. How should you test rubber nipples in order to avoid too rapid a flow of milk into the infant's mouth? 14. Briefly describe a method of cleaning rubber nipples. 15. What is the probable cause of intertrigo (red buttocks) of the infant?

Genito-Urinary Nursing—(For male nurses). What is the difference between retention of urine and suppression of urine? 2. How would you collect a 24-hour specimen of urine? 3. What symptoms would lead you to suspect an over-distended bladder? 4. What is the normal reaction of urine? 5. Describe in detail bladder lavage. 6. How could the nurse relieve the pain of external hemorrhoids? 7. Name two solutions frequently used for bladder irrigation and give the strength of each. 8. Define phimosis. Give the after care of a case of phimosis. 9. What is incontinence of urine? 10. Locate the perineum. 11. What is cystitis and what are its symptoms. 12. Give the symptoms of gonorrhea. 13. Why should a nurse observe aseptic precautions in catheterizing a patient? 14. Define orchitis. 15. What are the characteristics of the urine in (a) acute Bright's disease, (b) fevers, (c) diabetes mellitus?

Materia Medica.—1. Define materia medica. 2. What are (a) antiseptics, (b) carminatives, (c) narcotics, (d), diuretics, (e) cholagogues, (f) diaphoretics? 3. Name two important preparations of arsenic. 4. What is the chief alkaloid of belladonna? What are the signs of an overdose of belladonna? 5. Name three cardiac stimulants and state the dose of each. 6. Name four saline cathartics and state the dose of each. 7. State the action of quinine. Give the symptoms of an overdose of quinine. 8. What is the synonym of digitalis? State the action of digitalis. Give three preparations of digitalis and state the dose



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of each. 9. What is the treatment of poisoning by (a) strychnine, (b) morphine, (c) bichloride of mercury, (d) carbolic acid? 10. Name *four* preparations of opium and state the dose of each. 11. What is meant by (a) physiologic action of a drug, (b) idiosyncrasy? 12. Name a respiratory stimulant and state its dose. Name *two* expectorants and state the dose of each. 13. What is an emetic? Mention *two* simple emetics and state the dose of each. 14. Write the table of (a) apothecaries' weight, (b) apothecaries' measure. How many grains to the ounce are required to make a 1 per cent. solution? How many cc. are there in one-half of a liter? How would you make one ounce of a 2 per cent. solution of silver nitrate? 15. How would you prepare and give a hypodermic injection of strychnine sulfate, gr. 1-30? What drugs when given by hypodermic injection must be injected deep into the tissues?

Dietetics—1. State *two* methods of preparing eggs for nourishment and give reasons for your answer. 2. Explain the term balanced meal. 3. Mention *three* meat substitutes. 4. Mention *four* food principles and give their function in the body. 5. How would you prepare beef juice? How would you prepare one pint of baked custard? 6. Give *two* formulas for nutritive enemas. 7. What articles of food are to be specially avoided in nephritis? 8. What are the functions of nitrogenous food in the body? 9. Name the non-nitrogenous foodstuffs. 10. In what conditions is fat a valuable article of diet? Why? 11. Name the digestive juices. 12. Why is milk called a perfect food? 13. How should meat be cooked in order that it may retain its juice? 14. Name several articles of food that have laxative value. 15. What do you understand by (a) modified milk, (b) pasteurized milk, (c) sterilized milk?

Bacteriology and Surgery—1. Classify bacteria according to their shape or form and give an example of each. 2. How do bacteria gain entrance to milk? What diseases may be transmitted by milk? 3. How is infection transmitted in measles, diphtheria, typhoid and scarlet fever? 4. What *three* conditions are favorable to the growth of bacteria? 5. Mention *three* methods of sterilization by heat. 6. Mention *two* dangers to be guarded against in the care of a perineorrhaphy and state the preventive means to be employed. 7. How would you feed a patient after gastrotomy when the food is to be introduced through a catheter? 8. Name the two chief complications that may occur after an abdominal operation. What is shock? Give the nursing treatment of shock. 9. (a) How would you recognize an internal hemorrhage? (b) How would you render first aid in case of a hemorrhage from the carotid artery? 10. Give briefly the method of catheterization. 11. Immediately after an abdominal operation a patient voids urine very frequently and in small quantities without pain; what condition would you anticipate? 12. Describe the preparation of a patient for an abdominal operation. 13. Mention the common materials used for sutures and ligatures; give their sources and their behavior in the tissues. 14. Define the terms appendicitis, salpingitis, cholecystitis, colitis. 15. Give a classification of wounds. Describe *three* of the classes named.

New Jersey

The New Jersey State Board of Examiners of Nurses will hold an examination for the registration of nurses on June 15, 16, 17, 1915, if the number of applications warrant it, at the State House, Trenton. Applications must be filed with the secretary-treasurer, Jennie M. Shaw, R.N., 487 Orange Street, Newark, N. J.

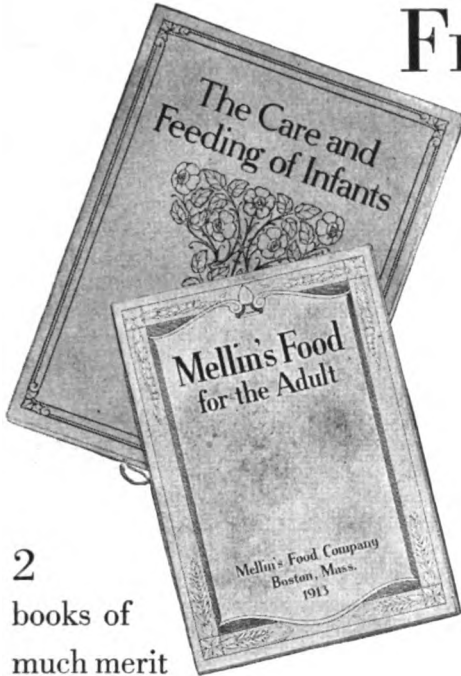
Graduation exercises of the Training School for Nurses, connected with the Elizabeth General Hospital and dispensary, took place in the lecture room of the Second Presbyterian Church, May 6. The program presented was a most appropriate and interesting one. Following the giving of diplomas, remembrances from the visiting staff and school pins, President Frederick J. Faulks, of the board of managers, announced the winners of the two gold prizes awarded annually in memory of Calvin B. Orcutt. Miss Florence Mabel Pearce secured the first honors, with an average of 97 for the three years, and Miss Rose Agnes Nash received the second prize, with a record only slightly below that of Miss Pearce. The other graduates are the following: Miss Celia Bendenberger Laurent, Miss Elizabeth May Weigand, Miss Clara Catherine Wenke, Miss Adelaide May Keiper and Miss Hildur Josephine Ofverberg.

The address of the evening was by Mayor Mravlag. The school pins were distributed by Miss Emma L. Stowe, superintendent of nurses. President Faulks presented the diplomas. In the afternoon the beautiful new Home for Nurses, which will be described in a future issue, was opened to the public.



Pennsylvania

The Nurses' Alumnae Association of the Woman's Hospital held an interesting meeting on April 14, 1915, at the Nurses' Club House, of Philadelphia, 1520 Arch Street, Philadelphia. The minutes of the March meeting were read and stood approved. Good reports were given by all committees. Several new members were elected, which adds more interest to the efforts of the present campaign workers. Miss Nettie Guthrie (president of Alumnae Association) was elected to act as delegate to the American Nurses' Association Convention, which will be held in San Francisco, Cal., from June 20 to 26. Resolutions were adopted and accepted on Miss Cromwell's death, Class of 1889. An interesting discussion arose on the four new amendments to the State Registration Bill, namely: (1) Fee raised to \$10 from \$5. (2) Reciprocity. (3) Educational director for



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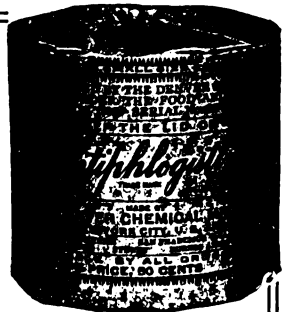
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The graduation exercises of the Class of 1915 of the Training School for Nurses of the German Hospital, of Philadelphia, were held May 11, at four o'clock P.M. in the auditorium of the Lankenau School for Girls. The program follows: Prayer, Rev. E. P. Pfatteicher; address, Alfred Stengel, M.D., Professor of Medicine, University of Pennsylvania; awarding of diplomas, Mr. G. A. Schwarz, president of the German Hospital; benediction, Rev. Adolf Hellwege. The graduates are: Charlotte M. Beck, Jaline A. McClure, Gussie R. Schultz, Ruth A. Hodgson, Marie E. Smith, Anna Valer, Maie Freeland, Miriam S. Erich, Anna L. Davis, Myra M. Brookmeyer, Marybelle Feagley, Emily R. Reichenbach, Helen Frances Cochran, Ella Wismer, Florence K. Moyer, Rosa C. Siegfried and Sister Mary Berntson.

The annual commencement exercises of the Training School for Nurses of the Beaver Valley General Hospital, Beaver Falls, were held at the First Presbyterian Church Friday evening, May 14. Invocation, Rev. M. F. Smith; address, Francis J. Torrance; presentation of diplomas, M. F. Smith; Nightingale pledge, Rev. W. Archbold; presentation of class pins, Florence Cameron; benediction. Following the exercises, a reception was held in the parlors of the church. The graduates are: Cora E. Boland, Clara B. Groscoft, Estella B. Knight, M. Ruth McCready, Edna L. Dillinger, Laura V. Scott, Jean A. Scott, Lillian F. Casassa.

Commencement exercises for thirty-eight graduates from the West Penn Hospital Training School for Nurses, Pittsburgh, were held in the Pittsburgh Conservatory of Music April 29. J. D. Hailman, member of the board of directors of the hospital, presided in the absence of James R. Mellon, president of the board, who was out of the city. The exercises opened with the invocation by Rev. W. E. McCullough, of the Home-wood United Presbyterian Church, who also pronounced the benediction. An address was given by J. F. Burke, former congressman, and the diplomas were presented by Chairman Hailman. Class badges were presented by Dr. M. C. Cameron, chairman of the training school committee.

Six nurses from the Presbyterian Hospital Sherman and Montgomery Avenues, Northside, Pittsburg, also were presented with diplomas and pins at graduation exercises held in the North Presbyterian Church, April 29. The exercises opened with Rev. Dr. James A. Kelso, of the Western Theological Seminary, asking the invocation. Addresses were given by Prof. George C. Johnston, of the University of Pittsburg, and Dr. W. W. Jones. The presentation of diplomas was made by Joseph J. Mathews, president of the board of trustees. Benediction was pronounced by Rev. F. W. Sneed, head of the hospital staff. The graduates are: Miss Winifred Brown, Miss Frances M. Nelson, Miss Mary L. Smith, Miss Jeannette P. Mechling, Miss Ida I. Huey, Miss Hazel E. Sutton. A reception was given the graduates at the new Nurses' Home, which was beautifully decorated for the occasion.

The Nurses' Alumnae Association of the Presbyterian Hospital, Pittsburg, held its regular monthly meeting at the Nurses' Home, Monday evening, May 3.

The incorporators, trustees, staff of physicians, graduate nurses and pupil nurses of St. Vincent's, Erie, were royally entertained at a banquet Tuesday evening, April 20, the event being in honor of Mother Ambrosia's golden jubilee. Following the banquet an interesting program was given in the Assembly Hall, to an appreciative audience. Musical numbers from some of the city's best artists, addresses by Mayor Stern, Postmaster J. T. Brew, Judge Benson and Dr. James E. Silliman, congratulations and loving wishes from all closed the day of celebration and honor of Mother Ambrosia's fifty years of faithful service.

The Alumnae Association of the Harrisburg Hospital held its monthly meeting with fifteen members present. The commencement exercises will be held June 1. A class of ten will graduate:



Delaware

The annual meeting of the Delaware State Association of Graduate Nurses was held at the Homeopathic Hospital, Wilmington, on Saturday, April 17, at 2.30 o'clock, when the following officers were elected for the ensuing year: President, Mrs. Allen Speakman, R.N.; first vice-president, Mrs. James M. Scully, R.N.; second vice-president, Miss Eva B. Hayes, R.N.; recording secretary, Miss Esther M. Hansen, R.N.; corresponding secretary, Miss Gertrude B. Ludwig, R.N.; treasurer, Mrs. Ralph I. Flinn, R.N. Ex-

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ecutive committee: Mrs. Walter O. Stack, R.N.; Mrs. Maria Hickman, R.N.; Mrs. Anna B. Ruthven, R.N., and Miss Elsie M. Barbar, R.N., to fill the unexpired term of Miss Jennette Duncan, superintendent of the Delaware Hospital. The following report was read by the president:

To the Registered Nurses of Delaware: Dear Sister Nurses—The year's work just past has little or nothing of especial interest to go on record for future generations of nurses to bless us for, yet I feel, notwithstanding our small meetings, that there has gone out from our little gatherings each time a desire for love and unity in our meetings and for higher ideals in our work. A conscientious striving to help each other do our best, to be a credit to our profession, that we are strengthening the firm foundation, and if our little beginnings may now seem worthless some day the Registered Nurses' Association of the State of Delaware will stand for all that is highest and best in the noble work we as women are trying to do. We can report for each individual member work well done and a very busy past year for all. Besides, all our hearts are filled with loving sympathy for one of our dear, capable members, Miss Duncan, whom we all miss here today, who has gone to help in the work in Europe. Shall we not, with renewed courage and strength, as bravely meet the work and trials and difficulties that God has for us daily here at home, and not forget the loving service we each as nurses owe to each other and to this society in the coming year?



South Carolina

The eighth annual convention of the Graduate Nurses' Association of South Carolina was held in Greenville, April 28–29. Miss Julia Irby, head of the Julia Irby sanitarium, Columbia, president of the Association, presiding. The sessions were held in the Chamber of Commerce. Following a meeting Wednesday morning of the executive board, the credential committee and the nominating committee, the convention opened at 10.30 o'clock with an invocation by the Rev. George W. Quick, of Greenville. Addresses of welcome were delivered by Mayor John B. Marshall on behalf of the city and on behalf of the local physicians by Dr. J. W. Jervey. The response was made by Miss Lucile Withers for the convention. The president's annual address was followed by addresses by Dr. C. E. Smith and Miss Sarah Babb, both of Greenville.

At the afternoon session the convention heard addresses by Miss Annie McInsch, Miss Mary

McKenna, Miss Margaret Gray, Miss F. C. Porter and Mrs. T. R. W. Wilson. At 8.30 o'clock Wednesday evening a reception was given the visitors by the Graduate Nurses' Association of Greenville. On Thursday the convention held a business session, at which reports were submitted by the various officers and committees and officers elected for the ensuing year. At 2 P.M. a luncheon was served at Sans Souci Club by the local association, and at 4.30 an automobile ride over the city was given by Greenville physicians.



North Carolina

The thirteenth annual meeting of the North Carolina State Nurses' Association will be held in the Hotel Wilmington at Wilmington May 25 to 27. Report of meeting in July number.



North Dakota

The third annual session of the North Dakota Nurses' Association was held at Grand Forks April 27 and 28. The sessions were held in the parlors of the Grand Forks Commercial Club. The meeting opened at 10 o'clock in the morning, Tuesday, April 27, with an invocation by Rev. W. H. Matthews. Dean H. E. French of the medical department of the State University, and Mrs. F. L. McVey, president of the Grand Forks Civic League, welcomed the nurses to the city. Miss Frances Riordan, of Devil's Lake, responded. Miss Bertha Erdman, of Fargo, president of the Association, delivered the annual address, Tuesday morning, and Miss Margaret Canning reported on the meeting of the State Federation of Women's Clubs at Valley City. The afternoon session was largely taken up by the reports of standing committees of the Association. Dr. H. G. Woutat, of Grand Forks, spoke on "Contagious Diseases."

The chief addresses of Wednesday morning were by Pearl Weed, of Bismark, and Elizabeth Bartle. Wednesday afternoon was devoted to business and an address by Beatrice Johnstone, county superintendent of schools, on "The Nurse as a Factor in the Community." The meeting closed Wednesday evening with a banquet at the Hotel Dacotah. Officers were elected as follows: President, Mabel Olson; first vice-president, Louise Hoerman; second vice-president, Mrs. A. Boleyn; secretary-treasurer, Frances Riordan; corresponding secretary, Ethel Stanford.

"A Man Is As Old As His Arteries"

—Osler

Authorities agree that "arteriosclerosis," the cause of old age, may be postponed many years by right living and the avoidance of stimulants.

The poisonous principle, caffein, in coffee and tea expends the reserve energy, leaving the body a physiologic bankrupt. The heart and blood vessels are whipped and damaged; the blood pressure is increased; the impaired circulation inevitably results in disease of the digestive functions, liver, kidneys and nervous system.

Such symptoms of caffeinism as chronic indigestion, cardiac palpitation, constipation, hepatic and renal insufficiency, nervousness and insomnia call for the interdiction of coffee and tea and suggest an order for

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Personal

Miss Tamson A. Gray, R.N., graduate of the Maine General Hospital, Portland, Me., has been confined in bed for the past fifteen months with tuberculosis, at the Washington, D. C., institution, of which she was a member of the official family the first three years of its life. Miss Gray is taking pneumo-thorax treatment and well on the road to a cure. She will be glad to hear from any of her old associates. Their letters will do much to relieve the long, monotonous hours into which she has been reluctantly plunged.

The friends of Delia J. Morley, R.N., graduate of St. Mary's Hospital Training School, Waterbury, Conn., Class of 1912, who underwent a serious operation recently at St. Mary's Hospital, will be glad to know that she is on the road to recovery.

Miss Harriet E. Holden, assistant superintendent of the Lowell General Hospital, has been chosen by the executive committee of the trustees of the institution, superintendent of the hospital, to fill the vacancy caused by the resignation of Miss Sara A. Bowen, and Miss Tirzah M. Dewhurst has been promoted to the position of assistant superintendent.



Marriages

On April 21, 1915, at the Catholic Church, New London, Wis., Mina Catherine Klug to Frank J. Mischo. Miss Klug is a graduate of St. Joseph's Hospital, Milwaukee, Class of 1907, post-graduate of Cook County. Mr. and Mrs. Mischo will be at home at Wabeno, Wis., where Mr. Mischo is post-master.

On February 16, 1915, at Waterbury, Conn., Lucy M. Sherlock, R.N., graduate of St. Mary's Hospital Training School, Class of 1912, to Patrick J. Dwyer, M.D. Dr. and Mrs. Dwyer will make their home in Waterbury.

On May 1, 1915, at the parsonage of the First Baptist Church, Reading, Pa., Ida Portz, of the nursing staff of the Homeopathic Hospital, Reading, to Dr. David Barnes Cooley. Dr. and Mrs. Cooley will make their home in Pottstown, Pa.



Deaths

On April 17, Augusta C. Reed, a nurse of the Somerset Hills, N. J., Visiting Nurse Association. Miss Reed was taking a boy to the Morristown

Hospital for treatment, when the Ford car she was driving turned turtle and she was crushed to death beneath the car. Miss Reed had been connected with the Somerset Visiting Nurse Association for nearly eight years and was also the school nurse. She served at the Chickamauga Camp in the Spanish-American War and spent a year and a half in the Philippine Islands. She was greatly beloved in the Bernardsville district. On the day of her funeral the schools in Bernardsville were closed and flags throughout the town were at half staff. The body was carried by six pallbearers through the streets from the Methodist Home, where a funeral service was held, to the Lackawanna Station. The body was sent to Brooklyn for burial. Commenting on her death one of the local papers says: "Hundreds, here and elsewhere—the sick and discouraged, the careworn and overburdened, the pining infant, the feeble, ignorant and helpless mother, the aged and infirm—to all of whom she came as a benediction and a tonic, will sorely

"Miss the touch of a vanished hand
And the sound of a voice that is still."

On April 20, 1915, at New York City, Honora McSweeney, ninety-one years old, widow of Dennis McSweeney, veteran of the Civil War, Company I, Fourth Massachusetts Cavalry, and bodyguard to Brigadier-General Benjamin F. Butler; beloved mother of Mary E. Sweeney, graduate of Mt. Sinai Hospital, Class of 1890, and Anna M. Sweeney, Class of 1889, Mt. Sinai Hospital, superintendent of Franklin County, Public Hospital, Greenfield, Mass. Interment at Greenfield, Mass.

On April 23, 1915, at Memorial Hospital, Johnstown, Pa., of typhoid fever, Mary Estelle Kline. Miss Kline was graduated in 1911 from the institution in which she died and was actively associated with the Conemaugh Valley Memorial Hospital Training School Alumnae Association. She was a registered nurse and since her graduation had been doing private nursing.

On April 20, 1915, at the Plant Park Infirmary, Tampa, Fla., after a short illness, Miss Anna Powell Wilson, graduate of Dr. Stuart McGuire's St. Luke's Hospital, Richmond, Va. At the time of her death Miss Wilson was employed as an office nurse. Previously she was head nurse in Bluefield Sanatorium, Bluefield, Va.

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Book Reviews

The Cancer Problem. By William Seaman Bainbridge, A.M., Sc.D., M.D., Professor of Surgery, New York Polyclinic Medical School and Hospital; Surgeon and Secretary of Committee of Scientific Research, New York Skin and Cancer Hospital; Consulting Surgeon, Manhattan State Hospital; Honorary President, First International Congress for the Study of Tumors and Cancers, Heidelberg, 1906. The MacMillan Co. \$4.00 net.

Dr. Bainbridge is a surgeon and a scholar of international reputation. He frankly admits and his book reveals strong sympathy with English methods and interpretations. He is a personal friend of Arbuthnot Lane. His latest work on cancer is a wonderful production. It bears the same relation to the general practitioner that Baedeker might to a traveler. It is exhaustive. It takes up comprehensively each country, plant, animal, century, industry or period in an individual's life which is a contributing cause to the growth of cancer or allied tumors. It relates in full the methods pursued everywhere to systematize the study of this subject. Dr. Bainbridge will stimulate the philanthropists to further giving, by having cited the honoraria bestowed on the past discoveries in this field. Ample statistics are given, though we know that of themselves these must be unsatisfactory, since many victims of such a disease are too obscure to be reached.

The summary of all the experiment on cancer is given, as well as the minutest technique required in surgery in every part of the body where cancer may occur.

Dr. Bainbridge's book should do much to comfort those suffering from cancer dread. In this capacity the book may perform a service distinct from that for which it was primarily intended. Many a man has quaked over the prospective inheritance of an ailment. Modern medicine has released us from many of the fears of heredity. In the case of cancer, the absence of heredity as a principal predisposing influence is a fact deserving to be proclaimed.

Again taboos have been issued against a great number of food articles, as meat and tomatoes, on the theory that the disease was spread by one or another of these. Since the universal study of tumors the world over, among men of all kinds who heaped up an abundance of data, it has

become possible to declare with fair certainty that cancer is not imparted by any kind of food. On the contrary, it is found prevalent among the vegetarian castes of India, among savages who never saw a tomato, and so on until all the suspected articles in our diet have been eliminated.

The author assures us that the outlook is hopeful, though there are many links to be established yet, to weld together this tremendous mass of apparently heterogeneous data. A fine reference list to the most modern works in every language on this subject is appended.



Sick-room Cookery Simplified; with Suggestions for Diet. By Mabel Baker, First-class Diploma. National Training School of Cookery. 152 pages. London: G. Bell & Sons, Ltd. Price 75 cents.

Although only a small volume, of convenient size to be carried in a nurse's case outfit, Miss Baker's book contains a great deal of information, very practically arranged. It is intended to supplement the brief training-school course in sick-room cookery which is the only preparation the average nurse has for this part of her work, and the directions have been made very simple and plain, so that the most untried amateur will find it possible to follow them, and to "cook suitable, wholesome food, or direct the cookery of such, for sick people."

There are short, practical chapters of "General Rules" and "Useful Hints," followed by sections dealing with food values, digestion, foods suitable and unsuitable for sick-room use, suggestions for meals, directions for peptonizing and pancreatizing, and a chapter on infant feeding. A large number of useful recipes are included in the sections on Baking, Boiling, Braising, Broiling, Frying, Grilling, Roasting, Stewing, Steaming, and those dealing with Cold Sweets, Beverages, Savory Dishes, and Substitutes for Meat. There is a well-arranged index for quick reference.

Although the book is intended for English readers, the differences in phraseology from our American usage are not sufficient to cause inconvenience in following the directions, and the volume cannot fail of being a useful addition to the working outfit of any nurse.

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Nemo "Wonderlift" KopService Corset, No. 555



The essential feature of this corset is the interior lacing device, whereby the semi-elastic bandages are accurately conformed to the exact shape and convexity of the abdomen. This appears in Diagram 1, showing the inside lacing before adjustment.

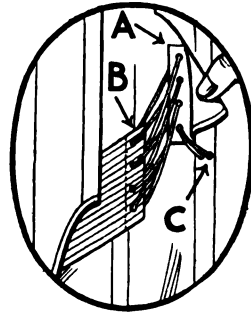


Diagram 1

One row of eyelets (A) is sewed into an open pocket in front of the hip section; another row is on the free end of the semi-elastic bandage (B), the other end being permanently attached to the end of the front steel. Before adjustment, the free end of the bandage is at least an inch lower than the attachment in the pocket. The lacers pass to *outside* of corset through two small eyelets (C).

To adjust bandage to abdomen (after corset is placed on figure), both protruding laces (on each side) are pulled evenly and firmly downward, and the ends tied in a bow-knot. This takes up the "slack" in the interior lacing, thereby lifting the bandage upward and backward as far as the size and shape of the abdomen will permit. When fully adjusted, the two rows of eyelets will be drawn approximately together.

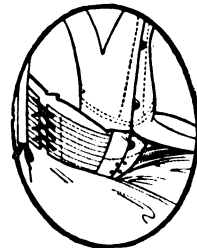


Diagram 2

It is a mechanical fact that, with this form of lacing, the traction, in adjustment, is entirely from the front toward the open pocket. The position of the back of the corset remains unchanged—it is not affected by the "pull" of the lacing.

It is impossible for the bandage to move out of its position after adjustment. It cannot slip, nor "ride up." It stays in correct position, no matter what posture the wearer may assume. Diagram 2 shows its position when the wearer is sitting.

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Nobody pretends, of course, that grape juice is of itself an all-sufficient diet. But as an adjunct to the necessarily meagre diet of the sick and convalescent, it is of the utmost value, besides exerting certain positive therapeutic effects. In pulmonary tuberculosis and in gastric catarrh it is excellent because of its high carbohydrate content in practically non-fermentable shape. Constipation with hepatic congestion is greatly benefited by it and the laxative influence of grape juice is beneficial in hemorrhoidal affections and in cardiac diseases with tendency to visceral engorgement.



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The climax of inventive genius has been reached in the new Nemo "Wonderlift" corset. A prominent New York surgeon has recently made a close study of this corset, with exhaustive tests upon a living model, and the following is an extract from his analysis.

"The principal feature of this corset is what may be termed a cast of the recti and oblique abdominal muscles. The imitation is so perfect that even Poupart's ligament is included. Just as the oblique muscles interdigitate with the important muscles of the back, so in like manner does the rear of the corset anchor or fix the front portion. When properly adjusted, the lower border attaches itself to the crest of the pubis and then runs obliquely upward and outward, following the course of Poupart's ligament.

"Every good corset thus far constructed gathered its real hold on the space between iliac crest and trochanter, and gave support by direct pressure over the lower abdominal zone. We know, however, that the abdominal muscles give support by a lifting action and only secondarily by pressure. The direction of the fibers of the oblique muscles fully demonstrates this. In a similar manner, this newly constructed corset gives support primarily by assisting the oblique muscles in their action, *viz.*, a lifting support; only secondarily by pressure.

"The inventor has gone a step further. He realized that muscles contract and relax. A good example is when a woman, after standing, sits—her recti abdominal muscles relax. By a very ingenious device, that part of the corset corresponding to the recti muscles also relaxes or bends outward when sitting, imitating exactly the normal function."

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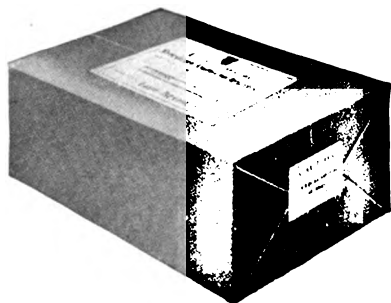
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Hospital Convention Program

(Continued from page 362)

Friday, June 25—Morning Session, 10
A.M.—Hospital Efficiency, Mr. Richard
Waterman, secretary Committee on Effi-
ciency, Philadelphia Medical Society, Phila-
delphia, Pa. Purchasing Hospital Supplies,
Louis Burlingham, M.D., assistant superin-
tendent, Peter Bent Brigham Hospital, Bos-
ton, Mass. A Few Hospital Problems and
Their Solution, J. McLean Moulder, M.D.,
superintendent Methodist Hospital, Indian-
apolis, Ind. Fire Protection and Preven-
tion in Old Hospitals, John M. Peters, M.D.,
superintendent Rhode Island Hospital, Provi-
dence, R. I. Medical Social Service De-
partment Problems in a State University,
Louis Morrow, M.D., University of Cali-
fornia, San Francisco, Cal. Interdepend-
ence Between Hospital and Outside Work,
Richard M. Bradley, Thomas Thompson
Trust, Boston, Mass.

Friday, June 25—Afternoon Session,
2 P.M.—Report of Membership Committee;
Report of Treasurer; Report of Auditing
Committee; Report of Committee to Study
the Character, Cost and Value of Direct and
Indirect Work for the Prevention of Dis-
eases now Conducted by Hospitals and Dis-
pensaries, to Arrange in the Order of Their
Importance and Practicability Successive
Steps for the Extension of Such Work, and
to Prepare Methods for Its Financial Sup-
port and for Its Correlation with the Similar
Work of Other Agencies, Public and Pri-
vate, Dr. J. A. Hornsby, editor *Modern Hos-
pital*. Report of Committee to Memorialize
Congress to Place Hospital Instruments on
the Free List, Rev. George F. Clover, super-
intendent St. Luke's Hospital, New York
City. Report of Committee on Time and
Place of Eighteenth Annual Conference;
Report of Nominations Committee; Election
of Officers; Introduction of President-Elect.
Adjournment.

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Managing Editor

ANNETTE SUMNER ROSE

Editor

CHARLOTTE A. AIKENS

LAKESIDE PUBLISHING COMPANY
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Short, practical notes upon personal experiences or brief reports of interesting cases, with results from remedies new or old, will be welcomed.

The Editors and printers will greatly appreciate the courtesy of having all manuscript typewritten; or, if this is impossible, clearly written, great attention being given to proper names and medical terms.

At the Exposition

We hope those of our readers who plan to attend the Convention at San Francisco will not fail to look up our advertisers and give them a word of friendly greeting. Some of our patrons are having special displays which will be well worth seeing. The J. B. Ford Company, of Wyandotte, Mich., will be found in the Agricultural Building, and they will be glad to demonstrate the merits of their products. Kops Service will exhibit their new "Anti-Ptoxis" Corset in Space 2, opposite Registration Bureau. These are only two of the many of our good friends who will be represented. Don't neglect to look them up. Any nurse who feels that she has been helped by THE TRAINED NURSE should remember the great factor our advertisers have been in the production of the magazine. Without them our best efforts would come to naught. Let them know that you appreciate them.



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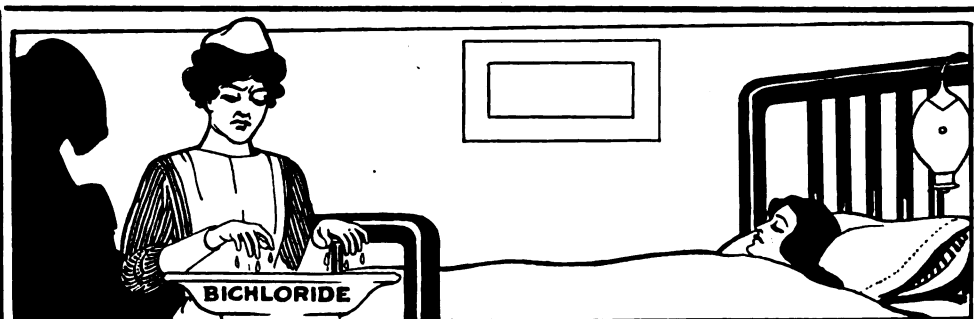
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J. S. TYREE, CHEMIST, Inc., Washington, D. C.

Rural Visiting Nurse

A press despatch states that the first rural visiting nurse in Pennsylvania is claimed by Muncy, a town of two thousand in a farming and hill country. The Pennsylvania Rural Progress Association has been largely responsible for this forward step. The first \$150 was contributed by the State Y. W. C. A.; \$350 was given by two local manufacturers, and the remainder was contributed by citizens of the community served by the nurse, who has been at work almost a year.



Don'ts In Regard to Utility Rooms

A well-known writer on hospital planning and equipment emphasizes the following things not to do when planning a hospital or an extension with its necessary utility rooms:

1. Don't have a patient's bath or toilet open off this room.
2. Don't have the maid's broom closet in a corner of it.

3. Don't have it the only place to put the patient's flowers at night.

4. Don't have it the only place for airing or drying clothing or bed-linen.

5. Don't put the slop-sink behind the door, in a corner or in an enclosure, but where it can be seen, kept clean, and gotten at by two persons at the same time.

6. Don't put the soiled linen receptacle in a separate closet; the theory is excellent, but it makes additional work for the nurses.

Notes

By the will of Mrs. Mary E. Johnson, the Lynn (Mass.) Hospital receives a gift of \$100,000 for a nurses' home.

Miss Kunz, of New York, has been appointed chief nurse at the Anderson County Hospital, Charleston, S. C.

Dr. John H. McCollom has resigned as superintendent of Boston City Hospital, owing to ill health.

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July • 1915

Lakeside Publishing Company
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This is the first of a series of articles on the uses of Stanolax Liquid Paraffin.

The facts presented in this series of announcements are based on authoritative clinical data.

Made from American Petroleum

Announcement

The research laboratories of the Standard Oil Company (Indiana), Chicago, U. S. A., have produced from American Petroleum a neutral, bland, tasteless, odorless liquid paraffin that is equal to any and superior to most of the mineral oils which have been offered for internal use, whether of European or domestic origin.

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STANOLAX is an intestinal lubricant and protective agent, and its use is not followed by artificial stimulus of peristalsis.

It's especially indicated in the treatment of chronic constipation and intestinal stasis. Its action is purely mechanical.

It is not absorbed and does not digest.

Bastedo, W. A. (Jour. A. M. A. LXIII, No. 9, August 29, 1914) says: "Liquid paraffin (petrolatum liquidum) is a remedy that has been exten-

sively employed since it was called to the notice of the profession by Sir Arbuthnot Lane. It is a viscous liquid that is not at all changed chemically by the intestinal secretions nor absorbed from the alimentary tract, as shown by Bradley, 1911, and by Bloor, 1913. By its action as a lubricant it serves to soften and to increase its bulk. It is also believed to be strictly non-irritant. Whether or not it exerts in the bowel a disinfectant on some of the strains of fecal bacteria has not been demonstrated. Finch and others have shown that it lacks disinfectant effect, but that by virtue of its viscous and oily nature, it acts as an agent which retards the growth of bacteria implanted in it, but this does not serve as a test of its antibacterial value when mixed with food residue in the ileum or colon."

* * * * *

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(351)

The Trained Nurse and Hospital Review

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No. 1

Dispensaries in the Smaller Hospitals: How to Organize and Manage Them

MICHAEL M. DAVIS, JR., PH.D.

Director of the Boston Dispensary

AS a preceding article endeavored to demonstrate, a hospital of moderate size in a city of fifty thousand to a quarter of a million population needs an Out-Patient Department for its own sake and for the sake of the community. How shall such an Out-Patient Department or Dispensary be organized and maintained in connection with the hospital? The present article will endeavor to present some of the practical details of interest to physicians, trustees and superintendents.

If there appear to be particular needs for certain special clinics, as for the care of the eyes or for throat work (such clinics are particularly called for in cooperation with the medical inspection of school children), it is possible to start such clinics without undertaking any general out-patient department. One or more medical men who are on the staff of the hospital and who specialize in the particular work desired may be asked to hold one or two clinics a week in the morning or afternoon, as may be convenient. A nurse must be in attendance and proper records kept, as suggested in what follows concerning an out-patient department proper. For, if a hospital is to give to the community the full benefits of a

dispensary and to reap the advantage which a well-organized dispensary will confer upon its own work, it should start general medical and surgical clinics. The requirements of organization and management may be summed up under six heads: First, rooms and equipment; second, medical staff and arrangement of services; third, admissions and fees; fourth, records; fifth, nursing and social service; sixth, organization as a whole.

1. *Rooms and equipment* for an Out-Patient Department of moderate size. It is desirable that, as far as possible, the main clinics shall all be open at the same time, as in this case the staff secures the great benefit of consultation with one another in difficult and, therefore, interesting questions of diagnosis. Consequently it is desirable, if the space available permits, to have sufficient room to accommodate all the clinics, or at least the main clinics, when in operation simultaneously. Sometimes this is impracticable and the same rooms must be used for different clinics on different days of the week or different hours of the same day. In any case, it is of much importance to have sufficient floor space available. Several small examining rooms are much better than a few large rooms. A useful plan is to

divide a room into examining booths (as for a medical clinic) by partitions rising about seven feet high, or by canvas curtains stretched on a pipe frame. At least some rooms which are wholly enclosed and, therefore, protected from ears as well as eyes, are important in order that physician and patient may, when necessary, be able to talk freely.

Sufficient space for waiting rooms is of importance and it must be borne in mind that should a dispensary, for example, receive an average number of visits of, say, 40 or 50 a day, the range in number would probably be between 15 and 80 and sufficient space for the maximum number must be provided. Separation of the sexes in the waiting rooms is essential, *unless* the waiting rooms are so placed as to be constantly under the eye of some responsible person or are part of a public hall where persons are frequently passing. The main admission door should be as accessible as possible from the street, and it is convenient if there is a vestibule so that baby carriages can be left by the mothers and be sheltered from the weather.

The equipment of the various clinics is a matter of too much detail to enter into here. In many clinics the surgical side gets the lion's share and the medical is neglected. The importance of providing the medical clinic with a microscope, blood-pressure apparatus and facilities for making the ordinary urine tests, can hardly be over-estimated. The general laboratory of the hospital should be accessible to the Out-Patient Department, but since it is desirable that all medical patients should have certain routine laboratory examinations made, it is found in practice much better to make these routine tests for albumin and sugar in the clinic itself, or close by, the equipment for this being inexpensive.

The use of the X-Ray for diagnosis is no longer confined to surgical clinics, and the X-Ray facilities of the hospital should be

made accessible to all clinics of the Out-Patient Department, as fully as possible.

2. *Medical Staff and Services*—Most clinics will have unsalaried medical staffs. The general principle which should underlie the arrangement of services is: *Have as few different clinical departments as possible, and have as long services in each department as possible.* The ideal is one chief in each department, continuous service throughout the year, and taking personal charge for at least nine months. A plan successfully worked in some clinics is to have the assistants divided up on a three-day-a-week basis, since many physicians find it easier to give three days a week for a fairly long period, than six days a week for even three months. But the most important factor is to have the responsibility for directing the clinic as a whole fall upon one man for as long a period as possible. If continuous service throughout the year cannot be secured, two "chiefs" with six months' service each are more than twice as satisfactory as four "chiefs" giving only three months.

The Out-Patient services should be intimately correlated with those in the hospital. The best plan is that one of the chief assistants in the hospital service should be the chief of the Out-Patient service in the corresponding clinic, medical or surgical. There are Out-Patient Departments in which this system prevails nominally, but in which the so-called "chief" gives no real attention to the Out-Patient Department. This is valueless.

It is unwise in a small dispensary to have a long series of different medical departments. One institution records in its catalogue medical, surgical, genito-urinary, gynecological, dermatological, gastro-intestinal, ophthalmological, laryngological, aural and dental. This is enough, or really too many, for an institution of ten times the size. The effect on a small institution is to have a lot of little departments independently managed, without proper coordina-

tion or team work in diagnosis and treatment, and to increase in some measure the expense, and in a great measure the difficulty of efficient administration. Therefore, let there be as few departments as possible! Medical, surgical and children's (if many children are expected as patients), are enough in a small Out-Patient Department with the exception that departments treating such specialties as the eye and the teeth must be recognized as independent.

3. *Admissions and Fees*—Here, again, it is impossible to enter into detail. The general principle is that there should be one person responsible for the admission of all patients. The physician should not be burdened with admitting, for his proper work is medical diagnosis and treatment. In the preceding article something has been said as to the policy of admitting patients, or of rejecting them because they are able to pay for the medical service they need. From the administrative standpoint the admission desk will work well and smoothly if the responsibility is concentrated in the hands of a person who has had training for the work and who is salaried. This person should be regarded as registrar, even if he or she has other duties, and should be responsible for the general statistics of the institution. If fees are charged, the registrar should be made responsible for remitting fees, whether of new or of old patients, this being properly part of the work of an admission desk.

The question of charging fees is one that has received some attention. There seems to be every reason why nominal fees should be charged patients. The money received is of benefit to the institution, because it furnishes funds for improving the quality of its work. The necessity of collecting fees and accounting for them assists in centralizing administration and in making it business-like. This is a positive advantage to every dispensary. Finally, the reaction upon the patients of charging these fees is a good one.

As for rates, the most frequent rate is

probably ten cents per visit and the same fee for each prescription. Especially expensive medicines may be rated somewhat higher. X-rays, injections of salvarsan, eye glasses, orthopedic plates, braces or surgical appliances can properly be charged for at prices estimated at a certain percentage above cost. In some dispensaries 25 cents is charged for the first visit for adults (10 cents for children) and 10 cents thereafter. It must always be understood that patients unable to pay fees are to receive treatment for whatever they can afford, or for nothing.

4. *Records*—The records of a dispensary may be divided into two kinds, administrative and medical. The important parts of the administrative records are the admission cards, index cards, and statistics. For each patient admitted two cards should be filled out—an admission card, given to the patient, with the name of the clinic to which admitted, the identifying number and preferably, also, the patient's name, age and address. The second card is a 3 x 5 index card, containing identifying information merely, viz., name, age and address of patient, dispensary number, clinic to which admitted, and date of admission. These index cards should be filed alphabetically in one central place, so that in a moment one can tell whether any particular person has been a patient in the dispensary. The card should be stamped with the date at the time the patient is first admitted, and the first clinic to which admitted, medical, surgical, etc. If the patient later enters other clinics, or is transferred thereto, or enters the hospital wards, the index card should be taken out and the new item entered.

The number of new patients received each day, the number of patients transferred, the total number of visits, should be recorded daily for each clinic.

This recording can be done at the admission desk if there is a registrar on duty there, or it can be done in the separate clinics. If there is a fee system the fees

should all be collected in one place and the daily statistics can best be recorded there also. These statistics should be summed up once a month. Patients should bring their admission cards with them at each return visit. If a card is lost they should be charged a small fee, 5 cents or 10 cents, for a new card. Each admission card should receive serial number and the index card should be stamped with the same number. This number should identify the patient in every clinic, as the medical record card in every clinic should be filed by number. Should a patient return without a card, the name may be looked up in the alphabetical index, the old number found, and a new admission card issued with the old number upon it.

The second sort of records contain the medical information. They should be kept on cards, not in books as used to be the custom. Each card should contain, besides the identifying information concerning the patient, a record of the date of each visit made by the patient to the dispensary, a succinct history of examination and treatment and, of course, the diagnosis. These medical cards may either be filed in one central place in the dispensary, all the records each patient has for different clinics being kept together in one folder, or the records for each clinic may be kept in the clinic itself. Filing in one central place will generally be found more advantageous.

The medical records of the Out-Patient Department should be correlated with those of the hospital.

5. *Nursing and Social Service in the Out-Patient Department.*—In surgical and gynecological work the attendance of a nurse is medically essential. Out-patient service is valuable as experience for nurses in training, and the training school of a hospital without an out-patient department suffers a serious handicap. The nurse in an out-patient department learns certain things which the ward does not give her, not only in relation to various diseases, dressings and modes of

treatment which rarely appear in the wards, but in dealing with patients. An out-patient clinic makes a demand upon executive ability which is valuable experience for any nurse.

An out-patient department without a trained social worker is handicapped in a way that may be called vital. When the source of a disease, or the cause that retards convalescence, lies in the patient's poverty or ignorance (or the ignorance of the mother, if the patient is a child), the doctor is helpless without the aid of a social worker, and the time which the doctor gives and the money spent in maintaining the clinic and providing medicines are all wasted. The functions and need of the social worker in hospital service or out-patient service are too well recognized today to require enlargement here. A few practical hints may be given concerning the place of social workers and nurses in a small out-patient department.

The admission of patients requires the attention of some one who is trained to deal tactfully with people and to show judgment and skill in ascertaining and interpreting the personal situations of patients. These qualities and abilities are part of the equipment of a properly trained social worker and a person of such training should be at the admission desk of the dispensary as registrar. If a small out-patient department of a hospital can only employ one full-time salaried person, this person should be a trained social worker who has had a nurse's training, also. She should have charge of the admissions as registrar, and supervision of the executive detail of the dispensary. One or more pupil nurses should be detailed from the hospital to assist the surgeons, gynecologists, etc.

If a dispensary is large enough to require and wise enough to afford two or more salaried persons, the person possessing the joint training of a social worker and a nurse (the training of a social worker does not mean a month or two of observation in some well-

established social service department, but a really extended and adequate course of training) should, as before, be responsible for the general supervision of the executive work of the dispensary and should take charge of the admitting. She should be responsible to the superintendent of the hospital. The second person employed should be a graduate nurse who does nursing work only, and who is responsible to the executive. If one or more pupil nurses are then detailed to the dispensary, they come under this graduate nurse, subject to the educational oversight of the superintendent of nurses. The graduate nurse should take charge of the medical and surgical supplies used in the dispensary, be responsible for the care of instruments, etc. Should there be need, an assistant social worker doing only social work should be provided, who will have no executive responsibility, but merely do case work. A clerk to assist the executive head of the dispensary, keeping statistics, case records, filing, and doing clerical work on the medical and social-service records, should be provided if the scope and importance of the work permit.

Finally, as to organization as a whole. Do not expect to maintain a dispensary successfully, to have it do work that is worth serious medical consideration, or stand intelligent public criticism, if a dispensary is allowed to run itself with the medical head of each clinic, changing every few months and running his own little kingdom without any central executive control. The principle of organization should be to centralize the executive control as fully as possible, even in a small dispensary, by employing such an executive as has been suggested, and to leave to the physician full responsibility for his proper work, the diagnosis and treatment of patients. The executive of the dispensary should be directly responsible to the superintendent of the hospital. Such a policy, once clearly explained to the medical staff, is certain to have their cordial support. It should be borne in mind that a dispensary deals with many people, including numbers of physicians, nurses and other employees and large numbers of patients. Efficient dealing with numbers of people requires organization. The first demand of efficient organization is a head.

EACH DAY

Each day I school myself to feel
That what I have and where I chance to be
Is for my present growth and future weal
The best for me.

Each day I seek for higher, better paths
Than feet of mine have ever trod;
Paths nearer to my brother man
And closer God.

Each day I try to touch some burdened life
And by that touch to make it strong;
To add a little to the world's great good
And weaken wrong.

Each day—which means each moment mine
I turn to heavy tasks, or tasks made light,
And glory in the power that comes to him
Who works with might.

—G. W. Hendricks, from *The Front Rank*.

Boiler Room Economics*

THOMAS HOWELL, M.D., SUPT., AND PHILIP MURRAY, ENGR.,
NEW YORK HOSPITAL, NEW YORK CITY

ABOUT 10 per cent. of the expenditures of the average hospital are for the engineering department. It is, therefore, apparent that this is an important department. As such it deserves careful study and oversight. In this paper the writers discuss some commonplace engineering subjects, but make no attempt to treat them in an exhaustive or scientific manner.

The question as to whether a hospital had better produce its own electricity is one which is occasionally asked. This question has been raised more frequently of late, because, in the large cities at least, so many business houses, for reasons of economy, convenience and cleanliness, or to utilize space more advantageously, are abandoning their electrical generating plants, and are buying their electricity from commercial plants. Their doing so naturally causes observing hospital superintendents to ask the question as to whether it would not be more advantageous for them to buy their current. In this connection it must not be forgotten that the requirements of a business house or factory are very different from those of a hospital. The demands of a hospital are usually much more varied, and are continuous day and night, including Sundays and holidays.

While freely admitting that factories and business houses are frequently more satisfactorily served from a central plant it is nevertheless our opinion that hospitals, at least those with over eighty or a hundred beds, should produce their own electricity. Hospitals of this size will usually have heating plants, steam laundries, steam cooking apparatus, steam sterilizers, refrigerating plants, etc. These serve to create a demand for steam throughout every hour of the year.

The steam required by part of these activities, at least, can be used in making electricity, and this without any loss of efficiency. In this way, electricity is produced as a by-product, and at a very insignificant cost. This is particularly true during the winter months, when a large amount of steam is required for heating purposes. Strange as it may seem, it has been proved that steam which has passed through an engine is more efficient for heating purposes than the same amount of steam direct from a boiler.

Mr. Wright, superintendent of the S. R. Smith Infirmary, Staten Island, reports that in 1912, the last year that the hospital purchased its electricity, its heat, light and power cost was \$8,068.21. In 1913, with its own electrical plant, the cost was \$6,458.91, and in 1914 \$6,369.89. This is a saving of over 21 per cent. Other hospitals have shown equally satisfactory results.

COAL

Bituminous coal will give better results, pound for pound and dollar for dollar, than will anthracite, but in many cities the use of bituminous coal is prohibited on account of its tendency to produce great volumes of smoke. Where it is not permissible to fire with bituminous coal, one of the steam sizes, or cheaper grades of anthracite coal, is ordinarily used. These are known as Pea, Buckwheat and Rice. The size and quality of the coal best fitted for its use must be determined by each hospital by actual tests. At the New York Hospital we have found by experience that the best grade of No. 1 Buckwheat is the most economical for our plant. We pay about fifteen cents a ton above the regular price for No. 1 Buckwheat

*Read at the Convention of the American Hospital Association, San Francisco, Cal.

in order to obtain coal from a certain mine, because it gives us the best results. A trial of No. 2 Buckwheat, which sells for about fifty to sixty cents less a ton than the coal we are using, gave unsatisfactory results. Our experience with Pea coal was also unsatisfactory. It cost more per ton than the No. 1 Buckwheat which we use, and the number of tons burned was about the same.

What we would emphasize in connection with this subject is that every hospital should make careful tests to determine what coal best meets its requirements, and then insist upon getting it.

FACILITIES FOR WEIGHING

Some dealers are dishonest. Some dealers have dishonest employees. Sometimes honest mistakes are made in weighing. For these reasons no hospital which buys coal can afford to be without suitable wagon scales. We know of one large hospital which had no wagon scales because they were considered unnecessary and expensive. At the end of the year it was discovered that they were short nearly 1,000 tons of coal. It is unnecessary to add that an order for scales was placed immediately.

MECHANICAL STOKERS

Mechanical stokers are occasionally of considerable service in bringing about boiler room economy. The Hospital of the Good Shepherd, at Syracuse, N. Y., installed a set, and in eleven months saved \$3,600 from its coal bill. Dr. Pratt writes concerning it as follows: "It burns only the amount of coal necessary to obtain the steam pressure desired. The cheapest kind of soft coal can be used. As it is a self-feeder, one man can easily take care of two boilers and also look after the engine room. The mechanical stoker has this additional advantage, that being self-fed from a magazine that is never allowed to become empty the cold air does not reach the fire nor metal work of the boiler, and so saves loss of steam and de-

struction of tubes and other iron work; as is the case when the door to firebox is frequently opened to throw on coal."

BOILERS

Boilers must have sufficient capacity to produce the required amount of steam without forcing. They must be kept free of internal scales, and the tubes and flues must be frequently cleaned. The brick work must be kept in good repair in order to prevent air leaks into the firebox and combustion chamber. It is very essential that the grate bars in the furnace be of a suitable design. If this is neglected a considerable amount of coal may be wasted. The furnace doors should be tight, and only a sufficient admixture of air admitted to consume the gases leaving the furnace. There should be a feed-water heater of sufficient capacity to supply water to the boilers at about 200 degrees. Pumps designed to pump hot water are essential.

Much depends upon the fireman, and there are very few who are competent. A careless fireman will nullify all attempts to secure boiler economy. When you inspect your boiler room observe carefully the work of the fireman. Notice whether he spreads the coal. To insure perfect combustion coal must be spread evenly and thinly over the fire. In cleaning the fires the fireman should do so as rapidly as possible, as the open furnace doors allow the cold air to rush in and cool the boiler. Care must be taken not to dump unconsumed coal with the ashes. It is very essential that the water in the boiler be kept at the proper level. A damper regulator is necessary, as it prolongs the life of the boiler and effects a saving in coal. However, with a mechanical stoker burning soft coal it cannot be used for it defeats the purpose of the stoker and produces great volumes of black smoke.

BOILER SCALE

One cause of boiler inefficiency is scale. This scale consists of impurities which are

precipitated from the water when heat is applied to it. Scale is familiar to you all. You have seen it in the steam kettle on the kitchen range. Scale collects on the inside of a boiler, on the tubes, shell and head. It acts to thicken these, and accordingly more fuel is required to produce the requisite amount of steam, as the heat must pass through the iron of the boiler and also through the scale, which is a poor conductor. It is apparent, therefore, that the more scale there is the greater the waste of fuel.

Many engineers favor the use of compounds in removing boiler scale. Our results with compounds have not been satisfactory because of their tendency to cause foaming in our boilers, and thus carrying the water from the boilers to the engines, a dangerous condition. Under certain conditions these compounds may be of service, but we have found it safer and more economical to remove scale by hand.

ENGINES

Opinions are divided as to the most economical engine, but no matter what kind of engine is installed it must be given careful oversight in order to obtain economical results. There is considerable loss of steam and, consequently, of coal when the internal parts of the engine are neglected. Care should be exercised in seeing that all valves are properly adjusted, and that the piston and springs are kept in proper alignment. Leaking stuffing boxes and valve stems show want of care on the engineer's part. It is very desirable that steam traps on high-pressure systems be kept in good working condition, as they are a source of loss if not kept in proper order.

PUMPS

Elevator, house and other service pumps are often overlooked, and their leaking pistons and steam valves are a great source of loss that is not apparent to the casual observer.

EXHAUST STEAM

With non-condensing engines exhaust steam is a fruitful source of loss, especially during the summer months. But, as stated before, during the cold weather this steam can be used for heating purposes, for which it has been found more efficient than direct steam. Exhaust steam can also be used in the laundry drying rooms. It is not practicable to use it for cooking purposes. It should be, however, used in heating warming tables, etc. One of the great uses of exhaust steam is in heating water for the house service. It is a decided waste to use live steam for this purpose. At the New York Hospital water was formerly heated by live steam, and the results were unsatisfactory on account of the expense, and because the thermostatic control did not always control, and as a consequence the water was frequently either too hot or too cold. Finally a hot-water heating device operated by exhaust steam was installed, and while it has no thermostatic control it has proved very satisfactory. This change resulted in an annual saving of approximately \$3,000.

LAUNDRY

In the equipping of a laundry plant it is desirable that each piece of machinery has its own motor attached, as in this way it is possible to operate any one machine without operating the entire plant.

Electrically heated flat-irons and body ironers consume a great amount of electricity. At the New York Hospital we have found steam presses very much more economical than electrical body ironers, and also more useful and easier to operate. We estimate that our two electrically heated body ironers consumed about \$3 worth of electric current daily. They were replaced with three steam presses, and the cost of operating these is not appreciable.

ELECTRIC LIGHTING

When we used carbon filament lamps at the New York Hospital and were, perhaps, a

little careless, generally, about the amount of electricity consumed, our ampere meter during the winter months frequently showed that we were delivering 900 amperes of current. Since Mazda lamps of the Tungsten type were substituted for the carbon filament lamps and other economies introduced, the ampere meter rarely indicates that we are using over 450 amperes.

Too little thought has been given to the lighting of institutions. In many instances the lamp fixtures are not properly located, and the number of lamps is too large or too small. For instance, in one of our small sterilizing rooms, which is very high, we had a cluster of eighteen lamp bulbs against the ceiling. By lowering the fixture we got just as efficient light with four bulbs.

MINOR ECONOMIES

By sifting the ashes from the kitchen ranges, it is possible to reclaim fifteen to twenty tons of coal annually. However, where gas sells for 80 cents or less a thousand cubic feet, it will be found much more cleanly and convenient and about as economical to burn gas in the kitchen ranges. We have done our cooking with gas for a year, and have found it very satisfactory. We should not consider again the use of coal in kitchen ranges.

To get the best results out of a refrigerating plant it must be carefully looked after. During the winter months, when the demands upon it are very light, the engineer should thoroughly overhaul it. It is particularly essential that he should see that the circulating water coils are thoroughly cleaned. If these coils are allowed to get choked up with sediment the efficiency of the plant is reduced to the minimum.

We have found that neglect to clean out the coils of our plant for six or eight months

will reduce the efficiency 50 per cent. In other words, before the tubes are cleaned out it is necessary to operate the plant twenty-four hours a day, but after they have been thoroughly cleaned it is only necessary to operate the plant twelve hours a day.

It would hardly appear necessary to call attention to such obvious wastes as leaky pipe joints and valve stems, and improperly covered steam, hot water and brine pipes. But there are many well-managed hospitals where too little attention seems to be paid to these sources of waste.

Superintendents will do well to thoroughly inspect the hospital piping at frequent intervals. They should insist that the engineer promptly and properly repair all pipe leaks instead of resorting to tin cans to catch the drip.

If you are planning a new hospital insist that the steam, hot water and brine pipes be so located that they are easily accessible for repairs and recovering. Pipes buried in the walls and floors have given us no end of trouble and expense at the New York Hospital.

It frequently occurs that the engines, boilers, dynamos, motors, refrigerating and other machinery selected for a hospital lack in that they have no reserve capacity. This is a mistake. Machinery worked to its full capacity soon wears out, whereas machinery worked below its capacity lasts a long time.

In the case of a machine worked to its capacity a little additional strain placed upon it results in a breakdown. Generally this break down comes at the most inopportune moment. The inadequate refrigerating plant breaks down during hot weather, and the inadequate heating plant during cold weather.

It is a pretty wise rule to figure out the plant capacity required, and then double it.



MEDEEM NEWS SERVICE

BLINDED SOLDIERS AND SAILORS IN THE WORKSHOP OF THE HOUSE OF HOPE

In the War Zone

IN A beautiful garden, which is always dark to the thirty-four soldiers and sailors who walk on its sunny lawns, stands the white House of Hope—hope that brings to them the dawn with new life of usefulness and interest.

The House of Hope is St. Dunstan's, Regents Park, which has been presented by the owner, Mr. Otto Kahn, a prominent American banker, for the use and instruction of our fighting men who have lost their sight in the defense of their country. It is known as the Blinded Soldiers and Sailors Hostel.

The tragedy of these brave men on whom the darkness has suddenly descended is uppermost in one's mind when entering the House of Hope and watching them move slowly from room to room; but this feeling is rapidly succeeded by one of astonishment, when one sees them at their work and knows

their marvelous intelligence and adaptability—reassurance comes, too, with their joviality as they laugh and joke over their task.

Miss Edith Cox, superintendent of the Faulkner Hospital, Jamaica Plain, Boston, is on three months' leave of absence, serving with the Harvard contingent at the American Ambulance Hospital, Neuilly, Paris, France. From an interesting letter sent to a friend in Boston we are permitted to give the following extracts to our readers:

"There are about 420 here now, but the great majority are convalescing. Most of them are French, a few Arabs from Northern Africa, and some from England. The English soldiers are now being sent back

home if at all possible. They are all such splendid patients, so cheerful and bright, in spite of their injuries, some of which have been very serious. They have had a good many amputations here and some dreadful face injuries. The other day I passed a young English boy of nineteen with both legs amputated above the knee. Think of it.

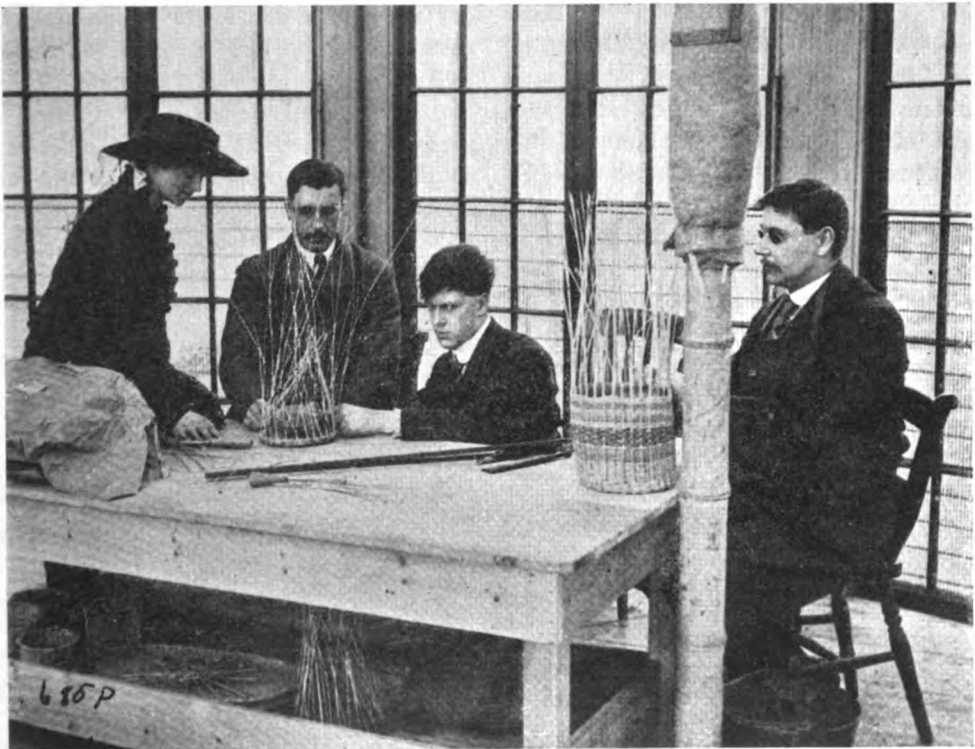
"The work done in this institution by the dentists is simply marvelous—about the best part of it all. So many of the men have been hit in the face by shells, having their jaw bones broken, all their teeth knocked out, and have been brought in terribly disfigured. The repair work has wrought miracles and they are very proud of the dentistry department.

"One poor man was sadly disfigured. He had been seriously wounded and was lying helpless on the field when a soldier (one of

the enemy) passed by, saw him move, hit him across the face with his rifle, breaking his jaw-bone, disfiguring him for life.

"Every Wednesday evening they give a concert in the dining-room for the soldiers. I was in last week for a few minutes and it made me heart-sick. The big room was filled with these soldiers, some without an arm, others with only one leg, some had lost both an arm and a leg, and, again, others with their heads all tied up, disfigured faces, etc. They seemed to be having a real good time and enjoying the performance thoroughly, but their cheerfulness was too much for me. The contrast between the performance and the audience was too great. Yet I realize the only thing to do is to be cheerful under even these conditions, and the French people are certainly heroes.

"The soldiers are very happy here. They receive excellent care and the building is



MENDEM NEWS SERVICE

BASKET MAKING AT THE HOUSE OF HOPE

flooded with sunshine every day, unless it rains. It does rain several times a day in Paris, but just April showers, lasting a few minutes. It is never safe to go out without your umbrella.

"I wish you could go into the dining-room some day at noon and see the people at luncheon. There are ten or twelve large tables in each room and every place is filled. There are doctors, auxiliaries, nurses, orderlies, chauffeurs, ambulance drivers, officers of the institution, boy scouts, etc., all together. It certainly is worth crossing the Atlantic to see.

"The 'auxiliaries' are the volunteer women, not trained nurses, who help out in the wards, the supply rooms, etc. Some are Americans living in Paris, and some French women. Secretary McAdoo's daughter and a friend of hers from Washington are here, as auxiliaries in the wards. They are both very attractive-looking girls. I don't believe any uniform in existence is lacking here. There are nurses from all over the world (about 150, I believe), with every uniform conceivable and the costumes of some of the auxiliaries are amusing. A great many of them wear flowing caps like bridal veils, a few wear brooches, bracelets, rings with big diamonds and emeralds, some even have necklaces and others have most unbecoming rigs. But the majority of them are splendid women, simply dressed and evidently very much in earnest, eager to help out in any way. A number are very prominent wealthy citizens of Paris, American born. There are several Counts working as orderlies, and doing good work.

"There is a small chapel in the building, one end of which is for Roman Catholics and

the other for the English Church. They simply turn the chairs round for the different services. Don't you think that a fine idea?

"At night our lights are turned off at 9.30 and the night nurses use candles the rest of the time. All our windows are shaded by dark blue curtains and the police are very strict about any light showing anywhere. It seems this big building is a landmark or supposed to be one for the Germans, who are very anxious to destroy the Eiffel Tower, the Marconi Station in communication with Russia. This building is practically at the gates of Paris, and is said to show up at night if well lighted. You have probably heard about the Zeppelin raid just before we arrived. A bomb fell on a street very near here but no harm was done. The people here are not one bit afraid of Zeppelins. They have to watch the terrace and keep the nurses back if a Zeppelin is supposed to be about; that is the rumor, anyway. The day we arrived one of the Massachusetts General Hospital girls came in our room, told us not to be alarmed if we heard a horn tooting in the middle of the night. It just meant that Zeppelins were about and was an alarm for the people. You can imagine how we felt but now we don't think about it at all; at least, we are not uneasy.

"We see aeroplanes going by almost daily. It is a most novel and interesting sight.

"I simply can't write any more now. It is time for me to return to the operating room and get some tea on the way up. Afternoon tea is served every day and nice little cakes which we never miss. The American ladies do that. Isn't it nice of them? I never met so many kind people in one place before."



Recreation for Nurses

CORA MCCABE SARGENT, R.N.

Sheppard-Pratt Hospital, Towson, Md.

MUCH is being constantly planned and ably executed in the way of work in our training schools for nurses, but the other side of their lives—the play side, which is of hardly secondary importance, because it means such an increase of that valuable asset to a nurse, health—is rarely given even a passing thought. The old saw about all work and no play producing dullness is as applicable to Jill as to her brother Jack and is freighted with truth.

Schools and colleges the world over have tested the value of rightly directed recreation as a stimulus to mind and body and, as a result, have incorporated certain exercises and amusements in the required class work of each term, assuming certain portions of the expense and employing directors whose duty it is to carry into effect the "play" part of the curriculum. The heads of many of our large stores have an organized recreation department for their employees and are so enthusiastic over the returns of the investment in the way of better service that the movement is rapidly spreading. Strangely enough, the heads of nurses' schools, save for a few notable exceptions, have not as yet sensed their duty in this direction. That is to say, they do not realize that the hospital or, more correctly, the school should assume the responsibility not only of providing certain recreations for their nurses, but should compel them at stated times to avail themselves of the provision.

A nurse is, by reason of the circumscribed life of the hospital, inclined to grow narrow in her views and her interests are largely bound by her profession. All this tends to produce limitation of thought and magnify the nurse's sense of ego, thereby greatly reducing her scope of influence in a profes-

sional way. Again, constant association with the sick and the constant presence of the sorrowful side of life, unless some other conditions are introduced to counteract their effect, are very apt to cause the nurse to become morbid and neurasthenic. Consequently, instead of an inspiration and a tower of strength to the patients with whom she comes into contact, she is a positive menace to their well doing, no matter how perfect her technique may be.

It may be argued that the nurse should realize the importance of recreation and seek it for herself. Granted that she does: There still remains the danger, and it is not an imaginary one, that her recreation being thus left to chance, will work its own undoing. The line which divides relaxation from dissipation is not always clearly defined in the mind of a young woman. Then, too, the hospital constitutes a little world of its own, and the nurse, coming as she does from the quiet of her own home, soon becomes so absorbed in the excitement of her new work that, before she realizes it, she is so securely hedged about by routine and the interests of the little world of which she has become a part, that she has no desire to break away from it, and, indeed, seldom does, unless some compelling influence is brought to bear. Even when she does avail herself of an occasional outing with some of her classmates, she and they more often than not carry the burden of their work with them, allowing it to form the chief object of concern and topic of conversation. In proof of this, one has but to overhear the conversation of a group of nurses, seemingly on pleasure bent, but so saturated mentally with the comings and goings of the wards and their school work that unconsciously all other interests are overshadowed.

Admitting the necessity for prescribed and properly directed recreation for our hospital nurses, especially those who are yet in training, the next thing is to consider the legitimate forms of recreation that will appeal to the pupils of such a school, made up, as it always is, of young women from various walks of life and of such different mental and social status.

Dancing may certainly be mentioned as one of the most universal amusements and, at the present time, has an unparalleled popularity with all classes. In every institution there is always some room which may be utilized at certain times for a "play ground," and a teacher may be employed at a slight money expense to give at least a few lessons, initiating the newest dances. There is always some one among the nurses themselves, provided a place and a time are at her disposal, willing and capable of supplementing the teacher's work. It will soon be discovered that there will be a full attendance on the evenings set apart for dancing. An evening spent in this way not only provides enjoyable relaxation for the nurses, but also promotes sociability and good fellowship. If light refreshments put a period to the evening, the joy will be complete.

As to the music for these occasions, the Victrola with its dance records almost suggests itself as a means of compassing this want. In fact, the Victrola is now classed under the head of essentials in all up-to-date institutions and should, of course, be at the disposal of the recreation director.

Cards form another popular diversion and there are so many different games included under this head that it is easily possible to interest everybody in at least some of them. One of the most relaxing of the card games, from the viewpoint of securing an entire change of thought absorption, is auction bridge, because it requires complete concentration of the mind while it is in progress upon the game itself. One evening each week might be given up to cards, serving at

the close, as at the dance parties, a little something to eat, the expense of which to the hospital will be so slight, but which adds the desired touch of festivity and is especially appreciated in an institution where even the meals must be more or less a matter of routine and often quite monotonous.

A course in current events, making the period devoted to it a social event rather than class work, will be both instructive and enjoyable. By way of suggestion, should this idea be adopted, the nurses might take turns reading aloud extracts previously selected by the recreation director, whether she happens to be the superintendent of the school or one of her assistants, while the others sewed, embroidered or were engaged in some similar occupation. Reading aloud is a wonderful practice for a nurse, teaching her to modulate her voice and acquire confidence in herself. A pleasant reading voice is much to be desired by a nurse, for in her profession she will often be called upon to read aloud. Being in touch with the vital events of the day is an absolute essential, yet when one is employed ten of the twenty-four hours and must devote a portion of the remaining ones to study and sleep, it is almost an impossibility to do any outside reading. Hence, the value of this form of relaxation should be apparent.

Handicraft offers another beneficial recreation for nurses. It will furnish pleasant diversion for the time being and a reserve occupation for future days, especially to the nurse on private duty which, while it may in a way be most confining, often leaves much unoccupied time on her hands. Again, it is a wonderful reserve accomplishment when a nurse is cast upon her own resources for a way and means of amusing a convalescent patient. Men, women and even children may be interested in handicraft, including as it does such a wide range in both materials and designs.

If the hospital with which the training school is connected boasts a gymnasium, a

wide scope in the way of diversion is possible. Volley ball, indoor tennis and similar games are great health promoters. Folk-lore dancing is an especially popular and attractive exercise for women.

Many of the modernly equipped hospitals have a hydrotherapeutic department, and in these swimming is suggested as a valuable recreation, which brings in return much in the way of increased health. If the hospital is in or near a city, roller skating and bowling are possible, and should be encouraged because of their exhilarating effects.

Moving picture shows are daily becoming higher classed, both in the subjects of the scenarios and the actors presenting them. They can be suggested as a cheap, pleasant and often a profitable way of spending an evening. It is now possible to bring this form of entertainment to those too remote to attend the theatres where pictures are featured. Moving picture machines for parlor productions are now on the market at a reasonable price and are so simple that they may be attached to the ordinary electric light fixture. But the lights, the crowd, the music, the little excitement of going and returning, attendant upon the public "movies," all contribute to the diversion and entire change of "thinking atmosphere" which is the thing desired. An occasional theatre party could easily be arranged and would never fail to be helpful and give pleasure to those making it up.

If, by fortunate chance, the hospital is

conveniently near a large body of water, a boating trip now and then during the summer would be an ideal way of securing a change. The extra time allowed for such excursions would bring its own reward in better service.

One thing which can and should be done in every hospital is to adopt the custom of serving afternoon tea to the nurses. The expense of such an arrangement is too inconsiderable to be even mentioned. Its value cannot be estimated. It is a stimulus to the body and a rest to the mind in that it affords a few minutes' diversion from the ward routine during the long hours of the afternoon. Each nurse in turn should be asked to assume the responsibility of the tea table for a week at a time, during the appointed hour. The daily time slip could be so planned that each nurse could be spared for a few minutes. The nurses' study or sitting room would seem to be the most appropriate place to establish a tea table.

The foregoing suggestions should certainly furnish food for thought to those superintendents of training schools who as yet have not wakened up to the value of providing recreation for their nurses. It would, of course, be neither possible nor advisable to adopt all the ideas presented. Each school must be a law unto itself in such matters. The one object of this paper is to bring the subject to the notice of superintendents, with the hope that it will so quicken interest that action will soon follow.



Eye Nursing

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PART III—*Continued*

FOLLICULAR CONJUNCTIVITIS (SIMPLE GRANULATED EYELIDS)

FOLLICULAR conjunctivitis is a form of catarrhal conjunctivitis resulting in the formation of enlarged follicles or rounded granules almost entirely upon the lower lid. The follicles, often arranged in rows, disappear after a time and leave few if any permanent changes in either the lid lining or cornea. The disease occurs most frequently in children (alluded to incorrectly as granulated eyelids by the laity) and is often found in schools and asylums. As the enlarged follicles on the palpebral conjunctiva resemble trachoma granules, it must never be confounded with this latter serious eye affection.

Treatment—A stringent solution of some kind and a 4 per cent. ointment of copper citrate are among the common remedies employed and will most likely be ordered. The palpebræ conjunctiva lining the under surface of the lower lid is frequently painted with a 2 per cent. solution of silver nitrate, and when necessary the granulations operated by squeezing out with forceps under a 4 or 8 per cent. cocaine solution. In addition refractive errors are corrected by the oculist and children placed under a good hygienic régime. Altogether the affection may be considered as decidedly chronic in character, the follicles eventually disappearing, as has been said, without any permanent injury to the lids or eyeball. This last fact is one of the chief points of differentiation between simple follicular conjunctivitis and the more serious and almost incurable disease, trachoma. In preparing for the operation of squeezing out these enlarged lid follicles the preparation (supplies) is practically the same as that described under the next

subject, *i.e.*, "Nurse's Preparation for Expression (Squeezing) of Trachoma Granules" and should be read over carefully.

TRACHOMA

Trachoma, or the true condition of granulated eyelids, is a most destructive and serious eye disease and quite prevalent. It is seen most frequently in the poor immigrant classes.

Etiology—The disease is caused by contagion from another eye and the infection is transferred principally through eye secretions. Immigrants afflicted with trachoma, according to United States law, are not admitted into this country.

Trachoma being more or less an incurable disease, because of its lengthy duration and disastrous complications, is responsible for a large number of cases of partial or complete blindness in the poorer classes of Russian Jews, Egyptians, Poles, Syrians, etc.

Symptoms—The entire conjunctiva (inner lining of the lids) is reddened and covered with coarse, fleshy-like granulations arranged in rows. The granulations (trachoma follicles) are mostly confined to the conjunctiva lining the under surface of the upper lid and upper retrotarsal fold, but both lids are seriously affected. In acute cases there is swelling of the lids, muco-purulent discharge, itching and burning of the eyes and great sensitiveness to light. The process after a time results as mentioned in serious scarring from scratching of the cornea, and interferes with vision if the opacities are in front of the pupil. There are also cicatricial changes in the conjunctiva and a tendency toward vascularization or growth of fine blood vessels. The conjunctiva in this

condition does not return to a normal condition, even though the granules may disappear. Relapses are frequent. The most common complication of trachoma is pannus (growth of small blood vessels over the upper half of the cornea), corneal ulceration, deformity of the edges of the lids and distortion of the lashes.

Treatment—The treatment of trachoma varies somewhat, according to the stage of the disease. As trachoma is a very serious condition, persistent care and constant medical supervision covering many months is imperative. Eye washes consisting of corrosive sublimate solution 1-5,000, and touching the granulations with a pencil of copper sulphate or 2 per cent. silver nitrate solution are among the usual remedies employed. Forcible and frequent rubbing of the granulation with a cotton-wound toothpick dipped in a 2 per cent. solution of silver nitrate solution is the ordinary procedure. Ointments of yellow oxide of mercury, etc., as ordered by the physician, are used routinely several times daily to keep the eyes well lubricated. Atropine sulphate 1 per cent. is ordered where there is severe corneal ulceration or inflammation of the iris. Both cold compresses and hot baths are beneficial in the acute stages. Where medicinal treatment does not secure decided results, the operation of squeezing out the granulations may be performed by the surgeon, either under a strong 10 per cent. cocaine solution or under a general anesthetic, as well as other measures which may suggest themselves. The treatment of trachoma is apt to be so varied that in the main only the general principles of approved ophthalmic nursing can be laid down for the nurse's guidance.

NURSE'S PREPARATION FOR EXPRESSION (SQUEEZING) OF TRACHOMA GRANULES

As this is a most common operation the nurse should have a good working idea of the materials required. The patient is first placed in a good light, flat on his back on a

bed, operating table or on a couch of good height. His clothes are next covered with a half sheet and a clean towel pinned around the head, covering the hair. A piece of cotton should also be inserted at the entrance of each ear canal, so that eye solutions accidentally flowing over the lids and down the side of the face will not fill the ear. Medicines and instruments are to be placed on a convenient table near the head of the bed within easy reach of the specialist, who usually stands at the right side of the patient or at the head of the bed, treating the lids from behind. Anesthesia for squeezing and rolling out the granulations is ordinarily secured by dropping a strong 10 per cent. solution of cocaine in the eye two or three times. Occasionally a general anesthetic is given.

The materials ordinarily required are as follows: Small bowl of sterile salt solution or boracic acid, cotton balls (sponges) for wiping away secretions, clean eye droppers, few toothpicks used in both turning the lid over or later wrapping the ends with cotton in order to apply a weak 2 per cent. silver nitrate solution to the inside of the lids, small bottle cocaine 4 per cent. and 10 per cent. adrenalin chloride 1-1000 solution, silver nitrate 2 per cent. solution, stick of copper sulphate, bichloride ointment 1-3,000, yellow oxide of mercury ointment (2½ grains to ounce of vaseline), Prince trachoma ring forceps (Fig. 22A), Knapp roller forceps (Fig. 22B) or Noyes trachoma forceps (Fig. 22C). In many eye and ear infirmaries or private oculist's offices, where a good deal of lid treatment is done, the above instruments are always kept at hand ready for use. In dealing with trachoma the nurse must be careful not to contaminate her own eyes by undue carelessness and the hands should be washed thoroughly when finally finished with the case.

PURULENT CONJUNCTIVITIS

This is one of the most important subjects

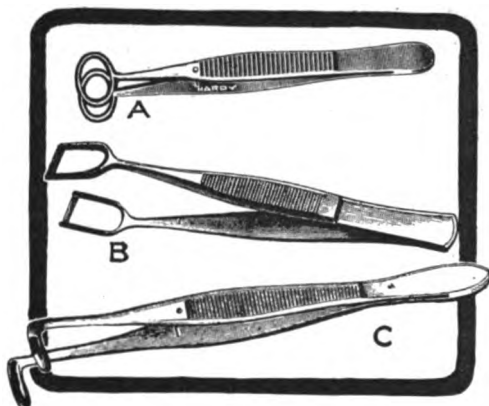


FIG. 22—(A) TRACHOMA (GRANULATION) FORCEPS (PRINCE'S). (B) TRACHOMA ROLLER FORCEPS (KNAPP'S). (C) NOYE'S TRACHOMA FORCEPS.

The instrument, Fig. A, the ordinary Prince ring forceps for squeezing out lid granulations, either in trachoma or in the simple granulations of children, is the one most commonly used. As the operation, especially in trachoma, is quite painful, both a four and ten per cent. solution of cocaine should be furnished from the drug department. As real trachoma is an infectious eye disease, the instruments should be boiled, both before and after use.

in the entire range of ocular nursing. In dealing with this affection it is customary to describe three forms: First form—that found in the new-born baby and called ophthalmia neonatorum or infantile purulent conjunctivitis. This condition is due to gonorrheal infection from the mother. Second form—gonorrheal ophthalmia of adults or gonorrheal conjunctivitis—which is also due to infection with the gonococcus organism. Third form—acute purulent conjunctivitis—due to any accidental infection which the microscope shows is not gonorrheal in origin. The manifestations in this last or third form of acute purulent conjunctivitis are, as a rule, less violent and there are fewer serious eye complications.

OPHTHALMIA NEONATORUM

Ophthalmia neonatorum is an acute purulent conjunctivitis occurring in the new-born child or within a very short time after birth.

Etiology—It is due to infection by gonorrheal secretions from the genitals of the mother during parturition and appears, as a rule, from three to six days after birth. Both eyes are usually affected. The gonor-

rheal secretion is highly contagious to other eyes.

Symptoms—The disease usually begins with slight redness of the eyes, followed by the formation of a purulent secretion and a little lid swelling. This infection is a very serious one on account of possible perforation of the globe from ulceration or loss of sight from the formation of scars over the pupillary area. Every nurse should become familiar with the subject of ophthalmia neonatorum. The condition is preventable if proper precautions are employed immediately after the birth of the child.

Crede's Method of Prophylaxis—This method consists in cleansing the eyes of the new-born child with warm boric acid solution immediately after birth and *instilling one drop of a 2 per cent. solution of nitrate of silver in each eye*. The instillation of the strong 2 per cent. silver solution occasionally causes slight redness of the conjunctiva for a day or two following, but is of no consequence. This treatment destroys any gonococci which may have entered the eye during birth. Thoroughly cleansing the eyes of an infant after birth by either the physician or nurse is imperative and should under no circumstances be neglected. It is good policy, also, to keep the eyes clean for a day or two following, by the use of a warm boric acid solution. In most States Crede's method for the prevention of possible blindness from ophthalmia neonatorum has become a State law.

Ophthalmic Nursing in Pus Cases—Intelligent, persistent and careful nursing is the important treatment in these cases and the big factor in success. Frequent cleansing every thirty minutes and the use of either argyrol 15 or 25 per cent.* or silver nitrate 1 per cent., is the routine method of procedure usually ordered. Cold compresses frequently repeated for lid swelling and an eye ointment such as vaseline applied to the margin of the

*Argyrol, 15 and 25 per cent., is the most frequent preparation used.

lids night and morning are also necessary adjuncts. Protection of the good eye, if only one is infected, by a bandage or cotton stuck down with collodion is at times of the greatest service. If there is haziness of the cornea or a corneal ulcer present, the physician usually orders atropine sulphate one-half of one per cent. solution instilled in the eye either one or three times daily, as he may think necessary. Careful nursing and expert medical supervision will save the sight in most of the cases. Gonorrheal cases are strictly isolated in the gonorrheal ward.

Preventable Blindness—About 30 per cent. of all the diseases of the eye which lead to blindness may be classified as preventable. Ophthalmia neonatorum alone in the past has been responsible for nearly 20 per cent. of blindness in infants and young children. Preventive or prophylactic medicine in relation to children should be studied by every nurse as "an ounce of prevention is worth a pound of cure." Nurses graduated from recognized hospitals are each year required to acquire a more and more comprehensive knowledge of the practical methods employed for the prevention and spread of infectious and contagious diseases. Ophthalmia neonatorum is a preventable disease and prophylaxis is of the utmost importance. Crede's method is a preventive which all nurses should keep constantly in mind. This simple routine of dropping a 2 per cent. solution of silver nitrate into the eyes of a child immediately after birth has greatly reduced the percentage of "pus eyes." It is worth repeating with Holt that "there is no more promising field in medicine than the prevention of disease in infancy and childhood." The majority of the ailments from which children suffer as a rule are preventable. Prophylaxis aims at the solution of two problems: (a) The removal of all causes which interfere with the proper development of children; (b) the prevention of infection.

DISINFECTION OF ROOM, BEDDING AND CLOTHING

In cases of ophthalmia neonatorum everything which comes in contact with the eye should be carefully disinfected. All cloths, cotton, etc., used for washing the eye should be wrapped in newspapers and burned. Clothing, sheets, pillow slips, etc., accidentally wet by any discharge from these eyes must be soaked in from 3 to 5 per cent. carbolic acid solution for several hours before being laundered. In the laundry, also, such clothes should be boiled at least twenty minutes in a boiler with the lid on confining the steam for better sterilization. The nurse from the very first should use every possible means to prevent the mattress on the patient's bed, furniture in the room and anything in the adjoining bathroom from becoming contaminated. Mothers must be cautioned against allowing any of the secretion from the baby's eyes to get into their own eyes. In institutions containing large numbers of infants and small children cases of ophthalmia neonatorum should be isolated. Next in importance to preventing infection is the early recognition of the disease, followed by some efficient treatment. Nurses should remember that a large number of bad results encountered in daily work often become so from neglect or through ignorance. An intelligent trained nurse can do a tremendous work in any community along the lines of social service if she will but try. As a rule it is best to take out all unnecessary furniture and draperies in rooms in which these patients are to be confined, in order to avoid the chances of unnecessary contamination or spread of the infection from the eye discharges.

GONORRHEAL CONJUNCTIVITIS (GONORRHEAL OPHTHALMIA)

Gonorrheal conjunctivitis is always acquired through infection from gonorrheal secretion. Usually the fingers of the adult patient transfer the virus from the genitals



FIG. 23—BULLER'S TRANSPARENT (ADULT) EYE SHIELD FOR PROTECTING A NON-INFECTED OR GOOD EYE FROM GONORRHEAL OPHTHALMIA WHEN ONLY ONE EYE IS INVOLVED.

This shield, consisting of a watch glass held between two pieces of adhesive plaster, is placed over the unaffected eye and securely sealed above and on the nasal and temporal side, but not so tightly below, where a slight aperture is usually left to permit of circulation of air. This is but one of several good methods for protecting an eye from infection with such a dread disease.



FIG. 24—KNAPP'S EYE DRESSING

Another method of preventing a good eye from being infected in gonorrheal ophthalmia as used at the Manhattan Eye, Ear and Throat Hospital. This dressing consists of a few layers of gauze cut to fit nicely over the eye and held in place by two narrow strips of adhesive plaster. Such a dressing forms a good protective dressing for almost any occasion.

to the eyes. It is a very grave eye infection, as almost one-half of the eyes infected with this disease are apt to be damaged in some way.

Symptoms—The onset of the disease is ordinarily as follows: In from one to two or three days after infection the eye begins to burn and smart a little and feel generally uncomfortable. Very soon the eyeball grows red and the lids swollen with beginning eye discharge. This rapidly progresses and in some cases the extent of the inflammation becomes so great that it is difficult to inspect and treat the eye. The treatment in these cases, however, must be kept up at frequent intervals day and night, in order to save the eye.

Ocular Nursing—The treatment here is practically the same as for gonorrhea of the eyes in infants (ophthalmia neonatorum) as previously described. A constant effort should be made to remove the purulent

secretion as rapidly as it forms. Considerable quantities of antiseptic solution, such as a saturated solution of boric acid (4 per cent.), sterile salt solution, bichloride of mercury (1-10,000), permanganate of potassium (1-5,000), etc., are best used in the form of copious eye irrigations. This is usually followed by the instillation of a drop of silver nitrate 1 per cent., or argyrol 15 or 25 per cent. Ice compresses to the eye should also be used continuously and vaseline applied to the margin of the lids night and morning. A day and night shift of nurses are often required to successfully combat the disease in adults and save the sight. The non-affected eye should be carefully protected from possible infection by the application of a cotton cocoon. It is important in handling these cases that the physician also be provided with a gown or apron and rubber gloves for his own protection when he sees the case. A wash bowl, bichloride of mercury solution and soap and towels should further be

arranged in an adjoining room or hallway for washing his hands before leaving the ward or home.

APPLICATION OF COTTON COCOON FOR PROTECTING NON-INFECTED EYE

The non-infected eye should first be cleansed with a boric acid solution, a drop or two of argyrol 15 per cent. instilled, a small bit of bichloride ointment (1-3,000) placed on the inner edge of the lower lid, and the entire eye finally carefully covered with a layer of cotton. The edges of the cotton may then be fastened to the skin with flexible collodion, which effectually seals the eye from future contamination. This dressing may be removed after a few days by applying a mixture of equal parts of alcohol and ether, which will dissolve the adhesive collodion, care being taken that none of the irritating alcohol or ether enters the eye itself. This is one of the most effective means for taking care of a non-infected eye in children or adults. Occasionally in adults some form of a shield, such as Buller's transparent eye shield (Fig. 23), or a good protective dressing of almost any kind, such as a Knapp dressing (Fig. 24), may also be used as

directed. Buller's shield consists of a large watch glass applied over the eye and held in place by adhesive tape. The junction of the skin and plaster is further sealed with a layer of cotton and collodion for greater security. The center of the glass left uncovered by the plaster permits of easy inspection of the eye at all times. In infants or very young children the hands usually have to be tied in such a manner that the good eye cannot possibly be reached and infected.

PURULENT CONJUNCTIVITIS

Purulent conjunctivitis, or the third form, may be defined as any purulent conjunctivitis which the microscope shows is not due to infection by gonorrhea. This is not as serious a disease as infection with the gonococcus and its manifestations therefore as mentioned are not so violent.

Ocular Nursing—The treatment consists in eye cleanliness by irrigation and the use of antiseptic eye washes, such as argyrol 15 or 25 per cent. An ointment is also applied to the lids night and morning. The management here does not vary greatly from that of gonorrheal ophthalmia. Treatments, however, are seldom needed more frequently than every hour.

(To be continued)

GLYCERIN FOR PERSPIRING FEET

Dr. Benians, in *The Lancet*, strongly recommends the use of glycerin for perspiring feet. Dr. Benians cites two severe cases which were completely cured in three days by the application of glycerin well spread over the soles and toes before the socks were

put on, this being repeated each morning as long as necessary. He suggests that the use of glycerin, by preventing the formation of noxious products, and thus keeping the skin of the feet in a healthy condition, would be of considerable value to an army on long marches.

The Relation of the Nurse to the Ownership of Clinical Records

GORDON M. CHRISTINE, M.D.
Philadelphia, Pa.

THERE is a widespread notion among nurses that bedside clinical records of a patient are the property of the attending nurse, and that they can therefore be rightfully removed by her from the home of the patient at the conclusion of her services.

Usually the nurse provides the printed forms for these charts and records without charge to the patient, and perhaps it is for this reason that there has arisen an assumption of ownership on the part of the nurse regarding these records.

Recently, cause existed for the discharge of a nurse from attendance on a patient who had been ill for a long time. The ailment was unique and the attending physician exercised care that the fullest notes be made of the symptoms, etc., on both the ordinary record sheets and clinical charts. All the varying phases of the disease were faithfully recorded, and the documents so made were therefore valuable in many respects.

When the nurse left she took the charts with her, which abstraction was not discovered until the new nurse sought to find them in order to continue symptom recording from the point left off by the other nurse. A demand was made by the husband of the patient for the return of the charts, but the deposed nurse refused the demand, stating that the charts belonged to her, that records and charts were always the property of the nurse and could be taken away or left at her discretion, and that it was only by an act of courtesy that a nurse would leave her charts for a succeeding nurse or the doctor.

Several demands were made for the return of the papers, but with an equal number of refusals. Finally, the husband informed the nurse that if the records were not returned

he would have her arrested on a charge of larceny. This evidently alarmed the nurse, because in a few days the property was mailed to the proper owner, the husband of the patient.

This incident was referred to a number of nurses, some of whom at first supported the contention of the nurse in claiming ownership of bedside records, while others either had not given the matter any special thought or denied the right of the nurse to claim ownership of such records, believing that they belonged to the doctor or the patient. All, however, finally agreed that ownership really vested in the patient. Those in charge of nurse directories stated that nurses often brought home their records and so seemed to establish a custom as to ownership, but they had known of no contest having been made regarding the matter, though now that it was brought to their attention they could well see the folly of a nurse assuming to own property so obviously not theirs.

It is quite evident, on a review of the relation between nurse and patient, that the former is simply an employee under contract with the patient to render a service termed "nursing." She receives certain orders from the physician in attendance, and to an extent she is subject to his direction; but she is essentially identical with the clerk or stenographer who is under contract to keep books. In the case of the nurse, in addition to her direct duties as nurse, there are notes to be made of symptoms, etc., and these are placed on sheets of paper known as clinical records or charts. The books of account of the clerk are the property of the employer; and so, in the same manner, the records kept

by the nurse are the property of her employer, the patient. If a clerk or stenographer is discharged, she would not dare carry away with her books or papers which have been the product of her work; nor should the nurse who leaves a patient take with her, on the assumption that they belong to her, any of the records or clinical sheets. Transferring our thought to a hospital, no nurse in such an institution would conceive it to be her privilege to remove from the file any of the papers pertaining to a patient. The heavy hand of hospital authority would soon be placed on her. A patient in a private home is none the less the proprietor of the clinical charts than she is of the services of the nurse.

In the experience of the writer, in only three other instances in many years of practice have nurses purloined clinical records and refused to return them. In two of these instances, they were removed because the nurses wished to cover up some of their mistakes and, in the third, it was done to embarrass the physician who was instrumental in her discharge.

This matter has been considered of sufficient importance to make it the subject of discussion, so that it may now be safely assumed that if a nurse wilfully removes her clinical records she does so with the certainty that she is removing something which does not belong to her and that she is just as liable to legal restraint as though she carried

away with her the spoons or forks belonging to the family.

The above article was referred to Dr. Samuel Wolfe, of Philadelphia, for comment, and the following reply was sent to the writer with privilege to publish:

"I agree fully with the article of Dr. Christine regarding 'The Relation of the Nurse to Her Clinical Charts,' in all the arguments he has presented to show that any and all clinical records which are made by the nurse, hired and paid, belong to the person employing her. The furnishing of all printed forms by the nurse is only a matter of convenience and labor saving to her which she can adopt or not at her discretion, and for which she cannot reasonably ask pay. My opinion is that she could refuse to do any writing for the benefit of the patient unless material for the purpose was furnished her. As this would have to precede the claiming of any records, her diplomacy, of course, would preserve her from so shortsighted a course. One can go still further than the writer does in defending the patient and her claim, namely, that without the patient's consent the nurse could not be defended for carrying away a copy of the notes she had made, even though surrendering the original. There is a privilege of privacy that attaches to all such records which must be sacredly guarded by the nurse as well as by the physician."

KEEPING TALLY OF PADS AND SPONGES

Keeping tally of the pads and sponges used and discarded during a laparotomy puts a serious responsibility and a great strain upon the nurses and always carries the chance of an error in calculation. Moreover, if a sponge or pad is unaccounted for it entails a manual search among the patient's

viscera and in the pile of discards. It is simpler and safer to leave no untaped sponge entirely within the cavity, even for a brief period, and to use as pads and packings only those that are long enough to so far protrude from the wound that they cannot be lost.—*American Journal of Surgery.*

Some New Treatments in Nursing

AMY ARMOUR SMITH, R.N.

DUODENAL FEEDING

IT IS not surprising to see how greatly the columns of American and foreign journals of nursing are filled with articles on the care of cases of ulcer of the stomach, both before and after operation. The condition is all too common, and will continue so, since people maintain far greater indiscretion in their diet than in anything else. The lay press has taken up this matter, one daily

tirely, "bridge it," and throw the food directly into the duodenum, the first section of the small intestine.

The tube invented for this purpose is about ten inches longer than that required for lavage, since it passes throughout the length of the stomach into the pylorus, while the upper end hangs out of the corner of the mouth and is fastened to the coat with a pin, like an eyeglass. It is of much smaller



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DUODENAL FEEDING

paper acting as our "guide, philosopher and friend" by not merely listing the reliable Government tested foods, but providing means for city people to get certain staple foods directly from the producers, waging, as well, a militant campaign against fine flour, fine sweets and other modern civilized products which wreck our digestive apparatus. But supposing that all has been too late and we have on our hands the patient with the ulcer. His stomach must get rest. The ulcer must not be touched or it might bleed or perforate. To meet such needs a means has been devised to skip the stomach en-

bore than the stomach tube, being "*in situ*" constantly after being swallowed, and is necessarily of first-class rubber. At the lower end, or eye, is a small gold ball, acting as a weighted director, guiding the tube through the pyloric orifice, while the patient lies for an hour on his right side after swallowing it, to help the ball fall through that opening.

To ascertain at the expiration of this hour or at any time after that, whether or not the tube is in the duodenum, a tightly fitting glass piston syringe is used to draw off some of the contents of whatever the cavity in which it lies.

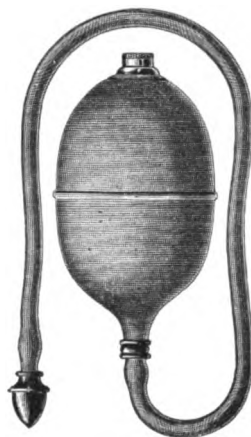
If the tube has remained correctly lodged, that is, in the duodenum, the contents expelled from the syringe into a clean basin and tested with litmus paper, should be alkaline. If they show acid reaction it is certain that the tube is not in the duodenum but in the stomach, in which event the patient must be put to bed again on his right side to coax the ball through the pylorus. The patient must not be fed while the test shows acid reaction.

After it has been satisfactorily made, he is seated in a straight chair by his table, at the hours for nourishment to be distributed, and is administered a glass of eggnog or broth, as ordered by a special technique. On the glass of food sits tightly a specially devised cover, through which two small tubes pass, crowned above with stopcocks. Of these tubes A is connected first with the patient's retention tube. Through B the nurse operates with the glass syringe.

The stopcock leading to A is closed, so as not to disturb the patient while there is a vacuum created in the glass. The stopcock in B is opened and closed for the withdrawal of air. Then the syringe is fitted into place again in B, and both stopcocks opened, and the fluid is gently propelled into the patient's duodenum. He is not at all perceptible of any new sensations, if there is no air in the canal and the food is kept at body temperature by standing in a warm bath. The tubes are then disconnected and the patient may "go on his way rejoicing," knowing that he will have no pain after this meal and no chance for his ulcer to be rasped by sharp particles of food till a violent hemorrhage ensues. There is no elaborate preparation required to save the linen by means of rubber sheets in this treatment.

LAVAGE AND GAVAGE

The most modern way to do these treatments speedily and effectively is with a Politzer bag and a stomach tube with a glass "T" inserted a handbreadth from the



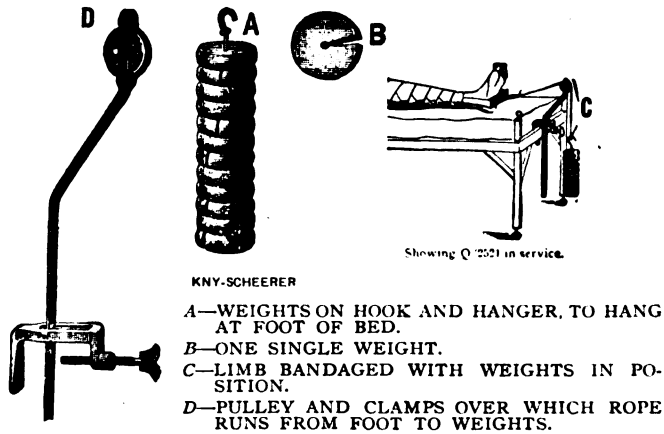
MEINECKE & CO.

POLITZER BAG

open end. There is no funnel required. Care must be taken, as always, to protect the patient from the flow of saliva, or vomiting around the tube, by means of rubber sheet and towel, the latter turned over the top edge of the rubber to keep the cold surface off the skin. He should be given a small basin with plenty of old muslin wipes. A chronic swallows admirably, but a new victim may create a scene and the operator should wear a rubber apron. There is also a large pail, into which the smaller basins are emptied as they fill.

The distance between mouth and stomach is estimated by the eye, bending the tube back to follow the line of the esophagus. It is then lubricated in ice water, and passed gently but insistently with instructions to swallow that "fine bit of steak." One nurse patient always begged for a suggestion. The operator then fills the Politzer bag and inserts it into the rubber tube. The amount contained by syringe, tube, basin, etc., must all be accurately accounted for, in order not to over-distend the stomach. When the patient begins a reverse peristalsis, the tube is lowered and the contents sucked out with the Politzer bag, in which a vacuum has been created.

The solution is of soda bicarbonate, salt or plain water, as ordered, depending on the



symptoms and tests previously noted. It should be administered at a little over body temperature, in an amount explicitly stated so many pints, or until the return is clear, but *not all at once*.

A test meal can be administered if of fluid, in this manner, or withdrawn, if first of solids, at the end of no longer period than specified. Many of the skilled persons who perform the withdrawals are too late arriving, and the poor patient has to be subjected to this mental misery all over again. Colored patients' "misery" is purely physical.

When the tube is to be withdrawn, it should be done with one stroke and laid in its own clean basin. One must care for these utensils just as if they were table silver and china. The food must be daintily conveyed and carefully withdrawn, but the "knives and forks" must not be mislaid.

BUCK'S EXTENSION

This, in a general hospital, is an appliance which must be kept in perfect condition, to be applied with methodical care, keeping in view the specific purpose for which it is employed. It may be easy to put on an even, beautiful bandage, but what about dark, swollen toes next morning? The fracture may be in the femur and the bandages will only be pulling the knee-joint apart unless they go above the knee to the

fracture, no matter how daintily they are applied.

The point where doctors begin and nurses leave off is between fractures and hip disease. On the latter cases this can be very well left to any competent nurse.

But for fractures there are too many surgeons who cannot control all the details, and no nurse should ever be expected to attempt it on them.

One needs a razor, soap and wipes to shave the skin closely as far as the plaster will extend. If any one who clapped on plaster without this precaution had to endure the torture of having it pulled off, he would never err thus again.

Moleskin plaster is made particularly for this, the cloth being a soft, velvety, but firm, thick twill. The plaster is thick and requires even, moderate heating over an alcohol flame. Cut it in strips about three inches wide; then trim off on each side a strip about half an inch wide to within an inch of the upper end. When this is laid on, the ribbon parts are braided over the front and rear skin of the leg, helping to hold the moleskin in place. The length must be estimated before cutting, usually from the fracture to the arch of the foot, turning back the lower ends, interiorly, so that the cloth side rubs the malleolus and reduces any strain on the ankle joint.

The loops running from the foot-plate to the moleskin are run through these folded ends, being of stout but fine rope.

The leg is then bandaged from the malleolus to the fracture, with unbleached muslin bandages, three, four or five-inch, with the edge rolled under, in a spiral, most satisfactory, and slowly, so as to note the circulation and evenness of pressure, as well as to disturb the painful member as little as can be. The moleskin needs assistance, since the bulk of the work falls on it. The muslin spiral is then stitched.

The foot-piece has a hole in the center through which passes a rope, running over a pulley fastened to the bed by a brace and clamps, holding a stout iron rod with weights. The nurses should be able to say correctly at any given moment how much weight the patient supported.

To permit the patient to move with ease, up and down in the bed, without letting the weights touch the floor, the limb is then bandaged to a board, which runs on a track or railroad in smooth V-shaped grooves.

For a fracture sand-bags are necessary, in slips of laundered muslin; also shock-blocks, to elevate the foot of the bed for counter-extension. A square cradle of pine or iron keeps the covers off the toes, but they should be wrapped in a soft woolen blanket closely first.

The fracture board is always required, too, in order to procure immobility.

If the bed cannot be raised a strap should be passed between the thighs to the head of the bed, to prevent the patient working down too far. Children can be secured, in hip disease, with a towel loose enough around the chest not to interfere with the breathing, then a bandage from it to the head of the bed. If you ever sat in a court room and heard your hospital berated and maligned by false witnesses or true, you would realize how much it means to the patient to have a perfect result. Daily measurement shows shortening. Unavoidable conditions should be explained to the patient or his guardian. Frequent X-ray pictures must be taken to prove the effectiveness of the Buck's extension, which, if not right, must be all taken down.

The whole bandage may be covered by a plaster cast for immobility. If so, the back requires careful nursing, and the nurse should in that detail shun being the cause of taking off the cast or causing the expense of a new X-ray picture. The plaster bandages therefore, are considered an accompaniment and must always be in readiness, correct as to numbers, width and age. A badly put-up Buck's extension is equally disastrous to a common laborer or a beautiful society girl.

Sugar as a Hand Cleanser

Dr. D. H. Stewart says: "The most careful antiseptic toilet may be brought to naught by the preliminary use of soap; therefore clean your hands with granulated sugar and also dress wounds with it if you have nothing better." His experience since 1895 has shown that "with sugar and water,

followed by chloride of lime and water, the physician's hands may be rendered sterile." This has been confirmed by laboratory tests. "Granulated sugar is gritty, takes the place of both soap and brush, does the work better and leaves the skin unscratched, soft and smooth."—*Mass. Med. Jour.*

My Most Interesting Case

MAUDE B. OSGOOD

IT WAS about noon one day late in September that word came that Dr. A. wished me to take charge of a case of measles with complications. I had just arrived in the village, and this was my first call from the physician, so was very anxious to "make good."

The case was five miles in the country. Before the carriage arrived for me the doctor gave me personal instructions about the case, as he would not see the patient again that day. He said the patient was a little girl five years of age, who had had a very light case of measles but, owing to lack of proper attention, had taken cold and now had pneumonia with bladder complications, being able to urinate but little at a time. He ordered a hot pack and told me to repeat it in three hours if the patient was unrelieved. He was unwilling I should catheterize unless absolutely necessary.

My first duties on arrival were to take temperature, pulse and respiration, recording them carefully on my chart.

The temperature was quite high, 104° by mouth, the pulse about 95 and of good volume, considering the difficult respiration. I turned the neighbors out of the room as tactfully as possible, established a means of ventilating the room, and while endeavoring to make friends with the little patient, prepared her for the hot pack. We wrung a sheet out of hot water, wrapped her in it, then placed a woolen blanket over and around her, adding a comfortable as extra covering.

In about twenty minutes she became restless and begged to be released. On examining her body I found a fine perspiration starting. I urged her to be quiet a little longer, telling her she would be so much more comfortable soon. In about fifteen minutes I removed the pack and gave her a rapid sponge bath. The bladder was en-

tirely relieved, nor did we have any more trouble with it during her illness.

For several days the case presented no unusual features, apparently an uncomplicated case of pneumonia. The bowels were not moving freely and we gave her a quart of normal saline solution as an enema daily, getting fairly good results.

The fifth day after I took charge, toward evening, the temperature began to drop quite rapidly and she was extremely restless. Not knowing just when the trouble began, we were on the lookout for the crisis most any time. The mother had been relieving me the latter part of the night, as patient was most quiet then and usually slept for several hours at a stretch.

I said nothing to the family of my suspicion that the crisis was near, but determined to watch all night.

About 11 P.M. patient began to grow quiet and seemed to breathe easier.

I kept close watch of the temperature and pulse, taking them every half hour; temperature dropped to 97° , then came up to 99° , where it remained. The pulse was rather feeble and she was very quiet. Having no stimulant in the house, I gave her some hot beef tea and placed a hot-water bag near the heart. She came through the night finely and awoke the next morning hungry. As soon as possible I called the doctor on the telephone, telling him the crisis was passed and all was well. For several days patient remained about the same, no temperature, pulse weak, languid, and did not seem to gain, as a pneumonia patient usually does. The doctor ordered strychnia 1-30 grain hypodermically every four hours for a tonic.

We had not been able to get the intestinal tract clear, so now we began giving her a high rectal enema, using a No. 13A catheter, with a quart of water, and after expelling

that, gave a pint of normal saline for the tonic effect. We gave this every twelve hours for four days before we got the bowels well cleared out. It was a surprise to me to see the accumulation, showing a neglected condition for a long time. After giving eight of the enema I was satisfied the intestines were clear. The night that this was accomplished she was very quiet, falling asleep early and hard to arouse for medicine. The pulse was small, a little weak, and as there had been no temperature now for nearly a week, we thought she would soon be sitting up and gaining fast.

When giving the hypodermic about eleven o'clock I noticed she was breathing very faintly; pulse showed symptoms of collapse, also. In fifteen minutes I counted the pulse again; had no result from the hypodermic. At 11.30 I again took the pulse, and as the pulse showed no result of the strychnia and was scarcely perceptible, I gave her some hot beef tea, which she could scarcely swallow, then filled the hot water bag, placing it close to the heart, turning her on her back and changed the air in the room. Because I had only the one hot-water bottle I put all the flat irons on to heat, placing one at her feet and two beside her hips.

At twelve o'clock I could scarcely find the pulse and could not arouse her enough to swallow. I prepared and gave another hypodermic of strychnia, dividing a 1-30 gr. tablet into two doses. I then called the family and asked the mother to go to her sister's, just a few steps, arouse them, bring their flat irons and hot-water bag. The telephone was at this sister's, and I knew I should need to use it, so wished them to be roused to open the door for me.

All our relief measures were useless. I had hesitated to call the doctor; it was so far to get there in a hurry and I had been so busy that I did not seem to have the time to go to the neighbor's to telephone. But when at 12.45 I could not find the pulse at all, and patient was breathing in gasps, and

life appeared to be fast ebbing away, I seized my trusty syringe, prepared and gave another injection of the strychnia, though I knew I was dealing with a powerful poison, but the situation was desperate. I had to work too quickly to be as gentle as I liked, so when I plunged the needle into her arm and she cried out, it was a glad sound to me, showing the life was still there, though the coma was so great. I dropped the arm and syringe, ran to the neighbor's and called the doctor on the telephone, telling him the patient's condition and what I had done.

He told me to keep up the hot applications, but thought I had given strychnia enough and not to give any more; he would come as fast as possible.

I hurried back to my patient's side to find her greatly improved; there was a strong pulse, flesh warm, and she was awake, bright, able to swallow, and wanted to talk. She had responded to the last dose of strychnia, or, in other words, I had given her enough of it to counteract the effect of the intestinal toxemia which was fast overcoming the vital spark of life.

I enjoined silence and told her to keep still and rest now, though she wanted to talk and play. I was thankful for the result of my desperate measure and was glad to think I had been prompt enough to save the day. As I sat by her side I was censuring myself for calling the doctor, she was so much better. I was afraid he would feel I had been needlessly alarmed. In just an hour, or at 1.45 A.M., I turned to prepare a dose of the intestinal antiseptic she was taking, my back being to my patient. Suddenly the mother, who now shared my watch, called "Iva, Iva," and tried to raise her, gently shaking her and blowing in her face. I turned at once, only to see she had collapsed again and seemed on the verge of death.

Quickly grabbing my hypodermic syringe I prepared and gave one-half a tablet; in a few minutes the pulse responded, the respir-

ation became easier and she lay in a semi-stupor, but still alive.

Just at this juncture the arrival of the physician relieved me of the most fearful responsibility I have ever endured. I promptly told him what I had done, expecting a reprimand for disobeying orders. He made a rapid examination of the patient, listened to all I had to tell him, then told me he had expected to find the patient dead from an overdose of strychnia, if nothing else, on his arrival. I explained the situation more fully to him, said there was nothing else I could do and that I had tried to meet the sudden emergency to the best of my ability.

He had looked for symptoms of strychnia poisoning, but not one sign of an overdose was apparent. He then told me he was well pleased at my promptness to meet the crisis, that he saw the whole situation and was glad I had taken matters in my own hands, for patient would have been dead long before he could have reached there.

As soon as she aroused enough to swallow, we gave her some more hot beef juice, as strong as was palatable.

When morning came the doctor ordered hypodermics every three hours and to give a little liquid diet, not disturbing her for anything but medicine and nourishment.

The forenoon passed uneventfully, until about midday, when, just twelve hours from the first attack, she suffered another slight collapse.

I had given the hypodermic which was due, not getting any response to the stimulus. I called up the doctor and he told me to give a second injection in half an hour. He promised to come prepared to stay, as soon as possible.

The second dose was effectual, getting the reaction we desired, and she began to arouse to her surroundings slightly. By the time the doctor arrived she was much better.

Toward evening she grew restless and it was difficult to keep her quiet. She could not understand why she must not talk to her brother or have him in the room. Finally she fell asleep and slept all night, only arousing enough for medicine and nourishment. I kept a close watch of her all night, the doctor remaining in the house, ready for any emergency, but it passed very quietly. When toward morning the doctor came into the room to see how we were getting on, and told me we had won the battle and she would recover now with care, though very weary after a fifty-four hour day, his words gave me new strength to keep awake and watch the rest of the night. In the morning she was much better and able to take a little light nourishment—a small piece of toast and part of a poached egg; she enjoyed the change so much, having had liquid diet so long.

She was so weak and had been through such a severe ordeal that her progress toward health was very, very slow, but still she was gaining. We counted the gain by weeks, for awhile; she just wanted to lie and sleep most of the time.

The care now assumed a regular routine, and I was able to get some rest, leaving her for a half hour at a time with her mother, then getting up to see she was all right and lying down again.

Slowly but steadily she won her way back to health and strength. It was a red-letter day when she could have her dolly on the bed with her and when she was allowed to see her brother her delight knew no bounds.

The getting-up process was a slow one, and when I left at the end of six weeks she had only been up a few times in a chair. The improvement was rapid from that on and in a couple of weeks she was beginning to walk a little and in time completely recovered.

Department of Public Welfare

Impressions of a Nurse at a Medical Convention

A. L. D.

How dependent we are in our busy lives upon pictures, charts and maps to help us grasp truths and in a few minutes give us a lasting impression and some real knowledge. Teachers have used this method of appealing to the sight in imparting knowledge to pupils with marked success, and today there are few people who have an idea they want advanced or a lesson taught who will depend alone upon giving out statistics in columns, or upon a written treatise, and expect the average citizen to give it any attention. They will rather, when possible, use a graphic chart, or a picture, that will instantly catch the attention and then drive home the lesson with terse statistics.

For instance, how many people will toil through statistics on infant mortality, and even if they do read the data, how much impression does it make? But, did you ever stand by a booth showing pictures prepared by some Infant Welfare Society, and see the tiny electric bulb flash off and on the light and read the sign: "Every time the light flashes out an infant dies somewhere in the States?" Have you watched the awed faces of wives who go and get their husbands and together they read all through the charts as to the *number* of deaths and their *causes*?

This method of getting the attention of the public and of teaching great lessons was graphically impressed upon my mind at the annual meeting of the New York State Medical Society held in Buffalo April 27 to 29. The public nurses were included in the

invitation to attend the "popular" evening programs.

The society had a very fine program and we not only *heard* some of the best men and women of the country lecture on new things in medicine and surgery, giving results of research work and experiments, but we *saw* them illustrate their ideas by diagrams, lantern slides and motion pictures.

The main floor of the Sixty-fifth Regiment Armory was given over to the hygienic and scientific exhibits and to the commercial exhibits pertaining to getting well and keeping well.

Of interest to nurses was the stress put upon the needs of the rural community as to sanitation of homes and school houses, and what can be done with the people of the great middle class who constitute the major part of our commonwealth when they are sick.

Dr. Thomas D. Wood, chairman of the Committee on Health Problems in Education, in a splendid address said they were depending in a large degree upon the trained nurse in the schools, and the visiting nurses to teach people better living. He also advocated traveling dentists, surgeons and eye men employed by the State to go into the rural communities and do the corrective work. The fact that the nurse has found so many children suffering from eye strain or adenoids did not help much, unless some means was provided to remedy the defect and make the child physically fit.

A booth near the door over which hung a banner with the words, "Bureau for Organizing Home Care for the Sick" was of especial interest. We found among other cities that Buffalo had such an office. The

plan is that through this office people may get the *kind* of nursing care they need, and that they can afford. For instance, if a man or woman was "sick-a-bed sick, doctor-twice-a-day sick" they were probably "trained-nurse sick" or else needed hospital care, all of which has been thoroughly organized and provided for them. Of the Independent rich who in illness can afford everything they need, we found there were five millions. Of the Dependent classes who must depend upon charity there are fifteen millions. Charity organizations of many kinds take care of them. The startling thing we learned was that there are eighty millions of Independent people of moderate means who can pay a reasonable sum for care in sickness and for whom in the majority of cities there is no effort made to provide organized care. For this vast army of people, who are the backbone of this country, we are only just awakening to their need and trying to help them solve the problem. For those needing expert help, we already have the trained nurse, but you might as well say that every man on a construction job should be a foreman, or that all of an army should be officers, as to say that all cases of illness must need and have trained-nurse care. There must be a field for a small army of auxiliary helpers who, under the supervision of doctors and trained nurses, will be *organized* to take care of these people, and do it with a reasonable amount of intelligence and at a reasonable cost.

We were glad to note the amount of thought given this subject, and feel sure that out of just such a movement will eventually come the solution of the vexed question of the unlicensed midwife; the elimination of the Sairy Gamp type of practical nurse, the correspondence school nurse, and the introduction of a *supervised* practical nurse who will take her proper place in the home as a household nurse, with a trained nurse to give general direction and oversight. Especially in minor ailments and chronic patients

and in maternity cases is she needed, and by caring for both patient and home she is proving a real blessing.

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Campaign Against Cancer

The Vermont State Medical Society gave a series of educational meetings on cancer in the principal cities of the State June 8, 9, 10 and 11. Speakers of national prominence were obtained. Identical programs were given at Rutland, Burlington, St. Johnsbury and Montpelier. In the morning of each day a clinic was held by the visiting physicians, to which local doctors brought patients for consultation. In the afternoon the meetings were for the medical profession, but the evening meetings were open to the public and the addresses were popular in character.

Dr. Francis Carter Wood, of New York, spoke at Burlington on the afternoon and also on the evening of June 9, and took part in the clinic at Burlington on June 9 and at St. Johnsbury on June 10. Dr. Wood is the director of the cancer research work of Columbia University.

Dr. J. M. Wainwright, of Scranton, Pa., took part in the morning clinics at Burlington on June 9, and at St. Johnsbury on June 10, and addressed the physicians at the afternoon meetings in these cities and also in Rutland on June 8 and Montpelier on June 11. Dr. Wainwright has long been the chairman of the Cancer Commission of the Pennsylvania State Medical Society, under whose auspices one of the first educational movements in America in regard to this disease was organized and carried on.

Dr. Charles F. Dalton, secretary of the Vermont State Board of Health, spoke at the public evening meetings on all four days, officially representing the State Health Department.

Dr. W. S. Bainbridge of New York was the principal speaker at the evening meetings at Rutland, St. Johnsbury and Montpelier.

The Hospital Council

Items of Interest, Annual Reports, Publicity Literature and Material Descriptive of Newer Methods and Plans in Any Department of Hospital Work Are Solicited

Hospital Efficiency and Hospital Waste

What is hospital efficiency? asks Mr. Richard Waterman, in the pamphlet which contains the report of the committee on hospital efficiency to the Philadelphia County Medical Society. In answering his own question, Mr. Waterman states that "the fundamental idea in hospital efficiency is the elimination of waste. A hospital is efficient if it thoroughly performs its functions—the care of the sick, the prevention of disease, the research work and the education of doctors, nurses and the public—with the least possible waste of labor, materials and money.

"There is an enormous amount of waste involved in the current methods of operating hospitals. The waste of money probably amounts to more than 20 per cent. of the \$250,000,000 paid each year for current expenses, and there is in addition a waste of human labor and of opportunity that is incalculable."

Continuing, Mr. Waterman enumerates eleven different ways in which hospital waste in small or larger volume occurs. He mentions as one way in which a great deal of money is wasted is by failing to devise a good system of serving food to patients. In one large hospital that has a very high reputation the food is handled seven times and reheated twice between the kitchen and the patient's bedside; and in one twenty-four-bed ward the number of trays on which food is left untouched has been known to be as high as 33 per cent.

Another kind of waste mentioned is in duplicating expensive equipment many times over in neighboring hospitals and then

allowing it to lie idle the greater part of the time. The whole report is thought-compelling and a valuable contribution to the subject.

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How Should an Operating Surgeon be Gowned?

After calling attention to the annoyance of a perspiring face while a surgeon is operating and the nuisance of having to have the beads of perspiration wiped off the face by others, Dr. Francis Reder, of St. Louis, in the *American Journal of Surgery* (December, 1914), proceeds to a description of what he considers proper operating attire for a surgeon. He makes the rather startling statement that "when one considers the great amount of surgery that is being done, there are but very few operators who are properly gowned for the operating room." Continuing, he says: "Before giving my version of a proper attire for the surgeon in the operating room, an expression of condemnation is registered of him who operates in his undershirt. This is a base fault, a surgical sin. At no time should the operator be more clean, more immaculate in his appearance than when he steps up to the operating table.

"What is the proper garb for a surgeon? Let us enumerate the necessary parts for his attire: For his head a piece of gauze, not less than six thicknesses, with a width of about four inches, long enough to encircle the head. This gauze bandage covers the forehead and should reach to the eyebrows. A similar gauze bandage is applied in a manner to cover chin, mouth (and nose, if so desired)

and the cheeks; it is secured on top of the head. Upon the head is then placed an operating-room cap. This covers up the hair. The dressing is not as hot as it appears. It is comfortable. The gauze bandages are thick enough to absorb all perspiration, so that there is no need of any wiping; the face feels quite dry. This face dressing is best applied by the surgeon himself, as he can better adjust it to his comfort than a nurse. For the body, a medium heavy shirt of a cotton fabric (a basket weave is admirably suited to absorb perspiration), duck trousers and duck shoes (tennis shoes with white rubber soles), constitute an attire that is beyond criticism. These articles of dress, excepting the shoes, should be surgically clean, *i. e.*, next to being sterile. The clothes are worn next to the skin, all other clothing (undergarments) having been removed.

"In this garb the operator prepares his hands and arms for his surgical work. Having finished with this process, he proceeds to don his sterile operating-room gown with the assistance of a nurse. It should be of a medium-weight cotton fabric. The fabric known as "galatea" is a very desirable one. The gown should fit comfortably and have a length that reaches to the ankles. Its sleeves should extend to the wrist, so that the operator may experience no difficulty in putting on his rubber gloves.

"As a precaution and additional safeguard, it has been my custom to wear a pair of sterile bags or mittens over my gloved hands while the patient is being prepared for operation. These mittens are very loose and reach up to the elbow. They are made of medium heavy duck, which gives them a certain amount of stiffness, thus facilitating the placing of the gloved hands into them.

"Some surgeons wrap a towel moistened with a 1:5000 bichloride solution, or with a normal salt solution, about their hands. This answers the same purpose, that of an auxiliary protection, while the final prepara-

tion of the patient is made. My preference is given to the mittens on account of their simplicity and their perfect protection. The idea was adopted by me after having seen Dr. Franklin Brady, surgeon to the Roosevelt Hospital, in Philadelphia, wear them."



The Bureau of Special Relief

The dedication souvenir booklet of the Chicago Municipal Tuberculosis Sanitarium is an attractive as well as "informing" bit of tuberculosis literature. This wonderful institution has three main divisions—the dispensary department, which operates ten free dispensaries and employs thirty-five attending dispensary physicians and fifty-five field nurses; the educational department, which has charge of the open-air schools, the exhibits and the literature, and the sanitarium department, which had at dedication 650 beds—350 for ambulant patients and 300 for infirmary patients. Of the beds for ambulant patients 120 are for children. The plans call for an increase in all these departments.

The Bureau of Special Relief which is attached to the dispensary department concerns itself with remodeling and building of inexpensive sleeping porches and supplying the necessary equipment for outdoor sleeping, such as beds, bed clothing, reclining chairs, canvas curtains, etc.

At present, open-air sleeping arrangements have been provided and are in use by sixty patients in forty families, representing an expenditure of approximately \$1,800. This is said to be the first municipal undertaking of its kind in this country, having for its object the isolation of the tuberculous patient from his family, and giving him a chance to carry out rational treatment at home. It is being economically and carefully worked out. There is no question that the Bureau is bound to become an important factor in the activities of the sanitarium and

that similar bureaus will be brought into existence in other cities.

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Laura Franklin Hospital for Children

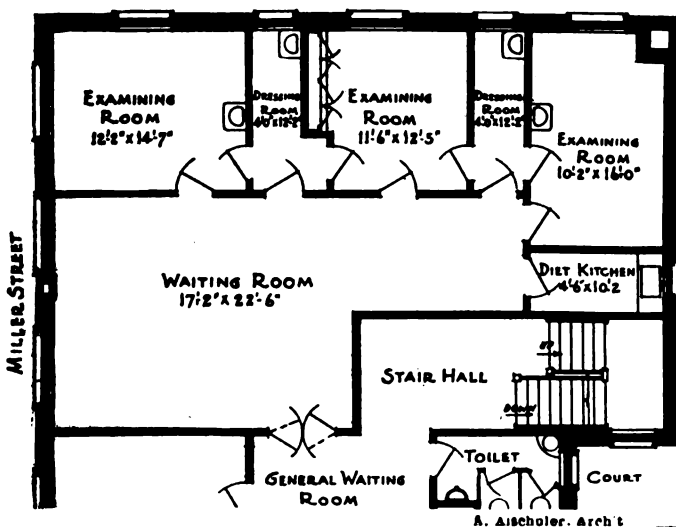
In the twenty-seventh annual report of the Laura Franklin Free Hospital for Children, the superintendent reminds us that "doing what cannot be done is the glory of living." The report shows here and there the "human touch" which redeems all such reports from the dry recital of statistics which seem to be necessary, yet which nevertheless make dry reading. We cannot but feel that the public will remember the three incidents from the report cited below when they will have forgotten or failed to read the seventeen pages of statistics.

"A hospital," says the superintendent, "is a world in itself, and children are a world unto themselves. One day, thanks to Messrs. George Borgfeldt & Co., we had enough automatic turtles to give each child one. The next morning a little curly-headed girl, who was not able to be out of bed, resembled a duck-pond with seven turtles around her. Again: the children, having received some fancy pins, one started a

millinery shop and in an hour had acquired almost all there were in the ward. On another occasion an unusual noise was found to be caused by a small boy with a lame leg who had been returned to us. He was jumping on his bed, exclaiming, 'Hurrah! Hurrah! I'm glad I'm back, I'm glad I'm back!'

"At Christmas many letters were sent to Santa Claus through the hospital office. One read: 'Dear Santa Claus, I am a little boy and I have been sick five years. Will you send me a moving picture machine? I have never seen one, but the boys tell me they are lots of fun. Please send Johnny one, too. He is sick now, but when he is home he lives in an orphan asylum. We won't make any trouble.'

"Dr. Garrison's Saturday morning throat clinics for indigent school children, owing to his tireless regularity and systematic work, have both grown and multiplied until we are almost unable to handle them. One day a ten-year-old girl came in to inquire about having her tonsils removed. She said she could not come on Saturday; she went to school and Saturday was the only day she had to 'clean up the house.' However, she



FLOOR PLAN OF ONE OF THE TEN MUNICIPAL DISPENSARIES, CHICAGO

did come, and, her mother being dead and having five younger children to look after, she brought the youngest with her. The little one spent a happy day with us and went home with the 'little mother' after her operation."

What puzzles us is how the per capita cost of any hospital can be 55 cents a day, as this one is stated to be.



Hospital Cars at Canadian Military Concentration Camp

The Canadian Northern Railway Company has equipped two of its cars for service as a hospital unit in conjunction with the Canadian military concentration camp at Valcartier, Quebec. One is a standard colonist car, used as the ward, and the other is a baggage car, used as the hospital commissary.

The interiors of both cars have been painted white, having been given three coats of a hard-drying highest grade enamel. The floor is of a sanitary material, fitted with hospital corners, to allow for flushing with hose and water, and is covered with carpet. The finish throughout is flush and easily cleaned.

The colonist car is 72½ feet long over body, of the standard Canadian Northern Railway type, and contains eighteen sections, providing accommodation for thirty-six patients in the upper and lower berths. There is a small kitchen at one end of the car, which is used as the hospital kitchen, and across the aisle from this kitchen section is a small baggage-storing space. This end of the car in the ordinary colonist car also contains the women's toilet and lavatory, and at the other end the men's lavatory and heater room. This provides a double lavatory accommodation for the hospital. The car is equipped with suitable bedding, including mattresses, sheets, pillows, pillow cases, pillow slips, blankets, headboard curtains, berth curtains, etc. Electric light, with

dynamo and storage battery auxiliary, has been applied, using 10-candle-power lamps. Each window is fitted with an air-intake ventilator, such as is standard for all Canadian Northern Railway cars, and, in addition, twelve automatic exhaust ventilators have been applied in the deck. Water is supplied by an air-pressure gravity system, such as is in use on Canadian Northern equipment. Combination hot water is used, so arranged as to operate independently as a unit or receive steam from an outside source.

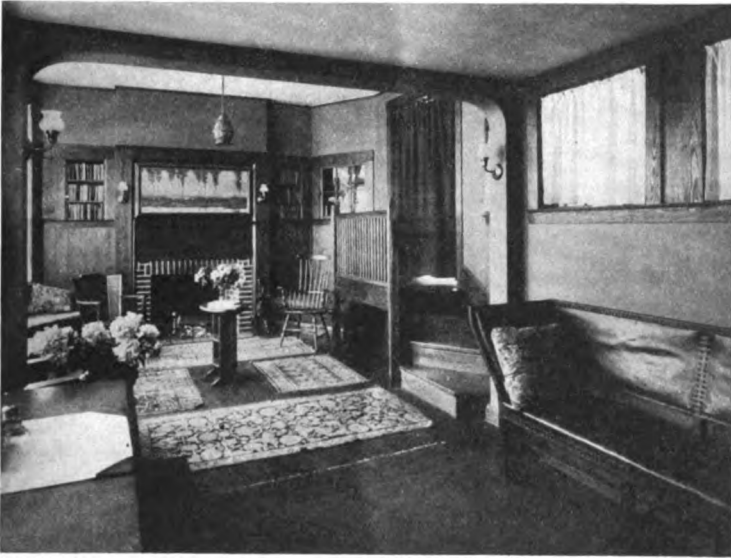
The hospital commissary car is a standard 60-foot baggage car, provided with electric light, steam heat, etc., as in the other car. It is used as a local hospital commissary and office car for the medical attendants. It is also possible that it may be used as an operating car, as the military authorities are making internal changes in its arrangement.

While it would be possible to use the hospital car as a transport for taking serious cases into the base hospital at Quebec, up to the time of the troops leaving for England it was used as a purely local unit, standing on one of the camp sidings. Both cars are marked on the outside with the Red Cross.



The Convalescent Room

One of the most attractive "lounging rooms" that we have seen connected with any hospital is that connected with the N. E. Baptist Hospital, Boston. Designed by a woman with "an artistic soul," and who knows the needs of the sick by long acquaintance with them, it is a beautiful illustration of economy and simplicity combined with beauty. It has plenty of sunshine. Note the open fireplace, with the beautiful landscape scene above it—the latter the gift of a devoted friend of the hospital. Note, also, the built-in bookcases, rarely found in an institution. The woodwork is stained an attractive shade of green, which makes the southern pine woodwork a thing of beauty.



CONVALESCENT ROOM N. E. BAPTIST HOSPITAL

The comfortable-looking couch was designed and built to order, the rests at each end being arranged on such a plane as to give the most comfortable support.

The rugs are chosen with a view to the general harmony. The convenient writing table and the comfortable chairs and cushions, not all of which appear in the picture, combine to make a "getting-well" room as far removed from the stiff institutional room as one can imagine.



Massachusetts Homeopathic Hospital

A melancholy interest attaches to the forty-fifth annual report of the Massachusetts Homeopathic Hospital, Boston, owing to the lamented death of the superintendent, Dr. William O. Mann, shortly after the issuance of the report from the press. The volume of over one hundred pages gives an interesting resumé of the important features of the many-sided activities of a great hospital with a daily average of 262 patients.

This hospital operates its own contagious disease department; its Evans Memorial department of clinical research and preventive medicine; its separate children's depart-

ment; a convalescent home for men and its Sunny Bank Home for convalescent women and children, operated by the hospital though owned by a separate corporation.

It has in process of construction a new maternity and out-patient building. Its social service department provides a graduate nurse to follow up recently discharged maternity patients and a trained social worker for general assistance in the out-patient department.



Contagion Among Hospital Employees

A study of the incidence of contagious diseases among employees of the hospitals of the Department of Health, New York, was recently made at the request of the Commissioner of Health. It was found that during seven years 203 employees out of a total of 3,879 had been infected, the resulting deaths numbering four. The percentage of infection for the period was 5.2, ranging from 9.4 in 1907, to 3.2 in 1913. The larger part of the cases occurred among the nurses, whose risks are the greatest and the least easily controlled.

Editorially Speaking

Should Nurses Invest In Private Hospitals

From time to time we receive letters from institutional nurses, asking to be directed to good locations for private hospitals. They long for a place of their own. They grow weary with dealing with "boards." They have heard of nurses who have made private hospitals pay. Can we direct them to the right location, etc. We have never yet taken the responsibility of advising a nurse to invest her savings in such an enterprise. Yet we know of numerous nurses who have private hospitals or sanitariums of their own or owned in partnership with another nurse who are meeting with splendid success. But the chances for loss are great and we know of too many failures to take the responsibility of advising a nurse to take the risk. Much depends on the personality, managing ability and business experience of the nurse herself. A nurse who has been well known as a successful institutional worker and who commands the confidence of a large circle of physicians, may locate in a large city, with the backing of one or two prominent physicians whose practice is sufficient to turn a steady stream of paying patients in her direction and work up a paying business. Many have done so and are now doing so. Nurses have gone into new places, where there was no hospital and, after a year or two, have placed the enterprise on a paying basis. Circles and clubs of women and of men in the town often assume the support of special cases. In course of time the municipality may be induced to help, though such cases rarely pay more than the bare cost. But there is no denying that the financial

anxiety for a few years is great and, to keep down expenses, the owner often has to do duties which in other hospitals are divided between two or three. Almost every city of any size has its wrecks of private hospitals—mostly owned and launched by physicians, it is true, but abandoned as losing enterprises in a few years or less. We have recently been asked as to the advisability of nurses starting a convalescent hospital or nursing home for convalescents. The Dubuque (Iowa) *Herald* of April 18, 1915, contained the following interesting announcement. It is too early to consider what the financial results of this experiment will be, but we wish it abundant success.

"The Dubuque Nursing Home for Convalescents will be open Monday, April 26. There has long been need for such a home to care for out-of-town hospital patients able to leave the hospital, but not well enough for a railway journey.

"The nursing home will care for such patients and also for any who need temporary care and attention that are not in need of actual hospital service. Miss Jessie Bahner, of Minneapolis, an experienced graduate nurse, will attend the patients. Miss Mary McCoy has charge of the home."

Speaking purely from a theoretical standpoint, it looks as if a convalescent home should be more of a financial success than a hospital, handling acute, medical or surgical patients, especially if the nurse manager can get the cooperation of the leading medical specialists of a city. Almost all specialists have patients coming from smaller places who need treatment for a few days or weeks, but who are able to be up and go around to

some extent. These do not need the facilities offered by hospitals, yet the doctor often wants some nursing oversight for them. These would include many eye and ear, stomach, kidney, rectal, nerve, heart and gynecological patients. The patients visit the doctor's office daily for treatment or observation. Yet, in this venture, as in many others, personality and business ability count so largely in success that one hesitates to recommend any unknown nurse to attempt it.

Another interesting experiment, "The Babies' Dwelling," is being tried out by two nurses in California, announcement of which is made in the Nursing World Department of this issue.

Certainly, the nurse who is going to be discouraged if her place does not run at its capacity in three or four months ought never to try this out. We will be glad of the advice and experience of others on this subject.



A Missionary Doll

Recently we had a letter from a nurse missionary in China telling of some of her difficulties and desires in getting ready to start the first training school for nurses in a province of twenty-five millions. In that far-off region she dreams and plans of how to get the things needed to begin the school. The hospitals—one for men and one for women—are moving to a new location, more accessible to railways than the old location.

Speaking of some of her difficulties, she says: "I think even your experienced, practical and housewifely heart would sink at the prospect of trying to keep a new hospital clean. Such a wind and such dust storms as have raged for the past two weeks! It is almost useless to clean. The fine yellow powdery dirt from the plains sifts in every crack and crevice, till everything is an inch deep, and we are all hoarse from the irritation. I thank the Lord we are not operat-

ing today. We have double windows on the operating room proper and I begin to fear we will have to put them all through the pavilions, despite their awkwardness and expense."

This nurse confided to us her great desire for an adult doll for demonstration purposes. She says: "It is a bit difficult to use either patients or nurses for some forms of demonstration, their sense of modesty (?) is so very very highly developed."

The editor is stirring up some interested people in a large church, hoping to get them to send this much-desired doll, but the thought has come that many nurse missionaries in China, India and other places would be greatly helped by having such a doll for demonstration purposes. There are also many American and Canadian nurses who would like to feel they are helping in a practical way the nurse missionaries who are working in those distant lands. With a little effort a few nurses could send such a doll to some mission field. Quite recently we heard of a nurse who has for some time been paying for a scholarship \$40 a year for a young Chinese girl to be trained as a nurse. As one nurse finishes her course she is assigned another, so that in a few years she will have numerous representatives working to usher in the new era in China.

The sending of the missionary doll is a practical possibility if two or three nurses will interest themselves in it. Write us in regard to how it can be done.



Nursing in the Present War

So far as nursing organization was concerned, the European countries believed they were prepared for the present war. Yet the confusion at the beginning was hardly less, probably much worse, than our own confusion and embarrassment in the Spanish-American War. It is questionable whether any country on earth could be said to be prepared for the care of the sick and

wounded in such colossal numbers as this old world has never known. Hundreds of hospitals, whose necessity a few weeks previous had been undreamed of, had to be brought into existence. Warehouses, prisons, barracks, schools, country residences, factories, barns, have had to be utilized as hospitals—to be cleaned and equipped for the care of serious surgical and medical cases; superintendents had to be found to manage them, nurses to do the nursing, employees to do their part; sanitation had to be carefully studied so as to prevent, as far as possible, the epidemics which follow in the trail of war. In one night an empty warehouse or factory may have deposited in it hundreds of desperately wounded men, dirty from the trenches, with foul-smelling wounds which beggar description. It is hardly to be wondered at that confusion has resulted.

If this country had to face the same conditions, equip hundreds of hospitals in a few months, yes, create the hospitals, it is questionable whether, with all our boasted preparedness, we would meet the emergency any better than it is being done abroad. The home hospitals in European countries have also to deal with largely increased numbers, and the problem of securing capable men to manage the field hospitals and capable women to manage the military hospitals, farther from the fighting front, has been more difficult than is easily realized.

When we think of how few nurses graduated in American hospitals really develop the *managing* ability, it is more easily realized. As usual, the romantic and aristocratic element among women added to the confusion, and the fact that many women of wealth were assuming large expense in vari-

ous ways connected with the new war hospitals, made the matter of giving the trained nurse, who should have been in active command of all of these hospitals, something to be handled with extreme delicacy and tact.

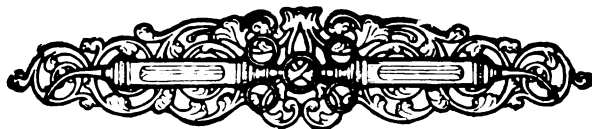
It was previously estimated that in event of war France would need to equip one thousand hospitals, while in reality more than four thousand hospitals have been needed to care for the unparalleled numbers of wounded.

This is the first great test which European nurses have been called to meet since trained nursing has been brought into existence. In this time of strain and stress, our sympathies must go out to the brave women on whom the burden rests of meeting the present emergency, so that the wounded and sick may have all that nursing care and medical science can do for them. Much of the confusion of the earlier days has been corrected and trained nurses in much larger proportions have been put in charge of the untrained or partly trained volunteers.

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Warning

We have learned with deep regret that a young man calling himself Otto Lake, and claiming to be a representative of this magazine, has been collecting from nurses money for subscriptions to *THE TRAINED NURSE*. We most emphatically state that this young man has no connection with our magazine and that his claims are misrepresentations. While we deeply regret this, we think, however, that nurses should be more cautious in giving their money to strangers for, so far as we can find, this young man had nothing to indicate that he was connected with our magazine. He simply made the statement.



Gleanings

"Twilight Sleep"

Dr. George L. Brodhead, professor of obstetrics at the New York Post-Graduate Medical School and Hospital, believes, as the result of his experience, that the much-discussed "twilight sleep" is still in an experimental state. He presents his views on the subject in an article in the *Post-Graduate*.

He agrees with Dr. Gauss that there is no danger to the mother from the drugs given, but is not so sure about the effects on the child.

While there is a certain amount of infant mortality under the new method, Dr. Gauss, as quoted by Dr. Brodhead, asserts that the percentage is no greater with the new method than it was before it was used. Many of the deaths which have come during the use of the twilight sleep could not be traced to the use of the drugs, but came from other causes entirely foreign to them.

Dr. Gauss made his conclusions from the five hundred cases in which he used the new method. Of these only 1 per cent. of the infants were dead at birth. Nearly 25 per cent., however, showed the effects of the drug and seemed to be in an intoxicated condition. It took some time to bring these babies to their natural health. Dr. Gauss believes that the amount of morphine given with the scopolamine has something to do with this and he has cut down the morphine as much as possible.

The experience of Dr. Brodhead covers the seventy-two cases where the twilight sleep was used in the Harlem and Post-Graduate Hospitals. Forty-six of these cases were at Harlem Hospital, and in only three instances did the drug have no effect.

In these cases thirty-one children were born normal, fourteen required some care, and several needed artificial respiration to preserve life.

Of these cases in which Dr. Brodhead worked there is only one in which he believes death of the child was due to the use of the drugs. Although there were several deaths they could all be attributed to other causes save in this instance. In the one case the baby died ten hours after being born, with such symptoms that the drug was clearly responsible.

Only one disadvantage in the Freiburg treatment has been experienced by Dr. Brodhead. He reports that in many cases the drug has a great exciting effect on the mother. So great was this in some cases that it was necessary to keep three nurses to hold the patient.

In ending his article Dr. Brodhead says: "We believe that the use of twilight sleep is still in an experimental stage, and, while highly desirable in many cases, further experience is necessary if we are to obtain ideal results. Patients should be treated at a hospital with a well-equipped staff of nurses and physicians under the supervision of a competent obstetrician. It is apparent, therefore, that the use of the method will be comparatively limited, but it cannot be denied that in properly selected cases, under competent supervision, twilight sleep may prove to be both safe and of inestimable benefit."



Iodine Treatment of Diphtheria

The local application of iodine has been successfully employed by Dr. A. H. Thomas

(*Brit. Med. Jour.*) in the treatment of diphtheria and scarlet fever, the form used being an ointment containing 5 per cent. of free iodine. This ointment is applied as follows: Three cotton-wool mops are used, two to remove the secretions and false membrane and to dry the affected surface; the third, after smearing it with the ointment, is thoroughly rubbed over the inflamed tissue and surrounding areas. These applications are repeated every three hours or, in severe cases, every two hours, until improvement occurs.

Under this treatment, Thomas says, many cases of diphtheria clear up within a few hours, the throat becoming quite free from false membrane on the second or third day. In the scarlet fever cases there was remarkable freedom from local complications.



Typhoid Vaccination

In a paper by Dr. L. J. Harris, assistant director of the Bureau of Infectious Diseases Department of Health, New York, in the *Journal* of the American Medical Association, he states that from the experience the Department has had the general conclusion is that the accurate observations recorded in thousands of cases leave no doubt as to the preventive powers of anti-typhoid vaccination in all but a relatively insignificant few, and that in those subsequently affected it strikingly decreases the morbidity and the mortality. Severe reactions, in the experiences of the Bureau, are comparatively rare and have never left a permanent injury. For a period of at least two years, and possibly more, immunization is as effective in protecting from an attack of typhoid fever as is a previous attack of the disease itself. The following rules for the avoidance of severe reactions are laid down by the assistant director of the Bureau: 1.

Never administer the anti-toxin to any but the healthy. 2. To permit of slow absorption, avoid puncture of a vein or intramuscular injection. 3. Clean the syringe and sterilize the area for injection, using tincture of iodine for the latter purpose. 4. Allow no hard work or indulgence in alcohol after the injection. 5. Avoid re-injecting in indurated areas.



Drugs Used in General and Mental Hospitals

Dr. Gregg states that the problems in medication at mental hospitals lie in the refinement of the use of drugs for purposes of elimination, in decreasing autointoxication, and in rectifying pathological action of the internal secretions. In eliminating substances from the body there is ample chance for skilful medication. There are cases needing mechanical relief by enemata, cases needing to have the fluids drained off by purges, and cases that are already desiccated and need more fluid, although still requiring relief from intestinal stasis. There are acute cases that may even need to be bled to reduce their fluids, or to have lumbar punctures done to lessen an excessive amount of cerebrospinal fluid. There are cases where autointoxication arises from infected teeth or tonsils, or from misplaced or adherent intestines. There are cases where presumably the thyroid, thymus or pituitary glands, or the reproductive organs are not functioning properly. In all these directions lie problems in medication for cases in mental hospitals. General hospitals have many lessons to learn from mental hospitals, especially in the management of the deliria. Not the least of these lessons is that depressants, stimulants and restraint lessen, whereas baths, packs and elimination greatly increase a patient's chance for recovery.—*Boston Medical and Surgical Journal.*

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

███ From [Darkest Mexico] ███

We have given so much of our consideration to the nurses who have offered their services in the great European war, that we have hardly thought of the little band of brave women who have stood at their posts for years through the dreadful conditions in Mexico—conditions for which the Government of our own country is in a large degree responsible, many believe.

To the Editor of The Trained Nurse:

Yours of the 13th of February reached me April 28, brought to Mexico by one of the escorts who accompanied Mr. Duval West to Vera Cruz. All the letters were old, but how glad I was to receive them! They were the first since February, when a little mail came in from the North. We have had no papers or magazines since January, when a few strayed in, among them my January TRAINED NURSE—not a copy since, however!

This morning's paper says a party of Americans will leave the city Sunday morning for Vera Cruz, going to Pachuca by automobile. All mail sent to the Brazilian Legation before four o'clock Saturday with a two-cent American stamp and a ten-cent Mexican stamp will be sent by them. I know the legation will be deluged.

I have been here through four years of this political strife—it cannot be called war—and would like to see it through if possible, though the end is not in sight. I assure you it takes both pluck and nerve to stay when I think of peace and plenty at home, but we are practically besieged at present, for we cannot leave if we wished to do so. For the past two months the foreign legations have been working to get a special train for foreigners who wish to leave, and the factions are continually promising a train and safe convoy out of the country. The list of names increases but the train is not forthcoming.

Prices are high and provisions, even native ones, are scarce. There is much poverty and suffering among the Mexican middle and lower classes and even the wealthy are not exempt.

The American Hospital is open and doing good work, though it was necessary to reduce the staff. The American dollar is worth 11 pesos and 42 centavos, so where private nurses formerly earned \$5 United States currency, or 10 pesos a day, they now receive 20 pesos a day, which is less than \$2 gold. People, however, cannot afford to pay more, and the few nurses who are here are needed and will probably stay as long as it is possible.

Conditions could hardly be worse. I believe if the two factions could agree among themselves long enough to have a telling battle one side might win, but that solution does not seem probable—each wishes to be *It*. The convention is composed of the northern forces and the southern or Zapatista troops, who at present occupy the city, and by comparison with Obregon's "reign of terror" they shine.

Last night there was firing in the city and this morning there is the report of a fight between the two factions composing the Conventionalistas. Two generals and about forty men are said to be killed. They are destroying for themselves and for every one one of the richest and most beautiful countries in the world. Dear old Mexico! I just love it and shall feel very badly if I have finally to leave it.

AN AMERICAN NURSE

✦

A Protest

To the Editor of The Trained Nurse:

The Woman's Peace Party is asking for the moral and financial support of organizations of nurses. May I voice a protest?

Peace, a righteous peace, our duty toward our neighbor and ourselves not left undone, to rise up in judgment against us, we can agree in desiring heart and soul. But can we agree with the program of this peace party? Had our navy been ready, would Germany have dared to touch our flag and murder our citizens? She knows, better than the rank and file of our people, how unable we are to enforce our righteous demands.

Had England had an army prepared, Germany would not have dared to fight. Belgium and Luxembourg both desired peace, but Belgium, armed and ready to do her duty, is the heroine of the nations; through her sacrifice France is saved. We glory in Belgium, we can but pity Luxembourg. Would we, unprepared to uphold our rights, deserve even such pity as we give with full hearts to poor little Luxembourg and her girl duchess?

Is it the time to cry "Peace, peace," while a nation on a murderous rampage believes and teaches her children that "Might makes right," and her rights are as great as her power to grasp them?

We want to stand loyally by our Government. May its head be enlightened to guide us rightly, its arms strengthened and trained to protect, and its body united and ready to respond to every call to duty, as well to our weaker neighbors as to ourselves, as we did in 1898. Then, and only then, can we effectually work for peace.

REBECCA JACKSON, R.N.,
Spanish-American War Nurse.



Exception Taken

To the Editor of The Trained Nurse

"The Hints for Prevention of Waste in Hospitals" by A. A. S., have interested me greatly. Some suggestions are indeed calculated to intimidate that bogey "cost per patient." Some hints I would take exception to, as this: "Sell the fat for soap, or make soap yourself." Don't, I pray you, do the latter, unless you have a detached laundry. A penny wise housekeeper in my training days made soap, until the united protests of long-suffering patients, doctors and nurses prevailed. "Keep chickens to use up left-overs." A few chickens would not profit, and a large flock would require an extra employee and chicken feed is high. There would be well-founded objection to feeding chickens from patients' left-overs. A neighbor collects our "clean" garbage once daily; the tray scraps are burned in the incinerator. "Use bread one day old. . . . Some bakeries will sell at lower rate for day-before's baking." Our local bakery sells yesterday's bread at half price, but will not guarantee it to be perfectly wrapped, thereby rendering it unsafe to use.

"Bottled milk is cheaper than milk in bulk in the long run." Very true. Bulk milk of the second grade can be bought in bottles. But do we ever wish to serve our patients and employees milk of the second grade? Perhaps for cooking purposes, but to my mind the best "commercial" milk is not good enough. To serve anemic ba-

bies, rachitic children and mothers with less than certified milk seems poor policy in a hospital. Pasteurized milk and cream may be secured in any city or may be prepared in the hospital kitchen.

How many have heard patient's comments: "I never *could* eat the butter at M—— Hospital," or "The bread was always served dry and the cream was blue."

My idea of economy and efficiency is to purchase an excellent quality of provisions, and to hold our staff of employees to strict accountability.

CHARLOTTE JANES GARRISON, R.N.
Supt. Hospital Sanatorium,
Kalamazoo, Mich.



In Answer to Miss Fletcher

To the Editor of The Trained Nurse:

Having read Miss Fletcher's article on "Ethics," I would like, with your permission, to present the viewpoint of a graduate of a correspondence school. I think the writer of "Ethics" knows nothing of the problem which confronts the general practitioner in the country towns which are remote from a good hospital, and where it is only the exceptional and not the average family who can afford a nursing fee of \$25 or more per week. The sick need intelligent care. What shall they do? Between the competent surgical nurse who is used to all the hospital at hand to work with, and the ignorant and totally untrained domestic nurse there is a wide gap which a correspondence nurse can fill.

I do not know the ethical position of a doctor who thus employs graduates of a correspondence school, but I do know that these nurses solve the problems for him, and I have yet to meet a physician whose prejudices did not disappear after an illustration of her work.

It has never been suggested that it is wrong for non-hospital nurses to care for the sick according to the best of their ability. How can it be wrong for such women, by any system of study, to become better nurses? At graduation the correspondence school nurse has not the mental equipment of a hospital graduate, but if the studies are taken jointly in connection with nursing experience, she is soon enabled, with the advice and cooperation of the physicians with whom she works, to be put in charge of difficult cases.

The rule applies to correspondence and hospital graduates alike that the real nurse must be born with an aptitude for the work. The mechanical

nurse is never a success when put on her own responsibility.

As to the question of a correspondence school doctor, that is absurd; his is a work which only study and experience can fit him for; his is the responsibility—the nurse is a subordinate.

The correspondence school nurse does not expect to rank with a registered nurse; she has a place of her own. N. E. P.



Answers to Examination Questions

To the Editor of the Trained Nurse:

I am a registered nurse and have subscribed to THE TRAINED NURSE AND HOSPITAL REVIEW for a long time, and have found it most interesting. I notice that the recognized nursing journals do not publish the answers to the State Board examination questions. Is there any good reason why these should not be published? C. E. O.

If a magazine publishes *unauthorized* answers to questions in State examinations, it is likely that most readers will jump to the conclusion that they are the *official* answers; from this, endless complications might result, which would work harm to nurses, to State Boards and to the magazine.

Moreover, it is hardly possible for one person to prepare a set of answers which another person would accept as entirely correct, unless the subject is one as exact as mathematics or kindred studies. Fully half of the subjects in a nurses' examination are of a kind about which authorities differ, either in actual statements or in emphasis. An answer which might be marked 10 by one board might be marked 9 by another, and if this held good throughout a long paper, the final mark might suggest incorrect answers, when in reality it indicated only a difference of opinion.

Authorities do not always agree and text-books differ considerably. A writer accepted as standard by one board might be repudiated by another. This is true in such subjects as general nursing, surgery, obstetrics and hygiene.

In other subjects, such as bacteriology, contagious diseases and even materia medica, in which progress is being made very rapidly, a text which was a few years old might contain statements which were contradicted by a later author and which in the light of recent research might actually be incorrect.

All these considerations suggest that any set of answers, except official ones, would be only approximately correct, and should therefore not be given out.—EDITOR.]

Illness of Mrs. McEvoy

To Our Readers:

A few months ago brief mention was made of the illness of Mrs. Fanny Wilde McEvoy, the aged Nightingale nurse whose support for several years has come from nurses scattered all over the world. The last contribution received came from a nurse at work in a mission station in India. The support of this veteran of the nursing body during nearly four years has been a veritable romance. How long it will need to be continued no one can forecast. Before this issue reaches our readers she may have passed into the Beyond. On the 30th of January she suffered a paralytic stroke and for days her death was momentarily expected. The paralysis affected the vocal organs and the left arm and side chiefly. However, when the first shock of the illness was passed, she began to improve. Her voice has been restored and she has gradually become able to swallow fairly well. She sleeps a great deal, fortunately, and when awake seems to be as clear in her mind as usual, though much more erratic in her notions. For some weeks a nurse was employed to give her special care, but as she improved this seemed unnecessary. She is being well cared for by the nurses and caretakers of the Home for Aged Women, where she has been for about two years.

This explanation has seemed to be due to those who have aided in her support. There are sufficient funds to meet present needs. On her behalf I wish again to thank her friends who have made it possible to care for her in comfort for such a long time. CHARLOTTE A. AIKENS.



We Want Your Opinion

To the Editor of the Trained Nurse

The enclosed question was handed to me by one of our staff physicians to answer. I pass it on to you to have your readers answer, as I think it might well be printed in the "Editor's Letter-Box." The physician who handed me the question had the very thing happen to one of his patients. E. G. C.

Here is the question: A nurse is engaged for confinement. Case turns out to be false pregnancy. Nurse is given four weeks' notice of condition. Is patient expected to pay nurse for time engaged, or any part thereof?



GRADUATING CLASS OF THE PENINSULA GENERAL HOSPITAL TRAINING SCHOOL,
SALISBURY, MARYLAND

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

Spanish-American War Nurses

The sixteenth annual convention of the Spanish-American War Nurses will be held in San Francisco, Cal., August 9 to 13, 1915. Headquarters, Sutter Hotel, Sutter and Kearney Streets. The program, as arranged, follows:

Monday, August 9, 8 P.M.—Reminiscence meeting, registration, parlors Sutter Hotel.

Tuesday, August 10, 9 A.M.—Executive committee meeting, Assembly Room, Sutter Hotel, 10 to 12 A.M.—Invocation, Rev. Joseph McQuaid, Chaplain S. A. W. V. Address of welcome, Mayor James Rolph, Jr.; response and annual address, President Isabel Harroun, Pasadena, Cal.; 2 to 4.30 P.M.—Business meeting, officers' and camp reports; 7.30 P.M.—Seeing Exposition.

Wednesday, August 11, 9 to 12 A.M.—Business meeting; 2 P.M.—Seeing San Francisco, Presidio, Letterman General Hospital; informal tea at Nurses' Home, Miss L. Keener, C.N., hostess; 7.30 P.M.—Seeing exposition.

Thursday, August 12—Spanish-American War Nurses' Day at Exposition. 9 to 12 A.M.—Business meeting; 2 to 5 P.M.—Reception and tea in California Building, Exposition Grounds. Hostesses: Miss Laura McKinstry, Mrs. Charles W. Slack, Mrs. E. R. Dimond. 7.30 P.M.—Seeing Exposition Grounds.

Friday, August 13, 9 to 12 A.M.—Business meeting, election of officers; 1 P.M.—Informal luncheon and adios.



California

Miss Mary Buckley and Miss Isabel Harroun, of Pasadena, both graduate nurses, have completed their new home, Los Ninos Vivienda (The Babies' Dwelling) on Kirkwood Heights, one of the most beautiful sites, just within the city limits, in North Pasadena. This home, with its spacious sleeping porches, pure air and plenty of sunshine, is especially designed and equipped for the scientific care and training of babies, under the supervision of the family physician. Miss Harroun is well known to many of our readers; she was for years connected with the Toledo

(Ohio) Hospital, is a Spanish-American War Nurse, and at present president of the organization. We wish Miss Buckley and Miss Harroun, every possible success in their undertaking.



Connecticut

The graduating exercises of the Hartford Hospital Training School for Nurses, Hartford, were held at the Nurses' Residence, Saturday, June 5, 1915, at eight o'clock in the evening. The program follows: March, orchestra; prayer, Rev. Samuel Hart, D.D.; address, Dr. E. T. Bradstreet; presentation of diplomas and prizes, Dr. P. H. Ingalls, chairman training school committee. Reception and dancing followed the exercises.

The following prizes were awarded: Senior year, first prize of \$50, donated by Dr. O. C. Smith, to Mary D. Boudreau; second prize, \$25, donated by a member of the executive committee, to Greta M. Ferris. Intermediate year, first prize, \$50, donated by Mr. Austin C. Dunham, to Annie R. Blenkhorn; second prize, \$25, donated by a member of the executive committee, to Mary E. Malloy. Junior year, first prize, \$50, donated by Mr. Austin C. Dunham, to Harriet S. Nelson; second prize, \$25, donated by a member of the executive committee, to Bessie E. Anderson. There were twenty-eight members of the graduating class.

The annual meeting of the Alumnae Association of the Connecticut Training School for Nurses was held at the Double Beach Hotel in Branford, about eight miles east on the shore on the afternoon of June 3. Miss Barron presided and all officers, excepting Mrs. Smith, treasurer, were present. Annual reports and regular business attended to. The same officers will serve another year. A fine, concise paper on "Mental Nursing" was read by Miss Rose Heaven and was very instructive. After adjournment a most delicious shore dinner was served to about twenty-five members and graduates which was greatly enjoyed by all. Next meeting will be held at Dormitory first Thursday in September.

District of Columbia

The Washington Camp of the Spanish-American War Nurses were entertained on May 26 at the home of Dr. Anita N. McGee. Miss Dora Thompson, superintendent of the Army Nurse Corps, was the guest of honor. On Memorial Day ten of the members went to Arlington as guests of Spanish War Veterans and their Auxiliary at their exercises and luncheon. A business meeting was held at the home of Mrs. Clark, June 4; Mrs. Prentiss (née Wiedeman) was elected camp chairman and Mrs. Cryor (née Yates) secretary.



Maryland

The Peninsula General Hospital Training School, Salisbury, Md., graduated five of its nurses on Friday, May 21, 1915. A musical program followed by reception, supper and dancing filled the evening. The following nurses graduated: Alice M. Holloway, Laura E. Knowles, Minnie K. Holden, Sadie L. Seward, Anna S. Henman.



Georgia

The ninth annual convention of the Georgia State Association of Graduate Nurses was held at Savannah, May 12, 13, 14. The main features of each session follow:

Afternoon of May 12—Invocation, Rev. Rockwell S. Brank; introductory address of welcome, Hon. W. J. Pierpont, acting mayor; address of welcome, Miss Luell C. Meier; response, Miss Mary Moran. Evening session, in the hall of the Georgia Medical Society. "Prayer for Doctors and Nurses" (Rauschenbush); introductory address, Dr. T. J. Charlton; address, "The State's Relation to Nursing Education," Miss Annie Goodrich, R.N., Teachers College, New York.

Thursday morning session—"The Twilight Sleep," Dr. H. H. McGee; "The Nurse and the Red Cross," Dr. A. J. Waring; "The Visiting Nurse," Miss Helen Hatch, R.N.; "The Milk Depot," Miss Anna J. Hill, R.N. Thursday afternoon session—"The Nurse as a Specialist," Miss Jessie May Candlish, R.N.; "The Visiting Nurse and Tuberculosis Control," Mrs. Eva S. Tupman, R.N.; "The Pupil Nurse and the Training School," Mrs. L. C. Saville, R.N.

Friday morning session—President's address, Miss Ada Finley, R.N., president of the Georgia State Association of Graduate Nurses; report of committee on resolutions; report of the commit-

tee on nominations; unfinished business; election of officers; adjournment.

The social features included an afternoon tea by the Oglethorpe Sanatorium Alumnæ, a garden party in the grounds of the Telfair Hospital, a luncheon at the Hotel Savannah and a river trip arranged by the Park View Sanitarium.



Maine

The Bill to Create a Board of Examination and Registration of Nurses which has become a law, reads as follows:

Section 1—Within sixty days after this bill shall go into effect the Governor, with the advice and consent of the council, shall appoint a board of examination and registration of nurses, consisting of four nurses and one physician.

The nurses appointed on this board shall have been graduated each from a different training school, connected with a hospital of good standing, presided over by a graduate nurse, giving at least a two years' general course in theory and practice of nursing in the wards, and shall have had at least five years' experience from date of graduation in professional nursing of the sick, and with the exception of those appointed as members of this first board shall have been registered under the provisions of this act.

The physician appointed on this board shall have been graduated at least five years, shall be a member of the Maine Medical Association, and shall be associated with a general hospital maintaining a training school for nurses.

There shall be at all times at least two members of the board who shall have had two or more years' experience in educational work among nurses.

All members of this board shall be actual residents of the State and engaged in professional work. Each member shall be appointed for a term of three years, except those first appointed, who shall serve as follows: One for one year, two for two years, and two for three years. Any vacancy in said board shall be filled by the appointment of a person qualified as aforesaid to hold office during the unexpired term of the member whose place he or she fills, and any member may be removed from office for cause by the Governor, with the advice and consent of the council.

Section 2—Said board shall, at the first meeting thereof, and at its annual meetings thereafter, elect from its own number a president and a secretary who shall also be treasurer. Said board may adopt a seal and pin, which shall be placed in the care of the secretary and may adopt such by-laws, rules and regulations for the transaction of the business of the board and the government and management of its affairs, not inconsistent with the laws of this State and of the United States, as it may deem expedient. Three members of said board shall constitute a quorum, and special meetings shall be called upon request of any two members. The secretary shall be required to keep a record of all meetings of the board, including a register of the names of all

nurses duly registered under this act, which shall be open at all reasonable times to public scrutiny and to furnish a certificate of registration to all such nurses, said certificate to be renewed at the end of five years upon payment of one dollar to the examining board, with affidavit to show his or her identity, at least three months' notice having been given, by registered letter, of expiration of said certificate. The board shall provide a schedule of the subjects upon which applicants shall be examined to qualify for the requirements of this act. On request of said board, the superintendent of public buildings shall provide a suitable room in the Capitol for its meetings.

Section 3—The members of said board shall receive their actual necessary expenses incurred in the discharge of their duties, and the secretary shall receive a salary to be fixed by the board, not to exceed \$250 per year. The other members of the board shall each receive \$4 per day while actually engaged in attendance upon meetings of said board. Said expenses and said salary shall be paid out of the receipts of said board as hereinafter specified. No charge or expense of any kind shall ever become a charge against the State.

Section 4—At a meeting of said board, to be held within sixty days after the appointment of members thereof and at the annual meeting in each year thereafter and at such special meetings as said board may deem necessary to hold for that purpose, notice of each of which meetings shall be given by publication at least one month previous to such meetings in such newspapers and nursing journals as the board may determine, said board shall examine all applicants for registration under the provisions of this act to determine their qualifications for the efficient nursing of the sick, and shall decide upon the qualifications of every such applicant and give notice of such decision within three months from the date of such examination. Application for registration shall be made upon blanks furnished by the board and shall be signed and sworn to by applicant. Any person twenty-one years of age or over and of good moral character, who shall show to the satisfaction of the board that he or she is a resident of the State, is a graduate of a training school for nurses in good standing, which gives at least a two years' course in a public or private hospital, in which a general course of instruction in theory and practice of medical, surgical and obstetrical nursing, or in case of male nurses, of genito-urinary work instead of obstetrics, is given, or has had such experience obtained by affiliation or post-graduate work, shall be eligible for such examination upon payment of a fee of \$5, to be deposited upon the filing of the application for examination. Said examination shall be oral and written and shall include the subjects of elementary anatomy and physiology, materia medica, medical, surgical and obstetrical nursing, dietetics, home sanitation and nursing. If such applicant shall pass said examination to the satisfaction of the board, he or she shall receive a certificate of registration.

Section 5—Any resident of the State twenty-one years of age or over, and of good moral character, applying for registration within two years from the passage of this act, and who shall, by affidavit or otherwise, show to the satisfaction of

the board that he or she is a graduate of a training school for nurses, which gives at least a two years' course in a public or private hospital, where a general course of instruction is given, or that he or she was, at the passage of this act, a student in such a training school for nurses, and afterwards was graduated therefrom, shall be eligible for registration without examination, upon the payment of a fee of five dollars. The board shall have the power to register in like manner without examination, upon payment of the usual fee, any person who has been registered as a professional nurse in another State under laws which, in the opinion of the board, maintain a standard substantially similar to that of this act, and which extends a similar courtesy to nurses registered in this State.

Section 6—Said board may cancel the registration of any person who has been convicted of any felony, or of any crime or misdemeanor in the practice of the profession of nursing.

Section 7—It shall be unlawful after six months from the passage of this act for any person to practice professional nursing in this State as a registered nurse without having a certificate of registration. A nurse who has received such certificate and pin shall be styled and known as a "Registered Nurse," and no other person shall assume such title, use the pin, the abbreviation "R.N." or any other words, letters or figures to indicate that the person using the same is such a registered nurse. Every person who shall violate any provision of this act, or who shall wilfully make false representation to said board in applying for a certificate of registration, shall be fined not more than \$100; provided that nothing in this act shall be held to apply to the acts of any person nursing the sick who does not represent himself or herself to be a registered nurse. The board shall cause to be presented to the proper prosecuting officer evidence of any violation of the provision of this act, and may incur any necessary expenses in the performance of this duty, said expenses to be paid out of the receipts of said board.

Section 8—The treasurer shall receive all fees payable to the board and shall quarterly on the last secular days of March, June, September and December, account for and pay to the treasurer of State all sums so received which shall be kept by the treasurer of State as a separate fund for the payment of the compensation and expenses of the members and the expenses of the board and for executing the provisions of law relating hereto, and so much thereof as may be required is hereby appropriated for said purposes. The secretary shall also be reimbursed for all expenditures for books, printing and other necessary expenses actually incurred in the discharge of his duties, but in no event shall payment for services and expenses of members of the board exceed the amounts received by the treasurer of State from the treasurer of said board. Any balance remaining to the credit of the board at the end of each year shall be carried forward to the next year. The treasurer of the board shall, before taking office, give to the State a bond with surety conditioned for the faithful performance of the duties of said office in the penal sum of not less than \$500. The board shall also submit to the Governor on or before the first day of January in each

year a general statement of the work of the board for the year preceding, including therein a statement of the number of applicants received during the year, the number approved, and the number rejected.



Massachusetts

At the Long Island Hospital, Boston Harbor, on the evening of May 20, a farewell dancing party was tendered the graduating class of the Nurses' Training School in anticipation of their approaching graduation. The library was prettily decorated with the school colors, Maytime blossoms and foliage, conspicuous being the American and Red Cross flags of Spanish War service, draped about the pictures of the Class of 1915, making a pleasing background for the uniforms of the pupil nurses, officers of the Coast Artillery and fancy gowns of the graduates. Delicious ices were served by Miss M. A. Meyers, superintendent of nurses, hostess of the occasion. The weather being perfect, made the sail on Boston Harbor to and from the hospital an added pleasure for the guests of the evening.

A meeting of the Massachusetts State League of Nursing Education was held at the Hotel Brunswick, Boston, on Saturday, June 5, at 11 A.M., the president, Miss Nichols, in the chair. The principal speaker was Prof. Selskar M. Gunn, who spoke on the public health nurse. At Miss Nichols' suggestion Miss Carr then gave an account of the two and eight-month courses of training offered by the Boston Instructive District Nursing Association, and of a special course of a month to six weeks to be given this summer, without fee, if applicants enough apply, as a preparation for the unusual demand for tuberculosis nurses that will necessarily follow the compulsory opening of tuberculosis dispensaries throughout the State on July 1 in all towns of ten thousand inhabitants or over. Miss Watson reported for the membership committee the sending out of a number of letters and blanks and the result of five new members. For the collegiate committee she reported the sending of a paper on opportunities in nursing to some six colleges and the sending of a magazine published at Barnard, containing an article on nursing by Miss Nutting, to Boston University, Radcliffe, Holyoke and various other colleges.

The following officers were elected: Miss Nichols, president; Miss Allen, vice-president, and Mrs. Flash, of the Homeopathic Hospital, secretary and treasurer, in place of Miss Cray, resigned. Miss Riddle was chosen delegate to the

conference in San Francisco. Miss Parsons spoke on the need of a publicity committee. Experience had proved it useless to try to get standards of education or inspection of training schools unless there was a demand from the public. Most important work for the organization or for nurses in general was to instruct the public in kinds of training schools existing, kinds of nurses, practicing, etc. Must be more symmetry of education and a demand for it from the public before there will be more applicants. Miss Parsons was chosen chairman of a publicity committee, with power to select the other members.

Miss Ikey, of the Lawrence General Hospital, spoke on the eight-hour day or, rather, the fifty-six-hour a week schedule. She gave four ways in which the work might be arranged under the latter, two of which gave eight hours work each day and two allowed an afternoon free. A suggestion was made for giving the night nurse extra time. All called for three sets of nurses. Tired nurses cannot do good work, and it is economy to keep them in good condition.

Miss Parsons spoke on the uniform curriculum. She said the National League had worked one up from a report by Miss Nutting and would present it at San Francisco, the idea being to work toward such a curriculum, though all schools would not be expected to adopt it. She expressed the hope that the State of Massachusetts would work out a curriculum fitted to the schools of the State, after studying that of the National League. At her suggestion the State League went on record as favoring fifty-six hours a week for pupils, inclusive of study and class work, a step she denominated "the most advanced step taken."

It was stated that Mrs. Sturgis, secretary of the Society for the Prevention of Cancer, had written the League and expressed the hope that it would go on record as approving their purpose and, perhaps, assist them. No action was taken. The meeting adjourned.

The twelfth annual meeting of the Massachusetts State Nurses' Association was held at Hotel Brunswick, Boston, on Saturday, June 5, at 3 P.M., Miss Riddle, president, in the chair. After a prayer by Rev. M. J. Splaine, Miss Riddle addressed the meeting, giving a brief history of the Association and its work for registration year by year. She said this year's bill, offered by the board of registration, had been reluctantly accepted by the State Association. The criticisms made of it had been, as a rule, misleading, and perhaps intentionally so, but they should not repine or criticize the legislators. They could,

however, criticize any of their own members who went against it, for to express criticism at an Association meeting was all right, but even the loyalty may be doubted of a member who opposes the aims of the Association in public. The reports of the secretary and the treasurer were read and approved. Miss Tower reported for the committee for the Field Hospital Fund, and Miss Tisdale, the treasurer, said \$632.35 had been received and much more promised. The treasurer reported 664 members, 104 being new since 1914. It was voted on the motion of Miss Davis that the number of councillors at large be increased by 21.

Mrs. Homer reported for the legislative committee. She spoke of the defeat of the registration bill this spring, and said they had decided to draw up a new bill for presentation at this meeting. It was based on the recommendations of January 20, 1914, and striking out Section 3 of the present law, would make the following requirements: That applicants for registration be twenty-one years of age, of good moral character and graduates from a training school for nurses giving at least two years in a hospital, and considered efficient by the board. The board should also have the power to investigate any training school to determine its efficiency. For this purpose an R.N. should be chosen from a list of names presented by the Massachusetts State Nurses' Association. After January 1, 1920, no person should be allowed to practise as a graduate nurse unless registered as provided in this Act. Miss Riddle said this brief report from the legislative committee would probably be followed by a full report at the next meeting.

Miss Davis reported for the nominating committee, and the secretary was authorized to cast one vote for the following officers: President, Sara E. Parsons; first vice-president, Mary M. Riddle; second vice-president, Lucia Jaquith; recording secretary, Mrs. Jane Barker Homer; treasurer, Esther Dart; corresponding secretary, Charlotte W. Dana. Miss Lucia L. Jaquith read a paper on ways and means to increase membership. Miss Emily O. Boswall gave a paper on the advantages to the private nurse of membership in her State Association. Except for the enlightening initial statement that either the advantages were too great for words or too ephemeral to be seen by any but outsiders, her only point was that it was broadening for the nurse to meet nurses from other schools. Miss Coughlin and Miss Howe, who were to have discussed the paper, were absent.

The meeting adjourned for tea and a social time!

Michigan

The eleventh annual meeting of the Michigan State Nurses' Association and the second annual meeting of the Michigan State League of Nursing Education were held in Ann Arbor, May 4, 5 and 6, in the Barbour Gymnasium, Sarah Caswell Angell Hall. On May 4, after the invocation by Rev. L. A. Barrett, an address of welcome was delivered by President H. B. Hutchins, University of Michigan. Following the reports by officers and committees, the president, Ida M. Barrett, read her annual address. Annie M. Coleman, State Inspector of Training Schools, reported that 600 copies of the new curriculum had been sent out, that 67 per cent. of the nurses graduating since 1912 have taken the State Board examination and that twelve schools have not sent nurses to take the examination. A parliamentary drill was then conducted by Mrs. Emma A. Fox, of Detroit. A luncheon was given in honor of the retiring members of the State Board of Registration, Mrs. Elizabeth Tacey and Dr. Arthur Scidmore, also to the new members, Emily A. McLaughlin and Dr. Reuben Peterson. At 4.15 P.M. an organ recital was enjoyed at the Hill Auditorium, by courtesy of the University School of Music. At 8.00 P.M. an illustrated lecture on "Causes of Insanity" was given by Dr. A. M. Barrett, professor of psychiatry and diseases of the nervous system, University of Michigan. Edna L. Foley, superintendent Visiting Nurse Association, Chicago, spoke of the 3,000,000 sick daily in the United States and that only 10 per cent. are provided for in hospital beds; as only 10 per cent. of the working people in this country earn over \$800 a year in wages, there is necessity for the public health nurse. The Association voted to become a corporate member of the National Public Health Organization.

On May 5 an illustrated lecture was given by Dr. Reuben Peterson, professor of obstetrics and gynecology, and medical director of University Hospital. Subject, "Relation of the Nursing Profession to the Cancer Propaganda, and Institutional Treatment of Contagious Diseases." Sarah Burrowes, social worker, University Hospital, spoke on "Hospital Social Service." Anna Schill, delegate, presented the report for the State Federation of Women's Clubs. At 2.00 P.M. the subject of "Vocational Training for Women" was presented in an address by Prof. A. S. Whitney. Alice Lake, assistant principal of Farrand Training School gave a paper on "The Nursing Profession as a Vocation for Women." Agnes G. Deans, chairman affiliation committee, reported

that a fund would be required to meet the expense of developing a plan for forming district organizations. The Association voted to allow \$200. A pleasant social event was the tea given by the Washtenaw County Graduate Nurses' Association, assisted by members of the Women's League and student nurses from the hospitals. In the evening the surgical amphitheater, University Hospital, was overcrowded by doctors, students and nurses, who watched a demonstration, planned by the State League, given by nurses from five different cities.

On Wednesday afternoon Annie M. Coleman presided at the second annual meeting of the State League of Nursing Education. The report on the revision of constitution and by-laws was adopted. Jane Pindell, chairman, presented a report on University Extension Work, covering a survey of thirty-three educational centers in the United States.

On May 6 a paper was read by Carol F. Walton, secretary, on "Work of the State Tuberculosis Association." Only five hundred beds are available in sanatoria. There are eight fresh-air schools. The State Board of Health has recently been allowed \$100,000 to fight tuberculosis, and a State nurse is soon to be appointed. Governor Ferris has given the work his endorsement in a public proclamation.

Kalamazoo was selected for the convention city in 1916. Officers were elected as follows:

Michigan State Nurses' Association: President, Ida M. Barrett, Grand Rapids; vice-presidents, Elizabeth Parker, Lansing; Mrs. Mary Foley, Houghton; treasurer, Kittie Hart, Saginaw; recording secretary, Mary Welsh, Grand Rapids; corresponding secretary, Mrs. R. K. Wheeler, Port Huron; councillors, Mrs. L. E. Gretter, Detroit; Sarah Sly, Birmingham.

Michigan State League of Nursing Education: President, Annie Coleman, Lansing; vice-president, Mrs. L. E. Gretter, Detroit; secretary, Mrs. Mary Lovering, Detroit; treasurer, Amanda Judson, Ludington; chairman, credential committee, Emma Cross, Ypsilanti.

The Kalamazoo County Nurses' Association, at its annual meeting, elected the following officers: President, Edith M. Cowie; first vice-president, Charlotte Garrison; second vice-president, Eva Knight; secretary, Mina Weber; treasurer, Effie Pierce; censor for three years, Nina Heath.

The commencement exercises of the Hurley Hospital Training School for Nurses, Flint, were held at the Elk's Temple on the evening of May

19. The following received diplomas: Anna M. Smith, Mary L. Cornish, Elizabeth D. Graham, Henrietta R. Schroeder, Margaret R. McGregor, Vera M. Thurston, Nina T. Petery, Lulu C. Thompson and Sara F. Cook.



Missouri

The Missouri Baptist Sanitarium Alumnae Association held its regular annual meeting at the Nurses' Home, 4529 McMillian Avenue, April 23. The following officers were elected: Mrs. Mary A. Nelson (superintendent of the training school), president; Miss F. Wegeman, secretary; Miss Mary Rynders, treasurer. Mrs. Nelson has recently been appointed member of State Board of Nurse Examiners, to succeed Mrs. F. E. S. Smith, who died March 4.

The commencement exercises of the training school for nurses of the German Hospital, Kansas City, Mo., were held Friday evening, May 14, 1915, at the Elk's Club. Six young women received diplomas. The superintendent of the training school is Miss Mary Burns. The graduates are Mary E. Curtis, Mary A. Kline, Olga Schmidt, Lulu F. Wilkins, Julia B. Engels, Mattie Periman.



New York

An invitation was sent to eight hundred graduate nurses to attend a meeting at the British War Relief Association Headquarters, 132 West Twenty-seventh Street, on May 12. A large number attended and were addressed by Dr. T. M. Spring-Rice, who told of the hospitals to which the Association had sent medical supplies. Major L. L. Seaman, president of the Association, addressed the meeting, telling of his experiences on the firing lines at Ghent and other Belgian cities, and describing the necessity for large quantities of medical dressings to be shipped there. This Association has sent 220 packing cases of supplies to Europe since the beginning of the war.

The Alumnae Association of the Syracuse Hospital for Women and Children met May 19 at the hospital to transact its annual business. Officers were elected as follows: President, Miss Gertrude Masterson; vice-presidents, Miss Winifred Higgins and Miss Margaret Macdill; secretary, Miss Isabella G. Smith; assistant secretary, Miss Jane McCall; treasurer, Miss Emma Munro.

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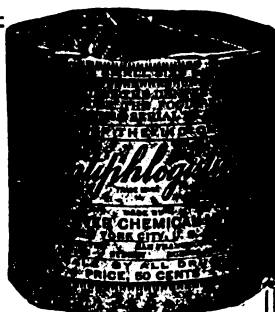
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applied thick, and, in burns, especially—COLD.

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New Jersey

The Newark German Hospital Alumnae has affiliated with the American Nurses' Association, with a membership of fifty-four. The following are the new officers of the Association for the year: President, Miss J. Halberstadt; vice-president, Miss R. Lindeburg; secretary, Mrs. J. Pollitt; treasurer, Miss W. Lonn.

This Association, after years of effort, has succeeded in accumulating the necessary funds to endow a room for the use of their sick members at the German Hospital. This room is to be called the "Clara Maas Memorial Room." Miss Clara Maas was a former member of the Association and lost her life in Cuba during the Spanish-American War. She submitted to tests by the United States Government to prove the method of transmitting the yellow fever germ. Miss Maas contracted the fever and died a martyr for humanity.



Ohio

The graduating class of Mount Carmel Hospital, Columbus, held commencement exercises in the assembly hall of the hospital, Wednesday, June 2, 1915, when twenty-three young women received diplomas. The program was as follows: Class song, graduating class; salutatory, Veronica J. Engesser; opening address, Hon. T. S. Hogan; "The Troubles of a Nurse," Laura V. Barker; class prophecy, Nelle Chiesa; conferring of diplomas, Dr. W. D. Hamilton; conferring of medals, Dr. L. M. Lisle; closing remarks, Rt. Rev. J. J. Hartley. The class motto is *Semper Fidelis*.

The graduating exercises of the Class of 1915, of the Mercy Hospital Training School for Nurses, Hamilton, were held at St. Stephen's Hall. Hon. M. O. Burns delivered an eloquent address. The closing address to the graduates was by Rev. R. C. Conner, who exhorted the Class of 1915 to a practice of true Christian charity and begged the young ladies not to become worshipers of the false god of gold in these materialistic days. Those who received diplomas are: Myrtle Charles, Elizabeth Menger, Eleanor Delaney, Mary Leahy and Kathleen Connel.

The first annual banquet of the Nurses' Alumnae was held in the nurses' dining room of Mercy Hospital, and was given in honor of the Class of 1915. Mrs. George Bramlage (née O'Neill), the first graduate of the school, was present. The toasts were responded to as follows: "Friendship," Mary Kynch; "Our Nurses,"

Cornelia Snyder; "The Future," Marie Danaher; "The New Nurses' Home," Henrietta Kallmeyer. Previous to the banquet the members of the Alumnae were guests of the Sisters' Hamilton friends on a motor trip to Fort Ancient.



Pennsylvania

The graduating class of the Norristown State Hospital Training School for Nurses held graduating exercises Thursday evening, June 3, in the Assembly Hall of the hospital, with the following program: Prayer, Rev. Harry St. Clair Hathaway; address to graduates, J. Burnett Holland, Esq.; presentation of diplomas, Col. William J. Elliott; presentation of medal to honor graduate of the men's department, Dr. S. Metz Miller; presentation of medal to honor graduate of the women's department, Dr. Jessie M. Peterson; benediction. There was also a fine musical program. The exercises were followed by dancing. The graduates are: Department for men: Garsett J. Frost, Joseph P. Howell, Samuel F. Hutchman, Nelson H. Laporte, Margaret H. Mount, Priscilla H. School, Anderson C. Williamson. Department for women: Helen E. Angstadt, Bessie M. Hallyburton, Anna E. Rickert, Edna P. Bogart, Mary E. Heisey, Olive M. Heisey, Theresa P. Stutzbach, Mabel E. Ward, Alice A. Eck.

The regular monthly meeting of the Alumni Association of the Philadelphia Lying-In Charity Hospital was held at the hospital on Thursday afternoon, June 3, at three o'clock, the president, Miss Clara B. Steinmetz, presiding. Twenty-six members were present. We adjourned to meet on the first Thursday afternoon in October.

The regular monthly meeting of the St. Francis Hospital Nurses Alumnae, Pittsburgh, was held Tuesday evening, April 13, in the nurses' reception room of the St. Francis Hospital, with a large attendance and all the officers present. The meeting was presided over by the president, Miss Adelaide Cushing, R.N.

The final plans were announced for the annual reception and dance, which will be given at the German Club for the entertainment of the graduates of the 1915 class. The election of officers was announced for the coming year: President, Miss Moyle, R.N.; first vice-president, Miss Brosnan, R.N.; second vice-president, Miss Holtzer, R.N.; secretary, Miss Burrey, R.N.; assistant secretary, Miss Aaron, R.N.; treasurer, Miss McKlinley, R.N.

The Alumnae expressed its appreciation of the

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outgoing officers, Miss Cushing and Miss Fahey, who have served faithfully as president and secretary for the last three years, and whose untiring efforts have made the St. Francis Hospital Alumnae a success.

Members of the graduating class of the State Hospital training school, Scranton, five in number, held their commencement exercises in St. Luke's parish house May 28. Hon. E. B. Hardenbergh, president of the board of directors of the hospital, delivered the introductory remarks. The address to the graduating class was made by Hon. Frederick W. Fleitz. Mortimer B. Fuller presented the diplomas to the graduating class after he made a short congratulatory address to them. Following this, Mr. Fuller handed out the many bouquets of flowers which friends and relatives of the five graduates had sent them.

At the Nurses' Home the class held a reception. Dancing was enjoyed and refreshments were served. About two hundred attended the reception.

The members of the graduating class are: Ruth Boyd Belles, Helen Madeline Bertree, Lila Lavine Heberling, Mary Elizabeth Jones and Mayme Aloysius Moffitt.



Rhode Island

The graduating exercises of the Class of 1915 of the Rhode Island Hospital Training School for Nurses, Providence, were held in the Service Building at the Hospital, Wednesday, May 12, at 8.30 o'clock. There were forty-three members of the Class. The address to the graduates was by Mary E. Wooley, president Mt. Holyoke College, who took for her subject, "Success." The diplomas were presented by Jesse H. Metcalf, Esq., president of the board of trustees. There was also music. A reception followed the exercises.

The graduating exercises of the Class of 1915 of the Butler Hospital, Providence, were held at Ray Hall. Those on the platform were Dr. Richard C. Cabot, of Boston; Charles H. Merriman, president of the board of trustees; Theodore F. Green, William L. Hodgman and Lauriston H. Hazard, trustees; Dr. G. Alder Blumer, superintendent, and Dr. Henry C. Hall, assistant superintendent. The hall was handsomely decorated and well filled with visitors. The music was furnished by an orchestra. The following is a list of the members of the graduating class: Three-year course—E. Beatrice Densmore, Marion Elizabeth Derry, Ada R. Hender-

son, Martena Charlotte Lawrence, Margaret Mary Lowe, Sadie Ethel Moore, Eva A. Pilling, Mildred G. Rowley, Florence Willena Scott, Susanna H. Simonson, Greta May Walden, Minnie E. Ward, Paul Hecker, Charles J. Murray, Thomas J. Ney, Ernest Lee Nichols. Two-Year course—Ralph Lamb, John F. Smith, Manuel G. Yeghia.

The speaker of the evening was Dr. Richard C. Cabot, of Boston, who delivered one of his brilliant addresses on "Things Worth While in Nursing," extracts of which we hope to publish later. The diplomas were awarded to the graduating nurses by Charles H. Merriman, after which a reception, followed by dancing, was held.

The third annual banquet to the graduating class in the training school at the Butler Hospital, tendered by the Alumnae Association, was held at the Narragansett Hotel, with forty present, including nineteen members of the Class of 1915. The post-prandial ceremonies were in charge of Miss Irene Betts. Toasts were responded to by Dr. G. Alder Blumer, the medical superintendent, Dr. H. C. Hall, the assistant medical superintendent and president of the board of examiners for trained nurses; Miss Evelyn Jehan, superintendent of the Butler Hospital Training School; Miss R. Helen Cleland, former superintendent; Dr. Arthur H. Ruggles, and Dr. Fred E. Webb and other members of the alumnae. An interesting feature of the ceremonies was the toast by Miss Cleland, who is a successor in line of Florence Nightingale through Miss Linda Richards and Miss Jehan, a successor in line following Miss Cleland.



Vermont

The annual meeting of the Vermont State Nurses' Association was held at the Rutland Hospital May 11. Miss Mary E. Schumacher, superintendent of the Brattleboro Memorial Hospital, and president of the Association, presided at the meeting. Prayer by the Rev. J. Bradford was followed by the business meeting. Three papers of exceptional interest were presented. Miss Clara Churchill, superintendent of nurses at the Mary Fletcher Hospital of Burlington, read a paper on "Miracles of Modern Surgery." Miss Cora Curtis, district nurse of Burlington, read a paper on "Public Health Nursing in Vermont State," and Mrs. R. A. Lawler, of Springfield, read one on "Twilight Sleep."

The following officers were elected: President,

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such as typhoid, influenza, pneumonia, puerperal fever, etc., means the realization of the following factors: (1) an abbreviation of the course of the disease if possible, (2) the prevention of complications, and (3) hasty and complete convalescence.

Success can only be attained by maintenance to the highest possible degree of the vital resistance of the patient by judicious feeding.

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Miss Mary E. Schumacher, of the Brattleboro Hospital; first vice-president, Mrs. F. Patch, of the Rutland Hospital; second vice-president, Miss Cora Curtis, of Burlington Hospital; secretary-treasurer, Miss Hattie E. Douglass, of the Mary Fletcher Hospital, Burlington; assistant secretary, Miss Annie Aitken, of the Rutland Hospital.



Marriages

On March 8, 1915, at Glenburn, N. D., Iva Etta Knox, Class 1908, Polyclinic Training School for Nurses, Chicago, to Luther Johnson, of Jefferson, Iowa. Mr. and Mrs. Johnson are homesteading in Montana.

On May 15, 1915, at Trull Hospital, Biddeford, Me., Mrs. Bessie A. Morse, a graduate nurse of the hospital, to Frank O. Smith, of Charlotte, N. C. The marriage had been planned to take place at Charlotte, but owing to the illness of the bride this was not possible. Not wishing to postpone the marriage, a bedside ceremony was performed at the hospital. Mrs. Smith is a native of Bath and was graduated from the Trull Hospital five years ago. For four and a half years she did district nursing in Washington, D. C. She has recently made her home in Salem, Mass.

On May 18, 1915, at Hanover Flats, Manchester, N. H., by Rev. Milford R. Foshay, Estelle Althea MacNutt to Dr. Henry Wells Newell Bennett. The bride is a graduate nurse of the Elliot Hospital, Class of 1912. On their return from a wedding trip Dr. and Mrs. Bennett will make their home at "Wildwood," Londonderry.

On March 31, 1915, at Seymour, Conn., Ada L. Daniels, R.N., graduate nurse of Lozier Memorial Training School, New York, Class of 1910, to J. Willard Austin, of Spencer, Mass. Mr. and Mrs. Austin will reside in Worcester, Mass.



Deaths

On April 10, 1915, at Hebron Sanatorium, Hebron, Me., Katherine Smith. Miss Smith graduated in the Class of 1910 from the Central Maine General Hospital.

On May 8, 1915, at the Providence Hospital, Holyoke, Mass., Margaret McNamara. Miss McNamara was district nurse and later resident nurse for the West Boylston Company, Easthampton. She died from blood poison, contracted from a patient. She was a graduate of

the Lawnia (N. H.) Training School. Miss McNamara was a most faithful nurse, having the confidence of every one, and her death means a great loss to the community.

On May 26, 1915, at St. Mary's Hospital, Waterbury, Conn., Margaret Leall, of Middletown, Conn. Miss Leall was graduated in 1914 from the institution in which she died. Since her graduation she has been engaged in private nursing, and was taking care of a patient at the hospital, when she was taken suddenly sick and died after a short illness. A requiem high mass for the repose of her soul, celebrated by Rev. Luke Fitzsimons, chaplain of the Alumnae Association, was held in the chapel at the hospital on May 28, after which her body was taken to Middletown for burial.



IN MEMORIAM

WILLIAM ORRIS MANN, M.D.

WHEREAS, The Hospital Bureau of Standards and Supplies has learned with deep regret of the death of DR. WILLIAM ORRIS MANN, and

WHEREAS, It is recognized that Dr. Mann was numbered among the ablest hospital administrators of the country, as evidenced by his efficient service in the several positions of trust occupied during his career, viz.: those of assistant physician in the Westboro (Mass.) Insane Hospital; assistant superintendent of the State Hospital at Fergus Falls, Minn., and superintendent of the Massachusetts Homeopathic Hospital, the last-named office having been held for nearly sixteen years, and at the time of his death, and

WHEREAS, The high esteem in which he was held by the hospital body of the entire country was marked by his election to the presidency of the American Hospital Association for the year 1915, be it and it is hereby

RESOLVED, That the bureau enter upon its minutes a record of its esteem of the service rendered by Dr. Mann to the cause of hospital efficiency and advancement, of its appreciation of Dr. Mann's character and personality, and of its sense of loss to the bureau and to the hospital community generally caused by his death; and it is further

RESOLVED, That a copy of this minute be transmitted to Dr. Mann's family.

The above resolutions were adopted at a special meeting of the executive committee of the Hospital Bureau of Standards and Supplies, held April 17, 1915.

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Book Reviews

Materia Medica and Therapeutics. A Text Book for Nurses. By Linette A. Parker, B.Sc., R.N. Instructor in Nursing and Health, Teachers College, Columbia University. 12mo, 311 pages, illustrated with 29 engravings and 3 plates. Cloth, \$1.75, net. Lea & Febiger, publishers, Philadelphia and New York, 1915.

The author has carefully and with much discrimination weighed the knowledge of materia medica and therapeutics requisite to the highest efficiency in the nurse, and has planned her work to embody precisely this material. Her aim has been not to qualify the nurse to take the place of the prescribing physician or the compounding pharmacist, but to give her that grasp of the subject which will enable her to handle and administer drugs with intelligence. She has carefully avoided the inclusion of material that will not be specially useful to the nurse.

She has brought to the preparation of this volume a comprehensive knowledge of materia medica and a keen insight into the problems of the nurse and her special needs as regards rational training. The student whose careful study of this volume is supplemented by class-room demonstrations of the appearance and characteristics of drugs along the lines clearly indicated by the author will bring to the performance of her duties just that degree of knowledge that is most likely to serve the needs of the physician in attendance and the interests of the patient.

Essential facts only are presented, and details that might confuse the mind of the student are avoided. The nurse learns from this volume not only that certain drugs are administered in certain conditions, but the reasons for their selection. Recognizing the nurses' viewpoint, the author places emphasis not on the fact that a certain drug is prescribed in a certain condition, but on what action the drug ordered by a doctor may be expected to have, what untoward effects may be looked for, and the emergency procedure pending the physician's arrival in case of an overdose.

In the preliminary sections tables, technic and the necessary definitions are clearly stated and explained. The consideration of drugs is logically arranged by systems—nervous, muscular, circulatory, etc., with an additional section devoted to specifics and drugs which affect nutri-

tion. A concise chapter on legislation concerning poisons and habit-forming drugs includes consideration of the Harrison law, indicates just which drugs are restricted and how to conform to the law. In the chapters on Psycho, Hydro, Electro, Serum and Ray Therapy a clear insight is given into a department of scientific medicine, access to which has heretofore been had only through the most technical of medical treatises.

The illustrations are at once striking, appropriate and illuminative. The author's easy style, faculty of clear expression and ability to absorb the interest of the reader add to the usefulness of the book.



Mothercraft for School Girls. By Florence Horspool, L.O.S., C.R.S.I. Illustrated. Price 40 cents. Macmillan Co., New York.

This book gives in detail full information for young people concerning the care of infants, and should be regarded as a welcome aid to nurses engaged in welfare work, and a book to put into the hands of mothers whose elder children are sharing with them the care of the baby.

Among the practical subjects taken up are suitable clothing, washing and dressing, feeding, babies' ailments, sleep and fresh air, etc. The material is offered in the form of short talks, interestingly supplemented by illustrations bringing out the important points. These illustrations show children carrying out the instructions indicated in the book as to making beds, washing the infant, etc.



Meatless Cookery. By Maria McIlvaine Gillmore. With an Introduction by Louis Faugères Bishop, M.D., Professor of Heart and Circulatory Diseases, Fordham University, New York. Cloth, 352 pages. Price \$2.00. E. P. Dutton & Co., New York.

The author of this needed book on cookery without meats has evidently endeavored to steer a middle course. She is not a rabid vegetarian, in that she includes milk, cheese, butter and eggs in her recipes. She even includes a few rules for chicken cookery at the end of the book.

(Continued in Publisher's Desk)

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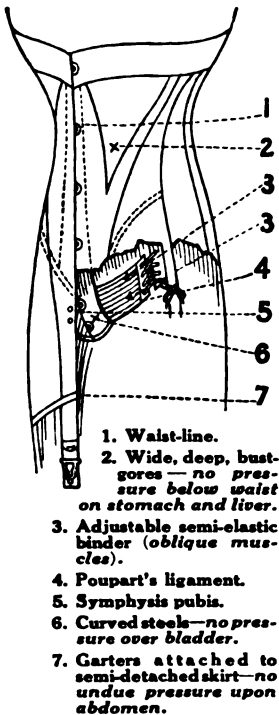
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Knox Sparkling Gelatine is put up in two packages—the No. 1 is the Plain Sparkling, unflavored, unsweetened, and the No. 3 is the Sparkling Acidulated. The gelatine and pink color in each package is just the same, and the only difference between the two is that the Acidulated contains an extra envelope of lemon flavor, affording the housewife a ready prepared flavoring. This takes the place of lemon juice, and saves the cost, time and trouble of squeezing lemons. It is called the "Busy Housekeeper's" package because the jelly is so easily and quickly made. Most gelatine dishes require lemon juice and here it is in the Acidulated package in concentrated form, ready for use. All that is added is sugar and water and the jelly is made.

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General directions: Apply at night after washing face and hands with warm or tepid water. Rub well into the skin with fingers, or, if preferred, on the wash cloth, and dry with soft cloth.

It can be used during the day with equal satisfaction and success, applying as above and finishing with face or other toilet powder. An application before going out will protect the skin and complexion from the ill effects of sun, wind and weather. On coming in, another application will remove all the dirt from the skin and pores and impart a feeling of cleanliness and comfort you will enjoy.

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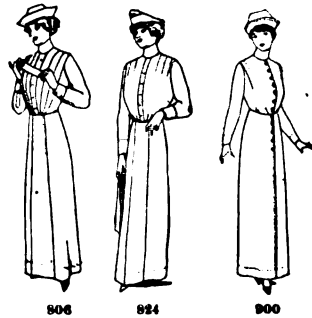
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For a number of years this company has been broadening out and enlarging the scope of its activities. As most readers of this journal will remember, some four or five years ago it entered the biologic field and now puts out a full line of serums, antitoxins, vaccines and similar products, both for human and veterinary practice. Also, it is engaged in the manufacture of pure chemicals and is constantly adding to its already large line of pharmaceutical products, many of which are not distinctively alkaloidal.

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A Monthly Magazine for Trained Nurses and Hospital Workers. Devoted to Trained Nursing in Private Practice and in the Hospitals of the Country

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The Editors and printers will greatly appreciate the courtesy of having all manuscript typewritten; or, if this is impossible, clearly written, great attention being given to proper names and medical terms.

BOOK REVIEWS—Continued

Dr. Bishop, in his introduction, states that there is great need for much closer attention to diets, especially in view of the prevalence of heart and circulatory disorders.

Dr. Bishop states that "food poisoning has generally existed for five or ten years before the heart is sufficiently damaged to cause distress on exertion."

Mrs. Gillmore's book certainly provides a variety of cookery for those who would avoid meat or who wish to reduce bills by providing a variety of wholesome substitutes for meat.

One would have to experiment with such dishes as seemed "likable," but one has only to look through the book to realize that a meatless diet need not be a monotonous diet, as the following recipes will show:

BOSTON ROAST

One pound can of kidney beans or like quantity of cooked beans; bread crumbs; one-half pound grated cheese; salt to taste. Mash the beans or put them through a meat grinder. Add the cheese and sufficient bread crumbs to make the mixture stiff enough to be formed into a roll. Bake in a moderate oven, basting occasionally with butter and water. Serve with tomato sauce. This dish may be flavored with onions, chopped, and cooked in butter and water.

RICE AND CHEESE

One breakfast cupful of rice; one-half pint of milk; four ounces grated cheese. Wash the rice and boil it till cooked in a double saucepan. Strain well; add the milk, a spoonful of butter, and pepper and salt to taste. Simmer again together; grease a pie dish well and fill with alternate layers of the above mixture and the grated cheese. Sprinkle grated cheese on top and a few pieces of butter. Put in hot oven and brown well. Serve very hot.



European War Nurses

Sailing on the *Rochambeau*, May 20, were ten nurses from Toronto, headed by Mrs. Maude A. Hirschfelder. They were going to Dieppe. Sailing on the same ship was Mrs. Mabel Harri-man, graduate of New York Hospital, Class of 1911.

The Trained Nurse and Hospital Review

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No. 2

Fire Protection and Prevention in Old Hospitals*

DR. JOHN M. PETERS

Superintendent Rhode Island Hospital, Providence

PREVENTION rather than cure is as sound and as practical when applied to the subject of fire as to that of disease. Preventive medicine is the aim of scientific medicine of today, and preventive measures against the starting and the control of fires are the aims of men and corporations whose time, thought and money are given toward these ends.

We point with pride to our wonderful fire departments, to their equipment, to the promptness with which their apparatus is brought to the scene of fire, to the bravery of the men, etc., yet figures show that the number of fires in this country is out of all proportion to the number occurring in foreign cities, and that the human and financial losses are very much greater. Why is this so? Why should it continue to be so?

Here where wood has been so cheap, where inadequate laws are in force, where adequate laws are not enforced, where carelessness is allowed, where the main question after a fire is "What was the loss?" and not "What was the cause?"—the matter is held lightly unless the damage to either life or property is heavy.

As my subject is "Fire Protection and

* Read at convention of American Hospital Association, San Francisco, 1915.

Prevention in Old Hospitals," I must limit my remarks to what can and should be done to this end in buildings constructed before the importance of this subject was appreciated by institutional people.

To find out what fire insurance companies think of institutions as fire risks, ask your agent for the rate, as compared to that for insuring factories, places of business or residences.

Factory mutual companies were organized to insure factory buildings, and are among the largest companies in the world. For years they have employed experts, have experimented as to materials, construction and safeguards. Before the property of a corporation is accepted as a risk, it is necessary for that corporation to meet the requirements of these insurance companies and periodically after that inspectors come at odd intervals during the year, make thorough inspections of the property and report in writing as to the condition of the plant, make recommendations which are checked up by the next inspectors, who are different men, and who, if the recommendations are urgent and have not been complied with, will report to the home office, which office will want to know the reason why.

I am indebted for what immediately follows in the paper to the president and engineers of the Blackstone Mutual Fire Insurance Company, one of the factory mutual fire insurance companies.

The engineers of the Blackstone Mutual Fire Insurance Company report as follows on "Prevention of Fires in Hospitals":

At present hospitals fall in that class of fire risks where a full protective system of automatic sprinklers, etc., has not become the rule, as it has in high-grade manufacturing plants.

The following notes are intended to indicate a protection against fire which should be installed, and the principal precautions to be observed in order to make a hospital as nearly immune from loss by fire as seems practicable, without the full protective equipment implied by 100 per cent. sprinkler installation.

1. *Order and Neatness*—It is a fundamental principle applying to all buildings for whatever purpose they may be used, that the fire risk is greatly reduced by maintaining excellent conditions of order and neatness throughout the premises. This fact has long been recognized and is emphasized by the constantly recurring fires in second-rate apartment houses, where the causes of fire are directly traceable to piles of rubbish left under stairs, in dark corners of basements and in similar remote places.

Not only do piles of refuse matter furnish light fuel for maintaining a brisk fire, but they often contain substances which may start spontaneous combustion. The materials most likely to ignite spontaneously are certain oils which have been used on waste, or polishing cloths, or spilled into waste matter. It is known, for instance, that a very small amount of oil in contact with lamp black will ignite spontaneously, especially under conditions of high humidity. Linseed oil is very dangerous.

All waste matter should be removed each day to points where fire resulting in them

could do no harm. Combustible waste is generally burned under the boilers each night. All waste papers, cloth, shavings, etc., should be collected during the day in metal cans, and should be kept in these until finally destroyed.

2. *Automatic Sprinklers*—The points at which automatic sprinklers will seem necessary will depend somewhat upon the construction of buildings. Under general conditions it may be stated that sprinklers should be installed in attics, basements, kitchens, power and heating plants, work-rooms, such as sewing rooms. If power and heating plants are of non-combustible construction throughout, sprinklers are not required.

Water should be supplied under good pressure to sprinkler and hose lines through a pipe not less than 6 inches diameter, connected to a large size public water main. If there is a yard where hydrants may be installed, this water connection should be not less than 8 inches diameter. In some cases it may be necessary to install an elevated tank or a pump as secondary water supply.

3. *Small Hose*—In portions of the buildings not enumerated above, it is desirable that lines of small hose be available. It is best that the hose be attached to stand-pipes which should preferably be located in or near stair towers, so that the hose may be used up to the last moment, then the person using it may escape safely at the stairway. The size of this hose should be not over 1½ inches diameter. 1¼ inches diameter being the more common size. The nozzle has an outlet of about ⅜ inch diameter. Under high-water pressure hose of this size can be handled easily by women and others not accustomed to handling fire apparatus, while large hose is sometimes dangerous for one strong man to hold alone.

4. *Fire Extinguishers*—It is desirable that for "first aid" purposes there be quickly available in all parts of the plant a very simple extinguishing agent of one sort or an-

other. Where their appearance is not objectionable pails of water are the simplest, most obvious and easily applied of these "first aids." These are usually covered and are kept on shelves some 5 feet above the floor and in groups of three or four each. One fire pail to each 1,200 or 1,500 feet of floor surface should be sufficient.

Another very good arrangement is on the market, consisting of a painted metal barrel, with hinged cover, nearly filled with water, and inside this are placed four to six metal pails nested together.

Chemical extinguishers, when well made, are very useful and not objectionable as to appearance. They are rather heavy, however, for women to use, and the method of use is not so obvious as in the case of fire pails. This type of extinguisher is not reliable after about one year, and should be recharged at least as often as this. For this purpose it is well to have the total outfit of extinguishers divided into groups, the recharging of one group following that of another at some stated interval.

Dry powder extinguishers are efficient in extinguishing fires at inception. These usually consist of a tin tube filled with bicarbonate of soda, which has a smothering effect. These are easily used, but soon exhausted, and the method of use might not be entirely obvious in case of excitement due to fire.

The "Pyrene" extinguishers recently put upon the market are also efficient under certain conditions. If the fire is confined to a small area, without a decided draught of air across it, this extinguisher works well; otherwise the vapor which forms a smothering blanket over the fire is easily dissipated and but little good results. The extinguishing element of "Pyrene" is carbon tetrachloride.

5. Hydrants and Hose—Whenever there is any yard room about the buildings, hydrants should be placed about 200 feet apart and furnished with a good supply of $2\frac{1}{2}$ -inch

cotton rubber-lined hose, underwriter play pipes with handles, the nozzles being $1\frac{1}{8}$ inch diameter. It is desirable that the hose be kept in a hose house, built over the hydrant, and the house should contain a good supply of spanners, hydrant wrenches, fire axes and crowbars.

6. Cut-offs—Buildings should be separated into units of moderate size, this separation being by means of fire doors at the ends of passages connecting buildings, or in the case of very long buildings, the doors may be placed also at partition walls. Of course, there should be no windows in such walls, if the fire stop is to be efficient. If windows are necessary at points where fire might easily be communicated from one unit to another, these should properly be of steel sash glazed with wire glass.

The best type of fire door is composed of a three-ply wood core covered with terne plates, the joints being locked with double fold in such a way that no nails are exposed. These doors are mounted on a heavy steel bar track, inclined so as to cause them to close by gravity. They may normally be held open by a weighted cord or chain containing a fusible link placed in a door opening, so that the first blast of hot air will cause it to fuse and allow the door to close.

These doors may be placed in a recess in the wall, if the latter is constructed with this idea in mind, in which case the door is invisible ordinarily.

Not only should rooms on the same floor be separated from each other, but there should be provision to prevent fire from spreading from one story to another. This provision is usually made by the use of fire doors at openings leading into elevator and stair towers. Unless thus protected such towers are open avenues for the rapid spread of fire to the upper stories. If the stairs cannot be placed in the tower, they should be enclosed with fire retardent material to obtain as nearly as possible the same result. Dumb-waiters should be enclosed with fire

retardent material, and openings should be protected by doors or shutters, which will be automatically released by fusible links in case of fire.

7. *Hollow Spaces*—The rapid spread of fire and stubborn resistance to being extinguished are greatly promoted by floors and partitions so framed and finished that there are hollow spaces between the two surfaces. This hollow construction in joisted framing is often felt necessary where a finished, smooth ceiling is required, but in attics and basements it is usually feasible to eliminate the finish at the lower surface. The "open joist" construction which is then presented makes the work of extinguishing fires much easier.

8. *Gas and Gas Lights*—As a means of lighting, gas is fortunately giving place to electricity. Its continued use for many other purposes makes it necessary to give careful attention to its proper installation and use.

It is desirable that the supply to each building or at least the main supply to the plant as a whole be controllable outside the walls. This is usually done by an outside valve or by a valve inside the building with the stem extending through the wall.

So far as possible all gas lights should be fixed in position and should be piped with iron piping. The use of gas through rubber tubing is considered very dangerous, as the rubber is not impervious to the flow of gas.

Where there is any danger that gas lights and inflammable material may come into contact with each other, the burner should be surrounded by a wire guard.

9. *Electric Wiring and Lights*—Probably the greatest danger from electricity is in short circuits, due to the insulation becoming injured either by sudden blows or by gradual wearing. The best method of wiring is considered to be by enclosing the wires in tubular conduits made for this purpose.

If it is necessary to transform the current before using it, and if oil cooled by trans-

formers are used, these should be placed outside the building. In a large installation, a small fireproof structure is best for containing the transformers, but if only a small amount of current is used, the transformers may be placed on poles at a safe distance from buildings. It is also desirable that the lines carrying the primary current be furnished with lightning arresters.

Fuses on the inside wiring should be of approved manufacture, and groups of these should be placed in closets with closely fitting doors. A metal closet is best for this purpose, though wooden closets lined with asbestos paper give fair protection.

There is such a variety of fuses on the market that no general directions as to selection can be made, but it may be said that it is well to avoid the refillable type. If electric lights are used in places where there are inflammable vapors, a vapor-proof lamp should be used.

When electricity is used for other purposes than lighting (e.g., for heating flat-irons) special care should be taken with the wiring, to prevent rapid wearing of the insulation, which may easily result in short circuits. When the wiring is much moved about, as in the use of flat-irons and electric cutters, a weak spot is likely to develop by frequent bending. This point can easily be determined in advance, and should be protected by a coil of wire or similar means, so that a short bend cannot occur.

In cases where current is used for heating, provision should be made against accidentally leaving the current active, when it is supposed to be turned off. The best safeguard is to introduce a small "pilot light" in the circuit at a point high above the floor, so that it can be readily seen from any point of the room and will be burning so long as the current is flowing.

10. *Volatile Oils*—The main supply of any volatile oils used should be stored in metal tanks buried outside the building. The supply may best be drawn by means of

small pumps designed for this purpose.

Benzine, gasoline and naphtha should never be stored, even in small quantities, in a basement. The vapors of these oils are heavier than air, so that if stored in a room below the ground level the vapors cannot escape to the outer air. If it is necessary to store these oils in a room above the basement, such a room should be well ventilated at the floor level. It should be remembered that severe explosions may result from these vapors, and the selection of a storage place should be made, with the view to prevent as little damage as possible if explosions should occur.

These volatile oils should be used directly from safety cans of approved construction. In general, cans containing not more than one pint will be found suitable for use in cleaning, etc.

11. *Fire Alarm*—A fire-alarm box should be secured near the premises, if possible in the hospital yard, and in a conspicuous place.

12. *Fire Drill*—It is very important that the permanent attendants should be instructed and reviewed at intervals in the matter of behavior if a fire should occur. The principal points with which they should be very familiar are knowledge of location of exits and all means of reaching them, location and use of small hose, fire doors and extinguishers, and the location and operation of fire alarms. They should also know the principle of operation of the fire doors. They should understand the importance of keeping them free from any obstruction which would prevent them from closing in case of fire.

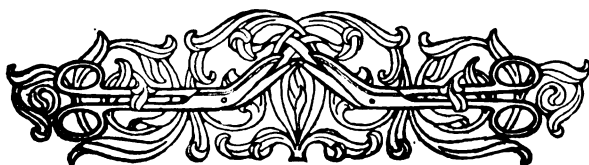
13. *Fire Brigade*—If possible, there should be an organization for the purpose of handling the larger units of apparatus, such as the hydrant hose streams. The men composing such an organization are usually engineers, firemen and such mechanics as may be employed.

14. *Weekly Inspection*—It should be the duty of some one reliable person to make an inspection at least as often as once a week of all fire-fighting apparatus, to see that everything is in place and in good condition, that all valves are open, that no combustible material is left near steam pipes, that all waste matter is promptly disposed of, and all fire doors unobstructed. He should make a detailed report to the superintendent or other official.

15. *Smoking*—It is desirable that smoking should be avoided in every part of all buildings. If it is not feasible to carry out such a rule it should be possible at least to prevent smoking in attics, basements, store rooms and such other places where a fire might not be discovered as soon as started.

16. *Watchman*—A reliable and able-bodied man should be employed to make rounds not more than one hour apart at night. There should be stations established at such points throughout the buildings that the watchman in visiting them will have the entire plant under his eye in making a complete round. A record of his call at these stations should be made on an electric or portable watchman's clock, so that positive evidence may be had that his visits were made at the appointed times.

(To be continued)



What Should Hospital Dietitians or Dietitian-Housekeepers Be Taught and How Trained?*

LAURA COLEMAN, R.N.

Superintendent Buffalo Homeopathic Hospital, Buffalo, N. Y.

THE demand of the present hospital world is for standardization—standard nomenclature, standard records, standard accounting, standard equipment, standard education for nurses, standard ideals. Is not this great body of hospital superintendents and trustees assembled for but one purpose—the standardization of hospitals in every department, by interchange of thought and plans of work, each giving to the other the best of experience and result in their special field? Why should there not, therefore, be a standard for hospital dietitians?

Within the past twenty years a great change has come over the educational side of hospital work. The length of a nurse's probation has been increased from one or two months to three or six months; her time of training from two to three and, in some schools, even to four years. The standard has been raised slowly but persistently. The nurse-in-training *must* have had one year at high school or, better still, she must have graduated from high school. Trained teachers have, in all schools that can afford them, replaced the old-time graduate-nurse teacher who taught what she knew and taught it well, too, but who often had no special training in the proper method of imparting that knowledge to others.

Trained dietitians are filling the place made for them by the recent attitude taken by physicians toward food and its effect upon the human body. Fifteen years ago little was heard even in our best-managed hospitals about food-value, calories, carbohydrates, etc., and a good steward, with a chef and his staff, supplemented by the work of the nurses in-training on the ward floors,

* Read at convention of American Hospital Association, San Francisco, June, 1915.

was considered sufficient. An occasional staff physician gave special attention to his patient's food, but with nothing of the definiteness of the present day, when even the smallest hospital has to meet this demand for every variety of special diet.

All nurses-in-training had, even twenty years ago, cooking lessons in which beef juice, custards, jellies, toasts, liquid diets and gruels were the predominating features.

Today a pupil nurse is taught in a course of from ten weeks to three months the preparation, constituents and caloric value of foods for patients and hospital household, with the proper way to measure and serve them. Before she leaves the dietary department she learns, or should learn, to prepare a well-balanced diet for any patient—salt-free, diabetic, fat-free, etc., and if the dietitian is the woman for the position, the young nurse will also learn the cost and quality of foods, relation of supply and demand, and, not least of all, when entrusted to assist with the checking of this, the heaviest expense-sheet of a hospital, she will learn how to so care for and dispense these foods that each shall reach its proper destination suitably prepared, and so palatable that there will be little waste because they "did not like the food," and absolutely no waste from carelessness in dispensing.

Intelligent nurses-in-training require intelligent, well-trained teachers; and this, for one thing, the dietitian must be.

In a thirty to sixty-bed hospital, the question of "How and what shall patients, officers, internes, nurses and last, but surely not least, our faithful domestics, be fed," is just as important as the same question in a hospital of one thousand beds. The same

problems of feeding patients in small hospitals present themselves as in large ones. One patient taken into any hospital deserving the name is as worthy of careful feeding as are one hundred such patients.

Many thirty to forty bed hospitals do not have a trained dietitian, but some one must do the work intelligently, and it is upon the already overworked superintendent of the small institution that this grave responsibility rests. Armed with her long, or short, training in hospital dietetics, she grapples with the question and grapples intelligently in most cases—for what she has forgotten, or perhaps never knew, of calories and food-values, she overcomes by study and preparation—her mind being trained to meet just such extra demands. Then comes the luxury of a dietitian-housekeeper, for in the smaller hospitals, usually because of economy in salaries, the positions are combined. Besides, there would be insufficient work in a small hospital in either department to keep a woman, mentally active, contented with one position alone.

With a trained mind, such as a dietitian should have, and with the executive ability a hospital dietitian must have, she can readily do any hospital housekeeping by an additional short course in laundry management; for this, of course, is the crucial point in hospital housekeeping. With the splendid training she will have had in asepsis and absolute cleanliness, in her general domestic science course as dietitian, and with some knowledge of laundry work, counting that she has ability to manage people, the housekeeping will be very easy, so on that side of the work I shall touch but lightly.

There is but one dietitian for any hospital, large or small, and that is the trained dietitian.

What shall she be taught? She shall be taught dietetics in all its branches—foods, quantity, quality, cost, value to patient, scientific distribution under a physician's orders; everything, in fact, that affects the

well-being of a patient or household in the matter of proper feeding. This course of training should not be less than two years, and, if any academic work is attached, it should, as in several colleges and schools of domestic science, reach to four years. Surely two years, however, is little enough for any one engaging in this, so important a branch of hospital work, to give to her training. The physician gives five to eight years to his training; the trained nurses give three years of arduous, continuous labor to their work, and why should the hospital dietitian, who can undo all the good work of the physician by badly prepared foods, give so much less, as is sometimes the case?

In a letter to me regarding this paper, the writer stated that one superintendent had said that the dietitians sent him by a domestic science school were so very young and impractical that, what with a training school of young women, it was but one more responsibility, and hereafter he would employ only mature, practical dietitians.

I sympathize sincerely with him, as in the first hospital of which I had charge, a small hospital of thirty beds, I came to the same conclusion. From two of the best training schools I tried dietitians who, of course, took the position of dietitian-housekeeper. They could talk most intelligently and scientifically on food-values, could arrange and display all kinds of desserts and salads, knew to a degree the caloric value of foods, theoretically, but lacked judgment—judgment as to quantity for thirty patients, nurses and hospital household; judgment as to care of and ordering of food supplies. A vegetable garden was to them an untried field. They counted vegetables only in bushels and baskets, or bunches, as they had seen them in the domestic science schools. They were excellent theorists, but their extreme youth and total lack of practical experience was very discouraging.

I then decided that the domestic science training schools were to blame entirely for

turning out and recommending to hospitals needing dietitians an unfinished product, to complete her training at the expense of the hospital; but I now believe that a word of our needs to those schools would have given them an opportunity to help solve the problem.

Perhaps the lack of hospital ethics which they displayed was not the least trying part of their failure to fill the situation. They had been taught no sense of responsibility to time. Fifteen minutes earlier or fifteen minutes later carried to them no grave responsibility.

Like the superintendent of whom I have spoken, I then decided that a trained dietitian was not for a small institution, and engaged a practical dietitian-housekeeper of mature years and judgment—one who could utilize the asparagus and other vegetables from our own garden and could preserve or can fruits purchased in quantities, when such fruits were seasonable; in fact, one who, except for the fact that she knew nothing of calories and food-values, gave our patients well-cooked porridge, delectable gruels, perfectly broiled steaks, and such vegetables it is a pleasure to remember them. She was also an ideal housekeeper. The special diets, however, had to be arranged and planned by the superintendent of nurses. The nurses-in-training took their practical work in housekeeping with the dietitian-housekeeper and were sent to Miss Fannie Farmer for their cooking lessons and special dietary work.

For a small hospital this did solve the problem, but from broader experience I have quite changed my mind. I find that to administer a hospital of 150 beds, or five times the original unit, there must be a housekeeper *and* a dietitian, and that dietitian must be trained and well trained.

Where should she be trained? I believe hospital dietitians should be trained in some one of the many perfectly equipped domestic science schools or colleges for not less

than two years, and that for at least six months this training should be supplemented by a practical course in hospital dietetics in some one of the many good hospitals of this country. For at least one month of this time it would be well if she could be given entire charge of the department.

The demand always creates the supply. If the members of this Association would appeal to the domestic science schools of the country for this extension course for would-be hospital dietitians, assuring them of cooperation in affording their qualified pupils an opportunity for this course of practical work, I believe they would be only too glad to do it.

As in our training school for nurses we select, from a class of fifteen or twenty, two or three or, maybe, but one, who will make a good executive, and add her to our junior executive force, for practical experience in hospital work, so I believe these domestic science schools might select the three or four pupils from each class who show signs of executive ability—mature pupils with tactful, well-balanced minds, wishing to qualify for hospital work, and recommend them for this hospital extension course. If this were done, I am convinced that hospitals, both large and small, would fill dietetic vacancies with less waste of energy and efficiency.

In the hospital of which I have charge at present we have tried this plan. Our present dietitian was trained for two years in a domestic science school, which already sends out its pupils to one of the large hospitals for hospital experience. In addition to this she remained one year as junior dietitian in the hospital, giving the practical course. She controls her kitchen force, selects and cares for the food supplies, is responsible for all foods, teaches the nurses theory in classes, and two, who are with her continuously, have their experience in applied dietetics. This she does in a businesslike manner. Of course, in a hospital of 150 beds, she does

not do the housekeeping, but were the same woman in a hospital of fifty beds, she would manage the entire domestic force, administer the housekeeping and, with a short course in the one trying spot in housekeeping—the laundry—would do it easily. It does not seem to me that this would be impractical if the domestic science schools would recommend for this extension course only those showing the proper qualifications for hospital work.

I have written several of the domestic science schools regarding a special hospital course in dietetics, and find that some of them already have a limited course, and that the schools themselves are giving thought to this subject. I quote from one school that says they give a normal course with dietetics, and a housekeeping course with dietetics. "But," says the director of the domestic science school, "I think a combination of both courses would be best for a hospital dietitian. And," she continues, "I think graduates of such courses as ours are not prepared for independent dietitian work in hospitals because of their ignorance of hospital discipline and conditions. This is probably at the back of the friction we so frequently hear of between hospital superintendents and dietitians. Probably the best preparation for a dietitian would be hospital training and experience, followed by a good normal or housekeeper's course in home economics. Failing this, the next best thing is a good course in home economics followed by pupil dietitian or apprentice work in good hospitals.

"A satisfactory course, I think, would be easy of arrangement.

"It is my experience that as yet we have no standards for hospital dietitians. Each hospital is a law unto itself with regard to the work a dietitian is expected to do. It may range from all the buying and housekeeping for the hospital to a mere matter of preparing and sending up private patients' trays. If your hospital association will discuss this and point out the wisdom of hospitals furnishing training schools with a clear outline of the duties demanded, it will help the cause of dietitian-training materially."

Another director of dietetics says: "Occasionally one of our regular seniors wants to go into hospital work, and we invariably advise such a student to take training as a student dietitian. We feel very strongly that we cannot give, under collegiate conditions, anything which approximates the broader training for hospital work."

Teachers College, Columbia University, says, in reply to the question as to feasibility of a practical hospital course for hospital dietitians: "Such a course of training in a hospital is not only practical, but highly desirable, and with suitable cooperation from the hospitals could easily be arranged."

It would seem to me, therefore, from my own personal experience and the data I have collected, that qualified hospitals have but to offer this extension course to the domestic science schools for their would-be hospital dietitians and the problem is solved.

I lay the matter before you for your consideration.



The Trained Nurse and Cancer of the Breast

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THE trained nurse has exceptional opportunity for real life-saving service to those of her sex who present early signs or symptoms of cancer of the breast. The opportunity lies in her intimate professional contact with women generally, which constitutes her the natural medium between cancer-stricken women and the means and source of help.

Such women have usually become alarmed by a persistent tenderness or soreness of some portion of the breast, coincident with the presence of a gradually growing lump or swelling. These disturbing symptoms are regarded with ever-increasing dread and misgivings. Fear and horror of having the condition pronounced cancerous causes them to shrink from the vitally necessary examination.

At this period, while the disease is in its only really curable stage, the trained nurse can help out mightily. The new growth is still wholly localized or confined to its own immediate vicinity, and can be permanently cured.

Almost invariably some injury is referred to as having preceded the soreness, swelling or lump. Such injuries undoubtedly stand in a causative relation to the disease in many instances, but will not be discussed here. In a general way, however, the recipient of a blow, wrench, bruise, lump or swelling of the breast, or of soreness from chronic irritation, as from rough manipulation, nursing, pressure from corsets, or any cause whatever, should be carefully investigated and kept under observation. Ninety-five per cent. of the above stated conditions are really at the time cancerous or about to become so; hence the importance of an early diagnosis and radical removal.

Early removal goes hand in hand with early recognition. The disease is progressive. Every instant, day or night, it never sleeps. It is progressive from the center outwards, in rings as it were, like waves started by a stone dropped into a mill pond, which by-and-by we are not able to overtake.

Early operation alone can check the advance of the deadly army of germ-infected cells. Every last one of these must be destroyed, for each cell is a living thing, and propagates its kind constantly. Hundreds soon become millions, millions billions, and so on. Later on these infected germ cells break down the barriers nature had built up against the enemy to hem it in, as it were, and keep it from spreading to vital parts. They then gain an entrance into the lymphatic vessels, and may make their way into the blood stream and thence into various parts of the body, there to set up new starting points of the disease, in locations where they cannot be reached effectually and safely by any known method.

Now a word as regards methods of removal. All surgeons are free to admit that surgical removal is far from proving permanently effective in a large majority of cases. This had been my own experience. I became convinced that in the sudden removal of the breast by the scalpel we exposed the remaining tissues to re-infection—much like cutting a troublesome ant-hill off close to the ground with one fell sweep of a great knife, with the idea of thus effectually removing the ants, only to find that all the ants were not in the cut-off portion, but that the remaining *site* of the amputated ant-hill was still swarming with ants—ants that dove down out of sight into subterranean pas-

sages, others welling up in masses, only to plunge down again out of sight, in terror and confusion. These byways and subterranean passages and channels must also be reached in the complete eradication of cancer of the breast. So we have to ask ourselves, does the knife cut off more than the top of the ant-hill? If not, the disease will simply continue. So that, in view of the foregoing, though actively engaged in surgical practice and an enthusiastic lover of the knife for the grand results it gives in a general way, I yet have not employed the cutting method in the removal of cancerous breasts in many years, preferring to cooperate with nature by the use of a physical method, the action of which I will briefly describe. By this method the entire breast, in any given case, is removed as extensively as with the knife, but in a different way, which admits of no escape of diseased tissue, infected cells or germ life whatsoever. *This is accomplished by the employment of twilight sleep or other general anesthesia and a definite chemical compound which necrotizes and removes all cancer tissues painlessly and effectually.* That this procedure does reach and destroy all infected cancerous cells in the deeper tissues underlying the breast itself in which the knife so often fails, is evidenced in the fact that in not one of the cases thus far operated by the new method, now covering a period of seventeen years, has there ever been a recurrence of the disease, within the limits of the operated area.

This chemical method really assists nature to perform its own cure by separating diseased from living tissues, at its own formed line of demarcation. Nature can cure her

own diseases in her own way, but sometimes she needs assistance. Meantime below this line of demarcation nature has thrown out a wonderful surrounding breastworks of defense, the all-important inflammatory wall, built by the phagocytes or white blood cells—the body's standing army—which not only helps to destroy the cancer cells left in the surrounding tissues, but also seals tightly all the lymphatic and blood channels leading from the infected zone into the body. In early cases inflammatory axillary glands disappear in the progress of the treatment, partly from the action of the absorbed chemical agent and partly because of the removal of the infective focus in the breast—the same as in the vicinity of any infected focus when that focus heals or is removed. In far-advanced conditions axillary masses are resected at the completion of the chemical operation.

Summing Up—All possessors of swellings, tumors, growths or ulcerations in any part of the breast, be such swellings, tumors, growths or ulcerations painful or painless, large or small, movable or fixed, superficial or deep, recent or old, in single or married, rich or poor—all need to know at once what the disease is and have it removed at the earliest possible moment. If proved to be cancerous, it should be removed without delay, but by a method which will afford protection against a fresh outbreak or continuation due to imperfect removal of the infective tissues at the time of operation. In this work the trained nurse has an important place as a part of the medical profession, and therefore also interested in its problems.



A Flight from the Invaded Country

IRENE D. SEDDON*

THE town crier came up the rue Sadi Carnot with the usual following of small boys and dogs, and stopped outside our *appartement*. He beat the drum loudly and the dogs barked. Windows opened and people on the street stood and listened. When the drumming stopped there were some stifled yelps of suppressed emotion from the enthusiastic dogs, whom the boys were trying to quiet. Then in an almost unintelligible monotone came the announcement. It was *pour les étrangers*. Vanves was under military rule and all foreigners must declare themselves.

As tourists rarely strayed here we knew the announcement was for us. Started to the *Commissariat de police*, thinking it would be a matter of a few minutes. It was not, however; a couple of hundred had already gathered and held *numeros*. Where had they all come from? Belgium, mostly, although a Russian woman spoke to me. Her husband was going to enlist. They had left their baby, who was ill, at home. This they explained to an officer at the door, and he allowed them to enter immediately, to declare themselves. After hours of waiting we got our permits, but not until after birth certificates had been produced. Since the war birth certificates are at a premium. And it is your good fortune to have one that is issued in a neutral country or that of an ally.

The refugees commenced flocking in. Sometimes a whole village full. No doubt the refugee is more fortunate than those left in the wake of the deadly combat. But their wretchedness is great, and many are overcome with apathy or insanity, which, like an anesthesia, deadens the suffering.

The horror of the rapidly approaching invader drives people hastily from their

homes. And they leave without a pang things that have long been cherished.

"*Vous avez la guerre chez vous*," said the *concierge*, after England declared war. England and America were the same to her. They were both across the water and both spoke the same language.

Up the street there is a small grocery shop. Father, mother and son all serve. It is their own business. The son has been sent to the front. They believe he is at Mulhouse, and there are rumors of a raging battle. Yesterday the mother replied to an inquiry for news, "*Il n'y a rien*." Today the father's haggard face tells of prolonged suspense.

"Have you heard from your husband?" I ask a woman at a small *épicerie*. Her little four-year-old girl is waving joyously a newly gained French flag. A postal has been received, the first for three weeks. It is an official formula, dated and signed, but does not say where from. Merely shows her husband was alive forty-eight hours ago.

Two days after the mobilization of the French troops my father and I went to Paris. How deserted the city was! Neither man nor beast, car nor auto bus to jostle you. If a stray cabby happened to come in sight, the most imploring attempts to hail him failed. He had his orders. Cab horses, like automobiles, were needed for military purposes. A soldier passes; he has a collection of six or seven weary-looking beasts, bearing the tell-tale marks of a harness long worn, their familiarity with noise and confusion probably the only qualification suited to the new occupation.

We enter one of the large department stores. No shoppers flock there today. The clerks, always so courteous and ready, now stand idly beside the neatly-folded piles of goods. I believe they would have treated

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RUE SADI CARNOT, VANVES

a purchaser with scorn. The escalator moved, but without a passenger. The elevators were still. We passed the counters of artificial flowers mocking in their brilliant gaiety. It was strange and silent as we stood in the rotunda of that huge mercantile palace. Everything in readiness and order but not a customer to be seen.

On the rue de Sèvres we passed several stores that had been attacked by a mob that had taken advantage of the Teutonic nationality of the proprietor to gratify a lust to riot. One was that of a poultry and game merchant. As our car passed by feathers were falling softly and clinging to the clothes of those who had gathered to see the ruin. When we reached *Vanves* a mob was gathering around a hideous old hag. She was waving an umbrella and in a shrill voice this raving Cassandra goaded the rabble on to loot a dairy. "*On va faire revolution*," said a woman, pale and trembling. It was ghastly to see how easily the fellows yielded.

For weeks we lived in this all-pervading dread. Day by day, through the streets pass trains of army wagons and automobiles, sometimes marked with the Red Cross. The people usually so demonstrative watch silently, the same foreboding depicted on every face.

Man-made birds of ill omen are hovering over us. The papers scoff at their onslaughts—the damage has been slight. Only a few injured and a woman killed! But one

frequently scans the sky by day and at night the eye follows the course of the flashing searchlight. People spring up from the pavement, as if by magic, should an aircraft of any description appear. Frequently you are startled by a shrill whistle, or the clatter of a galloping horse. All around us buildings are being dynamited to clear the way for artillery.

After days spent waiting in *queues*, we secure the necessary papers for leaving France. To buy a railway ticket it is necessary to show a *permis* from the military authorities. And one is not allowed to land in England without a passport from the British Consul.

We have some cases of things packed, books and pictures mostly. They will have to be left. It is doubtful whether we will ever see them again. We are giving the furniture to the Red Cross.

Paulette, Madeleine and Susanne come up to say good-bye. They have often been in our *appartement* before, but the carpet-stripped floors, ungainly cases and furniture askew delight them. They walk around to hear the sound of their feet on the bare boards, and the low cases make far more comfortable seats than chairs. In a cardboard box are some things put aside for them. They are overjoyed and can hardly keep from looking.



RUE SADI CARNOT: SOME OF THESE BUILDINGS HAVE SINCE BEEN DESTROYED

Suddenly there is a boom of a cannon. Flying to the window we see a black cloud of smoke overhead. The rattle of musketry in the distance reminds me of Fourth of July fire-crackers, and one cannot realize it is a warning as significant as that of a rattle-snake. Another boom from the cannon. Madeleine claps her hands in glee. Never has there been anything so thrilling. The shooting does not stop an instant. The cloud of suspense falls and as the prey before the serpent one gazes and listens fascinated. High up are two bomb-dropping *taubes*, their swift passage unimpeded by the bursting shells.

Four o'clock the next morning we began our flight. It seems as if we would have to go without trunk or suitcase, so difficult was it to get a vehicle. However, we got a man we knew to drive us in his wagon. When we arrived at the *Porte de Versailles*, one of the gates in the fortifications of Paris, it was closed and covered with steel, except one small opening. This was one of the few entrances into the city, for nearly all the other gates were built up with masonry.

When we arrived at the *Gare des Invalides* there were long lines of people waiting outside the ticket office and the gates leading to the platform. There were no porters; we pushed our own trucks. After returning from buying the tickets we found that much indignation was felt towards two young men who, with the aid of another, had forced their truck to the very front of the line in which people had been waiting for hours. A well-dressed woman was with them; possibly their mother. The name on the baggage bore the prefix "Count." Later we had an opportunity to get even with the count, or, rather, countess, for the two sons had gone off to smoke and left their mother to bear the brunt of the indignation. It seemed that, after all, we were standing at the wrong doorway. And the passengers to England had to enter another at some distance. When this was found out there was

a general rush. As we all pushed our own trucks at the end of the race several came in ahead of the countess. It can easily be imagined the general satisfaction at her ladyship's wrath.

The wearisome waiting was not at an end as the train drew out of the station. We were four hours going the first nine miles, so choked were the lines with military trains. One after another passed by. We came to a standstill at the side of a long line of cattle trucks filled with boys about seventeen or eighteen years of age. Many were restlessly jumping in and out or climbing on the top of the cars. A few were lying in the shade of a grassy bank. One or two of the boldest got in our train and eagerly took proffered newspapers and lunches. They were on their way to Versailles to go in training, and said they had been waiting in that place since four in the morning.

A little further on we caught up with a train packed with refugees. As soon as it stopped doors opened and men and women jumped to the ground. For not only were all the seats taken but many had to stand in the small, dusty compartments. They looked so unkempt and burdened with their babies and bundles.

Our engineer was remarkable for keeping in the same place without stopping. There were no reminding jerks to tell you of a changed direction. This could only be found out by diligently watching outside objects. My father said it was the "pace that kills."

At Versailles we seemed to draw into the midst of a British encampment. Khaki and kilts everywhere. The soldiers were on their way to the front. Like the French recruits, they were transported in cattle cars, and fled from their uncomfortable quarters as soon as the train came to one of its inexplicable stops. Their neat-looking uniforms were a bit the worse for the dusty trip from the coast. And one saw by the look of *ennui* upon their faces that the dream of doing something at the front had temporarily for-

saken them. No band, no cheering nor enthusiastic greeting in the newspapers one or two of them held. Discomfort, dust and smoke were the most conspicuous additions to the tediousness of barrack life.

Had they worn the scarlet coat as of old it might have aroused to enthusiasm the passing trains of refugees. One solitary voice cried out in English, "Hello, boys!" Somehow it sounded inappropriate. The voice continued, "Hello, boys!" After all, were they British soldiers, or was France adopting khaki for active service? Just then some one leaned out of the window and said, "You are English soldiers, ar'n't you?" "Yes, sir," was the reply. Nothing more was said, although each waited half-expectantly for the other to continue.

It was different from the lot of soldiers in the past. All these men would probably be killed or wounded in a couple of weeks. Yet they were not cheered for their valor.

Our train started. We passed carloads of soldiers. They were very close. I put my hand out. It was grasped by one or two rough ones. I have seen these soldiers since then in the London hospitals. Frightfully mutilated some of them. The train moved quicker and further every moment from the battlefield and the work that seems to a nurse so absorbing and thrilling.

When we neared Rouen half a dozen recruits got on the train. They told us they had been a week getting to that point from Calais. One of the boys showed us his army rations. A large piece of oatmeal-colored bread and a tin of *légume conservé* for soup. He had them in a dirty linen bag, which we were told was *tout propre* when he started.

During the afternoon a soldier on a stretcher was taken aboard. The train had

stopped especially for him. It was in the open country, and there were a number of military men standing about.

It was dark long before we reached Havre. Some diligence was required to ferret out our trunks from the big accumulation in the baggage room.

The channel boat was crowded. On the decks and in the passages women sat on their baggage and nursed their babies. My father was very ill and had been suffering all day. I managed to get a chair for him. The only place to put it was in a draughty passage.

Fortunately for the weary refugees, the sea was calm and many slept, in spite of their discomforts. At daybreak everyone was astir. Off Spithead we waited about an hour for a pilot to steer us clear of the mines.

We passed quickly through the English customs. One look at our papers was sufficient to satisfy the Government official. Soon we were seated comfortably in the train. Just before starting two ladies came in the carriage and took the only vacant seats. Again we were crowded; but that is the lot of the refugee. One of them had some skirts and other garments hanging over her arm. The rest of her belongings were wrapped in a coat and tied up with string. At an *octroi* on the Continent her suitcase had been taken away. She did not know why. We could not help laughing at her predicament. I think it was the first time I had laughed for six weeks. Soon we were all chatting. It was such a relief to be far from the enemy, and where everything was normal. No, it was different after all. We were in a carriage full of English people talking in a friendly manner to one another without being introduced!



Eye Nursing

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COMMON ACUTE AND CHRONIC EYE DISEASES

PART III—*Continued*

AS IN the previous chapter on Common, Acute and Chronic Eye Diseases, the order of study taken up for each disease is continued briefly as before: Definition, etiology, symptoms and practical management from a nurse's standpoint.

ULCER OF THE CORNEA

Ulcer of the cornea is an infiltration (ulceration) and localized loss of substance of the corneal tissue due to infection.

Symptoms—An ulcer begins as a grayish or grayish-yellow spot on some part of the transparent cornea. There is pain, eye redness (ciliary injection most intense around the border of the cornea), dread of light (photophobia) and excessive secretion (lachrymation). The infection is a grave one if neglected, as the ulcer may extend deeply and possibly perforate the cornea (letting out some of the aqueous humor of the eyeball), besides leaving bad scars to destroy the sight. Patients should be placed immediately under the care of an ophthalmologist (eye specialist or oculist), as the affection is a most serious one.

Ocular Nursing—The technique of flushing the eye with warm boric or corrosive sublimate solution, 1-10,000, or some other antiseptic solution, properly instilling a single drop of a strong drug, such as atropine sulphate, 1 per cent. solution, applying an eye salve, giving fomentations (hot eye applications), dusting the eye with fine powder, application of a pad and bandage if ordered, etc., should all be understood as outlined in Part 1—"Handling of Eyes in the Hospital Ward or Private Sick Room," and Part 2—"Principles of Treatment in

Ocular Therapeutics." With these few paragraphs read over carefully, the nurse is ready to turn to the orders on the treatment chart, which may be summarized somewhat as follows: Confinement in bed or complete rest in large easy chair in darkened room, easily digested diet, attention to bowels and such other obvious general nursing care as is seen indicated. Following this the oculist usually orders the eye flushed clean with some warm antiseptic eye lotion, followed by the instillation of a drop of a solution of atropine sulphate (1 per cent.) several times daily. An eye ointment as mentioned is also frequently ordered in the eye following the atropine instillation. Hot eye compresses may be ordered a number of times daily. Visits of the attending physician usually take place once daily, although in very bad cases both night and morning visits may occur. Emergency orders of drugs for severe pain at night are often left for the first night or two and are to be given as directed. In ulcers of the cornea occurring in patients in whom the general condition is below par, tonics, plenty of fresh air on the porch, dark glasses with often a heavy shade as well, nourishing diet, etc., will all find their place. The nurse is expected to report the progress of such features as pain, excessive tear secretion, inability to carry out the treatment well, increase or decrease of possible lid swelling, and any sign of particular moment which may be clear to her.

INTERSTITIAL KERATITIS

Interstitial keratitis* is a diffuse infiltration of the substance of the cornea without ulceration.

*Keratitis—The general term for inflammation of the cornea.

Etiology—In the majority of cases it is due to inherited syphilis and is most frequent in children between five and fourteen years of age.

Symptoms—In the beginning, slight ocular injection with faint corneal haze or cloudiness is usually noted near the center and spreading slowly over the whole cornea. In two to four weeks the entire cornea may be steamy, like ground glass. Gradually the cornea begins to clear most often from the periphery or outer portion of the cornea. The second eye is usually involved in from eight to twelve weeks after the inflammation in the first eye has subsided.

Ocular Nursing—Nursing in this affection follows closely that described under ulcer of the cornea and acute iritis, with the addition of the necessary prescribing for such a constitutional disease as syphilis. The cases run a protracted course as a rule and require much internal medication as well as local eye treatment. Most of the cases during the greater part of the time will be able to be up and about the ward or sick room, wearing dark glasses and an eye shade.

PERFORATING WOUNDS OF THE EYEBALL AND FOREIGN BODIES IN THE INTERIOR OF THE GLOBE

Perforating wounds of the eye are critical, first on account of the danger of escape of part of the contents of the eyeball (escape of vitreous fluid), second because of infection of the interior of the globe itself and, third, because in some locations they are more liable to set up inflammation in the opposite or sound eye. These wounds may be accidentally inflicted in various ways, as with knives, scissors, broken glass, etc., or the globe even ruptured by the force of a heavy blow.

Ocular Nursing—As an emergency or first-aid treatment, all severe eye injuries should be bandaged and then let entirely alone while they are being taken to the nearest oculist. Bad wounds are hospital bed cases

and require the operating room and special surgical attention in order to save the eyeball or sight. Metallic foreign bodies lodging in the interior of the eyeball are extracted at once and gaping wounds are sutured, the surgeon using a small, curved eye needle and fine black silk under careful aseptic conditions. These cases for the first few days are treated and dressed by the oculist himself once or twice daily, as may be required, with the nurse assisting and furnishing the supplies. It is well to make a list (see "Preparation of Cataract Dressing Tray"—Part 4) of the daily dressing materials which are required for such special cases and care should be exercised to overlook nothing if possible, at least after the first dressing, as it is not pleasant for the doctor to have to wait while material which should have been on hand is looked up in an adjoining room or some other part of the hospital. Proper ophthalmic nursing technique is very necessary in operative cases for the best results. The usual materials required for dressing penetrating eye-wounds may be briefly outlined as follows: Two sterile towels, two small packages sterile cotton, few sterile toothpicks, two sterile eye droppers, bowl warm normal salt or boric acid solution in sterile dish, atropine sulphate 1 per cent. solution, tube bichloride eye ointment 1-3,000, or tube of sterile white vaseline, two-inch roller bandage, sterile gauze for making eye pad, safety pins, scissors for cutting bandage and pan or paper bag for holding waste material. Bad eye wounds are kept quiet in bed in a slightly darkened room for several days.

SYMPATHETIC OPHTHALMIA

Sympathetic ophthalmitis is an inflammation of a sound or good eye, due to inflammation spreading from the other, usually a badly cut or perforated eye. The inflammation of the sound or second eye, due to the perforation of the eye on the opposite side, is especially liable to occur from eye cuts in the

region of the ciliary body (junction of cornea and sclera). Foreign bodies in the interior of the eyeball, if not removed, are also apt to excite sympathetic ophthalmia in the good eye and this danger cannot always be avoided.

Symptoms—Sympathetic ophthalmia usually begins some five to eight weeks after the injury. The eye which has been originally injured is known as the exciting eye, and the other the sympathetic eye. In some cases, but not invariably, the disease presents a preliminary stage known as sympathetic irritation—that is, the good or uninjured eye may show that it is becoming irritable by dread of light and lacrymations. There may also be beginning diminution in vision and very soon the sound eye may be noted distinctly reddened. The exact mode of transmission of the inflammation from an injured to a sound eye is as yet not definitely known.

Ocular Nursing—This consists in intelligently carrying out the doctor's instructions for the case at hand. Sympathetic inflammation, while fortunately not as common as one might expect, is one of great responsibility for the surgeon and over which he has only fair control. For this reason, therefore, if an injured eye is sightless or so badly damaged that it cannot be restored, and especially if the perforation (cut) is through the ciliary region, many operators prefer to remove the eye immediately rather than run the risk of such a disastrous complication as sympathetic ophthalmia. Nursing centering around the physician's examination of the patient, confinement in a dark room, the use of eye drops and often inunctions of mercury will all find a place and the description of such processes should be looked up if not well understood.

ACUTE IRITIS

Anatomy—The iris (rainbow) is the colored membrane, circular in shape, behind the clear cornea and hanging in front of the

lens. Its center is perforated by an aperture called the pupil (position of the pupil seen as a black hole in the colored iris). The iris is able to contract and dilate, not unlike the shutter of a camera. It is the external or outer surface of the iris which presents such great variation in color, some eyes being brown and others black, blue or gray.

Definition—Iritis is an inflammation of the iris.

Etiology—The causes of iritis are cold, rheumatism, tuberculosis, acute infectious diseases, syphilis, etc.

Symptoms—The iris looks altered, appears swollen and loses its lustre and fine markings. The pupil is contracted, sluggish in action when tested by shading with the hand and may dilate irregularly when atropine is used on order from the physician. There is always marked ciliary (circumcorneal injection) which has to be carefully differentiated by the ophthalmologist from simple injection of conjunctival vessels seen in acute catarrhal conjunctivitis as improper treatment would probably leave damaged sight. Interference with vision is also present in iritis and pain, often worse at night. As iritis may be mistaken for acute catarrhal conjunctivitis or even acute glaucoma, it is very important that the proper diagnosis be made by a skilled oculist, in order to institute correct treatment, and for this reason it is dangerous for any one unskilled to attempt the treatment of eye disease.

Ocular Nursing—As acute iritis is a very common affection and its care a typical example of proper ophthalmic nursing technique, it should be studied more thoroughly than is ordinarily the case. Elderly people with severe iritis are usually put to bed, with often a special nurse in attendance. The diet should be a light, wholesome one, sufficient to keep up the strength of the patient without lying heavy on his stomach or leaving an undue amount of residue in the bowel. The room should be darkened and more or less quiet enjoined on the part of those pass-

ing in the hallway so that rest and sleep will not be disturbed. The bowels should be kept open by the use of laxatives, given usually at night, so that a movement will follow naturally on the following morning. Sufficient liquids ought to be administered to keep the kidneys and body secretions active. Robust, young adult patients will, of course, not require as much attention as elderly ones and, indeed, are usually able to be up in an easy chair and to bathe the eyes with hot water themselves (see "Fomentations or Applications of Moist Heat"—Part 2), and thus help out on a busy hospital floor. In instilling strong eye medicines, such as atropine sulphate 1 per cent. solution, care should be taken to drop only one drop in the eye at a time and avoid any excess of the solution flowing out over the cheek into the mouth. It is also wise in using atropine to instruct the patient to hold a bit of cotton pressed against the inner corner of the eye close to the nose for five minutes, so that the drug solution will not flow down through the tear ducts into the nose and produce an excessively dry mouth or, perhaps, even mild symptoms of atropine poisoning. Emergency orders for severe eye pain at night (*i.e.*, a drop of cocaine 4 per cent. solution or dionin 5 per cent. solution, hot fomentations, heroin grains 1-24 by mouth, aspirin gr. 5 every ten minutes, for three doses) are aids to the nurse in carrying the patient through a bad night, without having to call upon the physician, and may be brought to the doctor's attention, if there is likely to be need of them. Local blood letting may also be employed in stubborn cases, leeches being chiefly used for this last purpose. Often inunctions of ointment of mercury are ordered rubbed into the skin of the temple of the affected side, so that this, too, must be looked up. (See "Mercurial Inunction"—Part 2.) Cases of iritis due to such general diseases as syphilis, rheumatism, tuberculosis, etc., receive, of course, the appropriate treatment and nurs-

ing for the general disease, as well as the local eye attention mentioned.

(NOTE—Atropine is used in iritis, but never in the disease glaucoma—which will be considered later—so that the nurse should make sure of this by looking on the label on the bottle, and avoid any chance of using the wrong medicine by mistake.)

GLAUCOMA

Glaucoma is an important and fairly common disease of the eye. Its pathognomic symptom is an *increase of intra-ocular tension*. The severity of the clinical types of glaucoma depends upon the rapidity of the increase in intra-ocular pressure and the height to which this tension rises. If the increase in tension is gradual, the eyeball to a certain extent accommodates itself to the altered conditions and external signs of inflammation are often absent, as in *chronic glaucoma*. Where the tension rapidly rises, however, and the eye becomes stony hard, the *acute glaucoma* occurs, *i.e.*, inflamed eye, hazy cornea, dilated pupil, shallow anterior chamber, corneal insensibility and violent pain.

Acute Inflammatory Glaucoma—In acute inflammatory glaucoma, after a slight initial stage, consisting in a little diminution in sight, colored rings or rainbow tints seen around lights at night, etc., there occurs rapid failure of sight and severe pain or violent headache. The pain may be so severe as to cause nausea and vomiting. The most characteristic symptoms of acute glaucoma are as follows: (a) Marked increase in intra-ocular pressure (increased hardness of the eyeball). (b) Corneal haziness, the cornea becomes cloudy (steamy) and partly insensitive to touch. (c) Inflammation of the eyeball and iris. (d) Dilation of the pupil; the pupil is dilated and often exhibits a peculiar greenish reflex. (e) Shallow anterior chamber. The anterior chamber, instead of being of normal depth, is so shallow that the iris seems almost pushed forward against the posterior sur-

face of the cornea. This shallow anterior chamber is caused by increased pressure in the eyeball (posterior chamber), pushing the lens forward and carrying the iris with it. (f) If the increase in intra-ocular tension persists for any length of time, a cuplike excavation of the optic nerve head in the interior of the eye takes place (*glaucomatous cup*), as seen by the physician on examination in the dark room. Under treatment the glaucomatous attack usually subsides but may recur. With each succeeding attack the vision becomes more affected, until eventually but little sight is left. The exact cause of glaucoma is at present unknown, with the exception that one of the small canals (canal of Schlemm) at the junction of the iris and cornea which drains the eye fluids out of the eyeball becomes closed and the intra-ocular pressure then becomes too high. The condition has at times been so frequently mistaken for other diseases and particularly acute conjunctivitis and acute iritis, or allowed to go along without any treatment in the more chronic cases, that a skilled oculist should be consulted promptly and as early in the disease as possible. Glaucoma, if unchecked, leads to permanent blindness.

Chronic Glaucoma—Chronic glaucoma, while characterized by increase in intra-ocular tension, is without the external signs of active congestion, and for that reason is often termed chronic non-inflammatory glaucoma. The diagnosis is made by the physician on noting the increase in tension of the eyeball, and an accompanying cupping or excavation of the head of the optic nerve as seen in the interior of the eye with the ophthalmoscope. Both eyes are usually affected.

Ocular Nursing—Cases of glaucoma require often an unusual amount of skillful surgical attention and care to bring them through to a successful termination without blindness, and may require the exhibition of

a rather wide range of general as well as special nursing knowledge, before the patient is entirely well. Perhaps the best way to illustrate the subject of nursing and treatment in glaucoma is to follow one of these cases from their appearance in the specialist's office to discharge from the hospital. The patient usually presenting himself with a reddened eye, dilated pupil, shallow anterior chamber and suffering severely with pain, is examined first by the oculist in a good light, as, for instance, in front of a window, and then examined in the dark room with the ophthalmoscope under artificial illumination. (See "Instruments, Materials and Room Arrangement Necessary for Physician's Examination of the Interior of the Eye"—Part 1.) The diagnosis made, a drop of pilocarpine hydrochlorate 1 per cent. solution is then dropped into the eye, dark glasses and a heavy shade placed on the patient, at which point he is ordered to the hospital. In most cases of acute glaucoma an operation, corneo-scleral trephine, with iridectomy, under a strong cocaine solution or even under a general anesthetic, is performed by the oculist at once, so that the patient will be prepared for the eye operations in the hospital operating room, according to the doctor's directions. After the eye operation the eye is bandaged and treated for the first few days by the operator himself, with the nurse assisting and supplying the materials for dressing beforehand on a small tray or stand. Following this, the treatment consists in the continued instillation of myotics, such as eserine sulphate one-half or 1 per cent. solution, one drop in the affected eye several times daily, or of pilocarpine 1 per cent. solution. Myotics (pupil contractors) act by drawing the periphery of the iris away from the so-called filtration angle at the sclero-corneal junction and facilitate free communication between aqueous and vitreous humors, as well as providing an escape for intra-ocular fluid through a small canal in this region.



UNDERWOOD & UNDERWOOD
AN ENGLISH HOSPITAL CAR. TWO VIEWS OF GERMAN HOSPITAL CARS WERE GIVEN IN
OUR APRIL ISSUE

Wounds in the Present War

ERNEST FRITZ HOYER

Graduate McLean Hospital, Post-Graduate Bellevue Hospital

HAVING received two interesting letters—one from an old Bellevue graduate, who has charge of a base hospital in Lodz, Poland—the other from a nurse traveling on a hospital train. I believe that a gist of the contents may be of interest to the nursing world, especially as the letters tell of wounds received in modern warfare.

First a few words about hospital trains—something we have not yet added to our Red-Cross service. The great work done on these hospital trains has been an example of what it means to prepare in peace for war. They consist of passenger cars with the seats taken out and fitted with stretchers on the system of our upper and lower berths on the

Pullmans. The stretchers, removable, have easily disinfected mattresses and linen-covered blankets. The German Red Cross had ten complete hospital trains ready at the beginning of the war, but at present about thirty-eight are in constant use.

Each train has four surgeons, one military officer to keep up discipline, one book-keeper, eight cooks, four female and twenty-seven male nurses. The train is made up of one dining car—in the middle—one kitchen car, two heat and water cars, twenty-six hospital cars, one operating car, as well as two cars at each end of the train, fitted out for dressings and bath. All on board, patients as well as personnel, are fed and housed

on the train throughout the complete return trip.

Speaking of wounds, both correspondents agree that the surgery in the present war is in every respect different than that in former campaigns.

For instance, the steel arrows and bombs thrown from aeroplanes are something absolutely new. These steel arrows are formed like a lead pencil, the end sharpened and made of hardened steel will travel, when thrown from a height of about 1,500 feet, 200 feet a second—the velocity of a modern rifle bullet—causing a more severe wound on account of their length.

Wounds caused by aeroplane bombs are different from those by shrapnels, as even the smallest particle will produce severe wounds; splinters of the size of a penny will tear through a whole arm or leg, destroying almost every artery and muscle—something shrapnels very seldom will do.

The notorious dum-dum bullets are still in use. They cause in almost every instance a dangerous wound, cutting tissues and bones to shreds. The French infantry bullets are softer than ordinary bullets and are rather more apt to stay in the body than pass through. All shrapnel bullets are made of lead and will flatten out like a mushroom.

There are three classified wounds caused by shooting: The ricochet or glancing-off shot, the stick shot and the through shot. The ricochet shot will not penetrate the body, the stick shot will stay in the body and, of course, the through shot explains its character itself. The through shot of an infantry rifle will bore a fine channel through the body and, if not hindered by a rather big bone structure, will heal in a very short time. Simple shot wounds through fleshy parts will heal in eight days. Shots through

chest and lungs, which used to be considered rather dangerous, are now almost simple, healing in about two weeks, with the exception of shots that will cause rib-resection.

Abdominal shot wounds, which in former times led almost in every instance to a laparotomy, are now treated with absolute rest and abstinence from food and fluid for about seven days.

Shots through the head are the most numerous in the present war, a direct cause of the trench warfare, as the head is the only part of the body that is really exposed.

There are three kinds of wounds caused by head shots: The through, and the in-shot; the third, the curve shot, is the most dangerous, as it will tear off a whole section of the cranium, exposing the brain.

Light shot wounds through the cartilage of knee and feet are easily healed. The same can be said of shots through the joints.

In former campaigns wounds used to be washed and dressed, but modern war surgery, with up to ten thousand wounded in one battle, uses only a piece of absolutely sterile gauze applied at once to the wound, if possible by the soldiers themselves, who carry enough of it, hermetically sealed, in their field kit. Another very interesting item in the treatment of wounds is that the bandages are very seldom changed, except it is absolutely necessary, so preventing the entering of bacteria.

We do not know the exact figures of wounded soldiers during the last ten months of this world struggle, but we may well say that over two million men have been treated immediately after battle, and about 60 per cent. of them have been saved through successful aseptic surgery, modern nursing and up-to-date Red Cross service.

Keeping Well on Night Duty

CHRISTINA GRACE RANKIN

NIGHT duty seems to be the bugbear of nurses and yet the experience seems so necessary! How can its benefits be secured without its ill effects, is an important question. As one who has had many years in which to observe the habits of nurses both on and off night duty, I think the nurse herself is often to blame when she breaks down. There are other things, however, which in some hospitals contribute to bad physical results. Very often a nurse has cherished a dread of night duty, has made up her mind that she is going to break down and manages to get excuse enough to get off night duty every time, before the allotted time has expired.

I have in mind one of my classmates who hated night duty and used to boast that she would not put in the full term. Almost invariably about the end of the first week or ten days of her service, she would send word that she was unable to come on duty. Her place would be supplied that night, and about a week later the same thing would be repeated, and usually she succeeded in making out a case of bad health strong enough for the superintendent to take her off. I was never sure whether she was faking or not.

I remember another nurse who had a similar record, but she really was ill—no faking about it. Her ailment was nearly always the same—a so-called bilious attack, with severe vomiting and prostration, lasting sometimes two or three days.

I have no hesitation in saying that I think the trouble was that she was a genuine coffee-fiend. We were expected to prepare our own hot food for our midnight lunch, a tray being sent to us with the supplies. Tea and coffee were always kept in the ward diet kitchens. As soon as she could find time after going on duty, Miss R. used to make

coffee for herself. She drank it again at midnight, and often took a cup before beginning the early morning work. She drank it again at breakfast, and it was little wonder that her stomach, liver and bowels became upset. However, nothing we could do or say would induce her to change her habits.

The nurse who sleeps well is the one who usually keeps well on night duty, but the problem of noise in a large city is one that seems most difficult to control. It goes without saying that night nurses should have quiet sleeping quarters; but even when the arrangement has been made for a quiet corridor in a nurse's home, with proper rules for insuring quiet inside the home, one has the greater problem of street noises, which seem uncontrollable. As a nurse, I have lain awake because of automobile horns, factory whistles, hucksters crying their wares and the small boy or girl with roller skates, or the noisy express-wagon propelled by one leg while the rest of the boy rides, till it has seemed to me I would give all I possessed or ever hoped to, for one quiet day. I have often counted as many as eight different hucksters in an hour, crying their wares within one block of the hospital—for in our city there is no society for the suppression of unnecessary noise. It seemed sometimes as if even the weather had entered into a conspiracy with other noise makers to keep nurses awake.

I feel quite sure that sufficient attention is not given in training schools to teaching young nurses what they must do to keep well and stay well on night duty—and also *what not to do*. There should be very careful rules on the subject, and nurses should be made to see the importance of observing rules made for their own benefit. If every night nurse were obliged to be in bed for eight hours, whether she wanted to or not, there would be fewer nurses break down on

night duty. Postum or cocoa should be served to night nurses for their morning meal rather than tea or coffee, which tend to prevent sleeping.

It is a common custom for some nurses to go for a walk after breakfast, and Old Sol very often helps to banish any feeling of sleepiness they might have had. Very often, too, the nurse takes the morning hours to go "down town" and comes home in the middle of the forenoon, with her hours for sleep decidedly curtailed. It is hard to resist the temptation to go out in the morning, but I am convinced that it is a bad plan and that such excursions should be few while on night duty. Perhaps others will disagree with me.

A great many superintendents seem to think that nurses can be trusted to do what is wise in this matter, but I know that most nurses in training can not. That is why I would have a rule that nurses should remain in bed from 8.30 to 4.30—for their own good. The hours of exercise may well be deferred till the nurse gets up in the afternoon.

The change from night to day or day to night does have a tendency to interfere with

digestion, and for that reason greater care is needed than usual about matters of food.

A good régime for a nurse on night duty is as follows:

Off duty 7 A.M.; breakfast over by 7.45, warm bath; in bed 8.30 to 4.30. Outdoor exercise 4.45 to 6. Hot dinner at 6.

Irregular hours of sleep will soon play havoc with the strongest people, and nurses are no exception. The nurse who has sense enough to know that her digestion is more easily disturbed when on night duty will be careful not to indulge in nibbling between meals. She will avoid rich candy and other foods likely to upset her digestion, and she will be careful in the use of tea and coffee, especially just before bedtime.

The question of class hours for pupil nurses who are on night duty is hard to manage, but I am convinced that it is unwise and unfair to call night nurses at 2 or 3 P.M. to attend lectures. If they have to attend lectures, the hour from 4 to 5 or 4.30 to 5.30 seems the most desirable. On such days the morning hour should be chosen for open-air exercise.



GRADUATING CLASS, KINGS PARK STATE HOSPITAL, LONG ISLAND, N. Y

Helpful Hints for the Probationer

MINNIE GOODNOW, R.N.

ANURSE must be a woman more than ordinarily good. If you do not wish to be such a one, choose another occupation.

Good intention is not enough. You must actually do or be what you wish to do or be.

The patient and his welfare is the prime consideration. The nurse's own training is second.

Try to get the patient's viewpoint.

Hospital discipline is hard, but it is necessary, since human life or health is the price of failure or disobedience.

Bear in mind that there are good and sufficient reasons for doing whatever is demanded of you. Keep your eyes and ears open and you will sooner or later discover these reasons.

The patient feels no wrong more keenly than a nurse's betrayal of his confidence.

Honesty is not only the best policy. It is the only rational policy.

It is never *necessary* to tell an untruth to a patient.

Do not contradict a patient's statement in his presence. His inaccuracies are rarely of great importance, and you can easily find opportunity to explain anything which may be necessary out of his hearing.

A hospital nurse is a reformer only indirectly. Her field is the physical, and does not include correcting patients' manners and morals.

Florence Nightingale called our attention to the fact that we find in nursing the only situation where a man is bodily in a woman's charge. In such a phenomenal situation, one cannot apply the rules which fit ordinary life, but must follow special regulations.

Look yourself over in a mirror carefully, front and back, before you go on duty. It may save you a reprimand or some embarrassment.

Remember that you are on dress parade every moment that you are on duty.

Study how to dress your hair so that it will remain tidy. With some people curling helps, with others it hinders.

Have a good watch with a second hand. A chatelaine fastening is most convenient for a nurse.

Have a pocket in your dress. Keep in it a handkerchief, safety pins, a pencil and small, blunt-pointed scissors. Articles stuck in one's belt or under one's bib look untidy.

The distance from the floor to the bottom of your dress is important. It should be neither too small nor too great.

Use no perfume, however faint. The daily bath is the nurse's best sweetener.

The shape of the heels of your shoes is one of the most important factors in your comfort.

If your feet tire badly, change both shoes and stockings in the middle of the day.

Bathe and rub the feet often. Do not soak them as it may make them tender.

A clean mouth and a good digestion are essential. A bad breath is sickening to a patient.

Take good care of your finger nails. Manicure them often enough to keep them smooth and in perfect condition.

It is wrong to have open wounds or scratches upon your hands. Cover them with collodion.

In scrubbing your hands, think of each finger as having four sides, and remember that your nails are the most difficult part of the procedure.

In cold weather, use a hand lotion each time that you wash your hands. Rough hands are not only uncomfortable for your patients, but cannot be kept clean.

Always wash your hands before you go to a meal.

So far as possible, keep the hands out of dirt or infection. Handle soiled things as little as possible.

Learn to keep your hands away from your own mouth and eyes, especially while on duty.

The less you talk the less trouble you will have.

Never whisper. Cultivate a proper tone. Listen to yourself.

Hospital noises are one of the greatest trials to a hospital patient. Try to have your share of the noise-making a small one.

Pay especial attention to the quality of your voice, its pitch and intensity. Most people judge others by their voices.

Consider your patient as a guest and you will get the correct viewpoint.

Remember that visitors are guests and are always entitled to courtesies.

Give a patient his own way whenever possible; when you find it necessary to insist you will get prompt cooperation from him.

Note the nurse who causes the patients to brighten up when she comes in. Find out why.

Cheerfulness is a habit. Get the habit.

Train your face not to reflect all that you feel.

You must expect to find some patients more attractive than others; but they are all suffering human beings.

Learn to show sympathy by tone and manner more than by what you say.

Try to think how it looks to a patient when you are (1) laughing and chattering with another nurse; (2) chatting or flirting with a doctor; (3) staying for a long time to talk to a man patient.

Never hurry. Patients will invariably interpret it as neglect or indifference. Make haste slowly while in the patient's room.

Do your feet ache? So does that patient's back.

Do not sit on a patient's bed. It is uncomfortable for him and looks badly for you.

Follow the Irishman's advice and "if you can't be modest, be as modest as you can." Never expose a patient more than is absolutely necessary.

When the old lady in the third bed is exasperating, go out into the bathroom and tell another nurse about it. Then go back and smile at the old lady.

In your relations with servants, keep the Golden Rule in mind, and remember that praise gets better results than blame.

Nothing is too much trouble if it adds to a patient's comfort.

Nothing is beneath your dignity if it helps your patient.

There is a scientific reason for every act which constitutes good nursing. Try to discover it.

Dusting is an important scientific procedure.

Ventilation means a little fresh air constantly rather than a large amount introduced at uncertain intervals.

A smooth draw-sheet makes a comfortable patient.

A wrinkle in a sheet may cause acute discomfort or start a bedsore.

Dampness is deadliest when it is under a patient's back.

When you get a patient out of bed, make the bed before you do anything else.

Before you begin a procedure, get everything ready for it. This is the secret of rapid, effective work. Make a list of what you need for each piece of work and commit it to memory.

Never give food nor drink without being *sure* that you are doing the correct thing.

Never leave a hot-water bag in bed with an unconscious or delirious patient, except by special order from the doctor or head nurse.

Keep flowers well supplied with fresh water, and remove any faded ones promptly.

Never use jelly glasses for drinking purposes. If you are short, ask for more.

Butter is bound to taste if left uncovered even for an hour.

Milk is more easily contaminated than any other food; therefore our special care of it.

Always look twice at the label of a medicine or solution before you put into use what you have taken from the bottle.

Familiarize yourself with the appearance and smell of all drugs which you handle. Only in that way are you safe.

Be economical with disinfectants, yet use enough for effective work. Get information about them.

Taste of medicines which your patients object to. You may see why they object and be able to do something about it.

Do not use soap on a patient's face until you have asked whether or not he wishes it.

When bathing hands and feet, always put them into the basin of water.

In combing hair, always begin at the ends and work up to the head.

Do not let men patients smoke unless by permission from their doctor.

Never leave alone, even for a moment, a delirious patient or one unconscious from an anesthetic, unless the doctor or head nurse has given you permission.

Place bedside tables so that patients can reach articles upon them without reaching backward.

Do not put a large handful of alcohol on a patient's back at one time. It is cold. Merely wet your hand with the alcohol.

Give an enema very, very slowly if you expect to get a satisfactory result.

There is fine art in the proper placing and removing of a bedpan.

Begin early to learn about quality of pulse. It is a ten-years' task.

If you cannot do a servant's work better than the servant does it, you are no better than a servant.

The nurse who does the most work is not necessarily the one who does one thing most rapidly, but the one who "uses her head to save her heels" and gets most quickly from one thing to another.

Thorough work means finished work. Do a thing well and you will not have to do it over again.

Be prompt in getting on duty. Tardiness gives at the very least a bad impression.

Do not be too eager to get off duty. It looks like lack of interest.

Read the daily paper for five minutes. It may mean much to you and to your patients.

Exact obedience is acquired by attention, listening to every word which is said; and by memory, retaining the instruction in your mind.

If you break, burn or destroy anything, report it promptly. You will be more respected and less punished than if you wait for it to be found out.

Cultivate a sense of humor. It is essential to success.

True sympathy is not emotion. It is work. The real way to show that you are sorry for a condition is to attempt to relieve it.

If you do not get your feelings hurt but once a day, you are lucky.

Lie perfectly quiet, flat upon your back, for fifteen minutes by the clock. Then go and extend sympathy to the patient who must lie in that position for twenty-four hours.

Have you been fascinated by Army nursing? Remember that unquestioning obedience is the first characteristic of a good soldier.

Hospital work gives remarkable opportunity for learning to manage work, *i.e.*, to do a large amount of good work in a short time. This ability, always acquired rather than natural, is invaluable in every walk of life.

The Hot-Water Bottle's Story*

M. B.

"OUCH! You're hurting me." For the third time I heard a high, squeaky voice saying this, and I opened my eyes wide for I was sure I was quite alone.

Again it was repeated and, sure enough, it seemed to be coming from the hot-water bottle on which I was laying my aching head.

"Please, let the air out. I am so distended. No wonder our lives are so short; we are so abused." Very much ashamed to have neglected so important a point, I quickly removed the stopper and pressed the air out of the poor bottle.

"Thank you, that is very much better," it murmured. Since the bottle seemed inclined to talk, which they rarely ever do, I cautiously asked, "Won't you please tell me the story of your life from its very beginning until now?"

The bottle sighed reluctantly, but finally said: "It is a very long story, but I shall try to tell you some of my history and adventures.

"In a dense forest on the banks of the Amazon River in South America stands a very large and beautifully leaved tree, which is my mother. There she grew for many years, happy and content, with no living companions except plants, snakes, insects, etc. Never going visiting, as your mother does, but sending her messages to our cousins in Africa by means of her friend, West Wind, who played with her daily.

"One day a cruel native Indian came and cut many deep gashes into my mother's side and allowed the creamlike sap to flow out. There was about three pints in all, and being with it, there, I bade good-by to my mother.

"I was then heated and smoked until I felt myself getting hard through and through in layers. Soon with many others I was floating down the river in a barge, while the

hunter crooned joyous weird songs, for he kept counting us over and over in his own way and saying what he would get for us.

"After a while we were all thrown into crates, not too gently to be sure, and were put on a high building, which I afterwards learned was a ship. Some new ones had joined us and soon we began to be sociable and exchange confidences. Some were from plantations, where their mothers had been planted and carefully cared for. Others, who had enjoyed the solitary wilds like myself, were very dirty, for they had not been gathered properly. At a place called Mexico many more masses or lumps just like us were taken on.

"Where could we be going and for what? We all began to wonder and wish we were back to our mothers, who had bade us be good children, for we had a mission to fulfill.

"At last, after many weary weeks of sea and homesickness, we were taken from the ship into a large room, which they called a factory, and I believe it was in the city of Boston. I was carelessly dropped into a corner, where I lay for many days and I was glad of it, for I saw what happened to my associates and brothers.

"Gloves were made of the choicest pieces, which were melted. Then of the others everything you can think of—erasers, overshoes, tubes, bottles, vulcanized rubber for insulators, etc., even to rubber cloth in all grades, some for sheeting, others for coats and garments.

"This was all very interesting and I wondered what they would do to me, although I was not anxious to be so treated.

"They told visitors that a man named Priestly had just discovered our use in the eighteenth century to rub out marks and that MacIntosh had found we would keep out water when made into cloth.

*A plea for care of the hot-water bottle.

"At last came my turn. 'A very fine piece,' the man said, as he looked me over. 'We will take this for those special hot-water bottles.' So I was melted and stretched and shaped, chemicals, alcohol and a little acid—I forget which, nitric or carbolic—were put on me, until I was pronounced cured, and I hoped I soon would be, if I were not then.

"Then I was put through great rolls and shaped into what I am now, while the smaller waste pieces were remelted and used for tubes, etc.

"I am really glad to have undergone this, for mine has been an eventful life. I have seen joy and sorrow and have helped rich and poor alike. But I have often been abused, too, like my poor brother, the tube,

across the way, who is no longer useful on account of too much oil, which softened him.

"Often I have been distended by air, which stretches me, too hot water has burned me, until I am not so strong as I used to be. See that spot on my neck, where chloroform, ether or benzine, I don't just recall which, was dropped and almost ate a hole.

"Then, too, I was often hung up wet and not allowed to dry properly. So thus they call me old, while I should have life for many years yet.

"O dear me, I have been talking too much. Forgive me this time. I try *ever* to do my duty to help cure others' ills. But I shall say good-by. Be good to my brothers."



GRADUATING CLASS, MERCY HOSPITAL, HAMILTON, OHIO

LEFT TO RIGHT: ELEANOR DELANY, MARY K. LEAHY, MYRTLE CHARLES, KATHLEEN CONNELL, ELIZABETH MENDER

A Sane Fourth of July

C. J. G., R.N.

"SAY, Miss G——, can we have a party on the Fourth of July? or a picnic?" Alma's brown eyes looked up at me full of pleading. "I," announced young Nicholas, "shall go out to Millwood, have a good time, much fire cracker and pop." I looked down at my small girl, and into the moody face of my young Greek. "Of course we'll have a picnic, just as nice a one as we know how," I promised.

We were spending our first Independence Day in the new City Sanatorium, and our flock numbered sixteen. Those who have nursed tuberculosis patients know of their restlessness and desire for active entertainment. For a greater number of our patients were advanced cases and were on absolute rest. A picnic supper was my first thought. Among my purchases that week were oiled paper, gay-colored napkins, paper plates and drinking cups. These last out of consideration of the maid who boils the patients' dishes.

The glorious Fourth was ushered in by our newsboy, who fired crackers considerably on the front drive, to the great delight of our children. Then the grocer was kind enough to include some torpedoes and crackers in his daily order. A commonplace dinner was glorified by the dessert, red molds of jello, heaped with whipped cream, topped with a big strawberry rolled in sugar and a tiny flag stuck in the center. After the rest hour, from 1 to 3, the usual egg-nog and milk luncheon was omitted for a sugar wafer and egg lemonade.

"I will go, Miss G——, to Millwood," insisted Nicholas, firmly, just before supper. "I will see the sky rocket and eat the pop."

"Just stay for the picnic, Nicholas," I

urged cordially, for I disliked to anger him by direct refusal. Nick was a young Greek of eighteen years, had been in America but nine months, to be the victim of a cruel accident in the mills. Left with but one hand and with intestinal tuberculosis, his case was most pitiable. The "up" patients were served their picnic on the porches, and dainty and cool their trays looked. A neat oiled-paper package, tied with red string, contained four sandwiches, each different; a delicious salad reposed on a crisp lettuce leaf. There was even a wee slice of pickle, to confirm the idea of a picnic. A block of custard and iced chocolate completed the menu. "Everything tasted so different," remarked our oldest patient. "I didn't suppose I'd ever taste a pickle again!" I don't suppose any other hospital nurse was guilty of such a thing, but the junior nurse fired a cracker under each patient's window, and how they enjoyed it. "Everything, it is different, in America," sighed the young Swede, who was too ill to sit up.

Night fell and the fun of the day at hand; blessed with a location on a high hill, we commanded a fine view of the valley, where lay the city. On our splendid flat roof had been placed reclining chairs, and those able to climb the stairs enjoyed the fireworks hugely. Others we wheeled to a porch, and no one had more joy from the city's playthings. Then, before bedtime, wee Alma must light her "sparklers" and let every one take a turn.

The last sky rocket had whizzed and the last Roman candle sputtered out, when I felt a hand shaking mine. It was Nicholas. "America, it shall be mine—I shall take out the papers," he said, simply.

Department of Public Welfare

TEACHING LITTLE MOTHERS

V. S. SIMMONDY

Anna was a girl of twelve years who came from Poland with her parent as an infant. She had a baby brother who was always sickly and under-nourished, as he had been improperly fed since birth and kept in the house as much as possible, so as not to catch cold. One day the baby was very sick, so the mother, after buying soothing syrups and several patent medicines, decided to go to the Babies' Dispensary and see if the doctor could not give him some better medicine.

Anna went to interpret, for although the mother had been in America nearly twelve years, she was unable to make herself understood. While in the waiting room, Anna heard the mothers discussing the number of ounces their babies had gained, and noticed that her baby brother did not look as well or as plump as the others did. The baby was duly weighed and examined, but to the mother's great disappointment, no medicine was prescribed, nothing but a formula and instructions were given.

When the nurse visited the home to show the mother how to prepare the formula, little Anna again did the interpreting. She was very interested in the methods used, asking numbers of questions all the time. "Why the bottles should be boiled and why they should be sealed?"

Next day, when the nurse called to see how her instructions were being carried out, she found Anna with a big apron on, the bottles and other paraphernalia spread on the table, just ready to prepare the feedings for the day. The mother had been so dis-



ANNA—A LITTLE MOTHER

appointed at being told not to give her baby any more medicine, and had realized that milk and barley water were some bother to prepare, that she had decided to follow the line of least resistance and continue with her old methods. But Anna was ashamed to think that her baby did not look so well as the ones she had seen at the dispensary, and had begged to be allowed to try what she could do. Her mother had shrugged her shoulders and turned to the wash-tub, not caring what happened as long as she did not have any trouble. So Anna started in as a "Little Mother," and as she was a bright child and anxious to learn, did much better work than her mother ever could have

accomplished, and at the end of the summer her baby was able to compete with honors with the other dispensary babies.



The County School Nurse

In one of the Dakotas an experiment in school nursing in a rural section has been launched and is probably in operation at this time. The entire county is to be the field for the school nurse. Having her headquarters at the county seat, she visits a new section of the county each week, the residents providing for her transportation from place to place.

In each school section, she is expected not only to assist in the medical inspection of children but to meet the people of the school district, especially the mothers, and to either herself give talks on health and home care, or to arrange for them to be given.

During the school holiday season she was to be an instructor in the summer course for teachers, for a part of the time. The salary offered is \$1,200 a year. It is expected that she will be "entertained" as the guest of each school district.

The county superintendent of schools is responsible for the initiation of the movement, which if successful is expected to extend into other counties.

Needless to say, the personality of the nurse who initiates such a movement in an agricultural community, with no large towns in the county, is certain to be one of the prime factors in its success.



Bad Air

The New York State Commission on Ventilation has definitely proven two counts against bad air, one of them for the first time in history, and will probably prove others later on.

The first indictment against bad air shows that an increase in temperature beyond the normal 70 degrees produces serious derangement of the vaso-motor mechanism of the

body, resulting in a rise of temperature, increased pulse and a lowered blood pressure, with a corresponding decrease in efficiency both physical and mental. In addition to this, overheating conduces to an undesirable congestion of the mucous membranes of the nose, thus possibly paving the way for colds, sore throats, and attacks of various germ diseases.

The work of the Commission also proves that chemical accumulations in the air as a result of air stagnation bring about a decreased appetite for food, which in turn must have an unfavorable effect on the entire body.

"These experiments," says Professor Winslow, "indicate that fresh air is needed at all times and in all places. While we have changed our ideas as to what causes bad air, ventilation is just as essential to remove the heat produced by human bodies as it was once thought to be to remove the carbon dioxide produced by human lungs, and it is now proved, also, to be essential for carrying away chemical products which exert a measurable effect upon the appetite for food. People who live and work in overheated and unventilated rooms are reducing their vitality and rendering themselves an easy prey to all sorts of diseases."



To Interest Physicians and Nurses

For the purpose of securing more cooperation from physicians and nurses in the anti-tuberculosis campaign, the National Association for the Study and Prevention of Tuberculosis has inaugurated a movement to bring the importance of this subject to the attention of these two groups.

Among the first things which the Association is trying to do is to induce the medical colleges and schools of nursing to give more instruction, particularly of a clinical nature, on tuberculosis. An effort will be made also to reach the individual practitioners and nurses by special booklets prepared for this purpose.

The Hospital Council

Items of Interest, Annual Reports, Publicity Literature and Material Descriptive of Newer Methods and Plans in Any Department of Hospital Work Are Solicited

The Matron in the Nurses' Home

H. A. L.

When I took charge of the training school in a 100-bed Eastern hospital I found, among other difficulties, an unattractive, over-crowded Nurses' Home. The maid service was under the control of the house-keeper, who with all her other duties had very little time for supervision in this department. The rooms were untidy, the bath-rooms and corridors dirty and the whole building presented an unkempt, neglected appearance.

After some trouble I persuaded the board to allow me to engage a matron and put the maids in the Home under the training school authority and directly responsible to the matron. My next move was to talk with the different classes and to get their co-operation, for I realized that there would be more or less resentment regarding another person around to watch them. I explained that our object in having a matron was not to watch them any closer, but to make them more comfortable and happy. They had never made their own beds, and as a consequence the overworked maids had simply flung them together. I asked that all nurses make their own beds, except one morning a week, when the linen was changed, thus giving the maids more time for cleaning. This caused a great deal of resentment, especially among the older nurses, but as no attention was paid to it, it gradually died down.

I had some difficulty in finding the right woman for the place at the salary allowed (\$35, with maintenance). I had in mind a middle-aged woman who was a good house-

keeper, had some practical knowledge of nursing, with sufficient dignity to win the nurses' respect and one who would generally "mother" them. After several failures we found the person who came near to this ideal and six months made a decided change in the appearance of our home and the health and happiness of our training school. She had her own comfortable room and bath on the first floor and Sunday afternoons served tea there, which served to brighten many dreary winter days.

Our private pavilion was small and the superintendent complained constantly of the number of rooms occupied by sick nurses. In most cases they were not sick enough to demand constant attention, but could not be left to the haphazard care of friends off duty. On the ground floor of the home was a small room used for storing odds and ends. This was cleared out and fixed up as an Infirmary and all cases of minor illness were sent there at once. We also felt that this lessened the danger of an epidemic, as we could isolate a nurse there with little trouble. In this room we had a plentiful supply of hot-water bottles, ice caps, etc., which could be obtained at any time from the matron, thus doing away with the removal of such articles from the Ward.

The difference in the amount of electricity used was an item that appealed especially to the board, as it decreased almost 40 per cent.

The nurses had supper at five o'clock, so by ten they were hungry again, and had been in the habit of buying all sorts of indigestible things at the delicatessen stores in the neighborhood. As a consequence we averaged a case a month of ptomaine or indiges-



A GROUP OF DELEGATES TO THE HOSPITAL ASSO-

tion, and had had a severe epidemic of typhoid only the year before which had been traced to this source. We installed a small ice-box and served crackers and milk at 9.30 evenings to all who wished them. This obliterated the promiscuous buying to a great extent, and the extra expense was more than made up for in the better health of our nurses.

Our matron's duties were many and varied. She looked after the housekeeping, made rounds at 10.30 to see that all lights were out and everything serene, gave out laundry, called the night nurses, mended the linen and other duties too numerous to mention.

These suggestions will not appeal to wealthy hospitals with beautiful nurses' homes and a graduate nurse in charge, but may help some superintendent who is trying to make the best of poor living conditions until times are better, and who feels that her nurses are neglected and dissatisfied.

Clinics for Mental Diseases

The growing attention to the prevention rather than the cure of insanity is one of the most significant features of progress in preventive medicine. New York State and Massachusetts have led the way, and done much to usher in the new era which is to follow. The Psychopathic Hospital, Boston, in its out-patient department, is said to be a model for out-patient organization.

One by one the State hospitals of Massachusetts have opened similar departments, and ten hospitals have opened clinics in more than twenty cities and towns of the State. Some of these clinics are monthly, some weekly and one is held daily. Practising physicians in the State are notified of the date of each clinic and notices are inserted in local papers. Former hospital patients are urged to report at these clinics from time to time to prevent relapses.

It would seem that a very effective co-operation between the general hospitals in other States and the State hospitals for insane, by having the general hospital provide



CONVENTION, SAN FRANCISCO, JUNE, 1915

a place and proper assistance for weekly clinics, the State hospital to provide the specialists to care for examinations and treatments.

The movement is one which is full of promise and it is hoped that general hospitals in large numbers may go more than half way in getting such work under way in their States.



Damages for Hot-Water Bottle Burns Under Anesthesia

In spite of all training, admonitions and precautions, hot-water bottle accidents still occur sufficiently often for most superintendents and principals to be uneasy lest their hospital shall be haled into court to defend in a suit for damages for an accident which should not have happened.

The *American Journal of Surgery* April, 1915, cites several cases where damage suits were instituted in 1914 for this too-common accident. In the St. Louis, Mo., Court of Appeals it was held that a verdict for \$1,500

damages to a husband for the loss of his wife's services, companionship and society, as a result of a hot-water bottle burn under anesthesia, and permitting the wound to heal over a drainage tube, was not excessive. The burn occurred during the patient's post-anesthetic recovery after an operation for cancer; although the hot-water bottle had been wrapped in a towel and rested against the patient's leg, which was covered by a flannel operating garment.

The court held that the application of the hot-water bottle for two hours, without investigating its effect, constituted negligence. The theory of accident was disregarded, the court holding that ordinary skill and care would have anticipated the possibility of the burn and prevented it.

The Supreme Court of South Carolina affirms a judgment for damages in favor of a patient who was burned by a hot-water bottle, while under the influence of an anesthetic. The question was raised: "Is a hospital with a charitable foundation liable to patients for injuries caused by the negligence

of employees?" The court held that, while a trust fund could not legally be diverted to a purpose other than that for which it had been created, under the circumstances, as the charitable foundation called for the relief of suffering, it was only consistent with strict justice for such a fund to repair the evil of its own doing.

In Pennsylvania the family physician was sued for damages from a hot-water bottle, while the patient was under an anesthetic. The Supreme Court held that a family physician who recommends a patient to a hospital for operation and merely acts as an assistant at the operation, cannot be mulcted of damages for burns from a hot-water bottle while the patient is recovering from the anesthetic, as this negligence was directly traceable to the attending hospital nurse, for whose negligence the attending physician could not be held responsible.

One superintendent, whom the writer knows well, makes a practice of calling the attention of the nurses in the school when they are assembled in a body for her monthly talks on ethics and etiquette and deportment, to every case of a suit for damages caused by a hot-water bottle accident. This practice has helped wonderfully in impressing nurses on this subject.



Flower Hospital Diet Department

"A Private Hotel for Sick People" is the name which has been given to the elegant new pavilion for private patients which was not long ago erected adjoining Flower Hospital on New York's upper East Side. This pavilion has been constructed with a precise and scientific thoroughness that seems to pervade every department and all its appurtenances.

Probably one of the most interesting features of this "Private Hotel," at least to the student of hospital methods, is the concentration of all purchasing powers and all matters relating to diet in the hands of one per-

son. This person is a trained dietitian and a woman of wide experience in the selection of meats, food stuffs, etc. Besides personally managing the work of the diet kitchen, she is the "housewife" of the hospital and under her critical eye must pass all orders, even those for the most insignificant article.

The diet kitchen at Flower cannot limit its efforts to special problems, as can some diet kitchens. At Rockefeller Institute, for instance, the diet kitchen is now preparing only those diets needed for diabetic patients, at the maternity and children's hospitals the diet kitchens are busy with babies' formulæ, and so on. But at Flower Hospital the diet kitchen attempts to serve all cases that are dependent on the food which the patient consumes.

The dietitian at Flower maintains a carefully indexed card system in her headquarters, located just off the main kitchen of the hospital. The card containing the instructions for making formulæ, for instance, contains this: "Use only earthen ware or new enameled ware. Sterilize or rinse all utensils under hot-water tap and set on tray. Sterilize bottles. Make gruels the day before, label, and set on ice." The careful statement of detail on this card is but an example of all the others. This is particularly noticeable in the specification of the utensils to be used, as above. Where fruits or acids are being cooked or any foods are being stored away in the ice-boxes, it is pointed out that pottery or enameled ware must be used to avoid the possibilities of corrosion which occurs with some other wares.

Following is the private patient diet list and the specific diets which Flower will use in the future for the rheumatism or gout patients and the diabetic patients:

PRIVATE PATIENT DIET LIST

LIQUID DIET

Clear coffee, tea, gelatine and albumen water, toast water, orange or lemonade; broths—chicken beef, mutton; clam bouillon; fruit and wine jelly;

milk and buttermilk, egg nogs, Fermillac, vichy, grapejuice, Zoolak, Kumyss.

SOFT DIET

Rice, all cereals, clear soups, gruels, cream soups, milk toast, soft cooked eggs, corn custard, custard, junket, orange juice, prune purée, baked apples, plain ice cream, gelatine, blanc mange.

LIGHT DIET

Cooked oysters, white fish; codfish, creamed; roast beef, rare; scraped beef balls, scraped beef sandwiches, sweetbreads, bacon, squab, chicken, lettuce, spinach, cauliflower, potatoes, stewed celery; grapefruit, prunes, oranges, pineapple, apple sauce, ripe peaches, strawberries, cantaloupe, all custard puddings and Bavarian creams.

HOUSE DIET

Steak, chops, roast lamb, broiled ham, lamb stew, Hamburg steak, fish; asparagus, tomatoes, peas, celery, squash, carrots, string beans, beets, oyster plant, brussels sprouts, parsnips; all fresh ripe fruits, apple puddings, plain cake.

DIET FOR RHEUMATISM OR GOUT

White bread or crackers, rice, potato, macaroni, purée of corn, celery or spinach flavor; apples, grapes, dates, figs, raisins, honey, nuts, oils, all forms of fat; milk and cheese in moderate amounts, eggs.

DIABETIC DIET

Soups—all stock soups and bouillons; meats—meats, poultry and fish of all kinds not prepared with flour; eggs in any form; vegetables—asparagus, artichokes, cauliflower, cabbage, brussels sprouts, sauerkraut, onions, young string beans, tomato, celery, lettuce, chicory, watercress, endive, spinach, pickles, olives, mushrooms, egg plant, swisschard, rhubarb, grapefruit; nuts, except chestnuts; breads—bran and gluten; desserts—gelatine sweetened with saccharine, flavored with coffee, cream, nuts, sherry; custards, without sugar; ice cream; cheese—all kinds used abundantly; beverages—tea, coffee, lemonade—no sugar, cocoa nibs; fats—used plentifully in cooking, salad dressing, creams.



The Hospital Basket

One of the ways taken to secure variety in food and reduce the cost of food supplies is the weekly hospital basket. The New Eng-

land Baptist Hospital, Boston, has used this method successfully for years, and it could be widely used, with a little effort in getting it started. In the annual report, the following list is found of supplies suggested to be included in the "basket," though any groceries, fruits or provisions, not perishable, are gladly accepted:

"Sugar, tea, coffee, cocoa, rice (unpolished preferred), jellies, soap, canned fruit, cranberries, potatoes, lemons, oranges, grape fruit, tapioca, cereals, raisins, salt, canned vegetables, etc."



Grace Hospital, Detroit

Grace Hospital, Detroit, reports a total of 6,515 patients admitted during 1914, with a total of 31 per cent. of the number of days for patients free, with a daily average in the main hospital and the convalescent branch of 208 patients. The daily cost per patient was \$2.70.

One of the important departments of outpatient work is the dental clinic, which is open from 8 to 11 A.M. and 1 to 4 P.M. It is operated under the direction of the board of health. School children needing dental treatment which their parents are unable to pay for are sent to one of the eleven dental clinics in the city.

The social service department under the direction of Miss Rachel Mulheron is rendering practical service, which greatly increases the efficiency of the hospital. "No other department," states the superintendent, "provides as much relief for the same expenditure of money as the social service department."

The training school department has been reorganized under the direction of Miss Harriet Leek; the corps of pupil nurses and graduate supervisors increased and the work of that department improved and strengthened in numerous ways.

Editorially Speaking

International Convention of Nurses

The week beginning June 20, 1915, will long be remembered by nurses as the week of wonderful opportunities, so far as meetings for the discussion of nursing, medical and hospital topics are concerned. Although intended to be international, the convention of nurses at San Francisco was hardly more than national in character as, owing to the European war, the only foreign delegates able to attend were two from England, one from Holland and one from Australia. Something like three hundred American delegates were present, besides a good many visiting nurses, who came to San Francisco to attend the meetings and to see the Exposition. The meetings were not very largely attended on the whole, in the day time, and they were almost invariably so late in beginning that there was little chance for discussion, a fact that was much deplored. Many felt that fewer papers and more discussion would have been more profitable.

The First Congregational Church of San Francisco, a beautiful structure, centrally located, had been chosen as the general meeting-place for the sessions of the three associations. On Sunday evening the visiting nurses were invited to a special sermon in the church by the pastor, Rev. C. F. Aked, on "The Nurse—Her History and Mystery."

The meeting of Tuesday evening, one of the largest of the Convention, was held in beautiful Festival Hall on the Exposition Grounds. Dr. Edwin R. Snyder, commissioner of Vocational and Industrial Education, California, was the first speaker on this program, his subject being "The Vocational

Trend in Education." He spoke at considerable length, but made a *fearful break*, in pleading on humanitarian grounds for more than one grade of nurses to meet the needs of the public. However, the situation was saved by prompt and energetic action on the part of the presiding officer, in correcting such heretical views on the subject of nurses for the people. This meeting was rendered much more enjoyable by the delightful musical program with which it was combined.

The star feature of the convention was to have been the meeting of Wednesday afternoon. The American Hospital Association had been invited to hold a joint session with the American Nurses' Association in the Greek Theatre, of the University of California at Berkeley, to hear addresses from Hon. Hiram Johnson, Governor of California; Maj.-Gen. William C. Gorgas, surgeon-general of the United States Army, and Dr. Winford H. Smith, of Johns Hopkins Hospital. None of these speakers were present, but those who had left the Exposition grounds and gone across the bay to Berkeley to hear the distinguished speakers who had been so widely announced, had the pleasure of listening instead to some half-dozen speeches of laudation of certain members of the nursing profession, and a paper from Miss Palmer on "The Power of the Professional Press." Mr. Chester H. Rowell, one of the Regents of the University of California, delivered a short address and Dr. Henry B. Favill, of Chicago, gave a paper on "What the Medical Profession Can Contribute to Nursing Education." Several fine musical numbers were rendered. The California sun beamed down its fiercest rays;

the gentle breezes for which San Francisco is noted were absent that day, and those who sat through the full program in that stone-lined theatre, with no protection from the sun, deserve a medal for endurance. Greek theatres at night may be altogether delightful meeting places, but Greek theatres under the glare of a California sun are different.

While all the meetings suffered to some extent from the division of interests and the attractions of the Exposition, those who were present felt amply repaid for the long journey. The local committee had left nothing undone that would conduce to the smooth working of the convention, and the inspiration carried from all these meetings will be felt by many a weary worker, who goes back to her task with fresh courage, and with higher ideals of service to her fellow-man.

We feel that we are to be congratulated on the splendid report which we are able to present to our readers, as it gives in condensed form all that was worth while of the happenings of the convention, and it loses nothing from the fact that it is the first report in the field. Our only regret is that space will not permit of the publication of the full report in one issue.



The Hospital Convention

The San Francisco Convention of the American Hospital Association has passed into history. It will long be remembered as a convention that was beset by difficulties innumerable, difficulties such as have never had to be met by any previous convention, and, it is hoped, such as may never again occur.

The death of the president, Dr. Mann, just previous to the convention, threw everything into confusion. Of the three vice-presidents, only Miss Barrett was able to plan to attend the convention. She being unfamiliar with the details of the situation, local or general, was reluctant to assume the

full responsibility of managing the convention affairs, and Dr. Summersgill, chairman of the executive committee, was placed in general charge of the program, with Miss Barrett assisting.

The absence of both the secretary and treasurer added still further to the confusion. When the convention was finally under way, combined with these difficulties, were the lure of the Exposition, the fact that the meetings of the medical and nurses associations were going on in other places in the same city, and that attendance at even one session of the convention program necessitated the payment of a fifty-cent admission fee to get into the Exposition grounds and reach the convention hall in the Inside Inn. Consequently, many members of the Hospital Association who were staying in downtown hotels, attended meetings of the other associations where there was no admission fee and the attendance at most of the sessions was small. At no time during the whole convention was it possible to have the Association members who were in San Francisco present at any one meeting. Valuable papers were not discussed because those who might otherwise have taken part in the discussion were either out on the Exposition grounds or away at some other meeting. It seemed impossible to get the careful attention to the program that ordinarily prevails. Business matters suffered for the same reason. The general feeling seemed to be that for the future the American Hospital Association should study to avoid holding meetings at the time when other conventions were being held and should institute careful inquiries before deciding on a place of meeting, to be sure that not even an old-fashioned circus was being held in the same town on the convention dates. It is probably well for the Association that all these complications occurred in the one year, to teach the lesson that conventions to discuss serious hospital problems and other attractions do not mix well, and that there is nothing to be

gained and much lost by holding two conventions following lines more or less similar in the same place at the same time.

The year 1915 has been an "off year" for the Association in regard to its convention. Next year we will swing back to normal conditions and will appreciate more highly many things which go to make up a successful convention.

The commercial exhibit was small. The non-commercial exhibit—in spite of the fact that a great deal more effort than usual had been put forth, was not up to the exhibit of last year in St. Paul or in other places. One reason for this is that at the nurses' convention a similar exhibit was arranged, and when it came to a question as to whether the superintendent of the hospital or the superintendent of nurses should have the exhibit prepared by local hospitals, the superintendent of the hospital gracefully gave way, which was certainly most generous, when one remembers that the Hospital Association dates were set first, and that the Nurses Association changed its dates from those originally set. Hence the exhibits from the local hospitals were conspicuous, for the most part, by their absence. The officers elected were: President, Dr. Winford Smith. Vice-presidents, Dr. Charles D. Wilkins, New Orleans; Miss Nettie Jordan, Aurora, Ill., and Dr. A. H. Warner, Cleveland; secretary, Miss Lydia Keller, St. Paul; treasurer, Mr. Asa Bacon, Chicago. Philadelphia was selected as the next meeting place.

At the close of the convention the San Francisco hospital superintendents were waiting with automobiles to take the convention members and visitors for a delightful drive through the prettiest parts of the city, stopping at the House of Relief, where bounteous and attractive luncheon tables were spread out of doors. Wives of superintendents acted as hostesses and the waitresses, we were told, were probationers and junior nurses from different hospitals. The

flower-decked and fruit-laden tables, the beautiful setting for the whole affair, and the genuine spirit of hospitality, will make this drive and luncheon a delightful memory for all who were present.

After the luncheon, those who wished to visit hospitals were conducted by the local superintendents to the Southern Pacific, Mount Zion, the city and county hospital, to St. Luke's, while others visited other institutions.



The Hospital Special Train

The hospital special train left Chicago on the evening of June 13, with a party of about seventy-five, bound for the San Francisco Convention of the American Hospital Association. Other members, who had started in advance, joined the party along the way. At Kansas City, a considerable number arrived during the day spent there to swell the list, so that one hundred or more members of the Association from Central and Eastern States were in San Francisco at the time of the convention.

When the train reached Kansas City a drizzling rain was falling, but the gloom occasioned by the weather was quickly dispelled by the warm welcome of the Kansas City members of the Association and local friends, who were ready with a long string of autos to take the visitors on a ride through the city. Before the arrangements were completed the rain had ceased and we started on a tour of one of the most beautiful cities of America, with a park and boulevard system which was an amazement to visitors from the East. Kansas City roses were at their best and the profusion and beauty of roses of many kinds added much to the pleasure of the drive. At noon the party was halted at Swope Park, where in a beautiful pavilion shelter a delightful luncheon was served by the Kansas City members of the Association, assisted by the hospitals and health board of Kansas City. Those

present will long remember the beautifully decorated tables, the dainty luncheon served in exquisite style, and the generous hospitality of the Kansas City officials and members. Kansas City has put itself "on the map" of American cities which can be depended on to entertain the convention of the American Hospital Association in royal fashion when the time arrives to swing back to a Western city.

After leaving Kansas City a day was spent exploring the regions round about the petrified forests in Arizona, and a long, beautiful day was spent at the Grand Canyon. Several of the more courageous lady members mounted mules and followed the Bright Angel Trail down the canyon, but the majority preferred to get their impressions from the top rather than the bottom.

The most restful day was that spent at Riverside, Cal. Here many saw for the first time the California oranges on the trees. A drive to the top of Rubidoux Mountain and a dinner in the Palm Garden of the wonderful Mission Inn were pleasant features of the day at Riverside.

A day in San Diego gave opportunity for a trip to the village of Tijuana, Mexico, in the forenoon, and to visit the San Diego Exposition in the afternoon. Sunday was spent in Los Angeles, with side trips to Pasadena and other places.

A very weary and dusty party of pilgrims landed in San Francisco on Monday evening, after a perfect orgy of sight-seeing. When all have reached home and had time to recover from the weariness of so much sight-seeing in such a short space of time, and begun to recount the pleasures of the trip, it is certain that they will retain pleasant memories of the places visited, a higher opinion of Western hospitals and a deeper interest in the hospital work and workers of the West.

The Nurse Anesthetist

The nurse anesthetist still continues to be a thorn in the flesh to many medical men, and in their eyes a distinct menace to the welfare of the patient. By other medical men she is considered an indispensable assistant, so far superior to her predecessor, the interne, that they are prepared to take up arms in her behalf. This is distinctly a question for medical men to settle. Nurses did not invade this field till they were invited. Probably the Mayo brothers are responsible for the innovation spreading as it has. An editorial writer in the *American Journal of Surgery* in an article in the April, 1915, issue, has the following opinions on the subject:

"Hospital trustees," he says, "should be compelled to protect the lives of patients entrusted to their care, by having all general anesthetics administered by or under the supervision of staff or visiting anesthetists.

"In this connection it is imperative that the medical practice Acts of the various States be so amended as to abolish the present menace of the nurse-anesthetist, and that medical associations should question the ethical standing of those surgeons who persist in employing lay anesthetists, in the presence of competent, licensed practitioners, who are ready to undertake the work and shoulder its full responsibilities."

One cannot help wishing that the interne, who a few years ago had this field entirely to himself, had taken more serious interest in the subject, and attended to the task better than he did. If he had, the medical men would not now be trying to secure legislation to protect the world-in-general against the so-called "menace" of the nurse-anesthetist.

The nursing world is wide and probably every nurse who is doing this work could make a good living at some other line of nursing. Certainly, as soon as the medical world is agreed and ready for this work to be taken entirely out of nurses' hands, it will be done.

Gleanings

The Cancer Problem

At the request of Dr. Wainwright, of the Commission on Cancer of the Medical Society of the State of Pennsylvania, a number of the medical journals devoted their issues for July to a discussion of the above subject.

The opinion of the majority of eminent specialists is that surgery is the best method, although the opinion is expressed that medical science eventually will discover some other method. Dr. Henry R. Harrower expresses the hope that extracts of the so-called ductless glands may some day be found beneficial. Dr. Mulford K. Fisher, of Philadelphia, states that X-ray treatment after removal seemed to tend to prevent recurrence of cancer.

Irritation is ascribed as the most common cause. Dr. Robert Abbe, senior surgeon at St. Luke's Hospital, states that use of tobacco was a common cause of cancer of the mouth, and that of ninety men whose cases he had seen in his office, all but one were inveterate users of tobacco.

Dr. William S. Newcomet, of Philadelphia, discusses the use of radium in certain cases. Dr. L. Morgan Bulkley, of New York, pleads for continued investigation into the real basic cause of the disease, that it may result in a "more rational treatment than the present one, of attempting to remove only the product of the disease, the local tumor, while the cause of the formation of the malgrowth still remains active."

Other articles are contributed by Drs. William Seaman Bainbridge, John B. Deaver, James Ewing, S. Politzer, Wolff Freudenthal, Benham Snow, William N.

Berkeley, Francis Carter Wood, J. C. Hemmeter and John F. Erdmann.

In commenting upon the communications the editor of the *Medical Record* says:

"Surgical treatment does not afford an absolute cure, and herein lies the weakness of the contention that cancer in its early stages, or at any stage, is a purely local disease. The argument for early operation is based upon this theory, but the result of early operation in many cases seems to disprove it. On the other hand, the theory of an infectious origin, and the one which looks upon a malignant neoplasm as the local expression of a vice of metabolism, are equally uncertain.

"Many of the best minds in the profession are occupied solely with this problem, and it is inconceivable that none of them will ever discover the secret of malignancy and the cause and pathogenesis of malignant disease. Until that is done, however, all attempts at a cure will be but groping in the dark.

"We have intimated that no absolute cure for cancer will be found until the nature and origin of the disease are known, but it is possible that the true cause may be revealed as a consequence of stumbling upon a successful method of treatment. For this reason we believe it is wrong to oppose every therapeutic suggestion that does not fit in with the theories of the moment.

"Many theories, both therapeutic and pathogenic, in regard to cancer, are wildly improbable, yet there is none so fantastic that it may not contain a suggestion which some other clearer-visioned and more logical mind may seize upon and develop into a tenable and fruitful hypothesis."

Bedsores

In the *Nursing Mirror*, London, England (February 20, 1915), the following question was asked and very finely answered by a nurse who signs herself "Wendy."

Question—Describe what measures you would take for the cure of bedsore, both slight and serious. Remember that often a nurse is not called in—among the poor—till a bed sore has assumed large proportions, and remember, also, that sometimes—though, I admit, not often—the best nursing will not prevent a bed sore commencing. Neither water, nor air beds, nor pillows, nor painting with collodion, are to be mentioned.

Answer—The treatment of bedsore varies with the condition and circumstances of each patient. All require antiseptic treatment. Applications should exactly fit the wound. Pressure must be relieved. If possible, a doctor should be consulted and his orders carried out. If left to the nurse, in slight cases, with clean surface, apply ointment on lint. Zinc, boracic, resin, zinc and vaseline, zinc and castor oil are all suitable. Stimulate healing with lotio rubra or tinct. benzoin. If discharging, cleanse with antiseptic lotion. If sloughing, apply boracic fomentations two-hourly till slough removes. The longer it remains the deeper cavity there will be to heal. For cavities use fomentations of unraveled boracic lint. Change treatment if the bed sore does not improve. Variety in dressings is very important. Dry dressings are good. Dust the wound slightly with iodoform powder. Apply gauze and wool, or use dry boracic lint. Occasional starch poultices suit painful bedsore. Lead lotion does well. Continued use of boracic or any drug may cause tenderness on sensitive skins. In serious, offensive bedsore, after cleansing with antiseptic lotion—Condy, biniodide, lysol—peroxide of hydrogen is good. Apply linseed and charcoal poultices four-hourly. When fetor ceases use boracic fomentations. Neither poultice nor fomentation must be applied too hot,

owing to the low vitality of the tissues. If bleeding occurs, gently irrigate with warm alum water. Smear the dressing with castor oil to prevent it sticking. Use the many tail T or triangular bandages to secure the dressings. Avoid strapping on restless or old patients with wrinkled skin. To relieve pressure make ring pads of tow or wool, cover with soft, old linen; when soiled, they could be washed and remade. If possible, change patient's position frequently to distribute pressure; arrange a pulley to assist the patient in moving. Prevent constipation. Improve circulation by friction; keep up a circular movement with soapy hand for few minutes on pressure points when washed twice daily. Gently massage around bedsore. Bed and patient's clothing must be kept clean and changed when necessary. Make the bed carefully; keep the draw-sheet free from creases or crumbs. For incontinent cases protect the skin of sacrum and buttocks by rubbing in zinc and castor oil. Absorb discharges with tow, peat moss and wool pads; burn them afterwards. Give and remove bedpan gently. Bedsore are much affected by the patient's general health, which should be well cared for, and a nourishing, suitable diet, with plenty of fresh air, given.

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Charcoal in the Treatment of Membranous Enterocolitis

Roidet reports excellent results following the treatment of this usually intractable condition by means of large doses of poplar-wood charcoal. From two to four tablespoonfuls of the latter are given daily, mixed with water and administered after the mid-day and evening meals. The efficacy of this remedy is said to be due to its power to absorb gases from the stomach and intestine, to its antiseptic effect, and to its action in stimulating the contractility of the stomach.—*Journal de Medecine de Paris*.

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

Nursing Problems

To the Editor of The Trained Nurse:

Will you allow space for a letter from one who is not a nurse, not even a doctor, but who is only one of the sick men without whom the others could not exist, and who cannot understand some things included in or excluded from nursing?

I have been very, very sick. If I had been worse I could not have lived at all. I am sure of this because I was sick to the extent of \$150 a week and—well, I couldn't have been any sicker.

Now, I had two nurses—one blonde and one brunette. They both took THE TRAINED NURSE and let me read it. Some time ago I read in it some letters about a nurse who had dosed a patient with something without a doctor's orders. I don't want to write about that, I know nothing about it, and my own case is much worse. I realize that there is much behind the scenes in medical life that the sick man is only called upon to pay for but I turn to your readers, knowing no one else who can put me right.

First, I am informed that a nurse is not allowed to give "drugs" to any one without a doctor's orders.

Second, I am informed that table salt is included within the wide reach of what you call *materia medica*. I deduce therefrom that a nurse is forbidden by law to give table salt without a doctor's orders. Is my deduction correct? If so, why can she not be trusted at least to the extent that my cook is trusted?

Now, my nurse (the blonde one) used to salt my salad! I don't like salt in my salad and my cook knows it. She (the nurse) admitted that she had received no orders from the doctor, yet she salted my salad and *I don't like my salad salt*. Did she do right?

Also admitting that she was employed for my welfare, in whose employ was she? The doctor's? I paid her and presumably would have been responsible under the employer's liability laws had she broken her leg. I am sure the doctor wouldn't have been. Yet when I told her that I should discharge the doctor (because he

came to see me when intoxicated) and put myself in her hands, she said she could not remain with me. Why not? Was she working for the interests of a sick man or for an intoxicated doctor? Why has a nurse no obligations to her patient except to obey another of his employees against the wishes of her employer? Why should she alone be exempted from what the world considers common decency and obligation to her employer? Will you please explain?

Is it impossible for me to get a trained nurse to do *her* best for *me* or must I, if sick again, depend upon my cook and my parlormaid?

THE GROUCH.

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The Correspondence Course Nurse

To the Editor of The Trained Nurse:

In the July magazine appeared a letter in defense of the correspondence nurse. Its writer very plainly does not understand the real reason why hospital-trained nurses object to their correspondence-trained sister.

Few people deny the usefulness of the nurse who is less than a hospital graduate. The partially trained nurse doubtless has her place in the community, just as the pupil nurse, who is likewise partially trained, has her place in the hospital. Please note that we even admit that the so-called "experienced" nurse *may* fill a useful place.

The real issue lies in the fact that many correspondence nurses misrepresent themselves. Nurses with hospital training who for some reason gave up their course before they graduated frequently do the same. There is a very strong temptation to any one who has had a year or so of training and who feels that she can take good care of the average sick person to at least tacitly assert that she is *as good as* a graduate. From this position it is not far to *letting people think* that she is a graduate, if she does not go even further and actually pose as a graduate properly accredited.

It is the deception which is so very commonly

practised by correspondence schools and by their graduates to which we object. The schools invariably advertise that their training will produce a *nurse*, whose services shall be worth up to \$30 a week. This says, by implication, that they produce graduate nurses; the fact being that most people measure ability by price. If a nurse announces that she is worth \$25 per week, they assume that she is a graduate and, therefore, skilled in all branches.

The correspondence nurse may, despite the deception practised by her school in assuring her, tacitly, of course, that she is the equal of the average hospital graduate, start out with the intention of being honest. Conditions are against her, however. The simple facts that she wears a full nurse's uniform and cap, and asks to be paid \$21 or \$25 per week makes most persons suppose that she is a hospital graduate, and she has not the heart to go out of her way to correct them. Few patients, and few doctors, ask outright if a nurse is a graduate, and even a hospital-trained nurse almost never shows her diploma or is asked to. The deception is so subtle, the doctor and the patient are so ready to take things for granted (remember that they are not at all interested in a nurse's training, but chiefly in her personality), that it is the exceptional woman who does not fall into it.

Correspondence schools deceive in implying at least the high quality of their graduates. They undertake to make a nurse out of any material whatsoever. Who ever heard of a correspondence school taking any one on probation or refusing her at the end of it? Yet the fact is, that most good hospitals refuse as many applicants as they accept, simply because they know that one must have the proper material out of which to make a nurse. Is one not justified in looking with suspicion upon an institution which deliberately undertakes the impossible? We know that they are not going to succeed in many cases in making even a fairly good nurse. And when both they and their product leads the public to think that she is what she is not, we have still further ground for criticism. M. G., R.N.



Books Which Have Helped Me

To the Editor of the Trained Nurse:

Here is a list of books that I have found useful for reading to patients during convalescence:

Rebecca of Sunnybrook Farm, Modern Chronicles of Rebecca, Helen's Babies, Laddie, a True Blue Story, Cy Whittaker's Place, Emmy Lou,

Mrs. Wiggs of the Cabbage Patch, Idle Thoughts of an Idle Fellow, Molly Make-Believe, Daddy-Long-Legs, Pollyanna, The Doctor (Connor), The Blue Flower (Van Dyke), Old Lady 31, Penrod.

This list includes only a few of the many bright and cheerful books that are easily procured from any public library.

HARRIET J. CARROLL, R.N.



Giving a Child Medicine

To the Editor of The Trained Nurse:

Acting upon a suggestion in a recent number, I am sending an account of an experience of mine. I was called to a family that had no experience with a nurse, and were prepared to disapprove of them in general. When I started to give my nine-year-old patient his medicine, he protested so lustily that the whole family rushed in. They were sure that he would take it for them. They each tried, but with no more success than I had had, for he screamed, spit at and fought them all. This scene was repeated when nourishment came due. I explained the best I could the absolute necessity of his taking medicine, food and water, telling them it would be less tax on his nerves and strength to have the liquids forced down. They did not take kindly to the idea, so I invited them to remain in and see for themselves.

After pinning both hands close to his sides, by means of a towel passed under his hips, I placed the little finger of my left hand inside of his right cheek, slightly stretching the corner of his mouth, while from a small pitcher I poured the medicine into his mouth. He was unable to spit, not having control of his lips, and before he could scream he had to swallow the liquid to prevent choking. As soon as it was all swallowed I unpinned his hands and he seemed quite as willing to rest as fight.

That was the last interference from the family. After a few such feedings he took what was offered without protest and, in fact, became quite anxious to take it, for I rewarded each dose, taken quietly, with a paper soldier or other picture card.

T. E. S., R.N.



A Practical Suggestion

To the Editor of The Trained Nurse:

Here is a remedy for the removal of warts which may sound like "old wives' stories," and as I am a nurse, and with not the right to prescribe, I am not offering this for the benefit of patients

but for the benefit of some sister nurse, who, like myself, may have tried every known remedy, to rid her hands of warts. I had what the laity would call a seed wart, growing closely around the nail of my little finger, and another one on the inside of my fourth finger, of the same hand. I had tried all the usual remedies without success, and had decided to have them removed with the knife. Quite by accident I got some milk from the poppy plant on one of them, and I noticed that part of it came off; so next day I applied more, and the wart was gone. Then I applied it to the other one, and it disappeared in like manner. This was two years ago, and my hand is still free from warts. I would add that this remedy was used before the passage of the Harrison Act, so perhaps you will need a doctor's prescription to use it now.

P. E. F.

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Answer to Question in July

To the Editor of The Trained Nurse:

In answer to the question of E. G. C., whether

a nurse should receive pay or any part thereof when an obstetrical case turns out to be false pregnancy, and she is given a month's notice. In my opinion it would be perfectly absurd for her to expect a cent, for she surely had not been refusing other cases previous to the notice she received of the false pregnancy. On the other hand, if the patient had been unreasonable enough to expect her to stay at home until her date of confinement, then by all means she should be paid for time lost.

PENNSYLVANIA.

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The Hospital Pin

To the Editor of The Trained Nurse:

Will you please tell me whether or not it is considered good taste for a nurse to wear a hospital or an R.N. pin on any other dress but her uniform? I enjoy reading your valuable magazine very much and feel that I would not want to be without it.

M. B. P.



GRADUATING CLASS, BLOOMSBURG HOSPITAL, BLOOMSBURG, PA.

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

The International Convention of Nurses

The International Convention of Nurses was held in San Francisco the week of June 20-26. Although intended to be international, it was hardly more than national in character, as, owing to the European war, the only foreign delegates able to attend were two from England, one from Holland and one representing Australia. Something like three hundred delegates were present, besides a good many visiting nurses, who came to San Francisco to attend the meetings and see the Exposition.

On Monday morning, June 21, the regular convention opened, though the three organizations did not meet together until evening. There was no morning meeting of the American Nurses' Association, the time from 8.30 to 11.30 A.M. being devoted to the registration of delegates and guests and the giving out of badges, but at ten o'clock the National League of Nursing Education held its business meeting, the only business meeting at which any but delegates were allowed to be present. The chief business consisted of the reports from various committees. Presenting Miss Nutting's report of the work at Teachers College, Miss Goodrich spoke of requests being received there for some one to come to training schools to take complete charge of the theoretical work, thus separating it entirely from that of the superintendent, of the next step being a university training school in connection with a hospital, for which an endowment of \$1,000,000 would be needed, thus putting at least one school of nursing on a sound economic basis, and of demand for a course in anesthesia. She said that as yet the demands for graduates of the college exceeded the supply and that advertising of the courses was therefore needed rather among the nurses than the general public. A report was made of the Isabel Hampton Robb Fund, with the plans for a loan fund for students, a traveling fellowship, scholarships, etc. Only \$15,000 have as yet been received of the \$50,000 originally determined upon. The committee on membership reported forty-four names of individuals and three of State Leagues. The collegiate and vocational guidance committees reported the sending out of pam-

phlet and the giving of talks, the former to college students, the latter to pupils in high schools.

The National Organization for Public Health Nursing also held morning meetings of committees and a general meeting for the presentation of reports and performance of business. In the afternoon the American Nurses' Association held its meeting, only delegates being allowed. Reports from officers and committees were heard. At four o'clock there was a recess and tea was served, after which Mrs. Rose V. S. Berry gave a most interesting and enjoyable talk on "The Art of the Exposition."

The first general session was held Monday evening in the First Congregational Church, Miss Cooke, president of the American Nurses' Association, in the chair. After an invocation by the Very Rev. J. Wilmer Gresham, Dean of Grace Cathedral, Mrs. Frederick G. Sanborn, president of the Woman's Board of the Panama-Pacific International Exposition, gave an address of welcome from the women of California and the Exposition. Miss Annie W. Goodrich, of Teachers College, responded. She spoke of the influence the war had had on the attendance at the convention, of the discouraging and inspiring aspects of the absence of many nurses in Europe. She ended by saying that State and Nation should assume some responsibility for the training of the nurses and that they should not rest until the doors of the universities were opened to them.

In her address Miss Genevieve Cooke spoke of the pleasure of the California nurses in having the convention in their State. She said the education of the nurse was one of the serious problems. The true nurse should not only possess technical skill and experience in surgery, but should understand souls in distress. She must come to recognize that the development of the soul is not a peaceful development but a conflict between high ideals and low standards, a constant struggle. She spoke of the problem of caring for people of moderate means and of the suggestion that there be three classes of nurses, but made a plea for one first-class standard only.

Miss Clara D. Noyes, as president of the National League of Nursing Education, like both

her predecessors, made a reference to the war and its effect upon the convention. On the schools the future of the profession depends, she said, and while unendowed they cannot properly be called educational institutions, but only a part of the hospital. They fail to realize their duty to the pupil as well as the patient, and the pupil is more important to the public after her graduation than she is to the hospital. It is the time to work for endowments for schools, education, professional recognition, and it is necessary for all to work together.

Miss Crandall spoke for Miss Mary Gardner, president of the National Organization for Public Health Nursing. She gave a history of public health nursing, emphasizing the need of organization and of efficiency, and said nurses were in danger of forgetting that if they used only body and mind, leaving out the spirit, they might do no more than those working without training. The public health nurse should not only nurse but bring her influence to bear upon the whole life of the men and women she meets from before birth until death.

On Tuesday morning, June 22, the polls opened at 9 A.M. for the election of officers for 1915-1916, to remain open until Thursday noon. At 9 A.M. also a meeting was held of boards of examiners, with Miss Lauder Sutherland, of Hartford, Conn., as chairman. The subjects discussed were headquarters, administration, location, office, equipment, clerks, etc., and examination questions. The National Organization for Public Health Nursing met at 9 A.M., under the direction of the committee on membership and finance, Mrs. J. L. Houghteling, of Chicago, chairman, to hear a paper on "Successful Organization Financed," by Mr. W. T. Selleck, manager of the San Francisco Industrial Bureau. The discussion was led by Mr. Robert Newton Lynch, vice-president and manager of the San Francisco Chamber of Commerce, and manager of the California Development Fund.

At 10 A.M. the private duty session was held, under the chairmanship of Miss Frances M. Ott, of Morocco, Ind. In opening Miss Ott urged the private nurses to be readier to speak and take their part in organized work. She implied there was only place for the public health, and private nurses in the family in times of sickness, not for attendants or pupils.

Miss Sophia L. Rutley, nurse registrar, read a paper on "The Private Duty Nurse and Her Relation to the Registry." She discussed how the nurse could help the directory and the directory the nurse, maintaining the desirability of one

central directory and pointing out the advantages afforded the nurse in the way of a permanent address, advice and sympathy, recommendations to positions. Miss Katherine Hyde, who has charge of the San Francisco County Association registry, next read a paper on "The Business Woman as Registrar." The business man, she said, has an article of merit and then advertises. So the directory list must be made up of nurses of known merit and character. The physician will not employ nurses he does not know. All nurses should join central directory and give its address instead of trying to build up a clientele of their own. Discussion was opened by Miss Minnie H. Ahrens, of Chicago, who spoke of the importance of having as registrar a woman who could select the right nurse from the list for each case. The ideal was a nurse who was also a business woman, but that she should be a nurse was most important.

In the absence of Miss Bessie Graham, of South Bend, Ind., who was to have read a paper on "Loyalty and What We Owe Our Schools," Miss Polluck read a paper by Miss Edith Ryan, on "The Value of the Alumnae Association to the Nurse." Miss Nettie Woods Guthrie, of Philadelphia, had a paper on "Contagious Nursing in the Home, According to Modern Methods," but she gave merely the ordinary routine of a not particularly up-to-date kind. A paper by Miss Alice Dalbey, of Springfield, Ill., on "Characteristics Requisite for a Private Duty Nurse," was read. The one word, "tact," was said to embody all the requisites of the nurse. Education was most necessary, and that she came from a good home desirable. Some training for private work outside the wards was desirable. A keen sense of humor was considered desirable and a quiet taste in dress. Religion was most important.

The following private duty committee was chosen from the floor for next year: Miss Ott, chairman; Miss Golding, of New York; Miss Baird, of Massachusetts; Miss Creech, of New Jersey; Miss McIntosh, of Philadelphia; Miss Peterson, of Pasadena.

At 11 A.M. the National League of Nursing Education had a conference on training school problems, Miss Noyes in the chair. Miss Mary Riddle, of the Newton Hospital, Newton, Mass., spoke on "The Social Life of Student Nurses." Miss Elsa Maurer, of Bellevue Hospital, New York, gave a paper on "The Planning and Furnishing of Classrooms."

In the afternoon at two o'clock a general session was held, Miss Crandall presiding, in the absence of Miss Cooke. In opening, Miss Cran-

dall said that because district nursing had become largely charity and because it did not meet all the problems of the family in times of sickness, household nursing had arisen to meet these problems and was run on a paying basis. Hourly nursing was older, however, and would have developed more if organized and advertised. District, hourly and private nursing were needed to round out home nursing. The first paper was by Miss Mary Riddle, on "The Origin, Growth and Future Development of Hourly Nursing." Twenty-five years ago, she said, there was an over-supply of nurses of all kinds, and people were considering how to get more work for the graduate nurses and better care for people of moderate means. The first of these problems has been met with the growth of hospitals and public health work, as well as private nursing, but the second remains unsolved. The people of moderate means need skilled care, not a nurse of Class B or C. Suggestions of lower charges or pay from an outsider savor of charity. Hourly nursing was tried, but difficulty was found in a patient getting the nurse at the right hour and the nurse could not make enough. Hourly nurses now care largely for chronic cases, but that does not help those of moderate means. Physicians should teach that much of the time of nursing service in the home is unnecessary and lay sentiment aside and stick to business. The patient should not be called on to pay a greater price by having a nurse all the time, because that is helpful to the doctor. Only the patient should be considered where the nurse is not considered at all. The matter of hours in the case of the hourly nurse could be adjusted by having a higher price for the more desirable hours and the nurse might make it understood that the sickest must be cared for first. Hourly nursing could be made successful by groups of nurses joining together, arranging an office to be open day and night, furnishing a nurse for a day or night or even longer and charging fair prices. It might even be well to have an attendant. Small capital would be needed where the nurses were living together, but they would need courage, business ability, willingness to work.

Speaking of the work of Mr. Richard M. Bradley as a challenge to the nursing profession, Miss Crandall next introduced Miss Isabel Clark, as the reader of his paper on "Household Nursing in Its Relation to Other Similar Services." In this the facts were brought out that untrained nurses were doing 80 to 90 per cent. of the nursing and often doing it well, that the trained nurse has done little in moderate homes where continuous care was needed, and is even losing ground, that the

criticism of untrained nurses has kept some good women from taking up the work, so that the standard is lower than it was. However, the untrained nurse was the first to recognize that it was essential to the patient's recovery that the household go right and to meet this need. The trained nurse has too often ignored the household side. There is need of adjustment between these two workers and that it can be effected has been proved at Brattleboro, where continuous care is largely given by attendants under the supervision of a trained nurse. The combination of different kinds of laborers is normal and the work that keeps the family together is better than that which puts the fragments together. Skilled care should be provided when necessary, but there must be no charity. The trained nurse has something to teach and also something to learn from one who has seen a need and tried to fill it.

The paper of Mrs. John H. Lowman, of Cleveland, Ohio, was read by Miss Crandall. Nursing was said to be organized for the rich and the poor, who appeal particularly to the imagination and a need to exist for care of those of moderate means. Yet no valuable standards secured by the trained nurse should be sacrificed. Only the best doctors realize the need of the best nursing care between their visits. So all sorts of young women are posing as nurses. Hospital care is perhaps ideal, but cannot be provided for all. Perhaps people could club together and engage the nurse by the year, in which case she could work for less. She must not only nurse the sick but help the well, improving the general public health. Most plants of household nursing are subsidized, but so is police protection, fire protection, etc. Why should not the District Nursing Association and the Alumnae Association join hands?

Dr. Lee K. Frankel, of the Metropolitan Life Insurance Company, of New York, spoke of the importance of keeping records and quoted many statistics. These last seemed too uncertain, however, to warrant the drawing of any conclusions. Miss Crandall said the 5,000 nurses doing public health work could never handle all the public health work that needed doing, but that private nurses by doing hourly and household nursing can round out their work.

From four to five o'clock a social hour was enjoyed and from five to six there were round tables on organization and administration, tuberculosis and mental hygiene. At eight o'clock in the evening another general session was held in Festival Hall on the Exposition grounds, with Miss Noyes in the chair. Mr. Brown presented to the American Nurses' Association a testimonial from the

Panama-Pacific International Exposition. Miss Goodrich received the testimonial in behalf of the Association.

The first speaker was Edwin R. Snyder, Ph.D., commissioner of vocational and industrial education in California, who spoke on "The Vocational Trend in Education." After considerable talk on apprenticeship and the rising of nursing to the professional basis, he said too much time was wasted on subjects having no relation to the work to be followed, as mathematics, apparently forgetting the mental discipline of such studies. Secondary schools do not fit their graduates for life. Girls should be fitted for home making, and the same subjects would fit them for nursing. If you raise the standards for nurses too high, you increase the cost of nurses. You cannot train all nurses with a long training and nurse all people. Three classes of nurses are needed: (1) Special nurses, (2) general nurses with a long training, and (3) preliminary nurses to care for cases that are not serious or are convalescent, the physician to decide which is to be employed. When Miss Noyes took issue regarding the education of the nurse, Dr. Snyder said: "You would not have 30,000 nurses now, if you had had a course as long as the medical course."

Miss Edna Rich, president of the State Normal School of Manual Arts and Home Economics at Santa Barbara, Cal., spoke very interestingly on "Possible Cooperation Between State Normal Schools and Training Schools." She said the school trained women in home making, sanitation, personal hygiene, economy, right living. Much of the illness in the world comes from ignorance of the laws of nutrition, and restaurants and boarding houses fail for the same reason. She planned a course especially for nurses, but had not had enough applicants.

Dr. Downing, of New York State, was invited from the audience to speak. He spoke with great enthusiasm of the advance of nursing from an occupation to a profession, of the need of academic and scientific training, and the desirability of vocational training from the secondary schools up, and said that no one had a right in a profession without an academic training. He hoped to see at least a high-school diploma required for entrance into the New York training schools. His remarks called forth great applause.

On Wednesday, June 23, the National Organization for Public Health Nursing held a section meeting at 9 A.M., under the direction of the committee on school nursing, Miss Lina Rogers Struthers chairman.

Dr. Clinton P. McCord, chief medical inspector

at Albany, N. Y., spoke on "The School Nurse." After the paper there were reports on school nursing from various sections of the country, Miss Edna G. Bridgeford, of Albany, N. Y., reporting on "Its Advance in the Northeastern States," Miss Coralie H. Johnston, of Richmond, Va., on "Its Progress in the Southern States," Miss Helen W. Kelly, of Chicago, on "Its Status in the Middle States," Mrs. Edith M. Hickey, of Seattle, Wash., on "Its Scope in the Western States," and Miss Lina R. Struthers, of Toronto, Canada, on "Some Interesting Points in England and Canada."

At 10 A.M. the American Nurses' Association held a Red Cross session, Miss Genevieve Cooke presiding. The paper of Dr. Adelaide Brown, member of the State Board of Health of California, on "The Opportunity and Responsibility of Public Health Nurses in Relation to Social Hygiene," was read at this meeting instead of before the National Organization for Public Health Nursing as scheduled. Dr. Brown gave an interesting account of the educational campaign against venereal disease and prostitution that is being waged in Oregon and California.

In her talk on "Red Cross Town and Country Nursing Service," Miss Fannie F. Clement, of the service in Washington, D. C., spoke of the general interest now in rural conditions, of the poor health conditions in the country as regards water, sewerage, etc., and gave a history of the origin of the Red Cross rural service.

Miss Katherine Kraft, of Jerome, Ariz., read a paper on "A Red Cross Visiting Nurse in Arizona," and gave a clear idea of the bad conditions existing in the mining camps and of the difficulties the nurse encounters in trying to combat them. One of the greatest needs, she said, was medical inspection. Other needs were the registration of midwives, a kindergarten for the children of working mothers, and a social center for the community.

The paper by Miss Sara E. Parsons, of Boston, Mass., on "The Effect of American Red Cross Standards on Training Schools, Nurse Organizations and the Nursing Profession" was read by Miss Dean. The recognition of the training school at first as an economical way of getting work done in the hospital, and the recognition that only legislation could better conditions. Registration effected this betterment, but only after strong opposition from the schools and when in New York it was found the educational equivalent was not being well interpreted, and credentials were required to be sent to Albany, the opposition was so strong they almost despaired. Then

the Red Cross came to their aid by setting the same standards. Of course, all graduates wished to belong to the Red Cross, and the schools wanted their graduates eligible.

Papers were also read by Miss Dorothea Mann, Red Cross nurse from duty in Gleiwitz, Germany, on "Has Red Cross Relief Work in Europe Been Worth While?" and by Miss Mathild Krueger, Supervising Nurse Unit No. 2, Geogelia, Serbia, on "Personal Experiences in Serbia."

At 11 A.M. the National League of Nursing Education had a conference on "Teaching in Training Schools," Miss Noyes chairman.

Miss Harriet Gillette, instructor Long Island College Hospital, Brooklyn, N. Y., spoke on "How to Help Pupils Study," after which Miss Anna M. Nicholson, of the department of education, Sacramento, Cal., read a very interesting paper on "What Constitutes Good Teaching?" The importance of teaching to the nation is, she said, that it preserves the ideals. Some women are better adapted to nurse than others, and there is need of vocational guiding and cooperation with the high schools, both for proper persons and preliminary education. The teacher is very important and she needs special training. She must enter into the life of the students, must know them. She must give them an idea of service, teach them ethics, must show the pupil the relation of her work to that of the institution. She should keep her faith both in herself and in her pupils. This last is the greatest help. Text-books should be tools, not an aim in themselves, and should be supplemented with reading in reference books. The product of the teacher's art should be human character and efficiency.

Miss Carry M. Hall, of the Peter Bent Brigham Hospital in Boston, Mass., gave a brief account of "The Teaching of Housekeeping in the Training School" from experience in her own hospital. She emphasized the importance of cleanliness and order and of fixing responsibility and advocated leaving much of the cleaning to ward maids.

The general afternoon session was held in the Greek Theatre at Berkeley. It was under the auspices of the International Council of Nurses, with Miss Goodrich in the chair, and the American Hospital Association as guests, though few attended.

Neither the governor, the Hon. Hiram Johnson, Major General Gorgas nor Dr. Winford Smith, attended, but Mr. Chester H. Rowell, Commissioner of the Exposition, spoke of the rapid advance in the nursing profession. He referred to the California registration law and to the eight-hour law, which he said was an educational

law to guarantee the nurses time to be students. He said nursing was a trained profession, but not yet a learned profession. The time would come when the possibility of having the services of the nurse would be measured by the need and not by the ability to pay, and it would come at the public expense and be a great economy.

Miss Sophia Palmer's paper on "The Power of the Professional Press" was largely taken up with a very long account of the history of journalism. Since the establishment of our official organ, she said, we have gone forward with remarkable rapidity, implying a sequence of cause and result that is far from clear. She deprecated the lack of restraint and disregard of privacy shown by the press, and the making the financial consideration paramount. She also spoke of the need of a complete reorganization of nursing education and advocated the establishment of central schools or departments in colleges for the preliminary training of the nurse, as relieving the hospital of the responsibility of training except where bedside observation was necessary, and giving all the same preparation. The public—hospital, medical and general—must be educated and can easily be educated through the professional journals. Smaller nursing magazines may serve to spread ideals and standards, but there is danger in establishing too many.

Dr. Henry B. Favill, of Chicago, gave his paper on "What the Medical Profession Can Contribute to Nursing Education" and it was one of the best papers of the convention. He said: A nurse should take up the work, not as a mission, but as a livelihood, but her work should, through experience, develop into a mission by the time she is graduated. This is effected in individuals, but not in general. The educational qualifications demanded should be good but one must be cautious in making them too high. The general rule of a high-school education is good, but it should not be universal. Some women with little education could not be spared. The rule should not be too hard and fast. A general rule of admission is needed as an index of aspiration, not as a modicum of knowledge. The education required is not crucial. What the nurse does need, more than any one, unless it be the physician, is a social consciousness, a knowledge of her relationship to the great problems of life. This is where the failure comes. The nurse needs to get into close touch with her patients in their hour of weakness and guide them. How can the medical profession assist? Probably they can assist most by the older men of experience being willing to teach in

the training schools and to help create an atmosphere.

There was no evening meeting.

(To be continued)



Spanish-American War Nurses

The sixteenth annual convention of the Spanish-American War Nurses will be held in San Francisco, Cal., August 9 to 13, 1915. Headquarters, Sutter Hotel, Sutter and Kearney Streets. The program, as arranged, follows:

Monday, August 9, 8 P.M.—Reminiscence meeting, registration, parlors Sutter Hotel.

Tuesday, August 10, 9 A.M.—Executive committee meeting, Assembly Room, Sutter Hotel. 10 to 12 A.M.—Invocation, Rev. Joseph McQuaid, Chaplain S. A. W. V. Address of welcome, Mayor James Rolph, Jr.; response and annual address, President Isabel Harroun, Pasadena, Cal.; 2 to 4.30 P.M.—Business meeting, officers' and camp reports; 7.30 P.M.—Seeing Exposition.

Wednesday, August 11, 9 to 12 A.M.—Business meeting; 2 P.M.—Seeing San Francisco, Presidio, Letterman General Hospital; informal tea at Nurses' Home, Miss L. Keener, C.N., hostess; 7.30 P.M.—Seeing Exposition.

Thursday, August 12—Spanish-American War Nurses' Day at Exposition. 9 to 12 A.M.—Business meeting; 2 to 5 P.M.—Reception and tea in California Building, Exposition grounds. Hostesses: Miss Laura McKinstry, Mrs. Charles W. Slack, Mrs. E. R. Dimond. 7.30 P.M.—Seeing Exposition grounds.

Friday, August 13, 9 to 12 A.M.—Business meeting, election of officers; 1 P.M.—Informal luncheon and adios.



Arkansas

The graduates of the spring class of 1915, from St. Vincent's Training School, Little Rock, Ark., are: Miss Lilian Atwood, Miss Fannie Hill, Miss Janet Browne and Miss Charlie Davenport.

The nurses of St. Vincent's Training School completed a course in diatetics in April, for which purpose a diet kitchen was especially fitted up in the year of 1914, with Miss Frankie Hutchinson as dietitian.

Miss Katherine Hoyng, graduate nurse of St. Vincent's Training School, Little Rock, Ark., spring class of 1914, who entered the novitiate of the Sisters of Mercy Convent, received the white veil in April, 1915. A number of her classmates

and sister nurses witnessed the solemn ceremony, and wish her much happiness in the life of self-sacrifice she has chosen. Miss Hoyng is now Sister Ramond. Miss Gertrude T. Groben, graduate nurse of the spring class of 1914, of St. Vincent's Training School, Little Rock, Ark., who has been doing private nursing, has returned to that institution to accept the position of head nurse in the operating room.



Colorado

The Colorado State Board of Nurse Examiners will meet at the Capitol Building, Denver, during the week of September 20, 1915, to examine applicants for registration under the new law which is now in effect. For information apply to Louise Perrin, R.N., secretary, State House, Denver, Colo.



Connecticut

The fourth semi-annual meeting of the Connecticut State League of Nursing Education took place May 5, in Waterbury, Conn. In the absence of Miss Evelyn M. Wilson, the president (who is serving with the Canadian soldiers in France) Miss R. Inde Albaugh presided. Various reports and matters of interest were discussed and acted upon. Miss Lauder Sutherland, of Hartford, was delegated to represent the League at the California meeting. Four new members were added to the roll, and Miss Harriet Allyn, of the Griffin Hospital, Derby, chosen to fill Miss Wilson's unexpired term as president. The meeting, a most interesting and successful one, was held in the Second Congregational Church. An excellent lunch was served by the Graduate Nurses' Association.



Maryland

The graduating exercises of the Allegany Hospital Training School, conducted by the Sisters of Charity, Cumberland, Md., were held in Carroll Hall on Wednesday evening, June 2, at 7 P.M.

The young ladies of St. Patrick's High School rendered a select musical program. Very Rev. E. J. Wunder, pastor of St. Patrick's Church, presented the diplomas, and addressed to the graduates a few words of congratulations and opportune advice. Mr. A. A. Doub made the principal address. After congratulating the members of the class upon having successfully completed their studies for the noble profession of a nurse, he pictured the advantages and difficulties attached to



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their profession, in which their first motive should be to do good, and their best reward the consciousness of duties well performed, and the happiness that comes from having served their fellow men.

The graduates are: Misses Jessie R. Cross, Barton, Md.; Irene M. Piper, Frostburg, Md.; E. Maude Spiker, Dobbin, W. Va., and M. Virginia Beasley, M. Virginia Almarode, Anna M. Ketzner and Leah V. Shields, of Cumberland, Md.

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Mississippi

The Forrest Club was the scene of the graduating exercises of the Hattiesburg Hospital School of Nurses Tuesday evening, June 8, when diplomas were awarded three young ladies, Misses Willie Lela Rowland, Bertha King and Sara Margaret Ferguson. Interesting addresses were made by Prof. W. I. Thames, of the Normal College; Rev. George H. Thompson, presiding elder of the Hattiesburg District, and H. G. McCormick, M.D., of Laurel, and prayers offered by Revs. T. W. Green and W. L. Linfield. Dr. T. E. Ross introduced the speakers and awarded the diplomas, as well as giving to each graduate, on behalf of the board of directors, a beautiful gold pin bearing the seal of the Hattiesburg Hospital.

Miss Jennie M. Quin, head nurse of the hospital, made a short but impressive address to the class, and before receiving their diplomas the graduates gave a pledge of allegiance to their profession. Between the addresses a musical program was rendered.

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New York

Twenty-three young women and one young man received diplomas at the graduating exercises of the Kings Park State Hospital Training School for Nurses on June 7. Many friends attended the exercises. The introductory remarks were made by Dr. William Austin Macey, superintendent of the hospital, and the address of the day was made by Magistrate Alfred E. Steers. The presentation of the diplomas was made by Charles E. Teale, of Brooklyn, president of the board of managers of the school. The invocation was by the Rev. N. H. Hudson, pastor of the Methodist Episcopal Church, while the benediction was pronounced by the Rev. John L. J. Smith, priest in charge of St. Joseph's Catholic Church.

The Middletown State Homeopathic Hospital Nurses' Alumni Association has become associated with the New York State Nurses' Association.

This alumni now has 118 members. Its first annual meeting was held at the hospital June 1, with 64 members present, including many from other cities. A business meeting was held from 7 to 8 P.M., and election of officers for the year resulted as follows: Agnes M. Valley, president; Annie Nearn, vice-president; Elizabeth Moran, secretary; Nellie Bull, treasurer. Executive committee: Louise Schaefer and Sadie Dedrick. Luncheon was served, followed by dancing. The decorations were extensive and beautiful.

The graduating exercises of the Class of 1915 of the Middletown State Homeopathic Hospital, Middletown, N. Y., was held in the Amusement Hall at the hospital, Tuesday evening, June 22, from eight o'clock. The program was as follows:

Music, orchestra; address, Hon. John C. R. Taylor, member of board of managers; class address, Lillian Pearl Roosa; class prophecy, Carrie Halwick; music, orchestra; response to prophecy, Ruth Cropsey; address to juniors, Ellen Loretta McCarthy; vote of thanks to Alma Mater, Bessie Louise Furman; music, orchestra; nurse's oath, Miss Agnes M. Valley, principal of training school; presentation of diplomas, Dr. Maurice C. Ashley, superintendent; music, orchestra; graduates' reception; dancing, nine to twelve. Those who received diplomas are: Ruth Cropsey, Bessie Louise Furman, Carrie Halwick, Ellen Loretta McCarthy, Lillian Pearl Roosa, James J. Brien.

The average of this class is 97 per cent., and each graduate has received the purple seal. The high-honor graduate, Miss Ruth Cropsey, was presented with a sterling silver thermometer, the prize given by the board of managers.

The exercises were followed by dancing until twelve o'clock, after which dinner was served. The hall and dining rooms were handsomely and appropriately decorated. The class colors are blue and white. The motto "*Nihil Sine Labore.*"

The annual commencement exercises of the Sanitarium Training School for Nurses, Clifton Springs, were held on Thursday evening, June 10, in the Sanitarium chapel. The exercises opened with the invocation by Rev. S. H. Adams, chaplain of the sanitarium. An address was given by Dr. M. S. Woodbury, medical superintendent, and the diplomas and school pins were presented by Dr. F. W. Spaulding, senior member of the faculty. Parting words were given by Mrs. Henry Foster, secretary of the board of trustees, then the benediction was pronounced by the chaplain. Following the exercises a reception

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was held in the beautifully decorated gymnasium of the sanitarium.

The graduates are: Mary E. McIntosh, Sadie S. Tugwell, Mabel T. Lyon, Florence I. Cober, Elizabeth C. Patton, Margaret H. McFadden, Stella M. Ellis, Esther C. Cornell, Lila E. Finlay.

A number of social affairs were given in connection with the commencement exercises at the sanitarium, beginning the previous week, when the class was entertained by the juniors in an auto ride, followed by a dainty tea in the nurses' parlor. On Monday, the 7th, the Alumnae gave the class an auto ride to Geneva, followed by a supper at the Seneca; Tuesday a reception was given in the sanitarium gymnasium by the Classes of 1916 and 1917; Wednesday a reception in the parlor by Miss Patton, a member of the class; Thursday commencement exercises; Friday the Alumnae Association held its annual meeting, when eleven nurses were admitted for membership; then followed a banquet in honor of the new members, at the close of which a number of toasts were given; then with the singing of "Auld Lang Syne" we closed the festive days of dear commencement time.

The Alumnae Association of the Troy Hospital Training School tendered the members of this year's class a charming reception and banquet at the red room of the Rensselaer, with the attending physicians as guests. The graduates are: The Misses Marguerite Duke, Gertrude Plunkett, Irene O'Donnell, Mary Dunn, Catherine O'Keefe, Helen Flynn, Ella Powers, Josephine Curtin, Margaret Whelan. Miss Frances Galvin, president of the Association, gave a splendid address of welcome, to which Miss Helen J. Flynn, president of the Class of 1915, responded. The prophecy, humorous in most of its details, was delivered by Miss Gertrude Plunkett. Dr. D. W. Houston gave a very interesting talk, in which he spoke of the ethics of nursing, and he also gave a comparison of the profession of today with that of the past. Woman's sphere of usefulness was cited and in concluding he offered good advice and helpful suggestions. The tables were prettily arranged with red and white roses, and the class colors, lavender and yellow, were used in decoration. After the banquet dancing was enjoyed, and a concert on the Edison Diamond Disc Phonograph was provided by H. W. Bates. Guests were present from New York, Albany and Amsterdam. The committee which so successfully arranged the affair comprised the Misses Helen Roarke, Beatrice Noonan, Helen McMahon, Margaret Callahan and Katherine Corcoran.

The graduating exercises of the twentieth class of the National Training School for Certified Nurses was held in the Auditorium of the Albany Institute Historical and Art Society, June 10. There were forty-seven members of the class. The exercises were as follows: Invocation, Rev. Alexander H. Abbott. Addresses by Dr. Christian G. Hacker, Mr. Porter Lee Merriman, Rev. Alexander H. Abbott and Hon. Martin H. Glynn, former Governor of New York. The certificates were conferred by the president, William O. Stillman. Mrs. Mary A. S. Bowman delivered the valedictory. There was also a musical program. The class motto: "Let the reward of duty be duty itself."



Ohio

A Bill to regulate the practice of nursing in the State of Ohio.

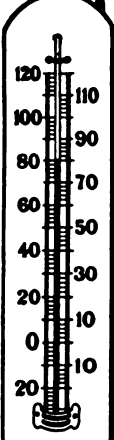
Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. Within sixty days after this act becomes operative the State Medical Board shall employ a secretary, entrance examiner and three nurses; said three nurses, with the secretary of the State medical board, shall constitute the nurses' examining committee, this committee to be chosen from ten nominations made by the Ohio Association of Graduate Nurses. The secretary of the State medical board shall be the secretary and executive officer of the committee. One nurse shall be employed for one year, one for two years, and one for three years, and thereafter as the term of any nurse expires a successor shall be employed in the manner hereinbefore specified for a term of three years. One of the nurses so employed shall be designated as chief examiner. The secretary shall have the power to administer oaths. Each person so employed shall file with the secretary an affidavit that she is a resident of Ohio, a graduate of a recognized training school for nurses and in addition thereto, she shall have had not less than five years' experience in nursing.

SECTION 2. Each member of the nurses' examining committee, except the secretary, shall receive five dollars for each day employed in the discharge of her official duties and her necessary expenses so incurred, except the secretary, entrance examiner and chief examiner, who shall receive an annual salary, to be fixed by the State medical board, and their necessary expenses incurred in the performance of their official duties.

SECTION 3. The nurses' examining committee shall meet in Columbus on the second Tuesday of January and July of each year, and at such other times and places as the State medical board may direct.

SECTION 4. The secretary of the nurses' examining committee shall keep a record of its proceedings. The secretary shall also keep a register of applicants for certificates, showing the name of the applicant; the name and location of the institution granting her a certificate or diploma of graduation in nursing, and whether she was granted or refused a certificate. The books and



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records of the committee shall be prima facie evidence of matters therein contained.

SECTION 5. On and after January 1, 1916, no person shall practise nursing as a registered nurse in this State without first complying with the requirements of this act. All graduates in nursing shall either personally or by letter or proxy, present their diplomas to the nurses' examining committee for verification. Accompanying such diploma the applicant shall file an affidavit, duly attested, stating that the applicant is the person named in the diploma and is the lawful possessor of the same. The applicant shall state date of birth and the actual time spent in the study of nursing. If the committee shall find the diploma to be genuine and from a nurses' training school in good standing, connected with a hospital or sanatorium in good standing, as defined by the State medical board, and the person named therein to be the person holding and presenting the same, and that said person has paid the fee as hereinafter provided for the examination of applicants, the committee shall issue a certificate to that effect, signed by its secretary and chief examiner; such certificate, when left with the probate judge for record as hereinafter required, shall be conclusive evidence that its owner is entitled to practise nursing as a registered nurse in this State. All other persons desiring to engage in such practice in this State, shall apply to the nurses' examining committee for a certificate, and submit to the examination hereinafter provided, except that all students who were on May 1, 1915, matriculated in a training school for nurses located in the State of Ohio, recognized by the State medical board of Ohio, and who shall have graduated subsequent to May 1, 1915, and who shall file their diploma for registration prior to June 1, 1918, shall receive certificates as heretofore provided. The applicant shall file with the secretary a written application, under oath, on a form prescribed by the State medical board, and provide proof that said applicant is more than twenty-one years of age and of good moral character. The applicant shall file documentary evidence that before matriculating in a training school for nurses, said applicant received an education equivalent to that required for completion of the first year of a high-school course of the first grade in this State, or four units of high school work as defined in the school laws of Ohio, and evaluated by the entrance examiner of the State medical board in the same manner as provided in Section 1270 of the General Code of Ohio, and a diploma of graduation from a training school in good standing, connected with a hospital or sanatorium in good standing, as defined by the State medical board, at the time the diploma was issued. At the time of application the applicant shall present with diploma with the affidavit that said applicant is the person named therein and is the lawful possessor thereof, stating date of birth, residence, the training school or schools at which said applicant obtained education and training in nursing, the time spent in each, the time spent in the study and training of nursing and such other facts as the State medical board requires. If engaged in the practice of nursing, the affidavit shall state the period during which and the place where said nurse has been so engaged.

SECTION 6. If the committee find the appli-

cant possesses the credentials necessary for admission to the examination, that the diploma is genuine and was granted by a training school for nurses in good standing connected with a hospital or sanatorium in good standing as defined by the State medical board, that the person named in the diploma is the person holding and presenting it and is of good moral character, the committee shall admit the applicant to an examination.

SECTION 7. The examination of applicants for certificates to practise nursing shall be conducted under rules prescribed by the State medical board. Each applicant shall be examined in anatomy, physiology, obstetrics, bacteriology, hygiene, materia medica, dietetics, practical nursing and such other subjects as the board and committee may require.

SECTION 8. If the applicant pass such examination and has paid the fee required by law, the committee shall issue its certificate to this effect, signed by its secretary and the chief examiner. Such certificate when deposited for record with the probate judge as required by law, shall be conclusive evidence that the person to whom it is issued is entitled to practise as a registered nurse in this State. An affirmative vote of not less than three members of the committee is required for the issuance of a certificate.

SECTION 9. The nurses' examining committee may refuse to grant a certificate to a person guilty of fraud in passing the examination, or at any time guilty of felony or gross immorality, or addicted to the liquor or drug habit to such a degree as to render said person unfit to practise nursing as a registered nurse. Upon notice and hearing the committee, by a vote of not less than three members, may revoke or suspend a certificate for like cause or causes. Such certificate may also be revoked or suspended on proof of violation of the rules and requirements established by the State medical board regulating the practice of nursing.

SECTION 10. An appeal may be taken from the action of the nurses' examining committee refusing to grant, revoking or suspending a certificate, for the causes named in the preceding section, to the State medical board, whose decision affirming or overruling the action of the committee shall be final.

SECTION 11. Each applicant for a certificate to practise nursing as a registered nurse in this State shall pay a fee of not to exceed \$10 for examination. The fees for examination shall be paid in advance to the treasurer of the State medical board and by him paid into the State treasury to the credit of a fund for the use of the said board in the enforcement of this act.

SECTION 12. Each person who receives a certificate to practise nursing as a registered nurse, before beginning to practise must deposit said certificate for record with the probate judge of the county in which said person resides. The probate judge shall record in a book kept for that purpose and indorse on the margin of the record and on the certificate the time when he received it for record and make an index to all certificates thus received and recorded. The probate judge shall also note the revocation or suspension of a certificate. The holder of a certificate must keep said certificate on record with the probate judge

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of the county in which actual residence is established.

SECTION 13. For services under the provisions of this chapter, the probate judge shall receive from the holder of the certificate a fee of fifty cents.

SECTION 14. During the month of December in each year, the probate judge shall furnish the secretary of the nurses' examining committee a list of certificates recorded and in force, and certificates revoked or suspended.

SECTION 15. The State medical board may dispense with the examination of a nurse duly authorized to practise nursing as a registered nurse in another State, or the District of Columbia, who wishes to remove from such State or district and reside and practise as a registered nurse in this State, upon said nurse complying with the rules and requirements established by the State medical board regulating such matters, and upon the payment of a fee of not more than \$10; provided the laws of such State or district require of the nurses practising therein qualifications of a grade equal to those required of nurses practising in the State of Ohio, and equal rights are accorded by such State or district to nurses in Ohio holding a certificate of the State medical board who desire to remove to, reside and practise as a registered nurse in such State or district.

SECTION 16. All persons shall be regarded as practising nursing as registered nurses within the meaning of this Act who use the words or letters "R.N.," "Registered Nurse," or any other title in connection with their names which in any way represent them as registered nurses, or who by any means accept employment by representing themselves as registered nurses.

SECTION 17. Nothing contained in this Act shall be construed in any way to prevent or prohibit the performance of services either with or without compensation in nursing the sick or injured by any person, provided such services are not performed by such person as a registered nurse.

SECTION 18. The compensation and expenses of the members and officers of the nurses' examining committee, and the necessary expenses of the committee shall be paid from a fund in the State treasury for the use of the board in the enforcement of this Act, upon a warrant of the auditor of State, issued upon vouchers signed by the president and secretary of the State medical board.

SECTION 19. The secretary of the nurses' examining committee shall enforce the provisions of the law relating to the practice of nursing in this State. If he has knowledge or notice of the violation of such law, he shall investigate the matter and upon probable cause appearing shall file a complaint and prosecute the offender. When requested by the secretary, the prosecuting attorney of the proper county shall take charge of and conduct such prosecution.

SECTION 20. Whoever practises nursing as a registered nurse, without first obtaining a certificate from the nurses' examining committee of the State medical board, in the manner required herein or so practises nursing as a registered nurse after such a certificate has been duly revoked or, if suspended, during the time of such suspension, shall be fined not to exceed one hundred dollars. A certificate duly certified by the secretary of the

nurses' examining committee to the effect that it appears from the records of the nurses' examining committee that no certificate to practise as a registered nurse in the State of Ohio has been issued to any person or persons specified therein, or that a certificate, if issued, has been revoked or suspended, shall be received as prima facie evidence of the record in any court or before any officer of the State.

SECTION 21. All fines collected under the preceding section shall be paid to the State medical board, and by it paid into the State treasury to the credit of the fund herein provided.

SECTION 22. Nothing in this Act shall, in any way, be construed to be in conflict with the laws of this State relating to the practice of medicine and surgery.



Oklahoma

The parlors of St. Anthony's Hospital were the scene of delightful graduating exercises Wednesday, May 19, when nine members of the training school connected with the hospital were given their diplomas as trained nurses. The graduates were Sister Mary Augustine, Sister Mary Monica, Sister Mary Loyola, Sister Mary Bernarda, Nona Esther Longworth, Mamie Clare McCarthy, Ethel Beard, Emma Poschel and Caroline Walch.

In the absence of Rt. Rev. Bishop Meerscheart, Rev. Urban De Hasfue made the opening address. Dr. M. Smith followed with a talk, the subject of which was "The Trained Nurse." He referred to the high calling of the professional nurse ministering to the needs of suffering humanity. Dr. H. Reed presented the diplomas in a few well-chosen words on their future work. Miss Lucy C. Maguire presented the pins. Miss Caroline Walch was valedictorian. The ceremony closed with the bestowal of flowers, followed by a reception.



Pennsylvania

The regular monthly meeting of the Alumnae Association of the Woman's Hospital of Philadelphia, was held May 12, at the County Nurses' Club, 1520 Arch Street. The minutes of the April meeting were read and approved and the treasurer's report referred to the auditing committee. There were thirteen members present and a number of interesting topics discussed—principally the four new amendments to the bill of State Registration for Nurses of Pennsylvania. Every member is hoping for the reappointment of Miss West, on the board of examiners, and a strong letter has been written to the Governor of Pennsylvania from the Alumnae to that effect. On May 19, twelve nurses were graduated from the Woman's Hospital Training School, and on the 20th the Alumnae gave a tea to the grad-

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uates, which was greatly enjoyed by all present. Mrs. Entwisle had entire charge of the affair and we extend our hearty thanks to her for the success, she being chairman of the entertainment committee. The room was decorated in blue and gold iris, class flowers and colors, and ice-cream, cake, sandwiches and tea and coffee were served. Two new members were received at the last meeting. Miss Guthrie (president of Association) was elected as delegate to the A. N. A. convention, held in San Francisco, Cal., in June. Next meeting will be held June 9. On motion adjourned.

Graduating exercises of the Friends' Hospital Training School for Nurses, of Frankford, Pa., were held on June 4, 1915. Presentation of diplomas by president of the board of managers, Alexander C. Wood, to the following graduates: Margaret M. Cuttle, of Tyrone, Ireland; Julia C. Driscoll, Danville, Pa.; Helen G. Flaghouse, Frankford, Pa.; Grace Churchill Greene, Tyrone, Ireland; Ada Estella Harris, Concord, N. C.; Helen Cecil O'Brien, Media, Pa.; Mary F. O'Brien, Media, Pa.; Marion Dexter Packard, New Hampshire; Bessye Lee Sewell, Maryland; Edith Walhay, Gettysburg, Pa.; Kathryn Annett West, Danville, Pa. The annual address was made by Stanley R. Yarnall, principal of Friends' School, Germantown. The Alumni held its meeting before the exercises with President Mrs. Jessie Urich in chair, secretary Rose Kerstan and treasurer Blanche Maxfield. Eighty members of the Alumni were present. Following the exercises a collation was served on the lawn, after which the visitors inspected the buildings and grounds of the institution.

Friends' Hospital was founded in 1813 and until February 1915, had been known as Friends' Asylum. In the past year it has also affiliated with the Samaritan Hospital, Philadelphia, for a one-year post-graduate course.

At the fourteenth annual commencement exercises of the training school for nurses of the Washington Hospital, Washington, held in the First United Presbyterian Church on Tuesday evening, June 8, a class of six was graduated. Invocation, Dr. W. E. Slemmons; address, Dr. Henry W. Temple; presentation of diplomas and medals, Dr. J. Y. Scott; organ solos, Miss Margaret Acheson; vocal solos, Miss Elizabeth Miller and Mrs. Z. McCutcheon; benediction, Dr. Henry Woods. The alumnae of the school reorganized for the coming year by electing the following officers: President, Miss Mary D. Hanlon; trea-

surer, Miss Emily Skelton; secretary, Miss Hazel Dunham, of the graduating class. The members of the graduating class follow: Miss Ruth J. Coon, Miss Hazel Dunham, Miss Jean A. McClintock, Miss Helen Frances Curry, Miss Millicent Jenkins and Miss Mildred Stukins.

The ninth annual commencement of the Bloomsburg Hospital Training School was held at the Columbia Theatre on the evening of May 20, with most interesting exercises. The Invocation was by Dr. D. J. Waller. The presentation of class pins by Ruth Sharretts, president Nurses' Alumnae. The address to the graduating class was delivered by the Rev. C. M. Barnitz, the orator of the evening. Dr. J. S. John conferred the diplomas and Dr. D. J. Waller awarded the prizes. There was also a fine musical program. The following are prize winners: Helen Winifred McHugh, first prize, highest average in graduating class; Mary Catherine Cain, second prize, for proficiency in bandaging. Helen Winifred McHugh, third prize, proficiency in dietetics. Gertrude Anna Lenahan, fourth prize, highest average in junior class.

The graduating exercises of the Dixmont Hospital Training School for Nurses held graduating exercises Thursday evening, June 10, in the chapel of the hospital, with the following program: Prayer, Rev. Henry H. Forsyth; address to graduates, Dewitt B. Nettleton, M.D.; presentation of diplomas, David A. Reed, Esq. The exercises were followed by dancing. The graduates are: Nell Sorrells, Docia M. Weaver, Martha E. Bennett, Jean Wiltshire, Mary Walsh, Louise Hahn. The annual meeting of the Alumnae Association was held in the afternoon. Six new members joined the Association. After seventeen years' service at the station and post-office of Dixmont, Pa., Mr. C. N. Shults, our highly esteemed postmaster, accepted a more lucrative position. In appreciation of his kindness the past years, a gold watch and chain was presented by the employees of the Dixmont Hospital, the fund being started by the Graduate Nurses' Alumnae Association.



Washington

The State Graduate Nurses' Association held its annual meeting at Seattle, June 10 and 11, at the Y. W. C. A. The program for Thursday A.M. included addresses of welcome by Hon. W. E. Humphrey, Dr. F. L. Horsfall, Miss Southmayd and Miss M. S. Loomis. Responses by Miss S. S.

(Continued on page 134)

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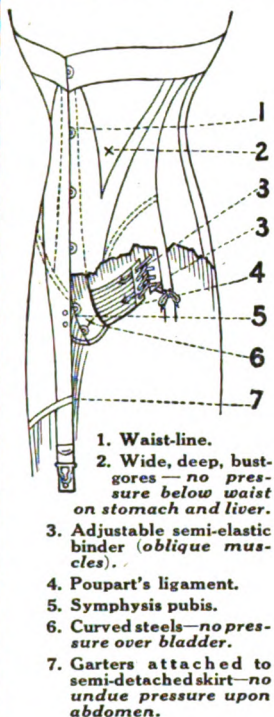
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Book Reviews

Essentials of Medical Electricity for Medical Students and Nurses. By George K. Abbott, M.D., Professor of Clinical Medicine, College of Medical Evangelists, Loma Linda, Cal. 12mo of 132 pages with 87 illustrations. W. B. Saunders Company, Philadelphia, 1915. Cloth, \$1.25.

In this book Dr. Abbott presents a brief manual on electrotherapy in such simplified terms as to make it serviceable for first instruction, and yet complete enough in the scientific basis of medical electricity to cover the main fundamental principles of its therapeutic application.

The author states that the teacher will find it necessary to add much oral instruction, and to use and dissect or construct before the class electric appliances and apparatus. To each of the chapters the author has thought suitable for nurses, a short list of review questions has been appended. The book is finely and profusely illustrated.



Psychology and Mental Disease. By C. B. Burr, M.D., Medical Director of Oak Grove Hospital, Flint, Mich.; formerly Medical Superintendent of the Eastern Michigan Asylum. Fourth edition, revised and enlarged, with illustrations. F. A. Davis Co., Philadelphia. Price \$1.50.

This book has been reviewed in our columns as each succeeding edition appeared, and needs no introduction to our old subscribers. To those not familiar with it we would state that it is intended as a handbook for use in training schools for nurses and attendants, and in medical classes, and as a ready reference for the practitioner. That it has reached its fourth edition is sufficient evidence that it has been found increasingly useful to those for whom it is intended.

The present revision concerns itself largely with those portions of especial interest to medical men. There will be found a new section entitled, "Symbolism in Sanity and in Insanity." Studies have been made of certain paranoid and hysterical states on the basis of Freud's researches, and a more detailed description of symptoms and symptom groups incorporated. The section on

"Management of Cases of Insanity from the Medical Standpoint" has been much amplified.

In speaking of the desirable qualities for the mental nurse, Dr. Burr emphasizes one of which we hear little in this connection. He says: "In enumerating the desirable qualities of a nurse, I would emphasize the importance of one—the sense of humor. Years of experience with those in attendance upon the insane has firmly fixed in mind the belief that the nurse who sees the amusing side, who notes her patients' whimsies and departures from conventional standards of acting and expression and derives amusement from them is practically safe and dependable, so far as intentional or even impulsive unkindness is concerned."



A Manual of Personal Hygiene: Proper Living Upon a Physiologic Basis. By American authors. Edited by Walter L. Pyle, M.D., Philadelphia. Sixth edition, revised and enlarged. 12mo of 543 pages, 138 illustrations. W. B. Saunders Company, Philadelphia, 1915. Cloth, \$1.50 net.

Dr. Pyle's work sets forth the best means of preventing disease—the best means to perfect health. It discusses in clear, simple language the care of the teeth, skin, complexion and hair, bathing, clothing, mouth breathing and its cure, catching cold; singing, care of the eyes, school hygiene, body posture, ventilation, heating, water supply, house-cleaning, etc. Dr. Wiley has contributed a chapter on food adulteration. The present edition contains a new chapter on the "Hygiene of Infancy."



Mothercraft. By Sarah Comstock. Illustrated, \$1.00 net, Hearst's International Library Company, New York.

The aim of this book, the chapters of which first appeared in the *Good Housekeeping Magazine*, is to teach how the inexperienced mother of yesterday can become the expert mother of tomorrow. The material upon which the book is based has been sifted from the teachings and preachings

"She Who Nurses One Must Nourish Two"

Prolonged lactation usually reduces the power of the mother to provide adequate and proper nourishment for her infant.

The value of a liquid product of Malt and Hops (when properly prepared) to increase not only the amount of milk but especially the fat content, is universally recognized.

But it **must be** a real medicinal preparation of Malt and Hops, not a cheap dark beer, masquerading as such.



It should be

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Malt-Nutrine
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which is the STANDARD MEDICINAL MALT preparation of its class.

MALT NUTRINE is a liquid food-tonic—not a beverage.

It is the product of skill and experience in the chemistry of brewing.

Malt-Nutrine is intended for Physicians' Prescriptions.

It stimulates appetite, improves digestion, nourishes the tissues, and increases the quantity and quality of milk.

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ERGOAPIOL (Smith) is a singularly potent utero-ovarian anodyne, sedative and tonic. It exerts a direct influence on the generative system and proves unusually efficacious in the various anomalies of menstruation arising from constitutional disturbances, atonicity of the reproductive organs, inflammatory conditions of the uterus or its appendages, mental emotions or exposure to inclement weather.

As an analgesic in gynecological cases, Ergoapiol (Smith) is superior to opium or coal-tar derivatives in that, besides relieving pain without exposing the patient to the danger of drug addiction, it also offers a tonic and restorative action upon the pelvic viscera.

It is a uterine and ovarian sedative of unsurpassed value and is especially serviceable in the treatment of congestive and inflammatory conditions of these organs.

The anodyne action of the preparation on the reproductive organs is evidenced by the promptness with which it relieves pain attending the catamenial flow, and its antispasmodic influence is manifested by the uniformity with which it allays nervous excitement due to ovarian irritability or other local causes.

Ergoapiol (Smith) proves notably efficacious in amenorrhea, dysmenorrhea and menorrhagia.



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ERGOAPIOL (Smith) is supplied only in packages containing twenty capsules.

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FOR INVALIDS and those recovering from influenza, typhoid fever and other illness. Made into gruel or barley water is a food constantly recommended by Physicians.

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Washington—Continued from page 128

Burns, R.N., and Mrs. Fletcher. President's address, reports of committees, and a paper, "Standards of the Graduate Nurse," by Miss Ella Wilkinson, R.N. Afternoon session, "Preventive Medicine and the Trained Nurse," by Dr. B. J. Lloyd, and Suregon-General W. C. Rucker, Washington, D. C. "Diseases of the Mouth," Isobel Wilson, R.N. Election of officers and automobile ride for visiting nurses.

Friday morning session: "Red Cross Work," Miss M. A. Loomis, R.N. "Recent Methods in Medical Nursing," Ethel Moore, R.N. "The Harrison Act," Attorney Clay Allen. "Caloric Feeding," Miss M. Smith, R.N. "Nursing Ethics," Edith Weller, R.N. "Post-Operative Treatment," Miss H. Newburg, R.N. "Post-Obstetrical Complications," Miss Buob, R.N. The afternoon session was devoted to a discussion of "Public Health Nursing" in all its phases. In the evening there was a banquet at the Y. W.C.A.

**Marriages**

On June 7, 1915, at the Central Presbyterian Church, Denver, Colo., Eleanor Lee, superintendent of nurses of the Park Avenue Hospital, Denver, to Walter H. Olin, commissioner of agriculture of the Denver & Rio Grande.

On June 23, 1915, at Beverly Farms, Mass., Ruth Larcom Hardy, graduate nurse of the Faulkner Hospital, to August H. Haffenreffer.

On June 2, 1915, at Lancaster, Mass., Mary E. McLaughlin to Patrick A. Lynch.

On June 5, 1915, Sarah McCann, of Waltham, Mass., graduate nurse of the Providence Hospital, to John Franklin Smith, of Providence, R. I.

On June 16, at Malden, Mass., Laura B. Southerland, of Melrose Highlands, Mass., to Arthur D. Gordon, of Reading, Mass.

Recently, Florence Couch, R.N., graduate nurse of Mt. Pleasant (Pa.) Memorial Hospital, Class of 1907, to Bolton Pore, of Mt. Pleasant. Miss Couch had been assistant superintendent of the Mt. Pleasant Hospital for the past six years, and in appreciation of efficient service rendered, the Ladies' Aid Society of the hospital gave a reception in her honor, and presented her with a substantial check. The Nurses' Alumnae Association, of which she is one of the charter members, also presented her a sum of money.

On June 16, 1915, at the Orthodox Congregational Church, Arlington, Mass., Fannie Ethel Gratto, graduate nurse, to Rev. Ralph Hartley Rowse.

On June 23, 1915, at Williamstown, Mass., Ethel A. Pattison, graduate nurse of Troy (N. Y.) Hospital, Class of 1908, to Dr. William Silcocks, of Green Island, N. Y.

On May 10, 1915, at Little Rock, Ark., Myrtle Young, graduate nurse of St. Vincent's Training School, Class of 1912, to George R. Overman. Mr. and Mrs. Overman will make their home in Little Rock.

On June 2, 1915, at Little Rock, Ark., Carrie Craig, graduate nurse of St. Vincent's Training School, Class of 1909, and president of the Nurses' Alumnae Association, to A. W. Eatherly. Mr. and Mrs. Eatherly will make their home in Little Rock.

**Births**

On May 4, 1915, at Little Rock, Ark., to Mr. and Mrs. Joe C. Berg, a daughter. Mrs. Berg was, before her marriage, Miss Lena Darscheid, graduate nurse of St. Vincent's Hospital, Class of 1912.

**Personal**

Miss H. T. McGovern, R.N., graduate of the Lawrence General Hospital, Class 1908, has accepted the position as head nurse and assistant anesthetizer at the Massachusetts Charitable Eye and Ear Infirmary, Boston, Mass.

Abby M. Wernette, of Grand Rapids, Mich., has been appointed public health nurse of Glens Falls, N. Y.

J. Helena Hooper, superintendent of the Contagious Hospital, Salem Neck, Mass., has tendered her resignation owing to ill health.

Sybil Smith, of Saco, Me., has received a temporary appointment as assistant superintendent of the Portsmouth (N. H.) Hospital, to succeed Alice Birtwell, who has been granted leave of absence, during which she will take up army nursing in England.]

Miss Hawthorne, of Springfield (Mass.) Hospital, has succeeded Miss Stewart as assistant superintendent at Johnson Hospital, Stafford Springs Conn.

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TRADE MARK
POWDER



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"For ten years in my work as a nurse I have depended upon Sykes' Comfort Powder with excellent results to soothe and heal skin soreness. I was recently called to a case of an old man, 84 years of age, who had been confined to his bed for months, and his body was simply covered with terrible sores. I immediately commenced to use Sykes' Comfort Powder as thick as I could sift it on and you ought to have seen the change that took place within twenty-four hours, and the sores were soon healed."—Mrs. C. L. Frost, Nurse, Catatunk, N. Y.

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The choice flavors of the cream, foreign fruits, nuts and other materials that may be combined with Knox Sparkling Gelatine, appeal to the imagination and the fancy, and the making of desserts becomes a fascinating pleasure that one enjoys and looks forward to from day to day. Even with such common and prosaic articles as apples, prunes and bananas, associated with Knox Sparkling Gelatine, the plain cook may make many pretty dishes that are most pleasing to the taste and sight.



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The feather-weight Dimity Quilt made at Allendale, R. I., makes an ideal summer bed covering, especially for the invalid. These quilts are as light and easy to wash as a sheet, and are most attractive in appearance. A line to Dimity Quilt Company, Department W., Allendale, Providence, R. I., will bring price lists and samples.

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Solmides are recommended in all conditions where the bromides are indicated, including epilepsy, nervous excitation, hysteria, infantile convulsions, tetanus, strychnine poisoning, neuralgia, delirium tremens, nymphomania, nervous dysmenorrhea, etc.

They dissolve quickly and should be administered during effervescence. Being perfectly soluble, they are quickly absorbed and are also eliminated more quickly; hence there is less likelihood of "Bromism." The unpleasant taste of the bromides has been overcome and Solmides can, therefore, be administered to patients who are not able to take or retain other preparations of these salts. Sharp & Dohme, Baltimore.



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Thousands of bottles have been sent gratuitously to physicians, nurses and hospitals, and the results obtained speak for its high quality and efficacy. It is neutral and agreeable to take, so the physician need have no hesitation in recommending it to his patient.

Vaseline White Mineral Oil is put up in bottles and tins. Any further information may be obtained by applying to the Chesebrough Manufacturing Company, Consolidated, 17 State Street, New York City, N. Y.



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MOST digestive disturbance, disorder or deficiency is due to functional derangement of some one or more phases in the digestive cycle.

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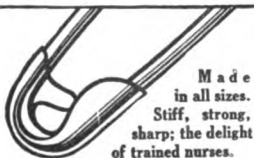
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Brooks Barley

Brooks Barley Company of Boston are preparing a fine barley flour that has won the endorsement of physicians all over the country for its excellence. It is called Brooks' Baby Barley and retails for twenty-five cents per pound package.

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Correctness and Dignity in Nurse Apparel

Everybody admires the dignity and charming simplicity of the strictly tailored uniforms worn by nurses (or Sisters of Mercy, as nurses are called in Europe).

Unless the uniform is cut along correct lines, fits well, hangs gracefully and is finished with skillful care, it is not "a thing of beauty" to the patient nor a joy and comfort to the wearer.

Nurses who take particular pride as to their uniforms are invited to ask for the well-known "Dix-Make," made in the model workrooms of Henry A. Dix & Sons Company, who have furnished all the uniforms to the American Red Cross in the present European war, and who have devoted nineteen years to the specialized effort to produce the best in nurses' apparel.

The Dix-Make Uniforms are sold by leading stores everywhere.



A Hospital Ironing Equipment

Ironing by hand has proved such a slow and expensive method that modern hospitals are now installing machines with very satisfactory results.

Actual tests made on the Thor Electric Ironing Machines have demonstrated that in ninety minutes one person can do as much work as would ordinarily require a full afternoon.

The tendency is, of course, to eliminate hand

labor wherever a machine can be found to do it better; and there seems to be no place where new ways and means can more logically be put into force than in the hospital laundry. Many institutions which now have washing machines still have the ironing done by hand. We anticipate the early and general use of the ironing machine, however, by institutions where efficiency is a matter regarded as worthy of study and application.



Pollantin Observations

The failure to secure uniform results is due more or less to the indiscreet action of the patient—the omission to apply even the simplest prophylactic precaution, such as closing the windows at night—at least to the windward—forgetting that the causal agent is everywhere present. And again harboring in the house certain plants—lily of the valley, asters, honeysuckle, chrysanthemums, cornflower and goldenrod, all of whose pollen are toxic.

Withal, and not the least contributory cause in cases not under the physician's absolute control, is the omission of the patient, after enjoying a few days' freedom from the ailment, to faithfully continue the morning treatment.



"Nurse's Friend"

Every nurse keeps her "kit" ready for an emergency call, and it invariably comprises articles and remedies upon which she relies for the greatest aid in her work. It is surprising to find how many nurses include a box of Sykes Comfort Powder and refer to it as a "Nurse's Friend." This is because years of experience has proved to them that there are few remedies that so quickly soothe, comfort and heal skin soreness caused by chafing, rashes, scalding and bed sores, as does Comfort Powder. For more than twenty years it has been used and endorsed by leading physicians, nurses and hospitals.



Royal Cook Book

A fund of most useful information about cooking and baking is found in the new edition of the cook book prepared for their friends and patrons by the Royal Baking Powder Company of New York. Formulas for every kind of cookery, ranging from the simplest to the most elaborate, with plain and carefully prepared directions, make the book one of the most practical and useful of its class. A postal card to the publishers, giving name and address, will bring the book to any of the readers of THE TRAINED NURSE free of charge.

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Dispensaries Without Hospitals

MICHAEL M. DAVIS, JR., PH.D.

Director of the Boston Dispensary, Boston, Mass.

A PRECEDING article has been devoted to explaining the value of a dispensary established as an out-patient department of a hospital, and another article to the methods of organizing and maintaining such a department; but in this country there are many hundred dispensaries not connected with hospitals and the question is often asked: "Are such dispensaries desirable? If so, when and how?"

A few large dispensaries not connected with hospitals are to be found in certain cities, particularly New York, Philadelphia, Chicago and Boston; but the typical dispensary of large size is an out-patient department of a hospital. On the other hand, when a typical dispensary is not connected with a hospital, it is usually an institution of small or moderate size, receiving from 500 to 5,000 patients annually; and most such dispensaries draw their patients from a prescribed local area or limit the cases received to certain specified diseases. In the country today there are from 600 to 800 such clinics. Why have they been established? Most frequently for the reason that somebody felt they were *needed*. Anti-tuberculosis committees, visiting nurse associations, infant welfare committees, charity organization societies and even churches have inquired of themselves whether the

health needs of the poorer people in their community were fully met. When the answer was in the negative, as it often was, they have propounded the further question: "Should we not establish a dispensary to help meet these needs?" Interest in public health work is increasing; therefore, more dispensaries are yearly arising. Possibly, therefore, it may be timely and useful to describe the policy and organization of successful dispensaries of this type.

The best description is a concrete example, for which we shall take the Maverick Dispensary in East Boston. East Boston is part of the city of Boston, but is practically an island and relatively isolated from the rest of the city. The population is 60,000. Boston is a great medical center, whose hospitals and other institutions are known the country over; but in East Boston there is no hospital and the growing population there, largely industrial, presented so many obvious needs that a dispensary was organized a few years ago.

As the 1914 report of the Maverick Dispensary explains, its purpose and aim is:

1. To supply the medical needs of those persons living in East Boston unable otherwise to secure adequate service.

2. To make such medical service more efficient by the aid of social service and of

skillful cooperation with existing agencies.

3. To seek through cure, education; through education, prevention of disease.

The Dispensary leases a small, three-story building, of which the main floor and half of the second floor are used for clinical purposes, the top floor for the residence of the nurse and social worker (one person) who has charge of the Dispensary. With her live usually one or two other nurses or friends not necessarily engaged in the building.

As to organization, the general clinic is in charge of a single physician, who receives a salary and is on service the year around, except for a reasonable vacation. The admission of patients is entirely in charge of the nurse and social worker, with an assistant. Each new patient is tactfully questioned, the financial circumstances ascertained, the character of the medical need determined, and, on the basis of this investigation, which is carried on in a screened corner of the waiting room, the patient is either accepted or rejected. The executive head is a trained nurse of experience, who also holds a diploma from the Boston School for Social Workers. She assists the physician in the clinics as nurse, with additional help from another nurse in certain parts of the work. The regular clinics are held in the morning and on two afternoons a week. There is also an eye clinic and on two or three mornings a dental clinic. These special clinics are open to adults, but are chiefly used by school children, who are brought by the school nurses on the recommendation of the medical school inspector. One morning a pre-natal clinic is held and one afternoon a clinic for well babies in connection with the so-called milk station (which is open every morning in the building before the clinic begins). The District Nursing Association of Boston has its local (East Boston) headquarters in the building, and the nurse attached to the milk station has her office there also; so that they are all in close touch with one another and with the head nurse

of the Dispensary. The school nurses provided by the city are, as will be seen, frequent visitors to the building.

Finally, the physician of the Dispensary is also employed by another institution as a district physician to treat the sick poor in their homes without charge. He receives \$800 a year for the joint work, which takes about four hours a day, divided nearly equally between the dispensary clinic and the visiting in the homes.

The number and classification of patients treated at the Maverick Dispensary was as follows, during the twelve months ending September 1, 1914:

	Number of Visits	New Patients
Medical.....	1,490	759
Surgical.....	1,999	809
Obstetrical.....	48	29
Dental.....	1,171	513
Eye.....	503	183
	5,211	2,293

As to cost, the running expenses of this institution, receiving 5,211 visits during 1914, were \$2,935. The approximate average cost per visit was thus 56 cents. The Dispensary charges small fees, 20 cents a visit, and nominal fees for dental and optical treatment; but no patients are rejected if they cannot pay. These fees brought last year about \$1,116 or about 30 per cent. of the total expenses of the institution.

The medical policy of this Dispensary is typical of the proper policy of such a local institution, unconnected with a hospital. It cannot afford elaborate diagnostic equipment with extensive laboratory service and X-ray; nor can it have a number of specialists on service simultaneously for joint work on difficult cases. Therefore, in justice to its patients, it should not attempt to diagnose doubtful or difficult cases, much less treat them; but it should refer them to the appropriate physician, specialist or medical institution and, through its social worker, nurse, or other agent, see that they actually

reach their destination. One-third of all the 2,300 patients were actually referred thus last year. Such a dispensary should emphasize the importance of early diagnosis of disease and should welcome persons presenting only minor complaints. It should lay stress on preventive work. Thus it must be a health center in the sense of pooling all the interests and agencies of the locality which make for public health.

The Maverick Dispensary thus brings together the interests of five different committees or societies and organizes in one building their relationships in behalf of the 60,000 people of East Boston, while, at the same time, it cooperates closely with the nurses and physicians provided by the municipality. It specializes in certain branches of preventive work through its prenatal clinic and its clinic for the supervision of well babies. It emphasizes the importance of providing social work where needed in conjunction with medical and does this to a great extent by utilizing charitable agencies—*e.g.*, the Associated Charities. It is thus a center for *organizing* health work and social work, as well as for *doing* them. The success of the clinic has been striking, as evidenced by a growth in numbers of about 100 per cent. during the last three years, during which period this policy has been developed.

The Maverick Dispensary has been described merely as a type of many dispensaries throughout the country, not connected with hospitals. The physician of the Maverick Dispensary is more favorably situated for his work than were he in a city of 50,000 or 100,000 persons. Isolated though East Boston is, in a measure, it is nevertheless accessible to the large hospitals, dispensaries and laboratories of Boston, so that for consultation purposes in special cases these resources are at the physician's command. Nevertheless a dispensary in a small city can secure the services of the best physicians of the town as consultants, if the proper organi-

zation is made and the cooperation of the local or State Board of Health is enlisted for laboratory work. The main task is to utilize to the utmost all available resources.

Of the existing dispensaries not connected with hospitals, the majority have been established for dealing with special diseases or problems, particularly tuberculosis and public hygiene. To a considerable degree, the establishment of dispensary clinics separate from hospitals have come about through the demand for treating certain special diseases. Tuberculosis was the first great scourge against which a national campaign was organized. Ten years ago there were eighteen tuberculosis out-patient clinics in the country. Today there are more than four hundred. In several States, the establishment of tuberculosis dispensaries is required by law, even in small cities.

Dispensary clinics for babies (often joined with the so-called milk station) represent another form of dispensary work, preventive in character, which has grown wonderfully in many parts of the country during recent years. The establishment of medical inspection of schools has revealed hosts of physical defects among pupils which call for remedies; as in a large proportion of cases the parents of the children cannot afford to pay for the medical services required, some special provision must be made, or else the defects will go unremedied. Now, a majority of these defects are in special organs, particularly the eyes, ears and teeth. Dispensary clinics for treating eye diseases and for testing the eyes and for prescribing and fitting glasses are needed for school children and the adults, also, because the amount of skilled oculists' service which is available is far below the demand. This is true even in the larger cities. There is no skilled service available for the masses of the people, except that of the optician or itinerant vender of eye glasses. A dispensary clinic for eye diseases is a boon to adults and children alike.

Dental clinics represent an effort to meet

a need affecting a still larger proportion of the population than do clinics for eye troubles. Clinics for obstetrical or "pre-natal" work, for mental diseases and for venereal diseases are increasing rapidly in number, owing to the demand of various groups of specialists and of public-spirited laymen (and women!) interested in meeting health needs. The committee on preventive work of the American Hospital Association, in a report rendered at the sixteenth annual conference of the Association, at St. Paul, in the autumn of 1914, called especial attention to the need of establishing dental clinics, eye clinics and preventive clinics for babies and their mothers. Whether such clinics are in conjunction with a hospital or not is immaterial. If they are to do their best work they must be brought close to the people. The more the work is to be made preventive in character, the more, generally speaking, it must be localized. Inasmuch as the various special interests and organizations which are demanding clinics for tuberculosis and eye diseases and babies often wish to enter the same district for their several specialties, the desirability and economy of combining the different clinics into a single dispensary should be kept in mind.

One objection to the establishment of a dispensary will usually be raised—namely, the objection that it competes with local medical practice. This issue must be faced and can be solved. The solution, while not always easy, ought to be assured if three conditions are fulfilled:

First—Have a really adequate system of admission to the dispensary, placing it under the charge of a trained person who is wise and firm, as well as tactful.

Second—Accept sick patients who, in the opinion of the person in charge of the admitting system, cannot pay for the medical service which they need. Do not accept others. Remember, however, that the

standard of judgment must not be that the patient is able to pay for one visit of a physician, but that the patient or family is able to pay for good medical service, and enough of it to secure adequate treatment for their disorder.

Third—Emphasize preventive work, as in tuberculosis or for babies; lay stress on care of general complaints of a minor order or for diseases in their early stages. Thus a dispensary will catch patients who are accustomed to call in a physician only when they are quite sick, but who will come to the dispensary or take their children there when the trouble is only beginning. Such preventive work assists the better medical practice of the locality and does not compete with it.

Frank relations with the reputable physicians of the locality should be maintained. In some neighborhoods and for certain types of work (as with eye diseases, venereal diseases, or tuberculosis, etc.) the protection of the community against contagion, or the fact that business interests, such as opticians or itinerant venders of eye-glasses, are the only persons with whom the dispensary competes, these considerations will modify in a measure the policy of the institution as to admissions.

The raising of funds for such work is always a problem. The charge of small fees to patients, as at the Maverick Dispensary, is desirable and helps out considerably; but half and more often two-thirds of the cost must be met by subscriptions. To raise money for such work is, however, comparatively easy, because it deals with obvious and concrete needs. If properly presented to charitable givers, its appeal ought to bring a ready response. After all, the chief force in establishing any organization and in raising funds to maintain it is faith in its beneficence—a faith warmed by enthusiasm and tempered by common sense.

Progress in Nursing*

HARRIET LECK, R.N.

Principal of Training School, Grace Hospital, Detroit, Mich.

IT is a simple law of human development that a people get on sanely and soundly only about as fast as they grow in like-mindedness, in ability to *feel* and *think* and *act* together.

From age to age progress has been made only as the world has renounced her independence and taken on bonds. Just so it must be with any real progress made in the profession of nursing. We must determine to renounce some of our pet schemes, perhaps, in order to work for the greater good of all concerned. In other words, we must bear and forbear with each other as individuals and as organizations if we would ultimately reach the greatest numbers with the most good.

At this particular period of the world's history the nations are looking upon the nursing profession with new interest, and it might be well for us to pause and think. For even as in the Crimean War, this may mean much in the advancement of our profession and we are reminded of the secret of the wonderful influence of our Founder, "the Lady of the Lamp." In trying to show the nurse "of how much use, unaware to herself, may be the simplest word of soothing, of comfort, or even of reproof," she says, "if she wishes to do this she must keep up a sort of divine calm and high sense of duty in her mind—this is the spirit of prayer which leads us in all our nursing silently to think of Him and refer it to Him." There was no secret about Florence Nightingale's religious spirit. I would ask how much of that same spirit are we putting into the solution of our problems today? Each individual, committee or organization has its own opinion of the solution of some problem, all working separately perhaps and

failing to see any good in the other's solution. Isn't it quite time for us to get together, to feel and act and think together, to feel our dependence on each other?

As heads of hospitals and training schools we have yet many momentous problems. It is well for us to "make haste slowly," to ponder and weigh what the outcome may be, to take a broader outlook and await developments, to cooperate.

The classification of nurses and training schools has been studied and much valuable time and energy has been given to its solution by many of the brainiest men and women of our associations. Its wise and just solution is tremendously important to special and struggling hospitals. The solution of this problem will come in the next few years, no doubt, *when we are ready for it* so why worry about it? Why not await developments? The conference to be held should mean much towards its solution. Within the next ten years it will work out its own salvation in a perfectly sane way and we will look back and wonder why we were so "stirred up" about it. Many difficulties will vanish when the "get-together" spirit prevails.

The primary aim of a hospital is the care of its patients. Is this fact ever lost sight of by the red tape of the administration? The ever increasing demands of service in the hospital have thrown a greater burden on the school. The schools have tried to meet the demands placed upon them by extending the course of training, by the reduction of duty hours, by placing the instruction in the hands of salaried instructors, etc. All of which has contributed to bring the schools to a standing equal to that of schools of medicine, law, pedagogy, music, etc. These schools are endowed and do not

*Read at American Hospital Association, San Francisco, Cal.

bring in any income. Why should schools for nurses?

It is upon the economy and efficiency of the training school for nurses that the reputation of your hospital depends, more than any other department. Dr. Hurd recently said that a well-conducted training school should be a source of expense, rather than a source of income. The authorities of training schools frequently take a one-sided view of their department and have too circumscribed an outlook.

On the other hand, the superintendent of the hospital, in the multiplicity of his or her duties, frequently takes too narrow a view of the broad training of the pupil nurse. He perhaps is inclined to blame the nursing department for something that could be remedied only by more instruction, more supervision or more nurses. He perhaps has not the time to look into some proposition, but throws it aside and says it is of no value or that it is too expensive, when careful consideration and time spent on it might lead him to not only look with favor upon its adoption, but realize its value later to the reputation of the hospital, as well as in dollars and cents. There can be no progress made in this instance without the cooperation of both individuals, the careful consideration each of the other's opinion, the dependence on each other and the learning to act and think and feel alike on these vital things which mean so much to the progress of the school, as well as to the hospital—the school dove-tailing into all administration work and both cooperating for the good of the patient.

The lack of supervision of pupil nurses is a waste to any hospital or training school. The workmen of any large business concern have very careful supervision at all times. Is it any less important where life and death is at stake? In a discussion at the last convention of the American Nurses' Association the suggestion was made that there should be one graduate nurse to every eight

pupil nurses. This ratio may be too high, but is it economy to place a pupil in charge of a ward of from twenty-five to thirty patients and expect the work to go on smoothly at all times, when nine out of ten nurses have not the necessary executive ability to manage that number of patients and the work entailed to say nothing of watching the work of the other nurses?

The strict adherence to a preliminary term for probationers is economy. At first this was met with disapproval; now no training school of any standard is without it because its value has been tested, tried and proven. Pupil-specializing is an economy because it adds to the training of the nurse and to the reputation of the hospital, which naturally follows.

The class schedule of studies taught by a paid instructor is an economy because it teaches the nurse the technical part along with the practical, thus resulting in intelligent care being given the patient. The nurse who is interested enough in her studies to be on the "honor roll," with very few exceptions, carries her knowledge and interest into the sick room and makes nursing a fine art.

But what are we preparing our nurses for? This might well be classified by what the three great organizations of nursing, with which we hold a joint meeting, represent—The American Nurses' Association, which is the alumni of our schools; the Educational League of Nursing, which is the institutional worker; and the National Public Health Nursing organization, including the school nurse, infant welfare nurse, tuberculosis nurse, social service nurse, etc. Now the alumni of our schools are three-fourths private duty nurses. This ratio may be a little high, since the public health nursing field has grown so rapidly, but the training applies to both. How are we preparing them for their field of work? The answer comes by looking at our graduate-special nurses in our hospitals. Are we satisfied with our own

product? If we find it so hard to deal with these nurses in the hospital, how are they getting along in the home? How economical are they with supplies? How well do they adapt themselves to the patient, family, servants, etc.? Why do so many patients able to pay for a graduate nurse not want one? The trouble lies chiefly in the fact that the average graduate does not know how to make a home; she lacks the home spirit; she does not know enough of nursing ethics; she has not studied the law of human kindness, of unselfishness, of bearing and forbearing. How much of this spirit is generated in the training schools? In other words, how much real motherly, homey interest do we take in our nurses? Getting the work done thoroughly and the class work attended to is our chief concern. The *spirit* is *first* and if that is taken care of the rest follows without any trouble. We get the "cart before the horse." I fear that is what is the matter with our private duty nurses. Not long ago a prominent doctor said to me, "Deliver me from a nurse whose God is her salary, who can see dirt outside the sick room and not lift her hand to obliterate it, who would not stoop from her professional work to lift a crying child or relieve a tired mother." The majority of our pupils come from well-regulated Christian homes. They are literally thrown into the cold routine stream of hospital atmosphere. How can you expect them to swim safely ashore amid the temptations without careful watching of all sides of their make-up, the mental, moral and spiritual? Now, I do not mean that we should preach religion, but I do mean that we should generate an influence of justice, of right living and high thinking, of interest, sympathy, unselfishness, of love in its true sense—is there any greater essential in the building up of home life? The school and hospital should be literally saturated with this home spirit.

If we make inquiries of our central directories for nurses we find that comparatively

few nurses register for communicable diseases because they do not care for that line of nursing. Why? This training need not be neglected because most schools are available to a hospital of that kind and can obtain that training by affiliation. The same is true of the nursing of nervous diseases. A certain amount of handicraft should be taught in every school, to be taken advantage of in a long convalescent period, in the nursing of children for their amusement, and in diverting the mind of a highly nervous patient. These are not new suggestions, but I would call them to your attention because they are points in which much progress could be made in the care of the patient, which is our first consideration. Statistics show that the average stay of our patients in the hospital is $13\frac{1}{2}$ days. Patients are rushed in and rushed out to make room for others. There is none of the good old-fashioned convalescent period for our nurses to get training in. As a result they do not like the long cases or the chronic cases, for when the short period of operation or acute illness is over with, the nurse no longer wants to remain, but gets restless and very unhappy because she has not had the importance of careful nursing (of a different kind, perhaps, and yet fully as important) during the period of convalescence called to her attention, nor has she had any experience with such cases in her training.

One of the most marked signs of progress in nursing, as a whole, is the change of attitude toward nurses of different localities and schools. Ten years ago nurses graduating from a certain training school considered themselves much better perhaps than graduates from a neighboring school. State registration, working toward a uniform curriculum, has greatly aided in stamping out this narrow view and the local leagues of nursing education have brought the principals of nurses together to discuss the problems common to all and encourage a social aspect, thus aiding in friendliness.

This leads up to a consideration of the institutional nurse. Not many days ago I received a letter asking me to recommend some one for surgical nurse in a small hospital, and the doctor, after stating the salary and outlining the work said, "I am particular about the type of young woman we get, as well as about her qualifications for work." Are we always as particular as we might be along this line, or do we frequently consider her qualifications for the work only? In my brief experience I have found that some drawbacks to institutional workers are: First, unwillingness to take any more responsibility than is absolutely necessary, especially by a tendency shown to shirk responsibility in the training of nurses. Second, lack of respect for authority, loyalty and honesty. Third, tendency to too narrow a view or outlook. "Well, I get so tired of telling them over and over," we hear her say. That is what a supervisor is for. Mechanical routine work accomplishes small results. There must be a live interest with thorough demonstration and with alert, watchful supervision on the part of each and every member of a training school faculty, carrying the responsibility of the training of each nurse under her and giving them personal attention—studying to bring out the very best that is in her and thus receiving the best service from her.

Where the lack of respect to authority, loyalty and honesty exists, the school has a very weak link in its chain. It is possible to inspire these in some, but in others it might well be said that they do not know the meaning of the word. The success of the training school depends upon how much leeway the superintendent has to choose her own faculty and her ability to pick congenial women who have been well trained in the above qualifications, than upon any other one thing. Women, as you know, are blessed with intuition, and it does not take

very long for the influence of one member to lower the tone of the whole school.

With regard to the last point—Nursing is too fine a profession for us to allow ourselves to only see our own little corner and unless we seize every opportunity of association, we are neglecting a great opportunity, not only for our own advancement, but also for helping others. We surely cannot afford to ever grow narrow or selfish.

Last, but by no means least, we have the nurses represented in the Public Health Nursing Association. It is needless to relate the great strides of advancement made by this association since its organization three years ago, not to remind you that ten years ago this line of work was hardly known. The summary of all the qualities of the private duty and the institutional nurse is necessary to the successful public health nurse, no matter what department of that work she is in.

In conclusion, I would urge unselfish devotion to the love of humanity and a realization that just in proportion that we put self first, we lose in true progress.

"What does it matter who sang the song, if only the song was sung?

What does it matter who did the deed—be he old in years or young?

What does it matter who ran the race, so long as the race was run?

And why should the winner be proud of himself, because it was he who won?"

"The one who ran and did not win, did he not do his best?

If he ran to the measure of his strength, what matters all the rest?

If the song was sweet, and helped a soul, what matters the singer's name?

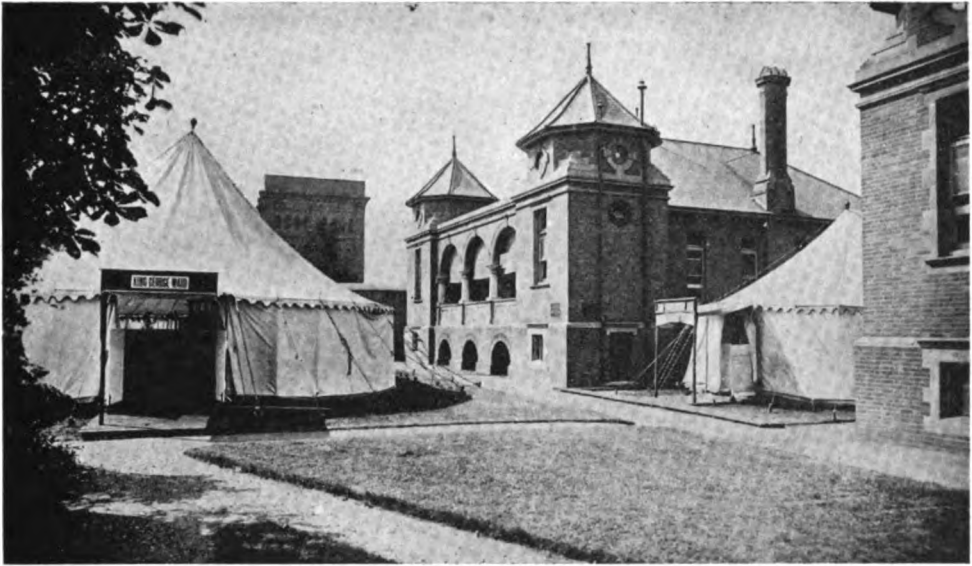
The worth is in the song itself, and not in the world's acclaim."

"O hearts bowed down with sense of loss because ye did not win,

If ye ran your best (I say *your best*), yet too have entered in,

The Song, the Race, the Deed are one, if each be done for *Love*,

Love of the Work (not love of self), and the score is kept Above."



ROYAL VICTORIA AND WEST HANTS HOSPITAL, BOSCOMBE, ENGLAND

Wounded Soldiers in Hospital and Camp

IRENE D. SEDDON

"**W**AIT lady till we turn the corner," said the conductor, as I was stepping from the platform when the 'bus was slowing up at Bond Street. London 'busses, you are told, stop when you want them to. Still it is reasonable that rules of the road should forbid certain places. These places I am prone to select.

On the sidewalk all along Piccadilly, right away to the Marble Arch, people stood. It was Alexandra Day, and the crowd was waiting to see the Queen-Mother who was driving through the streets in honor of the occasion.

The Alexandra rose sellers were everywhere, their dainty, thin white dresses contrasting strangely with the cloudy sky, drab pavements and darkened walls of towering masonry. Keenly every passerby was watched. Few had not already yielded to the alluring collector who exchanged the small pink flower for copper, silver or gold

coins. There seems no reluctance on the part of the public to give when the appeal is made for the wounded soldier.

On Oxford Street, between the lines of silent spectators, Queen Mary and the Mother Queen passed. The war has had its royal victims and both Queens were in mourning. Their approach was heralded by a forerunning flutter of handkerchiefs which accompanied the royal train on its way.

Soon I reached the Metropolitan Ear and Throat Hospital in Fitzroy Square. The growing number of patients there, as in all hospitals, calls for an increase in funds. There are several men in khaki in the dispensary. They have been to the front and are now undergoing treatment for more or less aggravated ailments, often caused by embedded shrapnel. One of them looks very cast down. He is deaf. The roar of the cannon made him so. Near by

a doctor is telephoning the sergeant to send for him. "For," says the doctor, "he's not bad enough to stay here." The man has had enough of fighting and would use his deafness as a means to get out of the army.

One morning last winter a mission worker of the East End took me to visit the London Hospital. She piloted me toward the building through one of those London fogs that veil the vision and muffle the din of traffic. "The hospital is just in front of us," she said. For all you could see you might have been in mid-Atlantic. Abruptly a solid wall arose before us. In a moment or two we stood in one of the largest and finest hospitals in England. The dispensary alone is a large building. Many patients waited there. When the doors are open at nine they come to get shelter from the cold. This building is ready, we were told, to be used for military patients. If it should be, one wondered where this stream of suffering humanity would get care and shelter.

This increasing need for medical care is being met systematically. New armies of nurses are being organized. Buildings, never intended for hospitals, have been fitted up for the wounded. Hastily erected "huts" and tents dot the country. Still the overflowing military wards constantly encroach upon others. You are told, "This was a woman's ward," or, perhaps, "a children's."

"Where are they now?" you ask. Nearly all have been sent home, the rest transferred to some other hospital. In the East End of London a building was pointed out as having been used for aged and infirm women; now it is taken for wounded soldiers.

Never anywhere have I seen more comfortable-looking wards than in the London hospitals. The luxurious armchairs in front of open fires are most acceptable to the soldier recovering from his injuries, the small curtained arrangements at the head of the bed giving the sleeper a certain amount of seclusion; the warm "nightin-

gale" spread at the foot of the bed when not in use and the growing plants all give an air of homelikeness not usual in hospitals.

A blind soldier was pointed out to me in one of the wards. He was playing draughts with a friend and they were laughing at the funny moves. A missile had indented the boy's skull in such a manner as to cause pressure upon the optic nerve. Operating would have been a great risk. The doctor thought nature would work its own cure. It did. Many weeks later light was distinguished from dark, and, by degrees, form made out with a continually growing clearness. It was the second case of blindness in this ward. The other, strangely enough, had no head injuries. Some nervous disorder seemed to have caused loss of sight. In the night the boy had been found on the battle-field calling wildly for his captain. He was delirious from pain and excitement. Some time elapsed before sight returned. But restoration was complete as in the other case.

"I'll never be any more use," said a Scotchman whose leg had been amputated a few days previously. He had other injuries. On his forehead was the deep scar of a shot wound. But courage comes with strength. For near him was a soldier who had thirteen shot wounds. He had been returning from India on leave of absence. When the ship arrived at Marseilles there was an order to go to the front. He has lost an eye and two fingers and cannot return to the ranks, but thinks he can do transport work.

I was favored by a retired officer who had held a high position in the British Admiralty with a permit to visit the Royal Victoria and West Hants Hospital at Boscombe on England's Southern coast. They have outside wards for the wounded. Two tents and a "hut," each accommodating about forty patients. "We take the less severe cases," said a nurse to me. "But of course,"



SUMMERDOWN CONVALESCENT CAMP NEAR EASTBOURNE, ENGLAND

then her voice dropped and I caught the words "bad case—shattered hip—hemorrhages. I will take you to speak to him," she added, as we entered a ward of about fourteen beds. Several patients were up and sitting at a table in the middle of the ward having tea. They looked well and one could easily imagine them again marching erect, although with a less self-reliant mien. "This one has a bad foot," said the nurse, indicating a man in bed. A "cradle" protected the painful limb from the weight of the coverings. "You are just sick of suffering, aren't you?" she continued, addressing the patient. Physical suffering had left its marks. Despite youth there were deep circles under the eyes, and restlessness betrayed how well-nigh insupportable was the unrelenting pain. But it was the patient in the next bed that attracted my attention. The meal on the tray at his side was untouched. Bolt upright he sat, quite still except for the wild shifting of his eyes. There was a look akin to that of a trapped animal. "They are all nerves when they first return," said the nurse. I had seen just such another case; the survivor of

a furious battle who after weeks of rest and care could not speak of the encounter without tears flowing. We came to the "bad case." The nurse by kindness had earned that look of implicit confidence that must needs be given by the helpless. One glance told of the bad condition, pale lips, sallow skin and auburn hair had lost its golden glint and clung together in heavy unlovely masses.

There are a lot of Indians at Bournemouth, hard by, a large hotel and grounds having been given over to the use of their wounded. They do not, however, have the services of English nurses, and rarely is an English doctor permitted upon the premises which are strictly guarded. For it is said, no amount of scrubbing can remove the ominous shadow that might be cast by a Christian upon the Moslem sufferer.

Most Americans who visit Europe have been impressed with the bold promontory, Beachy Head, that juts out defiantly on the English Channel. On the slopes of the bold rock is located the Summerdown Convalescent Camp. Three thousand wounded are here to regain strength in the invigor-

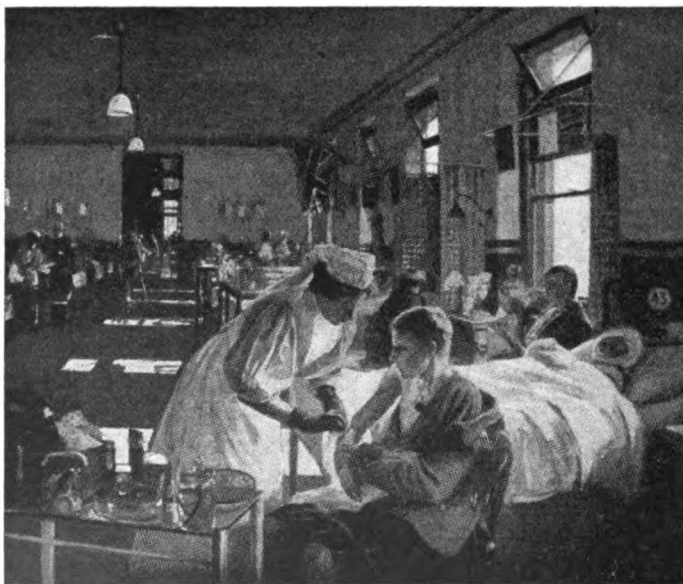
ating air before returning to the front. The streets of the city of Eastbourne, near by, usually gay with seaside visitors, are now flooded with convalescents. Each one attracts you. Vaguely you expect some unusual change—a charmed life to survive so many dangers. He looks odd in a suit that appears to be made of a butcher's-blue cotton material with white facings and scarlet tie. Thus giving the tricolor of the flag he serves. The cloth upon examination proves to be a soft woollen serge. "What a nice material," I remarked. The beaming boy said, to my astonishment, "Yes isn't it a pretty suit?" I often had thought something more subdued might have been chosen. But this boy, evidently, found genuine pleasure in departing from the sombre shades custom has assigned to men.

"The hospitals have changed their rules and regulations since you soldiers have invaded them," was an observation to a

soldier who sat in a park about three miles from the camp where he was a patient. He had been shot at a charge made on Hill 60. The sunken pulsating scar just off the forehead showed a narrow escape from death.

"We changed them," responded the restless convalescent. "At first several of the boys slipped off, then it became general, now it is the rule to be in at nine o'clock."

In the Royal Academy exhibition of paintings this season there is a picture which has struck a sympathetic chord in the heart of the British public. It bears the title of "Wounded: The London Hospital, 1915" and is by the well-known artist J. Lavery, A.R.A. It is being engraved and will shortly be published by "The Fine Art Society," 148 New Bond Street, from which I have received permission for its reproduction in *THE TRAINED NURSE*.



"Wounded: The London Hospital, 1915." Copyright. Published by special permission of the Fine Art Society, 148 New Bond St., London, who are publishing a large reproduction of the picture, to be sold in aid of the London Hospital.

Fire Protection and Prevention in Old Hospitals

JOHN M. PETERS, M.D.

Superintendent Rhode Island Hospital, Providence

(Continued from August)

FROM the report on "Fire Safety in Public Schools" made to Mayor John Purroy Mitchel of the City of New York, by Fire Commissioner Robert Adamson, I have abstracted the following:

Each building should have a city fire alarm signal box and gongs of mechanical, electro mechanical or electrical construction.

Every building should have a sufficient number of fireproof stairways and of exits to permit of its occupants vacating the same.

Every building should have at least two exits, remote from each other.

All inside stairs should be built of fireproof material.

All stairways of all buildings should be enclosed on each floor with fire and smokeproof partitions and doors. All such doors should be self-closing.

All stairways should be not less than three feet wide, and not more than six feet wide without an intermediate handrail.

Stairway terminals should be free and clear of any and all obstructions that would interfere with or retard the flow of traffic in any manner.

All stairways, landings and passageways leading thereto should be kept free from all loose furniture or anything that blocks or narrows the exits.

All doors opening on stairways should open on platform equal to width of the door.

Outside fireproof stairways should be provided in buildings where present stairways are insufficient or inaccessible and it is found to be impracticable to build an inside fireproof stairway.

All terminals of outside stairways should lead to the street where possible; otherwise, if to yard or court, there should be provided proper fireproof exit to street without crowding any exit used for other stairways.

Half doors and windows at openings leading to fire-escapes should be replaced with doors of at least 6 ft. 6 in. in height.

All clothes closets on half-story levels, opening on line of stairway, should be discontinued, unless there should be a separate stairway leading thereto.

All ladders leading to roofs should be of the double rung type, constructed of iron and braced in a firm and substantial manner. This includes all ladders leading to attics and those to a scuttle or bulkhead.

Platforms should be built in unfloored attics, at location of scuttle ladders, and protected with 2 x 3-inch guard-rail.

The stairs and connecting passageways leading from cellar to first story on or about the same level as the boiler-rooms should be enclosed in fireproof partitions, at either end of which there should be fitted a fireproof door, one of which should be hung on spring hinges or operated with an automatic spring, the other to be a standard automatic fire-door, which, when open, should be protected by a substantial steel enclosure.

All doors should be kept entirely clear of encroaching furniture. There should be a clear space at each door. Loose furniture should be removed from all aisles and passageways, which must be kept clear at all times.

Wooden doors along the line of exit stairways should be replaced with doors of

fireproof material, provided with self-closing devices.

Where hooks are used to hold stairway doors open, they should be replaced with automatic catches or holding devices.

Exit signs should be provided, the letters and figures on which should be not less than four inches high. All movable signs should be of substantial material.

All doorways from hallways should be designated by exit signs, numbered on all floors alike, as, for instance, a stairway shall be numbered the same on all floors. After all stairways have been thus numbered, the succeeding numbers may be used for any other exits.

In all buildings, lights with red globes should be provided over all exit doors and stairways, and outside fire-escapes should be properly illuminated at night.

The doors of all exits should open out.

In every case where practicable the floor areas should be divided by approved fireproof partitions, all openings in which should be protected by self-closing fireproof doors.

Attics and open cellars should not be used for the storage of furniture, books, lumber, etc.

Special provision of a fireproof storage room in cellar or basement should be made therefor.

Benches and the floors about the same in carpentry work room should be kept clear of all accumulations of sawdust, shavings and litter of all kinds.

All closets under stairs should be removed wherever possible. Those that cannot be removed should be vacated and kept securely closed against use.

Janitor's storerooms, in which supplies such as oil waste or paint are kept, should be of metal or other fireproof material, with self-closing doors.

All doors, windows and transoms in store-rooms should be of fire-resisting materials.

Enclosure of fire-resisting material, with

proper vents and self-closing door, should be provided for storage of oils, etc.

Enclosures of fire-resisting materials should be provided for storage of sawdust.

Metal receptacles, with automatic-closing covers, should be provided to receive waste paper and refuse.

Fireproof closets, with self-closing doors, should be provided for storage of paints, oils, etc.

Unprotected wood enclosures should not be maintained about boilers, machinery, pumps, coalbins, etc.

All brick-enclosed coalbins should be constructed so as to have an outlet at each end to the outer air, consisting of an eight-inch pipe, so that air may circulate through the same.

All wood chutes or shafts should be made fireproof.

All light shafts should be constructed of fire-resisting material throughout, or closed up if conditions warrant.

All wood lining under soffits of stairs should be covered with fireproof material.

The ceilings of all boiler-rooms, cellars and basements and all wood ceilings of non-fireproof buildings should be fireproofed.

All boiler-rooms should have two means of exit; where below ground level, one to be by means of an iron ladder to an areaway.

All attics of non-fireproof buildings should have at least one approved fire-stop, with an additional stop for all in excess of 5,000 square feet of area or fraction thereof. All doors through same should be fireproof and hung on strong spring hinges.

Partitions should be of plaster board, covered with 26-gauge metal or other approved.

In large open attics, where subdivisions are already made or provided for, means of access should be provided to each of such subdivisions from top floors.

A ventilator or skylight should be installed over each section, in the proportion of 100 square feet to 5,000 feet floor area,

and same should be protected by wire guards.

All frame structures in courtyards should be removed.

Steam or hot-water heating pipes should not be placed within two inches of any timber or woodwork, unless the same is protected by a metal shield. When so protected, the distance should not be less than one inch.

All steam or hot-water heating pipes passing through floors and ceilings of lath and plastered partitions should be protected by a metal tube one inch larger in diameter than the pipe, having a metal cap at the floor, and where they are run in a horizontal direction between a floor and a ceiling, a metal shield should be placed on the under side of the floor over them, and on the sides of wood beams running parallel with said pipe.

All vertical wood boxes or castings protecting the coverings on steam or hot-water heating pipes or piping in which the water contained therein exceeds 200° F., should be replaced with metal.

All indirect stack enclosures of wood should be removed and replaced with those of metal as rapidly as possible.

All steam coils, radiators or pipes in wardrobes should be protected by a screen or heavy wire netting so that clothing may not come in contact therewith.

All steam radiators or coils in all halls or passageways should be protected by metal shields. All vertical steam pipes and returns within reach should be covered with insulating material protected by metal.

All openings through floors and partitions through which steam or other pipes pass should be made secure against the passage of fire and smoke by the use of non-combustible materials.

Floor registers should be protected by a screen of one-half-inch mesh galvanized wire, fastened up close to the under side thereof.

All gas service mains should be fitted with a stopcock at or near the curb.

The use of all swinging gas brackets for any purpose should be prohibited. None other than short, stiff brackets should be used.

All brackets in basements, toilets, hallways and stairways should be fitted with detached keys and all, including those in the cellars, should be equipped with wire protectors.

In cooking classes, where a number of small gas stoves are used, teachers should be cautioned as to the use of matches and pupils instructed as to the proper method of lighting matches, as well as disposition of matchends after lighting gas.

Friction lighters should be used, where possible, in place of matches in class rooms.

Rubber hose should not be used for connections for gas ranges or gas stoves; neither for burners, except for laboratory tables.

All wood work at or near gas stoves should be carefully protected by stone linings or metal lined with asbestos.

Gas stoves or hot plates should not be placed upon a wood-top table or other similar surface, unprotected by stone or metal, with asbestos beneath same, or other incombustible materials.

Gas ranges should rest on a base of stone, cement or 26-gauge metal, lined with asbestos one-quarter inch thick.

All gas-meters should be provided with platforms or shelves of fire-resisting material.

Combustible material should not be stored under or near gas-meters or electrical meters or switch-boards.

For ordinary structures the standard fire-extinguishing appliance equipment should consist of:

One 3-gal. approved fire extinguisher.

One 5-lb. flat-head axe.

One 6-ft. hook, Fire Department pattern.

Additional fire-extinguishers: On floors where carpentry, chemistry, sewing, etc.,

are done, and in which combustible material of any kind is stored, one additional extinguisher should be provided, and where such floors cover areas of 10,000 square feet, two additional extinguishers should be provided.

Fire buckets: Two standard fire buckets, ten quarts capacity, should be placed in each carpentry shop.

Automatic sprinklers should be provided in large storerooms or workshops on first floor or below, and in all chutes, one being

placed at top and one at bottom. All supplies should be from house service.

Water connection, with length of small hose attached, should be placed in all furnace-rooms for use about ash-pits, and similar connections should be placed where waste paper or other refuse is burned.

Oil of any kind should not be applied to wood floors.

Kerosene oil should not be used for cleaning purposes alone or combined with any other oil or preparation.

(To be continued)



WOUNDED INDIANS IN THE MILITARY HOSPITAL, BOURNEMOUTH, ENG. (S page 149)

How Does the Nurse Acquire the Morphine Habit and How Can She Best Obtain Permanent Freedom?

C. V. PEARSON, M.D.

I HAVE frequently seen the statement that there must be some neurotic or degenerative factor in make up of drug addicts, otherwise they would not acquire the morphine habit. Statements of this sort are not in harmony with the facts.

The young men and the young women, who every year enter our nurses' training schools, medical schools, dental and pharmacy schools, are well above the average both physically and mentally. They come from good families. Furthermore the brightest and best in the class are every whit as apt to become morphine addicts as the dullards in the class. And yet there are more addicts in those four professions in proportion to numbers than in the population at large. The truth is morphine is no respecter of persons. And it is also true that morphine is dangerous to handle. There is no other reason of enough importance to account for the great prevalence of morphinism among the members of the four professions just named.

The uses of morphine are well taught in our medical schools. The nurse gets a good knowledge of its uses. But morphinism is one of the ills of the body and mind, that neither the nurse nor the medical student is sufficiently instructed about, and a major part of the instruction that is given is incorrect. The nurse has better opportunities to see the good effects of morphine than the physician. She is with her patient more constantly, she sees its soothing and quieting effects. The nurses' work is very exacting and fatiguing. This especially is the case in private work, where there is only one nurse employed. Some people seem to think that, because they are paying

the nurse, that the nurse has no right to sleep at all, and for the same reason that the nurse should be kept constantly busy whether there is anything that really needs doing or not. If people could only be taught that the nurse who has her sleep and outdoor exercise every day, can give more valuable services than one who is denied these privileges, both patient and nurse would be benefited. And on the other hand the nurse should insist upon her rights. If she does not in due process of time she is likely to get into a state where she cannot sleep even when the opportunity is afforded, and here is where the danger comes in. She may not commence with morphine, it is more likely that she will commence with the non-habit-forming hypnotics. However useful these things may be to one who has time to be sick, they are worse than useless to the busy nurse. Chloral hydrate, in a dose large enough to cause ten hours' sleep to one who can retire and remain undisturbed in bed for that length of time, would be worse than useless to a nurse who is likely to be called up at any time. For let the chloral sleep be broken and one cannot return to sleep without a second dose. While this may not be true of the first dose, if very many doses are taken it will be found to be the case. This is also true of nearly every hypnotic, except some form of opium or its alkaloids. The non-habit-producing hypnotics are of very limited value even to those who are so sick that they have nothing to do but be sick.

To the nurse who is likely to be aroused out of her sleep at any time, they only aggravate the insomnia. There is only one

rational thing for the nurse to do, who is troubled with insomnia, and that is to turn the case over to another nurse for a few days. There is only one hypnotic that is equally good, whether you wish to remain awake or wish to sleep and that is opium in some form. And no matter what any one tells you, there is only one habit-producing drug that cannot be discontinued at will, and that is opium. A person taking cocaine, cannabis indica, hyoscyne or whiskey could leave any of these things at home, and board a ship for Europe, and suffer no ill consequences in doing so. But in the case of morphine, the shock and suffering would be beyond the power of language to describe, and unless you had a very vigilant friend with you to watch you, you might jump overboard to end it all. King Opium is such a pleasing, such a delightful fellow when you first begin to flirt with him, but when you have lived with him for many years, you at last know him for the subtle, sardonic, satanic, and cruel despot that he really is. Wherever the blood goes morphine goes with it, and every cell in the body is more or less poisoned from the epithelial cells in the toe nails to the delicate cells in the brain. In the beginning morphine does seem to be a great stimulant and help. As I have said, good to sleep on and good to stay awake on. It deadens the sense of fatigue and apparently increases the power of resistance. Little by little it changes one's identity. The nurse's friends are usually able to detect this change long before the nurse becomes aware of it herself. Morphine, on account of abolishing sexual appetite and stopping menstruation, renders a woman unfit for marriage, and in the end is likely to render one unfit for service, although it is often astonishing the amount of work one is able to perform under its influence. In most cases it causes emaciation of the body. In a few cases it causes an increase of flabby adipose tissue.

Morphine is pretty certain to rob one of

all enjoyment, no matter whether one is successful in a professional or business way or not. Little by little the joy of existence ceases, and the despotic nature of the addiction becomes more and more apparent. The nurse has all the dangers of becoming an addict that the laity have, and in addition to these dangers the danger of easy access to the drug and the seductive influence of repeated demonstrations of the drug's happy therapeutic effects. I believe also that the lack of proper teaching, in regard to the dangers of morphinism, in a negative way increases the nurse's danger of becoming an addict. There is a feeling of contempt among many nurses and physicians for the addict that is not warranted by the facts in the case. Certainly the addict has as much right to his life and to his health as has the victim of venereal disease. Under proper care his prospects of regaining complete health are better than are those of the venereal patient. As to treatment I am not in favor of either rapid withdrawal or absolute withdrawal. These methods in order to get the best results should be followed by four months, after treatment. If this is not done the danger of relapse is very great. Briefly I use gradual reduction without restraints. The treatment consists in training the body to do without morphine and in training the mind back into normal channels. An unwise use of restraints or a lack of tact in the management of these cases in a few cases may possibly result in converting a case of morphinism into one of insanity. The rate of reduction has to be constantly changed and readjusted to meet the changing conditions and indications in each individual case. The patient should be able to eat and sleep throughout the entire period of treatment. There are many little technical details that one learns by experience that add very much to the patient's comfort and also to the patient's prospects of securing permanent health. While I am

familiar with the technic of absolute withdrawal and have used the method successfully, I very much prefer gradual reduction.

After five years' experience and study I am decidedly of the opinion that it is the best method for the patient and yields the highest percentage of permanent recoveries. And paradoxical as it may seem it is the quickest way of restoring the patient to complete health.

I will say this much for the guidance of the nurse, who is an addict and who is seeking relief, those institutions that promise the most are the ones that are likely to be the most disappointing in actual performance. Morphinism is a very serious disease and both physician and patient should be very much in earnest in their efforts to overcome it. And when the patient is past all actual craving for the drug, it is very important to devise means whereby the patient may not only always stay free from the drug, but may be restored to complete health as speedily as possible. Morphinism is a mental and physical disease. This does not mean that the addict is insane, but there are many mental symptoms and peculiar methods of thought that do not pass away with the last dose by any means.

To illustrate what I mean let us consider one of the most common mental symptoms of alcoholism, *i.e.* self assertion. Take a young man of modest, unassuming manners, let him gradually drift into the excessive use of alcohol, and he becomes loud in manner, indifferent to other people's opinion, etc., etc. Now we would not say that this young man was insane. But the change in character and methods of thought are clearly pathological, because they are directly due to the action of alcohol, a toxic material, upon the brain. It is my opinion that neither abstinence from alcohol, nor abstinence from morphine constitute a cure of either addiction. When their mental operations and outlook upon life have had

time to become in harmony with those of normal people, they may be said to be really cured. In all cases nature performs the cure, and all claims to the contrary are absurd. It is a matter of correct management during the withdrawal of the drug and during convalescence.

As I have already said normal methods of thought are to be desired. Familiar faces, familiar scenes, and familiar employment bring back constantly old trains of thought. For this reason I advise a complete change of environment and employment during the first year after the last dose. Sometimes this cannot be done. But as near an approach to complete change in environment and occupation as the circumstances will permit should be insisted upon. It is desirable that the patient should think as little about morphine and all that goes with it as possible. Hospitals, sick rooms, doctor's offices, nurses in uniform, and all kindred things had best be avoided.

Dr. T. D. Crothers of Hartford, Connecticut, states in a recent article in the *Medical Times* that there are some physicians who in his opinion will never become permanently free from morphinism until they discontinue professional work entirely. I believe this to be true also in the case of very many nurses. It is a great thing to be a nurse, but it is very much more important to be forever free from morphine. There is one feature of the convalescence from morphinism that is very deceptive. At the end of eight weeks or thereabouts, if all goes well, the convalescent becomes the very picture of health. In some cases there is a gain of as much as forty pounds. But in spite of all this, the convalescent can endure neither mental nor physical labor without very great fatigue. And if the efforts to work are too long continued, a condition approaching collapse is likely to ensue. The most rational thing to do is, of course, to avoid fatigue. However, if one

has overdone, no stimulants nor drugs of any kind should be resorted to, nothing but a hot bath and rest in bed is needed. Moreover, continued overwork, as late as six or even eighteen months after the last dose, will sometimes bring on a condition of nervous irritability, mental depression, insomnia, and loss of appetite that is very discouraging, and likely to bring on a relapse, especially if the convalescent has not been carefully forewarned and instructed

in regard to this danger. If the convalescent nurse has been properly instructed and fully realizes that these symptoms mean nothing more serious than the overtaking of the nervous powers of resistance that have not had time to become completely restored as yet, and that all she has to do is just take a complete rest for three or four weeks, no harm is likely to result. I advise the convalescent to use no drugs of any kind.

Administration of Salvarsan

AMY ARMOUR SMITH, R.N.

THIS drug possesses enormous interest for the masses as well as the classes, and though the shadows of war loom large, yet we are able to get our supply from one of the belligerent countries almost as usual. On account of the early symptoms of lues being a rash, and other skin lesions, common people consider it a skin disease and, on visiting a dispensary, tell the clerks such data as warrant their being guided to a skin clinic, though it is a systemic illness. In this way, this class of patients have come under the care of physicians who make a special duty of skin conditions at Vanderbilt clinic, Tenth Avenue and 60th Street, New York City, and any visitor there would be astonished at the extent, speed and efficiency of that service.

The patient lines up in his turn before the wicket, where the busy clerks assign him to Room ? according to his symptoms, and give him, on receipt of ten cents, a card of admission to that suite. On his arrival there, he with a few others is admitted into the consultation room, where he is locked into a locker to undress, and wait till called for inspection and interrogation. On this account, nobody can turn back to ask more questions. He must go out, and return as a new patient. From this room he is assigned

to the various work-rooms, for eczema, psoriasis, purpura hemorrhagica, *et al.* If the temporary diagnosis is lues, he has a Wasserman made. The blood is withdrawn, by an unusually efficient expert nurse, and sent to the laboratory on that floor, for the Noguchi test, the patient meanwhile directed to return in one week. That is an anxious week for a newly infected patient and he pays the penalty over and over again. A man of means would not defraud a dispensary the second time, after such a week, but would brave the rebuke of his own physician. When he returns, if the test is positive, he is treated with politeness and addressed by his own name, promptly getting his first injection. All stages of the disease are handled in this manner, primary, secondary and tertiary. My first glimpse revealed a pathetic sight, a beautiful boy guiding his middle-aged father, blind from a gumma, from the room where the last intravenous injection had been given. His case was so slow that the doctors intended to resort to the intraspinal method.

The week following the first injection, the patient again visits the clinic, and in an adjoining room is administered a dose of salicylate of mercury in the gluteal muscles. The patients partly undress and stand in

line, the sexes being segregated. But everything is cleverly thought out to enable the physicians to handle as many cases as possible.

These alternate treatments are kept up for six to ten weeks, till one negative Wasserman is found—then the whole course is repeated till again a negative reply comes from the laboratory. If a patient gets two negative reports he is declared cured. Naturally a very attenuated infection would be handled with prompt success, whereas a tertiary stage or a very virulent case is very slow. One patient came in who had a rather obstinate case, which of course left doubt in one's mind as to one of two causes.

The equipment consists of a sterilizer, flasks of saline, a tank of distilled water, dressings, alcohol, and the salvarsan outfit. Each patient buys his own dose from the apothecary, as a rule. In occasional instances it is supplied free, where it has been ascertained that the patient acquired it innocently and where the prophylaxis is worth many times \$3.00 to the community. It comes in a small ampoule, the neck of which is filed off with a delicate file accompanying it, similar to camphor ampoules. The tall cylinder of glass holding about half a pint, graduated in centimeters, has a solid flaring pedestal, and two stoppers, one of ground glass and one of rubber, with two small glass tubes running through it. Into this cylinder is poured 40 ccs. of plain sterile, distilled water. The dose is then added, and shaken till clear. Then sodium hydroxide 15% is added, a few drops at a time, till a thick precipitate forms, after which still more is added, and it presently becomes a perfectly transparent greenish-yellow. Then saline is added to make a total of 180 cubic centimeters of the solution, the whole being at body temperature, since it enters the vein. The rubber stopper is substituted for the glass and a doubled soft rubber tube, knotted twice, three inches apart,

makes an ingenious contrivance to slip over the cylinder to hang it upside down on a projecting arm over the patient's head.

A tourniquet of soft rubber tubing makes the deeper veins distend, and a small special needle with a key-like handle is inserted into the vein. Then a slight amount of the fluid is run off to prevent air entering the vein, and the connection is made. The longer glass tube running through the cork permits air to ascend into the top of the cylinder as the solution runs down, since there is a vacuum beginning where the salvarsan is withdrawn. The patient lies flat on the table, and at times he becomes hysterical or shows dilated pupils and slight depression, which soon passes off. He goes out, thanking the doctors and nurses, and knowing that he must return on a certain date. The skin is cleansed with alcohol, and a simple dressing applied afterwards. Nobody gets frightened if a little of the infected blood drops on his hands or on the apparatus, but the tubing, syringes and needles are kept religiously sterilized, because they can be used both for withdrawals and injections. When the patients require intraspinal injections the method is more involved.

Incipient tabes, a high leucocyte count and cerebrospinal involvement are indications of the intraspinal treatment, the theory of the last few years being well demonstrated, that the final home of the *spirocheta pallida* is the cord and brain tissue. But the medium for salvarsan in this case is blood serum, not saline. There are so many skin lesions which require a Wasserman for eliminative diagnosis, that one negative specimen is used for this purpose. It is centrifuged, and the serum expended as the medium for the infected case, without the knowledge of the clean patient.

Autogenous vaccines have not been yet made at this wonderful clinic, but stock vaccine is used for acne with success.

A frequent appearance of purpura hemorrhagica has led to coupling these cases with

the salvarsan patients; since the methods are somewhat alike. A clean, beautiful blonde girl has 20 c.cs. of blood withdrawn, centrifuged off, and an hour later this same serum injected without the corpuscles, into her vein. It is called, therefore, auto serum. Where there is no centrifuge, this has been very successfully done, even with hemorrhagic new-born infants, with parental blood, by letting it set, or coagulate, in an ice box, thus freeing the necessary serum.

In the adjoining laboratory, slides are examined and sections of skin, sections made by busy experts solely for this one department.

The whole building was endowed by the Vanderbilt family, who are also donors to Sloane and the College of Physicians and Surgeons. Their boundless philanthropy places at the disposal of the poorest the most modern and efficient medical care. There are also clinics for nervous diseases, with their same staffs and suites, fine electrical, X-ray and other apparatus, and methods of making laboratory tests for lues, again a fertile cause for illnesses of this kind.

There is a whole floor devoted to nose and throat work, and yet another for medical cases. Perhaps some day the few beds for people requiring care over night will evolve into a hospital, as the Polyclinic and Post-graduate did. The students of the P. & S. have a wonderful field for study in these enormous clinics, which in the winter run about 900 patients per day, and any nurse of any hospital connected with that medical school should know what is going on in this wing of the force.

Social service is getting well established in this dispensary. A day camp was instituted where groups of ten or more tiny tots are taken away daily to the woods and fields, coming back at early supper time to meet their mothers.

A crèche is conducted at Edgewater, at the Jersey end of Fort Lee ferry, where mothers and babies can spend a day, procuring good milk and sandwiches at cost, and getting fresh air without dragging, anxious fatigue.

Everywhere through the institution reign quiet, politeness order and industry. It is an education to visit there.

Recall of the Red Cross Units

American Red Cross surgeons and nurses will be withdrawn from the European battlefield on October 1, because of lack of funds to maintain them longer at their stations. It is possible that the two units in Belgium, where the greatest need exists, will be continued, but the other fourteen detachments will return to the United States.

French Military Cross to an American Physician

Dr. Richard Norton of Cambridge, Mass., founder of the American Volunteer Ambulance Corps, has been awarded the "Croix de Guerre," for bravery in his work among the wounded on the battlefield. The Government, in sending him the decoration, stated that the cross was given "in token of his great bravery."

Eye Nursing

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DISEASES OF THE LENS.

PART III—*Continued.*

CATARACT

THE subject of cataract is always an interesting one for nurses and not easily understood without explanation. In the main the nurse's duties on these cases has to do with nursing centering about the preparation of the patient for cataract operation, preparation of the operating room, whatever operative assistance is demanded and the very important care of post-operative cases and preparation of the cataract dressing tray all of which is taken up in Part V—Eye Operative Nursing—which is to follow.

Definition—A cataract is "any opacity occurring either in the lens substance or in its capsule." Thus a cataract may be partial when limited to some small part of the lens or complete when it involves the entire lens.

Among the different forms of cataracts as ordinarily encountered may be mentioned the senile cataract of elderly people, the juvenile or congenital cataract of the child, and lastly the so-called traumatic-cataract which always follows any wound of the lens, and which occurs very commonly in bad eye wounds.

Senile Cataract—Senile cataract is the most common form of cataract. It usually appears after 50 years of age. The exact cause of cataract is at present unknown.

Symptoms—The first symptom noted is gradual diminution in sight. Some cataracts in elderly people require years for maturing (full development) while others advance rapidly. There are no inflammatory signs and the eyes usually appear normal otherwise. Indeed unless the pupil is dilated it is sometimes difficult to see a cataractous lens (grayish or whitish condi-

tion of the lens) without throwing a beam of light into the eye with the ophthalmoscope. In senile cataract both eyes usually become involved, but generally one in advance of the other. A cataract is mature when it becomes entirely opaque (milky) and vision is restricted to counting fingers at two or three feet.

Ocular Nursing and Treatment—The treatment of senile cataract consists in the removal of the lens by an operation. No medical treatment is of any real value. As a rule the operation is performed when the cataract in one eye is mature and the other has progressed sufficiently far so as to cause considerable interference with vision in that eye also. Useful vision follows in the majority of uncomplicated cases of cataract operation, if there is good sight behind the cataractous lens. Patients will of course be obliged to wear cataract glasses after an operation for focussing either distant or near objects. To discover whether a patient has good vision behind the cataractous lens, the eye is tested by the oculist in the dark room, throwing a beam of light into the pupil from above, to either side and from below and finding out whether the patient is able to point out the direction from which the light is directed. The nursing in these cases, as mentioned, is that of handling special eye surgical cases.

JUVENILE CATARACT

In infancy and childhood cataracts are occasionally congenital. In children with soft cataracts or, in fact, any young individuals under 30 years of age, the lens is not extracted as in senile cataract, but is punctured or stirred up with a knife needle, the

so-called *discission or needling operation*. After a number of needling operations the lens becomes quite clear (absorbed) and the patient is able to see.

Secondary or After Cataract—In the ordinary cataract extraction operation for the removal of the lens in senile cataract, the capsule of the lens is usually left behind. Occasionally a bit of lens substance will stick to this capsule and forms a thin opacity termed secondary or after-cataract. The treatment consists in dividing that portion of opaque capsule with a small knife which will be followed by almost immediate improvement in sight. This operation is performed under 4% cocaine and the nursing naturally centers around the preparation and care of operative cases as outlined in Part V.

RETINA

Anatomy—The retina may be considered a delicate nervous membrane (expansion of the optic nerve) lining the interior of the eye. In the center of the posterior part of the retina there is an area over which the sense of sight is most acute. This spot is called yellow spot or macula lutea. In a small depression in the center of the macula called *fovea centralis*, vision is the most perfect of all. The retina itself is an exceedingly complex structure consisting of ten layers. The rod and cone layer is the light perceiving layer. The rods and cones, the terminal ends of the optic nerve receiving rays of light which fall upon the retina convert their sensations into impulses which are carried by the optic nerve and optic tracts to the brain, where they produce the sensation of sight. The head of the optic nerve called *optic disc* or papilla can be seen with the ophthalmoscope as a pale round ring with the retinal vessels converging to their point of entrance through the center of the nerve head.

Retinitis—Inflammation of the retina is called retinitis.

Nephritis, diabetes, syphilis, tuberculosis and various forms of anemia at times affect the retina.

Albuminuric Retinitis—In kidney diseases (acute and chronic Bright's disease) well marked changes are frequently first seen in the retina and affecting both eyes. The picture as seen by the ophthalmologist in the dark room, consists in swelling of the optic nerve head or disc, small hemorrhages, white spots in the macular region and tortuosity of the retinal blood vessels. The principal symptom experienced by the patient is early disturbances in vision although some cases do not complain of this feature at all. The treatment is directed to the kidney alone. As albuminuric retinitis is not infrequently seen in the nephritis occurring during pregnancy it should be of special interest to nurses in this connection.

STRABISMUS (SQUINT)

Strabismus, squint or cross eye is a common affection and its management (and nursing aid where possible) centers about such different aspects of the oculist's work as the fitting of glasses under atropine, measurement of the degree of strabismus by the perimeter, eye operation on the eye muscles for strengthening the eyes where glasses have failed and finally refitting of glasses following the operation.

Ocular Muscles—The eyeball is rotated in its various directions by the individual or combined action of six ocular muscles, i. e., external and internal rectus, superior and inferior rectus and superior and inferior oblique. The superior rectus rotates the eyeball upwards, inferior downwards, external rectus outward and internal rectus inward. The superior oblique muscle pulling obliquely moves the ball downwards and outward, while the inferior oblique turns the globe upward and outward.

Normal Balance External Eye Muscles—Except under pathological conditions there is always coordination in the movements of the eyes. When the movement of one eye is associated with that of its fellow on the opposite side both eyes will be used equally for seeing (binocular vision) and the result

is a perfect blend into one distinct clear image. In cases of paralysis of one of the eye muscles however, perfect muscular balance or harmony no longer exists and the image of an object falling simultaneously on a different spot of each retina often results in two images or diplopia. The eyeball in paralysis of for instance the internal rectus muscle (a weak paralyzed internal muscle) would be pulled outward (external squint or external strabismus) by its stronger antagonist the acting external rectus.

Definition—Cross eye or squint is a faulty coordination of the eyes.

One eye is most frequently affected, being deviated (turned) either in or out or occasionally up and down. The eye which is directed toward the object looked at is termed the *fixing eye* and the other the *squinting eye*. Occasionally both eyes are affected and the condition may at times alternate, being first one eye and then the other. The eye that turns in (convergent squint) is the most frequent of all the varieties and practically the only kind encountered in infancy and childhood. The chief cause is apt to be an error of refraction combined often with a general physical condition below par.

NURSE'S PREPARATION FOR SQUINT OR STRABISMUS OPERATION

The operation for the correction of strabismus or cross eye consists in cutting the tendon of the strong muscle pulling the eye in or out, and advancing or readjusting the position of the weaker muscle on to the globe sufficiently to hold the eye straight.

This operation is generally performed under local 4% cocaine anesthesia and a 1:1000 adrenalin chloride solution to produce practically a bloodless field. The patient should be placed flat on his back in bed in a good light with a firm hard pillow under his head. The operating bed or table should be as close to a window as conven-

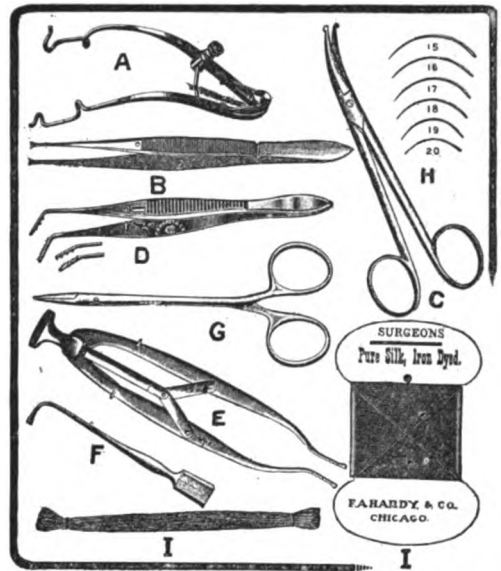


FIG. 25—INSTRUMENTS FOR STRABISMUS OR SQUINT OPERATION

- (A) Eye speculum. (B) Conjunctival fixation forceps. (C) Probe-pointed strabismus scissors. (D) Advancement forceps (Prince). (E) Tendon tucker (Todd). (F) Strabismus hook (Graefe). (G) Eye hemostatic forceps (light). (H) Eye needles. (I) Eye ligatures (black silk).

ient in order to obtain good light. A north light is usually preferable. The eyes in all operations are left open. The preparation of the eye for operation is similar to that described under Eye Operations in General—Part V—i. e., skin about the eye cleansed, eye flushed with a warm boric acid solution and face and forehead covered with a square piece of gauze with a hole cut in the center so that only the eye to be operated will be exposed. A small table covered with a sterile towel should be at hand upon which to place instruments. Cocaine 4%, adrenalin chloride (1:1000), atropine sulphate 1% solution, bowl of warm boric acid or normal salt solution, eye droppers, cotton for sponging in such easy forms as pieces rolled into small cotton balls or wound on toothpicks, pan for waste, etc., will all be required. The patient's shoulders should be covered with a half-sheet and one or two sterile towels arranged about the head. The operator and nurse should wear gowns and caps, and

the hands and finger nails are to be thoroughly scrubbed with soap and water and wiped dry with sterile towels provided for the purpose.

The instruments (Fig. 25) ordinarily picked out by the surgeon and sterilized by boiling or by placing first in a pan of 5% carbolic acid solution and then in alcohol, will be as follows: Eye speculum, conjunctival fixation forceps, probe-pointed strabismus scissors, advancement forceps, tendon tucker, two or three strabismus hooks, two or three slender eye hemostats, one of which may be utilized as a needle-holder, curved eye needles and strong black silk, preferably of two sizes. It is important that the needles be sharp and with a sufficient eyelet to carry the silk.

Following the operation the eye is cleansed and treated with atropine 1% solution by the physician, a bit of bichloride ointment (White's ointment) 1:3000 placed between the lids and the eye bandaged for two or three days if necessary so that these last supplies will also be required. The deep sutures holding the muscle advanced may be left in place for a number of days so that the daily dressing-tray requires little more than materials for cleansing the eye, atropine, bichloride ointment and a pad and bandage.

CHRONIC TEAR-DUCT OBSTRUCTION

Anatomy—The lachrymal apparatus consists of the following parts:

(a) *Secretory Portion* or lachrymal gland which secretes the tears.

(b) *Excretory Portion*, consisting of the puncta, two canaliculi, lachrymal sac and nasal duct. The *puncta* are two minute openings on the summit of a small elevation closely applied to the surface of the eye near the inner canthus of upper and lower lid. They are the openings of two short tubes termed *canaliculi* which empty into the lachrymal sac. The tears are sucked through the puncta and lachrymal canals

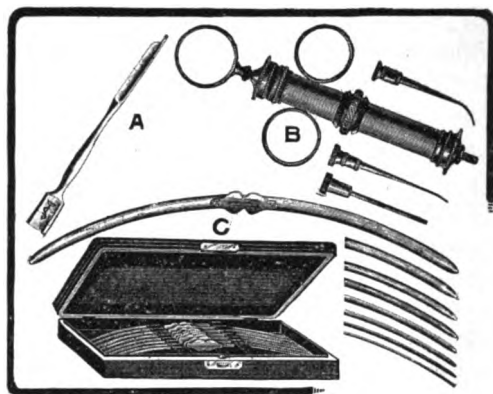


FIG. 26—INSTRUMENTS FOR TREATING CHRONIC TEAR DUCT OBSTRUCTION

(A) Canaliculus knife (Noyes'). (B) Lachrymal syringe (Anel's). (C) Lachrymal probes (Bowman's).

into the tear sac by lid and muscular action. The *lachrymal sac* is a dilated pouch or sac which for practical purposes may be considered the upper or enlarged end of the nasal duct. The *nasal duct* is a bony canal leading from the lachrymal sac downward to the inferior meatus of the nose beneath the anterior end of the inferior turbinate bone. The excess of tear secretion is being constantly carried into the nose to form a part of the nasal secretion.

Obstruction in any portion of the lachrymal drainage system results in an overflow of tears over the cheek termed epiphora or watery eye and is always a pronounced symptom in affection of the lachrymal sac or nasal duct.

Definition—Chronic tear duct obstruction is an obstruction of the tear passage in some part of its course, usually the result of chronic catarrhal changes extending upwards from the nose.

Symptoms—Epiphora or overflow of tears over the cheek and slight swelling in the region of the lachrymal sac near the nose, are the most prominent symptoms. By pressing upon the distended lachrymal sac its fluid contents may be expelled into the eye through the lachrymal canals. The

course of this affection is chronic and may extend over a period of years.

Ocular Nursing and Treatment—Recent cases are relieved for the time being, at least, by probing the tear duct and syringing the lachrymal sac with an antiseptic solution. In obstinate cases which have resisted all ordinary treatment the entire sac is often removed by operation (Extirpation of the lachrymal sac) and occasionally an intra-nasal operation is attempted through the nose. The nursing in such an affection centers around helping the surgeon in some kind of operative instrumentation of the tear passages as outlined.

MATERIALS AND INSTRUMENTS REQUIRED FOR IRRIGATING AND PROBING NASAL DUCT IN CHRONIC TEAR-DUCT OBSTRUCTION

Cotton balls for absorbing irrigating fluid, two towels, rubber apron to protect patient's clothes; cocaine hydrochlorate 4% solution, protargol 2% or argyrol 15% solution, bowl of warm boric acid water, small jar of bichloride ointment 1:3000, adrenalin chloride 1:1000 solution, clean eye droppers and such instruments as the operator will select, *i. e.*, canaliculus knife, lachrymal syringe, and set of Bowman's lachrymal probes (Fig. 26). One or two small glass dishes (like salt-cellars) for holding eye fluids are very convenient for holding small quantities of any eye solution.

NURSE'S PREPARATION FOR EXTIRPATION OF LACHRYMAL SAC

The preliminary preparation is much the same as that of any eye operation, *i. e.*, skin about the eye especially below the inner canthus (junction of lower eyelid with the nose) cleaned, eye flushed, patient placed in a good light in bed flat on his back in a comfortable position, with a couple of sterile towels in position so that the operative site at the side of the nose will be the part chiefly exposed. The operation is usually performed under local 4% cocaine anesthesia of the eyeball and deep hypodermic in-

jection through the skin of a solution of novocaine and adrenalin chloride. The instruments ordinarily picked out by the surgeon will be about as follows: lachrymal probes, small scalpel, fixation forceps, few small slender eye hemostats, small lachrymal sac retractor, blunt angular dissectors, small scissors, strabismus hooks, small curved needles, needle holder and black silk for suturing. Bichloride ointment 1:3000 and a pad and bandage are required at the end of the operation as a protective dressing.

ACUTE LACHRYMAL ABSCESS

The lachrymal sac may become acutely inflamed during the course of a chronic tear duct obstruction and result in abscess of the sac.

Symptoms—The skin over the lachrymal sac region (below the inner canthus) is reddened and tender and the tissue of this region badly swollen.

Treatment and Ocular Nursing—The abscess is usually incised through the skin with a sharp knife, and its pus contents evacuated. The wound is kept open for drainage with a small iodoform or plain gauze wick and dressed daily. Local anesthesia is secured by throwing a fine spray of ethyl chloride on the part until the tissues are white (frozen). Ethyl chloride is much used in minor surgery for local skin subcutaneous anesthesia. During the operation the head of the patient should be steadied by the nurse as the incision, although requiring but a moment, is quite painful. To recapitulate—After cleansing the skin over the affected region with a little soap and water and weak bichloride solution, the following materials should be provided by the nurse if possible: Two towels, absorbent cotton, sterile gauze, knife, tube of ethyl chloride, small pointed dressing forceps, bowl of warm water, eye dropper, pair of scissors, and a roller bandage. Dipping the blade of the knife into alcohol is usually sufficient for sterilization.

An Army Transport Trip from San Francisco to Manila

HILDA MILLER BOOTH, R.N.

THIRTEEN HUNDRED troops—a large majority of them raw recruits—three hundred sailors, and about forty officers with a few sprinkling of wives, sailed gaily away from San Francisco. On the wharf a regimental band thrilled us with a stirring march of Sousa's and, as we got further out, the troops with unofficial defiance of Secretary Daniels' neutral warning, broke into "It's a long way to Tipperary."

But our pleasure was all too short lived. The U. S. Army Transport "S——" was built for solid endurance but not for speed, so when we promptly struck the vicious tag end of a gale, she rolled and squirmed and then settled down to a gait which seemed like crawling in comparison with the long ragged-backed mountain waves which raced dizzily past her. Unlike the transport, most of the passengers were *not* built for steady endurance, and the speed with which they fled to their state-rooms was only equalled by the active regret with which they testified to the good times they had had on shore "the night before sailing!"

My husband was a naval officer and therefore—thank Heaven for small mercies!—a good sailor, while I myself was never on the active sick list. But the poor green troops, packed in way down to the third deck, were in misery. The large proportion of them had never been out of sight of land, and their three years of enlistment must have seemed a very doubtful pleasure as the ship creaked and groaned, and they tossed and moaned!

We were, of course, under military discipline. Even the allotment of staterooms and table seats depended on the date of one's husband's commission in the army or

navy, and I soon got used to the various bugle calls and the constant drilling on the quarterdeck. There was much speculation as to whether we should sight any German cruisers. According to the newspapers they dotted the entire Pacific Ocean much as a well-developed case of measles—prophetic word—dots the face of a child. But either we were good dodgers or else the Pacific occupies more space than the papers give it credit for, as we never even saw any suspicious German smoke on the further horizon!

The second day out a trooper came down with scarlet fever! This was a serious matter, as owing to the Christmas uprising scare in Manila, we were bringing many more soldiers than the little "S——" was supposed to carry. Consequently quarters were very crowded, and the ship's doctor had cheerful visions of an epidemic. The third day out a well meaning, but too generous-minded lady took the entire contents of a bottle of bromides as a cure for sea sickness! Fortunately the bottle was small and the lady's powers of resistance great, but it certainly proved to be a cure for sea sickness as she slept, in spite of all physical and medicinal attempts to awaken her, for one week! The seventh day out, two small children in the first cabin came down with whooping cough! The alarmed parents of the fourteen other children immediately treated the parents of the afflicted ones as social outcasts. In vain did they plead that they were innocent when they swore to the army doctor before sailing that they were well. "Didn't either of your children cough before the steamer sailed?" demanded the doctor sternly, as two soul-racking whoops re-

sounded from the roped-off cabin. "Yes, they did cough once or twice last week," admitted the mother. "But they often do. They are so apt to choke on their toy whistles." "Toy whistles!" grunted the doctor as he went pensively from the whooping children to the scarlet trooper. "There may be some merry whistling before we land in Manila three long weeks from now."

However, at Honolulu the "whoopers" whooped themselves ashore, and as they had been so promptly isolated, the rest of the first-class passengers were allowed to land and spend a delightful day and cool night on level ground. But the quarantine doctor laid stern hands on the troops and sailors. How they must have hated the unfortunate state of their stricken comrades. They were allowed to only march through town, ten feet away from even the fruit stands, and then they were marched back again to spend a hot, breathless night with the ship tied up at the dock and ceaselessly coaling. Ingenious natives hurled papayas and pineapples to them through the air, and the price paid for the fruit depended on whether it reached the buyer intact, or via a crushing contact with the deck!

"Honolulu is owned by the Japanese." This was my constantly recurring thought, in spite of American flags, American soldiers, and a slight sprinkling of American inhabitants. But the active little Japs swarmed everywhere. Japanese women strolled in the parks, their gaudily dressed sloe-eyed babies cuddled on their backs in their broad "obi" (sash). Japanese stores tempted you on every hand, and on the outskirts of the city lay the picturesque Japanese rice fields. I was far from surprised to learn that the census showed a population of 100,000 Japanese to about 20,000 Americans. Our ship brought an army major-general who is to stay at Honolulu besides the present general.

As nearly two weeks elapsed since the scarlet fever case developed, and no new ones broke out, we all drew a long breath. But our joy was short lived. Four days out from Honolulu a second storm struck the sturdy little "S——" amidships and again qualms—and worse—struck many a passenger in the same all too vulnerable spot. As if that were not disaster enough, a sailor stole a suitcase from Sergeant Buggs, U. S. A. Sergeant Buggs naturally objected, with the result that the light-fingered sailor was lodged in the "Brig" for five days. The "Brig" is a huge cage very reminiscent of a Zoo, and is the kind of prison used on board ship. The sailor had four companions and was therefore far from lonely, but prison life so disagreed with him that on the third day he was transferred from the "Brig" to the "Sick Bay" with an unfinished prison term, but a very finished example of measles. One by one his room mates wished they had not been so congenial, as one by one they too followed him on his "Measly" career. Finally the dreaded blow was dealt and measles invaded the first cabin via an army officer. Every man now looked askance at his neighbor, and many a budding friendship was hastily sundered by an often innocent sneeze or cough.

When ten days out from Honolulu, three more cases of whooping cough broke out simultaneously, the first cabin decks looked like roped-off cattle pens, and our last hope of being allowed to land at Guam Island fled utterly. That small coral-encircled island, so tiny that it is a mere dot on a large Pacific map, had a fascination for me as soon as I heard it was to be one of our stopping places, and I was therefore much disappointed that the laws of hygiene demanded that the healthy suffer with the sick! I saw the island, yes, but only tantalizingly. The "S——" sweltered in the shallow, sunbaked harbor for two breathless days, while every sort of freight

from baby carriages—for the infant Guamites—to beer, was swung out onto flat rafts by creaking and protesting donkey engines. But none of us landed and no one came on board our unpopular ship. Listless the dread yellow quarantine flag flung at our fore-mast and disappointedly we read the cordial wireless invitation of the Governor-General to lunch at the Government House. The picture postcards of Guam, which we had bought in advance at Honolulu, were now doubly tantalizing. We pictured ourselves strolling under the long palm and coconut avenue of Ajana, Guam's one and only town; even the stone wheeled ox-carts looked luxuriously comfortable, and I longed to have my laundry pounded into holes on the river stones by the washer-women of the island.

Our only excitement was the presence of the interned German cruiser the "Comorant." With twenty-four loyal officers and several hundred crew she lay idle only a quarter of a mile from us. As Guam possesses no newspapers, and the Germans are of course forbidden to use the wireless or cable stations, they must have longed to call on us and hear the war news. They had come very near falling into one of their enemies' hands, for shortly after the European war broke out they were hotly chased by three Japanese battleships and fled hastily into the neutral port of Guam. The Japanese commander sent a message to the Governor, asking when he would allow the German ship to sail out, whereupon he gave his opinion on the length of the war by replying "In a year or two!" Needless to say the three war ships decided not to wait!

The "Comorant" doubtless envied us as we steamed away, and we were glad our-

selves to get underway and contemplate landing at Manila. We said "Landing" and glanced furtively at each other. Seven unfortunates who had been ordered to duty at Guam had been, after much argument, allowed to land, but the quarantine doctor had a neat little row of tents waiting for them in the sun-baked grounds of the Hospital and we saw them depart for an enforced quarantine.

After two more weeks of uneventful steaming, broken only by a daily fresh case or two of measles, we reached the islands. For two days we sailed past green lands of varying sizes, all back-grounded by lowering volcanic mountains. Then Manila appeared, and for the third and last time our yellow flag was hung dismally out. Three doctors held lengthy converse over our sick list:

Whooping cough..... Four cases.

Mumps..... Six cases

Measles..... Thirty-two cases.

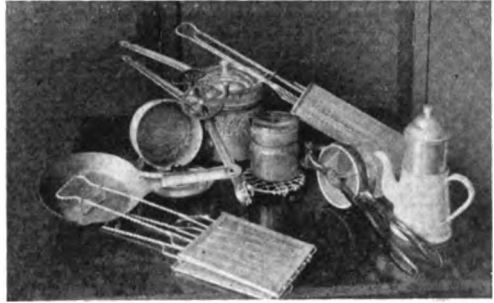
Undecided as to our fate, they went ashore, and not until late at night came their decision. The following morning all well passengers, having previously had measles, were to land free. All the sick and those who had never had measles, were to go to the Military Hospital at Manila for treatment or detention. Breathlessly, husband and wife inquired of each other, "Have you had the measles?" Sadly several parents confessed to the doctor (with an official checking list), "No, neither Tommie nor Baby have had them." My husband and I, having both been properly afflicted in childhood, spent an endless night wondering what we should do if one of us came down with them a second time before morning. And when morning came we fled the measles-laden ship!

The Practical Work of the Diet Kitchen

KATHERINE E. MEGEE

IN an institution, such as a big hospital, where the catering is of so varied a nature and the food is cooked in such large quantities, the central kitchen is to a certain extent a distributing station in so far as the wards are concerned. The finishing touches, the culinary frills, so to put it, which appeal so strongly to the eye as well as to the palate and which are such provocatives to appetite, also all the special diets, must of necessity be prepared elsewhere. Out of this necessity came the diet kitchen, which is an important feature and telling factor in any well regulated, thoroughly equipped hospital of today of whatever character. This for two reasons: It enables the patients to have better and more delicate service in the way of diet; at the same time, it affords the opportunity for the nurse in training to get the practical experience in dietetics, which should always supplement the classroom work in this important feature of the curricula, if she acquires any efficiency. A nurse must not only have a theoretical knowledge of food principles and their comparative values, but she must also understand the art of intelligently cooking and attractively serving food that it may not fail in its mission. The best of food may by improper cooking be converted into mere filling, which will severely tax the digestive organs.

Nor are the patient and the nurse the only beneficiaries from intelligent and correct catering. Indirectly, the physician profits, in that his efforts are supplemented by proper diet, which is no unimportant factor in the treatment of disease. Thus it will be plain that the dietetic department is of hardly secondary importance to the therapeutic department in a hospital. Strangely enough, in the face of this glaring truth, many diet kitchens in otherwise up-



SOME OF THE VESSELS FOR INDIVIDUAL COOKERY

to-date hospitals exist in name only, being, instead of dietetic laboratories, merely receiving and distributing stations. The reasons given when this arrangement, or rather mis-arrangement, is questioned are various and, while regrettable, they are not to be condoned, much less excused.

In the first place, the diet kitchen must be sufficiently large to accommodate the necessary furnishings and the workers. Otherwise, little can be done. It must also be well lighted and well ventilated. It is quite possible to prepare tasty food in a dark and even poorly ventilated room, but it is impossible to prepare wholesome food under such conditions. As the diet kitchen serves the double purpose of a place for preparing and serving food, provision must be made for taking care of the "set up" trays between meals. The ideal arrangement is to have enclosed shelves made on the order of a cupboard of a convenient height and wide enough to easily accommodate the trays. Doors of glass give it a finished appearance. The trays are thus out of the way and are free from dust. Lacking this, long narrow tables may be used to advantage. In the latter case, a connecting room or an alcove room should be used as a tray room.

The model diet kitchen is the all-white kitchen, that is to say, floors, walls, wood-work, all done in white. The time is gone by when dirt-hiding colors are selected for the culinary department of any well-managed establishment, whether private or public. Even cooking utensils, in so far as is practical, are white. The ideal diet kitchen has white-tiled walls and floor. In old buildings where the most is made of what happens to be, this is not always feasible. In such cases, washable paint and linoleum in tile pattern offer excellent substitutes.

The furnishings of the diet kitchen should be suited to the work to be accomplished. Unless they are, little in the way of satisfactory tray service can be expected. A good workman must have good tools, and these tools must be made for his particular sort of work. This is a trite but none the less true saying, and the cook's domain is no exception when the application of it is in question.

The first essential is a good stove of proper size. For the purpose the modern gas range, so complete and so satisfactory, suggests itself if gas is available, which it usually is in an institution. This supplemented with various electrical cooking appliances, such as toaster, broiler, coffee percolator, will compass all the work of such a kitchen easily. The first cost of electric appliances is always considerable, but in the end they pay for themselves many times over from the viewpoint of saving time and labor, which are always at a premium in a busy hospital, to say nothing of their cleanly properties. Then, too, their durability, when properly cared for, justifies the money outlay. A fireless cooker is invaluable for cooking the breakfast cereals.

A small steam table with a cupboard beneath is a necessity for keeping the hot food, which is sent from the central kitchen, hot until it is used and also for keeping the dishes warm. It is hardly a digression in

this connection to call attention to one of the most important but so often violated rules of correct service, and that is, that hot food must be served hot on warm plates; cold food should be served cold on cold plates.

Given a stove and steam table, a work table is next in order. A long narrow one with a running shelf beneath is the most practical kind. The top of the table, also the shelf, should be covered with zinc which is easily kept clean, durable, germ and insect proof. A rack suspended above the table on which to hang the smaller cooking utensils, spoons, ladles, etc., is indispen-



A SHIRRED EGG READY FOR SERVING

sable in a well ordered kitchen. Just a word here as to the cooking vessels: Much of the diet kitchen cooking is done in individual portions. For this work there are to be had utensils of a suitable size. A complete assortment of these should be at the disposal of the diet kitchen nurse, and will not only facilitate her work, but also enable her to prepare the food in a more appetizing manner. A cabinet for seasonings should be conveniently near the work table. If there is not a small pantry available, a supply cupboard will be another necessity. It goes with saying that each diet kitchen must have its own refrigerator. Any housewife will tell you that there is the greatest difference in the practicability of the various kinds of refrigerators on

the market. Some are simply ice consumers instead of food preservers. Others are so admirably constructed that the minimum quantity of ice accomplishes wonders in the way of food preservation; and as food for the sick must be strictly fresh and pure, the best refrigerator is the cheapest.

Given suitable working conditions, the responsibility rests with the diet kitchen nurse, who is lacking, indeed, in resourcefulness if any tray leaves her kitchen which is not both palatable and attractive.

Take potatoes, which like the poor we have always with us. In bulk they are most unappetizing, but by the addition of a few culinary frills and furbelows may be transformed into a palatable joy and a dish of beauty. For example, cut the plain boiled potatoes sent up from the big kitchen into tiny blocks, mask with a nicely seasoned cream sauce, serve in a pretty china ramequin, sprinkle the top with a little minced parsley and presto, change! we have a new dish. Or, instead of cutting into blocks, mash with a fork, add a little cream, beat very light, then put into cocottes, dot over with bits of butter and stand in a quick oven until nicely browned, garnish with a sprig of parsley and serve at once. Again, riced potatoes are a most delicate dish. A potato ricer is a necessity in a diet kitchen. Put the boiled potatoes in the ricer and press through, letting fall in a snowy heap. Serve without stirring.

Cream sauce is a most savory way of masking all of the green succulent vegetables, also minced chicken and other meats. Green peas dressed with cream sauce and served in a bread case make a most tempting dish. Spinach, chopped fine, covered with cream sauce and garnished with minced egg is another delicate combination. These food transformation possibilities are by way of suggestion. It is not the purpose of this article to give cooking recipes. All modern cook books and books on invalid cookery



MINCED MEAT MASKED WITH CREAM SAUCE

are teeming with recipes for dainty dishes for the sick. It is desired merely to call attention to and emphasize the fact that the kitchen should be in reality as well as in name a dietetic laboratory.

For obvious reasons, the central kitchen is always somewhat removed from the wards and there is always more or less delay in the transportation of food. So, it is plain that the work of the diet kitchen nurse is but half accomplished when she adds the finishing touches to the food which is sent to her from the central kitchen. Much of it, such as the smaller cuts of meat that are to be broiled, young chickens, birds, eggs and any other food which deteriorates by standing after cooking, should be sent to her in a raw state to be prepared as needed. Delicate custards and similar desserts, also salads, come under the head of diet kitchen cooking. Tea, coffee and cocoa should also be made there. The nurse in charge should prepare all special diets.

It is only when the foregoing conditions are complied with and this personal service and supervision is given that hospital cooking can be brought up to the highest standard; for as has been said, details of this nature cannot be compassed in a big kitchen where stress of circumstances demand that quantity must be the main consideration.

Department of Public Welfare

"CuSo₄"—Poison

ALICE L. HARVEY

Mrs. Bianca had secured and held for some little time a dwelling place on Boundary Street. This was the street of the socially elect of Little Italy, and bore no trace of former or future prosperity. It lay at the foot of a circular embankment which had, in its day, been a genuine hill. The houses at their rear fitted tightly into the embankment, and the street proper curved in front, filled with refuse, drainage, children and mud. Chickens and other livestock did not frequent the street in large numbers, but were kept penned in the grassless yards, and, more often, under the beds. To display such wealth openly by allowing it to strut about the street would be worse than rash, according to Boundary Street's idea of self-preservation. Dirt, disease and illness were minor evils compared to the popular belief in a tribute-demanding Black Hand, should any unnecessary wealth be discovered. Many a son or daughter of Italy gave this as a reason for living in poverty, when the family budget, in a few cases, seemed sufficient for better quarters.

When the visiting nurse first began her trips down the long flight of slippery wooden steps to Boundary Street, armed with a black bag, the principal contents of which were soap and castor oil, the inhabitants of Boundary Street looked upon her as the secret agent of the dreaded society. In their minds her bag contained no healing for their ills, but was merely the receptacle for their hard-earned money, and the nurse a collector of internal revenue in disguise. No method of attack more cruel could have been thought out by the most diabolical of minds,

To them she was a creature worse than the fabled wolf in sheep's clothing. Dressed in the very blue-and-white of their own beloved Virgin Mother herself, she came in this way to pry into every secret of their lives. Failing to find hidden treasure, this monster in woman's shape with her black bag, would pass on to their children. So reasoned the population of Boundary Street, and the population was distrustful and unbelieving.

Mrs. Bianca was the most suspicious of all. She had no material wealth in ready cash or in chickens, dead or alive, to appease this agent. Her one precious, priceless, adored possession was a small curly-headed brown-eyed boy of barely two years. He was so wonderfully precious that she had so far been unable to find a name sufficiently beautiful to be a perfect fit. Temporarily she had settled upon Angelo, but she still searched the calendar of saints and pursued the parish priest for a more suitable label.

Angelo had been "sick of the eye" for some time; Mrs. Bianca described it as a "wart," and this was a grave flaw in Angelo's otherwise perfect beauty. A week before she had added her best purple skirt to the collection she already wore, draped her shoulders in a wonderfully patterned shawl, and her head in a large handkerchief-shaped headgear of bright blue, and, with Angelo clinging fast to the front decorations, departed (a stout resemblance to the coat of many colors) for the children's dispensary.

There Angelo's marred beauty was shown to the doctor. The eye was treated and a small and inoffensive bottle of eye medicine given to the mother for future use. With much demonstration, using a long-suffering

nurse for a subject, waving of hands and raising of voice, Mrs. Bianca's apperceptive faculty was finally in good working order. She departed promising a quick return.

The promise remained unfulfilled at the end of a week. The suspected agent of the Black Hand was then sent out on a detective mission, with Mrs. Bianca's one-room apartment as a destination.

The nurse's reputation in that small and watchful Boundary Street was already established and Mrs. Bianca decided that her own day of reckoning had arrived when that person entered her door. The mother had never connected her in any way with the doctor who had treated Angelo's sick eye, but now that this nurse had appeared, she felt convinced of the evil intent of that curious label on the medicine bottle. The dispensary also must be a part of the Black Hand plot. It never paid to be too prosperous in Little Italy.

However, this human wolf seemed a tame creature, and was only asking about the sore eye. So far she had demanded neither tribute nor child. Perhaps it would be safe to offer a chair—one carefully dusted with Mrs. Bianca's large red calico apron. The visit proved to be a lengthy one, the information difficult to obtain. Why had Mrs. Bianca not brought Angelo back to the dispensary? Why had she not used the eye medicine? Reason enough. "Dottore no good! Dottore kill Angelo!" "But why, Mrs. Bianca, is the doctor 'no good'?" The doctor would make Angelo's eye well and beautiful." Pacifying were the tones of the nurse, but Mrs. Bianca's Black Hand faith still remained orthodox. She merely repeated in vigorous tones, "Dottore no good! Dottore kill Angelo!" and in still more emphatic tones, "Dottore Black Hand, nurse Black Hand, dispensary Black Hand! Dottore give medicine for eye and bottle ticket say 'CuSO₄—Poison.' Poison mean kill. No, me no put poison in Angelo's eye and Angelo no die. Ah, levatrice, she say

'Poison,' kill. No, I no come dispensary, I no come dottore, I no put poison in Angelo and he no die!"

Since then the one-time Black Hand agent has become the bosom friend of the population of Boundary Street, and that particular doctrine of Black Hand faith is no longer reckoned orthodox. But the beauty of Angelo's brown Italian eye still remains marred by the scar of the "wart."



Nurses Indorse Anti-Alcoholic Campaign

The American Nurses' Association, in session at San Francisco, Cal., in June, endorsed the anti-alcoholic campaign, which has been instituted by Health Commissioner Goldwater of New York City. The text of the resolution is as follows:

Whereas the American Nurses' Association believes that alcohol lessens vital resistance, fosters poverty and all the diseases that come from poverty, hindering the progress of the community; and

Whereas the American Nurses' Association is firmly convinced that it is the greatest cause of human ills;

Therefore be it resolved that the effort of the New York City Health Department to establish a betterment of public health by conducting a systematic, vigorous and definite campaign against this evil, be given a full and whole-hearted endorsement by the American Nurses' Association assembled in San Francisco.



Director of Public Health Nursing

Miss C. Josephine Durkee has recently been appointed Director of the Division of Public Health Nursing, New York. She is a graduate of the Philadelphia General Hospital, and has held the appointment of Superintendent of the Training School for Nurses at the John Seely Hospital in Galveston, Texas.

The Hospital Council

Items of Interest, Annual Reports, Publicity Literature and Material Descriptive of Newer Methods and Plans in Any Department of Hospital Work Are Solicited

Teaching the Pupil Nurse Economy

M. E. L.

From my observation of the management of hospitals in which I have lived as pupil, special nurse and patient, it has seemed to me that the economical side of the training is the most neglected part of the whole curriculum.

This is noticeably so in the larger municipal hospitals. The practice of economy in every branch is necessary in order to bring about efficiency. Would it not, therefore, pay the larger institutions to employ a woman who has had special training along this line of work, and who is especially adapted to it? "for there are those who are naturally inclined" to look after the ward supplies, not including the dietetic department, for all hospitals should have a competent and well salaried dietitian. The supervisor of nurses of the larger hospitals has her hands full teaching and demonstrating at the bedside and looking after the patients under her care.

The young woman, just entering the training school as a pupil, probably never before saw such a large amount of linen, toilet articles, sterile dressings, solutions, and in fact of everything in use in the wards, all supplied with no visible expense to her. Naturally she cannot be expected to use these articles with guarded care, for she sees no limit to the supply.

The employees and patients are very apt to use the supplies extravagantly, if they are not carefully dispensed. It is not possible for the pupil nurse, even after spending the required time for her nursing education, to conceive the value of these

articles, besides the time and labor employed to prepare them for use, or to realize what immense quantities are needed when many patients are cared for.

In the larger municipal hospitals it seems that less care and attention is given economics than in the smaller hospitals.

The municipal hospital is not supported by endowment, nor is it self-supporting. The money comes from the city treasury, and is raised by taxation.

It is not unusual to hear a remark like this, "O! well, use all you want. The city pays for it." Economics should be rigidly enforced and practised, for the financial benefit of the municipality and hospital, and for the benefit of the pupil nurses' good training.

I doubt if many nurses know that the institution pays for every gallon of water they use and that every electric light bulb costs, while burning, an average of one cent per hour. Where many are used for many hours it soon amounts to dollars.

The majority of nurses graduated go out as private nurses. In the homes of their patients, whether rich or poor, there is already the expense of the doctor, the druggist, and the nurse is expected to be economical with the supplies provided for the patient's use.

If the nurse has not learned economy in the hospital where she received her training, she is lacking one of the most necessary requisites for a good nurse.

To the duties of an economical manager or supervisor, might be added that of looking after repairs which are always needed, such as broken or loose door latches, torn

window shades, broken bed castors, and other things too numerous to mention.

Her duty should be to instruct the pupil nurses to report all such matters to her, and she in turn should report them to the proper department for repairs. In many instances she may be able to repair the article herself, with the assistance of the pupil nurses, thus saving possible long delay, and at the same time teaching the pupil nurse to be practical and self-reliant.

Most superintendents find themselves handicapped financially, when wishing to install a new department, appliance or teacher. If economy was more rigidly taught and practised, there would be more money on hand to meet the urgent needs ever present for the higher education of nurses in training.

This is a progressive age, and the young women who are being enrolled in our training schools, are women who are seeking a higher education. The hospitals must be prepared to meet all requirements of a higher education, or they cannot hope to enroll and retain in training such women. Thorough economy in all departments is one means of bringing this about.



Dispensaries in Smaller Hospitals

One of the lines on which hospitals are certain to progress in future years is in the more general establishment of dispensaries in connection with smaller hospitals and in smaller cities. In this, the initiative must often be taken by the superintendent of the hospital, who is usually a nurse. Inasmuch as she is sure to encounter adverse criticism, if not active opposition from some of the members of her medical staff, she needs to be ready to give good reasons for wanting a dispensary, and to be prepared to hold steadily to her purpose till the dispensary is really in operation. Once the real start has been made and a few months' demonstration has been made, the difficulties should lessen

and the criticisms will subside. In one smaller city, the superintendent prepared a carefully arranged paper to be read before the board of trustees, showing the need of the dispensary, the kind of patients who without it were not getting the medical care their condition required if they were to be restored to health. The approximate cost of the dispensary, ways of meeting this cost and also the rooms in the building where the dispensary work could be carried on, the probable equipment needed—all these were outlined. The result was that the board of trustees, with the facts before them, very willingly agreed to the dispensary proposition and voted unanimously that steps be taken to start it. After this it was easier to place it before the medical staff. It started on a small scale, opening for not over two hours a day, an average of about ten patients a day being the rule during the first year. But ten patients every day means sixty more patients in a week than the hospital was helping than before. The superintendent, after a year's experience, stated that no one thing which they had ever done had accomplished as much in popularizing the hospital and securing new supporters for it.

In another city of about 30,000, the nurses of the County Association became convinced of the need of a dispensary and took the initiative in getting it started. They went to the County Medical Society with their appeal and told of numerous cases needing dispensary treatment of which they had personal knowledge. The hospital was too crowded to house the dispensary, but other rooms were secured until the new building of the hospital now under construction is completed, when the hospital takes over the dispensary work.

The articles by Dr. M. Davis, of the Boston Dispensary, on "Dispensaries in Smaller Hospitals," which began in the June number of this magazine, are full of practical suggestions for starting and carrying on a dispen-

sary in a smaller community. These articles will stand more than one reading and should be preserved for future reference. The dispensary is not an institution needed only in the larger cities, as we have been led to believe. Dispensaries in smaller hospitals and smaller communities are demonstrating their value and their number is sure to increase.

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Are Institutions for Infants Necessary?

In the *Journal of A. M. A.* Dr. H. D. Chapin states his conviction that large wards and large institutions are undesirable for infants; and that the multiplication of infants' hospitals should not be encouraged. Small units, he believes, are the type of hospital best fitted for the care of infants.

The danger of cross infection is to be guarded against by skillful nursing. The principle of aseptic nursing should be observed. There should be at least one good nurse to three or four sick infants. Atrophic infants, with chronic indigestion and poor assimilation should not be treated in a hospital. The large institutions for the care of foundlings and abandoned babies could be abolished, with a lowering of the infantile death rate, if the facts learned from long observation and experience were more fully appreciated in this country. No less than 42 per cent. of the total deaths of infants in Manhattan during recent years have occurred in institutions. The system is wrong. Rarely is there sufficient individual care. The high mortality may be reduced by systematized and regulated boarding of infants. The author twelve years ago instituted a plan of boarding out atrophic or abandoned babies which has been in successful operation ever since. The following features are emphasized: Boarding out in a certain district noted for its healthful conditions; constant attention to diet and hygiene on the part of a well-qualified physician and nurse; keep the infants as long as necessary, until digestion

and assimilation are so improved as to result in a gain in weight; the training in a given neighborhood, of a number of foster mothers, who, by taking these infants into their homes, become fairly expert in handling them under conditions totally unlike those offered by the best institution and far superior to them.

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Dr Kavanagh Resigns

Dr. Abram S. Kavanagh has tendered his resignation as Superintendent of the Methodist Episcopal Hospital, Brooklyn, N. Y., after fourteen years of efficient and devoted service.

Dr. Kavanagh's reasons for retiring at the height of his usefulness, and against the unanimous wish of the Board, are given in his resignation which he presented to the trustees on June 24:

"I am resigning because I have, I think, more than accomplished all that I came to the hospital to do; and because I think some one else should take up the work now and devote at least as long a period to its interests as I have done; while I shall be permitted to return to the work which has always tugged a little bit at my heart-strings since I left it."

The following are some of the things Dr. Kavanagh has accomplished during his term of service:

The number of beds has been increased from 75 to 225. The financial situation has been so re-enforced that now for several years the monthly bills have been promptly paid from income. The invested and interest-bearing funds have more than doubled, having now reached the sum of more than \$903,000. The original buildings have not only all been completed and fully equipped, but required and large additions have been made, altogether at an expenditure of not less than \$300,000. A new and much needed home for nurses is now in process of completion, and will soon be ready for occupancy. The Training



THE STAMBAUGH NURSES' HOME, YOUNGSTOWN, OHIO

School for Nurses has been more than doubled in numbers. During the same period, by diligent, skilled, and unremitting efforts and methods, instituted a widening and helpful public recognition and interest have been attracted to the hospital.

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The Stambaugh Nurses' Home

One of the most useful and beautiful gifts that a hospital can receive has been received by the Youngstown Hospital, Youngstown, Ohio, in the Stambaugh Nurses' Home, presented to the hospital by the Stambaugh family. It is said to be a real home in every sense of the word.

It is three stories high, of gray limestone, and in harmony with the main hospital building. An old English style of architecture has been followed and the effect has been enhanced by the trimming which is of Flemish oak.

The design of the building, its finishing

and its furnishings, all are Old English in line and color effect.

There are two large verandas: one rather in the nature of a terrace is 12 feet broad and stretches 60 feet across the front; the other, on the opposite side of the main building, is 16 by 30 feet with a flat roof and Colonial pillars. The front terrace is open to the sky and has a red-tiled floor.

The living room is 22 x 37 feet, panelled in oak. Facing the entrance is a large stone-trimmed fireplace. The furniture is of fumed oak, dark brown wicker with leather upholstery.

Opening off the right end of the living room is a smaller reception room, the walls of which have been covered with canvas and tinted in a light neutral shade. It is furnished in light colored wicker with upholstery in cretonne.

At the left of the living room and facing the front is a suite of two rooms and a bath for the use of the directress of nurses. The

remainder of this floor is given over to single rooms, 14 in all, for the use of heads of departments and of graduate staff nurses. They are all finished in dark oak with buff walls and cream ceiling with hardware and fixtures in dull black. Each room has a built-in wardrobe and is furnished with a brass bed, fumed oak dresser, combination nurses' table, bookcase and desk with two rockers and bedroom chairs. The floors are of cement with sanitary cove base and are covered with rugs of gray fiber material with a border done in a floral design in blue.

The second and third floors are alike; each has 20 rooms and is devoted entirely to sleeping quarters for pupil nurses. These rooms are large and each has two or three windows. Two nurses occupy each room and each has her own separate built-in wardrobes. Besides the bed rooms on each floor are large linen rooms and clothes chutes.

On the ground floor are the dining rooms, kitchen, trunk room, linen room, pantry, dietetic laboratory and nurses' lecture and recitation rooms.

In the basement an entrance is provided for nurses who may accidentally come in contact with contagious cases while on duty. This entrance takes the nurse into a dressing room where she may remove her infected clothing so that it may be subjected to the proper disinfection. This small room connects with a bathroom where the nurse bathes and washes her hair. On the opposite side of the bath room is another dressing room where the nurse dons fresh clothing which has been brought there for her. This method gains her admission to the home with a minimum danger of carrying contagion.

The home accommodates 90 nurses; 26 in single rooms and the balance in double rooms. The cost was \$70,000. It is connected with the hospital by a subway.

Formulas Approved by the U. S. Internal Revenue Department for Anti-septic Purposes in Hospitals

No. 1. Alum 10 grains, camphor 3 grains, alcohol 4 ounces.

No. 2. Carbolic acid 1 part, alcohol 99 parts.

No. 3. Formaldehyde 1 part, alcohol 250 parts.

No. 4. Alum 2 ounces, sulphate of zinc 1 ounce, alcohol 1 gallon.

No. 5. Alum 1 dram, camphor 1 ounce, alcohol 1 pint.

No. 6. Bichloride of mercury 1 part, alcohol 2,000 parts.

No. 7. Alum 2 ounces, salicylic acid 2 ounces, II gaultheria 2 ounces, water 1 pint, alcohol q. s. $\frac{1}{2}$ gallon.

No. 8. Carbolic acid 2 drams, oil gaultheria 20 drops, alcohol 1 gallon.

No. 9. Bichloride of mercury 0.8 gram, hydrochloric acid 60 c.c., alcohol 640 c.c., water 300 c.c.

No. 10. Bichloride of mercury $1\frac{1}{2}$ grains, hydrochloric acid 2 drams, alcohol 4 ounces.

No. 11. Bicarbonate of soda 3 ounces, extract of hamamelis 16 ounces, water 16 ounces, alcohol 16 ounces.

No. 12. Formaldehyde 2 parts, glycerin 2 parts, alcohol 96 parts.

No. 13. Oil cajuputi 1 dram, alcohol 1 pint.

No. 14. Tannic acid 12 parts, alcohol 125 parts, water 125 parts.

No. 15. Carbolic acid 1 dram, tannic acid 1 dram, alcohol 1 pint, water 1 pint.

No. 16. Alum $\frac{1}{2}$ ounce, formaldehyde 2 drams, camphor 1 ounce, alcohol and water each 1 pint.

No. 17. Lysol 1 part, alcohol 99 parts.

No. 18. Liquor cresolis comp. (U. S. P.) 10 c.c., alcohol 1,000 c.c.

Editorially Speaking

Death of Mrs. McEvoy

Announcement of the illness of Mrs. Fanny Wilde McEvoy, the aged Nightingale nurse—who for four years has been supported from the contributions of nurses scattered in a dozen or more different countries—has been made through these columns from time to time. It will be therefore no surprise to her friends to hear of her death which took place in Detroit, July 29. She had passed her eighty-sixth birthday a few weeks before her death.

On January 30th of this year she was stricken with paralysis and since then has been bedridden. For two years she has been comfortably cared for in a boarding home for old ladies, and as far as human hands could secure comfort she lacked nothing needful. During part of her illness she had the services of a special nurse.

She is probably the last member of the first class of nurses trained in the Nightingale school at St. Thomas's Hospital, England, to be laid away. It will always stand to the credit of the nursing body that her last days were not spent in the county almshouse which, four years ago, seemed to be the only refuge for the old couple. However, once the situation was made known, nurses from the corners of the world rallied to her support and announced themselves as ready to contribute as long as might be needed. English nurses through the treasurer of St. Thomas's Hospital sent about \$75 the first year. Special mention should be made of the Ohio Nurse's Association, the West Virginia Nurses Association, the Ontario Nurses Association, the Alumni Associations of the Massachusetts Gen-

eral Hospital, the Waltham Training School, the Hospital for Sick Children, Toronto, the Toronto General Hospital and other hospitals who have sent annual contributions from the time the fund was started. The Spanish American War Nurses contributed



Fanny Wilde McEvoy

and until the past year the nurses in the American Hospital, Mexico, have contributed and, in a number of different cities, individual nurses have collected sums ranging from \$2 to \$25 for her care. The beautiful thing is, that nurses cared enough to want to help, and to do everything possible to make the last days of the old veteran of the nursing professions, free from worry of every kind.

Every letter received has been preserved,

and a careful account has been made of all contributions. A statement will be sent to any contributor who desires it.

Bills for funeral expenses have not yet been presented—but it is estimated that there will remain to her credit in the bank, about \$175—enough to provide a neat stone and leave a small sum for flowers, each year for some years to come.

To the writer, her care has been a labor of love—tedious many times when scores of dollar contributions had to be acknowledged—but from the beginning it has been a task which was never to be laid down till the end came. It goes to prove that when one starts a good thing, there will always be found willing hearts and hands to help. To all who have contributed in any way to care of Mrs. McEvoy during the past the four years the writer wishes to express her personal thanks. CHARLOTTE A. AIKENS.



Ex-President Taft on Law Making

In an address before the Boston Bar Association, on "The Evil of Multiplicity of Laws," Mr. Taft called attention to the fact that there had been passed, by Congress and State legislatures in the last four years, 65,000 laws, and that such a mass of legislation was an evil of burdensome proportions, as we were rapidly finding out.

"This excess of legislation," says Mr. Taft, "I attribute to two causes. The first is the erroneous belief that any reform can be accomplished merely by legislation; and the second that legislators are prone to enact laws, not because they believe their enforcement would do any good, or because they had their enforcement in mind, but only because they would profit them politically."

We have repeatedly called attention in these columns to the evils of *premature* or ill-digested legislation in nursing matters. Bill after bill relating to practical nurses have been introduced into legislatures this

past year by people who have never spent even one week in a close hand-to-hand study of the many-sided situation as it relates to practical nurses, yet they are sure they can frame a law on the subject. Any one who thinks that reforms in the practical nursing situation can be wrought at this time by State registration of practical nurses, has little or no real knowledge of the everyday problem involved in handling practical nurses.

The only way improvement can come is through the closest kind of local supervision. Given a knowledge of the women doing this work, and careful records, local boards of health have the power without additional legislation to control the situation. But the beginning of improvement is in constructive work, is having a bureau of public service in a community that will weigh the fitness of each applicant; keep records and when the proper hour arrives—it may be years hence—place the facts before the local health board and let it take the necessary steps to put the unfit out of business and to keep others from entering the field.

What the nurse registration boards could do and should do is to classify all training schools, and work to the end that all schools that profess to give training to nurses shall comply with a minimum standard. If two classes of schools were formed, public opinion would back up the effort to close those schools that refused to conform to a minimum standard. As matters stand now, the best schools are registered and a degree of supervision exercised—those failing to come up to the high standard set can do as they please. It is nobody's business how much or how little they teach. They need not even employ a trained nurse in charge of the nursing—but they can still run a training school. The inconsistency of this arrangement needs no argument except to those who are so fixed in their opinions that they refuse to try to see any viewpoint but their own.

The Pupil Nurses of the University Hospital

The recent disturbance among the nurses of the University Hospital, Philadelphia, Pa., is still attracting considerable attention. Like everything which gets into the newspapers, the matter has been much exaggerated. As we have received numerous letters of inquiry regarding it, we are glad to be able to give our readers the following authorized account of the trouble:

On the 16th of April, 1914, at a meeting of the Board of Managers, the plan to send six pupil nurses to the Phipps Institute for a term of two months each was, on motion, duly seconded, accepted and approved. A notice was posted in the Nurses' Home a few days afterwards, which remained on the nurses' bulletin board all summer. The junior class was sent two and three at a time, and no word of dissatisfaction or disapproval reached any of the authorities of the hospital until Thursday, May 27th, 1915, when a petition was received from the sub-junior class addressed to the board of Managers, asking that they be released from duty at the Phipps Institute and the course discontinued, giving as their reasons "certain facts brought to their knowledge." The board of managers replied: "The matter was referred to the committee on medical affairs for investigation and report to the board, and the superintendent was requested to notify the class that, pending receipt of such report, the plan heretofore pursued would be followed."

A copy of this resolution was sent to the sub-junior class.

On Friday afternoon the directress of nurses sent for the three members of the class whose turn it was to go on duty at the Phipps Institute. Each one refused to take the service. The superintendent was asked by the directress of nurses to address the class, which she did, and reminded them that it was impossible for an investigation to be completed in twenty-four hours, and

asked them to give the board the time and attention necessary. She talked to them for half an hour, giving individual nurses a chance to make any complaint they wished.

The next morning the directress of nurses received a letter stating that the whole class refused to permit any member to go to the Phipps Institute. An informal meeting of the board of managers was called and the subject was freely discussed. The professor of medicine was asked to address the class on the subject of tuberculosis and the very improbable danger of contagion. At the close of the address each nurse was asked privately as she left the clinic if she would go to the Phipps Institute and, with one exception, they all refused. Those who refused were told to leave the hospital immediately. This was about 3 p. m. By eight o'clock p. m., thirty-two out of thirty-eight had come back and asked the directress of nurses to keep them and put them on duty, which the board allowed.

The accusations made against the Phipps Institute at the time were only hearsay, as only two members of the class had been down there, and most of them have proved untrue.

The board of managers instructed the superintendent to make the following statement for the press:

"The service at the Phipps Institute assigned to the University Nurses is a privilege which adds to the thoroughness of their training and the value of their diplomas. It opens fields of usefulness and avenues of employment, which in their later lives, will be invaluable to them and to their patients. It teaches them not only how to take care of tuberculosis in the modern and scientific way, but also how to take care of themselves when, as will inevitably be the case, they come to be in charge of tuberculous diseases.

"Direct contagion between tuberculous patients and healthy adults in such re-

lationship as exists in a modern hospital is, according to the best expert opinion of the day, highly improbable if not impossible. It becomes still more so in this case as the Phipps Institute represents in all ways the most scientific methods of combating every possible avenue of transmission of the disease from the sick to the well.

"Moreover the nurses in question did not base their refusal to go on duty upon their fear of contracting this disease. If they had, their position would have been none the less untenable. Nurses or physicians who, on account of personal risk, decline to learn whatever is necessary to perfect themselves in their ability to care for sick persons, are obviously unfit for the practice of either profession.

"The complaints of some of the nurses were as to individual incidents which, if they were true, would be exceptional and easily corrected. Some of them the board have already found to be untrue. No rumor of discontent reached the board until its meeting of May 27th. An investigation was begun on May 28th. It is obvious that unless the board is prepared to turn over the management of the University Hospital and the Phipps Institute to a class of young women just beginning their professional education, the present rules must be enforced."



Mary J. Turner

We know our readers will all be interested in the picture of Mary J. Turner, one of the pioneer nurses to whom the trained nurses of today owe so much. Miss Turner graduated in the first class of the training school of the Hospital of the Good Shepherd, Syracuse, N. Y. In speaking of her class, Miss Turner says: "We were only seven, and our training was limited, and taken under great difficulties, but it put us on our mettle; we had to depend on ourselves, which was not a bad thing after all, in many ways." Not



Mary J. Turner

the least interesting circumstance about Miss Turner is that she had a copy of the first issue of *THE TRAINED NURSE AND HOSPITAL REVIEW*, and is still on the list. She also sent in the first club of subscribers. The photograph here reproduced was taken three years ago, when Miss Turner was seventy years old.

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

Sanatorium vs. General Hospital

To the Editor of The Trained Nurse:

In reply to the enthusiastic letter of Miss C. J. Garrison, of Kalamazoo, I beg to state that I, too, have been most anxious to have patients and nurses well fed, as anyone could affirm who had a personal knowledge of any situation where I had control. I maintain that a superintendent should fight for that, or resign, where the managing committee cannot lend itself to conditions well.

But there are points of difference between a sanatorium, such as Miss Garrison manages, and a general hospital. In a sanatorium, the kinds of patients and the kinds of food are limited. For consumption or nervous ailments, the food is the cardinal feature; nothing else counts much in the expenditures. In a hospital however, while the food must be nourishing, and tastily served in abundance, it need not be cream, or capon. The food must be, in a general hospital, such as will maintain vigor, counteract discharges, and satisfy all demands on the system. Good bread, butter and milk will put such flesh on a poor starving foreigner that he can scarcely be driven away from the place, back to his meagre lunches of soggy bread split to hold a slice of green peppers.

In a general hospital, the intestinal tract is usually in such a minor place of importance, that pasteurization, cream percentages, etc., concern only the babies' ward. In treatment of tuberculosis, however, the system must be liberally stocked with fat. The normal man or woman cannot successfully dispose of a large amount of cream daily. Many nurses grow bilious on cream, and others become pimply with too much butter. I have always contended that the pupils require cream on their cereals and puddings and fruits, but they need not be treated like tuberculous patients. Then, too, regarding butter: it should be of the best kind procurable for all alike, staff, patients, pupils, but at the very moment I was contending for such necessities, with any committee, had they walked into the dining-room they would have seen half a dozen

nurses each take and leave on her plate far more butter than she could use.

There are many cases of diet in which it is imperative to use skim milk, for instance high acid stomach conditions.

In a general hospital, money is lost on almost every patient. The institution has a deficit annually. In a sanatorium, as a rule, the charges are high enough to cover expenses, unless it is conducted for charitable purposes by a corporation.

In a general hospital, there are large expenses attendant upon the training of the nurses, which are never found in the administration of a sanatorium, where the kinds of nursing are limited.

In a general hospital there are so many thousand ways to spend far more than one's income, in x-ray equipment, operating-room appliances, libraries for pupils, teaching staff of nurses for the pupils' courses, drugs, vaccines, and all other modern forms of treatment, not found necessary in a sanatorium, that one fails to find many points of resemblance.

A. A. S.

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The Passing of Conscience

To the Editor of The Trained Nurse:

With individuals as well as industrial corporations we find the conscience subservient to commercialism. Conscience, although difficult to define, is, you will admit, the sense of duty, honesty and justice toward our fellowmen and, incidentally, ourselves. It is our sense of right and wrong. It is our best selves. It is conscience which makes a nurse boil a hypo or sterilize an instrument just as thoroughly when alone as when watched by a head nurse or doctor.

Are we consulting our best selves when we are ignoring the facts that many nurses in private and hospital practice today are fast getting away from the first principles of love, kindness, tenderness and consideration for others. These points I will admit are taught theoretically and every nurse has somewhere, perhaps in an old

trunk, a set of carefully written notes on "Department." But the goods are not being delivered. We grow very indignant when we buy an article from the store and find it defective, but are we giving always full value for compensation received? A nurse in one of our large hospitals not long ago was wakened by a groan from her recently operated upon patient. The nurse shook her violently with the remark, "How dare you waken me." The patient, being a sensitive, refined woman, became so nervous over the nurse's rudeness that she could not sleep that night nor the next. We could multiply incidents of this kind over and over. Neglected treatments, unsuitable meals and, again, patients being left alone unnecessarily long periods in critical conditions while the nurse has her regulation hours off.

Where is the conscience when a nurse will voluntarily do nothing for weeks at a time when all about her are people suffering for what she could give, simply because she is worshipping at the feet of trades unionism, which says, "You shall do thus and so," regardless of humanity's demands, and in spite of the conscience of the nurse.

The responsibility cannot be shifted on visiting nurses' associations, charities, domestic nurses, etc.; the ball must rebound and the blame must rest on those misguided nurses who are posing for what they are not, namely, a blessing to a household in time of trouble.

The most universal complaint we hear is that nurses require too much waiting upon. An R.N. not long ago waited for a servant to come upstairs to pour her coffee, which was at her elbow. The greatest Teacher said, "I came not to be ministered unto but to minister." The public label nurses correctly in spite of legislation, "O.K." or "N.G." and in spite of school pins and other regalia. A prominent surgeon expressed himself the other day in terms, it is true, not very elegant but to the point. He had just placed a nurse who was in need of work where, had she been agreeable, she would have been kept for some time but, as he expressed it, she was too d— classical to see anything to do.

Her place was soon taken by a sensible woman with a smaller fee who is filling the place successfully. We recently heard of a nurse in a home of wealth and refinement, who at the week's end was asked to take a bath, at the conclusion of which she was asked to pack her suitcase. Is not the knowledge of hygiene one of the essentials in the training of our graduates? "Character," that greatest of all assets, is no longer a necessary

qualification, or, if it is, it does not eliminate the frivolous type which stoops to flirt and makes for herself a name which injures the reputation of the profession at large.

Too much emphasis is being placed on suitable appellations, high standings and official recognition, and not enough on *efficient nursing* of the sick. Can I appeal to you as women with consciences, to do some thinking for yourselves, for every woman who enters a training school has entered it because she wished to be of some use in the world, but she often leaves the school with such an exaggerated idea of her importance that what she *won't* do in a home so far exceeds what she *will* do that the majority of nurses have gone into disfavor with the public in general, because of their uselessness and correspondingly high rates, which are out of all proportion to the average man's pocketbook. Let us sit alone with our conscience once in a while and let us come forth from that sacred consultation and "deliver the goods" to a waiting public.

EDITH M. RICE, R.N.



The Grading of Nurses

To the Editor of the Trained Nurse:

I am a late subscriber to your magazine, but am much interested in all the articles on the various subjects relating to the work.

I am sorry to see there is so much feeling about the different standards of nursing and I feel sure the whole thing could be adjusted by the nurses themselves if they would all get together and talk the matter over.

I have been fourteen years in the work, and I find a great many practical nurses in the field, who have not had the advantages of hospital training. I think there could be some way of giving special training to most of these, having central classes near all large nursing centers, where they could attend lectures, cooking classes, etc., and spend a portion of each year in some hospital.

They could take examinations on what they have studied and be graded according to their knowledge and ability.

There are a great many very good women, who cannot spare the time to give to the hospital training and I feel that it would offer a very good field for some one of executive ability to help along these people instead of condemning them, as a great many such women have done very faithful, conscientious work.

I was much interested in the article on "A

Year of Organized Neighborliness," by Miss Carson, and think it is a fine thing, only I feel that the workers should be graded for their work and credited and then allowed to either continue or finish in some hospital.

In nearly all schools one is allowed credit for study and I feel the same rule should apply to nursing.

I am very much interested in the welfare work, and also would like to see special convalescent work. The work is so broad that one can use all her talents and still not conflict with anyone else.

MARY J. HAYDEN.



Choosing Probationers

To the Editor of the Trained Nurse:

I was much impressed with the article "A New Scheme for Choosing Probationers," in the June issue, by Cecil Charles. I read it through several times, and I feel that she is right. Many may think question number 9 of her questions for probationers—"name five imported fruits and the countries they come from"—rather far-fetched, but I can state that it is not.

While doing special nursing in a hospital in this city, one of the nurses told me that when she had first come to the training school, she had been sent out to buy a pineapple. Not wishing to let it be known how little she knew about fruits, she said "I will take one of these." But "these" proved to be a cocoanut, and not a pineapple. At another time while doing special nursing in a hospital, one of the nurses in training asked me from what school I had graduated, before I could answer, my patient spoke up and said "from the school of experience," the nurse said, "Oh! out of the city."

I am neither a graduate from high school, nor an R. N., but my heart is in my work. I am a widow of 28 years, and the mother of three children, two living. I started rather young to graduate from the school of experience. I have been nursing four years and, in the offices of some of the leading physicians, there is a star after my name. I do not want any graduate nurse to feel that in relating the above incidents, I am casting any reflection on the graduate nurse, for if I had the means to train and at the same time provide for my two promising girls of nine and ten, I should most certainly train, and try to be an honor to the profession. I enjoy reading THE TRAINED NURSE, and always take one with me on a case.

SAGINAW, MICH.

Was She Right or Wrong?

To the Editor of the Trained Nurse:

On a recent case, the attending physician blamed me for not applying hot moist applications, on my own responsibility, though this was not part of his orders. I am very particular about giving fomentations or applications of any kind, as I know there are times where they may do more harm than good. Was I right or wrong for not giving them without the doctor's orders? I would like very much to have various views on the subject.

FLORENCE KELLOGG.



Should She Have Charged for Time?

To the Editor of the Trained Nurse:

In the July number of THE TRAINED NURSE, the question is asked: "Should a nurse charge for waiting for a confinement case—such case proving to be a false conception?"

If the nurse was notified four weeks before the date of expected birth (unless she had lost other cases while waiting), I do not think she should receive any pay. But if she had refused cases, and so lost time and money, I think she should receive part pay.

Last summer I held myself in waiting six weeks. Then went to the patient for two weeks, the baby did not come, and did not seem to be inclined to come. The family did not want me to stay and do nothing, so I charged for one week, and left, giving my address, which they failed to put down. The baby came the next day. I lost the case. Should I have charged for any of the time lost?

A. E. B.



Clinical Records

To the Editor of the Trained Nurse:

I read with considerable interest the article in the July number of THE TRAINED NURSE, "The relation of the nurse to the ownership of clinical records."

I, for one, must confess that it opened a new line of thought to me. Heretofore, if the subject had been under discussion, I would have assumed without question, the clinical records could be of interest only to the physician and the nurse.

In conclusion I may say that I am still finding it hard to convince myself of the proper attitude in this matter, but am anxiously awaiting the comments of other nurses on this subject.

ONA JOHNSON, R.N.



GRADUATING CLASS, WASHINGTON HOSPITAL, WASHINGTON, PA.

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

U. S. Navy Nurse Corps

APPOINTMENTS: Winifred V. Maynard, R. N., New York City Hospital Training School, Gouverneur Hospital, N. Y.; Charge Nurse, Santo Thomas Hospital, Panama; Nelle M. Sherzinger, R. N., Wheeling Hospital, West Va.; Marguerite Leathley, R. N., Harper Hospital, Detroit, Mich.; Helen B. Kenney, R. N., Philadelphia General Hospital, Philadelphia, Pa.; Edith V. Kiester, R. N., Medico-Chirurgical Hospital, Philadelphia, Pa., head nurse, Rockefeller Hospital, N. Y.; Eva E. Macleod, R. N., Massachusetts General Hospital, Boston, Mass., assistant superintendent, St. Luke's Hospital, Bellingham, Wash., night superintendent, St. Frances Hospital, San Francisco, Cal.; J. Beatrice Bowman, R. N., Medico-Chirurgical Hospital, Philadelphia, chief nurse, Navy Nurse Corps, Red Cross Service, England, six months; Alice Newman, R. N., Los Angeles County Hospital, Cal., P. G. Course Columbia Hospital, San Francisco, Cal.; Louise Blake Reed, R. N., New York City Hospital, Blackwell's Island; Frances C. Bonner, R. N., Philadelphia General Hospital, Pa., post graduate course, St. Christopher's Hospital, New York Gouverneur Hospital, New York; Julia T. Johnson, R. N., Maryland General Hospital, Baltimore, Md., night supervisor, Maryland General Hospital.

TRANSFERS: Chief nurse, J. Beatrice Bowman, to Washington, D. C.; chief nurse, Mary H. Du Bose, to Canacao, P. I.; chief nurse, Ada M. Pendleton, to Tutuila, Samoa; chief nurse, Nell I. Disert, to Mare Island, Cal.; acting chief nurse, Mary H. Humphrey, to Chelsea, Mass.; Winifred V. Maynard, to Washington, D. C.; Nelle M. Sherzinger, to Annapolis, Md.; Marguerite Leathley, to Newport, R. I.; Helen B. Kenney, to Newport, R. I.; Edith V. Kiester, to Washington, D. C.; Eva E. Macleod, to Newport, R. I.; Alice Newman, to Mare Island, Cal.; Louise Blake Reed, to Washington, D. C.; Frances C. Bonner, to New York; Julia T. Johnson, to Norfolk, Va.; Esther Le C. James, to Mare Island; Mary T. O'Connell, to Mare Island, Cal.; Alice Henderson, to Mare Island, Cal.; Florence M. Vevia, to Canacao, P. I.; Julia T. Madden, to Canacao, P. I.; Frida



GRADUATING CLASS, HATTIESBURG HOSPITAL, HATTIESBURG, MISS.

Krook, to Canacao, P. I.; Mary J. Anderson, to Canacao, P. I.; Julia A. Nicholls, to Guam; Anna M. Swanson, to Guam; Julia T. Coonan, to Newport, R. I.; Selina M. Griffith, to Newport, R. I.; Carrie M. Luppert, to Newport, R. I.; Ella A. F. Blain, to Washington, D. C.; Ruby E. Wood, to Chelsea, Mass.; Eleanor Gallaher, to Washington, D. C.; Mary Brooks, to New York; Anna M. Fallamal, to Chelsea, Mass.; Blanche C. Moran, to Chelsea, Mass.; Lily E. White, to New York, N. Y.

HONORABLE DISCHARGE: Sara A. May.

RESIGNATIONS: Alice E. Wheeler, Emmeline Bauer, Jean Allan, Edith G. Lightle, Minnie E. Holtam.

DISCHARGED: Antoinette Montferrand.

LENA S. HIGBEE,
Superintendent Navy Nurse Corps.

International Convention of Nurses

(Continued)

On Thursday, June 24, the National Organization for Public Health Nursing met at 9 A. M., under the direction of the Committee on Industrial Nursing, with Miss Eva I. Anderson of Chicago, in the chair, and heard a brief but interesting paper on "The Study and Prevention of Cancer," by Dr. Edward Reynolds of Boston, vice-president and director of the American Society for the Control of Cancer. The main point emphasized was the development of malignant, from long continued benign growths, and consequent desirability of treating the latter. It was affirmed that any lump in the breast, except when there is acute inflammation, should be excised to avoid the chance of cancer developing and that any unusual vaginal discharge, even if apparently only symptomatic of ulceration, should also receive treatment.

A number of short papers on varied types of industrial nursing were read by Miss Van Allen of Los Angeles and others, and the report was heard of the committee on industrial nursing.

At 10 a. m. the American Nurses' Association held a meeting. The first paper was on "Indian Nurses and Nursing Indians," and was read by Miss Estaiene M. De Peltquestagne of Massillon, Ohio, herself a member of an Indian tribe. Her paper was extremely interesting—giving a sympathetic and vivid picture of the condition of the Indians under the reservation system, which was designated a great pauperizing scheme, adopted for the convenience of the white people. She spoke of the prevalence of disease among the Indians on the reservations, especially trachoma and tuberculosis, the latter a disease that in their natural out-door life they did not have to contend with, whereas they now live in close quarters, and of the little care that has been taken of their health, one physician often caring for some 17,000 souls scattered over a million acres of land. The chief difficulties in improving health conditions were dirt, the medicine men, and superstition. Doctor's orders were disregarded, contagious diseases concealed, babies spirited away, young mothers died in childbirth. There are some seven nurses of Indian blood in the employ of the United States Government, and they are doing good work. A larger number are doing private nursing. They have the advantage of understanding the people and having no prejudice to overcome, but though they are painstaking and conscientious, they are not of the most educated class. Little can be done to improve conditions so long as they are kept apart,

clothed, fed and thought for. What they need is to be taught to do these things for themselves, to be made to realize their responsibilities in life and that they have the capacity to live up to them. When the Indian girls and boys are given this inspiration and a foreigner's chance to make good, they will take care of their own problem. Nurses should use their influence to make the Indian a part of the nation.

Mrs. Annette Alison of Oakland, Cal., next spoke on "Some Points in Organization Work." After stating that the work was young in California and that results lay largely in the future, she said that organization was the banding together of people for mutual good and that it was valuable in proportion to the service rendered. The nurses' salvation lies in organization and the individual nurses, especially the private nurses, should join together. Need to reach the nurses and hold them in this matter. Our organization is not a political arena or a social ladder but the largest body of professional women in the civilized world, our work the highest. We must look how we build and there are two points to work from, the association and the local registry. The latter is the more important and it should be restricted to members of the local association, which must get the good will of the medical association. It should have the assurance that any nurse entering a doctor's office or a hospital will be directed to the registry. Pupil nurses should be told to go here and to join the association. A registry should not be handling only one per cent. of the work and sending out strangers. Then, association gatherings should be interesting and helpful. There should be less of parliamentary law and more of the law of human kindness. A simple initiation ceremony was suggested as appealing to the average person and that a program be made up from subjects under consideration in the national organizations and published in the journals. Offices should be more generally distributed, it perhaps being made a law that after two years' service a person should not be eligible again for five years. Nurses from one hospital should not have control, and life membership might be a good thing. The formation of a private duty nurse league was suggested, to give the private nurse the opportunity to manage her own affairs, free from the influence of hospitals and doctors. The question of the male nurses was also brought up and whether they were given sufficient consideration by their co-workers.

After some discussion of the Indian service, the supply of nurses, their remuneration, etc., a

vote was passed that the executive board be instructed to find out if any effect could be produced by a plea from the American Nurses' Association to the Governor that better medical and nursing service be supplied to the Indians.

The paper of Miss Elizabeth C. Burgess of Chicago on "The Future of the Central Registry" was read by Miss Eldridge.

In the discussion of this paper, in which Miss Ahrens of Chicago took a prominent part, it was considered that one reason the central directory had not been more successful was that it did not afford a comfortable home. It must have the support of the large hospitals, which should turn over their directories to it and it should be made the general nursing center, with offices and rooms for the meetings of associations, and a pleasant home for the nurses. It needs also to advertise widely. There was considerable discussion as to what constituted a "commercial registry." It was generally agreed that any registry run to make money was "commercial," though some considered one not restricting membership to registered nurses in that light.

There were two other papers, "Directory Rules and Government," by Miss Agnes G. Deans of Detroit, and "Competition of Non-Professional Registries with Central Directories," by Miss Lydia A. Giberson, of Philadelphia.

At 11 A. M., the National League of Nursing Education held a conference on "Practical Problems in Training School Administration," with Miss Noyes as chairman. Miss Pickhardt, of Pasadena, Cal., read a paper on "Training School Records," which was discussed by Miss Sara E. Parsons, of Boston and Miss Amy Hilliard of New York. The greatest interest centered, however, in the paper on "The Eight-Hour Law for Pupil Nurses in California, after One and One-Half Years' Practical Demonstration in a Hospital of 100 Beds," by Mrs. H. W. Pahl, superintendent of the Angelus Hospital, Los Angeles, Cal. At first, she said the problem seemed great. It increased the number of pupils and of teachers each one-third and raised the hospital rates. It also meant that each patient had at least five nurses in twenty-four hours, so the work of the pupil nurses must be perfected that the changes may be as smooth as possible. A time chart is made and posted and each pupil checks off her time on duty. That the off-duty hours may be well spent, studies fill much of the time and there is an instructor in theory and another in practice, with the result of an improvement in the theoretical work. Each nurse has one day free a week, getting through at 7

or 10.30 P. M., and having about 32 consecutive hours, in which she can go home. The night nurse has the same time off duty. People say this is subversive of discipline, but young women of twenty-two should not need discipline. It should not be necessary to teach morals and arithmetic, and the free time keeps them fresh and well. Hospitals are too freely criticized. The eight-hour law can be operated to the advantage of the nurse and the hospital, but it is hard on the public pocket. Then as the nurse must go off duty at the end of her eight hours it inevitably happens that she has frequently to leave in the middle of childbirth or an operation. The remedy lies with the people. Neither nurses nor hospitals asked for it and the public can change it. Four months of private nursing in the hospital during the third year would be good. The law was passed to get better hours and better instruction for nurses and it is a long step in the right direction.

Miss H. McMillan of the Presbyterian Hospital, Chicago, who was to have opened the discussion, was not present and Miss Effie Taylor, of Johns Hopkins, was the first to speak. She spoke of the different laws governing the working hours of women in different States and said that long hours and much standing had been shown to cause ill health. Long hours were not conducive to efficiency and usually improvement in work came with shorter hours. It seemed expensive for the hospital to have shorter hours for pupils, but was it really so if the time lost through sickness and needed rest on the part of the nurses was considered.

Mrs. Charles F. Edson, of the California State Industrial Commission, said that she was responsible for the eight-hour law for nurses. Much of the prejudice against the law came from a mistaken idea that it was brought about by the Federated Labor Council of San Francisco, but, in reality, many relatives and friends of pupil nurses had brought complaint of the long hours of their work, not understanding why they should have such, where there was a law to regulate the working hours of women. The Bureau of Labor is not a labor organization. The complaints that came to the members made them feel the pupil nurses should be brought under the law and they got the word "hospitals" inserted in the bill drawn up by the American Association of Labor. The law covers all workers in hospitals except graduate nurses. The hours can be arranged in any way so that they are accurate. The reason eight hours a day were stipulated for rather than 56

or 48 hours a week was that, in the latter case, it would have been impossible to detect infractions of the law.

The point was brought out that the unfortunate part about the law, is that something is lost in the spirit of the work. The nurse should be working for the welfare of mankind, and, if she works by the clock, it is demoralizing to her. Then, if a nurse is careless or slow or shirks, there is no way of keeping her to finish up her work, which is also demoralizing. Asked how the law affected moderate class people who cannot afford high expense, Mrs. Pahl branched off into a statement of the high-class women they got in their training school, with high school, and many with university training, with the advantages of the extra free times and the nurse not dropping out of the community life, of having a day free and forgetting all professional matters and ended with the suggestion that a few private cases in pneumonia, typhoid, etc., for the nurses would give the poor patient a chance for special care at less expense. To the suggestion that nurses would not learn long hours of endurance and that being under the labor law might be a drawback to the realization of the dream of being a profession, Mrs. Pahl answered that they were losing sight of the origin of the law and that pupils were constantly warned of the long hours of work before them after graduation.

Miss Goodrich said that when the nursing schools were schools it would not be possible to come under any labor laws. If their students work like other students, they will learn endurance.

Miss Parsons said that States without a law should avoid the necessity of a law. To avoid expense to patient, she would have the pupil pay for her instruction when unnecessary duties are eliminated. Then the course could be shortened and a charge made of \$200, or the nurse could be allowed to pay in last six weeks of course by specializing private patients.

At 2 P. M. a session on legislation was held, with Miss Anna C. Jamme in the chair. The first subject to be considered was the "Administration of Registration Laws," and this had been divided into several minor topics, of which two, the headquarters of administration and the setting of examination questions, had already been discussed at another meeting. The object was to consider the machinery in operation and see if it is effective.

The first paper was that of Miss Jane V. Doyle, of Oregon, on the "Administration of

Registration by a Board of Nurses." In it she maintained that given the proper personality and qualifications a board of nurse examiners was most satisfactory because the nurse was best fitted by her experience for the work.

They had had no response to a request for information as to administration by a medical board from the board of examiners in New Hampshire, but a letter was read from Louisiana in which the objections to a medical board were stated to be lack of interest and willingness to act and lack of knowledge. The only advantage was said to be that it was removed from nursing politics.

In the absence of Miss Johnson of Iowa, who was to have spoken on "Administration by a State Board of Health," the experience of such administration in California was cited, the statement being made that the organization of the board of health in California differed from that elsewhere in that it consisted of seven bureaus and the bureau of nursing was in charge of a registered nurse. It is outside politics and is doing good work.

Miss Nancy E. Cadmus, of New York, spoke on the administration by the regents of a university, as carried on in New York only. After a long and rather detailed history of the New York law and explanation of its requirements and working, the statement was made that it had brought great benefit in the condition of student nurses, in curtailing the sending out of pupils, in raising the standards of schools, etc. All agencies doing nursing now demand a registered nurse. That nursing is a profession is shown by the attitude of the Red Cross (it was not stated how). The law had influenced the alumnae associations and the nurses of New York consider the plan of registration by the regents of the university very successful.

Before calling for an expression of opinion regarding a mixed board, the chairman said New York was most favored in being able to have its nurses register under the regents.

Miss Lawson reported for the mixed board, and then the discussion was opened. Miss Squires, of New Jersey, favored an all nurse board, considering the public health commission a political machine. Georgia thought such a board far from ideal and preferred an educational board. Miss Palmer spoke of the great opposition at first encountered in getting an all nurse board in New York, and said they were told to keep free of medical politics because if even one doctor was on the board, they would

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get no justice and have no freedom. She had kept in touch with mixed boards and the doctors had never been of any use, and had usually been obstacles. A poor law was worse than none and it was better to wait than pass one. In view of these remarks it was interesting to hear Miss Riddle, who is a member of a mixed board in Massachusetts, state immediately afterwards they had found their connection with the medical board (one member is secretary of the board of registration of medicine) gave them a standing at the State House it would have taken them long to attain alone, and that it had assisted them to a system of records and examinations they would have been long in developing. The presence of doctors on their board had not been their ideal, but they thought it was better as it was and were glad to have the advantage of their experience.

Miss Wilkinson, of the board of examiners of Washington, in her paper on "Basis of Reciprocity," said all felt the need of reciprocity, but did not know how to bring it about. The first step is a standard of education. The difficulty comes in the number of beds, but a hospital of even twenty beds with a good superintendent can graduate good nurses. There must be uniform registration laws and uniform administration of them.

Miss Goodrich said they had had to obtain their laws in the different States as best they could and they were often very different when passed from what they were when proposed. Therefore, it is only through the boards of nurse examiners that a uniform standard of education can be worked out and State reciprocity eventually established, as States can only reciprocate with those having the same standards. A minimum standard should be set. Boards of examiners could collect information, raise standards in schools, and gather statistics to use when desiring legislation. They should find out how many trained and how many untrained nurses are working in a district. The cheapest place to get free nursing is under supervision in the hospital. It would be well to have a committee from the boards of examiners to determine some standard by which the examiners shall be appointed, as the most popular nurse is not always best adapted to the position.

Miss Palmer offered a motion to the effect that the directors draw from the boards of examiners of different States to form such a committee and have them report their work at the end of the year, but to continue indefinitely

until every State has been thoroughly gone over. After amended so that the committee should confer with the committee on legislation to avoid duplicating, the motion was passed.

Miss Louise Perrin, of Colorado, gave a brief, statistical paper on "General Legislation Pertaining to Nurses and Nursing."

After some discussion, in which reference was made to a ten hour law for nurses in Illinois, a vote was passed that a copy of the proceedings be sent to each board of examiners.

Several telegrams of greeting were then read and round tables on district nursing announced for 7-8 P. M.

At 8 P. M. a session was held under the direction of the committee on Infant Welfare, Miss Carolyn C. Van Blarcom in the chair. Miss Goodrich read a letter from Miss Nutting, urging cooperation in a new effort of the Health Department against the use of spirituous liquors, and it was voted that the Executive Board of the three national organizations take action in the matter.

After a brief account of infant welfare work by the chairman, Dr. Sherman Kinsley, arose to read the paper "The Prevention of Infant Mortality and the Work of the Public Health Nurse," that was to have been given by Dr. Philip Van Ingen, secretary of the American Association for the Study and Prevention of Infant Mortality. He gave an interesting account of the work done by milk station nurses and their opportunity for instructing the mothers, showing how the death rate had been lowered by this kind of work. He also spoke of the havoc wrought by dirty and ignorant midwives, making a plea that the trained nurses take up that work here as they have in England.

Miss Ahrens read the paper of Dr. Grace L. Meigs, of Washington, D. C., on "The Work of the Children's Bureau for Infant Welfare."

A paper on "The Nurse's Part in Infant Welfare Work" was read by Miss E. I. McCune, visiting nurse of the Infant Welfare Department of the Associated Charities in San Francisco.

Dr. Hans Barkan took the place of Dr. Ellice M. Alger, director of the National Commission for the Prevention of Blindness, and read his paper on "Prevention of Infant Blindness: The Trained Nurse's Opportunity."

Dr. Ira W. Wile was scheduled for a paper on "Civic Nursing," but did not appear.

On Friday, June 25, business meetings were held by the different national organizations for reports of committees and the election of the following lists of officers for 1915-16 were announced;

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NATIONAL LEAGUE OF NURSING EDUCATION

President, Clara D. Noyes; vice-president, Sara E. Parsons, Boston; secretary, Isabel M. Stewart, New York; treasurer, Mary W. McKechnie.

Councillors: Menia S. Tighe, president of Arkansas State League; Harriet Fulmer, president of Illinois State League.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

President, Mary Gardner, Providence, R. I.; vice-president, Mary Beard, Boston; secretary, Mary E. Lent, Baltimore.

Directors: Elizabeth Ashe, San Francisco, for unexpired term of Mrs. Hickey, resigned; Ida M. Cannon, Boston; Edna L. Foley, Chicago; Elizabeth G. Fox, Washington, D. C.; Mathilda Johnson, New York; Margaret F. Search, Los Angeles.

Friday afternoon the San Francisco branch of the Guild of St. Barnabas held a half-hour service in Grace Cathedral Crypt, to which all the nurses were invited, and an informal reception at the deanery followed.

The following San Francisco hospitals extended a cordial invitation to the nurses to visit during Friday afternoon: The Hahnemann, Children's, Lane, German, St. Mary's, under the Sisters of Mercy; Mary's Help, under the Sisters of Charity; St. Luke's, San Francisco City and County and St. Francis.

For Saturday, June 28, a trip to Mt. Tamalpais and Muir Woods was planned but few of the nurses took advantage of the opportunity.

All during the meetings a nurses' exhibit was open in the building next to the First Congregational Church, where most of the meetings were held. Foods, books, appliances, etc., were among the things exhibited. The exhibit was not large and far the most interesting part was that provided by Meinecke & Company,

Louisiana

STATE BOARD EXAMINATION

Anatomy.—1. Describe cartilage and tell where some cartilages of body are found. 2. Give anatomical difference between voluntary and involuntary muscles. 3. Name six of the chief voluntary muscles. 4. Give briefly the structure of arteries and veins and show the main difference in their structure. 5. Name the two important arteries of the forearm. 6. Trace the blood from the left ventricle to the right forearm. 7. Describe briefly the stomach. 8. Name the three biliary ducts. 9. Tell all you know about the calcium. 10. Give briefly a description of the kidney.

Physiology.—1. (a) What are the chief functions of the bones? (b) What is the periosteum? 2. (a) Into how many acts is respiration divided? (b) What is the normal respiration rate in a healthy adult? 3. Name functions of the pericardium. 4. (a) Name the organs composing the circulatory system. (b) What is the normal pulse rate in a healthy adult? 5. (a) Define mastication, (b) deglutition, (c) digestion. 6. What secretions combine to digest food in the intestines? 7. (a) Define elimination. (b) Name the chief eliminating organs. 8. (a) Name several functions of the nerves. (b) Name two nerves of special sense. 9. Name the functions of the lacrimal gland. 10. (a) Name one serous membrane. (b) Name one organ lined by a mucous membrane.

Medical Nursing.—1. Describe the fumigation of sick room after contagious disease. 2. Describe sponging in typhoid fever. 3. What is the duty of the nurse in the case of the dead? 4. What would you do in an emergency case of morphine poisoning? 5. Duty of a nurse in care of a case of pneumonia. 6. What are the symptoms in pneumonia? 7. Describe cold pack. 8. Describe the preparation of an inhalation. 9. How prepare a hypo. of 1-60 of strychnine if given in 1-30 tablets? 10. What would you do for insomnia?

Surgical Nursing.—1. Describe the preparation of an operating room for abdominal operation. 2. Preparation of patient for a radial mastoid. 3. Name some causes for the retention of urine and describe the preparation for catheterization. 4. Describe the spiral reverse bandage and name a case in which it is used. 5. What is an interrupted suture? 6. What is a continuous suture? 7. What is an intravenous infusion? 8. Differentiate between arterial and venous hemorrhage. 9. Give symptoms and treatment of

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shock. 10. How should a dressing that has stuck to wound be removed?

Obstetrics.—1. Preparation of patient for delivery. 2. What should be the conduct of a nurse during obstetrical case? 3. State usual diet for parturient woman. 4. Name stages of labor. 5. What two orifices have to be dilated before birth of child is possible? 6. Name bones that make up pelvis. 7. What are the different varieties of hemorrhage in pregnant woman? 8. First aid to patient in hemorrhage? 9. State a few symptoms of eclampsia. 10. Give treatment of breast after birth.

Dietetics.—1. Give definition of food. 2. Define briefly digestion and absorption. 3. Name the several forms of animal foods. 4. Tell all you know about milk. 5. Define and tell what you think of vegetarianism. 6. What are the four methods of feeding infants? 7. Give four or five recipes for nutrient enemata. 8. Give what you would consider the best diet in habitual constipation. 9. What would you consider the best diet in diabetes mellitus? 10. Give pre and post operative dietetic management of a case of fibroid uterus.

Infant Feeding.—1. What should be the system employed for the first feeding of infants? 2. Mention usual age and some of the food that can be given to a child when changing from breast. 3. Give method of preparing modified milk. 4. State feeding of infants in contagious diseases. 5. What would be the best form of feeding in diarrheal condition? 6. What are the most important differences between cows' and human milk? 7. When would solid food be advisable for a child? 8. What foods are especially beneficial in treatment of anemia? 9. Mention some reasons why solid food is restricted or withheld when there is high temperature. 10. How often and how much liquid should a child between three and six months be given?

Materia Medica.—1. (a) What is the equivalent in fluid drams of the following: teaspoonful, dessertspoonful, and tablespoonful? (b) What is the equivalent in fluid ounces of the following: wineglassful, teacupful, and tumblerful? 2. Name drug of animal origin, two of mineral origin, and three of vegetable origin. 3. Define idiosyncrasy. (b) What is meant by the cumulative action of a drug? 4. What is meant by a 25 per cent. solution? 5. What is the average dose of the following: codeine sulphate, aspirin, Fowler's solution, infusion of digitalis and atropine? 6. (a) Name a drug which has emetic properties, (b) expectorant properties, (c) sedative proper-

ties, (d) astringent properties, (e) anesthetic properties. 7. What alkaloid is derived from coffee? (b) What is the common name of phenol. 8. What is an emulsion? 9. What are the symptoms and treatment of arsenical poison (acute)? 10. I desire a prompt effect of a medicine which may be administered either in solution, powder, or compressed tablet form. Which is preferable and why?

Bacteriology and Hygiene.—1. Give amount of fluid average adult should consume in 24 hours. 2. Will sewer gas cause disease? 3. What are the healthiest methods of heating houses? 4. What are advantages and disadvantages of fireplaces? 5. Name a defect of the eye incident to school life. 6. Give common sources of contamination of drinking water. 7. What are spores? 8. Why should soda be added to water in which instruments are sterilized? 9. Mention advantages and disadvantages of carbolic acid as a germicide. 10. What per cent. carbolic acid is necessary to disinfect excreta in typhoid case? 11. Name nature's disinfectant. 12. How is a room prepared for fumigation?

Chemistry.—1. Give chemical subdivision of matter. 2. How and why can potassium permanganate stains be removed? 3. What is Labarraque's solution? 4. Give per cent. of formaldehyde in formalin. 5. Name four gaseous elements. 6. How can water be made synthetically? 7. Give properties of O. 8. Give chemical constituents of air.



New Jersey

The graduating exercises of the class of 1915, of the St. Mary's Hospital Training School for Nurses, Orange, New Jersey, were held in the assembly hall of the hospital, Thursday, June 17, at 8.30 o'clock. The assembly hall was handsomely decorated with the school colors and American flags. Music was furnished by Deignan's orchestra. An elaborate musical program was prepared by the nurses which included violin, piano, vocal duets and solos.

Dr. Charles W. Banks, Dr. Francis Knowles and Dr. Thomas N. Gray, presided. The address to the graduating class was made by Dr. Martin Synott. Mother Mary Joseph, O. S. F., presented diplomas. Miss Katherine V. Kane, R. N., superintendent of nurses, presented the school pins. Following the exercises, the class held a reception, followed by dancing and a collation was served. The following is the list of graduates: Sister Mary Paschal, S. F., Alice Scherer, Ruth F. Powers, Gertrude R. Ward, Mary Myron

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New York

The ninth annual graduating exercises of the Cumberland Street Hospital, Brooklyn, were held in the Cumberland Street Presbyterian Church. A class of ten nurses received their diplomas.

The graduating nurses are: Miss Gertrude L. Cook, Miss Margaret M. Moore, Miss Beatrice E. Enggren, Miss Julia R. Sprague, Miss Elsie Richardson, Miss Catherine Henry, Miss Caroline C. Bennett, Miss Jennie Palmer, Miss Nazlie Halahy, Miss Mary Noallen.

A splendid address was given by Hon. John A. Kingsbury, commissioner of public charities. Annual report of school was read by Miss Ella A. Lawrence, superintendent of training school. Interesting addresses were given by Dr. Edward B. Shallow, associate city superintendent of schools, and Dr. Henry B. Minton, medical board of Cumberland Street Hospital.

Hippocratic Oath was administered by Dr. Orlando S. Ritch. Diplomas were presented by Hon. John A. Kingsbury.

Refreshments were served to a large number of guests, followed by dancing.

Winifred A. Higgins, assistant superintendent of the Syracuse Women's and Children's Hospital, has been appointed superintendent of the City Hospital, Ithaca, N. Y.



Oklahoma

At a recent meeting of the Oklahoma County Association of Nurses a committee was appointed to investigate the field of nursing.

After a thorough investigation by the committee it was deemed advisable to make a public announcement that Oklahoma has a sufficient number of nurses, and each year the training schools are adding to this number.



Pennsylvania

The thirteenth annual meeting of The Graduate Nurses' Association of the State of Pennsylvania will be held in Philadelphia on Wednesday, Thursday and Friday, November 10, 11 and 12, 1915.

Miss Anne K. Sutton, R. N., The Henry Phipps Institute, Seventh and Lombard Streets, Philadelphia, is the chairman of the committee on arrangements.

The place of meeting and program will be published later.

After serving seven and a half years as directress of nurses at the State Hospital, Fountain Springs, Pa., Mary A. Gearhart, R. N., has resigned her position, to accept a similar position in the beautiful new Geisinger Memorial Hospital, at Danville, Pa. The new hospital will be dedicated in September.

The graduating exercises of the class of 1915, of the Warren State Hospital Training School for Nurses, Warren, Pa., was held in the chapel, Thursday evening, June 17, at eight o'clock. The address to the graduates was given by Hon. Watson D. Hinckley, Warren, Pa. The diplomas were presented by Hon. W. E. Rice, president of the board of trustees. A reception and dance followed the exercises.

The members of the graduating class were: Sadie Florence Bailey, Marion MacLaren Butler, Margaret Rooth Corl, Lorena M. Godel, Florine Margaret Goodenow, Anna Elizabeth Hill, Florence Iola Hilyer, Belva Estella Lockard, Delcie Anna Moore, Laura M. Morrison, Annie Marie McDermott, Marietta Frances McDermott, Blanch Ohlson, Ida Setley, Mary Catherine Songer.

The examination for State registration of nurses was held at the State Hospital, Warren, Pa., June 21, 1915. Forty-two nurses took the examination, fourteen of whom were graduates of the Warren State Hospital.

Miss Mabel Clawson, a graduate of the Warren State Hospital, has accepted a position at the Sewickely Heights Hospital, Pittsburg, Pa.

Miss Ada Clawson, a graduate of the Warren State Hospital, was appointed assistant matron of the Warren State Hospital.

The closing meeting for the summer, of the Nurses' Alumnae Association of the Samaritan Hospital, Philadelphia, Pa., was held Tuesday evening, June 29, 1915, in the Nurses' Home. Meeting was opened by the president, Mrs. Agnes Baumann.

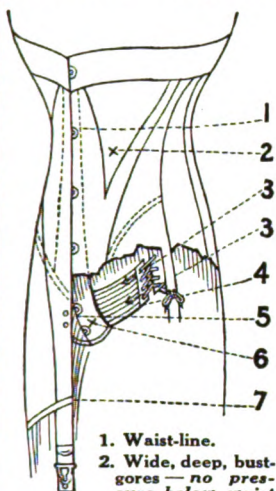
There were thirty-seven present. After the routine business, election of officers was held. The old officers were all unanimously re-elected, but owing to the resignation of our faithful secretary, Miss Francis, it was necessary to elect a new secretary; Miss Kathryn Lewis was elected to the office. President, Mrs. Agnes Baumann; vice-president, Mrs. H. Schlichter; secretary, Miss Kathryn Lewis; assistant secre-

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tary, Mrs. M. Mayer; treasurer, Miss Marie Baehr; assistant treasurer, Miss V. Wilkinson. Four committees were appointed, namely: Sick Committee, Press Committee, Flower Committee, Entertainment Committee.

Nine new members were elected.

The business meeting was followed by a social, chief feature of this social was the class reminiscences, dating from the year 1906 to 1915, which included this year's graduating class, who were our guests of the evening.

The reminiscences were witty and humorous, brought forth enthusiastic applause and certainly recalled many good times, many happy days of long ago.

Miss Margaret O'Brien responded in song for the class of 1909.

An address entitled, "A Nurse's Vocation," by Miss Woodburn, the directress of nurses, was much appreciated.

Instrumental music by two young ladies, was also a feature of the evening. Ice cream and cake was furnished by the entertainment committee.



Rhode Island

The first graduating exercises of the nurses' training school of the State Hospital for the Insane, at Howard, were held in the assembly hall of the institution, June 17, 1915. The speaker of the evening was Dr. Charles P. Bancroft, superintendent of the New Hampshire State Hospital, Concord, New Hampshire. An essay on "The Value of an Insane Hospital Training," was read by Miss Agnes E. Bolivar, a member of the graduating class.

Hon. Walter A. Read, chairman of the Board of State Charities and Corrections, presented the diplomas. Reception and dancing followed the exercises.

The class motto is, "Achievement is the Crown of Effort."

The graduates are Agnes E. Bolivar, Jennie Johnson Chambers, Agnes Kerr Carnes and Alice Marie Favorite.

Miss Carrie P. Van der Water, R. N., has been appointed as the new superintendent of the Homeopathic Hospital of Rhode Island. She is a nurse of wide experience in large hospitals and is a woman of marked efficiency and executive ability.

Miss Van der Water is a graduate of the Worcester Memorial Hospital and of Dr. Bull's Hospital in New York City. For three years she was superintendent of the Toronto Western

Hospital and, following that, was for three years in charge of the Toronto Hospital for Incurables.

She was seven years superintendent of nurses in the Grace Memorial Hospital of Detroit, and last year graduated the largest class of nurses ever graduated in the Middle West. Miss Van der Water has been authorized by the board of trustees to reorganize the staff and will retain Miss Evelyn Porter, graduate of Saratoga Hospital, as operating room supervisor. She has just appointed Miss Anna B. Northrup, graduate of Homeopathic Hospital of Rhode Island and post graduate of Woman's Hospital of New York, as floor supervisor, and will appoint at once a dietitian housekeeper to take charge of the general housekeeping of the hospital and the teaching of the nurses in dietetics.

The business office will be reorganized, Miss Van der Water keeping the main management in her own hands. The training school for nurses will be increased in number as soon as space permits. The training school is affiliated with the City Hospital, of Providence, for contagious diseases and with the Flower Hospital of New York City.

Dr. C. H. Finch, who was superintendent of the Homeopathic Hospital since its founding 10 years ago, resigned recently to resume private practice.



Wisconsin

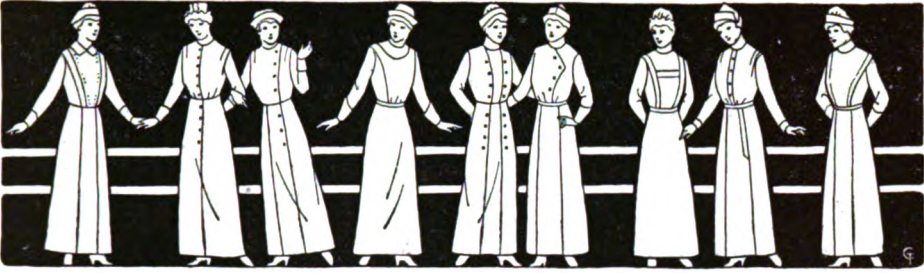
The third annual commencement exercises of St. Mary's Hospital Training School, Racine, Wis., were held June 2, 1915, at 5.00 p. m. A specially arranged program was carried out at the nurses' home, which was decorated with white and yellow daisies. The program was followed by a reception, supper and dancing. The following received diplomas: Barbara A. Patzel, Alice E. Peters, Josephine M. Patzel, Joan M. Peters.



Marriages

On June 12, 1915, at Memphis, Tenn., by Dr. A. B. Curry, Carrie T. Swayze, graduate of Kings' Daughters' Hospital, Greenville, Mississippi, class of 1913, to John F. Poffenberger, of Sunbury, Pennsylvania. At home, 871 Vance Ave., Memphis.

On August 4, 1915, at Hartford, Conn., Elizabeth Margaret O'Rourke, R. N., graduate nurse of St. Francis Hospital, Hartford, Conn., class of 1912, to Harvey Dussinger. Mr. and Mrs. Dussinger will reside in Hartford.



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On July 10, 1915, at Jacksonville, Fla., Sarah Agnes Sweeney, R.N., graduate nurse of St. Francis Hospital, Hartford, Conn., class of 1912, to John Arthur Boyd. Mr. and Mrs. Boyd will reside in Miami, Fla.

On July 20, 1915, at Collinsville, Conn., Marie Valcia Pouloit, R.N., graduate nurse of St. Francis Hospital, Hartford, Conn., class of 1912, to John McNamara. Mr and Mrs. McNamara will reside in Collinsville.

On July 17, 1915, at Columbus, Ohio, Martha Harvey, graduate of the Orthopaedic Hospital and Infirmary for Nervous Diseases, Philadelphia, Pa., and Herbert Acton Lowes. Mr. and Mrs. Lowes will reside in Hartwell, Cincinnati, Ohio.

On July 6, 1915, at Concord, Mass., Isabella Pelton, head nurse of Buffalo, N.Y., Homeopathic Hospital, to Dr. George P. Moseley, the well-known Buffalo surgeon.

Recently at Kingston, Ont., Canada, in St. Mary's Cathedral, Rose I. Gibson, a graduate nurse of St. Mary's Hospital, Rochester, N. Y., to Frank McDonald of Railton.

On July 14, 1915, at the Little Church Around the Corner, New York, by the Rev. Dr. Houghton, Hazel Kirke Simpson, graduate nurse of Johns Hopkins Hospital, Baltimore, Md., to Kenneth D. Murray, of London, Ont., Can.

On July 19, 1915, in San Francisco, by the Rev. L. L. Loufbourow, Miriam Ethel Maxfield, graduate nurse, to J. B. Beauregard.

On August 4, 1915, at Savannah, Ga., May Gertrude Horne Hall, R.N., graduate nurse of Hillman Hospital, Birmingham, Alabama, Class of 1912, to George Rawls. Mr. and Mrs. Rawls will make their home at Statesboro, Ga.

On June 14, 1915, at Jersey City, N. J., Mrs. Gladys Davis Lavender, R.N. to Alfred

Warren Brooker. Mrs. Brooker is a graduate nurse of King's Park State Hospital, New York, Class of 1913, and was nurse for the Board of Health of Flushing, at the time of her marriage.



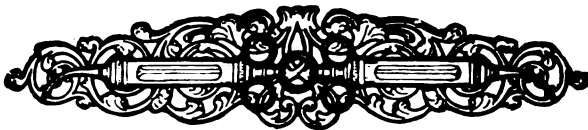
Deaths

On June 27, 1915, after a long illness, Florence Bamford Leinhass, R.N., graduate nurse, Gowanda State Hospital, Collins, New York, class of 1911. Since her association with the hospital in 1906, she had been universally beloved, for her remarkably amiable, sunny disposition, and her unflinching patience and kindness to all with whom she came in contact. Although apparently in perfect health until shortly before her illness and operation last November, her condition proved to be more serious than anticipated, and until her death she suffered much pain with great fortitude. In the sad death of Mrs. Leinhass, the hospital sustains a great loss, and much sympathy is felt for the bereaved husband.

On June 16, 1915, at the Woman's Hospital of Philadelphia, Pa., after a long illness, Martha Harris, of Vineland, N. J. Miss Harris was a graduate nurse of the Woman's Hospital, class of 1893.

On July 16, 1915, at Yonkers, N. Y., Ella Sigourney Murdock, graduate of Bellevue Hospital, and for twenty-three years matron and superintendent of nurses of the Hospital for Ruptured and Crippled, New York City. Interment, Wellsville, Ohio. Those who knew her professionally appreciated her aim for justice, and realize that they have lost a woman of exceptional executive ability in hospital organization work.

On August 16, 1915, at the Tuberculosis Hospital, Washington, D. C. Tamson A. Gray, R.N. Miss Gray was at one time Head Nurse at the Hospital in which she died.





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Book Reviews

Primary Studies for Nurses—A Text-book for First Year Pupil Nurses. By Charlotte A. Aikens, formerly superintendent of Columbia Hospital, Pittsburg, and of Iowa Methodist Hospital, Des Moines. Third edition, thoroughly revised. 12mo of 471 pages. Illustrated. Philadelphia and London. W. B. Saunders Company, 1915. Cloth, \$1.75 net.

In the review of the first edition of this ever increasingly popular work, it was stated that "Any pupil who has mastered even the major portion of this work, would be one of the best prepared first-year pupils that ever stood for examination." This statement will bear repeating and emphasizing.

In this third edition, the entire matter of the book has been reviewed and much new matter introduced. Most of the chapters on anatomy and physiology have been elaborated. A new chapter, "Notes on Surgical Anatomy," has been added. Several new illustrations have been introduced in this section. In the section on bacteriology, the important additions have been made in the introduction of notes regarding the history of bacteriology and elementary facts relating to asepsis. In the section on *materia medica*, a table showing the physiologic effect of food and alcohol is added. There has also been a rearrangement of the review questions to conform to these changes.



A Manual for Midwives. By C. Nepean Longridge, M.D., F.R.C.S., M.R.C.P., and John Bright Banister, M.A., M.D., B.C., M.R.C.P., F.R.C.S. Second edition, with 51 illustrations. J. Blakiston's Son & Co., Philadelphia, Pa. Price, 85 cents net.

This book is especially designed for midwives, and the instruction is given in such a manner as to leave no chance for misunderstanding. All the illustrations have been especially drawn for the book, and most admirably illustrate the text. A chapter on cancer has been added, because it is believed that the midwife has opportunity for preventive work in the anti-cancer campaign. The book contains rules of the Central Midwives Board of England and the Queen Charlotte's Hospital leaflet on "Advice to Mothers as to the Care of Their Children,"

which is given to each patient on her discharge from the hospital, and a valuable lecture by Mr. Sydney Stephenson, upon the care of the infant's eyes.



Sex Problems in Worry and Work. By William Lee Howard, M.D. Price, \$1.00 net. Edward J. Clode, New York.

There are few professions which offer larger opportunities for helping on the campaign for proper popular education along the lines of sex hygiene than that of the trained nurse; and no nurse can read Dr. Howard's new volume without becoming thereby better equipped for such work. The book, which is uniform with the author's "Facts for the Married," "Confidential Talks with Girls," etc., is intended for the non-medical reader, and treats sex problems from a somewhat different angle from most books on social hygiene.

In the first chapter, "Worry and the Primitive Sources of Nature," Dr. Howard writes of the fundamental instincts of humanity and the necessity for utilizing them to the best advantage. In the chapter entitled "Is Chastity Consistent with Health?" while giving a generally affirmative answer, he makes it very plain that the vital force which exists in every normal man or woman must have proper outlet, or its repression will lead it to find an undesirable one or will result in some form of disturbance of the personality. Among such outlets he instances work, physical or intellectual, especially creative work of some kind; exercise and sports; the care of children or of the sick. In another chapter, "The Sexual Problems of the Neurasthenic," the author comments on the frequency with which nervous and mental disorders are caused by sexual excesses, by lack of outlet for vital energies, as among those who lead a useless and self-centered life, or by some shock received in early life, though perhaps long forgotten. "Why You Worry Over Unknown Fears," deals with the causes of phobias and obsessions, and the new psychoanalytical methods of getting at their origin. Later chapters, "Internal Sex Forces and their Effect upon Efficiency," "How Emotions . . . Cause Injury to Bodily Health," and "Character and Sexuality," treat of the

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✦

Nursing and Care of the Nervous and the Insane.

By Charles K. Mills, M.D., Professor of Neurology in the University of Pennsylvania, Neurologist of the Philadelphia General Hospital. Third edition revised by the author, assisted by N. S. Yawger, M.D., instructor in Neurology in the University of Pennsylvania, assistant neurologist to the Philadelphia General Hospital. J. B. Lippincott Company, Philadelphia and London. Illustrated. Price, \$1.25.

The contents of this book are the substance of a course of lectures delivered first at the Training School for Nurses of the Philadelphia, and subsequently at the Training School of the Woman's Hospital of Philadelphia. The book was the first of the kind prepared for nurses in this country, and has always been looked upon as a standard authority.

In the present edition, the author, with the assistance of Dr. Yawger, has endeavored to bring it up-to-date. Attention is particularly directed to some new facts regarding epilepsy, fibrositis and insanity. New illustrations of the charts and the apparatus most useful in electrical practice have been added. The unusually fine motor-point plates, from Dr. Toby Cohn's excellent work on "Electro-diagnosis, and Electro-therapeutics," have been obtained through the courtesy of the author and publishers. Instruction regarding hydrotherapy, not included in previous editions, have been incorporated.



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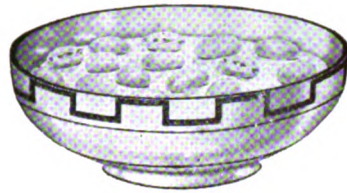
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spout, invalid cushions, ice bags, with unlosable washers, paper sputum cups, non-slipping back rest, non-slipping knee and thigh support, proctoclysis outfit with saline heater, an irrigator holder for attaching to bed posts, and several other of their specialties.

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The Mentally Constructive Nurse

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THE constructive nurse is a builder of something; a finder of things as they are and, dominated by the purpose and the will to improve them, evolve them and, where possible, make them flower out into a final perfection. Her motto is

"Build thee more stately mansions."

The improvement and evolution to which I refer has no reference to the management of sepsis, the treatment of cases, or the diet and hygiene of a patient—in short has nothing whatever to do with the usual medical treatment of the sick. The subject deals wholly and exclusively with usual and slightly abnormal mental states of patients—ways of sensing them, methods of improving them and procedures for their final evolution. What is here presented, then, are undertakings in the construction of mental states.

Before the start to build, there must first be laid some deep and sound foundations for the structures intended. It is then apropos to insert at this juncture some of the preliminaries that must be passed before entering upon the domain of mental construction. For example, before anyone can build in the mind of another, he must know what mental states or mental plane there is developed there already.

The key to knowing what is in a patient's mind already comes through the possession of that accomplishment known as the reading of the voice.

By observing a person's usual intonations, there is stored in the memory of the vocal combinations of that certain person that individual's vocal norm or, as expressed in common parlance, "I know his voice." From this basis considered as normal all variations and changes of voice can be noticed and interpreted by contrast. But if the norm is not first established it becomes difficult to determine whether variations are within the norm or not. Vocal variations report to the initiated ear whole constellations of ideas, feelings, emotions, attitudes and imaginings of those whose voices are heard. So much can the subtilized perception sense, that words become a mere hint of what the meaning is. At first sometimes very little can be sensed; by practice, however, growth in voice sensing advances quickly so that before long a whole world of ideas, imaginings and reflex conceptions can be sensed in the background of mere words.

Not only must the nurse develop in herself the sensitive ear to catch the contents of the vocal background; but she must train herself to create within herself pictures,

ideas, concepts, impersonations and that, all in an instant, she may give out any concept, feeling or relationship she may desire instantaneously.

With these two accomplishments as foundations—the possession of the subtilized ear, sensitive to delicate connotations, and the power of instantaneous creative imagination to picture any concept, feel any emotion, live any experience as and when desired—when these attainments are thoroughly instigated, then the nurse can start upon her crusade of constructing in the patients' minds more stately (mental) mansions.

The building of higher centers in others takes time, much effort and work on the part of both nurse and patient, and yet good centers are pretty permanent and are worth the effort. It is the same with centers already created; for example, the writing center. It has taken years to grow it and years to perfect it. Of the time needed to build up the center for stenography less is known. It may require little effort. Thus is built up a motor and a sensory area, the one requiring great attention to execution; the other hardly more than the direction of the attention with considerable concentration. So it is with the expressive speech centers; they require much external execution for their growth; while the sensory or perceptive speech centers require only a guiding of the attention with resulting concentration on vocal elements observed to fix them in memory for comparison later.

STORY TELLING

Telling stories is a faculty by itself, a nest of little functions, a separate cultivatable accomplishment all by itself. Let the nurse size up her group of patients by a study of their vocal norms, and their imaginative capacities and select one in whom to evolve the attainment of story telling.

Then first urge the starting of that activity between him and some friend; closely watch the procedure to see from what background the presented elements come. If future growth on the present background is possible, hint lines along which to tread. The set example of the nurses telling stories is often bad, as it leads naturally to imitation when the patient's own presentation is better for his own growth. Only until the initiated nurse finds no further growth forthcoming can she show by suggesting additions to the pictures in the mind of the speaker through her ability to sense them, and last of all may she hint the way by her presenting a story herself. The imitation likely to result therefrom may be easily side-tracked by insisting upon individual interpretation.

Such story telling would soon grow into the ability to relate tales to more than a few friends; even the whole ward could become audience; then a contagion would arise and others would offer to relate adventures or accidents. This is always a sign that the growth of this center for story telling has sprouted in other minds and demands expression. After contagion has run some riot there naturally will result the feeling of rivalry and a competition to excel each other arrives. This can but have one effect—to enhance the whole situation in everyone's mind, make the center of speech in stories grow deeper and firmer until, finally, it gets tired of growth and the demands of the storytellers turn to some other field. Then start and evolve another center.

SEEING THE FUNNY SIDE

is a trait in itself. Not all have it. A famous Harvard football captain once expressed as his lifelong regret that he could not see a joke or tell a funny story. We say it is a gift—rather set it up a separate attainment in the world of accomplishments. And so it really is. Or, in terms

of present use, it is a new and isolated brain center not always developed, in many never developed, but possible of training in anyone. It is really no more than creating a funny situation out of a real situation by a voluntary attempt at comical interpretation. To start this phase of creative imagination, one must first present many illustrations, then urge imitation; lastly, play for original expressions in it. The way to do this is as follows: By presenting illustrations, the nurse will be obliged to interpret herself many situations as comical; and that so frequently that some marked progress in interest appears in her hearers. This will start the center to grow in others. Then she should turn to the next step and urge imitation, generally upon one naturally inclined; later, on others picking up the cue, and finally intensify the contagion by an urging and stimulating original manufacture of comical episodes.

Thus, by a little judicious engineering, constant spurring on and final long continuance, one finds quite a widespread, well-developed comical trait at large among the group of individuals attempted. Everywhere of course may be a few exceptions—those so prodigiously and ponderously matter of fact, they seem never to condescend to enjoy the twist of trivial wits. Let them pass while we evolve.

READING BOOKS TO OTHERS

I doubt not that the habit of reading is an isolated function done in a single area of the cortex; and that, too, an activity well worth working up as a habit in anyone as a key to further accomplishment, as a means of general information and education, and as an employment worthy of the idle.

Strange it is, that schooled people often read little and even the interest and desire for it have to be drummed up again after exit from halls of learning.

No reference is made to the ordinary

humdrum reading, but a rendering or loud reading that pictures forth in vivid imagination the conceptions easily created over and above the mere words by the quickly imaginative mind. This high class of reading takes training and much time to attain to, and is worth it. For such work at first a good reader should be picked; then there will be little time lost in preparing him; coaching privately by a previously self-trained nurse for each reading should follow, with points on picturing the connotations—presenting a picturesque environment and the elements of personification where needed. Then should follow the reading to a group, and the starting of someone else to follow up said method, and do it next time. If readings are, with tact, made easy and conversational, others may be induced to enter the activity, and thus a series of consecutive, say weekly, readings are put running and take up quite a deal of otherwise wasted time. Not only does the reader advance in this work, but by proper criticism on his work, the rest gain a great deal.

LOOKING ON THE BRIGHT SIDE

Cheerfulness is a cortical area all should develop; it is easy—worthy of possession—and worth the trouble. It can either be developed by effort against disparagement, by cultivation among sympathizers, or by absorption in a sort of overwhelming contagion. I have known a whole ward of gloomy tuberculous patients to become cheery and light-hearted by the arrival in their midst of only one more who had cheer to burn, and at once all the inmates of that ward felt the final death blow to their gloom had arrived. Thus, more or less, can a nurse do. She can shine out her own cheer and make others respond that way; she can grab hold of some old, gloomy, confirmed one, who, perchance, has been cause for most of the previous gloom, and conquer it here first. Get her hold on the

others off; make her get up and turn the corners of her mouth up; say a good word about the food, etc., and thus the situation is made easier to advance further and further.

More hardly need be said. From other kinds given above, this procedure can easily be pieced out and made whole.

One point, however, is sure. No progress worthy of the name is to be permanent unless the undertaking is to be long persisted in, so that a well-drilled in and dominantly active mental habit is deeply instilled and unswervingly activated thereafter.

Thus from gloom grows cheer; from sadness, joy, and out of the dark and dreary, ever comes the bright side.

Many more such centers could be mentioned if space allowed, and surely many more should be developed in us all; but a word must be said about the combinations of those centers and what they lead to in the final evolution of the individual. The greater the number of brain centers developed and active, the greater the complexity of the inter-relation of these multiple centers. The evolution and inter-relation of multiple brain centers constitutes personality, and Kant says, "Personality is an end" to be sought. Then the life of evolving personality—the creation and building up of multiple cortex centers—is a life worth while, for it is progressing to an end worthy to be sought as a final goal in itself.

How to start, then, on this worthy road of evolving personality—start by developing one single center. Many people have little or no higher centers developed in any strong way, so that they become a guiding factor in their lives. These people are simply little reflex automatons, sensing situations and immediately reacting reflexly to them *sine* any higher center guidance, judgment, thought or educated interpretation. From this utter lack of

higher development to branch out and establish even one new center, is a worthy accomplishment. Every center is a step made to an evolved, rounded personality. And that rounding increases in proportion thereafter. That is, when a second center is founded you have not only that, but the previous value and influence that its relation to the first center must have, and so it goes; the third becomes related to the previous two and the fourth to the previous three, and so on more and more complex, until finally, an intricately evolved and related constellation of centers has evolved, and you have the flower of a whole complicated personality. Such people constitute our great men. Such are our leaders; such are the savants. Such ends of personality are open to all, but few make the effort, few know how, less would try if they did know; some drop by the way but, happily, many catch the spirit heading to a full development of personality and start on that long road to that goal of goals.

The greatest capacity of the centers that can be developed should be obtained by a threefold development—sensory, cogitative and motor, or perceptive, intellectual and reactive, or observative, interpretive, expressive, terms differing as to where you choose them, medical, psychological or oratorical. He is weak who develops alone on only one of these three avenues; he is well rounded who passes each field of activity he seeks to develop as a center in line toward a personality through all these three different anatomical parts of the center's triune elements—intake, retention, expulsion.

Life means then, or its end should be, multiplicity of accomplishments and the more varied, the greater the personality, the grander the man. The greatest spirit one can instill into another, then, is the will to complete an array of individual accomplishments.

All a nurse can do with a passing patient,

is to start him on one or two evolving cortical centers, and then inspire him to do the rest himself in successive steps toward building higher mansions.

This, then, is my idea of a mentally constructive nurse. First, through the cultivated powers of vocal perception, she learns accurately to read the mental plane and intellectual content of her immoulded subject; secondly, by her own powers of inward creative manufacture, she creates the ends and means to evolve another person; thirdly, she begins with one center

after another, and evolves as many complete accomplishments as she can well instill, seeing to it that observational, cognitive and expressional sides are all three developed to their utmost and then finally inspires that subject to undertake thereafter a whole series of gradually increasingly important attainments up to the final Kantian end of being a complexly evolved and intricately related human personality, and each can say I live and lead others to live in those "more stately mansions of the soul."



2 ONE OF THE TWO AMBULANCES FURNISHED BY THE CADILLAC COMPANY FOR THE EMERGENCY HOSPITAL AT THE PANAMA-PACIFIC EXPOSITION. THEY ARE THE LAST THOUGHT IN AMBULANCES, BEING WELL-EQUIPPED HOSPITALS IN THEMSELVES. THE ENTIRE EQUIPMENT OF THE HOSPITAL HAS BEEN CONTRIBUTED BY DIFFERENT MANUFACTURERS, AND EACH ARTICLE IS ITSELF AN EXHIBIT.

Fire Protection and Prevention in Old Hospitals

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(Continued from September)

IN THE United States we are so prone to consider the rights of the individual that we are apt to overlook the rights of the aggregation of individuals. If laws requiring uniform fire-resisting building construction after any fixed date would be exacted and enforced, it would only be a question of time that the benefit would occur to the community in the way of reduced fire losses, reduced insurance premiums, and reduced expenses for maintaining fire-fighting equipment and added security to life and property interests.

Statistics show that in 1907 our preventable fire waste according to European experience amounted to over \$366,000,000 or nearly enough to build a Panama Canal each year.

Carelessness was found to be the cause of at least 56 per cent. of the fires occurring in the City of Boston during a period of twenty-five years.

Mill construction has been designated slow-burning, because, although largely composed of combustible materials, intelligent use and sufficient mass have greatly lessened the chance of the rapid spread of fire, or the probability of serious structural damage before the fire can be brought under control through the equipment of fire protection devices which should always accompany this type of construction. Such equipment includes watchman's service, automatic sprinklers, fire pails, hose, pumps and hydrants, besides an efficient private fire brigade. It is these safeguards, coupled with the better adaptation of all manufacturing or storage buildings to the risks inherent in their occupancy, that have caused the losses in the older Factory Mutual Fire

Insurance Companies to average four cents per hundred dollars annually, as compared with sixty cents in other property (or a ratio of one to fifteen), while the average cost of insurance to the owners of approved factories has been reduced to less than seven cents.

The following notes are excerpts from a Hand Book on Fire Prevention and Protection compiled by Joseph K. Freitag, and from various other sources:

"In Europe they have learned that fire waste emanates in larger part from either criminal indifference or criminal intent, and that to this extent it is preventable through laws which go directly to the root of the evil by holding the individual citizen to a rigid accountability for every act of omission or commission which tends to increase the danger. In all parts of Europe where the Code Napoleon prevails, the law of Voisinage holds the landlord responsible for his negligence to all concerned, tenants or neighbors, and if fire originates from carelessness of tenant, he is held responsible to all concerned, landlord or neighbors. This law places the responsibility where it belongs and works automatically in making everyone interested in having his premises as safe as they can be made by human foresight."

If our enormous fire losses were unavoidable, speculations as to the improvement of conditions would be idle, but that such property losses are preventable is irrefutably shown by comparing statistics of fire losses in United States and in Europe.

Reports of United States consuls in Europe show that the average per capita loss in six European countries for a period of five years was \$0.33, while the fire losses

in five of our States during five years was \$2.12 per capita, or six and one-half times as great. Figures show that at least 27 per cent. of the losses for fire occurring in the country resulted from fires extending beyond the building of origin, while abroad, the percentage of such losses from the extension of fires to other buildings was a fraction of 1 per cent.

Management.—Mr. F. M. Griswold who, through his connection with insurance interests, has had a wide experience in fire prevention matters, has stated that, whatever the construction of a factory or manufacturing building, or the nature of its occupancy, or the completeness of its fire protection, shop management or “good housekeeping” is the most important basic element in fire prevention, the acceptable practice of which requires the following:

The enforcement of rules which will insure cleanliness throughout the plant as a matter of daily practice, not only as a means by which the possibility of fire may be avoided, but as of profit.

(a) Floor sweepings, greasy papers, oily wiping waste, paint, rags and like material, subject to spontaneous ignition, should be deposited in “Standard” safety cans suitable for their reception, the contents of which should be safely disposed of each night, preferably to be burned under the boiler.

Ashes should be kept only in metal receptacles; should be removed from building each night and not be deposited in contact with combustible structures or material.

(b) Workingmen’s clothes and overalls, when not in use, should be kept in ventilated metal closets or lockers not in contact with readily combustible material.

(c) All combustible process waste and other refuse should be carefully disposed of by removal from the buildings at the close of each day’s work, and be safely deposited in locations not endangering the plant in case of ignition of such refuse.

(d) All volatile and inflammable fluids should be kept in and used from “Standard” safety cans; not in excess of one day’s supply of such should be kept inside of building at any time, and all unused portions should be removed to a place of safety outside of the plant at the close of the day’s work. . .

(e) Watchman’s service should be maintained at all times and the record of service be shown on such mechanical device as will not permit evasion of duty; records should be examined and checked over, filed and dated each day. . . .

The principal auxiliary aids in detecting or extinguishing incipient fires, or in coping with particularly severe fires, or in preventing panic and confusion among employees consist of the following:

1. Automatic Sprinklers.—These should be ranked first among auxiliary aids, because they both detect and extinguish fire.

2. Automatic Fire Alarms, ranked second in importance because of their automatic functions in discovering fire.

3. Other agencies, such as fire pails; extinguishers, etc.; auxiliary boxes; watchmen and watch-clocks; standpipes; hose-racks and roof nozzles; private fire department.

4. Discipline of tenants and up-keep of appliances, to insure instant efficiency, involve:

Fire drills, and inspection and maintenance of protective appliances.

Sprinklers have been called “the greatest economic invention of the present generation.” Heretofore used only in non-fire-resisting buildings, their use is now gradually extending to a wide range of fire-resisting structures, not so much on account of the protection directly afforded the buildings as in recognition of their great value in controlling incipient fires in the stock and contents. A broad view of fire protection should consider safeguards almost as important as fire-resisting construction *per se*, as any means which tend

to extinguish or limit fire are of incalculable value.

After the horrible Asche fire in New York City, Superintendent Stewart recommended:

1. A fire drill and private fire department should be organized among the employees of all factories to prevent panic and extinguish fires. The plan of organization outlined in the recommendations of the National Fire Protection Association should be used as a guide for this purpose.

2. All stairways, or a sufficient number of them, should be located in fireproof shafts having no communication with the building except indirectly by way of an open-air balcony or vestibule at each floor. Hose connections attached to standpipes should be located on each floor in the stair towers for public or private fire department use.

3. Stairs, if any inside the building, and elevators, should be enclosed in shafts of masonry and have fire doors at all communications to floors.

4. The provisions ordinarily necessary for fire escape towers might be somewhat modified in buildings equipped with a system of automatic sprinklers installed according to the standards of the National Fire Protection Association.

5. Present buildings with inadequate fire escapes should be provided with automatic sprinklers and smoke-proof stair towers, but additional outside fire escapes passing in front of or near windows should be discouraged.

6. Automatic sprinklers should be installed in all buildings to control a fire and thus prevent it from spreading rapidly from floor to floor by way of outside windows. The use of wire-glass in metal frames for all exterior windows would also retard such vertical spread of fire but not so effectively as a complete equipment of automatic sprinklers throughout the building.

A wet-pipe system is considered to give

much better protection against fire than the very best dry-pipe system, and for this reason dry-pipe systems should be used only for rooms or buildings which it is impracticable to warm during cold weather.

If an automatic sprinkler fails at time of fire, the neighboring heads will usually check the fire. If a dry-pipe valve fails, every sprinkler becomes useless, and the ruin of the whole building may follow. Furthermore, with a dry system, water does not reach the fire as promptly, on account of the air in the pipes.

FIRE ESCAPES

Fire escapes may be located either on the interior or exterior of a building, but in either case three requisites are necessary, *viz.*—Safety, unobstructed outlet and access to the roof.

The best type of interior fire escapes is the so-called Philadelphia Vestibule type of Tower Stairs which consists of a stairway enclosed in walls of brick or other approved fire resisting material and isolated from the several floors of the building, except for an exterior balcony at each floor level which forms a means of communication through the open air between the stair towers and the interior of the building.

Exterior fire escapes are generally inefficient, especially when built so that they pass windows, unless the latter have metallic frames and wired glass. If they must be used, they must be in the form of stairs and never in the form of ladders because they are never used except in case of panic or danger, are at best of light construction, and because of their unsightliness are generally placed in inconspicuous locations rather than where most serviceable, and especially because of their inadequate capacity. If they must be used, they ought to be in the form of "straight runs."

Fire Escapes—Stairs should not be steeper than 45 degrees, balconies not less than 4 ft. wide, entrance door to be on floor level,

doors or window openings onto or under fire escapes to be metal covered and wired glass.

OUTSIDE HOSE—COTTON RUBBER-LINED

For use on the yard hydrants of the ordinary building, unjacketted cotton rubber-lined hose is recommended. Specify that it be guaranteed "conformable to specifications of Associated Factory Mutual Fire Insurance Companies."

For nine-tenths of the yards the above hose is preferable to the thicker and heavier jacketted hose used by the city fire departments, as it is easier to handle and more quickly dried and more economical for the consumer.

By purchasing only the best, and giving it the small amount of attention suggested, the greatest practicable durability will be assured.

Experience has shown that a good cotton rubber-lined hose, properly cared for, will frequently last ten or even fifteen years.

No hose smaller in diameter than $2\frac{1}{2}$ inches should be used. The actual inside diameter of the so-called $2\frac{1}{2}$ inch Underwriter hose is $2\frac{1}{8}$ inches.

INSIDE HOSE—UNLINED LINEN

For fire hose to hang up in dry, warm rooms or stairway towers of textile mills, corridors of office buildings, etc., we recommend unlined linen hose. Specify that it be "guaranteed conformable to the specifications of the Associated Factory Mutual Fire Insurance Companies."

It costs less than half as much as good cotton rubber-lined hose, and if not used will last two or three times as long. Its chief value is for short lines for brief use inside the mill, and it is best on account of its superior lightness, compactness and convenience for use by one man alone, and because there is little or no chance of its becoming stuck together by the ordinary heat of the rooms.

If possible, the stairs and elevators should be separated. Each building should have at least two stairways remote from each other and enclosed in fire-proof shafts with fire doors on the several floors. No point to be beyond 90 ft. from the stairway.

All stairways should be enclosed in fire resisting walls such as brick or concrete, which should be rigid for the proper mounting of free doors, and stable to prevent damage on the stairs, caused by falling partitions.

If glass must be used in these partitions, it should be mild glass set in cast iron.

Stairways should be fireproof and if marble or slate treads are used, cast iron sub-treads or platforms under the marble or slate should be used.

Experience and tests have shown that for effectiveness, reliability of operation, durability and cost, the tin-clad fire doors with wooden cores are best. The horizontal sliding type takes up the least room and has the simplest closing device, the single swinging door is the next most desirable, and swinging doors in pairs are least desirable. Exit doors should be of the swinging type opening outward, this arrangement being already required by ordinance in several States.

In hospital and other public institutions every consideration of design or construction must be subordinated to that of safety.

Boiler and storage rooms should however invariably be cut off from the balance of the building by thorough fire-resisting walls, preferably brick or concrete, with as few openings into the rest of the building as possible. These openings should be provided with automatic self-closing doors.

Many reputable construction companies are willing to install a sprinkler system at their own expense, carry it until the reduced premiums pay for it, and then deliver it free and clear to you.

Eye Nursing

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EYE OPERATIVE NURSING (PREPARATION AND CARE OF OPERATIVE CASES)

PART IV

NOT a great deal need be written as an introduction to this chapter. For the first few days, usually, the operator looks after the operative cases himself, hence up to that point a graduate nurse should be able to get along on such training as she may have already acquired. That this does not quite fully cover the situation, however, goes without saying for in order to be of the greatest possible assistance the nurse should not only be able to take a patient through operation and recovery, but during this time should further understand approved ophthalmic nursing technic if she is to feel at all sure of her ground. Such special information can naturally only be obtained in some definite course of instruction on the subject and for that reason a perusal of Part I—Handling of Eyes in the Hospital Ward or Private Sick-room, and Part II—Principles of Treatment in Ocular Therapeutics, is fully as important as the few pages which may be devoted to consideration of surgical cases alone.

Eye Operations in General—As a rule, operations upon the eye such as the removal of small lid tumors, incision of the cornea, extraction of a cataract, removal of a piece of the iris, straightening eyes in squint, etc., are all performed with the patient lying quietly in bed flat upon his back. Cocaine, 4 per cent. solution, is the local agent employed for securing anesthesia and a solution of adrenalin chloride (1-1000) is often dropped in the eye to insure a bloodless field as well. Severer oper-

ations, such as the complete removal of the eye in enucleation, iridectomy in glaucoma, and operations on very young children, are about the only ones carried out under general anesthesia with ether and chloroform. Eye bandages and bandaging play a very important part in the work as the nurse is frequently requested to either complete a bandage started by the operator or apply one herself at various times later on in the course of treatment.

STERILIZATION OF HANDS, INSTRUMENTS AND DRESSINGS

Strict attention must be paid to the matter of clean hands, sterile dressings and irrigating solutions, a clean operative field and sterilized instruments. Not only must each individual item in the surgeon's working equipment be germ free, but also every individual assisting him should realize that a break in the chain of complete asepsis may result in wound infection. It cannot be emphasized too strongly that the slightest neglect to preserve surgical cleanliness at any and all stages of an operation is nothing short of criminal carelessness.

Hands—The nurse assisting should sterilize her hands and forearms when everything is in readiness in order to be as clean as possible. Sterilization of the hands is an established measure and cannot be excused under any circumstances. Sterilization of the hands consists in thoroughly scrubbing the hands and forearms with warm water and tincture of green soap for several minutes. Special attention must be given

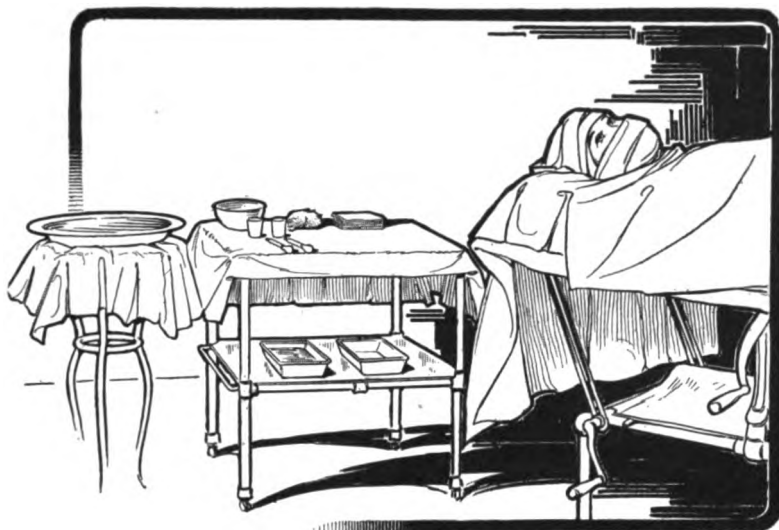


Fig. 27.—Patient on operating table ready for cataract operation. Both eyes open. Lower portion of face covered with a single layer of gauze, moistened in 1/3000 bichloride solution. Stand for supplies and instruments conveniently at hand ready for use. The operator takes his position at the end of the table and performs the operation while bending a little over the patient's head. The two rectangular basins on the lower shelf of the stand contain 5 per cent. carbolic acid solution and the other 95 per cent. alcohol for sterilizing eye instruments. The bowl holds sterile water or normal salt solution.

to the finger-nails, which will require the services of a cheap nail-brush and file. After scrubbing, the hands are dipped in a 1-3000 bichloride of mercury solution, rinsed in sterile water, then in 80 per cent. alcohol and finally dried on a sterile towel. The surgeon and his assistants usually sterilize their hands in the room adjoining the operating-room, where there is also hot and cold water and similar accessories for "scrubbing up." Following scrubbing of the hands with soap and water, the operator further sterilizes his hands in the operating-room in the same way as the nurse by immersing them in a bowl of 1-3000 bichloride, then in sterile water, next in 80 per cent. alcohol and dried with a sterile towel when he is finally ready for his sterile gown and cap. As the hands are among the most common sources of wound contamination, as few as possible should come into actual contact with the actual wound itself. Sterile articles should not be picked up by the nurse unless her hands are surgically clean.

Instruments—Only the larger, coarser eye instruments are to be sterilized by boiling for from 8 to 10 minutes in the steam sterilizer. It is always wise for the nurse to carefully pick out such instruments as can be boiled without danger and when in doubt ask the operator if he wishes the particular instrument in question boiled or not. Delicate cutting eye instruments such as cataract knives, knife needles, etc., cannot be boiled without running the risk of being damaged and for this reason are sterilized by being placed first in a pan of 5 per cent. carbolic acid solution and then into a pan of 95 per cent. alcohol.

Dressings—Small bundles of articles necessary for the operating-room and dressings of various sizes are prepared under the supervision of the operating-room nurse and sterilized in the large hospital sterilizer. After sterilization, when a bundle is once opened its contents must be handled with sterile forceps and not touched with the hands.

PREPARATION OF ROOM AND BED FOR HOME EYE OPERATING

While it is unnecessary to go into the preparation of the average hospital operating room, a word or two will not be found amiss for the preparation of a home eye operating room which is sometimes necessary to arrange. An eye operation at the patient's home is best done in a single bed, pulled close to a window and preferably using a bed which will enable the operator to stand at one end (utilizing either the head or foot of the bed for this purpose) and lean over the patient's head while he is operating. In delicate eye operations, especially in somewhat inconvenient places, by operating in the same bed in which the patient is to remain, the patient does not have to be moved at all after the bandage is once applied. Such a plan has many things to recommend it. Since most of these eye operations also are performed under local cocaine 4 per cent. anesthesia, much of the very formal arrangement of either the patient or the room as in the administration of a general anesthetic will not be found necessary. Finally, the pillow on the bed should be flat and act as a firm pad rather than a soft pillow, so that the patient's head will not sink into it and be partly buried.

PREPARATION OF PATIENT FOR CATARACT EXTRACTION OPERATION

The night before the operation the eyebrows, eyelids, and skin about the eye are cleansed with soap and water or a weak 1-5000 corrosive sublimate solution, being careful at the same time that no irritating substance is allowed to enter the eye itself. This done, the eye is flushed with boric acid solution, covered with boric acid gauze, either dry or moist, or plain sterile gauze, and bandaged. No medicine should be used in the eye before operation, which will in any way affect the pupil, unless definitely ordered. When once in the operating

room, the pad and bandage are removed and the eye flushed again with a warm boric acid solution. A cataract extraction operation is performed with the patient lying quietly in bed or on the operating table (Fig. 27) flat on his back and both eyes open. The eye to be operated is cocaineized by instilling one drop of a 4 per cent. solution of cocaine every two or three minutes for three or four doses. As the foregoing is the standard type of preparation for practically all operations on the interior of the eyeball, the simple outline as given, if read over carefully, will be easily remembered.

NURSE'S DUTIES AT CATARACT OPERATIONS

During the operation no noise or sudden movements are to be permitted in the room, or, in fact, anything which might distract the patient's attention and cause some unexpected movement of the eye, perhaps to spoil the entire operation. A nurse may, at the request of the physician, act as his assistant in sponging the wound. When wiping away blood at an eye operation, never press down hard upon the globe, but merely allow the moistened end of a bit of cotton to gently absorb the blood or excess of fluid present. The lids themselves may be wiped more forcibly, but the eyeball seldom. The nurse in a very short time, by being a good observer, should be able to provide whatever material may be required for ordinary eye operations without asking unnecessary questions of the attending surgeon. As a solution of atropine sulphate 1 per cent. and also adrenalin chloride (epinephrin) (1-1000) will be called for, these should be conveniently at hand ready for instant use. Often the request is made that such solutions be sterilized before being used. After operation, great care must be observed in handling and putting away all small eye instruments, so that their cutting edges will not be dulled. Often

mere contact of the cutting edge of a cataract knife with another instrument is sufficient to spoil the point of it and for this reason such instruments are at once put away by either the operator or nurse in special compartment boxes made for the purpose (Fig. 28).

POST-OPERATIVE CARE FOLLOWING EYE OPERATIONS

With the completion of an eye operation, the surgeon flushes the eye with a warm boracic acid or normal salt solution, instills a drop of whatever medicine is required, and applies a bit of bichloride ointment 1-3000 or sterile vaseline to the inside of the lower lid. Bichloride ointment (White's ointment) is the most frequent ointment applied to the eyeball before bandaging, to prevent sticking of the bandage to the lids and is also antiseptic. It is always wise in bandaging eyes, especially where delicate eye operations have been performed, as in cataract cases, to prohibit the patient from raising the head himself. The head should be raised by the nurse or assistant while the bandage is being put on. At the first dressing, and especially where the eyes have been bandaged for some time, the skin about the eyes and forehead is often cleansed with warm water containing a few drops of peppermint or a weak solution of alcohol and water. This treatment is very agreeable to the patient, as it allays itching and other discomfort due to the constant presence of a bandage about the head. Severe operative cases are confined to bed in a darkened room for from 5 to 9 days following operations, and kept as quiet as possible. Patients should be cautioned to avoid accidentally striking an operated eye with the hands. Possible attacks of coughing and vomiting or severe straining to produce a bowel movement should be kept in mind before operation, and proper measures taken to prevent this if possible. For the first few days following the opera-

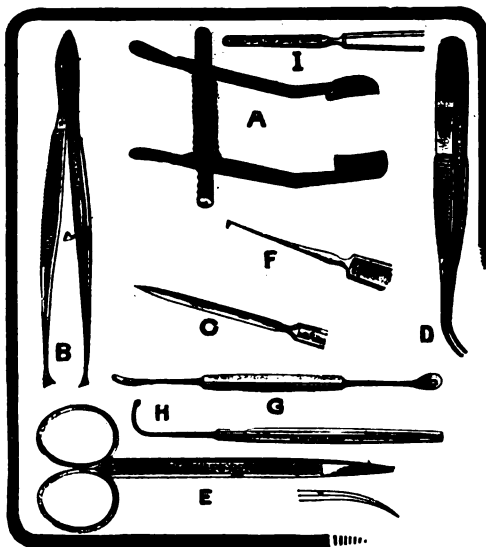


Fig. 28—These instruments are picked out by the operator and placed by the nurse in a pan of 5 per cent. carbolic acid solution and then into 95 per cent. alcohol. A bowl of sterile water or normal salt solution should also be at hand in case the surgeon wishes to dip them into some bland solution before being finally used. Great care should be taken that cutting edges or delicate points do not come in contact with either other instruments or the sides of the sterilizing pan. Cataract knives may be tested by the doctor in a small "testing drum" before being given out to the nurse.

tion, the operator does his own cataract dressings. Before each dressing the curtain of the room is raised so that not too much light will be admitted, the bandage removed, eye cleansed with normal salt or boric acid solution, a drop of 1 per cent. atropine sulphate solution instilled, a bit of bichloride (White's) ointment applied to the edge of the lower lid and the eyes rebandaged (pad and bandage) with either a roller bandage or some special cataract bandage designed for the purpose. Occasionally elderly or very aged people stand darkness, atropine and strict confinement to bed quite poorly, and may become restless or even mildly delirious. If this occurs, careful watching is necessary in order to prevent them from getting out of bed or accidentally striking the operated eye with the hands.

NURSE'S PREPARATION OF CATARACT DRESSING TRAY

The materials commonly required for a post-operative eye dressing tray are as

follows: Two eye droppers, small bowl of warm boracic or normal salt solution, small package of sterile cotton and of sterile gauze, roller bandage (unless a special cataract bandage is being worn by the patient), small bottle of atropine sulphate 1 per cent. solution, tube of sterile vaseline or bichloride ointment (1-3000), condensing lens and a couple of sterile towels. Safety pins for pinning bandage more securely, scissors for cutting the bandage, pan for used materials, a doctor's clean apron and a place and materials for the doctor to wash his hands before doing the dressing should also be thought of and provided.

ENUCLEATION (REMOVAL OF EYEBALL)

The eyeball is frequently removed for penetrating wounds which have destroyed the globe, for foreign bodies in the eye which cannot be extracted, and for malignant growths. The operation is performed under a general anesthetic and requires the usual preparation for a major surgical operation, *i.e.*, no food for at least six or seven hours preceding, rectal enema and emptying the bladder on the morning of the operation and the removal on the operating table of any mouth plates or false teeth which might become loose while taking the anesthetic. The local preparation consists in cleansing the lids and skin about the eye with soap and water, flushing the conjunctival sac with boracic acid solution, and applying a sterile dressing over night. As enucleation of the globe is a common eye operation, its preparation should be carefully observed. The instruments and materials required, previously sterilized by boiling, are as follows: Eye speculum, fixation forceps, strabismus scissors, two strabismus hooks, strong curved scissors for cutting the optic nerve, needle holder, eye needles, black silk thread, sterile gauze for sponging and for dressings, bulb syringe, bowl of hot boracic acid solution, tube of bichloride eye ointment, one

or two small eye hemostats and a roller bandage. As this is a hospital operation, the usual operative routine of the institution will naturally prevail. It is always a safe plan with eye and ear patients, especially when several operations may be grouped together, to mark the skin of the temple (on the side to be operated) with an aniline pencil so that by no possibility could the wrong eye or ear be accidentally operated.

PREPARATION OF GENERAL SURGICAL DRESSING TRAY FOR ABSCESSES ABOUT THE ORBIT OR AFTER REMOVAL OF THE EYEBALL

For the dressing of abscesses about the orbit or face, the following surgical materials should be provided routinely: Package of sterile dressing gauze of two sizes, small package sterile cotton, two sterile towels, iodoform gauze strip for insertion as drainage wick in keeping suppurating wound open, a pair of sterile dressing forceps, scissors, blunt-pointed probe and paper bag for collecting waste.

The supplies which may be required in enucleation (removal of eyeball) consist in eyedroppers, few tooth picks, small bowl normal salt solution or boric acid, tube of bichloride ointment or sterile vaseline, sterile gauze for cleansing and dressing purposes, roller bandage and safety pins. On the fifth or sixth day stitches are removed, which last requires a pair of sterile forceps and scissors. The nurse should be careful to include practically all of the above articles in the treatment tray (according to the nature of the case) as it is not a pleasant experience for the surgeon to have to wait unnecessarily while materials are being procured in some other part of the hospital. No where does a nurse's real qualifications stand out so plainly as in her intelligent thoughtfulness in preparing a dressing tray and in making mental note of extra materials which seem to be required for future treatments of the case at hand.

A Year of Festivities in the Hospital

CORA MCCABE SARGENT

Sheppard-Pratt Hospital, Towson, Md.

ONE has only to be a "shut in" for a short period of time to realize the almost overwhelming monotony of such an existence. It can then be easily imagined what it must mean to the patients in hospitals, especially those for special diseases, where even the convalescent period is drawn out through many weary months. One day is much the same as another; the same routine of sleeping, eating and treatments, until the matter of living itself becomes one of routine.

Because of this monotony, any break, however simple, in the way of social recreation comes as a welcome ray of sunshine on a cloudy day. It has also a broader and fuller mission in that, for the time being at least, it takes the patients out of themselves, thereby becoming a valuable aid to therapeutics. In fact, psychiatrists now acknowledge the fact that occupation and amusement play a prominent part in the treatment of mental and nervous disorders.

In one of these hospitals where the nature of the illness necessitates a prolonged residence, the plan for providing one social entertainment on a Red Letter Day of each month, was inaugurated as an experiment to test the practical as well as theoretical benefit to be derived from some special form of entertainment. The results were most gratifying. In the first place, the patients were pleased and flattered that their desires had not only been recognized, but catered to. Then too, there was the delight which comes from anticipation, coupled with curiosity—for each entertainment comprised one or more surprise features—following this, was the realization, which for days afterward provided food for conversation. In view of all this, it

must be admitted that the end justifies the means, that is to say, the time, labor and slight money outlay.

The yule-tide season was selected as a most fitting time to initiate the good cheer festivities, as the patients have called them. The calisthenics room, being large and unfurnished, was selected as the "seat of action," and for days before each festivity, was pervaded with the air of mystery, which is always so fascinating.

On Christmas Eve, on the stroke of eight, the guests assembled in the entrance hall to greet good old Saint Nick who, as he announced in full cheery tones, had turned over everything else to his helpers and come in person to inaugurate a year of festivities in this particular hospital. The announcement was greeted with cheers, then amid much laughter and chatter, the Patron Saint led the way to the entertainment hall. If there had been any doubts as to the success of the venture, they were dispelled the instant the door of the room was thrown open and the guests beheld the surprise prepared for them.

The room had been made gay with Christmas greens, Christmas bells and other symbols of the season. In the large bay window stood the tree, festive with strings of dazzling tinsel, balls, etc., and laden with toy musical instruments. Tiny vari-colored electric light bulbs gleaming here and there among the branches completed the charming effect.

With Santa in the lead, the guests gathered round the tree and, with piano accompaniment, sang Christmas carols. The guests were then asked to be seated. A basket of nuts was passed, each person taking one. Inside of the nut, instead of a meat

kernel, was a slip of paper containing a number, which corresponded to a number on one of the gifts on the tree. Santa distributed the gifts, and it is needless to add that the music rendered did credit in quantity, if not in quality, to the occasion.

Refreshments consisting of sherbet, fruit-cake, nuts and candy were served, after which the victrola was called into requisition and dancing was indulged in for an hour or so.

The success of this first party was an inspiration to renewed effort upon the part of those who planned and carried it through.

It had been decided in the beginning, that variety should be the dominating feature of each festivity, and thereby impart the added charm of distinctiveness; so, the January party took the form of an evening of cards. The Christmas decorations, typical of the season, rather than the day, had remained undisturbed, except that the words Merry Christmas, which had bridged over a bare stretch of wall, were replaced by Happy New Year.

In order that none might feel slighted or unable to take an active part—which is one of the ends desired—a certain number of tables were arranged for auction bridge, others for "500," and still others for such games as should appeal to those who did not play cards. Prizes were awarded for each kind of game played, and although these prizes did not represent any real outlay of money, they had been carefully selected with a view to the eternal fitness of things.

The victrola was played during the entire evening. The refreshments, served on the card tables, comprised chicken salad, olives, cheese, crackers and chocolate with whipped cream. At ten o'clock, "ward bed time," the record "Good Night Ladies" was played and reminded the guests the time had come to say their adieux.

February has such an embarrassment of

riches in the way of Red Letter Days, that the entertainment committee was rather at sea in the matter of choosing which to celebrate. After due deliberation, it was decided to give the preference to the patron saint of hearts; accordingly a Valentine Party was arranged.

It goes without saying that the color scheme was red, with just enough green—provided by "green things growing"—to give the necessary setting. Chains of hearts of varying sizes cut from red cardboard festooned the room, draped the bay window, were suspended from the chandelier, in short, were everywhere that the slightest excuse was offered for their being. By the way, cutting and stringing these hearts furnished many hours' occupation for the patients.

A Love Letter Contest, assuming that well known lovers in fiction were the characters writing, was the game of the evening. At the finish, the letters were read aloud, and the prize awarded by vote. This was a beautiful heart-shaped box of candy. As may be imagined, the letter reading furnished no little fun. Following this, old time love ditties were rendered on the victrola.

Frozen pudding was served in heart cases of red paper, lined with white. Each serving was decorated with tiny red candy hearts. The small cakes were heart shape and each one was pierced by a tiny gilt arrow, cut from very stiff cardboard. Motto candy hearts in little heart boxes were the favors.

March, with its contradictory weather, always brings one bright day—in the spirit, if not in reality—and that is the day which commemorates the birth of Saint Patrick, of fragrant memory. In order to honor tradition, and at the same time have pleasure of a lighter vein, it was decided to divide the evening's entertainment into two parts. The first half comprised a brief

sketch of St. Patrick's life and work, the paper being prepared by one patient, and read by another. Irish songs were given by several patients of a musical turn, and several Irish sketches were read.

At the conclusion of the program, characteristic refreshments were served. These consisted of pistache ice cream, served in shamrock cups (made by the patients), and cakes cut out with a shamrock cutter, then iced with white and decorated with bits of citron. The favors were miniature papier-mâché pots of artificial shamrock. Upon examination, it was revealed that the pots were candy boxes filled with green candy mites.

The inner man refreshed, the victrola was called into requisition, and dancing was in order for the next hour. Each dancer wore a green paper cap.

The Easter party was certainly a thing of beauty and one is tempted to add a joy forever; for it will surely never be forgotten by the participants.

To impart the real "springy" feeling to the occasion, the guests were asked to wear pretty white or light color summer dresses. The entertainment room was made festive with potted plants and foliage. Low bowls of violets from the hospital conservatories were placed here and there, and accentuated the color scheme, purple and white.

Dancing was indulged in for an hour, then the door of an adjoining room was thrown open, disclosing a table in the center of the room, of sufficient length to accommodate all the guests. As this was an entirely new departure, it was received with enthusiasm. The table was covered with the regulation white cloth. In the middle, on a centerpiece of lace over purple rice cambric, which had all the appearance of satin without the cost, was a big round basket arranged to simulate a nest; this was filled with gaily colored Easter eggs. On the outside of the nest, and looking

into it, was a most natural looking bunny, contemplating the eggs which, according to the graceful legend, it was supposed to have laid. On each side of the table, just within the plate line, and running the entire length of the table, was a six inch band of purple, cut from crepe paper. The ends of these bands terminated in cleverly constructed rosettes, from the center of which peeped tiny chicks. Half way between the centerpiece and the ends of the table were smaller nests filled with chocolate eggs, one for each guest. Tall glass candlesticks with white candles were placed here and there on the table, and not only did honor to tradition, but also gave the festive touch which lighted candles always impart to a table. The name cards were clever little drawings, typical of the season, and were the work of one of the patients, who had an artistic trend.

The refreshments were as delicious as they were unusual, that is to say, unusual for an evening spread. They consisted of fricasseed chicken, waffles, maple syrup, and coffee capped with whipped cream. Four of the junior nurses doffed their uniforms for the time being, and masqueraded as trim maids in black dresses, maid's aprons and caps. Their very proper behavior and formal attitude as they dispensed hot waffles was as exemplary as it was amusing.

The feast was one of reason and flow of soul as well as mere gratification of the palate; for from time to time during its progress, there was a pause while one of the guests gave what appeared to be an impromptu (but in reality specially prepared) account of the various Easter traditions and customs, such as "Why Rabbits Lay Eggs at Easter"; "Why Easter Eggs are colored"; "The Significance of Easter Candles," and other subjects bearing upon the season.

The May-Day party was one of the prettiest as well as most notable of the

series. The color scheme was pink and white—the May colors. A May-pole dance was the distinctive feature. The pole stood in the middle of the big entertainment room, which had been profusely decorated with branches of pink and white dogwood. The dancers wore Grecian dresses made of pink, white and green cheesecloth, and made a never to be forgotten picture as they wound gracefully in and out of the ribbons.

The refreshments were served in one of the ward sitting rooms, which like the entertainment room, was brave in May-day colors. The guests were seated four at a table. In the center of each table was a miniature May-pole, with a ribbon leading to each plate, and ending in a tiny basket filled with pink and white mints. The refreshments were iced tea, garnished with rings of Maraschino cherries and lemon crescents, olive and mayonnaise sandwiches, and charlotte russe.

June brings many material delights, but none more popular than the luscious strawberry. Appreciating this, the entertainment committee planned to give a Strawberry party while the price was still high enough to make the fruit a luxury. To give the distinctive feature, it was decided to have a masked dance for the social part of the evening. Each guest was asked to represent a June flower. The result was most pleasing. A pretty vase filled with exquisite June roses was the prize given for the most successful costume. During the intervals between dances, fruit punch was served from a small table prettily decorated. The refreshments consisted of strawberries capped with strawberry ice cream, and angel food cake. Each guest was given a miniature market basket filled with candy strawberries.

A Stars and Stripes party emphasized "the day we celebrate," and was a wonderful success. The entertainment hall was

resplendent in the national colors and emblems. National hymns and airs were played on the victrola. The guests were asked to come in costume, a request which met with a hearty response, and Mesdames Martha Washington, Dolly Madison and other real and fictitious characters of colonial times, graced the occasion with their presence. For this one evening, the new dances of the day were tabooed, and the more dignified ones belonging to the day when our country was in process of making were in order.

The refreshments emphasized the *motif* of the festivity. Delicious frozen punch was served in paper drums; the cakes were baked to simulate miniature cannon balls and in the top of each was stuck a tiny silk flag; red, white and blue bags, filled with freshly roasted peanuts, without which no Fourth of July is complete, and popcorn balls, wrapped in red, white and blue paper comprised the list. The favors were liberty caps.

Perhaps the very prettiest of the whole series of parties was the August one, a Japanese Tea served on the lawn. The very announcement of the prospective tea was exhilarating, and started everybody thinking, planning, guessing. All that the guests were told beforehand was that they were to wear kimonos and dress their hair a la Japanese.

The lawn looked like an enchanted grove. A tea room had been improvised by means of a trellis overrun with vines, from which hung bunches of wistaria bloom made from paper. Hundreds of paper lanterns of varying sizes furnished the light, both in the tea room and on the lawn. On grass mats stood low tables, around which the guests were seated true Japanese fashion, and were served to tea in the daintiest of Japanese cups, rice cakes, preserved ginger, and spiced glazed almonds. The victrola was played during the evening.

An indoor fete was planned for September, and took the form of a Harvest Home picnic. The entertainment room was made "woody" with trailing vines brought in from a nearby woods and tree branches. The floor was bedded with leaves and freshly cut grass. Out-door games were played for an hour or so, then a cloth was spread upon the "grass," the picnic hamper brought in and unpacked, its contents being home fried chicken, beaten biscuits, sandwiches galore, devilled eggs, cookies, fresh fruit, nuts, candy and real pink picnic lemonade. It is almost superfluous to say, everybody went home "full and happy."

October brings Hallowe'en, with its mystic rites. It was decided to give a Hallowe'en supper, which was noteworthy for its novel decorations and other characteristic features.

To begin with, the color scheme was very unusual, being red and black. The table was covered with a plain red cloth. In the center was a gigantic black cat standing on a large four-leaf clover cut from black paper. Narrow red ribbons tied around the cat's neck led to smaller cats, one at each guest's place. Candlesticks of black wrought iron held red candles with red shades, on which were pasted the tiniest of black cats, and completed the novel, weird, but most effective decoration. The refreshments consisted of cold sliced chicken, brown bread and butter sandwiches, olives, pickles, pumpkin tarts, ginger cakes, apples and nuts.

After supper the guests repaired to the sitting-room, where the old Hallowe'en fireside games were indulged in, such as the apple test, the "three luggies," made immortal by Burns, the nut toasting test,

and others too well known to need enumerating.

Bleak November brings to the "shut-in," many days of depression and Thanksgiving more than any other season, is one of gloom and sadness, for it recalls forcibly to mind home and the things that have been. For this reason, the entertainment committee decided that the November party, which completed the cycle, should be one of the most joyous of the year. To this end they put on their thinking caps and set to work sharpening their wits. Many plans were discussed and abandoned before it was decided to give an amateur play, to be followed by a chafing dish supper.

In so far as practicable, parts in the play were assigned to patients, the others were given to nurses. The piano and victrola were both pressed into service to furnish music for the occasion. A stage was erected at one end of the entertainment room, and chairs arranged for seating the guests. That nothing might be wanting, a ticket office was improvised in the lobby, and "polite ushers" showed the audience to their seats. As all the plans and preparations had been kept a profound secret, the surprise constituted a big feature of the enjoyment.

While the play was in progress, a half dozen small tables were brought to the sitting-room. On each was a chafing dish and its accessories, also the necessary ingredients for cooking. The fact that the guests helped with the preparation and serving of the food lent an added charm. The menu was very simple, consisting of creamed oysters served in china ramequins, and garnished with sprigs of parsley, toasted crackers, celery salad in rings of tomato aspic, and hot chocolate capped with marshmallow whip.

Diphtheria

A FEW HINTS

AMY ARMOUR SMITH, R.N.

BEDS are very peculiar furniture. They have so many uses. For instance, they are excellent to keep trousers pressed, so if you ever get a hurry-up call to some confinement case, where you are an absolute stranger, be sure to look under the mattress and remove the husband's evening trousers, or they will be ruined, unless you have time to make a big bed pad.

Beds also can be used as diphtheria culture incubators. When the physician takes the culture he keeps it in his vest pocket, where it remains at body temperature, at which it is correct for the Klebs Loeffler family to live. At nightfall, he transfers it to the pocket of his pajamas. But if he has some calls in the night, he promptly hands it over to his wife, who actively keeps up the process until twenty-four hours have elapsed. Then it can be examined.

Antitoxin is procured for charity cases by the physician from the board of health, or some sub-station, on the deposit of twenty-five cents for the syringe only, this to be returned when empty. It is prepared in various degrees of concentration, 1,000, 1,500, 2,000 units, etc., according to the age of the patient and the degree of severity of the disease, as well as the purpose, whether prophylactic or curative. A wise, far-sighted board of health keeps all the various doses on hand, of the proper date. A nurse seeking in the supply ice box for a dose for the physician, in a hospital where diphtheria may accidentally break out, or where there are contagious cases taken, should look well to the date on the box and the date on the syringe. They have been known to vary.

A physician in general practice in a small

town, finds it hard to get this drug in the wee small hours of the night, where the multifarious tasks of the day cloud his sense of forehandedness. But he can perfectly easily keep three or four strengths of antitoxin in his refrigerator, and have it to draw upon serenely in his worst emergency. All it requires is exchange from time to time as one dose is used, or as a date expires.

If you were on a case and the physician asked you, after diagnosing, to give 1,500 units, what would you do, supposing you found only a syringe marked 2,500 units? So few nurses are mathematicians, and so many do not know that they are not, that the wonder grows why more people in hospitals are not poisoned. The Arab proverb says "Beware of the man that knows not that he knows not." Empty the 2,500 units into a sterile minim glass. It may measure 40 minims, say.

Then if 2,500 units = 40 minims,

$$1 \text{ unit} = \frac{40}{2,500} \text{ minims}$$

$$1,500 \text{ units} = \frac{1,500 \times 40}{2,500} \text{ minims} = 24 \text{ minims}$$

Draw 24 minims back into the same syringe, apply needle, and administer.

Hives, or a severe erythema may result, more likely in persons of the extreme blonde type. This comes from the poisoning or toxin produced by mixing the horse's serum with the human being's, as referred to elsewhere, in regard to hemolysis, transfusion, etc. A nurse may employ various simple remedies to allay the itching and discomfort. Baths of soda bicarbonate solution, magnesia and similar substances produce some degree of comfort, if given copiously, and as ordered.

Formerly, in an outbreak of diphtheria,

in any hospital or town, every person coming in contact with the disease was immunized by antitoxin. But if a second outbreak occurred even so long as three or four years afterward, and the same persons were again immunized, a certain percentage of sudden deaths occurred among these, without any other illness. This immediately caused elaborate experiments on guinea pigs and other animals. It was found that a guinea pig showed no reaction after a first injection of any protein from any animal of an alien species, such as horse serum, or hen's egg white, but if after a long period, it was reinjected with the same sort of protein, it suffered a very violent reaction or death.

Therefore the desire to immunize everyone within reach as often as he is exposed

to the disease has greatly abated. A careful history is elicited before any antitoxin is administered whatsoever. The deaths formerly attributed to guessed-at defects in the horse serum were probably only following out a long chain of natural laws about species. It is in instances of this sort that a nurse does well to keep a still tongue, and not advise immunization, thus exciting the family or creating ill-will against an intelligent wide-awake physician. It would be absurd to expect a nurse to be thoroughly, if at all, familiar with the laws governing this condition of anaphylaxis, but she may ask pointed questions at an appropriate time; and learn enough to show her the vastness and consistent correlation of the potent forces ruling the universe.



GRADUATING CLASS, STATE HOMEOPATHIC HOSPITAL, MIDDLETOWN, N. Y

Some Impressions of the San Francisco Convention

THE OBSERVER

THERE is a sense of whirl in my mind as I look back upon the meetings of the Nursing Congress in San Francisco. There were meetings galore, and a certain atmosphere of importance, but what did we take away with us besides the memories of old friends and new acquaintances? When I remarked to one nurse on the third day of the convention that some of the papers hardly seemed worth while, she said, "Oh, I am enjoying all the meetings very much." A few days after, this same nurse volunteered the information that it was strange, but somehow very little of what she had heard seemed to have remained with her. I fear there were many who, after the first enthusiasm had died away, felt much the same.

There is a curious egotism about the nursing profession at present or, at least, about its "leaders." This impressed me very much in San Francisco. Self-sufficiency, self-complacency seemed the keynote to the whole convention. One could not suppress the feeling that all the convention was for, was to impress two ideas upon nurses and the public; if indeed the public was reached to any extent, *i. e.* the need of more preliminary education for the nurse and the need of central registries, to the exclusion of all others; nurses, doctors and hospitals to be forced to their support. Regret was expressed that after the papers were read, no time remained for discussion, and yet, out of ten papers read Tuesday and Thursday mornings, six were on the same phase of the central registry and the only discussion (except a little on Indian nurses), was arranged for on the same subject. This was not all, for but one side of the registry question was discussed, the central registry being advocated by all. If

discussion was felt to be so desirable, as it undoubtedly is, since papers can be read at home, why this reiteration of the need of a central registry at the expense of all discussion? All that was said on the subject could easily have been put in two papers at most, leaving abundant opportunity for the expression of all shades of opinion.

As for the emphasis on the educational requirement, it began with Miss Goodrich's somewhat ambiguous assertion that they should not rest until the doors of the universities were opened to nurses, and sounded and resounded from speaker to speaker throughout the convention, till one felt like imitating the small boy and saying "Oh, ring off." Dr. Downing came all the way from New York to say that no one had a right in a profession who had not had an academic training. Were it not for the serious effect of such words, one could have laughed at the delightful humor of this for, without doubt, three fourths of the women to whom he said this, and who applauded him loudly, had never had more than a grammar school education. How can women, while telling of the great things they have themselves accomplished, and of the great need the world has of their services, how can they in all seriousness say that other women of the same education are not fit to enter their profession, that the others must first go to high school, or better still to college. Is it not inconsistent? Is it not ridiculous?

It seemed almost as if the leaders had gone mad on the subject of education, while the really vital matter of personality was left unconsidered. I could not help wondering how Miss Dalbey's statement, that the essential requirements of the private nurse could be summed up in the one word " *tact* "

struck the "leaders." It was almost the only reference made to personality throughout the convention. To be sure, Miss Crandall told us we were in danger of forgetting that if we left out the spirit, using body and mind only, we might do no more than those working without training, and for a moment I felt quite pleased. But she went on to interpret her words as meaning that it was not enough for the public health nurse to nurse, but she must join hands with others and affect the whole life of the people, in prenatal work, infant welfare work, school work and so on through old age. So it was not a spirit of personal service in nursing she was inculcating, but a spirit of impersonal service, with only the end to be attained in view, and no especially human touch. And what a conception of the importance of the nurse! Undoubtedly the nurse's opportunities are tremendous, but they should make her humble, not arrogant. Yet not a tone of humility was apparent throughout.

The attitude in regard to registration and toward the attendant, which came up at a number of meetings, was based on the assumption that the graduate nurse, notably the R. N., is collectively and individually, the only person fit to care for the sick, and no need of her studying or bettering her preparation after registration was recognized. All trouble was tacitly or by innuendo laid to the practical nurse or attendant, and at no time, was there any sympathetic reference by a nurse to the attendant or her possibilities as a co-worker and assistant. Though much was said of the public's need of the nurse, and the necessity of its having the best nursing service, it all seemed to come down to a war upon the attendant, because she is, or is thought to be, encroaching upon the nurse's sphere, and to a desire to exalt the nurse and her importance.

The wish to appear fair led to Mr. Bradley being invited to give his views on

household nursing as a means of caring for people of moderate means, but how was his paper placed? Immediately before it came a paper by Miss Riddle, on hourly nursing, in which she made the extraordinary suggestion that having a private nurse in the house all the time during sickness, was merely an assistance to the doctor, who ought to teach people that it was unnecessary, and that the hourly nurse could do all that was needed. It was followed by a paper on the possible amalgamation of visiting, hourly and household-nursing. This paper began by saying it was significant that district nursing associations employ the graduate nurse rather than the household nurse, and it continued to dodge the point of using household nurses and to praise the care given by the graduate nurse. These are the views which were given regarding attendants: "That only the most thoughtful doctors realize the need of the best nursing care between visits; as a result all sorts of young women in cap and uniform pose as nurses; it used to be that the doctor knew the limitations of the practical nurse and she was acting out of kindness, not for hire, while today, where the woman is earning her living, there is no guarantee of her honesty; you may even find her price as high as that of the trained nurse; in money we demand sterling value, we should demand the same guarantee in personal relationships." If the fact that they are earning their living makes the attendants unreliable, one wonders at once whether the same holds good of the graduate nurse. Dr. Favill certainly thought it an advantage for her to be earning her living, as it gave her balance. Moreover, if so much is made of the attendant's personality why is no emphasis laid on that of the nurse? Education does not guarantee right conduct by any means.

The fight against the attendant seemed to me to be carried on so strenuously, that the risk was run of eliminating the private

nurse except in the care of wealthy patients, and of leaving the care of all other patients to the hospitals, the district nurses, and the public health nurses. Why? Not for the sake of the public, though it was made to appear so, but for the sake of the nursing profession, so-called, because attendants must not be countenanced and the services of the private nurse cannot be afforded by people of moderate means. Moreover, the regularity of the hours and the variety in the work of the district and public health nurses appeal to more people, and better educated women are more likely to be drawn to that kind of work.

Perhaps the constant laudations of the nurse and her work serve the "leaders'" purposes, but they are not wholesome. It was a noticeable fact that it was the flattering remarks that called forth the applause. Doctor Favill's wise warning against raising the requirements too high, lest good women be barred out, and against the danger of hard and fast rules met with little response, while Doctor Snyder's similar warning against high requirements as calculated to increase the cost of nursing service to the public, and his advocacy of three classes of nurses as the only means of providing nursing care for all, aroused a storm of protest. From all of which it will be seen that only the official views received any serious consideration and discussion.

As for reciprocity between States in the matter of registration, there can be none, so they said, till all States demand equally high standards. Oh, there were those who did not agree with this, but they kept quiet in public. What a burst of light came as Miss Goodrich, in speaking on reciprocity, said that they had to obtain registration laws in the different States as best they could, and then through the controlling body, generally the nurse examiners, work out a uniform standard of education that

will eventually make State reciprocity possible. Behold a vision of the New York law, and of the subsequently devised sub-rules which bar from registration schools, which under the law are plainly eligible. Miss Parsons added further light when she said that when protest followed the demand that credentials be sent to Albany, they became discouraged, but just then, word came that the Red Cross had adopted the same standards, and as every one would want to be eligible to the Red Cross, the victory was won. So that a great debt was owed to Miss Delano. One wondered how many words went to Miss Delano and the Red Cross before that word came back to Albany. Perhaps one should not be surprised to find that of the officers of the A. N. Association for 1915-16, the president, secretary-treasurer, and one director are all from New York State, with a first vice-president and director from Chicago, and only a second vice-president and four directors to represent the whole of the rest of the country. New York was, as before suggested, very prominent at the meetings, members from that State reading the papers of those unable to attend, making motions, etc. Indeed, only a small number of nurses took an active part or seemed to have any influence. It is a great pity that this should be so and nurses should see that it is not so another time. More nurses should be encouraged to take a part in such meetings and nothing would assist this so much as free discussion, with the opportunity it would afford for a little practice in speaking before people. May such an opportunity be afforded another time, even at the expense of a few papers. The nurse's relation to others should be rather that of a wise mother than a teacher and she should see that emphasis is laid on the qualities inherent in the former rather than on the education of the latter in the training of the nurses to come.



SAINT NEWS SERVICE

RED CROSS NURSES DRESSING A SHRAPNEL WOUND AT A FRENCH AMBULANCE HOSPITAL

Soldiers and Parasites

BY MARK L. HYDON

Late Royal Army Medical Corps

ONE of the most perplexing questions facing the Medical Department of an army in the field is the elimination of lice, and kindred parasites. Soldiers on active service are more subject to parasitical diseases than any other class of people, on account of the impossibility of satisfactory sanitary arrangements for large numbers of men who are constantly on the move, and the almost entire lack of the perquisites necessary to personal hygiene. It is well known that all parasitical diseases are communicable from man to man, and in many cases from animal to man, and unless a parasitical patient can be isolated immediately he is discovered, the disease is likely to affect a large percentage of the men in contact with him before it can be checked.

Lice, or *pediculi*, are probably the most loathsome and prolific of all parasites, and lack of cleanliness is always associated with

these nauseating insects. Probably the most effective agent for the destruction of lice is mercurial ointment, while the ova, or nits, which become attached to the hair may be destroyed by the free use of acetic acid.

Pets are the most fruitful sources of many parasitical diseases. Wherever soldiers are stationed there will be found all sorts and conditions of dogs, and where one dog suffering from the mange is found, it is safe to say that fifty per cent. of the dogs in that district will be mangy, to a greater or lesser degree.

The most common disease among dogs is sarcoptic mange (sarcoptic meaning parasites that burrow in the skin), and this is caused by minute insects invading the skin structure, resulting in a high degree of irritation, inflammation, and watery exudation. In this way the dog rapidly loses condition, often becoming an object

of sympathy. The parasites are not slow in perpetuating their like, therefore the surface is soon overrun and denuded of its hairy investment. Very often great difficulty is experienced in eradicating these pests from situations where the infected animal has been living, or otherwise touching objects with its body.

The sarcoptic mange mite has four pairs of legs, and an oval-shaped body, while the follicular mite, which is the parasite of follicular, or black mange, has a lobster-like body. The former reside upon the superficial parts of the body, while the latter invade the hair follicles, or pits from which the hairs originate. Sarcoptic mange parasites are readily transferred from one dog to another, and often from dog to man. Not so, however, with the follicular parasite, which is far more irritating, but non-contagious.

The symptoms of sarcoptic mange are constant scratching, rubbing, and biting at the affected part. This leads to the falling off of the hair in patches, inflammation and vesiculation of the skin. When mature, these little blisters burst and their contents desiccate upon the surface, matting the broken hairs, and resulting in the production of one or more scabs. If neglected, the invading parasites overrun the body just as do weeds in a garden, making life a misery to the dog.

The soldier, regardless of all this, will pet and fondle the dog and even allow it to sleep on his blanket. The results are obvious.

Scabies, or itch, is a common disease among soldiers. It is caused by *Acarus Scabiei*, a minute, burrowing parasite affecting the skin. In other words, it is sarcoptic. It burrows between the cuticle and the true skin, causing great irritation, scaliness and itching. Its most prominent feature is an intense itching, so aggravating, that in many cases the skin is torn by the nails. Unlike other diseases of the skin, it is not due to inflammation, but is caused by animalculæ, or the parasite *acarus*. Robust health, a hot climate, and unclean-

liness are indications which predispose the system to infection.

The successful treatment of scabies generally requires only local applications, for the object to be attained is simply the destruction of the parasites which cause the eruption. Happily, we possess an unfailing specific for this purpose. Numerous agents have been employed with success but sulphur enjoys the greatest reputation for efficacy, and is used throughout the leading armies of the world. Take a quantity of pulverized sulphur and mix with sufficient vaseline to make an ointment. Having first divested the body of clothing, anoint it all over freely, and rub the ointment thoroughly into the skin. The application should be made at night, before retiring, and the patient should wear woolen night-clothes or lie between woolen blankets. In the morning after the application, the patient should take a warm bath, washing the skin thoroughly and using plenty of soap. This treatment should be repeated two or three times to make certain of a perfect eradication of the disease. After this course of treatment, the wearing apparel as well as the bed-clothes should be thoroughly cleansed and disinfected, as a precaution against the return of the disease.

During the South African War of 1899-1902, one of the commonest sights was to see hundreds of men, at the end of a long march, take off their flannel shirts and search diligently for a far more troublesome enemy than their political enemy. Lice, *pediculi pubis*, and all kindred parasites are debilitating in a general way.

I fully realize that an article such as this knocks all the romance out of warfare, but the nurse intending to take part in the European struggle will do well to pay particular attention to what has been said, as she will find that a considerable portion of warfare is closely related to the facts stated, and it is not by any means romantic.

"Articles of Faith" Concerning Cancer*

WILLIAM SEAMAN BAINBRIDGE, M.D.

A PLATFORM upon which to unite in the campaign of education:

(1) That the hereditary and congenital acquirement of cancer are subjects which require much more study before any definite conclusions can be formed concerning them, and that, in the light of our present knowledge, they hold no special element of alarm.

(2) That the contagiousness or infectiousness of cancer is far from proved, the evidence to support this theory being so incomplete and inconclusive that the public need have no concern regarding it.

(3) That the communication of cancer from man to man is so rare, if it really occurs at all, that it may be practically disregarded.

(4) That those members of the public in charge of or in contact with sufferers from cancer with external manifestations, or discharges of any kind, need at most take the same precautionary measures as would be adopted in the care of any ulcer or open septic wound.

(5) That in the care of patients with cancer there is much less danger to the attendant from any possible acquirement of cancer than there is of septic infection, or blood poisoning from pus organisms.

(6) That in cancer, as in all other disease, attention to diet, exercise and proper hygienic surroundings is of distinct value.

(7) That, notwithstanding the possibility of underlying general factors, cancer may, for all practical purposes, be at present regarded as local in its beginning.

(8) That, when accessible, it may, in its incipency, be removed so perfectly by radical operation that the chances are overwhelmingly in favor of its non-recurrence.

(9) That, when once it has advanced beyond the stage of cure, suffering in many cases may be palliated and life prolonged by surgical and other means.

(10) That while other methods of treatment may, in some cases, offer hope for the cancer victim, the evidence is conclusive that surgery, for operable cases, affords the surest present means of cure.

(11) That among the many advances in and additions to cancer treatment, the improvements in and extensions of surgical procedure surpass those in any other line, and fully maintain the preeminent position of surgical palliation and cure.

(12) That there is strong reason to believe that the individual risk of cancer can be diminished by the eradication, where such exist, of certain conditions which have come to be regarded as predisposing factors in its production.

(13) That some occupations, notably working in pitch, tar, paraffin, analin or soot, and with X-rays, if not safeguarded, are conducive to the production of cancer, presumably on account of the chronic irritation or inflammation caused.

(14) That prominent among these predisposing factors, for which one should be on guard, are: general lowered nutrition; chronic irritation and inflammation; repeated acute trauma; cicatricial tissue, such as lupus and other scars, and burns; benign tumors—warts, moles, nevi (birthmarks), etc.; also that changes occurring in the character of such tumors and tissues, as well as the occurrence of any abnormal discharge from any part of body, especially

*During the four-day Cancer Educational Campaign, held under the auspices of the Vermont State Medical Society, June 8-11, 1915, Dr. William Seaman Bainbridge, of New York City, presented the accompanying twenty-one "Articles of Faith" at several sessions. They form the conclusion of a paper entitled "The Cancer Patient's Dilemma. A Plea for the Standardization of What the Public Should be Taught in the Campaign of Education Concerning Cancer," which Dr. Bainbridge read at one of the sessions, and which appears in full in the Cancer Number of the *New York Medical Journal*, July 3, 1915.

if blood-stained, are to be regarded as suspicious.

(15) That while there is some evidence that cancer is increasing, such evidence does not justify any present alarm.

(16) That suggestions which are put forward from time to time regarding eugenic, dietetic and other means of limiting cancer, should not be accepted by the public until definitely endorsed by the consensus of expert opinion. Such consensus does not exist today.

(17) That so far as we know there is nothing in the origin of cancer that calls for a feeling of shame or the necessity of concealment.

(18) That it will be promotive of good results if members of the public who are anxious about their health and those who wish to preserve it will, on the one hand,

avoid assuming themselves to be sufferers from one or another dreadful disease, but, on the other hand, will submit themselves periodically to the family physician for a general overhauling.

(19) That at all times and under all conditions there is much to be hoped for and nothing to be feared from living a normal and moderate life.

(20) That the finding of any abnormal condition about the body should be taken as an indication for competent professional and not personal attention.

(21) That watchwords for the public until "the day dawns" and the cancer problem is solved, are:—Alertness without apprehension, hope without neglect, early and efficient examination where there is doubt, early and efficient treatment when the doubt has been determined.



HOSPITAL BOMBARDED BY GERMANS AT SENLIS

Winning Her Stripes

I. R. F., R.N.

"MAY I speak to you a moment, Miss Colmery?"

The busy superintendent of nurses glanced up from her writing and answered, "Certainly, Miss Justin, what's on your mind?"

"You know, Miss Colmery, my probation is nearly over and you thought I would do, but it seems I cannot get over feeling faint and sick at the sight of blood. I want to ask you if there is any way that I can take the training without the operating room experience?"

"None whatever," replied the superintendent, rather crisply. "That's a most important part of the work. I really think you will overcome that feeling in time, as others do," she added, not unkindly, "and for that reason I am willing to extend your probation a trifle. You will just have to make up your mind, Miss Justin, that you *will* conquer that feeling and you will eventually do so."

"I'll certainly try, Miss Colmery, and thank you so much for extending the time for me. Good night."

The superintendent smiled, then sighed. "I wonder if I'm right in giving her a longer time," she said to herself. "The girl has been too delicately reared, but comes of good stock, and I believe will make good."

Three days later Miss Colmery was just finishing supper when a hurried call came for her to come to the third floor.

"Saxton has cut his throat."

Saxton was a D. T., who had had both feet frozen while sleeping off a drunk. His mind had seemed clear up to this time. Miss Colmery hastily stepped to the 'phone and called Doctor Willis, then literally flew

upstairs where Miss Justin had been left on duty while the other nurses were at supper.

What a sight greeted her in the men's ward! Blood was everywhere! Saxton's bed was drenched, the floor was slippery with it and Miss Justin's apron and skirt were soaked with the red fluid. She tried to clean as much as possible of it away while a senior nurse brought sponges, solutions, etc., for the doctor's use.

The blood flow was checked by hot sponges by the time the doctor arrived and took the necessary stitches. The gashes were not so deep as would appear from the amount of blood lost, having been made with a very dull jackknife belonging to one of the patients. Saxton was removed from the ward after dressings were applied, but it was some time before the excitement in the men's ward would permit of sleep to its occupants.

"Well, Miss Justin, did you feel faint?" asked the superintendent when all was over and Miss Justin was about to exchange her blood-drenched garments for others.

"Not a bit," she replied. "I had no time to think of it."

"You have had your baptism of blood," replied the superintendent, "and have learned that when you're sufficiently interested in another you forget self. That's one of the first lessons a nurse has to learn. I think you'll have no more trouble with faintness."

And she didn't have during the balance of her three years' training.

Saxton recovered from his self-inflicted wounds but died several weeks later from gangrene.

The Hospital Council

Items of Interest, Annual Reports, Publicity Literature and Material Descriptive of Newer Methods and Plans in Any Department of Hospital Work Are Solicited

Little Things That Are Big Things in Hospital Management

One of the most comprehensive and practical papers presented at the hospital convention in San Francisco was the paper by Dr. Robert J. Wilson, director, Bureau of Hospitals, Department of Health, New York City, on the subject named in the head line—"Little Things that are Big Things in Hospital Management." In enumerating some of these little things, Doctor Wilson touches on a great many phases of hospital life and calls attention to a great many of the weak points in hospital management. First on the list of the little things which occur in the wards and which affect materially the comfort of the patients and the reputation of the hospital is placed the matter of courtesy, and next to it is sympathy. The writer of the paper states that courtesy can be purchased, but sympathy cannot. Incidentally, the inference is made that modern methods of efficiency and economy may be carried too far, and that it is quite possible, by carrying these methods too far, to educate out of a nurse or hospital worker that valuable quality of human sympathy which she needs—which "a great many start with, and few end with."

Discussing the ways by which sympathy is manifested, the writer mentions the manner in which new patients are received, the care that should be exercised in protecting patients against the horror of seeing the dying—of protecting them against callous remarks, relative to the passing of

the patient—against talking about the condition of patients in their presence.

THE PATIENT'S CLOTHING

On the subject of the handling of the patient's clothing, Doctor Wilson makes some pertinent comments. He says:

"When a patient enters the hospital he is divested of everything material that he has. How is this accomplished? Are his clothes and valuables torn off of him by rude and ignorant attendants, or is he told in an intelligent way why he is deprived of them? Is he given a receipt for them? If there is valuable property, is the hospital and its employees protected by having two persons as witnesses present when he gives up his valuables? Does the hospital provide a proper place to store his clothing? Is it kept on proper hangers, and is his underclothing laundered before he is discharged, or does the attendant bundle up all his effects, hat, shoes, clothing, in a jumbled mass and tie it up in a bundle to be given to him on his discharge in a dented, wrinkled, and generally unfit condition? Does anyone take any interest in his clothes? They should! It costs little and means much both to the patient and the hospital. In our hospitals we are about to adopt the system of sending a nurse with a doctor on each ambulance, who will carry with her an outfit of hospital clothing, and who will remove the patient's clothing and jewelry in the home, so that on admission to the hospital, the question of clothing and valuables will not have to be considered."

"How often," says the writer, "are patients neglected in the matter of body hygiene! The rules of all hospitals say that the patient shall be supplied with an individual towel, an individual soap dish, an individual tooth brush; and how frequently these things, together with a wash basin, are placed before patients who are utterly unable to help themselves!"

MEDICAL ASPECTS

On the subject of medical care the writer suggests that "doctors should not be allowed in the wards after eight o'clock in the evening, unless sent for by a nurse for special cases." Doubtless a great many people would be glad to have the writer tell them how to control the matter of doctors coming to make rounds at meal-times, or to give important treatments at night when the force of workers to assist in such treatments is depleted, as it is in all hospitals at night.

"It should," states the writer, "be impressed upon ambulance doctors and admitting physicians that their duties are of a two-fold character: first, as medical officers they receive the patients and assign them to the proper wards; second, as administrative officers they come in contact with the relatives and friends of the patients, and from their attitude these people draw their conclusions as to the character of the institution and the kind of treatment that is being accorded to the patients. This is a very important item for the reputation of the hospital, and for the peace of mind of the relatives and friends." . . . Except in emergency cases, the first medical thing that happens to a case on admission to a hospital is the taking of the history. Its value depends upon the thoroughness and accuracy with which it is taken; its accuracy depends upon the ability of the doctor to draw out of the patient the salient points. What kind of person do you propose to send to a patient

to make on him the first and most lasting impression of your hospital? What kind of instruction is he to have from the medical and administrative staff to prepare him for this very responsible work? Do you ever think what this laying open of his life secrets means to the patient? Is his confidence and feeling to be lightly considered? Our duty is not fully performed if we fail to protect the hospital and the patient in this respect."

CHOOSING A COOK

Choosing a cook, Doctor Wilson believes to be one of the biggest little things about a hospital. We all know the qualities that go to make up a good cook, he states, but do we all know that half of the responsibility and half of the success of the cook rests on us? The average cook saves or wastes in direct proportion to the saving or wasteful disposition of the superintendent of the housekeeping end. The cook does not make the menus, but the menus often make the cook.

THE DIETITIAN

"In a large hospital a dietitian is a useful and sometimes necessary adjunct. Her usefulness, like that of the cook, depends upon the common sense of her immediate superior. It is a joke to believe that you can feed people on calories; it is a calamity to reject the value of calories in balancing a ration. It is just as easy to give people food that they like and that contains the appropriate number of calories, as it is to give them a highly nutritious, but unappetizing food they don't like and won't eat.

"For the last few years," Doctor Wilson states, "I have had a good many fool food ideas advanced to me. I have had a good many calorifically good, but personally distasteful meals proposed to me, and I am more convinced than ever that it is food and not calories that is needed in the kitchens and dining-rooms of our hospitals.

Mark you, I said kitchens and dining-rooms. In the office it should be calories. I should say that next to a knowledge of weights and measures a knowledge of calories is most valuable to a dietitian and a medical superintendent. Without a thorough knowledge of physiology I should say that a knowledge of calories was about as valuable to anybody as a sextant in a fog.

"Recently the Department of Health, through its Bureau of Public Health Education, established an educational lunch room, where the menus are printed in such a way as to show the food, its price, quantity, number of calories and protein in grams. The tendency of the present time seems to be toward a closer knowledge of food values, and, considering the hard work performed by nurses, the adoption of such a plan in the doctors' and nurses' dining-room might add to their knowledge of how to take care of themselves as well as to supply them with information, that they may answer intelligently questions asked by patients about food values. . . . The establishment of a basic dietary table will be found to be not only a convenience, but a saving proposition as well. A table of menus should be made and adhered to; and in making menus, the heads of divisions should be consulted. It is better to give them what they want, and restrict the variety, than to serve an abundance of things that they will not eat. Meals should be served in such a way that the recipients will not be able to tell by experience just what each day has in store for them in the way of food. Menus should be arranged numerically from one to ten or fourteen or twenty-eight, and repeat irregularly, not by week or month. . . . The enforcement of stringent regulations against diners at table ordering the serving girls or criticizing the service or the food, will do away with many complaints commonly made in the hospital about the diet and service. Constructive, helpful criticism about any part of the service should

be invited and thankfully received in the office. This should be understood by employees and they should be encouraged to *submit such in writing.*"

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Teaching the Cost of Supplies

The charge of extravagance is frequently made by the public in regard to nurses, and it must be admitted with justice in many cases. To a considerable extent the training school is at fault, for in many schools no attempt is made to enlighten nurses as to the cost of the sick-room supplies in daily use. Few nurses have had experience in the purchase of even the commonest household supplies before their entrance to the school. They know little of thrift, and the term "economy" is to them synonymous with "stinginess," or "niggardliness." They are constantly using supplies for which they do not pay, and the cost of which they are in blissful ignorance. They waste materials many times without knowing they are wasting. They are encouraged frequently in too lavish use of dressings by medical men who are careless in the use of supplies paid for by some one else.

Under such a system waste is to be expected, and nurses form extravagant habits because they have never been taught what true economy means—because they are ignorant of the value of everyday supplies. They do not realize that economy—using just what is needed and no more—is one of the fine arts—or that their extravagant habits are a detriment to them as nurses.

Miss Margaret Cummings of the Buhl Hospital, Sharon, Pa., has devised an interesting method of teaching pupil nurses the cost of hospital supplies. An "instruction board," the foundation made of heavy cardboard or bookboard—size about 10 x 20 inches—has on it the pictures of all common articles in ward use; hot water bottles, rubber ice caps, catheters, glass

and rubber douche nozzles, irrigation cans, dressing basins, rubber sheeting, babies' bottles, etc.—all the smaller articles which are included in the term "equipment." The pictures are clipped from catalogues and pasted on the board, with the cost inserted with pen and ink just below. Enough of these instruction boards can be provided so that each floor or each nurse's work-room can have one.

In Hartford Hospital, Hartford, Conn., the different articles are listed, and type-written with the price opposite, and included in a loose-leaf book, every loose-leaf book containing standing orders, may very wisely have such a list inserted for ready reference. In that hospital, all requisition slips have a column headed "Estimated cost," and the total cost of each requisition slip is charged up to the ward. This is carried out with diet requisition slips as with other supplies. A sample requisition sheet has columns as follows:

EX-CHANGE	NEW	NAME OF ARTICLE	ESTIMATED COST
	1	Gauze	\$2.25
	2	Cotton, absorbent	.30
	2	Cotton, common	.20
	24	Bandages (2 inch)	.72
	50	Safety pins	.07
	1	Temperature Charts	.23
	1	Daily ward report	.15
	1	Temperature book	.20
	2	Blotters	.06
	1	Roll adhesive	.80
	6	Orange Wood sticks	.12
	6	Baby bottles	.18
	1	Medicine glass	.03
	1	Flower vase	.10
		Total,	\$5.51

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New Site for Presbyterian Hospital, New York

A site of nine acres in the Washington Heights District, New York, has been secured for the Presbyterian Hospital, in combination with the medical department of Columbia University. In the new hospital nothing will be allowed to lack in equipment

for both medical and surgical treatment. In addition to departments of general surgery and internal medicine, eight special wards and seventy-five private rooms are planned. The wards are to be for genito-urinary diseases, orthopedic surgery, diseases of eye, ear, nose and throat, children's diseases, diseases of the nervous system and of the skin. The hospital will have ward service for every department of the present Vanderbilt Clinic, which will be affiliated as the out-patient department.

The new medical school will not only continue the courses now offered in the College of Physicians and Surgeons, but will also house the George Crocker Foundation for Cancer Research. Departments of preventive medicine and public health are planned for; also opportunities for graduate study and laboratory research in every field related to medicine.

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Children's Hospital, Cincinnati

This hospital, operated by the Protestant Episcopal Church in Southern Ohio, cares for sick, injured and crippled children from birth to sixteen years. Its work is materially helped by the publication of one of the brightest little hospital papers, *The Blue Bird*, which carries the story of its work far and wide. During the year a fine new solarium was opened and also an out-patient department. It rejoices in its Larz Anderson Memorial Garden, which adds greatly to the attractiveness of the place.

It gives a course of eight months' training to nursery maids, whose work is chiefly with convalescent children and an eighteen months' course of training for children's nurses. In the nursery maid's course those in training are trained in caring for active children in the play room, to amuse them, serve meals properly, keep clothes in order and in general care of "getting well" children. In the other course those in training devote themselves to the care of infants and sick children.

The Dietary Question-Box

BY E. GRACE MCCULLOUGH

Dietitian, Peter Bent Brigham Hospital, Boston, Mass.

DURING the recent meeting of the American Hospital Association in San Francisco, the number on the program devoted to the Dietary Question Box for Small Hospitals was crowded out, owing to the joint session of the large and small sections.

Many interesting questions had been sent, dealing with different phases of the dietary problem, showing clearly how real and vital are the difficulties. Some were concerned with the organization construction and equipment of service buildings or rooms. Others wished for methods to simplify the routine of work. There were some concerned with food, both raw and cooked, together with per capita costs. Still others had special reference to the nurse and her connection with dietetics.

To a group of members of the association deeply concerned with the future of dietetics, it was suggested that before the broad outlook could be grasped, the ever present petty difficulties must be solved again. All who are in touch with the large hospitals realize there has arisen, during the past five years, new thoughts upon the subject of food and methods of feeding. We have begun to realize that quantitative diets or metabolic feeding is not confined to research laboratories. The change is in the air, and has come to stay. It was, therefore, proposed that such a question box in the *TRAINED NURSE AND HOSPITAL REVIEW* might be of assistance to many, by giving other and unbiased points of view.

To show that the questions submitted were simple, yet asking information, a few have been selected, which illustrate their diversity.

1. What salary should a small hospital pay a dietitian?

2. If a small hospital cannot afford a thoroughly trained dietitian, yet has a visiting doctor and resident interne, demanding weighed and calculated diets, how can they meet the requirements?

3. Why do so many college graduates fail as practical dietitians?

4. What are the duties of a dietitian? (These four questions have been placed together to show that a dietitian is a real problem.)

5. Who should make out the menus?

6. Is there a simple method for making out menus to avoid the deadly monotony?

7. Why is hospital coffee never hot, and never strong?

8. What are the best substitutes for butter? Can any of them be used on the table?

9. Is it worth while for a small hospital to purchase food by contract?

10. To what extent is it possible to observe the personal idiosyncrasies of patients on quantitative feeding?

11. What can be done to make food, when salt is prohibited, more palatable?

12. What can be done when finances are very low and patients will not eat the food, although well cooked and nutritious?

13. Do electric labor-saving devices in the kitchen really save labor and money?

14. Are fireless cookers of value in a small hospital?

15. Would you kindly furnish an outline of how and what to feed night nurses?

16. The usual six weeks' service in a diet kitchen seems long; could the time be shortened without loss to the nurse?

17. Will you give the cost of opening and equipping a diet laboratory to meet the needs of today and the expense to run it?

18. Will you give a list of six reference books on Dietetics for a nurse library?

This last question should have come first, as it is of primary importance that preparation precede execution if there is to be any success.

I. "Chemistry of Food and Nutrition," by Henry C. Sherman.

II. "The Principles of Human Nutrition," by Whitman H. Jordan.

III. "Modern Theories of Diet" (English), by Alexander Bryce.

IV. "Food and Feeding in Health and Disease," by Chalmers Watson.

V. "Nutrition and Dietetics," by Winfield S. Hall.

VI. "Foods—Their Origin, Composition and Manufacture," by William Tibbles (English).

VII. "Food Values—Calculated Tables," by Edwin A. Locke.

(The last one is necessary if doing any metabolism work.)

In this department, from month to month, these and similar questions will be discussed. Further questions are invited, and will be discussed through the TRAINED NURSE AND HOSPITAL REVIEW.

Ways of Helping a Hospital

Hospital workers, as a rule, believe in the power of suggestion, yet few of them practise it as diligently as they might in regard to their hospitals.

The Memorial Hospital, Worcester, Mass., publishes a very interesting list of suggestions of ways of helping that hospital which are sure to be "suggestive" to other hospitals:

1. Building and equipping a nurses' home, \$150,000.

2. Building and equipping a new outpatient department, \$75,000.

3. Building an isolating department, \$15,000.

4. Providing for a larger dining room for nurses, \$1,000.

5. Building a house for maids, \$25,000.

6. Building a new administration building, \$100,000.

7. Building a fence around the hospital grounds, \$10,000.

8. Supporting a social worker for one year, \$1,200.

9. Contributing to a fund for supporting the social service department.

10. Establishing a library fund.

11. Establishing a fund for pathological work.

12. Establishing a free bed as follows:

\$100 endows a bed for one year.

\$1,000 endows a bed for ten years.

\$5,000 endows a bed for one life, with the right to extend it to two lives.

\$500 endows a bed in a private room for one year.

\$10,000 endows a bed in a private room for one life.

13. Contributing sheets, draw-sheets and pillow-slips. Pequot sheeting, 2 yards wide, is used. Size of sheets, 2 yards wide by 3 yards long—2-inch hems at both ends. Draw-sheets, 40-inch goods, 2 yards long, with half-inch hem at both ends. Pillow-slips, 42-inch goods, making the slip 21 inches wide by 34 inches long—3-inch hem.

14. Contributing fruit, vegetables, jellies, preserves or any food supplies.

15. Contributing to a training school fund—to be used in securing additional advantages for the nurses.

16. By establishing or contributing to a fund for the dental clinic.

Cleanings

Abdominal Exercise for Dysmenorrhea

Abdominal exercise has given good results in the treatment of dysmenorrhea, according to Mosher. The procedure is as follows: All tight clothing is removed, and the patient is placed on her back, on a level surface, in the horizontal position. The knees are flexed, and the arms are placed at the sides to secure relaxation of the abdominal muscles. One hand is allowed to rest on the abdominal wall to serve merely as an indicator of the amount of movement. The woman is then directed to see how high she can raise the hand by lifting the abdominal wall; then to see how far the hand will be lowered by contraction of the abdominal muscles, the importance of this contraction being especially emphasized. This exercise is repeated ten times, night and morning, in a well ventilated room. The patient is warned to avoid jerky movements, and to strive for a smooth, rhythmical raising and lowering of the abdominal wall.

In a large number of cases there has been a disappearance of all pain, and in many instances a reduction in excessive flow will occur after the institution of this simple regimen.—*Journal A. M. A.*



Membranous Colitis

One among the most painful and intractable diseases is the one named above. Nine times out of ten it involves the descending colon principally and is often diagnosed as simply proctitis, but it includes not only the rectum and sigmoid but, more or less, the entire colonic tract.

While all physicians recognize its character, and location, the all important de-

sideratum is, the best line of treatment to pursue. Cathartics should be given sparingly, and with careful discrimination. Irritating vegetable and chemical purgatives must be avoided. Enemata of a nonirritating character can not be avoided as they most thoroughly remove muco-membranous matter. Soda bicarbonate in sterilized water is serviceable. Emulsions of olive oil or sweet almond oil should be used as injections twice a week. It has a fine effect. Solutions of nitrate of silver, when bowels are cleared up, act well, and also a solution of borax and salicylate of sodium. Some recommend the use of 1 per cent. solution of permanganate of potassium, ichthyol, and sodium salicylate as almost specific. For the fermentative condition of the alimentary tract, nothing does better than salicylates: benzoate of guaiacol, solol, resorcin and, sometimes, small doses of calomel.

The diet is of vital importance. It should be bland, and well cooked. Blancmange, milk custard, egg albumin, milk with Robinson's pearl barley, etc. No gritty food and no fruit but oranges and pineapple juices may be given. To do much good in treatment, the remedies must be used topically so as to come directly in contact with the seat of the inflammation and ulceration.—*Charlotte Medical Journal.*



Castor Oil

American Medicine (March, 1915) makes a plea for more frequent use of castor oil, and suggests that, ancient remedy though it be, castor oil possesses quite as many therapeutic virtues as many newer remedies with high-sounding names. Its more frequent

use in cases of intestinal stasis is strongly recommended, and also in cases of milder forms of constipation. The case is cited of an English matron "who would not discharge or scold her servants when they became cross, but lined them all up and gave each a dose of castor oil, after which they were a joy to the household for a few weeks or months. We forgot all these things when we learned the role of infections, and it became fashionable to sneer at our old teachers. It is not reactionary to halt a little in our tendency to seize the new, for we ought not to lose hold of the old until the new is found to be better, nor should we forget that there are other poisons besides those made by bacterial cells. As in the case of ipecac, castor oil may have unsuspected virtues which were dimly and empirically observed. We do not know, of course, but the suggestion is made with the hope that in this, as well as other old drugs, we look more closely into the experiences of our medical forefathers—some of whom were far keener observers than we have been willing to admit."

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An Easy Way to Sterilize Dressings

An easy method of sterilizing linen by ironing, as advocated by Professor Weil, of Lyons, is described in *The Lancet* as follows: From his experiments on baby-linen, Professor Weil finds that the temperature at which laundresses use the heated iron is about 150 degrees C. But linen is not sterilized every time it is ironed unless it has been previously dampened throughout. A fire, a flat-iron, some linen, these are all that is necessary to provide a supply of sterilized dressings, and they can be obtained almost anywhere; even in the country one can find plenty of used linen which, in consequence of its greater suppleness than when new, is admirably adapted to make dressings. It is cut into pieces of the required size and folded into compresses of

suitable shape. Some flat surface is necessary to serve as an ironing board, and it is covered with some thickness of stuff in cushion fashion so as to make the ironing easier. This is covered with linen, which is carefully ironed first, and is left in place, forming a sterile surface upon which the dressings can be ironed. It is necessary before sterilizing each object, to pass the hot iron afresh over the linen covering of the ironing board. The iron may be considered as sufficiently hot when, on bringing it within a few centimetres of the cheek, a heat too powerful to be borne is felt. In ironing it is necessary to touch the linen, wherefore aseptic hands are required, and in addition it is a good plan to paint the tips of the fingers with tincture of iodine. The blue mark caused on the linen thereby is of no consequence in this case. The *sine qua non* is that the linen should be carefully moistened before ironing. Finally, the linen is ironed surface by surface and fold by fold. It is important never to touch the linen save at the corners and always to run the iron over the place that has been touched. If the material is not to be used immediately it should be covered as soon as possible away from dust in the air. A soldier's mess-tin makes a very good dressing receptacle; it is easily sterilized by boiling or heating.

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Dimensions of Draw-Sheets

An English nurse states that in nursing a patient for seven and a half years on a water-bed, she finds the best draw-sheet is one made of flannelette. She states that this material is easier to wash than the common bleached cotton sheet, does not require boiling and does not feel cold to the patient. Nine yards of material a yard wide makes four sheets, $1\frac{1}{2}$ yards each way. She sews tapes on either side and at the end and ties to the bedstead.

Editorially Speaking

Efficiency and the Smaller Training Schools

One significant thing accomplished by the registration examinations has been to effectively counteract the idea that prevailed some years ago that the smaller school was necessarily doing its work with less efficiency than larger schools, or that the efficiency of a school necessarily increased with the number of beds—after a certain required limit had been reached.

The smaller school can supply, in a much greater degree, the individual instruction so often needed, namely, the personal oversight of an experienced superintendent in helping a pupil nurse to strengthen weak points.

Hence it is often found that the pupils of a comparatively small school of 20 to 40 nurses or less often make a high record at the State examinations. In a large school, unless a careful checking-up system as to what a pupil has been taught, prevails, it is easy, so easy, for a nurse to go through her training without ever having performed some important nursing duty—not because any one intended this to occur—but because the duty had not happened to come in her daily routine. This can also happen, of course, in a smaller school, but in such schools, senior nurses are trained to carry responsibility and to do many things which in a larger more highly organized school may come in the internes' or head-nurses' province.

That this condition is attracting attention not only in nursing schools but in medical schools is shown by a report in the *Journal of the American Medical Association*, stating that "as a rule, the larger the col-

lege, the higher is the percentage of its graduates who fail before the State examining boards."

American Medicine in commenting on this report says: "The cause of the phenomenon is thought to be inadequacy of the teaching staff of the large colleges which makes it impossible to give sufficient individual instruction to each student. This is undoubtedly true, and fully accounts for the remarkable careers of many men who have been turned out of institutions notoriously lacking in equipment. We have often called attention to this phenomenon as well as the parallel in academic colleges, and have often advised that young men be induced to matriculate in small institutions instead of the big ones where they might be submerged and neglected. The staff automatically enlarges with the number of students but this throws the teaching into the hands of the young and inexperienced and possibly the inefficient, while in the small college, more of it falls to the professor of recognized ability. The mere enlargement of the faculty does not therefore suffice, and in medicine enough teaching material may not be in the locality. A city of moderate size may furnish plenty of talent for a small college, and such institutions should therefore be encouraged. They are doing better work than the big ones and could do still better with a bit more equipment furnished by local public-spirited rich men. Yet after all is said, success depends on the brains in the student's skull. Good or bad teaching merely makes the student more or less successful than he would be with mediocre teachers."

Dietary Problems

Among the big problems of life is the problem of feeding—a problem that begins with the infant at birth, and even before birth, and remains with the individual till death.

Always present, and always pressing, this problem assumes its most acute form in sickness, and in hospitals takes second place in importance to few if any other phases of hospital work.

To a marked extent, the reputation of a hospital depends on proper management of its dietary problems. Contented, cured patients are the hospital's best advertisement, but human nature is so constituted that if they are not well fed, patients are rarely contented. It must be admitted also that a contented mind is often an important element in the curative measures used.

Because of the importance of this phase of hospital work, it is with pleasure that we announce the beginning of this new department by Miss E. Grace McCullough of the Peter Bent Brigham Hospital of Boston. Miss McCullough ranks among the greatest dietitians of the country. She brings to her work a keen insight, breadth of study and research with a boundless enthusiasm, and has manifested a rare grasp of the dietary problems of both large and small hospitals. In the main, the problems in the two classes of institutions do not widely differ. The fifty sick people in a smaller hospital need to be as carefully and scientifically fed as the five hundred patients in the larger institution. The difficulties in the way of a proper solution are probably greater in the smaller hospitals. Send your problems to Miss McCullough, but do not ask for individual answers. If matters of a purely personal nature are presented to Miss McCullough, a stamped, self-addressed envelope should always be enclosed for reply.

What Medicine Owes to the Layman

The medical profession as a rule is jealous of its honors, and that any medical knowledge worth while could come from a layman who had not been through the medical schools is something most of the members of the profession have been loathe to believe.

But there are exceptions to all rules. Two conspicuous exceptions of recent years are the adoption of "Fletcherism," or of Mr. Horace Fletcher's rules in regard to mastication, and of the Towns-Lambert treatment for alcoholism and drug addictions. This treatment, originated by Mr. Charles B. Towns, a layman, and given gratuitously to the medical profession, has received the unqualified approval of many prominent physicians and is in use in many hospitals.

A recent article in the *Medical Review of Reviews* describes this treatment, quoting freely from the articles of Dr. Alexander Lambert on the subject.

Incidentally, the writer calls attention to the fact that some of our most valuable drugs and methods of treatment have been given to the world by laymen.

Cinchona, which has saved hundreds of thousands of lives, and which has opened up to the white man regions otherwise uninhabitable, was given to the world not by a physician, but by a layman. Hydrotherapy, which was sneered at and ridiculed by our profession for a long time, was given to the world by an ignorant peasant and is now one of our most valuable methods of treatment. In fact, our great Oliver Wendell Holmes recognized the indebtedness of medicine to the laity, and the well-known passage may be quoted here:

"It (medicine) learned from a monk how to use antimony, from a Jesuit how to cure agues, from a friar how to cut for stone, from a soldier how to treat gout, from a sailor how to keep off scurvy, from a postmaster how to sound the Eustachian tube, from a dairy-maid how to prevent smallpox, and from an old market-woman how to catch the itch

insect. It borrowed acupuncture and the moxa from the Japanese heathen, and was taught the use of lobelia by the American savage."

So, says the writer, the question should not be whether the introducer of the treatment was a layman or a physician, but whether the treatment was successful or not. If the treatment is undeniably successful, then its parentage is of no consequence whatever.

This attitude of tolerance, coming from a medical man, is one of the refreshing signs of the times.



The Moral Effect of the War

The past few months have proven times of trial, and, in some cases, hardship for nurses, for nursing organizations, and for hospitals. In the latter case needed buildings have been delayed, campaigns for lifting debts have had to be cancelled, and debts for running expenses far above the ordinary have had to be incurred—and the end is not yet. How far-reaching in its devastating effects the war will be no one can tell.

Speaking recently on the subject of the moral reaction of the wholesale human slaughter now on, Miss Jane Addams suggested some of the lines on which such reaction is bound to come. She said:

"All organized social welfare activities are put back for years. We have to work upon public opinion anew.

"When a million men are suffering in trenches, wet and cold and wounded, what are a few children suffering under hard conditions in the factories? Take old-age pensions, upon which England, France, and Germany have been working. With widows and fatherless children numbered by the thousands in each of those countries, what are a few old people more or less? It will be

years before these things are taken up again. The whole social fabric is tortured and twisted.

"Infant mortality is one of the things which we are just beginning to deal with. We are trying to learn why such numbers of little children under two years of age die. In Germany the nation's statesmanship was challenged in the Reichstag because, out of approximately 2,000,000 children annually born in that country, some 500,000, or one-fourth, die.

"But what are half a million new-born children in comparison with such a slaughter—the hideous, wholesale slaughter of thousands of men a day?"



The Nursing Instinct

In a very practical paper presented by Dr. Robert J. Wilson, of New York, at the Hospital Convention in San Francisco, the statement is made that the most important item in the efficiency record of every nurse that should be kept by every school is the nursing instinct.

What is the nursing instinct? Is it that acute perception of the importance of small things in the comfort of a patient—that sense that prompts a nurse to see a hundred small things which would make him more comfortable and to do them, while another nurse contents herself with doing what she considered important and seeing nothing further that she might have done. If a nurse seems to be lacking in this nursing instinct, can it be cultivated during training? If so, how?

In keeping an efficiency record of nurses for reference after they have gone from the school, what items should be included? Do you agree with Doctor Wilson that the nursing instinct is the most important item?

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

"We Protest"

To the Editor of The Trained Nurse:

I have just read an article in the August number of *McClure's*, entitled "Miss Smith of Bellevue," written by Kathleen Norris. Being a nurse, I resent very much the wrong impression of my profession that this article gives to the public.

Miss Smith of Bellevue is, of course, a fictitious character. No graduate nurse would give utterance to a conversation as unintelligent and unethical as the one which I have just read. A woman, who has been through training at the Bellevue Hospital, has been night superintendent there for a year, and spent extra time in their surgery, would not speak of an appendectomy as an appendotomy. She would also know that in the removal of an eye, the surgeon could not pick up an instrument and sever the optic nerve with such lightning-like rapidity that a nurse would have no time to say, "Doctor, it was the other eye." There is always a surgical preparation of the field of operation, and there would have been ample time for the nurse to notice that the wrong side was being prepared. A girl who has had three years' training in ethics does not tell stories which tend to destroy the confidence of the laity in the medical profession. And she does not call instruments, "tools."

Therefore, we suspect that Miss Norris either was nursed in the "long hours of the silent night" by a practical nurse, or, what is more likely, that the character is her own original production. In either case it is unfair, because those who read of Miss Smith of Bellevue will accept her as a type, and by this type will judge the nursing profession.

The remark, "Nurses are not always marrying doctors," is neither clever, humorous nor interesting. We wonder why it occupies so conspicuous a place. Of course, nurses are not always marrying doctors. I have pondered long over this remark, wondering of what possible value it can be to the public. I have even tried adding to it, and saying, "Doctors do, however,

frequently marry nurses." Even that does not make it interesting. What if they don't. Or do? In heaven's name why shouldn't they? Speaking, I take it from her very wide acquaintance with nurses, Miss Norris says, "Miss Smith, like many nurses, is a little simple." On reading the paragraph, it is found that she is simple because she speaks of "Somebody's Spring Song," and because her favorite novel was "Beulah."

Nurses, as a rule, do not spend much time in developing themselves along the lines of music, art and literature. We admit that. I know a little woman who has, and while she is giving public concerts, her thirteen months' old baby lies in a close room with a pacifier in its mouth. If one cannot be thoroughly educated along all lines, there is a question which type of ignorance is the most deplorable.

Miss Norris says that the world into which we are plunged is the very drain pipe of the city's moral sewer. Evidently she is sorry for us, or wishes the public to be. We do not consider that we work in a drain pipe of any kind. When you stop to consider the matter, one couldn't work in a drain pipe. It is not a very good figure, I'm afraid, but then I won't be too critical. It sounds good. But whether or not we work in a drain pipe, we courteously decline to be pitied. We have found no reason to be ashamed of our profession. Suffering, we see, disease, pain and sorrow. Not without feeling do we see these things, but with feelings well controlled. We stand by and see the mystery of death, as a life departs. But we also see the curing of disease; when we see suffering, we do something to relieve it. We see the helpless, and we give our strength for their comfort. One day we see the solemn mystery of death, the next the wonderful miracle of life. Here we see a tragedy, there, a joyful coming back to health. One moment we see the results of crime and shame, another, we are placing in a young mother's arms her new-born baby. But whether joy or sorrow, birth or death, we see life. Life as it really is. We know people as they really are. If this is a drain pipe, it is a

very broad one. It is our world, and we love it. It makes us women intelligent, strong and well balanced, quite different from the shallow, callous creature whom Miss Norris calls, "Miss Smith of Bellevue." RUBY I. McLEAN, R.N.



In Answer to "The Grouch"

To the Editor of The Trained Nurse:

May I have space for a few words in answer to the letter signed "The Grouch," which appeared in the August issue of our magazine. The idea of not using table salt without a doctor's permission seems to me absurd. If the patient did not like the salad salt, there is no reason why it should be salted. I believe it is entirely within the jurisdiction of the nurse (and the patient also) to *use* or *not to use* salt to season food. It is not necessary to be ordered by the doctor. When given as a placebo, salt should always be ordered by the doctor; otherwise, I say use it freely unless *ordered* by doctor to *omit* it entirely from the diet. The nurse is undoubtedly employed by the patient; still she is *always* under the doctor's orders. He is the superior officer; generally she is employed by the suggestion of the doctor and entirely unknown to the patient until the acquaintance is made at the bedside. A good nurse never prescribes or suggests. That is infringing on the doctor's field. A good nurse always does her best for the patient, but at the same time she must remain loyal to the physician. The nurse in question who refused to remain in charge of a case (without the doctor) did quite right. However, I think it would have been permissible to remain, had another doctor been engaged. What a mix-up there would be should a nurse take orders from the patient or family. If you are a factory owner, you are not Boss; your foreman has that honor, and everything is referred to him. Is not a doctor equal to a foreman? Why not leave the doctor in his place, as superior officer, and take all orders from him? I take off my cap to the doctor every time. Let us all do the same.

A. E. C.



Male Nursing in Pennsylvania

To the Editor of The Trained Nurse:

From the letter of D. H. Gibson, R.N., on "Male Nursing in the East," which appeared recently in THE TRAINED NURSE, I judge that male nurses in Massachusetts are much more respected than male nurses in Pennsylvania.

I am a graduate of a hospital in Pittsburgh,

and passed the State Board of examination, but my experience has been that male nurses have little chance in Pittsburgh. I have been doing private nursing since leaving training school, but I have hardly nursed anything but alcoholic and mental cases. Hospitals and doctors do not encourage male nurses, and only call one when it is impossible to get a female nurse, or when they have a bad alcoholic or insane case. The excuse given is that male nurses are unreliable. I admit that there are some unreliable male nurses, but are there not some unreliable female nurses also?

Some of the steel companies employ nurses in their emergency hospitals, paying a female nurse \$75 per month for eight hours work, while they offer a male nurse the same money for 12 hours. Another excuse is that most male nurses were only orderlies before entering the training school. I know a number of female nurses who have come from poor families, had only common school education and had been employed as servants. They have made just as good nurses as high school graduates. I wish the hospitals and doctors of Pennsylvania would follow the example of Massachusetts, and respect and patronize male nurses. Give each a fair trial, and then weed out the bad ones.

A DISAPPOINTED MALE NURSE.



A Registry Difficulty

To the Editor of The Trained Nurse:

For many years a registry has been kept in the hospital for graduates of the school connected with the hospital. Lately, for several reasons, the school registry was merged with the central registry for graduate nurses of the city. The hospital, when it needs special nurses, sends to the central registry for them. I have always, when the registry was kept in the hospital, felt at liberty to call any nurse I chose for any case. Knowing the patient, I have tried to choose the nurse who seemed most likely to be congenial or temperamentally fitted to deal with her. If the patient happened to need only "ordinary care" the nurses were called in rotation. I have continued this policy with the central registry, but have been severely criticized for not *always* calling nurses in the order in which they were listed in the registry. In fact, I have been more than criticized. I have been waited on by a delegation of graduate nurses, demanding that I send no more calls to individual nurses, but take them as they are listed without any consideration of the patient's disposition or general

condition, and without any reference to the record which a nurse has left in the hospital on previous cases. This I have refused to do, claiming my right to call individual nurses whenever I chose to do so. I would like to ask what the custom is in other hospitals in regard to this matter. Is a nurse who conducts herself with kindness and consideration toward other workers, who is loyal to the hospital, who needs no rules to teach her how to conduct herself while in a hospital; who is an example to pupil nurses as to what a graduate nurse's deportment in the hospital ought to be; is such a nurse to have no rewards for her effort to live up to the highest standards? Has a nurse who has left a record of carelessness, lack of neatness, unwillingness to consider the rights of others and who is in various ways a bad example to pupil nurses any right to expect to be called back to the hospital?

My own feeling is that the whole standard of nursing is lowered when the nurses are reduced by a machine-like process to the same level, when those who wilfully disregard rules and the rights of others are placed on the same footing as those who are always considerate, obliging and anxious to please. When right doing receives no recognition, what incentive is there for a nurse to try to do her best, to live up to her ideals, if nobody notices and nobody cares?

I may be wrong in taking the stand I have. If so, I would like to be shown why.

INQUIRER.



An Answer

To the Editor of The Trained Nurse:

I would like to answer the letter signed "One Who Wants to be Shown," in a recent number of *THE TRAINED NURSE*. I am a graduate of a nurse correspondence school, and will state some of my experience in Colorado. I was two years taking my course and, during that time, I worked with two of the best doctors in the city. When I graduated, I went to a large Catholic Hospital, showed the sister superior my diploma, and told her the experience I had had in private nursing. She engaged me as a relief nurse, with the same salary she was paying her hospital trained nurses. I stayed there for two months, and then made application to enter a training school in the same city. I asked the superintendent to let me enter the senior class, and was told that if I could pass the examinations of the first and second years' work, I could take up the third year's work. I took the examinations and

passed with a good grade, and took up the third year's work. The last four months I was in the training school, I was second assistant in the operating room, and had charge of one of the surgical wards. Since leaving the hospital three years ago, I have nursed 18 obstetrical cases, 11 surgical cases, and 39 medical cases. Besides I nursed 6 weeks in our county hospital, which I think is very good for a correspondence school nurse.

NOT AN R. N.

According to the statements in the above letter, our correspondent has had two years of practical bedside teaching under the direction of two prominent doctors, she has also had more than fifteen months of hospital experience and training. Such being the case, we cannot refrain from asking why our correspondent discounts all this practical training and experience and gives all the credit to her correspondence course. If during the time she was nursing for the doctors, she had purchased a set of text-books, and applied herself to them, would she not have derived equal benefit, without the large outlay necessary for the correspondence course? From our point of view, any success our correspondent has attained in private nursing, should be credited to her practical bedside teaching, and her hospital training rather than to her correspondence course—EDITOR.



A Rival of Twilight Sleep

To the Editor of The Trained Nurse:

I found myself the mother of four beautiful and healthy children, and awaiting a fifth visit of the stork. I had just begun to hear and read about Twilight Sleep and its wonders. I eagerly read everything upon the subject that I could find of the new discovery. It all seemed so wonderful, yet incredulous, to believe that there could possibly be such a thing as painless childbirth. Nights I lay awake thinking it over and wishing that Twilight Sleep was used in this country.

If I could have known what was in store for me when my hour arrived, I would not have brooded over the non-use of Twilight Sleep. I felt that my fifth arrival must arrive, as its predecessors, with hours of pain. It had always seemed to me that I had to leave this bright world for a while to bring the little fluttering life. The end was so different, that I feel I must tell others that they may know of this Twilight Sleep's rival as I termed it.



CLASS OF 1915, EASTERN MAINE GENERAL HOSPITAL, BANGOR, ME.

My former confinements had been under a practitioner who had been in practice for about thirty years, while the one secured for my last had only been in the profession about a decade, hence the newer methods. The latter was called after labor had commenced and had never seen me before; I add this last to show that knowledge of my physical condition had nothing to do with its use.

After labor had started, I dragged wearily along for hours with no apparent sign that the end was approaching. Dilation had started, and that was all. Noting that my pains were doing me no good, my doctor said, "Suppose I give you something and have it here in fifteen minutes?" I laughed. He replied, "You don't believe me; wait and see." Absent for a moment, he returned and injected a small needle in my arm, saying, "Four o'clock, in fifteen minutes, your baby will be here."

Even then I did not believe him, but inside of five minutes I knew he was correct, for the last labor pain had begun, and only ended with my baby's birth. The previous pains had been the weak kind that any woman could endure, and then there was the one hard one, but how much better than hours of hard ones. I was amazed.

The doctor glanced at the clock. It was four-fifteen. "What did I tell you?"

I felt almost well enough to get up, in my mind I did anyway. I asked many questions that I had been eager to know at other times, yet was too sick to attempt to talk.

After it was all over, the doctor told what he had used, pituitrin. And I would recommend it to any suffering sister at childbirth. Under ordinary condition, I would probably have gone

twelve hours longer, each hour becoming more harrowing and weakening. Think of the hours of suffering saved by using pituitrin. And with this there is no added expense to confinement, so any expectant mother could demand this in their own home, while in the Twilight Sleep there is the big expense and the being away from home that must be considered.

I hope I may encourage the use of this harmless treatment, and will say that I would never face confinement with a physician again unless I asked if he would use pituitrin.

LOUISE FAIRCHILD CURRIER.



The Hospital Pin

To the Editor of The Trained Nurse:

I enjoy reading your valuable magazine very much and feel that I could not do without it. In answer to the question of M. B. P., whether or not it is professional for a nurse to wear a Hospital or R. N. pin on any dress but her uniform, I think they should be worn only with uniform while on duty. If worn on street dress, or on all occasions would look like advertising our most noble profession.

E. P. FAIRCLOTH, R.N.

To the Editor of The Trained Nurse:

In replying to M. B. P.'s question as to wearing the nurse's pin on any other dress but uniform, would say that I do, and have found my pin of great value in traveling, etc. You cannot carry your diploma with you, but a little pin, with name of hospital, your name and date is very handy to have.

E. B. W.

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

Massachusetts

The Board of Registration for Nurses will hold an examination for applicants for registration on October 13 and 14, 1915, in Room 15, State House, Boston, beginning at 9:00 A. M.



Connecticut

The Connecticut Training School for Nurses Alumnae Association resumed its regular meetings for the year on September 2, with a rather small attendance, but with nearly all the officers present, Miss Barron in the chair. After routine business, followed an interesting report from Mrs. M. J. C. Smith, the delegate appointed to Nurses' Convention in San Francisco last June, which was closely followed by those present.

An effort is to be made in the near future to get more of the graduate nurses residing in the State interested sufficiently to join our State Association.

A program committee has been appointed to prepare some form of entertainment for each month for the Alumnae meetings.



New York

Dr. Otto R. Eichel of Albany has been appointed director of the division of sanitary supervisors of the State Department of Health.

Doctor Eichel has been connected with the department since the beginning of Doctor Biggs' administration in January, 1914, having served at that time as smallpox expert during the epidemic in Niagara Falls and Western New York. He was afterward employed by the department to make a survey of the county tuberculosis hospitals in this State, the final report on which is now in press for publication. On August 1 of last year Doctor Biggs appointed Doctor Eichel as sanitary supervisor for the Capitol district counties—Albany, Columbia and Rensselaer, with headquarters at Albany. In addition to the duties of this office, he has served during the past year as hospital expert for the department.



CLASS OF 1915, ST. MARY'S HOSPITAL,
RACINE, WIS.

The new director is a graduate of the University of Buffalo medical college, and at one time practised medicine in that city. He began his public health career as the first tuberculosis inspector in the Buffalo health department in 1908. Later, when that department established a division of tuberculosis, he was made its first chief and organizer. He was subsequently prominently identified with the local tuberculosis movement, and was an active worker in the day camp and dispensary. As a member of the Buffalo Social Service committee, he was closely associated with the various philanthropic work of the local public health and charitable societies. He was chiefly instrumental in organizing and directing a tuberculosis class system for adults and children.

As a part of this system he conducted one of the first children's preventive classes in America,

a work which interested wide attention at the time, and was later instituted in other cities. As medical expert on tuberculosis he was employed by various institutions and charitable societies. Later, Doctor Eichel obtained special training in the hospital care and treatment of tuberculosis in the Adirondack sanatoriums, and was subsequently appointed superintendent of Buffalo's sanatorium for tuberculosis at Perrysburg, one of the largest institutions of this kind in the country.

The Middletown (N. Y.) State Homeopathic Hospital Training School for Nurses is featuring in its class organizations an innovation that is proving highly successful.

In February, the Junior Class of 1916 perfected an organization, having for its object the advancement of class interests, study, work and fraternity. Much initiative and spontaneity was shown by the twenty-two members, seven of whom are men. President, vice-president, treasurer and secretary were elected. The principal of the school was made honorary president.

Meetings are held the first Thursday evening of each month. The small dues of five cents are paid at that time, the fund being used for incidentals, flowers or dainties for a sick member.

The suggestion made at the first meeting that case papers be prepared and read at these monthly meetings found instant favor, and has been consistently carried out.

The president assigns to three or four members of the class at a time, and in turn, various diseases and types of psychosis for study, observation and presentation at the forthcoming meeting. Clinical records and temperature charts are kept in each instance, and every phase of the case gone into that could be of value in reaching a proper understanding of the disease.

The idea has inspired thoroughness and a nicety of detail wholly gratifying. Queries and discussion follow the reading of the papers which, thus far, have served to bring out the latent possibilities of the individual pupil nurse.

The weekly complimentary lectures on "General Anatomy and Surgery," given by Dr. E. S. Burdsall, an assistant physician at the hospital and a member of the training school faculty, each Friday evening in the assembly hall, and open to all employees, have been largely attended, beside attracting a lively, supplementary interest and helpfulness to the school.

They were begun in March, will be resumed following the summer recess.

On the recent visit of the inspector of Nurse Training Schools to the hospital, the inspector expressed her pleasure at the progress made in the schools since her last visit one year ago. The entrance examination, held August 4, was attended by a large class of candidates. Miss Agnes M. Valley, R.N., principal of the school, conducted the examination.



New Jersey

The New Jersey State Board of Examiners of Nurses will hold an examination for the registration of nurses, Tuesday, November 9, 1915. Applications must be filed fifteen days prior to November 9, 1915, with the secretary-treasurer.

Information and application blanks may be procured from Jennie M. Shaw, R.N., Sec.-Treas., 487 Orange Street, Newark.



Pennsylvania

The thirteenth annual meeting of the Graduate Nurses' Association of the State of Pennsylvania will be held in The College of Physicians, Philadelphia, on November 10, 11 and 12, 1915.

The meeting will be called to order at 10:30 A.M., on Wednesday, November 10, 1915. On Thursday morning Miss Isabel M. Stewart, Teachers' College, Columbia University, will speak on "Instruction in Nursing Education." On Friday morning Miss Anne W. Goodrich, Teachers' College, Columbia University, will address the Association on "The Functions of State Association and Board of Examiners." On Friday afternoon Miss Ella P. Crandall will talk on "The Public Health Nurse."

Other subjects of interest will be discussed by members of the Association. A banquet will be given at the Hotel Rittenhouse on Thursday evening.



West Virginia

The tenth annual convention of the Graduate Nurses' Association of West Virginia, and the sixth annual meeting of the Superintendents of Training Schools for Nurses of West Virginia, were held at Charleston August 31 to September 3, 1915, headquarters, Hotel Kanawah. Tuesday evening, August 31, was devoted to an informal reception and signing the register.

The sessions of September 1 opened at 9.30 with prayer by Rev. Dr. Ernest Thompson. Address of welcome, by Hon. George Breece, mayor of Charleston. Response by Miss Katherine Moriarty. Addresses followed by Hon.

Henry D. Hatfield, governor of West Virginia, and Mrs. H. C. Lounsbury, president Graduate Nurses' Association. Reading of the minutes of last meeting by Mrs. R. J. Bullard, secretary. Through the courtesy of Mr. J. Chilton of Charleston, there was a trolley ride to St. Albans and return, with luncheon. The afternoon session was devoted to Public Health Nursing, and was opened with prayer by Dr. Albert Evans. Address, "The Tuberculosis Situation in West Virginia," by Dr. Harriet Jones. Short addresses were given by public health nurses, representing tuberculosis, school nursing, district nursing, Red Cross district nursing. There was an adjournment for supper at 5.30, which was followed by auto ride around Charleston, and to Charleston General Hospital, where refreshments were served. The evening session was devoted to a trip to Panama Exposition and return, via post cards and projector. Pictures of hospitals in Europe where West Virginia Red Cross nurses were in service, and letters from them were read.

The sessions of September 2, opened at 9.30 with prayer by Rev. R. D. Roller. Reports of officers, delegates, and county societies were heard. Paper, "Diphtheria," by Miss Theresa Flynn, address by Dr. Vincent Churchman, and paper, "Common Causes of Blindness," by Miss Van Blaricum, read by Mrs. H. C. Lounsbury. Reception of new members. Recess for luncheon. The afternoon session was for Superintendents of Training Schools, and opened with prayer by Rev. Doctor Bird. Addresses were given by Dr. G. C. Schoolfield, Mrs. Lena Warner, Miss E. Vernon, and Dr. J. McKee Sites, president West Virginia Board of Nurse Examiners. Conference of Superintendents of Training Schools for Nurses with Doctor Sites, adoption of a standard for "recognized" West Virginia training schools. Boat ride and supper.

The session of September 3 was at the Sheltering Arms Hospital, Hanford, where luncheon was served. After election of officers and delegates, and the selection of next place of meeting, the convention adjourned.

An attractive souvenir has been issued by the Graduate Nurses' Home and Registry of Charleston, which was established November 30, 1917. The Home and Registry is under the direction of Mary E. Reid, R.N., known to the readers of *THE TRAINED NURSE AND HOSPITAL REVIEW*, through her book "Bacteriology in a Nutshell." Miss Reid was superintendent of Charleston's first training school for nurses,

which was organized at the Thomas Hospital, (now the Charleston General Hospital) in 1898, and superintendent of nurses, Charleston General Hospital, 1905 to 1907. The souvenir gives interesting bits of history, showing the progress of trained nursing in West Virginia, in which progress Miss Reid has played an important part.

Miss Blanche Allebach, who is in England, under the auspices of the Red Cross, writes Charleston friends that she is enjoying nursing there very much, and is not at all homesick for the U. S. Miss Nena B. Sell, a graduate of the Sheltering Arms Hospital, Hanford, Class of 1913, has accepted a position as head nurse at the Coleman Hospital, Berkley. Miss Clara Samples, graduate of Glendale Memorial Hospital, Moundville, Class of 1915, has accepted a position at Sheltering Arms Hospital, Hanford. Miss Lelia M. Lewis, of the Charleston General Hospital, is spending her vacation at the Panama-Pacific Exposition. Miss Nettie Price and Miss Charlotte McAlister, of the McMillan Hospital, are spending their vacation at Jacquet River, New Brunswick, Canada.



District of Columbia

The Nurses' Examining Board of the District of Columbia will hold an examination for registration of nurses, Wednesday, November 17, 1915. Applications must be made before November 1, 1915, to Helen W. Gardner, R.N., Secretary and Treasurer, 1337 K Street, N. W.



Kentucky

The Kentucky State Board of Nurse Examiners will hold the third (3d) semi-annual examination for State registration, at the City Hospital, Louisville, November 16-17, 1915, beginning at ten (10) A. M.

For further information apply to Flora E. Keen, R.N., City Hospital, Louisville, Ky.



Texas

The Texas Board of Nurse Examiners will hold examinations November 9 and 10, in El Paso, Fort Worth, Houston and San Antonio. M. M. Taylor, Secretary, Physicians and Surgeons Hospital, San Antonio.



Minnesota

The Minnesota State Board of Examiners of Nurses will hold its semi-annual examinations for the registration of applicants at the New

Capitol, St. Paul, Minnesota, on October 1 and 2, beginning at 9 A. M.

Applications with fee of \$5.00 must be filed with the secretary before September 25. For further information apply to the secretary, Harriet B. Leach, 902 South 7th Street, Minneapolis.

Miss Ida Isaacson, superintendent of nurses at the Swedish Hospital in Minneapolis, has been appointed by Governor Hammond as a member of the State Board of Nurse Examiners, to fill the vacancy created by the resignation of Miss Helen M. Wadsworth.

The annual meeting of the Asbury Hospital Nurses' Alumnae Association, Minneapolis, took place at the hospital September 1, and officers were elected as follows:

President, Miss Lydia H. Keller, R.N.; first vice-president, Miss Eva Bangs, R.N.; second vice president, Miss Dency Reekie, R.N.; recording secretary, Miss Etta Paul, R.N.; corresponding secretary, Miss Grace Woodside, R.N.; treasurer, Miss Eve Milburn, R.N.

Eleven new members who had made application were taken into the Alumnae Association. The next meeting will be Wednesday, October 6.



North Dakota

A training school for nurses was opened April 4 at St. Alexis Hospital, Bismarck, with a class of fourteen pupils. Miss Mary B. McPake is the superintendent of the training school, and Sister M. Boniface, superintendent of the hospital.

The North Dakota Bill for State Registration was approved by the Governor March 9, 1915, and reads as follows:

An Act creating a board of nurse examiners, providing for the appointment of inspectors of training schools, and for the examination, registration and regulation of graduated nurses, and exempting practical nurses from registration and prescribing the course of study and standard for training schools and prescribing a penalty for the violation thereof.

Be it enacted by the Legislative Assembly of the State of North Dakota:

SECTION 1. BOARD OF NURSE EXAMINERS; APPOINTMENT. That a board to be known as the board of nurse examiners of the State of North Dakota is hereby created and established. Said board shall be composed of five members, appointed by the Governor of the State as herein-after provided.

Upon taking effect of this Act, the North Dakota State Nurses' Association at the annual meeting shall nominate and submit to the Governor a list of ten graduated nurses from which appointment shall be made. Each nurse whose name is thus submitted shall be at least twenty-

five years of age, of good moral character and eligible to registration under the terms of this Act. There shall always be two of such members of the board selected from nurses who have had at least two years of experience in educational work among nurses, or who have had two or more years' experience in the instruction of nurses in training schools.

SECTION 2. TERM OF OFFICE; VACANCIES. Each member of said board shall serve for a term of five years and until her successor is appointed and qualified, except in the case of the first board, whose members shall hold office, as follows: One member for a period of one year; one member for a period of two years; one member for a period of three years; one member for a period of four years; one member for a period of five years; the members and their respective terms to be designated by the Governor.

Vacancies in the said board shall be filled by the Governor in accordance with the provisions of this Act for the establishment of the original board and persons appointed to fill vacancies shall be selected from a list of three registered nurses submitted by the North Dakota State Nurses' Association, and shall hold office during the unexpired portion of the term for which their predecessors were appointed.

SECTION 3. ORGANIZATION OF BOARD; OFFICERS. The members of said board shall, immediately after their appointment, meet for the purpose of organizing, and shall elect one of their number secretary, who shall also act as treasurer of said board. The secretary-treasurer shall give to the State treasurer a bond for the faithful discharge of his or her duties in the penal sum of \$1,000 to be approved by the Governor. The board shall adopt an official seal which shall remain in the custody of the secretary; the secretary shall keep the records and minutes of all meetings of the board, and shall record in a suitable book the names of all nurses and training schools registered under this Act.

SECTION 4. COMPENSATION; DISPOSITION OF FEES; INSPECTOR OF TRAINING SCHOOLS. Each member of said board shall receive \$5 per day while actually and necessarily engaged in the performance of the duties of the office which, together with all the legitimate expenses incurred in the performance of such duties shall be paid from fees received by the board under the provisions of this Act, and no part of the expenses of said board shall at any time be paid out of the State treasury. The secretary shall receive extra compensation, not to exceed \$100 per annum, payable quarterly. Any money in the hands of the treasurer at the end of any year, in excess of \$250, shall be paid over by the said board to the State treasurer, to be kept by him for the future maintenance of the board, and to be disbursed by him upon warrants signed by the president and treasurer of said board.

The board shall elect one of their numbers to act as inspector of training schools for nurses.

SECTION 5. SCHEDULE OF SUBJECTS. Said board shall examine applicants for registration under this Act upon the following subjects: anatomy and physiology, general medical nursing, obstetrics, materia medica for nurses, general surgical nursing, dietetics, sanitation and hygiene

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contagion and diseases of children, bacteriology, ethics.

SECTION 6. DUTIES OF INSPECTOR OF TRAINING SCHOOLS; COURSE OF STUDY IN TRAINING SCHOOLS. The member acting as inspector of training schools shall inspect all schools for nurses in North Dakota and shall report to the board such schools as shall provide courses of instruction, both practical and theoretical, in the subjects mentioned in Section 5 of this Act, except that in the subject of contagion the instruction may be theoretical only and, in addition, such schools must have such daily average number of patients as may be determined by the board of nurse examiners.

SECTION 7. REQUIREMENTS FOR TRAINING SCHOOL FOR REGISTRATION. Any training school complying with the requirements herein mentioned shall be entitled to registration as an accredited school upon the payment of a fee of \$25 to the secretary of the board, provided that in the event that any such school shall subsequently become disqualified by failure to comply with the terms and conditions required upon registration, the board shall have the power to cancel their registration, and thereupon such school shall no longer be an accredited school under the provisions of this Act.

SECTION 8. MEETING OF BOARD OF EXAMINERS. Such board shall hold two regular examinations in each year, and such additional meetings at such times and places as it may determine. Notices of such examination shall be published in at least two newspapers of general circulation in the State, and in at least one nursing journal, at least thirty days previous to such meeting, such notice shall be mailed to each person who has made application for examination under the provisions of this Act at least twenty days prior to such examination. Applications for examination must be in the hands of the secretary at least ten days prior to the date set for examination.

SECTION 9. QUALIFICATIONS OF APPLICANTS. Any person desiring to practice professional nursing in this State shall make application to said board as provided in Section 8 of this Act, and shall pay to the secretary at the time of making application for registration the sum of \$10 as an examination fee, and shall present himself or herself at the next regular meeting of said board for the examination of applicants, and said board shall proceed to examine said applicant, and upon said board being satisfied that: (1) Said applicant is of the age of twenty-one years or over; (2) of good moral character; (3) has received the education required for admission into the high schools of the State, and (4) has graduated from a training school connected with a general hospital, where three years of training in a systematic course of instruction is given in the hospital, or has graduated from a training school in a hospital of good standing, supplying the systematic three years' training corresponding to the above standards, which training may be received in two or more hospitals, and providing that the results of the examination show a general average of 75 per cent. or more and not below 60 per cent. in any subject, said board shall enter the applicant's name in the register, hereinafter provided for, and

shall issue to said person a certificate of registration authorizing said person to practice as a registered nurse.

SECTION 10. WAIVER. WHO MAY BE REGISTERED WITHOUT EXAMINATION. All persons graduating prior to January 1, 1917, possessing the above qualifications, shall be permitted to register without examination upon the payment of registration fee. Nurses who shall show to the satisfaction of the board of examiners that they are graduates, prior to the year 1916, of a training school connected with a general hospital or sanatorium, giving two years' training; or prior to the year 1899, giving one year's training; and are engaged in the profession of nursing in the State of North Dakota at the date of the passage of this Act, or have been engaged in nursing five years after graduation, prior to the passage of this Act, shall be entitled to registration without examination, provided such application be made before January 1, 1917.

SECTION 11. RECIPROCITY. APPLICANTS REGISTERED IN OTHER STATES. The board of examiners may issue licenses without examination upon the payment of ten dollars registration fee to applicants who have been registered in other States in which the registration of this State is recognized and having equal registration requirements.

SECTION 12. On and after January 1, 1917, all applicants for certificates of registration under the provisions of this Act, shall pass the examination required by the board, before receiving a certificate of registration.

SECTION 13. It shall be unlawful hereafter for any person to practice professional nursing as a registered nurse without certificate as herein provided for.

SECTION 14. CERTIFICATE OF REGISTRATION RECORDED; FEE. Every person to whom a certificate of registration shall have been issued shall within thirty days thereafter cause the same to be recorded in the office of the register of deeds of the county in which such person resides, and shall pay to such register of deeds the required fee for recording the same, and said fee shall be turned into the general fund of the county.

SECTION 15. PRACTICAL NURSES EXEMPTED. This Act shall not be construed to apply to gratuitous nursing of the sick by friends or members of the family, nor to any practical nurse or person nursing the sick for hire who does not pretend to be a registered nurse.

SECTION 16. NAMES TO BE ENTERED ON REGISTER. The board shall keep a register in which shall be entered the names of all persons to whom certificates are issued under this Act, and said register shall be at all times open to public inspection.

SECTION 17. REGISTERED NURSE. A person who has received his or her certificate according to the provisions of this Act shall be styled and known as a "Registered Nurse." No other person shall assume such title or use the abbreviation R.N. or any other letters or figures to indicate that he or she is a registered nurse.

SECTION 18. BOARD MAY REVOKE CERTIFICATE FOR CAUSE. The board shall have the power to revoke any certificate issued by said board in accordance with the provisions of this

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Act for the following causes: gross incompetency, dishonesty, or any act derogatory to the morals or standing of the profession of nursing, as may be determined by the board; provided that such revocation shall only be made upon specific charges in writing, under oath, filed with the secretary and by a majority of the whole board, a certified copy of such charges and thirty days' notice of the hearing of the same having been personally served upon the holder of such certificate. Said board shall be authorized to furnish a list of the names and addresses of those whose certificates have been revoked to the board of examiners of other States upon the written request of such board.

SECTION 19. PENALTY FOR VIOLATION. Any person violating any of the provisions of this Act, or who shall wilfully make a false representation to the board of examiners in applying for a certificate shall be guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine of not more than \$100 and not less than \$10.



California

STATE BOARD EXAMINATION QUESTIONS

Urinalysis—1. Give instructions you think a patient should have before collecting a sample of urine for analysis. 2. What would you expect to find in making an analysis in a case of Bright's disease? 3. Give the characteristics of diabetic urine. 4. Give two tests for albumin.

Contagion and Children's Diseases—1. Give the nursing care of a child with rickets. 2. What is thrush? What would you do to prevent it? 3. Name important adverse symptoms to be carefully watched for in scarlet fever and state significance of each. 4. What would you do for a child in convulsions?

Medical Nursing—1. What particulars regarding a chill should be noted and recorded? 2. Describe briefly how you would give a bed bath. 3. How would you administer a hypodermic? 4. By what methods do you ascertain the temperature of the body; give detail of procedure. 5. State briefly the nursing care of a case of croupous pneumonia.

Surgical Nursing—1. How do you prepare a patient for a vaginal examination? 2. How would you distinguish between arterial and venous blood in case of hemorrhage? 3. Give technique of catheterization in the male or in the female. 4. What are the symptoms of shock and what would you do until the arrival of a doctor? 5. What is the general preparation of a patient before giving an anesthetic?

Nursing Ethics—1. Define nursing ethics. 2. Name important ethical duties of a nurse entering on the care of a patient in a private home. 3. What attitude should a nurse take in case of dissatisfaction of the family towards the physician in charge. 4. Discuss briefly the essential points of success from an ethical standpoint in private nursing; hospital nursing; public health work.

Obstetrical Nursing—1. How would you prepare a patient for labor? 2. Describe the stages of labor. 3. What would you do in case of post-partum hemorrhage after the doctor had left? 4. What are the causes and prevention of masti-

tis? 5. What is ophthalmia neonatorum and how may it be prevented?

Anatomy and Physiology—1. Into what classes are bones divided? 2. Give the names and function of the outer covering of the bones. 3. Name the bones entering into the formation of the chest. 4. Of what does the digestive apparatus consist? 5. Name the organs of circulation. 6. Describe the blood. 7. Name the respiratory organs. 8. Name the important excretory organs.

Materia Medica—1. Name five ways of introducing medicine into the system. 2. By which method would you obtain the slowest action; the quickest action? 3. Give the average adult dose of the following: morphine sulphate, paregoric, strychnia. 4. Give symptoms and treatment of opium poisoning. 5. Define hypnotic; diuretic; diaphoretic; give an example of each. 6. How would you prepare one quart of bychloride solution one-one thousandth (1:1000)?

Hygiene and Bacteriology—1. What are the principal factors in maintaining health? 2. What do you understand by ventilation? 3. Show how a nurse may be a "carrier" of infection from one patient to another. 4. Why are flies a menace to health? Why are mosquitoes a menace to health? 5. What are the conditions most favorable to the growth of bacteria? 6. Name three of the most common pus-producing organisms. 7. What precautions would you take in the care of a typhoid patient to protect yourself and others from infection? 8. In what discharges are the following bacteria most frequently found: tubercle bacilli, typhoid bacilli, diphtheria bacilli.

Dietetics—1. Name the five food principles and classify them according to their function. 2. Name the chief tissue building foods; the chief heat and force producing foods. 3. Give one method of pre-digesting milk. 4. What effect does toasting have on the digestibility of bread? 5. What articles of food are especially to be avoided in nephritis?

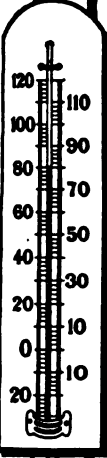


Personal

Miss Mary Cavanaugh has been appointed superintendent of nurses at the A. S. O. Hospital, Kirkville, N. Y. Miss Cavanaugh has had wide experiences as a training school teacher, having done institutional work in the Metropolitan and other hospitals in New York City and for two years was superintendent of the New York Polyclinic Hospital and held the position of superintendent of nurses in the German Hospital of Jersey City. She was graduated from Kings County Hospital in Greater New York in 1904.

Mrs. Mattie Thompson, a graduate of the Los Angeles County Hospital, Cal., has been appointed superintendent of nurses at the Judge Mercy Hospital, Salt Lake City, Utah.

Mrs. Millicent Northway of Benton Harbor, Mich., has been appointed superintendent of



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Winter Class Opens January 19, 1916

Duration of Term, Four Months

Pennsylvania Orthopaedic Institute and School of Mechano-Therapy (Inc.)

1709-1711 Green Street, Philadelphia, Pa.

MAX J. WALTER, M.D., Supt.

When you write Advertisers please mention THE TRAINED NURSE

the Kenosha Hospital, Wisconsin, to succeed Miss Harriet Jean Robinson, who resigned. Mrs. Northway has been in charge of the Calumet-Hecla Hospital at Calumet, Mich.

Miss Elizabeth K. Smith has been appointed superintendent of the Galesburg, Illinois, Hospital. Miss Smith has had years of experience in hospital work, having for a long time been superintendent of the hospital at Rockford, and more recently has been engaged in an important position in Chicago.

Miss Sybil Smith of Saco, Maine, has been appointed assistant superintendent of the Portsmouth Hospital at Portsmouth, N. H. She is a graduate of the Webber Hospital Training School of Biddeford, while she has had special courses in the Children's Hospital in Portland and at Boston hospitals.

Miss Charlotte Wood, graduate General Hospital, Buffalo, who was in American Ambulance Hospital, Paris, for five months, is now in Florence, Italy, aiding in preparation of opening a hospital for sick and wounded soldiers.

Norene Henckel, a graduate of the Allegany Hospital, Cumberland, Md., Class of 1914, is taking a post-graduate course at the New York Polyclinic, Post-graduate Hospital, N. Y.



Marriages

On July 31, 1915 at the rectory of St. Patrick's Church, Erie, Pa., by the Rev. Joseph Cauley, May Margaret Callaghan, graduate nurse of St. Vincent's Hospital, Erie, Pa., Class of 1911, to Thomas Carson Arnold. Mr. and Mrs. Arnold will reside on the island off the southern coast of Florida, opposite Fernandina, where the bridegroom is the chief engineer of the extensive electrical equipment for the Carnegie home. Mr. and Mrs. Carnegie have built a handsome new home for the young couple.

On June 2, 1915, at Fresno, Cal., Lela Ethel Ellis, R.N., graduate nurse of Asbury Methodist Hospital, Minneapolis, Minn., class of 1910, to S. Lee Carr. Mr. and Mrs. Carr will reside in Coarse Gold.

Recently at the Deems Memorial Church, New York City, Bertha May Whitford of Whitestone, N. Y., to Dr. Rupert Folger.

Recently at Craig, Colorado, Ella May Arnold, to Oscar W. Hogsett of Boulder, Colorado.

On August 3, 1915, at Falmouth, Mass., Dora Dickson of Reading, Mass., to J. E. Dwight, Jr., of New York.

On June 9, 1915, at Winchester, Mass., Alice Maude Clark, graduate nurse of Waltham Training School, to Edward Smalley.

On June 26, at Jamestown, R. I., Marie Dupont Emmons, to Dr. James Prince Lewis.

On June 18, 1915, at Duluth, Minn., by Rev. Father P. J. O'Brien, Maureen A. Ryan, graduate of St. Mary's Hospital, Duluth, Class of 1913, to John T. Eggen of Duluth. Mr. and Mrs. Eggen are making their home in Duluth.

On April 12, 1915, at Welch, West Virginia, Elizabeth Lilly, head nurse, Miners Hospital, Number One, Welch, West Virginia, to Dr. William Bolden. Mrs. Bolden is a graduate of the Sheltering Arms Hospital Training School for Nurses, Hansford, West Virginia, Class of 1911. Dr. and Mrs. Bolden will reside at Leckeyville, Kentucky.

Dr. Wm. H. Campbell announces the marriage of his sister, Honsie Edna Campbell, to Joseph Williams, on July 31, 1915, at Colorado Springs, Colorado. Mrs. Williams is a graduate nurse of the Minnequa Hospital, Pueblo, Colorado, Class of 1910 and, until her marriage, practised her profession in Charleston, West Virginia, of which State she is a native. Mr. and Mrs. Williams will reside in Pueblo, Colorado.

On June 30, 1915, at Wray, Colorado, by the Rev. F. S. Rice, Mercy Annie Keeley, graduate nurse of the Charleston General Hospital, West Virginia, Class of 1909, to Charles Meadows. Both bride and groom are well and favorably known in Charleston, W. Va., where the bride was a very efficient nurse for six years following her graduation. Mr. and Mrs. Meadows will reside in Glen, Colorado.

On June 16, 1915, at Frametown, West Va., by the Rev. J. H. Frame, Ida Dell Craft, graduate nurse of Charleston, W. Va., General Hospital, Class of 1914, to William M. Pierson. Mr. and Mrs. Pierson will reside at Rosedale, W. Va.

Mrs. James Veazey Stockton announces the

The Treatment of Neurasthenia

"Stimulation is always succeeded by depression." That is a great law of Nature, which, if habitually ignored, results in deterioration and, ultimately, annihilation of living tissue.

Neurasthenia, really a condition of nervous exhaustion or "depression," presents in many cases a history of the prolonged use of coffee or tea either in moderate or excessive quantities.

To the habitue of coffee and tea the plaintive cry of his caffein-whipped, over-stimulated tissues is "**Don't.**" But because of the momentary seductive exhilaration following each dose of the stimulant poison, this warning cry is not heeded until the tissues have "gone to smash." The nerve force and muscular energy have been spent, the organs of digestion and elimination are damaged, and we have before us a typical case of Neurasthenia.

These patients should be prohibited the use of coffee and tea and put on

POSTUM

"There's a Reason"

In so doing, we not only remove the cause of the disease, but we are giving the patient a pleasant food-drink which resembles coffee in appearance and snappy taste, but does not contain caffein or other drugs.

Postum is made of clean, whole wheat, skilfully roasted with a small quantity of wholesome molasses, and comes in two forms: The original **Postum Cereal**, must be well boiled. **Instant Postum** requires no boiling and is made instantly by stirring a level teaspoonful of the soluble powder in a cup of hot water. Both kinds are equally delicious and cost about the same per cup.

The ***Clinical Record***, for Physician's bedside use, together with samples of **Instant Postum**, **Grape-Nuts** and **Post Toasties** for personal and clinical examination, will be sent on request to any Physician who has not yet received them.

Postum Cereal Company, Limited, Battle Creek, Michigan, U. S. A.

marriage of her daughter, Elizabeth Stockton, to Nat Warren, on August 18, 1915, at Vermilion, Ohio. Mrs. Warren is a graduate nurse of All Saints Hospital, MacAlister, Okla., Class of 1906 and, since her graduation, has practised her profession in Charleston, W. Va.

On June 30, 1915, at San Francisco, Cal., Edna May Gray, to Dr. Thomas Reese Foster. Mrs. Foster is a graduate of the Illinois Southern Hospital, Class of 1910, and was superintendent of nurses at the Livermore Sanitarium, Livermore, California. Dr. and Mrs. Foster will make their home at Watseka, Illinois.

On July 22, 1915, C. Josephine Landry, of New Orleans, La., graduate nurse of Presbyterian Hospital, to Edward Murphy.

On September 1, 1915, at the bride's home in Tionesta, Penn., Evelyn Esther Clark, graduate nurse of St. Vincent's Hospital, Erie, Pa., to Ralph Miles of Sharon, Penn. Mr. and Mrs. Miles will reside in Sharon, Penn.

On August 24, 1915, at Toronto, Ont., Dora Ash, Class of 1912, General Hospital, Buffalo, to Mr. J. Kaufman of Eldred, Pa. Mr. and Mrs. Kaufman will reside at Flint, Mich.

On April 3, 1915, Mabel Waltam, Class of 1914, General Hospital, Buffalo, to Mr. W. Buckley. Mr. and Mrs. Buckley reside in Buffalo.

On August 10, 1915, Gertrude Moran, Class of 1914, Buffalo General Hospital, to Dr. Forest Frye. Dr. and Mrs. Frye will live at Wausau, Wis.



Births

In July, to Mr. and Mrs. Griffeth Amies (née Mary Lücking), a son, Griffeth Henry.

On May 16, 1915, to Mr. and Mrs. Lawrence A. Davis (née Estelle White), a daughter, Barbara White Davis.

On July 20, 1915, to Mr. and Mrs. F. Mahood (née Katherine Reid), a daughter.

On August 26, 1915, a son to Mr. and Mrs. J. Kirby. Mrs. Kirby was Miss Gertrude Willis, Class of 1909, General Hospital, Buffalo,

On July 31, 1915, to Mr. and Mrs. Arthur Most (née Meda Sanderson), a daughter, Elizabeth.

On August 10, 1915, to Mr. and Mrs. Edward Appleton Bailey (née Edith Burton), a daughter Margaret Burton Bailey.



Deaths

On August 9, 1915, Annie Damer, graduate of Bellevue Hospital.

On May 31, 1915, after fourteen months' illness, Annie Howard, R.N., a graduate of Morristown, N. J., Memorial Hospital of the Class of 1912.

On July 9, 1915, at New Haven Hospital, after a lingering illness of several months, Jane P. Hill, Class of 1903, Connecticut Training School, New Haven, Conn.

On July 14, 1915, at New Haven Hospital, after a lingering illness of several years, Harriet B. Hutchings, Class of 1897, Connecticut Training School, New Haven, Conn.

The first break in the ranks of the Home and Registry, Charleston, W. Va., caused by death for several years, occurred on January 21, 1915, when the Grim Reaper took from us Miss Mary Mulcahy, of Warden, West Virginia, and who for five years was one of our best loved and most efficient nurses.

Miss Mulcahy was graduated from the Charleston General Hospital and Training School for Nurses June 15, 1908. In July, 1913, she was stricken with tuberculosis and forced to give up her beloved profession. Her physicians hoped that a year of complete rest at her country home in the West Virginia mountains would restore her to us again in good health. This hope was not realized; although naturally a strong, brave spirit, she made a good fight for two and a half years.

To know Miss Mulcahy was to love her. When the message came to old friends, classmates and patients that "She was not, for God took her," many hearts were saddened, and yet gladdened because, for her, all pain and suffering had ceased forevermore.

Beyond the gloaming she is waiting "Until the day break and the shadows flee away."

M. E. R.

To
BUILD
UP

To
BRACE
UP

To
TONE
UP

Supplied in 11-ounce bottles
only—never in bulk.

Samples and literature sent upon
request.

Prescribe original bottle to avoid
substitution.

In ANY form of DEVITALIZATION
prescribe

Pepto-Mangan (Gude)

Especially useful in

ANEMIA of All Varieties:

CHLOROSIS: AMENORRHEA:

BRIGHT'S DISEASE: CHOREA:

TUBERCULOSIS: RICKETS:

RHEUMATISM: MALARIA:

MALNUTRITION: CONVALESCENCE:

As a GENERAL SYSTEMIC TONIC

After LA GRIPPE, TYPHOID, Etc.

DOSE: One tablespoonful after each meal.
Children in proportion.

M. J. BREITENBACH COMPANY
New York, U. S. A.

Our Bacteriological Wall Chart or our Differential Diagnosis Chart will be sent to any Physician upon request.

A Nourishing and Cooling Drink for the Sick

In convalescence, for weakness, nervousness or feverish conditions, Horsford's Acid Phosphate is safer, more palatable and more beneficial than lemonade or lime juice.

HORSFORD'S ACID PHOSPHATE

contains valuable nutrients—phosphates of calcium, sodium, magnesium and iron. It is, therefore, far superior to Dilute Phosphoric or other acids.

It is recommended especially for promoting digestion, strengthening the nervous system and in wasting diseases.

A teaspoonful in a glass of cold water
makes a most grateful beverage.

NURSES AND PHYSICIANS PLEASE WRITE FOR FREE SAMPLE.
RUMFORD CHEMICAL WORKS, **Providence, R. I.**

When you write Advertisers please mention **THE TRAINED NURSE**

Book Reviews

The Care of the Baby. By J. P. Crozer Griffith, M.D., Professor of Diseases of Children in the University of Pennsylvania. Sixth edition, thoroughly revised. 12mo of 463 pages. Illustrated. W. B. Saunders Company, 1915. Cloth. \$1.50 net.

The changing of methods and the continued demand for this book have necessitated a careful and complete revision in the preparation of the sixth edition. New illustrations have been added, and others altered to make them thoroughly modern. Professor Barton Cooke Hirst of the University of Pennsylvania has revised the portion of the book bearing upon the management of pregnancy and allied topics.



Outlines of Internal Medicine. For the Use of Nurses. By Clifford Bailey Farr, A.M., M.D., Instructor in Medicine, University of Pennsylvania; Assistant Visiting Physician, Philadelphia General Hospital; Pathologist to the Presbyterian Hospital. 12mo., 408 pages. Illustrated with 71 engravings and 5 plates. Cloth. \$2.00 net. Lea & Febiger, Publishers, Philadelphia and New York, 1915.

The plan of the work, while novel, is most logical, and from a didactic standpoint presents many advantages. It is divided into ten "Parts," eight dealing with diseases of the various systems and two with harmful agencies (physical, chemical and bacterial) invading the body from without. In each "Part," general considerations are first taken up, to be followed by sketches of the more important diseases, including briefly their etiology, and in more extended detail their characteristics, symptoms and prognosis, with frequent suggestions for emergency procedure. In appropriate sections much information on dietetics of special and general value is presented. The sections dealing with infectious diseases are peculiarly useful both from the logical grouping of topics and the extended consideration of prophylaxis and from the clear insight afforded into serum and vaccine therapy, infection and immunity, and the application of the principles of immunology in diagnosis. A useful section gives in detail the relative frequency of diseases and their relative mortality.

Realizing that an understanding of technical

terms is of prime importance, the author makes no effort to avoid their use, but is at pains to supply clear definitions and explanations. While the consideration of every topic is ample and suggests no abridgment, the author's purpose is plainly to develop the student as a well equipped nurse and not as an internist.

As a basis for a systematic training school course in Internal Medicine or as a reference volume for the graduate nurse, Doctor Farr's work has been most logically planned and perfected with a discriminating grasp of the requirements and limitations of a nursing textbook.



Elementary Bacteriology for Nurses. By G. Norman Meachen, M.D., B.S., London, Physician, Skin Department, Prince of Wales' General Hospital, Tottenham, etc. Illustrated. Cloth. 65 cents net. The Scientific Press Limited, London, England.

This little work consists mainly of reprints of articles which have already appeared serially in the pages of *The Nursing Mirror*, its object is to serve as an elementary guide to the subject of germs in general, more especially from the nurse's standpoint.



Nursing in the Acute Infectious Fevers. By George P. Paul, M.D. Illustrated. Second edition. Thoroughly revised. W. B. Saunders Co., Philadelphia. Price, \$1.00 net.

In this second edition, much new material has been inserted, several chapters rewritten, new articles on Acute Anterior Poliomyelitis and Para Typhoid Fever added, and important additions and revisions made in the chapters on Reduction of Fever, Alleviation of Symptoms, Detection of Complications, Urine and its Examination, Poisons and their Antidotes.



What Every Mother Should Know About Her Infants and Young Children. By Charles Gilmore Kerley, M.D., Professor of Diseases of Children, N. Y. Polyclinic Medical School and Hospital. 107 pages. Bound in paper. 35 cents. Paul B. Hoeber, New York.

This little book was prepared at the suggestion

(Continued in Publisher's Desk)

The Nemo "Self-Help" Exposition

From Monday, Oct. 4th to Saturday, Oct. 9th

In Principal Stores and Corset Shops Throughout the United States

TO THE MEDICAL PROFESSION: After many years of private experimenting, and six months of public test, we are convinced that the Nemo Wonderlift Corset is an effective substitute for separate abdominal binders and bandages; and that, in a large majority of cases, it will prove vastly superior to the best of such appliances.

During the past six months, to our personal knowledge, the Nemo Wonderlift Corset has been critically examined by not less than five hundred physicians, most of whom have generously endorsed it, and are now prescribing it in cases where complete visceral support is indicated. We do not know of a single instance of adverse criticism.

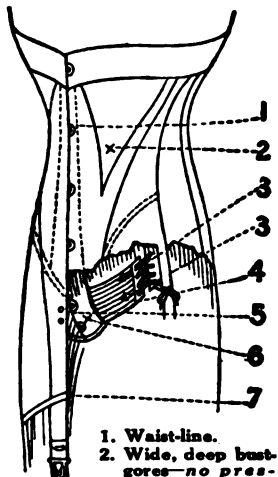
It is our desire, therefore, to quickly acquaint the medical profession and their patients with this **ENTIRELY NEW** kind of hygienic service. To that end we have arranged for a special display of Nemo Wonderlift Corsets during the week beginning October 4. This will be observed in the principal stores throughout the country, in many of which a member or graduate of our Institute will be in attendance.

This is a special invitation to physicians to investigate what we believe to be a long-wanted medical adjunct, and an easy and sure solution to thousands of bothersome cases.

For your own benefit, therefore, we ask you to study the Wonderlift. We believe that you will quickly and cordially endorse our claims as to its *prophylactic* and *therapeutic* qualities, and its great **HUMANITARIAN VALUE** in preventing and helping to cure the ills from which millions of women are suffering.

A description of the Nemo Wonderlift is given below.

A Truly Scientific Supporting Corset



1. Waist-line.
2. Wide, deep bust-gore—no pressure below waist on stomach and liver.
3. Adjustable semi-elastic binder (oblique muscles).
4. Poupart's ligament.
5. Symphysis pubis.
6. Curved steels—no pressure over bladder.
7. Garters attached to semi-detached skirt—no undue pressure on abdomen.

The semi-elastic bandlets are in exact apposition to the internal broad ligament, and, in position and action, closely simulate the lifting and supporting functions of the external and internal oblique muscles. The inner side-lacing permits exact individual adjustment, each side being independent of the other, thus providing for inequalities in size and shape of abdomen. The mechanical construction is such that the entire weight of support is carried upon the hip bones, thus protecting the kidneys from undue pressure and the spinal column from distortion.

For all forms of ptosis. Invaluable in inoperable floating kidney. A great help in anteversion, retroversion, prolapsus, ante-partum, post-partum, obesity, hernia. The corset acts as a splint to the internal organs and their ligaments, giving them "physiological rest" until they regain their tone. The elasticity of the bandlets produces a passive massage, reducing fat, correcting the circulation, relieving early adhesions and preventing new ones.

SELF-HELP
Nemo
WONDERLIFT

This New Kind of Binder "Stays Put!"

It can't shift. It gives *added comfort*. It does not bulk the figure, but *reduces* it. It accomplishes its purpose *without offending the woman's pride of figure*. Your patient will wear this corset gladly. Too often she throws your binder aside the minute your back is turned.

It is *inexpensive*. The price of this corset is \$5.00—less than the cost of the cheapest binder; and it's a big value, simply as a corset, at \$5, saying nothing of this new supporting feature.

We shall be glad to furnish further information on request.

The Nemo Hygienic-Fashion Institute, 120 East 16th St., New York, U. S. A.

New Remedies and Appliances

A Model Laundry Plant

One of the most important features of a model hospital organization is the laundry equipment of washing machine and ironing machine.

The day of hand work in the laundry is passing or, we may more correctly say, has passed. The spirit of efficiency is in the air. Economies in every direction are in order, and there is no question as to the superiority of the machine in saving time and cost of labor.

The Hurley Machine Co., Chicago, report a large volume of orders from hospitals for their Thor washers and ironers, and can give figures which are really startling from the standpoint of the saving made possible in operation.

We shall be glad to hear from hospitals as to their experience in using laundry machinery.



A Window Tent

The Cabinet Manufacturing Company of 380 Main St., Quincy, Illinois, manufacturers of the Walsh Window Tent, are issuing a valuable folder, "The Evolution of Fresh Air Treatment." They will send this upon application to any nurse mentioning this magazine. If you are not familiar with the Walsh Window Tent, you should inform yourself at once. It is one of the most unique articles of the kind on the market.



The Modern Way of Buying Uniforms

The ready-made Dix-Make Uniform has put an end to the inconvenience, anxiety, time, and money loss of having your uniforms made to order.

The Dix-Make way is the simple way, the easy way, the modern way of buying uniforms. Costing practically what you would pay a dressmaker for a garment made to your measure, the Dix-Make Uniform, *ready to wear*, offers a style and quality of workmanship that dressmakers cannot be expected to give.

The manufacturers, Henry A. Dix & Sons Co., 116 West 14th Street, New York, will be glad

to send to any nurse their uniform booklet, which contains the information about styles, and assists you in determining what garment will be most appropriate for each requirement.



Colgate Talc Has a Direct Sanitary Effect

A talc powder which possesses positive antiseptic and disinfecting properties is offered in Colgate's Talc Powder, with its handy six-holed top controlling the flow of powder.

One of the best known firms of analytical chemists in the United States reports—after carefully testing Colgate's Talc—that it has a marked inhibitory action on the growth of virulent, pus-forming bacteria, such as staphylococcus pyogenes aureus, the bacillus pyocyaneus and the streptococcus pyogenes. It is also stated in the report that the perfume used in the Violet Talc adds directly to the value of the powder.

In addition to the Violet Talc mentioned, Colgate & Co. manufacture seven other perfumed talcs. The latest addition to the Colgate Talc family is the Baby Talc Powder, which possesses the same antiseptic and healing properties as the others, but is more delicately scented.



Antiphlogistine

Antiphlogistine provides the best, most agreeable and convenient known means of supplying continuous moist heat, in all inflammations. This can be maintained for 24 hours or longer, at a uniform temperature. Ordinary poultices soon become cold, clammy and uncomfortable to the patient and lose any remedial effect they may have had, before becoming cold.



Walter Baker & Co. Ltd. Receives Still Another Grand Prize

The Grand Prize for superiority of Cocoa and Chocolate preparations has been awarded to Walter Baker & Co. Ltd., Dorchester, Mass., at the Panama-California Exposition at San Diego. Only a few weeks ago this company was awarded the Grand Prize at the Panama-Pacific Exposition at San Francisco.

GLYCO - THYMOLINE

Is Indicated in the Treatment of

*Congestion and Inflammation of
Mucous Membranes in
all Parts of the Body*

**ALKALINE
ANTISEPTIC
EXOSMOTIC**

LITERATURE SENT ON REQUEST

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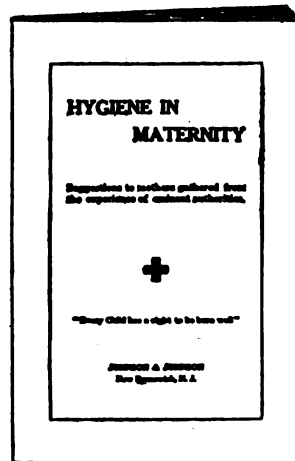
Hygiene in Maternity

PHYSICIANS generally would find their work easier, and could treat their patients with more confidence and satisfaction to themselves, if they were sure that their obstetrical cases were surrounded with all sanitary and hygienic means for their condition.

We have prepared a treatise on the subject of hygiene in maternity that we believe will fill a long-felt want in this direction, and which we offer free to the medical profession for distribution to patients.

It will supplement and aid the work of both physician and nurse.

We shall be glad to supply physicians and nurses with copies of this booklet upon request.



Johnson & Johnson

NEW BRUNSWICK, N. J.

When you write Advertisers please mention THE TRAINED NURSE

The Trained Nurse Must Keep Herself at Her Physical Best

THE professional nurse gives of her vitality so unflinchingly and so unceasingly that nature makes quick demands upon her for repayment. In my work, which has been the means of bettering the health and figure of over 70,000 women, I have advised and instructed thousands of women who have been suffering from worn-out muscles and weary nerves resulting from the arduous requirements of hospital and home nursing.

My instructions are always individual. You will find, if a friend of yours is a pupil of mine, that the advice I give her is as distinctly individual as that which I shall give you.

Naturally you wish to develop and retain the vitality which you must have for your duties, but even more than that you desire to build up and enhance the physical and mental poise and charm which is the duty of every woman. To weigh what you should weigh, to feel as you should feel, to radiate cheer and happiness—these are accomplishments which are normally and simply attained by my methods.

Simple and Scientific Personally Directed Instructions

I teach my pupils to stand correctly, to breathe properly, to exercise beneficially. A few moments each day are all that are required, and before long you are delighted to find that being your true self has become an unconscious habit with you. My exercises not only stimulate the body but they stimulate the mind, dispelling languor and depression and encouraging happiness and vibrant health. They will materially help you should you suffer from

Chronic Constipation, Indigestion, Anaemia, Neurasthenia, Weakened Heart Muscles, Undeveloped Lungs, Poor Circulation

Increase the resistance by strengthening the physical and nervous system.

Physicians Approve of My Work

when they know its character and, without exception, every physician who knows the details of my exercises, frankly welcomes my help in caring for certain classes of ailments.

The mental interest and incentive developed by the individual lessons, dispel that indifference which physicians often find hard to overcome in some patients. It is my custom to study each pupil's special requirements and prescribe for her individually. I give no promiscuous exercise, but direct each woman according to her needs and her strength. I have spent years in the study of anatomy and physiology, and accept no cases where pronounced pathological conditions are present, as I know the possibilities of my work and I realize its limitations.

In many cases I insist that the pupil has the consent and advice of her physician; in others a regular weekly examination by physicians is required.

For 12 years I gave personal instruction to women before attempting instruction by mail.

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Miss Cocroft has perhaps had a wider experience than any woman in America in prescribing remedial exercises for women



Stanolax

Stanolax acts in the intestinal tract as a lubricant and protective agent. It causes no irritation and no dissipation of strength.

The lubricant and solvent action of Stanolax removes all waste from the kinks and folds of the intestines, but without irritation.

It's especially indicated in the treatment of chronic constipation and intestinal stasis. Its action is purely mechanical.



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IN SUMMER—To prevent tan, sunburn and freckles, and as a clean-up after outdoor exercise.

IN THE NURSERY—More soothing to baby's skin than starch. A bed-time clean-up is a comfort and an aid to health.

FOR MASSAGE—It is ideal. Being easily absorbed, it promotes the nourishment and growth of the underlying tissues.

EVERY DAY—To keep the skin soft and the pores clean and active.



Important to the Nurse

"Every day in the year"

Everybody knows what 365 stands for, but to the nurse it has a new significance. It means S. E. B., uniform justly famous as a most graceful and smart garment for every one of the "365" days in the year.

The S. E. B. make uniform is strictly tailored, scientifically cut, assuring absolute fit and comfort, made of standard quality material, washes and wears well and retains its shape after laundering. It is an embodiment of the best in the art of ready made uniforms manufactured by S. E. Badanes Co., 151 W. 19th Street, N. Y.

Nurses of discriminating taste insist upon S. E. B. make. Sold at all leading stores.



Special High Operation Belt

The Storm Binder is unique in its adaptation to operations upon stomach, gall bladder and liver. In addition to giving a comfortable support to the incision, traction upon the site of operation is avoided, by extending the belt downward and supporting the viscera from below. This belt is unusually wide and has a second reinforcing band, and a high improved back.

In measuring for this belt, take one additional circumference, 2 inches above the upper end of the incision, above waist line.

When you write Advertisers please mention THE TRAINED NURSE

COLGATE'S TALC POWDER



*For the
Patient's
Comfort*

NOT only is Colgate's the *real* Boric Powder (see report herewith) but its wide choice of perfumes meets any preference that you or your patients may have for a particular scent.

Messrs. Colgate & Co.

In comparison with several other widely advertised talcums, I find that Colgate's Talc contains more than EIGHT times as much boric acid.

It also contains two other ingredients described in the U. S. Dispensary as being antiseptic, soothing and healing in their nature. They were not found in the other talcums examined.

(Signed)

A. A. Brenneman, M.Sc.
New York

Cashmere Bouquet	Tinted	Baby Talc
Monad Violet	Dactylis	La France Rose
Éclat	Unscented	Violet

A dainty trial box of Baby Talc will be sent you free if you mention this publication—also a trial size of Colgate's Charmis Cold Cream, indispensable for Cleanliness—Comfort—Charm

COLGATE & CO.

Established 1806

Dept. 5, 199 FULTON St., NEW YORK

Makers of Cashmere Bouquet Soap—luxurious, lasting, refined

The Publisher's Desk

The Trained Nurse and Hospital Review

A Monthly Magazine for Trained Nurses and Hospital Workers. Devoted to Trained Nursing in Private Practice and in the Hospitals of the Country

Managing Editor

ANNETTE SUMNER ROSE

Editor

CHARLOTTE A. AIKENS

LAKESIDE PUBLISHING COMPANY
PUBLISHERS

OFFICE—38-40 West 32d St., New York City

THE TRAINED NURSE AND HOSPITAL REVIEW

is a magazine of practical nursing and progress—not an organ. It is the magazine for the nurse who desires open-minded, free discussion of all nursing questions, and who expects to keep abreast of the times in regard to practical methods in the nursing field. The magazine with the courage of its conviction, which numbers among its contributors the cleverest writers in the hospital and nursing world.

Annual Subscription, postpaid	\$2.00
Single Copies	.20

Entered as Second-Class Matter at the New York
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Exclusive publication must be insured to all contributions offered to the Editors. Rejected manuscripts will be returned if stamps be sent for this purpose.

Exclusive publication not required for contributions to Nursing World Department.

Illustrations for articles are particularly solicited. All expense for drawings, plates, etc., will be borne by the publishers.

No responsibility is accepted by the Editors or publishers for the opinions of contributors, nor are they responsible for any other than editorial statements.

Books and monographs will be reviewed promptly.

Short, practical notes upon personal experiences or brief reports of interesting cases, with results from remedies new or old, will be welcomed.

The Editors and printers will greatly appreciate the courtesy of having all manuscript typewritten; or, if this is impossible, clearly written, great attention being given to proper names and medical terms.

Book Reviews—Continued

of a child's welfare organization. Its purpose is to place in the hands of the mother of moderate means, concise, readily understood, and practical instructions for the care of their infants and young children. It is divided into thirteen chapters, namely: Hygiene, Maternal Nursing, Artificial Feeding, Food Formulas for Well Infants, Feeding from Fifth to Sixth Year, Diet after the Sixth Year, Dentition, Ailments, First Aid to the Baby, General Instructions, General Considerations, Don'ts and Formulas. Every nurse engaged in infant welfare work should have a copy of this little book.

✦

Nursing Ethics—a Lecture. By T. Percy C. Kirkpatrick, M.D., Fellow and Registrar of the Royal College of Physicians of Ireland. Chicago Medical Book Company. Price, 50 cents.

The little booklet is dedicated to the nurses, past and present, of Steevens' Hospital, which was the first modern hospital in Dublin, and the first to welcome the services of the trained nurse.

✦

A Florence Nightingale Booklet

Nurses, and others interested in nursing, will, we feel sure, warmly welcome an attractive booklet prepared by Charlotte A. Aikens, outlining some of the important lessons which nurses should learn from the life of Florence Nightingale. The price of the booklet will be low enough for every nurse to own her own copy, and will make an appropriate gift book. The booklet will be available early in October. It is published by Lakeside Publishing Company and orders should be sent to the office of the TRAINED NURSE AND HOSPITAL REVIEW.

✦

Canada

Anastasia M. Walsh, R.N., has accepted a permanent district with the Victorian Order of Nurses. She has a large district of 17,000, with no street cars—not even jitneys. Miss Walsh is the first U. S. graduate to fill the position, all others having been English hospital graduates.

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Interdependence Between Hospital and Outside Work*

BY RICHARDS M. BRADLEY

Trustee, Thomas Thompson Trust, Boston, Mass.

THERE has been growing in the public mind a stronger consciousness that the hospital cannot be an isolated unit working independently in order to perform a certain function of usefulness, namely, the care and cure of those who come to its doors.

It has become more and more evident that the final test of a hospital's efficiency is not only how it handles the cases which it receives into its care, but what impression it makes directly or indirectly upon the *whole* sum of sickness and suffering in its community. From that point of view it can, under certain circumstances, be a total failure as to net results, while at the same time it is reasonably efficient in the details of its immediate work.

Just as we need a word to express the idea that a real hospital is not a building, but rather the work of a devoted body of men and women who happen to be occupying a certain edifice, so we need a word to express the general community work in preventing and handling sickness, in which work the hospital has its place. It is little or no credit to a community if a small part of its sick are well cared for, and the balance grossly neglected, and the hospital must

fill efficiently its proper place in a good general system covering the whole ground. With this more extended work, the hospital work is interrelated in countless ways, and the study of making those relations effective is only beginning.

The absorbing nature of hospital work produces, with average human nature, the defect of making the hospital too self-centered in its work. This is something so natural to a hospital management, that the intelligent hospital head must constantly fight against it.

In this conflict, it is possible that you can acquire some help as well as possibly some irritation from what I may call the stupid layman's point of view, a point of view so detached from your own that in its very ignorance of the many things that you know to be of vital importance, it may possible help you to see other aspects of the situation.

A canvass was recently made of two districts in New York City to ascertain, among other things, what impression the hospital work was making in certain classes of serious cases.

This canvass showed that out of a population of 17,000, 86.6-10 of the cases of

* Presented at the Convention of the American Hospital Association, San Francisco, June 15.

sickness were cared for at home, and not in the hospital, and that out of the deaths from typhoid and pneumonia, 70 per cent. of the typhoid deaths occurred in the homes, and 85 per cent. of the pneumonia deaths were in the homes, showing that a very large number of serious cases were not treated by the hospitals.

The question instantly asking itself from these figures is: by what system of selection did the hospitals receive some of these cases and by what system of selection did they not receive others? If, as seems probable, they missed cases that were in desperate need of their services, was it because they were filled by cases still more desperate, or if not, what was the cause? In other words, what was their relation to the whole problem of sickness and suffering, and what place, if any, did they hold in the comprehensive system for handling that problem if such system existed.

Another canvass was recently made of all ascertainable cases of sickness in a certain group of districts in Central New York, containing, in all, some ten thousand people. The circumstances of all ascertainable cases of sickness, some sixteen hundred in number, were gone into, so far as their conditions were ascertainable in order to find, among other things, what was the proper number of beds to provide in that community. The number of beds to be prescribed was figured out with great care and elaborateness from the cases apparently needing hospital care, but when conditions came to be analyzed, the problem ceased to be in any degree so simple.

Areas were found where the cesspools, taking care of an abundant water supply, were closely intermingled with the old family well, whose sparkling waters possessed a tang, lacking in the more insipid beverage offered by a town water company. Other areas existed where a sloping village site offered a succession of vaults and wells, with the vault given the preference as to altitude.

Our figures called for additional hospital accommodation for the abundant typhoid patient, but maturer thought suggested that a few well adjusted drain pipes would probably be a more radical and less expensive remedy for that particular ill.

Similar veins of thought were opened in all directions. Certain poor girls had no proper accommodations in their confinement, and more hospital beds were figured out. But, was not a permanent asylum for these feeble-minded and helpless victims, where they could be permanently cared for and protected, better than additional accommodations to enable them to burden the community with more offspring like themselves?

Many families had no fit dwellings to *live* in, much less to be sick or to die in. Was the remedy better housing or more hospital beds? Some of us were tempted to ask in our haste, "Is the hospital bed to be the place where all our other senses of social obligations shall slumber undisturbed until the day of judgment?"

Of course the answer to this problem is that the hospital provision must be an indeterminate quantity, tending to increase, as we learn and teach the people the proper uses of the hospital; and tending to diminish as we learn to apply effective methods of preventing disease, and as we learn to abate those social conditions that deprive too many of our people of real homes in which to die or be born. It will tend to diminish also as we succeed in developing a comprehensive system of home care that will prevent our hospitals from being overloaded with cases that could be cared for properly in the home, or could convalesce there under care, thus making room for more urgent cases.

To put things more concretely, some time in the future we may have correspondence somewhat as follows:

"To the Secretary of the Wisdom Bank Foundation,

Dear Sir:

I am directed, in behalf of the citizens' improvement association of Anyville, to seek your advice upon the problem of additional hospital accommodations for our city. A large increase of our population is taking place, as a result of the prosperity and expansion of our industries and a number of our leading and public-spirited citizens have requested us to ascertain what additional hospital accommodation should be provided for a town of this size, promising to contribute to a properly planned plant. Would it be possible for you to make an expert investigation of the situation and give us your advice upon that point?

Respectfully yours,
J. Smith, Secretary."

The following answer results after due process:

"J. Smith, Secretary of Citizens' Improvement Association, Anyville,
State of Average.

Dear Sir:

Pursuant to the request of your association, several agents of our foundation have made a careful survey of conditions in your town, the results of which we herewith furnish you in detail in the appended exhibits.

With reference to your question as to the number of beds which a town of the size of Anyville should have for the accommodation of hospital patients, we offer a schedule of a few special accommodations which we believe should at once be added to your present plants in order to accommodate a certain limited number of cases that cannot now safely be admitted to those institutions and are a danger to the community if left outside.

In addition to that, we would advise you that by instituting an inexpensive system

of home care for convalescents, the capacity of your present accommodations could, in our judgment, be increased by about ten per cent., and another fifteen per cent. of capacity could be added by giving the same home care to a class of patients who are sent to your hospitals, not because of the nature of their trouble, but because of the difficulty of obtaining responsible and efficient care at home. This home care, if properly organized through a health center, could be furnished at a smaller cost and without an expensive plant. We regret to find that in addition to these cases there are other cases in your hospitals who are there, simply because it is the easiest place to put them, regardless of the fact that there are numerous cases vitally needing the service of your institutions, of which cases the managements appear to be ignorant.

Although we believe that the use of your present plants can be made some thirty per cent. more efficient, present conditions in your city are such that some one hundred beds, if provided, could at once be filled with patients who have not now suitable care in sickness. The plant to accommodate these beds would cost some two hundred thousand dollars and their maintenance would amount to a charge of about \$70,000 per annum; irrespective of physicians' services.

We hesitate, however, to advise you to undergo this expense without going into the following considerations. A certain proportion of these cases are due to entirely preventable causes among which are the following: A large part of your city still clings to vaults and wells and a steady supply of typhoid is the result, the condition of your milk supply is neglected and, in addition to occasional milk epidemics, the children's ailments are very numerous. Your State offers no sufficient asylum accommodations for a certain class of feeble-minded women, and the calls upon your

maternity wards are therefore unnecessarily large. Your people are uninstructed in the matter of avoiding the spread of contagious diseases, and the work of your health officers is consequently largely perfunctory and ineffective.

One of the largest sources of candidates for hospital beds is due to your industrial conditions. Your prospering manufacturers are developing methods of organization that dispense so far as possible with skilled and well-paid labor, and make use of continually larger quantities of labor, willing to take low pay and to put up with extremely undesirable living conditions.

Some twenty-five per cent. of your population is already of the kind where the family occupy three rooms and take boarders. Your housing regulations are inadequate and their enforcement is a farce. Your operatives' quarter is squalid, neglected, unsafe and unsanitary and this condition seems to be on the increase rather than otherwise. It is obvious that a tenant of the usual dwelling in your main operatives' quarter has no fit place for either illness, convalescence or child-birth. If your city intends to perpetuate these conditions, the providing of some hundred additional beds as a beginning would seem the conventional thing to do, as a step in the way of palliation.

If, however, the reduction of these conditions should commend itself to you as more humane and more desirable, we recommend a more conservative programme. This would embrace, at the outset, only the slight addition to your hospital plant above specified and its more efficient use. It would require first a campaign of health education among your people through preventive medicine physicians, health officers and school nurses.

It would entail the removal of unsanitary conditions and reform in the administration of the health laws. There would also be needed better building laws, the forbidding

of room crowding, and the construction of decent and sanitary quarters for your wage earning classes.

It would necessitate the building up of a well-organized health center, which would have for its function the bringing together under a competent head for effective team play of the school nurses and the various kinds of nurses, graduate and non-graduate, who look after the sick. Such a center would act as a natural clearing house for service in sickness, being the first place of call in case of any illness. It would insure, so far as possible, that the cases requiring institutional care should receive it as soon as needed, and that the institutions should be promptly relieved of those cases no longer needing their service. This health center should not be a charitable institution or it will not be generally used. It should be a place where the average citizen can go in sickness to obtain help in meeting his emergency needs, and can obtain the kind of help required, whether household help or nursing at a fair price. We would expect to pay his bills for this service as for his other ordinary requirements. Where charitable funds are needed to pay for nursing or other service, they could be provided, not by nurses, but by proper administrators of charity. The average citizen, however, will be found not to need or desire charity, but to require some simple form of benefit insurance that will enable him to carry his family through those sickness emergencies which entail large and unexpected expenses irregularly distributed. He requires this kind of insurance just as he requires insurance for fires, accidents, or death and other emergencies. If he is not employed by a parasite industry that does not expect to support its employees, he can thus be kept from becoming a candidate for charity, either in or out of the hospital. Also, by this method your system can be given a sound financial basis for a full development, being supported by the classes

who support themselves and the rest of the country.

Those of your citizens, however, who can afford it will still have ample opportunity to benefit the community by furnishing funds for better plants; funds for research and development work and funds for better salaries and retirement funds for the now underpaid workers in the field of hospital and nursing work.

We are able in this letter to give only a bare outline of the course of action and system recommended, but we commend to you further study of its practical application elsewhere, before a large amount of your resources are devoted to purposes that promise palliation rather than remedy.

Very truly yours,
H. F. JOHNSON, Sec."

This is a very inadequate attempt to indicate the bearing of the larger problems involving the hospital. The question of what effect your hospitals are having on the whole problem, is going to become more and more insistent, and you have got to do your part in answering it. It means that more of you have got to be able to answer questions as to what happens to the cases that you do *not* get, and as to why you have so many cases put upon you that are not the ones most in need of hospital service.

I venture to bring to your attention one form of tabulated report that would tend to bring out how far your hospitals are answering this question of efficiency of *use* as well as those of efficiency of operation.

In almost every hospital there are the following classes of cases. The first I may call real hospital cases, namely: those that cannot, without undue trouble and expense, or without danger to the community, be cared for outside of the hospital. There

are plenty of these if you only get hold of them to occupy all the hospitals that we can maintain.

There are other cases that seek to enter the hospital for various reasons such as: for the convenience, financial or otherwise, of the family; for convenience of the doctor, because outside of the hospital there is no adequate provision for nursing or care, because the patient has no proper home to be sick in, etc.

These cases could be classified and tabulated as follows: Real Hospital cases, Defective Care cases, Defective Home cases.

There is another classification, namely that of the hospital days during which hospital patients are kept in the hospitals while convalescing because they cannot be sent out to proper conditions at home either from lack of organized care or lack of proper home conditions.

I do not know how many of you will venture to make such a classification but I do know that any hospital that does make it and makes it without fear or favor will add substantially to the efficiency of that hospital.

In addition to this I bespeak your sympathy and attention to the efforts that are now being made to coordinate and make effective in something like a comprehensive system, the forces that have to do with prevention and handling of sickness both within and without the hospital.

We need a system that will *cover the whole ground*, not fragments of it, and we need to have the hospitals and their graduates take their proper places in organizing that system.

The stupid layman wants to know what impression you are making on the whole job, and you have got to answer that question.

An Ideal System of Inspection for Nurse Training Schools

EVA BEECROFT

IT is by this time rather bromidic to say that, considering how young the science of nursing is, it has made most wonderful strides. Everybody says it. It is, however, true, and to use the statement as the introduction of an article on any one system in this science, is merely to express wondering praise for something which could yet, and, we confidently expect will be, better still.

There are many features in the present methods of school inspection—whether for the health of public school tots, or for the drills to secure safety in fires, whether for the purpose of determining efficiency in a teaching staff or the value of hospital equipment—which permit errors to creep in that embarrass officials who are honestly trying to do their duty, and leave serene and unscathed those who are merely bluffing to nab a good salary. How to avoid these errors in nurses' schools is the subject of this sketch.

Just as it is imperative to have pupil nurses well taught and closely supervised; not only to correct, but to prevent mistakes, and to supply an adequate number of supervisors with a *standardized* technique, so it naturally follows that the head of every training-school should feel herself responsible to a very "live wire" in the person of an inspector, for the maintenance of State methods.

But, to do the inspecting most efficiently in a State as large as Pennsylvania, or with schools as full as those in Illinois, for example, the State must employ at least four inspectors, each of whom is relieved from all clerical or departmental work, but carries on a living, enthusiastic inspection or head-nurse-ship over the whole of her district.

Her reports will tend greatly towards clearing up the old-fashioned ideas of local hospital boards. Her visits will probably cause in the pupils a finer *esprit de corps*, a desire to help their superintendent to outclass other schools. Her inspection will have great weight with the medical board, if they see her scouting in the wards, dealing with concrete things, watching one nurse make a sinapism, another give a Murphy drip, or yet another serving trays; while a fourth bathes a baby. They will also be vividly impressed with the feeling that they must teach the nurses carefully, so as to get the best results for their patients.

It is not necessary for any special date to be set for an inspection, because a hospital cannot have an upheaval of preparation for it. The condition of the patients and the daily rounds of the physicians forestall that.

It is natural, however, that all the hospitals should be inspected in one vicinity at one time. But the inspector does the superintendent the courtesy of telephoning her a day ahead to secure her being on duty. She might be ill, or off duty for her afternoon, doing hospital shopping, getting a class photograph taken, or any other of the multifarious littlenesses that make up one's institutional life.

While an assistant may be very capable, she has only fixed duties, and all theories, ideals, plans for the future, arrangement of classes, reports on existing or hoped-for administrative conditions, rest only with the directress of nurses. All corrections of errors should be made to her directly, not through any medium.

On the inspector's arrival, she clears up the clerical end of the task first—the nurses'

records. These are rather complicated.

1. The card of admission to the school, obtained from the State Board of Education before the pupil arrives. Exceptions to this should be grouped, and the actual work they are doing in night school to reach the desired point should be shown on cards signed at regular intervals by their externe tutors. If a nurse should have a modicum of education, it is in her *first year* she needs it most, not to help get her diploma, and I think it wrong to encourage girls to cram at night school a few hurried, ill-digested subjects that are not directly connected with hospital work. Besides, when a pupil gets her card of admission, she should see it herself, deposit it in the hospital safe, and receive in exchange for it a small pin to be returned at graduation. It follows, too, "as the night the day," that all R.N.'s. should wear a simple unostentatious pin. It would be very interesting to know how many registered schools in New York City have pupils in their third year frantically cramming some high school subjects to get out.

2. The card showing the pupil's length of service and demonstrations witnessed and redemonstrated by her in all kinds of wards, medical, surgical, obstetrical, etc., as well as her deportment, errors in work, and particularly her fine points—practice card.

3. The card showing each lecturer's signature for her marks obtained on his examinations for all years.

4. The lecturers' register, showing when the physicians or other teachers arrive and depart, or miss a class.

5. The list of operations, maternity cases, medications, diets and treatments for that day.

Armed with this latter, after thoroughly investigating the former, the inspector proceeds to the wards. She meets a nurse, asks her name, and looks over her demonstration card which the pupils carry like their scissors, everywhere, and finds

"douche" listed, which is due now on the treatment list given her in the office for that ward today. She requests this pupil to show in the work room how to give a douche to an "up" patient, how to note results, clean up, disinfect utensils and prepare one for a bed patient. If there are faults in the pupil's work due to ignorance or nervousness, these go down in the inspector's report against the teaching staff, showing lack of frequent supervision and bad management in allowing such a nurse to endanger all these patients.

This method can be employed in any work that the pupils do, whether charting, dusting, making dressings, giving a hypo, or acting as unscrubbed nurse in an operation. Unfortunately there are differences in technique in many hospitals. The notes taken in silence are reviewed with the operating-room supervisor when she is at leisure.

Each supervisor wearing her R.N. pin, this is embodied in the report to the local governing board and to the State board.

After seeing the treatments done, which does not take long, since an inspector soon can note with the flash of an eye all salient points, she questions any or every pupil in turn about the symptoms and medication of those patients under her immediate care. The pupils are given the diagnosis as early as it is made, even the tentative, and they couple with that the accompanying symptoms, etc., as per their text-book. Here again, if the pupil flounders, the error is charged to her supervisor to find out whether the latter had noticed these symptoms and instructed the pupil in what they signified.

The administration of medicines by hypo, inunction, etc., is also taken up, since the visit of the inspector lasts some hours. She can determine whether any are forgotten or overdue.

The manner of the pupils, whether they fumble or color up, hesitate, or run about

like a chicken with its head cut off, are all indicative of one thing, that they have not been sufficiently drilled, and have no self-confidence. With the presence of physicians in the ward, an inspector's presence need not interfere at all, since work must always go on.

Lack of supplies, bad management, the main methods of the office and the medical staff can all be read in one visit to a hospital.

In the evening the classes should assemble by their year, and answer questions relating to duties performed by their grade, showing whether each class has its proper rank, or whether by mismanagement, seniors are left doing probationer's work. They are questioned to find out if they have absorbed the principles involved in running a ward, in ethics, and in relation to the world they soon must face.

The nurses' dining-room, with its infectious laughter, and its steamy odors, its doubtful foods and hurried service, come in for a critical friendly survey also, to determine one of the big causes of dispirited inefficiency.

Their rooms, furniture, privileges, laundry arrangements, social life, recreation, and all the other features of a troublous, complicated existence are carefully and sym-

pathetically entered into, from the *pupil's* standpoint, to provoke a sentiment that will express itself in happier terms by and by, through brick or stone, plumbing and decoration, the cuisine and the library.

One danger lies, for all hospitals, in getting work, drudgery, not nursing, out of the pupils, to save expense. Another is that supervisors make rounds with the physicians, instead of teaching and nursing, and letting the pupils make rounds to learn diagnosis and treatment. Boards think largely in dollars and cents, but the crying needs of a group of pupils is reflected a thousandfold in the discomfort of the patients due to errors in their treatment. A board is twice as responsible for its pupils as a university, since they make or mar the recovery of the patients, for whom they stand directly and voluntarily in trust to the community. A workman is known by his tools, and to the board the training-school is the tool, but it must be kept well tempered, sharp and bright. This bears fruit in a future crop of high class pupils. The inspector is the State's tool to operate for this result. If a board does not comply with the reported requirements in a specified time, it should lose its status, and be publicly condemned by its own townsmen.

A THOUGHT OF COMFORT

Hast thou a care, whose pressure dread
Expels sweet slumber from thy bed;
To thy Redeemer take thy care,
And change anxiety to prayer.

Hast thou a hope, with which thy heart
Would feel it almost death to part;
Entreat thy God that hope to crown
Or give thee strength to lay it down.

Hast thou a friend, whose image dear
May prove an idol worshiped there?
Implore thy God that ought maybe
A shadow between Heaven and thee.

Whate're the care, that breaks thy rest,
Whate're the wish that wells thy breast
Spread before God that wish and care,
And change anxiety to prayer.

A. M. L.

Eye Nursing

HENRY GLOVER LANGWORTHY, M.D.
Dubuque, Iowa

WORKING OR DIOPTRIC SYSTEM OF EYE

PART V

IN THIS final chapter we have to do with the refractive system which has to be understood to some extent in order that the nurse may rightfully consider that she possesses special training on the subject. Indeed, on the whole, an understanding of the matter embraced in this lecture is absolutely necessary for any intelligent conception of questions centering about eye disease. As in my class work I shall be forced to largely dismiss the anatomy and physiology of the organ by asking that the nurse read over carefully anatomy and physiology as given in her text-book of anatomy and to draw the following two drawings: (a) a cross-section of the eyeball (Fig. 29); (b) a sketch showing the lachrymal tear drainage system (Fig. 30) and its relation to the nose. The making of two such drawings will go far toward creating an excellent understanding of the anatomy of the eye and for this reason in the classroom I usually allow these drawings when handed in, to count as one question in the hospital examination. In addition to the above the nurse is also expected to look up the terms, optics, light, ether vibrations, luminous body, rays, refraction of rays and focus.

From a working standpoint the eye may be rightfully considered an optical instrument similiar to the ordinary photographic camera in which by means of a refracting or so-called dioptric system a small (inverted) image of external objects is formed on the retina. The impression is received by the rod and cone layer of the retina and is carried backward by the optic nerves to

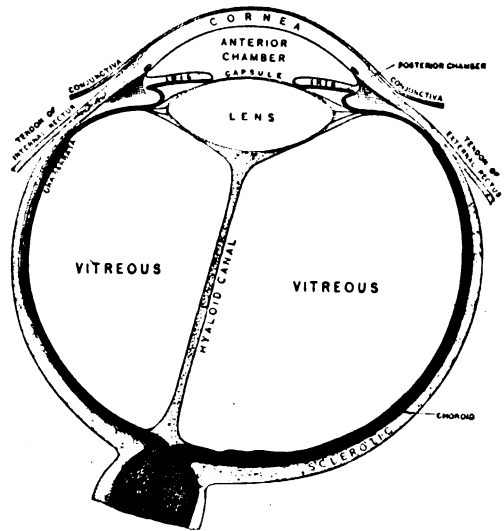


FIG. 29—CROSS SECTION (HORIZONTAL) OF THE RIGHT EYEBALL. (GERRISH AFTER TESTUT)

the visual area of the brain (occipital lobe). Here it may be said the visual act is finally completed (image properly interpreted and reconstructed to an upright picture) resulting in what we call the sense of sight. In the case of the camera the images of objects at different distances are obtained by placing the plate nearer to or farther away from the lens. In the eye, however, the distance from the retina to the lens remains constant and the adjustment for different distances is made possible by changing the focal length (increased thickness) of the lens itself. If the normal eye is perfectly relaxed the lens has just the proper curvature and thickness to focus all distant objects upon the retina without effort and there is no so-called error of refraction. On

looking at near objects, however (nearer than twenty feet), the eye must normally accommodate itself to them.

MECHANISM OF ACCOMMODATION

Theory of Accommodation—to reiterate—since the globe of the eye is inextensible there must be some other mechanism in the eye possessing the power of adapting its refraction (focussing) for different distances or in other words to accommodate. Accommodation is this power of altering the focus of the eye so that rays of light nearer than twenty feet are brought together on the retina and made to form a clear image. The degree of accommodation therefore normally varies for each and every distance. The exact mechanism is well described by Dr. May as follows: "The lens is an elastic structure, and when released from the flattening influence of its suspensory ligament tends to assume a spherical shape. During accommodation, the ciliary muscle contracts drawing forward the choroid (middle coat of the eye) and relaxing the suspensory ligament; this diminishes the tension of the lens capsule and allows the inherent elasticity of the lens to increase in convexity. The change in curvature affects chiefly the anterior surface of the lens."

SYMPTOMS OF EYE-STRAIN

Glasses are prescribed as a rule for two reasons: (1) To allay headache and pain about the eyes due to eye-strain and (2) To improve either near or distance vision. The vast majority of people under forty years of age do not consult the eye specialist for poor sight but for such symptoms of ocular discomfort as headache, brow-ache, difficulty in maintaining distinct images of small letters in print for any length of time, blurring of vision, twitching or heaviness of the lids, ocular discomfort in a bright light, watering of the eyes, etc. Indeed the symptoms of eye-strain may be many and exceedingly varied. Perhaps the most char-

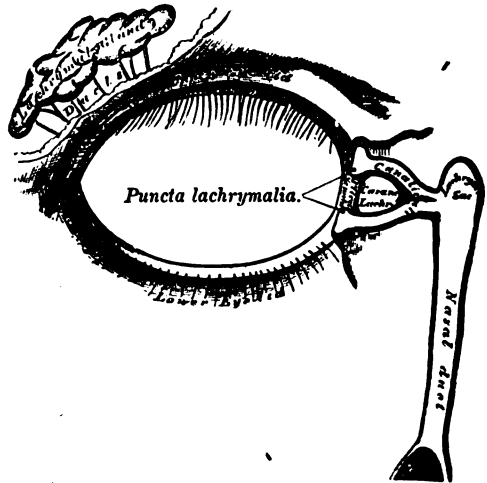


FIG. 30—LACHRYMAL (TEAR) DRAINAGE SYSTEM OF THE EYE (RIGHT SIDE) AND ITS CONNECTION WITH THE NOSE (GRAY)

acteristic feature, however, of eye-strain is in the main that the discomfort of headache comes on after use of the eyes and ceases with a few hours or night's rest. Sick headaches or shopping headaches are usually due to eye-strain. Astigmatism is often responsible for the most aggravated cases of eye discomfort. According to de Schweinitz: "Over one-half of all functional headaches are caused by this type of error either alone or as is more frequently the case associated with other forms of ametropia." There may also be various reflex disturbances such as dizziness, nervousness, pain in the neck or between the shoulders, nausea, etc.

HEADACHE A SYMPTOM

The subject of headache is an important one from a practical standpoint and of interest to every nurse. In considering this question it is quite necessary that special emphasis be laid on the fact that headache in the main must be accepted as a symptom and not a disease. Headaches result not only from local anomalies of the ocular apparatus but may also be caused by organic lesions elsewhere. At the start, however, we may grant with safety that

about seventy per cent. of all headaches are due to eye-strain and usually cured by wearing glasses. Eye-strain can be easily regarded as the most important single cause of headache. Every case of persistent or recurring chronic headache if not clearly shown to be due to disease of some other organ should have a thorough eye examination by a skilled oculist.

FAR-SIGHTEDNESS OR HYPEROPIA

In this form of refractive error the eyeball is anatomically too short so that parallel rays of light are brought to a focus behind the retina. In order to correct hyperopia so that rays will be brought to a focus exactly on the retina, a convex lens (converging or plus lens) must be placed in front of the eye to bring the normal focus farther forward. An eye turning *in* (cross eye) is usually far-sighted. Hyperopia is nearly always congenital, the majority of all eyes being far-sighted with often astigmatism. Since the far-sighted eye (unlike the normal) must constantly accommodate for all distances the condition is abnormal and throws too much work upon the muscles concerned in accommodation and therefore fatigue (symptoms of eye-strain) follows. Distant vision in the far-sighted eye usually registers normal but the vision is good only for the reason that there is a constant effort being made by the eye to see distinctly. Reading and close work especially in far-sighted eyes is accompanied by still greater muscular effort.

NEAR-SIGHTEDNESS OR MYOPIA

In this form of refractive error parallel rays of light are focussed in front of the retina. The eye-ball is anatomically too long so that the retina is situated behind the principal focus of the eye. In order, therefore, that the short-sighted eye may see distant objects clearly and the rays be brought to a focus (moved backward or dispersed) exactly on the retina, a concave lens (minus lens) must be placed in front of

the eye. Near-sighted eyes are to be regarded as sick eyes. A small per cent. only of people are near-sighted. Various pathological changes occur in the interior of the eye in high degrees of myopia which may result in more or less blindness if unchecked. Eyes turning out (diverging) are usually myopic. A near-sighted condition, especially in the young, is apt to become rapidly worse unless glasses are worn. The defective distant vision can usually be brought up to normal by proper correcting glasses.

ASTIGMATISM

In this form of refractive error the refraction of the two principal meridians of the cornea (vertical or horizontal) is unequal. Astigmatism, therefore, does not involve the matter of length of the eyeball (as in far and near-sightedness) but is that of unequal corneal surface. The cornea, instead of being curved in all directions like the ordinary sphere, is egg-shaped, *i.e.*, curved more in one direction than another and this unequal curvature through which rays of light must pass to reach the retina, makes accurate focussing and clear fine vision well nigh impossible. The presence of astigmatism is apt to intensify all of the ordinary symptoms of eye-strain and is an especial cause of so many reflex nervous symptoms both about the eyes and head as well as in distant regions of the body.

PRESBYOPIA (SO-CALLED OLD SIGHT)

The power of accommodation diminishes (the near point recedes) as one grows old chiefly owing to the loss of elasticity of the lens which will no longer respond to the releasing action of the ciliary muscle. Old sight is a physiological change affecting every eye and beginning between the ages of forty and forty-five years of age. Since the power of accommodation is thus gradually lessened we must ordinarily supply that defect in power by a suitable convex reading lens (magnifier) sufficient to bring the near point to a convenient distance and make

the print clear. The symptoms of presbyopia are as follows: Near point gradually recedes until the patient is unable to read or sew at a convenient distance and work is then often held at fully arms' length. The threading of needles, fine work in a poor light, etc., also becomes difficult and the patient is conscious that the eyes are at

fault. The normal reading distance should roughly be considered about fourteen inches and failure to read well and comfortably at this distance indicates a need of glasses. Many young people are found lacking in accommodative power fully as much sometimes as older adults.

(To be continued)

My Personal Experience With Tuberculosis

B. G. M., R.N.

"EXPERIENCE is a hard schoolmaster," and "We learn by our mistakes." These are maxims which are familiar to all of us. Since in search of health I have been doing some hard work under this schoolmaster, and learning lessons by my many mistakes which may prove of value to others similarly situated, I have no apologies to offer for making public this brief sketch of my three years' search for a cure for tuberculosis.

Let me recount my mistakes. In the first place, I should have gone to a sanatorium as soon as I knew of my trouble, but I thought I knew how to take care of myself and, being a nurse, my friends thought the same. I did not know how to take care of myself and many of you do not, unless you have been to the right kind of tuberculosis sanatorium.

When one has tuberculosis, doctors usually advise the right treatment, but it seems almost impossible to adhere strictly to the many rules which they lay down until after one has had the training in a sanatorium. There we are taught to do the right thing at the right time. I was advised to go to a sanatorium, but I delayed two years before taking this advice, growing continually worse during that time. I

have recently spent a year at the Agnes (Phipps) Memorial Sanatorium in Denver and, as a result, am now on my way to recovery. Had I come in the first place, I feel confident that I should have saved two out of these three years. And again, I should have given up work sooner; I should not have tried to economize on my board; I should not have visited friends, especially in cold weather. And last, but not least, I should not have constantly changed from one place to another.

My first attack of tuberculosis was in 1901. It took me over two years to recover from this attack. Of this time I spent four months in bed, six months on a farm, and the following winter I spent six months in Pinebluff, North Carolina. In 1904 I was able to return to my hospital position. I then worked steadily for six years, with the exception of a seven weeks' illness and a month's vacation every summer. The last summer, however, finding myself breaking down, I spent two months in the Adirondacks, but the following year the disease had definitely relapsed. I did not realize then how much harder it is to recover from a second breakdown.

The only way to fight tuberculosis is by raising the body's power of resistance to the

highest point and then letting it fight against the disease. Now to do this there are six cardinal points which must be observed. None of these can be slighted if we wish to gain results. They are, first and foremost, rest; second, fresh air; third, nourishment; fourth, contentment; fifth, climate; sixth, exercise.

Few people realize the necessity of rest, absolute rest, flat on one's bed with only one pillow, ten hours at night and at least one out of every three hours during the day.

"Keep a-restin'

If you strike a 'temp' of one hundred and two,

Keep a-restin';

If you burn thro' and thro',

Keep a-restin';

'Taint no use to pout and whine

'Cause the mercury goes up the line—

Shake it down and keep on tryin',

Keep a-restin'."

—R. W. B.

In this part of the country, resting is called, somewhat paradoxically, "chasing," or "chasing the cure." An hour's chasing is always required at the sanatorium before and after meals. Much harm can be done even in one day by neglecting this one thing, rest.

Second, fresh air. In the two years I have been in Denver, during which time my trouble has cleared up seventy-five per cent., I have slept on an open porch every night with the exception of about ten or twelve, when there were severe storms. I would cover my bed with canvas and stay out in the snow even if the thermometer went below zero, often from one to twenty degrees below, and one night it fell thirty-four degrees below. One must be guided in this matter, however, by one's doctor, as individuality is so marked in this disease, that what is safe for one patient is not for another. I kept warm and comfortable by having an electric pad. I also used the Walsh Capote, the hood of which draws down over the face, and the cape protects the shoulders. Then, by placing a piece of

cotton over my nose and fastening it there with a small strip of adhesive plaster (or I would have had a swollen red nose in the morning) I would enjoy a most comfortable night's rest, inhaling pure, brisk, fresh air. In the morning, often shaking the snow off my bed, I would rise rested and refreshed. I then went into my warm room to take a cold chest bath and to dress. I also had a Kenwood sleeping bag, convertible into a square blanket. A paper blanket is good to keep out the dampness. The use of ordinary bedclothes and hot water bags is not sufficient for many people in extremely cold weather. In sitting out on the porch, the Kenwood sleeping bag forms a covering for the lower part of the body, a heavy cape for the shoulders, and a hood for the head so that one can sit out in the cold wind or in the snow quite comfortably. By this means I could spend twenty out of twenty-four hours out of doors.

Third, good nourishing food. It is far better to pay for *good food* and not to economize on your board. But over eating is just as dangerous as not eating enough. To eat the right kind of food, and the quantity that will enable you to hold your weight and strength, is the important thing. Warm milk directly from the cow is especially good for some people. Most doctors say the less medicine one takes the better. Medicine is sometimes necessary, however, to alleviate complications. Digestive complications are often brought on by forced feeding and unnecessary medicine. One must beware of both these mistakes as the stomach is one of the most important mainstays in fighting the disease. On this subject I speak from unhappy experience.

Fourth, contentment. Bar out with all your will power any homesickness, worry, disappointment or fear. They only serve to greatly aggravate one's condition and retard one's recovery. Accept bravely and gallantly this new experience, and get from it all the good you can. There are deep and

lasting lessons to be learned from it. Therefore, agree with thine adversary quickly. Learn to turn even a loving face to the seeming enemy. My motto is, "Whatsoever be Thy will, I will always try to be contented still."

Fifth, climate. Select a climate that agrees with you and *stay* there. Doctors say patients with small means often do better than those with plenty, because they cannot afford to go from place to place. That was one of my mistakes. I have already told you I went to the Adirondacks for two months, then I was on the hills of West Virginia for one year, on a farm in Ohio three months, also visiting in Ohio, Iowa and Missouri for four months. Then I was in El Paso, Texas, six months and, finally, I went to the Agnes (Phipps) Memorial Sanatorium in Denver.

Sixth, exercise. Here was another of my mistakes. I neglected to take properly regulated exercise until my weight went up to two hundred and ten pounds. Then my troubles were increased by many distressing stomach, heart and nerve symptoms. But the amount of exercise and the hour at which it should be taken should always be prescribed by the physician and strictly followed out by the patient. One should never hurry or over exert himself in any way, knowing that recovery depends upon paying attention to small details as well as to big ones.

The resistance gained after overcoming the disease must be held steadfastly for many months before one tries to take up work again, therefore, it is necessary to take properly graded exercise to gradually get to that point.

Now just a word about avoiding infection. Sputum cups are easily obtained and useful on the porch or in the house; a pocket sputum cup may be used elsewhere. I have found paper handkerchiefs both convenient

and economical on the street. After using one I slip it into the open end of an envelope which is standing upright in my hand bag for that purpose and burn as soon as I return. All my letters I open at the narrow end of the envelope, seal up the open places, if there are any, and use such envelopes for this purpose. Gauze and paper bags cost more, and are not quite as impervious as envelopes and paper handkerchiefs. One should use handkerchiefs preferably of paper or gauze before the mouth to catch the spray while coughing. Experiments have shown that the spray from coughing is often projected four feet. Mixed with the dust and other particles in the air, it becomes a grave source of infection. One should use an antiseptic mouth wash and should cleanse the hands frequently. Never moisten stamps or envelopes with the mouth. Keep the clinical thermometer in an antiseptic solution. It is necessary to sterilize the dishes one uses by boiling. Laundry, too, should be disinfected. It is often a source of great danger to laundresses.

We so often hear it said and see it in print that graduate nurses are afraid to nurse tuberculosis, which so many undergraduates take up without hesitation. Why should a nurse fear it any more than any other disease? With good health and precaution there is no danger. A lady of my acquaintance has kept tuberculous patients for eight years, and several of them have died. She and her daughter are well and strong after this long, constant, close contact with the disease. I have met many nurses, who have nursed for years among tuberculous patients. They have never contracted it and have no fear of it. Such nurses should observe two things; first, they must keep up their own resistance; second, they must see that they themselves, and their patients, strictly obey the rules that guard against infection.

From the War Zone*

AMERICAN WOMEN'S WAR HOSPITAL

PAIGNTON, SO. DEVON, ENGLAND, AUGUST 30, 1915.

DEAR EDITOR: It is a decided relief in this land of strife and turmoil to turn one's thoughts to our own dear America and mine are often with my friends in my dear old home town, Huntington, and it has occurred to me a letter direct from the zone of this barbaric European war might be of interest.

There were three American Red Cross nurses who left with me on the U. S. M. S. St. Louis from New York for Liverpool on June 12 last. We had a most delightful trip, the weather man was good to us, as also was Father Neptune. All our interests were centered on what might happen when we entered the war zone. During the latter part of the following week when we neared the zone the lifeboats were lowered and made ready for instant use. Everybody had been assigned to a certain boat and had been drilled, as in a fire drill, in the method of entering the boat. That night the American flag was kept flying from the masthead with a search-light thrown upon it. "American Line," in large white letters, was painted on the side of the ship and lighted with electric lights. One would think we were in the Hudson River, taking part in a pageant. Everybody slept on deck with their clothes on and life belts under their pillows.

Saturday morning we passed the place where the Lusitania went down but a few weeks before. We arrived at Liverpool on Sunday at about 9 p. m., without mishap and having seen nothing but a lot of mine sweepers and patrol boats guarding the harbor.

After a ten hours' railroad journey from

Liverpool through the heart of old England, we arrived at our destination, The American Women's War Hospital, Paignton, Devonshire.

The hospital, "Oldway House," the summer mansion belonging to Paris Singer, had been turned over to the A. W. W. H. Association and converted into what is probably one of the finest, if not the finest, and best equipped hospitals in all Europe. Mr. Singer also gave \$25,000 toward its equipment. It is situated upon a hill behind the town of Paignton in beautiful Devonshire, the land of sunshine, junket and cream. From its balconies can be seen five different towns, Tor Bay and the English Channel. The hospital has fourteen bright and airy wards in which are beds for 250 patients. The operating room is perhaps the finest in England. Special walls have been built and floors laid so that the whole can be kept surgically clean (aseptic). On the second floor is an up-to-date X-Ray room. The wards are all named after women of the committee who are American born or who married Englishmen, and now make their homes here. They are named as follows: Astor, Churchill, Crocker, Hadfield, Harcourt, Jean, Loughlin Leeds, Mary Burns, Marlborough, Munsey, Paget, Singer and Vanderbilt. Munsey, the largest ward of all—containing 67 beds—was originally the gymnasium, and is apart from the main building. It is the most popular ward in the place, for the reason that the patients are all together, and that the most serious cases can be more conveniently taken out of doors into the sunlight. Close to the Munsey ward is the St. George, which has just recently been transformed from a swimming tank and

*The letter is published by permission of Dr. John P. Heyen, father of Miss Louise Heyen. It was also published in the *Long Islander*.

riding school to a ward of fifty beds. The wards are all most completely equipped, every detail having been looked after.

The staff consists of six American doctors, of which Dr. Howard W. Beal is the surgeon-in-chief. The nursing staff consists of twenty-four American Red Cross nurses and about twelve English nurses, besides eighteen young English ladies who give their services as helpers to the sisters (the Red Cross nurses are called Sisters here) or do whatever they can about the wards. Sir William Osler, Bart., F.R.S., is the consulting physician. The medical staff live at Little Oldway, a quaint Old World house on the grounds. Farnham, another old house, is the nurses' home, and Mar Plaisir, a house just outside the grounds, is the night sisters' home. Nothing that can add to the comfort and care of patient, doctor or nurse has been neglected.

Many have claimed that the unusual success in difficult cases with which the hospital is credited is due to this fact.

On my first night of duty we received a convoy of wounded from the front (trenches). The train arrived at the station at 1:30 a.m. The wounded were brought to the hospital in Ford ambulances and private conveyances. All the staff—nurse and doctors—were on hand to greet them and give attention. In the main hall the men are assigned to the various wards, where they are given a bath, and, if necessary, immediate surgical attention, and a bowl of hot soup and put to bed; a bed with clean sheets and flannel blankets. The poor fellows had not seen a bed nor had they had a bath for weeks; some not in months. They slept like babes. Is it any wonder? Occasionally during sleep someone would call: "The Germans! The Germans! Kill 'em! Kill 'em!"

Many sad tales the "Tommies" have to tell of their life in the trenches. Private Pat went out to make a charge with seven hundred others; only two hundred came back. He was badly wounded in a leg and

was deaf and dumb from the shock; only now is he beginning to talk and realize where he is. Corporal A. was in his trench with his men waiting to make a charge on the enemy's trench, which had been mined and timed to blow up at 7 o'clock; at 6:55 their own trench was blown up by the Germans. When he came to himself he was lying in a heap of dying and wounded. A Royal Army Medical Corps man came along and gave him a dose of morphine to ease his suffering until he could be moved to the field hospital. It was found he had a compound fracture of both legs and an injury to his back. It will be months before he will be able to leave us. On the table beside his bed is a photo of his wife with infant twins. He has never seen the twins.

Smith, only 19 years old, had 57 shrapnel wounds and his left arm shattered by a hand grenade. He was brought in in a box similar to a coffin. One might say his whole body was a wound. Today he is walking around, the pet of the doctors and sisters. The cases might be multiplied, but enough.

Those who have pieces of shrapnel or bullets removed from their bodies seem to be very proud of them and keep them to have made into watch charms, etc.

We have also had a large number of cases of gas poisoning. A gassed patient suffers about the same as a person with a bad attack of asthma. It takes them a long while to get their strength back. In the trenches when they are gassed some climb right out of the trench, so as to be seen and shot by the enemy, rather than live and suffer the terrible agony; others tear their throats until they bleed.

Since beginning this letter we have received 125 wounded and sick from the Dardanelles. Most of them were present at the famous landing at Gallipoli. Most of them have dysentery or jaundice, besides being wounded.

Drinking water was very scarce at the



BAINES' NEWS SERVICE

RUSSIAN RED CROSS NURSES

Dardanelles and difficult to get at. A good many times the Tommies went three days without a drop of water to drink, and then under cover of the night a few would volunteer and crawl out for water; always some would be shot before returning, as the Turks kept their guns trained on the water holes. At best the water would be muddy, with dead Turks lying in the other end of the little stream, the only source of supply.

The flies were so thick they were obliged to eat their food, consisting mostly of bread, jam and canned milk, at night. If they tried to spread a piece of bread with jam during the day there would be more flies than jam and it could not be eaten. The heat was intense, and often the rations would spoil before they could be consumed. While the boys were telling of these horrible conditions, conditions sure to breed a malignant form of typhoid, under ordinary conditions, I thought what a debt of grati-

tude humanity owes the discoverer of typhoid vaccine! We have had but one case of the disease all summer. Thus are we conquering disease through science and destroying life with bullets.

With all the suffering and distress there is a prevailing air of cheerfulness throughout the hospital. Surely the English soldiers are wonders, for, badly wounded as they are, many of them, they are bright and happy. The patients who are well enough pass their time making sandbags, knitting and putting together jig-saw puzzles. Those able to be out on the lawns enjoy lawn bowling, handball and croquet.

Am afraid my letter has been too long.

Our motto: "To care for him who shall have borne the battle, and for his widow and orphan, to do all which may achieve and cherish a just and lasting peace."—*Abraham Lincoln.*

Most sincerely,

LOUISE S. HEYEN.



Practical Experience in Nursing the Aged

ANNA L. SMITH

ACRYING need of the nursing world of today is the more thoughtful care of the aged sick. Doctors and nurses, as well as the laity, have gone mad over surgery, the prevention of infant mortality, twilight sleep, etc., and to the complete disregard for our old folk.

Even the modern hospitals and training schools devote little time or place and take very little interest in the care of the senile patient. The "Old Chronics" as they are disrespectfully classed, are crowded back into the smallest, darkest rooms and wards while the larger, more airy ones are reserved for the surgical patient. Now, why should this be? Our old people deserve better, I am sure! Why should not their wards or rooms be made more comfortable and attractive, more home-like and less hospital-like? In their case, it should seem that some of the "iron-bound" rules could be relaxed and the patients generally less neglected.

The directors of a training school should see that the pupil nurse, when detailed on duty in a "Grandma" ward or given charge of a chronic or aged patient, does not sulk and feel slighted or form the idea that she has nothing to learn. She should be impressed that this is the opportunity to cultivate those most necessary traits of a successful nurse, namely: tact, patience, cheerfulness, sympathy — sympathy untinged with pity, and the power of close observance.

To the nurse who contemplates entering the field of private practice, no other service will avail her so much.

In the three years of my private practice, fifty per cent. of my patients were men and women past the age of sixty years. Owing to this fact, I found it necessary to work

out and originate a method of my own, a method which may not meet with the approval of all owing to its variance with established rules of nursing, but one that I have found to be successful. This method may be of interest to the pupil nurse or to the nurse just entering the private practice field.

We all know the prevailing characteristics of old people, how they feel that they are in the way, that they are not loved nor wanted, that they have performed their service in the world and no longer have anything to live for. This mental attitude often renders them dissatisfied and unhappy, many coveting the end long before their allotted three score and ten years. Just why our old folks should form this impression, I cannot say, unless the younger people are so busy and self-absorbed that they really do neglect those dear ones to whom we owe so much. However, this may be, the impression prevails and while it makes our aged ones unhappy in health, it renders them almost impossible to save when sick. The "have nothing to live for" idea robs them of that all-saving will-power, without which, the efforts of physician and nurse are fruitless. Therefore, in these cases, a nurse's chief assets are cheerfulness, a true love for and an understanding of this class of patient, also, the ability to make them feel that, after all, they have a great deal in life to live for and that the world really could not get along without them.

My method, as stated before, of necessity varies widely from the care given my general run of patient. For instance, on entering the room of a sick child, or any other patient but an aged one, should I find the room crowded, close or untidy, I very soon disperse the crowd, throw open the

windows, make the acquaintance of my patient, proceed to bathe them, change the bed linen and tidy up the room. But, I cannot proceed so rapidly with the patient of seventy summers. First, they would not understand and would likely resent the seeming unnecessary dismissal of their friends and cronies. Knowing this, I therefore try to make friends with these folk and once I've won their confidence, I have no trouble in persuading them to remain out of the room. I usually address my elderly patients as "Grandma" or "Grandpa" which pleases them, that is, if they have ever been married, which fact, I am always careful to ascertain. I once made the mistake of calling a Miss of seventy, "Grandma" and—well, I am very cautious making that error again.

I try to bear in mind that the past generation were not such great believers in fresh air. The old folk are especially afraid of "night air." I reason that since they have lived like snails, so to speak, all these years, they might suddenly die of shock were I to throw open all the windows and doors. And so I go slowly, very often waiting until my patient falls asleep before easing up (or down) the windows.

For the same reason, I do not pounce upon them with soap and water. Many old folk, especially old men, are very squeamish about being wet when they are sick. I try to gain their confidence by first sponging the face, hands and arms. This usually makes them feel so much better that it is not long before they will consent to an entire bath. I find that to permit them to retain their flannels or any other apparel they have been accustomed to, really does no harm. I rather find it best, because it does not get them upset and uneasy about themselves.

As for bed linen, I try to be as economical as possible because a majority of old folk depend upon someone else and it will worry the patient if you are too extravagant in

this respect, thus increasing the "wash." This class of patient is absorbed with a morbid dread of their being too much trouble and expense to those upon whom they are dependent.

Now comes to my mind, the greatest "bug-bear" of all, the feather-bed. Training schools overlook this feature entirely. You are supposed to discard such an unsanitary old thing. But I don't and for the same reason that I disregard so many other rules of nursing when applying them to this class of patient. Why, even to suggest the removal of Grandma's or Grandpa's feather-bed would be cruel and tactless in the extreme and not to be thought of a minute, even granting they are unsanitary indeed. I can't protect them properly with a rubber sheet nor can I even keep the sheets tucked over them neatly. Oh! I often sigh and envy the future generation of nurses, that is, if the present generation of people do not take to feather-beds in their old age.

The following statement, I know, will shock the nursing fraternity and probably meet with the disapproval of all, all but my dear old patients, but—I do not clean up my patient's room. By this I mean, I do not take down and clear out all unnecessary things. I find that it upsets the poor old souls, especially the women, to have their few precious belongings disarranged or removed from their accustomed places. I tidy up a little, but I leave Grandma's work-basket on the table, her apron and bonnet hanging on a nail by the door and Grandpa's knife, glasses and pipe laying around so that he can see they are all there, safe and sound.

Taking up the question of the administration of medicine; fortunately, of late years, physicians do not give as much medicine as in former years, but I find that while the old folks reject the doctrine of fresh air and water, they have unbounded faith in medicine and are usually willing to take any amount

of it. Sometimes though, they will become prejudiced or lose confidence in some certain drug and then I am up against it. With a child I can hold the nose and pour it down, with an older person I can reason but with the class of patients under discussion, there is left only persuasion. In this way, I often get them to submit with an "anything to please the baby" air that is trying in the extreme, knowing that without their confidence in the medicine, its best effects are lost.

Very often these patients conceive the idea that a "home remedy" is the very thing they need. Now should I know that the "home remedy" will not counteract any of the Doctor's treatments and otherwise do no harm, whether I have any confidence in the remedy or not, I humor the patient and in some cases I have been pleased at obtaining the desired effect. For instance, some time ago I was nursing an elderly lady suffering with acute gastritis and persistent emesis. The doctor had prescribed a powder containing ingluvin but the patient felt that if she could get a little tea made from the lining of chicken gizzards that it would relieve her. While I knew that she had been getting this for several days in her medicine, I made and gave her the

"gizzard's tea" and she quit vomiting immediately. Of course, I knew my doctor well and felt sure that in doing this, I would meet with his approval. Some doctors get angry if you crook your finger without their having first ordered you to do so, but these are young doctors and I seldom meet with them when caring for old people. This class of patient usually has no confidence in young doctors and the older ones are not above recognizing the psychological effect of home remedies.

The next question is nourishment. Most elderly people are light eaters. So many things do not agree with them. Many, on account of some chronic, organic disease, have to live on a special diet. It is my experience that, of all patients, the aged ones are the hardest to nourish by far, and their failing to do so worries me more than anything else because it is upon their nourishment that I place most of my dependence for their recovery. I usually get some concentrated food, there being a few good ones on the market, and with these, eggs, milk, and fruit-juices administered in small quantities but frequently, and with all the patience and persuasive powers I can sum up, I generally win out.



NURSES' HOME AND REGISTRY, CHARLESTON, W. VA.

Nursing in Hotels and Boarding Houses

MINNIE G. MORSE

WITH regard to the difficulties to be encountered, nursing in hotels and boarding houses bears somewhat the same relation to nursing in private houses that the latter does to the care of the sick in the hospital or sanitarium. The nurse newly graduated from an institution, where every sick-room appliance and convenience is at hand as a matter of course, is apt to find some difficulty in adjusting herself to the demands of private nursing, until she learns the adaptability and the ingenuity in finding or manufacturing substitutes for unobtainable articles which have so much to do with her success in this field of work. In the private house, however, the invalid usually becomes at once the center of the household universe, and everything is made to give way to her comfort, while in the hotel or boarding house she is only one among many, and only too often the other guests of the house feel distinctly injured by the presence of illness in their midst. The servants of such establishments, overworked as they often are, are even more apt than the servants in a private house to resent any extra demands upon them. Conveniences for use in illness are frequently enough missing in even well-to-do households, but in the hotel or boarding house they are almost never at hand. Nor is there often sufficient room for the necessary paraphernalia of a sick-room, or for the nurse and her belongings.

Fortunately, however, there is a large amount of sympathy and kindheartedness in human nature, and a nurse with tact and good management can usually not only obtain everything for the comfort of her patient that the establishment can supply, but will find guests in neighboring rooms ready and willing to second her efforts to

avoid noise in the corridors, to give her as nearly as possible unrestricted use of public bath and toilet rooms, etc. If the servants realize that she is trying to save them all avoidable extra work, they will seldom feel "put upon." The writer has never met with anything but courtesy and cooperation from the management, employees or guests of such establishments, and during a long and very serious illness of her own in an apartment hotel the kindness shown her on every side will not soon be forgotten.

People of every sort are to be found in public hostleries, and there are few places where a nurse needs to use greater care to maintain a rigidly professional dignity. "Courtesy toward all, but familiarity with none," is never a better motto than under such circumstances. It is needless to say that there must be no gossiping about the patient or her affairs; and, while all inquiries for her should be answered with courtesy, reserve rather than freedom of speech regarding the case should be the rule. Occasionally, there is a scare regarding the possibly infectious nature of the illness; but all troublesome questions on this or any other subject can be referred to the physician for answer. With regard to the wearing of the uniform when mingling with other guests, it may be said that most nurses remove the cap on going to the dining-room, office, or telephone booth; if, as is so generally the case at present, the white uniform worn on private duty differs but little from an ordinary unprofessional white dress, there is nothing about it to make the nurse conspicuous, or to call the attention of guests to the fact that illness is among them.

Where two nurses are employed on a case, both can usually spend their rest

hours at home, thus obviating the necessity for sleeping accommodations. Sometimes the patient has a private sitting-room, or there is an unoccupied room near by, which can be put at the disposal of the nurse or nurses. In many cases a couch or cot can be placed in the patient's room. If the latter is very small, a folding cot can sometimes be supplied, and if it can be removed from the room during the day, so much the better. A mattress laid on the floor during the night is a possible solution of the sleeping problem under some circumstances.

In hotels of good standing, bed and toilet linen can usually be supplied in almost any quantity, but in boarding houses, especially those where moderate prices prevail, there is generally a fixed number of each article supplied to each guest per week, and it is sometimes difficult to obtain a sufficient supply to answer the requirements of a sick-room. This means very careful management on the part of the nurse, and occasionally she may need to wash out a towel or two herself. If the patient is not well off financially, a nurse should take pride in reducing the expenses of the illness to a minimum, and should never demand the purchase of any article not strictly necessary. If bath blankets are not to be had, large thick Turkish towels placed about the patient, especially if a piece of rubber sheeting or oilcloth is obtainable, will serve to protect the ordinary bed clothing during the administration of a bed bath. If it is not possible to obtain enough bed pillows to make the patient comfortable, pillows from a couch, or even cheap, uncovered silk-filled sofa pillows, wrapped in clean towels, will answer the purpose. Where no bed table is at hand, a lap board or large tray, laid on a pillow, or supported by two pillows placed on either side of the patient, make a fairly good substitute. A patient who has neither couch nor reclining chair for the first days out of bed can often be made very comfort-

able in an ordinary easy chair, with a smaller chair for a foot-rest, if plenty of blankets are used to soften the angles. A folding steamer chair is not a heavy expense, however, and when not in use can be packed away in a small space. Those with canvas back, seat and foot-rest have the advantage over those of cane that the back is adjustable, changing from an almost erect to a nearly horizontal position. Newspaper makes a fairly efficient substitute for rubber sheeting in protecting the bed, etc. When vaginal douches are ordered for a patient who has no douche-pan, and who is able to walk about, they may be very satisfactorily given in the bath-tub, the patient reclining comfortably against the sloping end of the tub. Experience develops ingenuity in making articles at hand take the place of the unattainable, and in saving expense for the patient of small means.

Keeping the sick-room tidy is a much more difficult proposition in these cases than in private-house nursing; in fact, at times it is a task which no one short of a genius in keeping order can accomplish. A nervous and ultra-fastidious woman known to the writer, who was suddenly taken very ill in a boarding house, seemed actually less distressed by her very considerable sufferings than by the disturbance of her cherished possessions, which filled every available inch of space in her small room, and each of which had a location as unalterable as the laws of the Medes and Persians. With patients of this type, it is better, when practicable, to spend a little extra time and pains in keeping articles as far as possible in their accustomed places, if by this means the invalid's nervous condition can be improved, for there are always plenty of unavoidable discomforts and inconveniences connected with illness under such circumstances without adding to them any that can be prevented by a thoughtful and painstaking attendant. Nor does the fact that the furnishings of the house are not

the property of the patient justify a nurse in carelessness as to the defacing of wall paper or furniture, though unfortunately one occasionally sees a nurse who appears to hold such a theory.

How to secure necessary articles of diet for the patient, and where to keep food supplies that are purchased privately, often constitute a good deal of a problem. Milk, raw or cooked, eggs, soups and broths, cereals, light puddings and fruit can usually be obtained for extra meals from the kitchen, and if the establishment is a small one, special articles can often be cooked there for the patient, or the nurse may be permitted to prepare them there herself. Many invalid dishes can be ordered from a woman's exchange. Nearly always, however, a certain amount of food will need to be prepared in the sick-room, and fortunately at the present day there is an endless variety of appliances for making such work convenient and easy. Nicer than anything else for sick-room cookery is the electric stove. Many different kinds are now on the market, most of them costing only a few dollars, and many people who board, habitually have them in constant use. Some are very elaborate, with deep and shallow pans and toast racks; these can be used for the preparation of an entire meal. At the other end of the scale is the tiny "hot plate," and even the electric iron—which, by the way, is an enormous help to the nurse on a case of this kind—can be used as a stove by means of a holder which comes for the purpose. Nearly all of the electric stoves take up but a very small amount of space, and they are especially to be commended because of their cleanliness. Where there is only one electric connection in the room, a double or triple joint can be obtained from any electric outfitter, which will make practicable the use of any needed appliances without cutting off the light. If there is no electricity in the room, a small gas stove, of the one-

burner plate type, is very useful for cooking, heating water, etc. A chafing-dish is by no means to be despised for sick-room cookery, and the modern electric chafing-dish is one of the most attractive of cooking appliances. The demand for boiled or boiling water for sterilizing, etc., that is so constant in many sick-rooms, can be met in many ways. If none of the appliances already mentioned are at hand, water can be heated over an ordinary gas or oil heater (though this is not a very rapid process), by means of an afternoon-tea outfit, or by a new electrical contrivance which is plunged directly into the water to be heated. There may also be obtained a small circular frame to fit over a gas burner and hold a small saucepan.

In a small establishment, articles of food purchased for the patient may often be kept in the ice box of the house until needed. Where this is impracticable, and a considerable amount of food must be kept on hand through a long illness, it may be desirable to get a small nursery refrigerator, which does not occupy much space, and which is not only a convenient place of storage, but obviates the danger of giving the patient food which has deteriorated, a danger which is by no means small in hot weather.

The injunction so prominent in every nurse's training in the serving of sick-room meals, to have hot dishes very hot and cold ones very cold, is never more difficult to carry out than in the hotel or boarding house, where the kitchen and the patient's apartment may be a considerable distance apart. If the nurse herself brings up the patient's meals, she can see that hot meats, eggs, and vegetables are closely covered, and the dishes wrapped in napkins or placed over other dishes containing a little very hot water. In hot weather a few small pieces of ice will keep butter from melting and fresh fruits and vegetables from losing their crispness. Hot dishes will retain their heat a considerable time in the sick-room

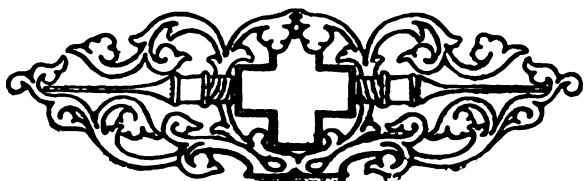
if kept over a hot-water pan, while hot milk, coffee, cocoa, etc., if turned into a thermos bottle previously heated with hot water, can be used several hours afterward. The thermos bottle is an especial boon where night feeding is to be done. It is also equally useful for cold liquids. Another convenience less generally known is the "frigidor," made on the same plan as the thermos bottle, but in appearance more like a quart pitcher in a metal case; this will keep hot or cold liquids at an unchanged temperature for several hours, and is especially useful for holding cracked ice. A piece of ice of fair size may, however, be kept in the room for some time unmelted, if wrapped in several thicknesses of heavy paper, when the weather is not too hot.

Even well-equipped establishments do not always keep their guests comfortably warm, especially in the changeable weather of fall and spring. If a patient's room is insufficiently warmed, a gas or oil heater can often be supplied by the management. The small "Pluto" heaters that fit over an ordinary gas burner throw out an amazing amount of heat. It must not, of course, be forgotten that gas and oil heaters, like gas lights and oil lamps, burn the oxygen out of the atmosphere very rapidly, so that a room where one of them is being used requires an extra amount of ventilation. This is not true of electrical appliances, but, though electric heaters are now on the market, they use so much current as to be too expensive for general use. For keeping a patient comfortable in bed, or for the relief of pain, there is nothing so satisfactory as an electric heating pad; this maintains an even temperature, relieving the at-

tendant of the necessity for heating water in the middle of the night to refill a cooling hot-water battle, and can be adjusted to furnish several different grades of heat.

Keeping a patient cool in a small, close room in hot weather is not always easy. Many hotels, however, have electric fans for use in the dining-room or elsewhere, and in case of serious illness it may be possible to borrow one for the sick-room. If the case is one where a curtain can be hung across the doorway of the room, so that the door can be left open much of the time, the freer circulation of air will add much to the comfort of both patient and nurse. Many of the milder methods used for the reduction of temperature in fever cases are useful in such instances; even placing the patient's hands in a basin of cold water and gently dripping it over her wrists will sometimes give great relief. In at least one case the writer has seen a threatened heat prostration averted by placing a water bottle containing a little cold water (not ice) at the back of the patient's head.

The foregoing suggestions are very simple, and few of them are entirely new, but they may perhaps prove helpful to nurses who serve patients who are so unfortunate as to be taken ill away from home, or whose home is bounded by the four walls of a hotel or boarding-house room. Never are home comforts and plenty of space more longed for than in the days of illness, and the nurse who can alleviate some of the inconveniences and discomforts of the case where these are missing will render her patient a service which will be long remembered.



The Nurse-Typist

M. MABEL RICHARDS

ONE profession that at present is not overcrowded is that of combining stenographic work with some of the many branches of trained nursing; either as surgical assistant, office assistant, reporter for medical meetings and conventions, private secretary, school nursing, etc. It covers a field of usefulness which, to the woman of sufficient patience and intelligence, is almost unlimited.

A stenographer entering a training school will find that her ability to take notes of lectures in shorthand to be of great value to her in her studies; and the experience she has gained in the business world will make her more efficient in the keeping of hospital records, and the many other details of hospital work.

If a trained nurse engaged in private work will take a scholarship in a good business college and will spend part of the time when she is unemployed—either resting or waiting for cases—in the study of shorthand and typewriting, and if she cares to proceed further in the study of book-keeping and business forms, she will eventually find that the time has been well spent. Some of the most successful nurses are today employed by medical men, acting as secretary and assisting them in their professional work—operations, office work, laboratory work, etc.

After she has had sufficient experience and practice in shorthand and typewriting, and sufficient knowledge in the use of medical terms, she will find her services in great demand as reporter for medical conventions and meetings, and will find this work more remunerative than almost any other branch of nursing that she could follow. This will only come after years of experience and hard work, but is certainly worth aspiring to,

One of the most desirable branches, especially for those who are fond of the young, will be that of school nursing, as this gives the nurse an opportunity to get the best out of both professions, and places her where she can do a vast amount of good. As most schools and colleges have their own hospital and resident nurses, she may take charge of the hospital and also find time to do considerable stenographic work, acting as secretary to some of the heads of the institution. This gives her two distinct lines of work, and she will usually find the change from the care of the sick to the literary part of her duties for a few hours a day a pleasant one. Only those possessing a good English education should apply for a position of this kind. If she shows an ability to teach, she may find plenty of openings as teacher of shorthand and typewriting.

If the nurse cares to enter the business world permanently, she will find that her training will make her more efficient, and usually more acceptable for those for whom she will be employed. Anyway, in order to make a success of her shorthand, she should have at least a year of practice with some good business firm in order to give her sufficient speed, and also that she may become familiar with business forms, phraseology and letter writing. It is of course, hard for a woman capable of earning \$25.00 or more per week to start on the small salary that it will be necessary for her to accept in order to gain this experience; but if she will just persevere, she will find that it will be worth all the seeming hardships to which she may be submitted. And even if she decides to return to private nursing, she will, in the periods of "dull times," or when she is tired enough to want a longer rest from night work than her purse will

conveniently stand, that the "temporary work" which she may obtain, and which will earn for her from \$2.50 to \$3.50 or more per day, will tide her over many little financial difficulties, and will in no way detract from her "professional dignity."

In order to make a success, however, she must possess a good general education,

must be careful to select a good training-school and business college, and then be prepared to "practice, practice, practice, and work, work, work," in order to become thoroughly efficient, doing her work neatly, quickly, systematically, and with the tact and accuracy necessary to the success of either a good nurse or stenographer.

THE VALUE OF SILENCE

A Training School Incident

"Miss Knowles, you are wanted at the office." So spoke a trig little nurse to the second assistant in an immaculate hospital ward. All through the long day she had waited for that summons, because she knew she had been guilty of that cardinal sin for nurses—indiscriminate talking.

Arriving at the office, the superintendent came to the point at once. "Miss Knowles, my attention has been called to the fact that you have discussed one patient's illness and condition with another. This is not the first time I have had to speak to you about talking in the wrong place. Any patient who enters this or any other hospital or who requires medical attention in any way is entitled to privacy. Suppose your mother entered this hospital and her private affairs were carried from one to the other, would you like it? Silence is said to be golden, and in no other field is it so necessary as in the nursing profession. Because of her position a nurse learns the innermost secrets of the home, and it is her duty to keep her mouth closed. How long do you think you would be tolerated in the profession if you told

Mrs. A's business to Mrs. B? You will meet many things as you go out in the world, some of which will shock you to the bottom of your soul. But you must look on with closed lips and remember that you are there to minister to bodily needs primarily. Observe for yourself the nurse working with you. She who does the least talking accomplishes most. Her decisions are always referred to and she is universally respected by patients. Now I want you to correct this tendency of yours, for surely you can see how it compromises your dignity. You have a great number of the ideal nurse's qualifications—good health, education, refinement, a charming personality. You are tactful, and some of our best recoveries were cases in your hands. You are truthful, conscientious and frank to a degree which pleases me; but offsetting all these attributes is your tongue. Go now and keep close guard on that tongue and, above all things, do not forget that you are filling a nurse's place and should dignify it. For I promise you you have had your last warning!"

Multiple Neuritis

HELEN M. SARGENT, R.N.

MY patient, who was 72 years old, had been ailing several months and had been down in bed two weeks when I was called on the case. At the time, it was diagnosed as creeping paralysis bordering on neuritis, and I was told she might live through the night or perhaps live a week. Entering the room, I gripped myself hard to conceal an inward shock one has at the first sight of deformity of any kind. She had an immense goiter and a lump on the left side of the neck as large as a man's fist. She was paralyzed from the hips down.

The first evening I bathed her, I found the left arm above the wrist about three times as large as the right arm. This edemic condition was quite marked in the left hand, also, often more marked at times than others. The skin of the limbs was characteristically shiny and smooth. On the left inner ankle was a large raw place, where a blister had been as large as an open hand. The son and daughter insisted it was caused by a hot water bag put on it just after a liniment had been anointed, but the doctor said that only helped to cause the herpes or blister over a dead nerve end, a symptom of neuritis. The worst condition was on the back, low down over the region of the coccyx. A space of the skin as large as two open hands was black and dry and hard, not the red, sloughing skin of a bed sore, but necrosed tissue—gangrenous. As soon as I saw it, I remarked that it would be terrible, but I did not realize how much so then.

To get the patient off her back to treat it was difficult, as she could only turn on her right side for a few minutes at a time. So every detail for the dressing and changing of pads under her was

prepared beforehand, so no minutes would be wasted. First we used Prix Cresol in solution and applied also in sterile tallow on the back and ankle. In a few days, watery blisters raised on the inner thighs and, being opened, left dark red spots. One morning a severe chill came on lasting nearly an hour, in spite of hot plates all around her and more blankets. Soon it was followed by a very free passage of the bowels and the doctor attributed the chill to that. Afterwards the fever went up to 104°, and the irregular pulse to 130, and respiration, 36. Several mornings I noticed the left pupil of the eye was dilated about twice as much as the one of the right eye. The hard, teeth-chattering chills came every other day or so, several times soon after the dressing had been done, so we thought it might be due to exposure or exhaustion. No stimulants were used except 1-100 gr. strychnine by mouth at such a time, or hot tea. After being there a week another physician was called in consultation and he gave no hopes for her at all, saying her life was only a question of a few days.

Occasionally there were sensations of touch, heat or cold in the lower limbs, but no sign of motion but once—the inner left thigh muscles twitched slightly. Scarlet Red or Scarleto—a preparation for broken down epithelial tissues—was spread on linen and applied to the ankle and back twice a day. As time went on we kept discovering blisters or herpes on the outer ankle bones, outer knees, and elbow points. Both heels had spots as large as a dollar, hard and black as ink. Pressure was relieved by pads. Also spots appeared under the shoulder blades and creeping up the spinal column on several vertebra. After the first appearance they gradually grew

darker and got black. Some spread and seemed to sink deeper into the flesh. We thought pressure might cause it, but the spots came where there was no pressure, as high on her back. She was propped in a semi-sitting position all the time. All antiseptic dressings and external treatments made no impressions on any of the necrosed tissues.

The dressing for the back was made as simple as possible. Next to the wound on the back, was placed a large oblong non-absorbent pad. Under it across the back we placed a long strip of strong canvas with packets at the ends to aid in grasping it. This enabled the son to turn and lift her straight up so I could adjust the air pad. This canvas strip saved stretching and pulling on the muscles of the back. Newspaper pads were kept next to the sheet. One day, when we turned her over, there was a strong odor as of pus from the back, and we were afraid of general septicemia. The black skin was breaking away slightly around the edges of the live flesh, and an offensive discharge was oozing out. Under this skin we irrigated with Prix Cresol solution and as the skin sloughed more, we packed inside with equal parts of bovine and castor oil. Finally, the black skin had loosened all around, and left a raw-red cavity as large as a two-quart basin. We cut away the dead tissue still clinging in the center to the vertebra. One vertebra was exposed and there was a slight bleeding, oozing out between two of them. There was no feeling at all when this big place was dressed, and the necrosed spots kept spreading all around it until it seemed like it would spread clear across the hips and connect with the spreading, deepening spots up the spine.

The right lower limb began to swell and became twice as large as the left. A saline laxative was given nearly every morning to help eliminate poisons. The catheter was

used three times daily. The internal medical treatment was adjusted to daily symptoms. The doctor said very little literature concerning poly-neuritis, as it was finally diagnosed, could be found in American medical books and very little in European.

About the third week there were about eighteen spots, large and small, to be dressed twice daily. My patient's appetite was poor and gradually failed to respond to any tempting things. All through the progress of the disease—necrosed spots, dilated pupil, edema and all general symptoms seemed worse on the left side—on which side was the large growth of the neck.

For some time it seemed as though she might be in about the same condition indefinitely, and we began to look up adjustable beds. But we could find nothing suitable for her in particular.

The problems of dressings, chills, medicines, diets and general care were plenty, but one of the greatest was the mental attitude. She did not know the condition of her back. Sometimes her eyes would shine with hope from optimistic suggestions. Especially when her seven stalwart, men-grown sons came home, their first reunion for twenty-two years, lined up around her bed and asked if they could go swimming. Then again she would wish she could be at rest since there was no improvement. She asked the doctor how long it would last and the doctor said, no one knew. When she talked to me I would tell her not to worry and take things as easy as she could.

One great comfort she had throughout her sickness, was that of gently waving her little black fan herself.

In spite of the wasting and dying tissues, nature was kind to her in sparing her pain. The fatal hour came suddenly and spared her children days of seeing her in a state of coma,

Department of Public Welfare

THE INFLUENCE OF THE VISITING NURSE

EMILY HARRISON BANCE, R.N.

SEVERAL years ago I heard a sermon in Old Trinity Church, New York, which left a very deep impression. The sermon was on "Influence"; the influence for good or evil which one person exerts over another. The speaker was very broad in his assertions and even went so far as to say that this law was so strong that people passing each other on the street or in public places, even if they did not speak or come in contact, had power to influence each other, perhaps very slightly, for good or evil.

In this way people leading good lives were wonderful factors in this law of influence and, on the other hand, an evil life made its sure impression on other lives and the community. Since becoming a district nurse, I have often thought of this sermon and the truth of it.

Nurses, going as they do into the homes, and entering into the lives of others have a great responsibility and much depends upon their moral character and the impressions they give and take. Especially true is this of the nurse who practises visiting nursing in a tenement district of any of our large cities.

A young woman who begins this work must be very careful that the influences of the city and its conditions are not stronger than her own moral sense of right and wrong. The nurse who practises private nursing enters homes of the middle-class and the well-to-do and she takes the home conditions as a matter of course. The houses

she enters have good plumbing, the rooms are well-ventilated, the children, if there are any, sleep one or perhaps two, in a bed; the fire-escapes are in proper condition and if a pet cat or dog dies the "Board of Health" acts promptly to remove it. The latter are also very strict about the removal of garbage and the inspection of cellars.

If a contagious disease happens to be the malady, great care is exerted to prevent the spread of disease and guard the community. The patient and nurse are isolated, antiseptics are used wholesale and the neighbors warned. Now all this is as it should be, but let this same nurse begin work as a visiting nurse in the tenement district and what does she find?

Let us follow some of the conditions which the visiting nurse meets in her daily rounds among the tenements, and learn how she can equip herself to cope with many trying situations.

One of the first things which impressed me as a visiting nurse was the wretched housing conditions of my patients, many of whom are factory workers, as in my district there are factories of all kinds. This class of people should have well-ventilated houses to return to after a day spent in the factory, instead of which, many of them are housed little better than animals. In some sections one tenement is built behind the other with very little space between. Often this small area is polluted by odors caused by deficient plumbing.

The little children born in these places, especially those living on the lowest floor of one of the rear houses, have a poor chance regarding health and decency of living. In many places, which are sure death-traps there are no fire-escapes. One tenement I visit has but one entrance and that is through the cellar. There are no fire-escapes and eight families and twenty children dwell in that house.

It is the custom among a certain class of factory workers to take in boarders. The money they receive from these boarders helps pay the rent and buy food and coal. But when you consider that the small railroad tenement is generally so crowded that the children sleep four or five in a bed and often on no bed at all, and privacy is absolutely impossible, it is not surprising that the morals of these people and the growing children are so corrupt.

There should be an enforced law in every city controlling the number of people allowed to live in each tenement. What chance have the children born and living in these crowded filthy homes to become clean upright American citizens?

The people of the tenements generally pay a big price for their coal as they have to buy it in small quantities. In each house there should be a place for coal so that families could buy more than a bag at a time. But in many cases the cellars are not in good condition and quite unsafe, having no locks on the doors and practically open to the public.

I know of one poor family who scandalized the landlord by storing a quantity of coal in the bathtub. However, this was the only place where they could put it, and as the bathroom was intensely cold and as no boiler had been provided for heating water they could not use it in winter. To heat up enough hot water on the stove to

fill the tub was an expensive proceeding. Then too, the cellar was four flights down, and being open to the public a very unreliable storage place. So you see there is a reason for everything if we only look for it.

All over this country, in all the principal cities there is a great movement for promoting child welfare and the betterment of babies. Mothers are instructed in the preparation of milk and the systematic feeding and weighing of the babies. Special stress is laid on the danger of the house-fly and the cleanliness of the home. This is all very well for mothers living in good neighborhoods where the tenement laws are observed but, take a mother whose large family is housed in front of a stable and practically above it, whose landlord is not particular about screening the windows with wire netting—what is the sense of talking to her about the “deadly house-fly.”

When we clean house, we begin to sweep in the corners and the closets, not the middle of the room. The first practical step in baby welfare work is the inspection of tenements and an order issued to tenement owners compelling them to make their property sanitary and fit for human beings to live in and little babies to be born in.

The fire-escapes should be in proper condition, the plumbing should be faultless, the windows well screened and only a certain number of people allowed to dwell in a specified space. Stables for horses and cows should be abolished in the crowded parts of the city. Diseased cats and dogs should be removed and when contagion occurs in a tenement the sign should be placed on the outer door of the house as well as on the floor where the patient lives. Thus everyone in the street and passers-by will be promptly warned.

(To be continued.)

The Hospital Council

Items of Interest, Annual Reports, Publicity Literature and Material Descriptive of Newer Methods and Plans in Any Department of Hospital Work Are Solicited

Standardizing Technique in Open Hospital

The greatest drawback to the "open hospital" has been the great variety in technique and surgical paraphernalia required when a large number of different surgeons were allowed to operate. Each had his whim or his fad about something, and each felt that he had as much right to have his methods carried out in precisely his way as some other doctor had. This has resulted in waste—waste of time and energy of nurses and other hospital workers, waste of surgical supplies and unnecessary duplication of hospital appliances with no resulting good from it. This condition has been felt and complained of for years but only recently has it been really taken hold of with a view to simplifying matters. It is generally admitted that it is not a good thing for pupil nurses to graduate with the idea that the methods pursued by the few chief surgeons on the staff are the only right methods or the only methods that will produce good results; but neither is it a good thing for them to have to keep in mind the details of the technique of perhaps thirty to fifty surgeons as is not uncommon in many places.

In the effort to eliminate the waste resulting from so much variety in technique, Grace Hospital, Detroit, has seriously tackled the problem of simplifying and standardizing surgical technique by getting the medical staff of the hospital first to agree on a standard surgical technique which would be carefully tested out and then presented

in printed form to surgeons not on the staff who were operating in the hospital.

This standardization of technique has proceeded along the following lines:

1. The adoption of a brief outline of "house orders" for the preparation of patients for operation.
2. The adoption of a uniform method of care following operation.
3. Adoption of uniform operating room methods in the preparation and sterilization of cotton, gauze, ligatures, and general supplies.
4. The adoption of a uniform surgical technique by surgeons in all general surgery.

In putting the plan into operation the following general plans and suggestions to other operators were agreed on by the staff:

That all surgical patients save emergency cases, be sent to the hospital as early the day preceding operation as possible.

That in abdominal operations all operators dispense with gauze sponges for use in abdomen and use only the large gauze towels. Loss of sponges in the abdominal cavity will be obviated by the use of towels, and the operator will soon become accustomed to their use.

That small sponges never be used in the abdomen except on a sponge holder.

That gauze drainage be dispensed with.

That cigarette drains or rubber tubes, enclosing wicking be used.

That irrigators and basins containing solutions be dispensed with in the operating room.

That gloves be worn dry.

That the only solution used in the operating rooms shall be dilute alcohol.

That 20 minutes be allowed to prepare room for next operation.

That the preparation of the skin for any operation be carried out by sponging with 3 per cent. solution of iodine.

That operators shall report in operating room 15 minutes prior to operation and be prepared to operate on schedule time.

That irrigation in vaginal cases be discontinued.

That in operations on cervix and perineum the vagina be sponged only with 2 per cent. solution of iodine.

That operators lock their instrument cases and lay out instruments only with the help of the instrument nurse.

That operators furnish their own rubber gloves, except for use in staff operations.

That the operating room supervisor be notified the day previous of special material or supplies needed for operations.

That physicians do not talk or congregate in rotunda or visit in the operating room corridor.

That physicians be on time for use of dressing room.

That lay visitors and relatives of patients be not admitted to operating room floor or operating rooms except in emergencies.

That the keynote of technique be simplicity.

That whims and fads be abandoned.

That operating room technique be standardized.

Standard scrub for hands and arms—Scrub with soap and water two minutes, trim nails to 1 m. and then scrub with soap and water five minutes; finish with dilute alcohol. Dry hands and use gloves dry with sterile powder.

The standard rules have not yet extended to the genito-urinary or to the eye, ear, nose and throat department, but several months of experiment have shown that standardization in surgical technique is

possible and that it has so demonstrated its value in the saving of time, strength and supplies, that it will be extended to other departments.



The Well Babies' Clinic

The Hospital for Sick Children, Toronto, is justly proud of the record of the past year in its Well Babies' Clinic to which 982 babies were brought and in which hundreds of mothers received advice and instruction in regard to the care and feeding of their babies so as to prevent sickness. A graduate nurse from the Health Department of the city attends this clinic and assists the workers connected with the hospital.

The establishment of this preventive clinic is cause for rejoicing as a sign of progress and the question arises if this preventive clinic is needed in Toronto are there not hundreds of other places where the need is fully as great?



Green for Operating Rooms

For years, one has heard a plea now and again that we introduce a little more color into our wards—that we do not insist on all white walls, white screens, white beds and spreads and furnishings in general. But till recently, the all-white operating room has seemed to have come to stay. Now it appears that the white which seemed to signify purity—the acme of cleanliness—has certain disadvantages. One of the examples of an operating room fitted up in green, is to be found in St. Luke's Hospital, San Francisco.

Dr. H. M. Sherman of that city writing in the *California State Journal of Medicine*, gives his experience and opinion on the subject as follows:

"The discomfort I have had in the present-day white operating rooms led me to suggest that we have dark floors and wainscots in these rooms," says Dr. Sherman, "so that the operator who looks up



THE WELL BABIES' CLINIC—HOSPITAL FOR SICK CHILDREN, TORONTO

from a wound shall not encounter a glare of light and find his eyes useless for a moment as he looks back into the less well illuminated wound. The color scheme, it seemed to me, should start from the red of the blood and of the tissues, and therefore I advised that green, the complementary color to red, should be chosen for the color of the floor and wainscot. The particular shade of green to be selected was that which was complementary to hemoglobin, and it was found to be the green of the spinach leaf. Incidentally it may be stated that the iron in the chlorophyll of spinach is said to be in the same chemical combination as is the iron in hemoglobin, but I know nothing of the value of this in making spinach green complementary to hemoglobin red.

"A room painted in this way, the floor and the walls for six feet from the floor a bright spinach green and all above a glazed white, was matched for use against a room painted a glazed white—floors, walls, and ceilings—in the little operating pavilion

built at St. Luke's Hospital just after the fire. No one who could get into the green room to do an operation ever went into the white room, and after some months of this experience the point was accepted as settled sufficiently to warrant the innovation of a room similarly colored in the operating suite in the new hospital. Here, however, we could not get in tiles as close an approximation to spinach green as we could in paint; the tile for the floor had to be duller and darker and that for the wall darker, but the two shades harmonize, and answer the purpose perfectly of preventing the bright daylight from being reflected upward from walls and floors into the eyes.

"Above the level of the six-foot green wainscot is white encaustic tiling to the ceiling, and the ceiling itself is a bright buff. This arrangement imitates fairly well the optical environment out in the fields or among low bushes, where the ground of the surroundings, to above the level of the eyes, is green, and the sky overhead is full of white daylight. This

again is the optical condition for which the eye was originally adapted by natural selection, and it seems only right to reproduce the condition for the eye when it is to be relied on for quick and accurate work; while the conditions of greatest eye-strain—the dead white and glare of snow on ground and bushes—is the optical condition reproduced by the white rooms and the white furnishings.

"At the first ground glass in the windows was tried, but this was changed to clear glass as giving more light from a desirable direction. In course of the experimental work it was found that the light reflected into the operator's eyes by the white sheets and towelings was as dazzling and as interfering as was that reflected from the floor, and so the same color scheme was followed out, and green towelings and green sheets of galatea were provided. The color in these, however, did not stand the superheated steam in the sterilization. They became a dingy gray. Then I decided to surround the whole operation field with black, as giving a surface from which no light whatever could be reflected, using it around all wounds, as I had used it around the mouth in cleft-palate operations and around the vagina in operations there. I not only had sheets and towelings of black, but I had black gowns made and the coverings for instrument tables were all of black. I found that they were exceedingly satisfactory."



An Endowed Training School

Miss Margaret Cumming and her associates in service at the Christian H. Buhl Hospital, Sharon, Pa., are rejoicing in the prospect of the realization of a long-cherished dream of a beautiful training school building and nurses' home with ample endowment.

The home which is now under construction will be known as the Peter Kimberly

Memorial Nurses' Home. It is expected when completed and equipped at a cost of from eighty-six to ninety thousand dollars, to be one of the finest training school buildings in the State of Pennsylvania. Each nurse will have her own room and two sound-proof rooms on the top floor are provided for night nurses, also a special room for nurses who are ill. The plans provide for eight bathrooms, suites for the superintendent and her assistant, a solarium and roof garden, also a guest chamber with private bath. The living room will be 32 feet long. There will be besides this room, a library, lecture-room, reception room, nurses' dining-room, recreation room, trunk room, diet kitchen, kitchen and pantries, and laundry for nurses' private use. A large porch on both the first and second floors faces the gardens. The endowment is one hundred thousand dollars with prospect of more to follow. The building and endowment are the result of a gift from the Peter Kimberly estate.



Whooping Cough Hospitals for New York City

"If whooping cough had only been born with some kind of rash," states a writer in the *New York Medical Journal*, "its prevention would not now need any advocates. As it is, the laity regard it as not particularly dangerous, and physicians often foster this idea or express their hopelessness in face of it, so that comparatively little medical attention is given until the patient has serious and often fatal complications."

Among the large population in New York City there appear constantly cases of whooping cough in families which are unable to provide medical care and attention because of poverty. They are compelled to go to the dispensaries. From these, after having waited and mingled with other groups of children, they are singled out as pariahs and sent home, often untreated, because of

lack of suitable provision, and with no instructions as to the care and prevention of the spread of the disease.

If an intensive study of the disease were made in a selected section of the city, many more cases of whooping cough would come to light than are ever reported. On a more accurate basis the need for hospital beds could then be apportioned, and the public notified that the city is ready to care for those who are in need.

At the present time, no suitable buildings are available. These should be built on the open pavilion plan near the water-fronts, and designed especially for this purpose; at least one for each borough. For the great number of uncomplicated cases which go about spreading the disease, disused ferry boats or barges moored to the city docks could be utilized; on these a small hospital ward should be arranged for cases needing medical attention and feeding. Dispensar-

ies for the ambulant treatment of whooping cough could be established here, and cases referred to them which had appeared in other clinics. Children, with their mothers, perhaps, could be taken in stages provided by the city to these boats, and allowed to spend the day outdoors, returning to their homes at night. Such a plan is particularly advisable, owing to the fact that whooping cough differs from the other contagious diseases in that it will often demand many weeks' or even months' stay in a hospital ward, or until the period of contagion is over.

There is little question that provision for whooping cough cases will promote the public welfare, and, moreover, give physicians an opportunity more effectively to study the disease as to its early diagnosis, and to perfect the treatment along more exact scientific lines, now that the specific organism is known.



THE WAITING-ROOM IN THE NEW OUT-PATIENT DEPARTMENT AND FREE DISPENSARY, HOSPITAL FOR SICK CHILDREN, TORONTO. THE PHOTO SHOWS THE ROOM AS IT IS GENERALLY FROM 9 A.M. TO 1 P.M.

The Dietary Question-Box

E. GRACE McCULLOUGH

Dietitian, Peter Bent Brigham Hospital, Boston, Mass.

PART II

THE questions for this month have been selected from many, all pertaining directly or indirectly to the food serving problems when either long distances or very small accommodations interfere with ideal methods. Still others were considering new buildings and plans.

If new buildings are being erected see to it that architects, trustees and building committees meet your practical views. It will require much tact, seed sowing by suggestion and more than one interview in order to accomplish the desired results.

If dealing with old conditions, you may be able to improve with very little expense and simple re-arrangements. In both cases, whether new or old, *the practical working basis* must never be sacrificed in favor of appearances.

1. Taking into consideration a reasonable economy in the preparation of food for private patients and the sick generally, what are the arguments in favor of—(a) A centrally located kitchen for all departments? (b) A small kitchen on each floor?

Ans.—It is difficult to lay down any hard and fast rules, without knowing the character or location of the institutions, the various buildings or units, the distances, etc., but for the average hospital a centrally located kitchen has many desirable features, provided it is of sufficient size and suitably equipped. The word suitably has been selected with care, because much expensive, up-to-date equipment has been purchased and installed by those who are unfamiliar with the details of the work and who have no ideas regarding efficiency methods. Because one institution works out its problems along certain lines, it does not follow that

you should adopt any method or appliance unless it will increase the efficiency of your particular hospital or decrease the running expenses. After you have your building as you wish, be sure that your equipment, be it small or great, is properly installed. The kitchen is a work shop where the workman must have his tools at hand. Much time is saved if all is planned ahead. Centrally located kitchens reduce the labor 25 per cent.; the fuel 50 per cent. and material 10 per cent.

(b) Small kitchens in any institution are an abomination and when cupboards and tiny rooms are found with "cuddy-holes" leading off, they are "unspeakable." They are impossible to keep in order and use up undreamed of time in trying to keep them clean with everything tight against walls and out of sight. Oh! I beg of you, tear out every partition, do away with every cupboard and drawer, make a clean sweep, leaving only four straight walls. Put in open utensil racks and wire baskets to hold knives, forks and spoons. The kind that are used for office work and divide the number of utensils in half.

Small kitchens on each floor increase the number of cooks. Every kitchen needs a good cook and one good one will do for 100 as easily as for 20—a good cook demands a salary for time, not for numbers. A cheap, incompetent cook is one of the most expensive propositions there is in a hospital.

In caring for private patients, it is frequently advisable, from the location of the building or character of food, etc., to provide a separate kitchen or range for the preparation of meats and vegetables, but all bread, desserts, ices, cakes and such,

should be supplied from the central plant, where ovens, freezers, etc., are placed. Even very small hospitals today have electric attachments for such equipment, using the current by easily adjusted Hubbell plug or socket plug. With small kitchens on every floor there is a multiplication of odors, and a patient oversensitive to odors loses the zest for his own meal and absorbs through his nostrils the food for all the others. In fact the whole hospital smells of cooking.

2. Should each floor or department be provided with a separate pantry for setting up trays, or is it more economical and expeditious to serve meals by means of elevators and lifts from a large central pantry?

Each floor should have a separate distributing pantry, where trays may be set up and with one of the several heating tables or appliances for keeping the food hot.

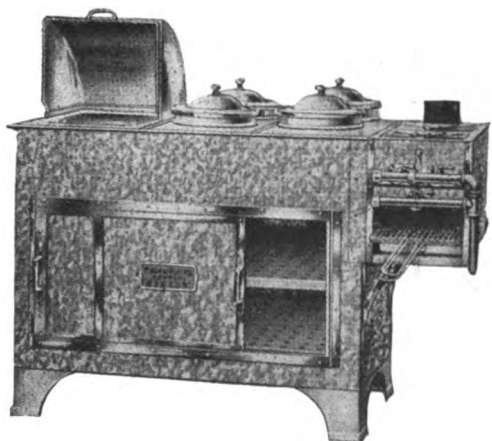
The kind and character of this equipment is determined by the heat available—the simplest being a Bain-Marie, heated by gas, electricity or steam. If gas is used, it can be connected by direct permanent piping, or placed upon a I, II or III unit portable plate and attached by rubber tubing. If electricity is used, the same base-pan may be used and the water heated either by an electric plate or an electric rod placed in the pan, the connection being made with any plug or bracket convenient. If steam were available, one of the small steam tables, with fitted food containers at the top and dish warmer below is desirable. Frequently, a tiny hot-plate or stove is attached for boiling water or toasting bread. Further—if the hospital is located too far from conveniences or a camp hospital, and it is impossible to have any of the three above mentioned heating arrangements, there is no reason why a three-lamp oil stove could not be utilized, with a home-made galvanized



BAIN-MARIE PAN



HOT PLATE UNITS



DIET TABLE

This table is designed specially for hospital use and can be furnished with either a polished copper, nickel-plated, or white porcelain enamel top with a warming closet below, made of Russia iron, galvanized iron, or with white porcelain enamel panels or nickel-plated copper. It may be heated by either steam or gas and there is an attachment for quick cooking and broiling and toasting.

box, fitted to the stove with seven-inch sides, to hold the water, and food containers compactly arranged in it. Care should be observed that there are no long handles projecting.

One central distributing pantry always serves cool food which should be hot, and allows the cold things to lose their crispness or solidity. Second, orders of any favorite dish, require too long to intervene between the asking and the serving, so the desire and full pleasure are gone.

3. Should individual trays be carried from the pantries to private rooms and to the sick by nurses or pantry maids?

The mere carrying of trays from pantry to wards or private rooms by maids is all right if it simplifies the work, provided the maids are clean and suitably dressed, but unfortunately, few hospitals can afford maids for pantry duty alone. They sweep, scrub and mop between meal hours, and are not in condition to handle food, (usually far from it) or to serve the sick; nor can they adjust the patients so they may comfortably eat. If the maids carry them, the trays should be delivered at the door, to a nurse, who knows how to add a few

extra pillows to one, to turn over another, to raise a third, and possibly feed the fourth. Obviously, it is the nurse's duty to attend to bedside details.

A nurse should always be in charge of the diets, to set up the trays as per order for each patient; the order *to be written* and within easy eye reach. (A pantry bulletin board is generally used.) The trays *should be marked* by writing on a slip of paper, a place card, or even on adhesive—anything which will prevent the mixing up of trays, with the disastrous results, familiar to us all.

4. What member of the official family of the hospital should counsel with the chef in the preparation of menus?

The dietitian only should have anything to do with the preparation of menus. She should make out all menus for the hospital. She should be familiar with both the raw and cooked food stuffs available; the market price and the needs of all included in the hospital family. The chef should be under her control; and when menus are issued, they should stand as orders. If she be not qualified by training and executive ability to do it, there is no reason for her being retained.

Improvements at Willard Parker Hospital

A new Medical Staff House and Nurses' Home is under construction at the Willard Parker Hospital, New York. It will provide quarters for 35 doctors and 115 nurses, each group having separate entrances, halls, stairways and dining rooms.

In the basement there will be a large swimming pool to be used by doctors and nurses on alternate days. On the seventh

floor there will be a well-equipped gymnasium for nurses. Ample provision has been made for special rooms, sewing rooms, etc., that will add to the nurses' comfort.

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New Buildings for Mt. Sinai

The Mount Sinai Hospital, New York, plans to largely increase its capacity by the addition of three separate buildings to cost about a half million. One of the buildings will be a children's dispensary.

Editorially Speaking

The Virtue of Reticence

The nurses who were trained twenty or twenty-five years ago missed many classes in nursing and allied subjects now considered essential, but they were carefully drilled in several important essentials which now seem to be practically overlooked in teaching nurses.

Twenty years ago it was considered a heinous offense for a nurse to discuss hospital affairs with any one outside the institution. The enormity of that offense was impressed on a nurse during her probation period in a way that she was not likely to forget and she was given clearly to understand that if it was ever found out that she had been discussing hospital matters or the affairs of patients with her own family or friends outside the institution, something very dreadful would happen. The virtue of reticence was held before her as one of the essentials to a good nurse.

But times have changed. Now, pupil nurses and graduates discuss the affairs of patients whom they have nursed in the hospital, with the same freedom one would expect of a clerk who sold gloves or shoes. There is no one thing more frequently complained of today by physicians and the public than this habit of gossiping over affairs that should be guarded with professional caution or secrecy. One hears this complaint everywhere from the laity and from physicians—this penchant for “talking shop.”

A few days ago the writer was asked by a doctor why some attempt was not made to train nurses to refrain from discussing their patients in other homes and outside the

hospital. He said that when he graduated as a physician he was obliged to sign a pledge binding him to professional secrecy regarding the affairs of patients of which knowledge had come to him in the practice of medicine. He thought nurses ought to be made to sign the same sort of pledge. He gave several instances of embarrassment that had come to him recently through the nurses of a hospital to which he had brought several prominent patients discussing, in the homes of their friends, the details concerning those patients which should never have been heard of outside the hospital.

Kathleen Norris's story in *McClure's Magazine* for August, “Miss Smith of Bellevue,” has occasioned considerable flurry, especially among nurses in and around New York, and we are told that considerable indignation has been engendered. Is it not just possible that Kathleen Norris is endeavoring to portray the kind of gossip that thousands of nurses are indulging in with their patients and friends—not in New York only. And, while this portrayal hurts, it should do good. It took the pen of a Dickens to portray certain abuses in such a way as to make the country he lived in wake up and correct them. The pen of a Harriet Beecher Stowe, in portraying the horrors of slavery, helped mightily in crystallizing sentiment that led to its abolition. If the pen of the novelist can do anything to wake up training schools and nurses to the correction of this pernicious habit of gossip about hospitals and patients with people who should never have this gossip inflicted on

them, and should never be admitted into the secret affairs of patients, we can stand it to have a few such stories as "Miss Smith of Bellevue," even if Miss Smith is described as "a little simple."

The so-called "Florence Nightingale Pledge" is put down on the program as a part of the entertainment provided for the public at graduation, so it is little wonder that it fails utterly in impressing most of the nurses on the stage who repeat it in parrot-like fashion. What is needed is a pledge *at the beginning of the course* when pupils are in a highly impressionable state of mind, and when they know that their violation of such a pledge is very likely to be discovered. As it is, the taking of the pledge at graduation in many schools is a hollow mockery, a matter of form, which could be omitted without losing anything really worth while. How many nurses keep it?

The stamping out of the pernicious habit of gossip portrayed by Kathleen Norris is a question that should seriously concern training school people and nurses all over the country. Anyone who feels she has succeeded in approaching anything like ideal conditions in this respect, will confer a favor on a long-suffering public, as well as on nurses by telling how it was done or can be done.

We can sympathize with Miss McLean's protest in the October magazine. The type portrayed by the fiction writer is overdrawn in many particulars and not true to life in others. It is unfortunate that Miss Smith was "*of Bellevue*" for there is no justice in locating the character portrayed in Bellevue. The nurse who "talks shop"—who has no hesitation in discussing hospital affairs with her patients or friends is not confined to Bellevue or to New York. You can find her in Buffalo, Cleveland, Detroit, Chicago, Kansas City, and any other city, North, South, East or West. The big question which the story of "Miss

Smith of Bellevue" has raised is "Do nurses talk shop or do they not?" "Do nurses discuss with patients and friends, affairs of the Hospital and of other patients or do they not?"

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A Call to Service

A few months ago we called attention to the great uncrowded field awaiting Christian nurses in China, India, Africa and other countries. How little we know of the needs or conditions in many places! Seldom have we seen a more powerful plea for help for our sisters in far-off lands than was contained in a recent letter from a missionary nurse in *The Nursing Times*, of England, describing Midwifery in India.

In order to understand some of the practices, it is necessary to remember that the cow is a sacred animal in India.

"Native medical treatment and the practice of midwifery are appalling. Little babies a few days old suffering from simple ophthalmia are often made blind for life by the pouring of cayenne pepper into their eyes or the burning of the eyelids sometimes right through to the eyeball with red-hot wires. All the children, save our little second generation of Christian children, bear three deep scars across the abdomen which, if they survive, they carry to the grave. If they survive! Hundreds die of septic poisoning, for the awful wounds are left uncovered and undressed. Why are they treated thus? Not from cruelty, but simply because the parents believe that such treatment will give protection to their children from evil spirits and immunity from digestive disorders. Only a fortnight before leaving for furlough, I was called to the village to see a girl who had become a mother. It was too late to do anything; the girl was in the awful, almost continuous, spasms of tetanus. Knowing their barbarous practices I warned them not to burn

her and hurried back to the dispensary for drugs. Although not away five minutes, when I returned I met the witch-doctor bearing away his branding-irons; while I had been examining the patient he had been heating his irons, and as soon as my back was turned he had applied them. But I did not need the sight of them to know what had happened; the smell of burnt flesh was enough; that poor girl's back was raw the whole length of the spine. She died within an hour; and she was only fourteen years old.

"The Indian midwives are always the wives of the native barbers, who also practice medicine. When first called to a patient, the midwife with her own hands mixes cowdung with water and pours it all over the floor. This is for cleanliness and to keep the evil spirits at bay. Then with unwashed hands she proceeds to make both abdominal and vaginal examinations of her patient, after which she rubs her hands along the cowdung floor and finally wipes them on the patient's none too clean clothes. Then she pours hot water all over the nude patient, who is next placed on her back on a dirty rush mat on an outer verandah, and in front of the little room in which she will afterwards lie; this is fairly clean and always provided with a new mat. The midwife then sits on the floor in front of the patient, and placing her dirty feet against the vagina presses the vulva and holds it open with all her might. This often results in a bad perineal tear before birth. Putting her still unwashed hands in oil, she pours it from her hands into the vagina, afterwards with oiled fingers dilating the os. This goes on for some time, of course accompanied by weird incantations; then if the birth is still delayed, the midwife roughly pulls her legs and presses the abdomen. Sometimes if there is long delay, the men are called in and they in turn stand on the abdomen with all their weight, or roughly roll on it with a heavy wooden rol-

ler. If after all this treatment there is still delay, the patient is made to kneel on hands and knees for about two hours, in spite of sickness, weariness and pain, and on further delay, a rope is passed round a hook and she is made to pull and strain for two hours without respite. If that is also unavailing hooks are passed up the vagina, and an attempt is made to drag the child out by force. If this is also without avail, the midwife declares it is the will of the gods that the patient shall die, and leaves her, surrounded by wailing relatives; or the men come for us, or pack her into a rough basket slung on a pole and bring her to us. If, however, the child is safely born, they support the patient standing absolutely nude against the wall in order that the blood may drain away more freely. The women frequently collapse and die. The placenta is always dragged away by the cord immediately after birth.

"Is it any wonder that many of these poor women die of tetanus, and if they recover, rarely if ever escape uterine and bladder troubles?"

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Are You Sure You Know?

Tubercular—Tuberculous—Tuberculosis. After listening to a number of speakers at a meeting held recently in the interests of public health, we could not refrain from asking the question: How many nurses know how to apply these words correctly? When you say, "She's the *tubercular* nurse of such a dispensary," Do you really mean just that? When you refer to the *tubercular* dispensary, Are you sure the dispensary *is* tubercular? The meaning and application of these three words is well worth looking up, for if you would but know it you attach a peculiar stigma to yourself when you refer to *that tubercular hospital or dispensary*.

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

Was I Right or Wrong?

To the Editor of The Trained Nurse:

About two months ago I was called on a case, the woman having been operated on about nine days previous to my going. I was informed that the patient seemed to be getting on nicely, when about the eighth day after her operation she began having chills. The first thing I noticed after being on the case a short time, was the patient was voiding small quantities of urine at intervals of about ten minutes apart. The nurses on the floor told me this had been reported to the doctor. She complained of a great deal of pain at each micturition. As the attending physician made two visits every day, sometimes three, on his next visit, I informed him of the patient's condition. She also was somewhat distended. He examined her, and ordered hot mag. sulph. stupes to be kept to the abdomen constantly. In the afternoon she began voiding more frequently, about from 3 to 5 minutes apart, 2 or 3 oz. at each micturition. She seemed to be getting more distended, and the pain was not relieved. Thinking that (*some*) of the distention was probably due to gas, I gave an enema. Bowels moved well with some flatus. About 9 P. M., at doctor's visit, I informed him that patient was very much distended, that I had given enemas, kept stupes on constantly but no relief. I also told him the amount of urine voided at intervals as stated above. His orders were keep up the stupes and give morph. gr. 1-4 for pain if she cannot sleep. She slept about two hours after giving morph., and at short intervals after that. Stupes were kept up through the night. Next morning condition seemed worse. As the doctor had examined the patient, I felt that all responsibility was taken from me, and my only duty was to try and make patient comfortable, carry out all orders and give report; these I did. At the doctor's next visit, I said, "Doctor, our patient is becoming more distended, and the distention seems to be over region of bladder." He again examined her, and said to me "Did you cath-

terize her?" I said, "Why no doctor you didn't order it." The patient was catheterized by doctor and urine was measured (two quarts). I am very particular about catheterizing a patient without a doctor's order. Should I have done it without an order, and informed the doctor sooner that the distention was over region of bladder, when he had examined patient repeatedly, and the report was given on each visit?

M. C. B., R.N.

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The Nightingale Pledge

To the Editor of The Trained Nurse:

I am looking forward to the first graduation exercises for nurses ever held in this small city. The hospital was opened in 1912. In planning with the training school committee for the exercises I mentioned the Nightingale Pledge used by so many training schools as a part of the graduation exercises. One of the doctors present expressed his opinion of the pledge as being undesirable, a mere matter of form, which meant nothing to most nurses. He said few nurses ever pretended to keep such a pledge and that Florence Nightingale never saw the Nightingale pledge, much less wrote it. I had always believed that the pledge was written by Florence Nightingale for the nurses of the Nightingale school. Can you enlighten me as to the facts in the case. I was obliged to admit that such a pledge might be a mere formality and that nurses did not always live up to it, but I still have the feeling that the taking of the pledge is a good thing, though I cannot give very clear reasons for my belief. I would much like to know the origin of the pledge, and to have the opinions of others as to whether it is or is not a good thing to ask nurses to take this pledge.

DIRECTRESS OF NURSES.

EDITOR'S NOTE:

There is room for considerable difference of opinion as to the desirability of nurses taking the so-called Nightingale Pledge. That nurses regard it seriously is doubtful in many cases.

Regarding the origin of the pledge we think

that many besides the writer of the above letter have the erroneous impression that Florence Nightingale wrote it. The Nightingale pledge originated in the training school of Harper Hospital, Detroit, something over twenty years ago. It was prepared by the training school committee of that school and was given the name: The Nightingale Pledge. This pledge must not be confused with the modified version of the Hippocratic Oath which is used in some schools.



The Eight-Hour Day

To the Editor of The Trained Nurse:

Since the subject of the eight-hour day for nurses and the getting of laws passed to ensure it still occupies a place on programs devoted to nursing affairs and is either violently approved or disapproved of by many nurses, I thought this skit on the question from the pen of "Mr. Dooley" might be interesting. It was sent to me by a friend who, I believe, clipped it from a Sunday paper.

"Yes, sir; free hospit'l an' free mid-cine an' an eight hours' day f'r nur-rses. That's me frind Jawrge's plan. 'Tis a fine sunny mor-rnin' whin we star-rt out f'r yeer operation, Hinnissey, an' th' bur-rds is twitterin' gaily in th' threes as th' Ger-rman attendants bear ye on yeer luxurious litter to th' operatin' room. It is a pr-rroud but inixpinsive ixpayrience in yeer life whin th' Doc. administhers th' chloryfor-rm to ye an' puts ye to sleep at th' State's ixpinse. All at wance, just as th' surgeon is about f'r to plunge his knife into th' most sensitive par-rt iv ye an' disclose yeer hideous past, th' nur-rse dhrops th' basin iv wather an' th' bandages. 'What th' divvle is th' matter?' says th' Doc. 'Pick up th' bandages,' he says, 'an' sind out f'r another basin iv wather,' he says. 'I can't,' says th' Nur-rse, she says. 'Th' hooter have just gone,' she says. 'Th' rules iv me Union says an eight hours' day,' she says. 'I sym-pathise,' she says, 'wid th' onhappy patient,' she says, 'that lies writhin' on yonder table,' she says, 'but,' she says, 'th' rights iv the wur-rkers must be rispicted,' she says. 'F'r,' she says, 'appendix or no appendix,' she says, 'I will niv'r be a scab,' she says.

"I tell ye, Hinnissey, they'll be gr-reat times whin Mr. Hills's Bill passes. Ye'll r-read all th' midical news in *Th' Worker*. Here ye ar-re: 'A meetin' iv th' Amalgamated Society iv Hospit'l Nur-rses was held yisterdah in th' Thrades Hall whin sivil subjects iv impor-

rtance wor discussed. It was raysolved afther an illoquent address be Comr-rade Hills, to char-rge over-time f'r all patients sufferin' fr'm insomnia, an' to knock off wur-rk on Wednisdah afthernoons. Hospit'l patients ar-re therefore requested not to divilop dangerous symptoms on Wednisdah afthernoons, as their wants cannot possibly be attinded to before th' whistle blows on Thursdah mor-rnin'."

Trusting that I have not trespassed on your valuable space and wishing **THE TRAINED NURSE** the greatest possible success, I remain,
G. BLANCHE MARSHALL.



A Substitute for Alcohol

To the Editor of The Trained Nurse:

I am superintendent of a small hospital in a State which has "gone dry." While I rejoice in the new law prohibiting the manufacture or sale of intoxicants, my rejoicing is nevertheless tinged with anxiety. I have been told that it will be difficult if not impossible for hospitals to secure alcohol when the new law goes into effect at the new year. This statement has been repeated to me several times. I am wondering what substitute has been devised for alcohol for rubbing backs and for solutions. Will some one who lives in "dry territory" please inform me through your magazine how they manage the alcohol question and oblige
CONSTANT READER.



Ownership of The Clinical Chart

To the Editor of The Trained Nurse:

I have read with much interest the article in the July number of **THE TRAINED NURSE**, by Dr. Christine in regards to the "Ownership of the Nurse's Clinical Chart."

It certainly opened a new line of thought to me. I never thought for one minute the Chart was the property of any one but the attending physician or nurse. The nurse brings her chart, it is a part of her equipment the same as her thermometer or hypodermic and the patient would not think of claiming them. Clinical Charts are always left in the hospital never being considered the property of the patient, although they have paid hospital fee and a nurse too.

Only in rare cases would the record be of any value and that would be (as was an experience of mine) when there was a lawsuit to follow. In my opinion the chart is kept for the doctor, a record of symptoms during his absence and

for his written orders for the nurse. So the record rightfully belongs to one or the other of them. To the average patient they care little for the Chart and would not understand it. In my seventeen years of work I have never been asked by the patient for the Chart.

E. B.



To Induce Flow of Urine

To the Editor of The Trained Nurse:

Enclosed find check for renewal of my subscription. I have enjoyed the magazine so much the past year, and gained so much useful knowledge, I would not wish to lose a single number. I am enclosing a few hints which I hope may help some other nurse, as they have helped me with a number of patients.

How to induce flow of urine.

1. Sitting over hot steam.
2. Hot applications over bladder.
3. Have water running near patient's room.
4. Give fluids to drink.
5. Enemata often help.
6. Heat over kidneys.
7. Pouring warm water over parts.
8. Holding hands in water.
9. Smelling salts to nostrils.
10. Hot tub bath or sitz bath.
11. Turpentine and hot water in bed-pan.
12. Catheterization as last resource cannot be too carefully done.

Always boil catheters carefully with plenty of absorbent cotton in same basin. Use sterile water for cleansing or make a solution of bichloride of merc. 1-5000. Use forceps and cotton for cleansing parts. Scrub hands carefully before beginning. Measure urine. Note the position of glass catheter before inserting. Use rubber catheter the first time you attempt, and always in obstetrical work. CLYDE IRWIN.



To Organize Alumnae

To the Editor of The Trained Nurse:

I wish to organize an alumnae of my school. Will some of our nurses please tell me how to proceed. I am surprised to find the question of the nurse, the hypodermic and the woman who fainted on the street car still being debated. Or rather, I am amazed to find there is still one nurse who can take the stand that the hypodermic did right!

Is a faint such a serious affair that Miss S. must jump in and apply emergency remedies?

How did Miss S. know the woman had not

just taken a dose of strychnine with suicidal intent. And if the case was serious all the more reason for a doctor seeing the patient first. Also just how sterile was Miss S's. hypo I wonder.

Granting Miss S. all the credit due her for her philanthropic motives I still think as I have no doubt a majority of the laity present on the occasion perhaps thought: Miss S. was just a little too previous.

I think the magazine is fine, I enjoy the letter box so much. But I wish more nurses would contribute. It is not nurse-like to "absorb" all and give nothing.

LILLIAN BREARTON, R.N.



Of Interest to Nurses

To the Editor of The Trained Nurse:

The first meeting of the Nurses' Alumnae Association of the Samaritan Hospital, Philadelphia, for the year 1915-1916, held Tuesday evening, September 28, in the Nurses' Home.

Following the business meeting all adjourned to the Gymnasium where through the courtesy of Dr. C. F. Chandler, the originator and president of the Educational Film Company, we witnessed what we believe to be the first motion pictures of surgical operations ever taken; these pictures were photographed by Dr. Chandler about one year ago at the Garretson Hospital, Philadelphia.

The Wassermann Test by the Harmer Laboratories were the first pictures shown in detail, including the anesthetization of rabbit and guinea pig. Cholecystectomy by Dr. Swithin Chandler. Appendectomy by Dr. Swithin Chandler. Arthroplasty of Hip by Dr. Wayne Babcock, chief surgeon of Samaritan Hospital. Dr. John Leedom lectured during the entire operation by Dr. Babcock.

The pictures were very distinct. To recognize the surgeons and nurses whom we know and associate with daily, to recognize etherizing and operating rooms, to distinguish each instrument as used and handled by the surgeons, to watch the progress of operations and recognize specimens removed from patients, to distinguish respirations of patients, made the pictures very realistic.

The meeting was attended by over a hundred physicians and nurses; needless to say it was a very enthusiastic audience and all felt they had witnessed something destined to be of great value and interest to future generations, when the valuable services of these surgeons to mankind have ceased.

JESSIE M. ROWE.

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

Spanish-American War Nurses

The Sixteenth Annual Convention of the Spanish-American War Nurses was held at San Francisco, California, August 9-13, 1915. Headquarters at Sutter Hotel. The program, published in August issue, was fully carried out. The association was honored by the presentation of the bronze medal of the Exposition management. The nurses of San Francisco extended many courtesies. Officers were elected as follows: President, Dr. Laura A. C. Hughes; recording secretary, Ella B. King; corresponding secretary, Mary E. Craig; treasurer, Anna Charlton; vice-presidents, Eugenia Hibbard, Mary J. McCloud, Isabel Harroun, Isabel J. Walton. Laura A. Beecroft, Esther V. Hasson, Mrs. J. W. Taylor, Dr. Ermina B. Davis, Mrs. H. H. Ludlow and Jennie R. Dix. New Orleans was selected as the place of next meeting.



Massachusetts

The Taunton State Hospital Training School for Nurses held graduation exercises in the Assembly Hall of the hospital on Thursday, September 30. There were thirteen graduates and two post-graduates. Rev. James Coyle, LL.D., gave the address to the class. The diplomas were presented by J. C. Desmond, one of the Trustees of the hospital. Miss Emily Rose Durland delivered the valedictory.

The prizes were awarded as follows: \$25 in gold to Miss Frances Bournes, given by Dr. Stedman, Brookline, to the nurse who showed the greatest efficiency in the way of personal interest in and individual care of the patients. Second prize of \$10 in gold to Miss Emily Rose Durland.

A prize of \$15 in gold donated by Dr. Goss, Medical Superintendent, to that member of the graduating class, who during their entire period of hospital service shall have shown the greatest general improvement. This was won by Pauline Martha Brether. Second prize of \$10 in gold, won by Rose Renaud.

A prize of \$10 in gold, donated by Dr. Ripley, Assistant Superintendent, for the nurse who showed the greatest efficiency in the industrial



BAINES NEWS SERVICE

SISTER BEATRICE BARTLETT, OF FRANCE, WHO IS HERE ON A SPECIAL COMMISSION TO OBTAIN HOSPITAL SUPPLIES FOR THE SUFFERING SOLDIERS ON THE WESTERN BATTLE FRONT. SISTER BEATRICE HAS MADE FIFTY-TWO TRIPS ACROSS THE CHANNEL FOR SUPPLIES FOR THE MILITARY HOSPITALS

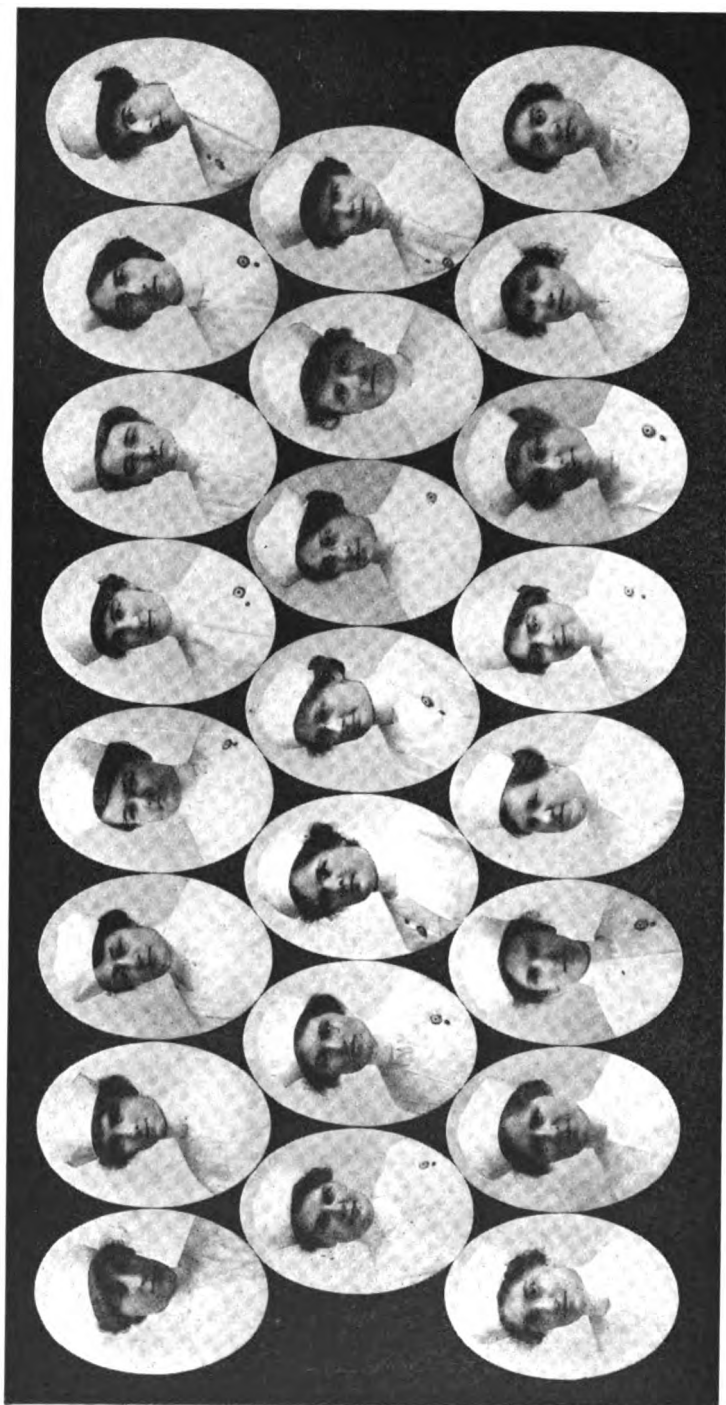
pursuits on the wards, was won by Miss Blanche Provost.

After the exercises a reception was held after which a class ball was continued until midnight.

The class presented Miss Cameron, superintendent of training school and director of industries, with a very beautiful Persian ivory toilet set, as a parting gift.

The class colors were crimson and gold and the class motto, "Loyalty."

GRADUATES—Francis M. Bournes, Pauline M. Brether, Sarah F. Dean, Emily R. Durlan, Della A. Hannon, Terence J. MacShea, Mabel E. Moore, Margaret A. Morrison, Blanche A.



CLASS OF 1915, MT. CARMEL HOSPITAL, COLUMBUS, OHIO

Provost, Rose Octavia Renaud, Charlotte B. Seely, Edward R. Upton, Nora M. Walsh. Post-graduates: Mildred E. Perry, Appie L. Stewart.

The graduation exercises of the Waltham Training School for Nurses, were held at the Training School on Friday evening, September 24, Dr. Fuller presiding. The program was as follows: Entrance of class (music); violin solo, Norval Terrio; opening prayer, Rev. F. E. Webster; song, Mrs. H. A. Pearson; address, Dr. Worcester; song, Mrs. H. A. Pearson; presentation of diplomas; benediction, Rev. Timothy Brosnahan. Those graduated were: Flora E. Atherton, Anna E. Backman, Harriet M. Chapman, Mabel C. Cox, Alice C. M. Dusossoit, Adele J. Fairbrother, Annie L. Gillis, Annie V. Hamilton, Mary J. O'Connell, Elizabeth Ormand, Vera L. Puffer, Helen L. Spalding, Charlotte B. Tice, Marguerite L. Tice, Ruth L. Tuttle, Edith L. Williams, Lucia Woodworth.

A significant occasion in the history of New England trained nursing was the celebration in September of the forty-second anniversary of the founding of the Massachusetts General Hospital Training School for Nurses. The reunion brought together many distinguished graduates of the school. At the banquet which was a feature of the celebration, Linda Richards, the first graduate of the United States, was the guest of honor, and spoke on Pioneer Days.

The Boston Nurses Club, has been doing excellent work for the McGill College Unit in France. A box of supplies has been sent each month, free transportation being given by the Cunard Steamship Company.

Ethel Scott McLean, graduate nurse Massachusetts General Hospital, Class of 1900, sailed September 7 for service in the American Ambulance Hospital in Paris.

Miss Fannie R. Howe, graduate of The New England Baptist Hospital has entered Teachers College, Columbia University, for the course in "Teaching in the Schools of Nursing."

Miss Howe was appointed a delegate from her Alumnae Association to the meeting of the A. N. A. in San Francisco, June, 1915.



Rhode Island

The Rhode Island Board of Examiners or Trained Nurses will examine applicants for

registration at the State Capital, Providence, Rhode Island, on Wednesday and Thursday, November 3 and 4, 1915. For application blanks and information address the secretary-treasurer.

LUCY C. AYERS.

Woonsocket Hospital, Woonsocket, R. I.



Connecticut

The October meeting of the Connecticut Training School for Nurses' Alumnae Association, was held on the 7th at the Nurses' Dormitory at 3 p. m. with the president, Miss Barron in the chair. Routine business was transacted, after which Miss Degnan talked on school nursing. Refreshments followed. It is planned that two members will furnish some form of entertainment each month.



New York

Impressive services marked the dedication of the new home for nurses of the M. E. Hospital of Brooklyn, on the evening of September 30, 1915.

The big auditorium of the latest addition to the institution was unequal to the attendance and many had to stand throughout the exercises.

Piano selections by Miss Olivia May Kavanagh, daughter of the superintendent, the Rev. Dr. Abram S. Kavanagh, and the chapel organist opened the program. Following the hospital hymn, which was led by the Rev. Otto Brand, field secretary and assistant chaplain, came the responsive reading by the Rev. Dr. W. A. Layton, superintendent of the Brooklyn South District; the new testament lesson by the Rev. E. C. Tullar, pastor of the Sixth Avenue Methodist Episcopal Church, and the invocation by the Rev. James E. Holmes, superintendent of the Brooklyn Church Society. Dr. A. Ross Matheson, chairman of the building committee, presented the key of the new building to Superintendent Kavanagh.

Dr. Kavanagh in accepting the key spoke at length on the new home and also referred to the wonderful work being accomplished by the nurses.

He said that the cost of the new building totaled \$164,850.23, and that the furnishings, which included the laundry and office equipment, reached an additional sum of \$10,600. He stated that not a dollar had been expended in its construction for anything that was merely ornamental.

Five Florence Nightingale societies, the

speaker said, had pledged a total of \$5,000 toward the cost of the building.

After referring to her as the nurses' real friend, the Rev. Dr. James M. Buckley, president of the board of managers, who presided, introduced Miss Charlotte A. Aikens, editor of *THE TRAINED NURSE*, who spoke eloquently on "Ideals and Opportunities of the Nurse To-day." She remarked that the nurse was one of the greatest assets the Nation has to-day and we should have many more of them, as there are large fields untouched where their labors could be used to great advantage.

Felicitations were received from Miss Grace Hinckley, supervisor of nurses; from the Newark Conference through Dr. James H. Joy, editor of the *Christian Advocate*, and from the New York East Conference, through the Rev. David G. Downey, book editor of the Methodist Episcopal Church.

In response to the congratulatory remarks, William Halls, Jr., vice-president of the hospital board managers, spoke briefly, thanking the audience for its presence and paying an earnest tribute to the nurses.

The Rev. Bishop Luther B. Wilson of New York delivered the dedicatory address, offered prayer and pronounced the benediction.

A full description of the home was given some months ago in *THE TRAINED NURSE AND HOSPITAL REVIEW*.

The New York State Nurses Association held its fourteenth annual meeting in the ball-room of the Hotel McAlpin, New York City, on October 20 and 21.

The New York State League for Nursing Education held its meeting October 19. Reports of both meetings will be given in a subsequent issue.

The Bellevue Alumnae Association at its annual meeting elected the following officers: President, M. A. Redding; corresponding secretary, M. A. Allen; recording secretary, M. E. Cameron; treasurer, E. G. Paulding.

The German Hospital Nurses Alumnae Association of Brooklyn, at its annual meeting elected the following officers: President, Miss Seaman; vice-president, Mrs. Ward; recording secretary, Ida M. Engelhard; corresponding secretary, Miss L. M. Welsch; treasurer, Miss M. Horrocks.



New Jersey

The New Jersey State Board of Examiners of Nurses will hold an examination for the registration of nurses, Tuesday, November 9, 1915.

Applications must be filed fifteen days prior to November 9, 1915, with the secretary-treasurer.

Information and application blanks may be procured from Jennie M. Shaw, R.N., Sec.-Treas., 487 Orange Street, Newark.



Pennsylvania

The annual meeting of the Graduate Nurses' Association of Pennsylvania, has been changed from November 10, 11, 12, to November 8, 9, 10.

The Nurses' Alumnae of the Harrisburg Hospital held its monthly meeting October 6, in the nurse's home. About thirty nurses were present and the meeting was addressed by Dr. Harvey F. Smith, a surgeon of the hospital staff. Dr. Smith's subject was cancer and the nurse's duty in teaching the public the early recognition of cancer. A social hour followed the talk. The annual meeting of the Alumnae Association will be held in the nurse's home, November 3.

The regular monthly meeting of the Nurse's Alumnae Association of the Philadelphia Lying-in Charity Hospital, was held on Thursday afternoon, October 7, at three o'clock, the president Miss Clara B. Steinmetz, presiding. Twenty members were present. A donation of \$131 was given the hospital from the proceeds of the strawberry festival given last June. Mrs. Mary Warrington Stokes will be asked to address the nurses at the November meeting.



District of Columbia

The Nurses' Examining Board of the District of Columbia will hold an examination for registration of nurses, Wednesday, November 17, 1915. Applications must be made before November 1, 1915, to Helen W. Gardner, R.N., Secretary and Treasurer, 1337 K Street, N. W.



Kentucky

The Kentucky State Board of Nurse Examiners will hold the third (3d) semi-annual examination for State registration, at the City Hospital, Louisville, November 16-17, 1915, beginning at ten (10) A. M.

For further information apply to Flora E. Keen, R.N., City Hospital, Louisville, Ky.



Tennessee

The third annual convention of the Tennessee State Nurses' Association was held in the rooms of the Knox Co. Medical Society, Knoxville, September 16-17. Rev. Walter C. Whitaker,

D.D., rector of St. John's Episcopal Church, pronounced the invocation at the convening of the convention, after which Mayor S. G. Heiskell spoke words of welcome. Mrs. Emma Brockman of Chattanooga, responded to the welcome. The first speaker on the program was Dr. Reese Patterson, a member of the Tennessee State Examining Board, who discussed "The Dignity of the Profession."

In the absence of Miss Catherine Schukin, who could not be present, Miss Kersh, of Memphis, spoke on "The Visiting Nurse." "The Prevention of Infant Blindness" was the topic of a paper read by Mrs. Katherine Carroll, of Nashville. Mrs. M. B. Brown, of Chattanooga, discussed "Tuberculosis." Mrs. Cora B. Keys, treasurer for the eastern division, made a report on the business condition of the association. In the absence of Miss Mary Trigg Jackson, who is now doing Red Cross rural work, and who could not be present, Miss Ada Lawhorn spoke on "The Premature Child, and its Treatment."

Features of the afternoon session, which followed a luncheon at 1.30 o'clock at the Stratford hotel, were an address by Mrs. Elizabeth Minnis, who is superintendent of the Child's Free clinic here, and a talk by Dr. Oliver W. Hill on "Infantile Paralysis," in which he developed some interesting technical points. At the close of the afternoon session, the nurses were shown over the clinic, making an inspection of the rooms and equipment. The night feature for the entertainment of the nurses was a banquet and dance at the Hotel Atkin. This was given in the main dining room, the banquet being from seven to nine o'clock, and the dance following.



Ohio

The members of the Ohio Board of Nurse Examiners recently appointed are: chief examiner, Anza Johnson, Springfield; Harriet Friend, Dayton; Augusta Condit, Columbus; George H. Matson, M.D., secretary.



Indiana

Miss Ida J. McCaslin, of Logansport, was re-elected president of the Indiana State Nurses' Association at the thirteenth annual convention held at Indianapolis in September. Miss Mary A. Myers, of Indianapolis, and Miss Frances M. Ott, of Morocco, were re-elected to their respective positions of second vice-president and treasurer, Miss Edith G. Willis, of Vincennes, was elected first vice-president, and Miss Laura B. Roser, of Rushville, was elected secretary.

It was decided to discontinue the semi-annual meetings in the future, make the annual sessions of three or four days duration and hold them throughout the State rather than in Indianapolis or any particular city. One afternoon of the convention to a discussion of Public Health.

The chief address was made by Miss Harriet Fulmer, president of the Illinois State League of Nursing Education, who spoke on "Why are Nurses Unprepared to Meet the Demands of the New Health."

Miss Carrie Paddock, whose subject was "School Nursing," and who has charge of the school nursing in Indianapolis, told of her experiences. She said that among the many improvements made in the Indianapolis schools in the course of the last year was the appropriation of a sum of money that provides dental and optical inspection for the pupils.

Miss Annebelle Peterson, the only factory nurse in Indianapolis, spoke on "Industrial Welfare." She told how her work increases efficiency by bringing employers and employees closer together.

Miss Laura Wilhelmson gave a talk on "Milk Stations," illustrated by stereopticon views. Miss Cora Ganaway told of the work among the colored people. Miss Maud Heath read a paper, giving one day's experience of a visiting nurse. Miss Olive Bailey of South Bend spoke on "Public Health Nursing from an Administrative Point of View," and Miss Lora B. Roser of Rushville spoke on "Public Health Nursing in Smaller Towns."



WISCONSIN

STATE BOARD EXAMINATION

Ethics—1. What do you understand by the term, "Ethics of a nurse?" 2. What does the state hope to gain because of state registration of nurses? 3. What changes should be brought about in the training schools for nurses because of the law in regard to registration? 4. What are the provisions under the law, whereby a certificate of registration may be annulled? 5. Why do you wish to obtain a certificate of registration? 6. What is the duty of a nurse in regard to her patient's personal and family affairs? 7. Define the duties of a nurse toward physicians? 8. How may a nurse do much harm toward the profession of nursing? 9. What should be the attitude of a nurse toward hospitals? 10. Give reasons why nurses should not wear their uniforms on the street or in public places.

Hygiene and Sanitation—1. What are conditions, necessary to health, about which a city should be responsible? 2. Why should impure milk not be sold? 3. Why is the quarantine of contagious diseases a necessary requirement of public health? 4. Name agencies that are

carriers of diseases. 5. What are nature's best common destroyers of disease germs? 6. Why should excreta and garbage be destroyed daily? 7. What has been accomplished by vaccination in prevention of disease? 8. Name personal conditions the tendency of which are to undermine health? 9. How early should food habits begin and why? 10. What is a nurse's responsibility in regard to the health of the public?

Anatomy and Physiology—1. Define the words anatomy and physiology. 2. What organs are in the thoracic cavity? 3. What organs are in the abdominal cavity? 4. What is the use of joints? 5. Name the kinds of joints, giving examples of each. 6. Describe the stomach. 7. What digestive juice is found in the stomach? What is the action of the saliva? 8. State four ways by which waste substances are eliminated from the body. 9. What is meant by voluntary muscles? What is meant by involuntary muscles? Give examples. 10. Where is the blood purified in the body? Give briefly the plan of the circulatory system beginning with the heart.

Materia Medica—1. Give the apothecaries liquid measure in common use in giving of medicines. 2. If you have cocaine 4 per cent. and the physician wishes 1 per cent., how do you prepare the solution? 3. Give the meaning of the following terms: qs; aa; qid; m; t.i.d. 4. Tell how to prepare the following: sat. sol. boracic acid; alcohol 25 per cent.; tincture of iodine as commonly used for wound irrigation. 5. Name five drugs that, if given in overdose, are very poisonous. 6. Name three heart stimulants, giving dose of each. 7. Give common dose of atropine and chloral hydrate. 8. Give the effects of morphine, and state your attitude in regard to giving it without strict orders from a physician. 9. How are the following usually given: salol, quinine and phenacetine. Tell why they are given so. 10. What is the action of a diuretic? Give two examples. What is the difference between a cathartic and a laxative? Name four cathartics and laxatives with doses.

Sick Children (non-contagious)—1. How would you take the temperature of a sick child? Why? 2. What is the characteristic cry of ear-ache; croup; pain in chest; weakness, and of colic? 3. What are the most frequent causes for sudden rise of temperature with children? 4. Describe the stool of a baby suffering from very severe indigestion. 5. What observations in regard to a child would lead you to immediately call a physician? 6. Define the term malnutrition. 7. What are the very important points to be observed in caring for a child with tendency toward marasmus? 8. How would you give an enema to a baby? 9. Tell how to prepare albumin water, barley water, and beef juice. 10. How do you care for eyes of the new born child? What is the cause of a large per cent. of blindness.

Infectious and Contagious Diseases—1. Tell what you know about typhoid fever. 2. What are the grave complications of typhoid fever? 3. Indicate general orders of daily care of a typhoid patient. 4. Tell how to disinfect stools and

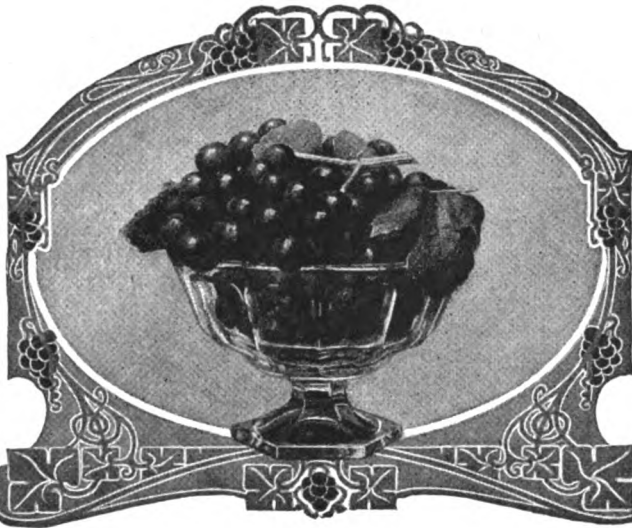
urine of typhoid fever patient. 5. What are the most important factors in regard to the care of tuberculosis patients in behalf of the patients? 6. What are the most important factors in regard to the care of tuberculosis patients in behalf of the public? 7. Define desquamation. What protection is due the public as long as it lasts? 8. What effect has diphtheria on the heart? 9. Give nurse's care of a patient after tracheotomy operation. 10. Tell how a nurse should disinfect herself and her clothing before leaving a contagious case.

Gynecology—1. What are the most frequent causes for gynecological operations? 2. How should the nurse prepare the patient for a vaginal examination? 3. State the functions of each of the pelvic organs. 4. Define hysterectomy, perineorrhaphy, and salpingectomy. 5. What frequently causes prolapse or retroversion of the uterus? 6. Should a nurse ever give an intra-uterine douche? What is a tampon? 7. What instruments does a physician usually need when giving a vaginal examination of uterus? 8. What is the Trendelenburg position? 9. What is your attitude in regard to catheterization? Tell in detail how you catheterize a woman. 10. Tell how to give a vesical douche?

Urine and Urinalysis—1. Name the urinary organs. State the functions of each. 2. What is the understood order in regard to urine with all new patients? 3. When a single specimen is taken for examination, what part of day should it, if possible, be procured? Why? 4. Upon what points is report made in regard to urine? 5. What properties in urine indicate the need of medical attention? 6. Tell how to collect a twenty-four-hour specimen of urine? 7. Give two tests for albumin. 8. Why is it necessary to examine urine both before and after an operation? 9. Name two important causes for the suppression of urine. 10. Name six general symptoms of patient, which would lead you to make a very careful record in regard to urine.

Surgery—1. Tell how to cleanse the hands so as to perform duties where absolute asepsis is desired. 2. Why are rubber gloves commonly used in all surgical work? 3. Name five of the greatest sources of infection in surgical work. 4. What are the most common sutures used? 5. How are abdominal dressings applied after an operation? 6. What do we mean by sterilization? Give two ways by which this may be obtained. 7. State all the articles necessary for anesthesia. 8. What are the complications which may directly follow an operation? 9. What are the symptoms of shock? 10. Tell how to give normal salt solution per rectum, slow method.

General Nursing—1. If asked to give a colonic flushing how would you proceed? 2. Explain in detail preparation necessary for gastric lavage. 3, 4 and 5. Make out clinical chart for twenty-four hours, for an imaginary pneumonia patient, who is very ill, including all care, diet, treatment, symptoms and medicines given. 6. What would you do if your patient were having a severe chill? Why is a chill a grave indication? 7. What conditions in regard to mouth and tongue should be reported to a physician? In what diseases should a nurse give special attention



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to the mouth? What may a nurse do to quiet delirium? 9. What is a common formula for a glycerine, turpentine, and epsom salt enema? 10. Tell your management of ice compresses for an eye.

Dietetics—1. Name some of the important factors that especially affect the digestion. 2. How would you give nutrient enemata? 3. If a child vomits curds of milk, what are a nurse's duties at once? 4. What food contains all the elements necessary for the maintenance of life? 5. Give general rules for feeding the sick. 6. Where does food absorption take place mostly? 7. Give some general rules for preparing meats. 8. What are the most important animal fats? 9. Give diet in habitual constipation. 10. Is diet in diabetes mellitus of primary importance?

Obstetrics—1. Give preparation necessary for an obstetrical case in a private home. (The Sisters may give preparation necessary in a hospital.) 2. Give important daily care for the first ten days, excluding diet. 3. What facts in regard to lochia would you report to a physician? How do you care for the external parts? 4. Why does a physician always wish to examine the placenta? 5. What symptoms, aside from seeing the flow, would lead you to fear post-partum hemorrhage? 6. What would you do in case of post-partum hemorrhage, if the physician were not present? 7. What is puerperal fever? Give causes. 8. What is your care of nipples? Do you use a binder for engorged breasts? If so, how do you apply it? 9. What special care should be given a premature baby? How might such a baby have to be fed? 10. Give reasons for a baby's cry which may be largely eliminated by a good nurse.



NEBRASKA

NEW NURSE REGISTRATION BILL

Be it Enacted by the People of the State of Nebraska:

SECTION 1. The Nebraska State Board for the Registration of Nurses shall consist of the governor, attorney general, and superintendent of public instruction. Said board shall establish and maintain a department for the examination and registration of graduate nurses, and shall appoint five persons as assistants from a list of names submitted to it by the Nebraska State Nurses' Association, who shall have been residents of the State for one year, and graduated for at least three years from a school of nurses in good standing and duly registered under the provisions of this act. One of the original appointees under this act shall serve for one year, two appointees for two years, and two for three years. Upon the expiration of their terms, said board shall appoint successors for the terms of three years. The terms of said original appointees shall begin on May 1, 1915. Vacancies shall be filled by said board within thirty days after notice thereof. Said persons so appointed shall assist said board by conducting all examinations for the registration of nurses and in the performance of all its duties, and to that end shall be known as the Nebraska State Board of Nurse Examiners.

SECTION 2. The members of the State Board

of Nurse Examiners shall, as soon as organized, and annually thereafter, elect from their number a president, secretary, and treasurer, and shall have their headquarters at the State Capitol. The secretary may also serve as treasurer. The State Board for Registration of Nurses shall adopt rules, not inconsistent with the law, to carry out the provisions of this act, and may also outline and establish a course of instruction to be followed by accredited schools for nurses, and a system of inspection of such accredited schools for nurses. The State Board of Nurse Examiners shall adopt a seal, and the secretary shall have the care and custody thereof. The secretary shall keep a record of all proceedings of the board, including a register of the names and addresses of all nurses duly registered under this act, which register shall be open at all reasonable times to public scrutiny at the office of the board.

SECTION 3. The State Board for the Registration of Nurses shall cause the prosecution of all persons violating any of the provisions of this act, and may incur necessary expenses on that behalf to be paid out of fees received, as hereinafter provided. The secretary of the Board of Nurse Examiners, shall receive a salary, to be fixed by the Board for Registration of Nurses. Each member of the Board of Nurse Examiners shall receive compensation at the rate of Five Dollars per day for each day during which said member is actually engaged in attendance upon the meetings of said board and also actual expenses incurred in the discharge of official duties. Said expenses and salaries shall be paid only from fees received under the provisions of this act; and the balance of such fees shall be paid into the State treasury for the benefit of the general fund. The secretary shall annually make a report to the governor of the work of said Board of Nurse Examiners, together with the amount of fees collected, and disbursements. All fees received by said Board of Nurse Examiners, under the provisions of this act, from time to time, deposit the same with the State treasurer. Said State treasurer shall pay the same out on vouchers issued and signed by the president and secretary of said board upon warrants drawn by the auditor of the State therefore.

SECTION 4. Three members of the Board of Nurse Examiners shall constitute a quorum. Special meetings of said board shall be called by the secretary upon the written request of any two members. It shall be the duty of said board to meet for the purpose of holding examinations not less frequently than twice a year, at times and places to be determined by said board. Notices of the holding of such meetings for examinations shall be published in at least one newspaper in Lincoln and Omaha, and also in one nursing journal, at least thirty days prior to the date of such examination. At such meetings it shall be the duty of the said board to examine all eligible applicants for registration under this act, and to recommend to the Board for Registration of Nurses the issuance of certificates to those nurses who pass the prescribed examination to the satisfaction of the Board of Nurse Examiners. Any person to whom a certificate has been, or shall be, issued, or any renewal thereof, shall within ninety days thereafter cause the same

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"About five per cent of all physicians still adhere to the theory that pneumonia, being a so-called self limited disease, admits of no active treatment, but requires only good nursing and patient watchfulness. The other ninety-five per cent, out of their individual and collective experiences, are convinced that, with prompt treatment of the right kind, pneumonia can be often greatly lessened in its severity, shortened in its course, or (as some affirm) actually aborted. We are of the opinion that about seventy-five per cent of the physicians believe there is no single or similar remedial measure which equals Antiphlogistine in its prompt effectiveness in the treatment of this disease."

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to be filed in the office of the county clerk of the county in which such person resided at the time of receiving such certificate, or any renewal thereof. The county clerk shall be allowed twenty-five cents for filing such certificate. Each county clerk shall keep in a book, provided for that purpose, a complete list of all certificates filed by him under the provisions of this act, together with the date of the issuance and filing of such certificates.

SECTION 5. No person, unless previously registered or licensed to act as a registered nurse in this State at the time this act becomes operative, shall be allowed to practise as a trained, graduate, or registered nurse without first applying for and obtaining a certificate for such purpose from the State Board for Registration of Nurses, except as hereinafter provided for. Application shall be made to the Board of Nurse Examiners in writing and shall be accompanied by a fee of Ten Dollars, together with satisfactory proof that the applicant is a resident of the State, is at least twenty-two years of age, has received an education equivalent to one year in high school, is a graduate of and has a diploma from an accredited school for nurses requiring a systematic course of three years' training. When such application is found satisfactory, the Board of Nurse Examiners shall notify the applicant to appear before it for examination. The Board for the Registration of Nurses, upon written application and upon payment of Ten Dollars as a registration fee, shall issue a certificate without examination of applicant, if said applicant has been registered as a registered nurse under the law of another State having, in the opinion of said Board of Nurse Examiners, an equal or higher standard than the State of Nebraska for the registration of nurses.

SECTION 6. Any person who is a resident of the State, of good moral character, and twenty-one years of age or over who has received an education equivalent to that required for admission to high schools of this State, and has graduated from a training school connected with a general hospital, sanitarium or sanatorium where two or three years of training with a systematic course of instruction is given in the hospital; providing graduates of training schools in connection with special hospitals, giving a two years' course, who shall obtain six months or more additional training in an approved general hospital, shall be eligible to examination within one year after this act takes effect. All nurses who have been graduated prior to January 1, 1905, possessing the above qualifications and meeting the foregoing requirements, shall be entitled to register without an examination, by paying the registration fee and making application on or before May 1, 1916. Nurses possessing the above qualifications who are in training, or who enter upon training hereafter, in hospitals, sanitariums, or sanatoriums, meeting the above requirements, provided they graduate and receive a diploma from said hospitals, sanitariums or sanatoriums, shall be eligible for examination on or before June 1, 1918.

SECTION 7. All certificates to nurses shall be issued by the Nebraska State Board for Registration of Nurses, and shall be countersigned by

the Board of Nurse Examiners, and when so issued shall confer authority upon the said persons to practise as registered nurses. Said nurses shall be entitled to use the letters "R.N." after his or her name, and it shall be unlawful for any other person to assume such title or use the abbreviation "R.N." or any other letters or figures to indicate that he or she is a trained, graduate, or registered nurse, or for any person to practise nursing as a trained, graduate or registered nurse without a certificate, as aforesaid.

SECTION 8. This act shall not be construed to apply to the gratuitous nursing by members of religious societies, or of the sick by friends or members of the family, nor to any person nursing the sick for hire who does not in any way assume to be a trained, graduate or registered nurse.

SECTION 9. Any certificate issued by virtue of this act may be revoked by the Board for Registration of Nurses for dishonesty, gross incompetency, habitual intemperance, immorality, or any act derogatory to the morals or standing of the profession. The holder of such certificate shall be entitled to thirty days' notice in writing of the complaint, together with notice of time and meeting of the State Board of Nurse Examiners for the hearing thereof, who shall report its findings and recommendations to the Board for Registration of Nurses.

SECTION 10. Any person violating any of the provisions of this act, or who shall practise or attempt to practise in this State as a trained, graduate or registered nurse without a certificate, as heretofore provided, or who shall willfully make any false representations in applying for a certificate, shall be guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine of not more than One Hundred Dollars.



Texas

The Texas Board of Nurse Examiners will hold examinations November 9 and 10, in El Paso, Fort Worth, Houston and San Antonio. M. M. Taylor, Secretary, Physicians and Surgeons Hospital, San Antonio.

Miss Sara Haag has taken charge of the Seguin Sanitarium, Seguin, Texas.



Washington

Grace L. Holmes has been appointed superintendent of the new County Sanatorium at Spokane, Washington.

Work has been started on Walla Walla's new \$25,000 hospital. The institution is one of which a city many times Walla Walla's size might well feel proud.



Utah

The regular quarterly meeting of the Salt Lake City Nurses' Association took place at the Y. W. C. A. rooms, October 6, 8 P. M. Annual election of officers as follows: President,

"A Dependable Ally"

All too frequently when the natural defences of the body call for support and reinforcement, the reserve forces are found to be weak and inadequate. The aid of a good tonic becomes urgent, therefore, if the body is to win in the conflict with disease.

As a dependable ally to the physiologic forces of the body

Gray's Glycerine Tonic Comp.

has proven its value beyond all question during the twenty-five years it has been at the command of the medical profession.

It is simple yet appealing in its composition; the ingredients of "Gray's" are selected and combined with a care to quality and uniformity that assures therapeutic effects impossible to obtain with nondescript substitutes.

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Miss Dofuer; first vice-president, Miss Ellen Lees; second vice-president, Miss Laura Willis; recording-secretary, Miss Card; corresponding secretary, Miss Frae Korous; treasurer, Miss B. Smith. A large number of nurses were present.



Marriages

On September 2, 1915, at Baltimore, Md., Mertu E. Shelley, graduate nurse of Harrisburg Hospital, Class of 1914, to Tolbert Fritz. Mr. and Mrs. Fritz will reside at Paxtang, Pa.

On September 29, 1915, at Lock Haven, Pa., Esther M. Hanna, graduate nurse of the Harrisburg Hospital, Class of 1913, to Frank B. Long. Mr. and Mrs. Long will reside at Tulsa, Oklahoma.

On October 4, 1915, Emmeline Sivomley, graduate nurse of the Harrisburg Hospital, Class of 1911, to Dr. Wm. Lewis Crawford. Dr. and Mrs. Crawford will live in Dillsburg, Pa.

On July 12, 1915, at Duluth, Minn., Althea I. Carpenter, graduate nurse of St. Mary's Hospital, Duluth, to Walter S. Smith.

On August 17, 1915, at Gaffney, South Carolina, Irene Templeton, graduate nurse of Magdalene Hospital, Chester, South Carolina, to Parker Hamilton of New York City. Mr. and Mrs. Hamilton will reside in New York.

On February 7, 1914, at Decatur, Illinois, Laura M. Muller, graduate nurse of Mullanphy Hospital, St. Louis, Mo., to Dr. F. H. Pringle, chief resident physician of City Hospital, St. Louis. The marriage has only recently been made public.

Recently at Bellingham, Wash., Grace Scribner, graduate nurse of St. Luke's Hospital, Bellingham, to Guy A. Duncan. Mr. and Mrs. Duncan will reside in Bellingham.

On August 28, 1915, at Sullivan, Ind., Lillian Laughlin, to Earl Wine.

On September 1, 1915, at Mt. Tom, Mass., by Rev. G. Burrill, Edith J. Corb, graduate nurse of the Worcester Memorial Hospital to William Underwood of Mt. Tom.

On August 24, 1915, at Quincy, Ill., Leonora Welsh, a graduate nurse of Quincy, to Dr. John Henry Rice,

In August 1915, May Vera Wheadon, a nurse of the Trull Hospital, to David Taylor Parker, of East Orlean, Mass.

On September 9, 1915 at Westfield, Mass., by the Rev. George M. Fitzgerald, Mary E. McMahon, graduate nurse of Hampden Hospital, to Weston G. Carey.



Births

On September 26, 1915, to Mr. and Mrs. Joseph A. Ross, a daughter. Mrs. Ross was Lillian Walls, Class of 1907, Rhode Island Hospital, Providence R. I.

On September 3d, at Seattle, Wash., to Mr. and Mrs. Morris R. Moon, a son. Mrs. Moon was formerly a nurse at St. Mary's School, Faribault, Minn., and later at Valdez Hospital, Alaska.

On August 26, 1915, to Mr. and Mrs. Joseph Kirby, a son. Mrs. Kirby was Gertrude A. Willis, Class of 1909, Buffalo General Hospital Training School for Nurses.

On August 21st, to Dr. and Mrs. Goldstine, a son, Mrs. Goldstine was Lola Rumly, graduate nurse of Wesley Memorial Hospital, Class of 1912.

Deaths

On September 5, at the McIntyre Hospital, Virginia, Minn., Miss Bertha E. Olson died of typhoid fever.

Miss Olson was a graduate of Waldheim Park Training School for Nurses, Oconomowoc, Wis., Class of 1912. She was a young woman of fine character, sweet disposition and a most capable nurse.

After five weeks of severe illness, when her recovery seemed assured, she died suddenly of hemorrhage and complications. She was one of the many noble young women who daily sacrifice their lives for the relief of suffering humanity.

On June 14, 1915, at her home in Crafton, Pa., Mary F. McMaster, R.N., graduate nurse of the Homeopathic Hospital, Pittsburg, Pa. Miss McMaster had been superintendent of several hospitals, including the Lincoln Memorial Hospital of Knoxville, Tenn., the Southern Pacific Hospital of Houston, Texas, and at the time of death was superintendent of the Good Samaritan Hospital, Lebanon, Pa.

Children, as soon as their molars appear, should be systematically taught to masticate their food—not bolt it, as is too often the case—thus avoiding digestive troubles later, and insuring sound teeth.

To secure the best and most prompt results with children, any salutary or otherwise desirable habit is most easily inculcated, if made pleasant to the child. Parents and teachers realize this fact.

There is, probably, no food preparation so admirably adapted to the cultivation of the habit of thorough mastication as

Grape-Nuts

When combined with cream or rich milk (and a reasonable amount of sugar to suit the taste of some) Grape-Nuts food is most agreeable to the palate; and at the same time is an all-round perfectly balanced ration.

Made of whole wheat and fine barley (malted), Grape-Nuts nourishes the child and affords a pleasant, scientific means of instilling correct habits of eating at this early age.

Physicians appreciate the immense value of Grape-Nuts to children as a regular daily portion of their dietary.

The ***Clinical Record***, for Physicians' bedside use, together with samples of **Grape-Nuts**, **Instant Postum** and **Post Toasties** for personal and clinical examination, will be sent on request to any Physician who has not received them.

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Book Reviews

The Psychic Treatment of Nervous Disorders.

By Paul Dubois, Professor of Neuropathology, at the University of Berne, Switzerland. Cloth, 466 pages. Funk & Wagnalls, New York. Price, \$3.

This book which in a few years has reached its sixth edition has been translated for American readers, and edited by Smith Ely Jelliffe, M.D., Visiting Neurologist to City Hospital and Instructor in Columbia University, New York, and William A. White M.D., Superintendent Government Hospital for Insane, Washington, D. C. It has long been considered a standard text-book by those physicians, nurses, social workers, clergymen and others who are particularly interested in the psychological aspect of the treatment of disease—not simply of nervous and mental disorders, but of a wide range of diseases, not included in those classes.

The book gives the experiences and principles of the psychic treatment used by the author in more than twenty years of successful specialization in this branch of the healing art. The work of the author is both that of psychologist and physician. An especially valuable feature of the book and one that will appeal especially to nurses, is the full and accurate description of the methods used by the author in the practice of psychotherapy in a great variety of cases. The author discusses in detail the use and advantages of suggestion, auto-suggestion, hypnosis, persuasion in their relation to therapeutics, the objections to them and the method found most valuable in different situations. Dubois pins his faith and not without good reason, to persuasion to the re-education of the will or reason, in preference to suggestion which he has tried and practically abandoned.

He calls attention to what he considers a defect in medical education which leads a physician to overlook the overwhelming influence of emotions of all kinds on the development of disorders in which the nervous symptoms are prominent that leads the physician to restrict his treatment to the body, and to go hunting among the organs of the abdomen for the cause of all these psychic and nervous troubles.

Dubois contends that the object of treatment ought to be to make the patient master of himself, that the means to this end is the educa-

tion of the will. He claims that whether he wants to or not, the physician ought to be a psychologist and that in general practice he will see that his knowledge of the human heart is more useful than his ability in questions of normal or pathological physiology.

The author discusses the nervous element in various digestive disorders; in intestinal conditions, in disturbances of circulation, dyspnea, disturbances in urinary functions, sexual psychopathy, menstrual difficulties, nervousness at the menopause, insomnia, and a great variety of other disorders, giving suggestions as to the applicability of psychotherapy to such disorders, and illustrations from his own practice as to how to effectually influence such disorders through the education of the patients' will.

The translators of this valuable book call particular attention to the fact that the book is not intended solely for physicians but for all whose life and work brings them in contact with disease, and with people who are not in the possession of normal health. "The strong optimistic tenor of the book, its simple untechnical language and the directness with which its philosophy is applied to life, make it capable of becoming a vital fact, not merely to physicians, but to every one who has pondered on the relations between the psychic and the physical—to every one, indeed, who honestly desires to keep down the sum total of needless suffering in the world."

✱

Nursing in Diseases of the Eye, Ear, Nose and Throat. By the Committee on Nurses of the Manhattan Eye, Ear and Throat Hospital, New York City. Second edition, thoroughly revised. 12mo. volume of 291 pages, illustrated. Philadelphia. W. B. Saunders Co., 1915. Cloth, \$1.50 net.

The special features of this second edition are a thorough revision of text, the addition of new matter, and the omission of matter now considered obsolete. Several subjects have been added, namely: The Preparation of Surgical Dressings, Mental Disturbances after Operations on the Eye, and Functional Tests of the Static Labyrinth. These additions should materially increase the value of the book.

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Pepto-Mangan (Gude)

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ANEMIA of All Varieties:

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DOSE: One tablespoonful after each meal.
Children in proportion.

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Our Bacteriological Wall Chart or our Differential Diagnosis Chart will be sent to any Physician upon request.

A Nourishing and Cooling Drink for the Sick

In convalescence, for weakness, nervous or feverish conditions, **Horsford's Acid Phosphate** is safer, more palatable and more beneficial than lemonade or lime juice.

Horsford's Acid Phosphate

contains valuable nutrients—phosphates of calcium, sodium, magnesium, and iron. It is, therefore, far superior to Dilute Phosphoric or other acids.

A teaspoonful in a glass of cold water makes a most grateful beverage

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New Remedies and Appliances

One Solution of a Vexing Problem

Hospitals of a hundred beds or less would do well to obtain a proposition from the Hurley Machine Company, 29 South Clinton Street, Chicago, manufacturers of Thor Washers.

Their new all-metal Hospital and Hotel Washer is very rugged in construction, built to stand the heavy wear and tear of steady work in a hospital, institution or a hotel.

Every hospital having electric current available is losing money when they send their linen to the commercial laundry, or when they handle it by hand methods.

These modern machines operate for two or three cents per hour per machine for current, and will do about as much work per hour as an expert hand worker can do in a full day.

The quality of work turned out will average much higher than the average hand work.



A Special Shoe for Trained Nurses

A shoe that fills a long-felt want, made especially for trained nurses, is now sold direct to nurses by the "Nurses Specialty Shoe Company," and a brief description of this special shoe may prove of interest.

This shoe is a genuine Goodyear Welt, with a long wearing, heavy sole, made pliable and flexible by a secret process. It combines the style and wear of the Goodyear Welt with the flexibility and comfort of the turned shoe, making it by far one of the most comfortable high-grade nurses' shoe ever made.

The shoes are all equipped with the well-known "Cats-Paw" Rubber Heels, which make the shoes absolutely noiseless, and are just the thing for nurses.



Finkle Uniforms

The Finkle Uniform Company, 47 West 42d Street, New York City, have issued a very attractive catalogue, showing the various styles of uniforms, caps, aprons, collars and cuffs made by them, with full description and prices. Nurses who have once worn the Finkle Uniform will send in another order, because of the complete satisfaction it gives,

Sabalol Spray

This well-known balsamic preparation not only cleanses the nasal mucous membrane, freeing it from dust and scaly accumulations, but it exerts a mild astringency and thus prevents the ingress of dust and germs to the deeper tissues. It is tonic and raises the resistance of the mucous membrane. Used before and after automobiling or any trip leading to exposure to dust, Sabalol Spray will give the exact protection needed to insure avoidance of the nose and throat irritations that are so apt to lead to graver affections.



Hospital Garments

Hospital superintendents, have you ordered your fall supply of operating gowns, coats and aprons? If not, send to Elmer A. Gore, Worcester, Mass., for catalogue and samples. He can supply all kinds of hospital garments for the use of physicians, nurses and ward patients.



For the Complexion

Rainier Natural Soap is a natural complexion soap. The medicinal properties of mineral Saxonite put the skin in a healthy condition, remove the disagreeable and unsightly eruptions and keep the complexion fresh and the skin smooth, soft and velvety. There are no drugs or chemicals in this soap to harm the most delicate complexion or tender skin.

The regular use of Rainier Natural Soap will prevent chafing, chapped hands, roughness and redness. Many men use this soap after shaving. It makes the skin smooth, and cools and soothes the tingling sensation that sometimes follows. It disinfects and renders the skin antiseptic.



Toko-Zol

Toko-Zol is a high-class preparation, prepared in tablet form, and a line to The Toko-Zol Pharmaceutical Co., 68 William Street, New York, mentioning the TRAINED NURSE AND HOSPITAL REVIEW, will bring a sample to any nurse.



We Are Extremely and Truly Grateful

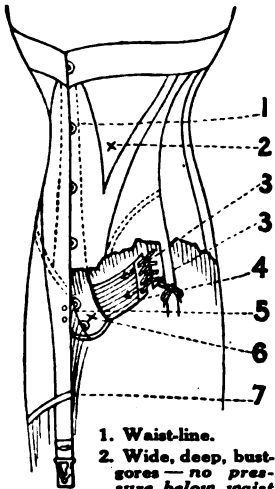
—for the generous endorsement of the Nemo “Self-Help” Wonderlift Corset by thousands of physicians, surgeons and gynecologists. We have not heard of a single instance of adverse criticism.

We are very grateful for the fact that apparently we have provided the medical profession with a supporting device that will solve the often bothersome problem of inducing a patient to wear a supporting bandage which shifts, hurts and “bulks” the figure.

See the illustration of No. 556 for slender figures. Note the ultra-stylish lines of this corset, giving no hint of the concealed device that gives such excellent visceral support. Other models for medium and full figures have similar graceful and fashionable lines.

HOW TO ADJUST THE NEMO SELF-HELP WONDERLIFT BANDLET

The corset is first fitted upon the figure, well down, curved steels reaching lowest point of abdomen. The adjustment of the Nemo Wonderlift Bandlet must be done in this extremely simple manner: The two protruding laces (on each side) are pulled evenly—the same pull on one as on the other. To do this, both laces are wound, flat and even, once around the fore-finger, and firmly held by the thumb. The pull must be directly downward—not outward or upward. Pull slowly. Do not jerk or twist the laces. Tie laces in single knot, finish with single bowknot.



1. Waist-line.
2. Wide, deep, bust-gores—no pressure below waist on stomach and liver.
3. Adjustable semi-elastic binder (oblique muscles).
4. Poupart's ligament.
5. Symphysis pubis.
6. Curved steels—no pressure over bladder.
7. Garters attached to semi-detached skirt—no undue pressure upon abdomen.

Why This is a Truly Scientific Supporting Corset

The semi-elastic bandlets are in exact apposition to the internal broad ligament, and, in position and action, closely simulate the lifting and supporting functions of the external and internal oblique muscles. The inner side-lacing permits exact individual adjustment, each side being independent of the other, thus providing for inequalities in size and shape of abdomen. The mechanical construction is such that the entire weight of support is carried upon the hip bones, thus protecting the kidneys from undue pressure and the spinal column from distortion.

For all forms of ptosis. Invaluable in inoperable floating kidney. A great help in anteversion, retroversion, prolapsus, ante-partum, post-partum, obesity, hernia. The corset acts as a splint to the internal organs and their ligaments, giving them “physiological rest” until they regain their tone. The elasticity of the bandlets produces a passive massage, reducing fat, correcting the circulation, relieving recent adhesions and preventing new ones.

This New Kind of a Binder “Stays Put!”

It can't shift. It gives added comfort. It does not bulk the figure, but reduces it. It accomplishes its purpose without offending the woman's pride of figure. Your patient will wear this corset gladly. Too often she throws your binder aside the minute your back is turned.

It is inexpensive. The price of this corset is \$5.00—less than the cost of the cheapest binder; and it's a big value, simply as a corset, at \$5.00, saying nothing of this new supporting feature.

We shall be glad to furnish further information on request.

The Nemo Hygienic-Fashion Institute, 120 East 16th St., New York City, U. S. A.

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A Systemic Boost

It is safe to say that the average physician is called upon to prescribe a tonic more frequently than any one other form of medication, unless it be a cathartic. Patients who are patients solely because they are tired, "run down" and generally debilitated, are constant visitors at the physician's office. Such individuals need something that will boost them up to their normal point of resistance and then hold them there: in other words, not a mere temporary stimulation, with secondary depression, but a permanent help to the revitalization of the blood and a general reconstruction. Pepto-Mangan (Gude) is not only prompt in action as an encourager of appetite and better spirits, but is also distinctly efficient as a blood builder and systemic reconstituent. It is pleasant, non-irritant, free from constipating effect and does not stain the teeth. It is thus a general constitutional tonic of positive service in all conditions of general devitalization.

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Baby Ricinol-Grape

As the grape is delicately flavored it not only disguises the taste, but gives the child the impression that it is getting some confection or candy.

The dose for babies from one to three years old, one to three capsules (more can be taken if necessary).

Children from three to six years old require from three to six capsules. Melt in the mouth or swallowed with a drink of water. They are absolutely harmless and cannot injure the most delicate stomach.

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Correct Glasses

Every nurse who wears glasses needs an accurate and scientific examination and a perfectly made glass. J. C. Liederbach has complete and up-to-date apparatus for making the proper examination of the eyes. There is no charge for examination if he makes your glasses and if you already have a prescription he will fill it more reasonably than any first-class optician. His guarantee is all you need to know and his work for the nurses of many New York hospitals is his recommendation. Any information cheerfully given.

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Help for the Baby

A case has just come to our attention in Lowell, Mass., where Margaret E. Farley, a trained nurse, says her little niece, Edith White, when only ten days old, was completely covered with festers or sores and the physician said it was caused by a highly perfumed powder they

were using on the baby. He told the nurse to stop using this powder at once, and use only Sykes' Comfort Powder, which she did. It quickly healed the sores so the skin does not show a blemish. There are thousands of nurses who never go without Sykes' Comfort Powder, because it saves so much suffering of infants, children and bedridden people, and brings comfort and peace to the nurse.

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The Abbott Laboratories

For the great bulk of your surgical work, doctor, you do not need to bother with the inhalant anesthetics—ether, chloroform, and the like—which are so awkward to handle and so disagreeable, and even risky, in their effects upon the patient. Most of your cases will come within the range of the much cleaner, simpler, safer hypodermic method. For minor operations, of a more or less superficial character, Anesthaine is the anesthetic of choice, ten to twenty minutes, injected into the tissues, procuring and maintaining total anesthesia for twenty to thirty minutes. When you wish for deeper and more general anesthesia, your hypodermic syringe is still your resource, but this time it should contain H-M-C (Abbott) in solution. With these two anesthetics in your case—and they can be carried anywhere, and administered by yourself without any assistant you are master of all but the exceptional requirements in anesthesia.

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The Ideal Germ Destroyer

Science has recognized oxymethylene (formaldehyde) as a powerful germ destroyer, disinfectant agent, deodorizer and antiseptic, yet safe.

Unfortunately it is, under ordinary conditions, too pungent to use as such, or in ordinary combination.

But a means has been discovered by which this valuable and efficient substance has been combined in such a way as to render its use pleasant, easy, absolutely safe and effective.

The result is Formamint Tablets.

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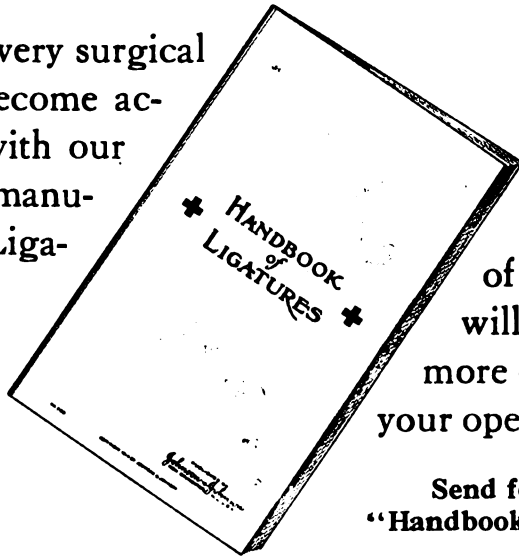
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What Hospitals Can Do in Preventive Medicine*

A committee consisting of Dr. W. L. Babcock, Mr. Sidney Goldstein, Miss Charlotte Aikens, Mr. Michael M. Davis, Jr., and Dr. John A. Hornsby, chairman, was appointed at the Boston meeting to consider this question.

REPORT OF THE COMMITTEE

The resolution creating this committee touched on a number of points in a very broad field. The committee intends to pursue the matter during the coming year and presents the following only as a preliminary:

We have confined this report to a single question: "What practical steps should a hospital now take for doing preventive work?" "What are the obligations of the hospital in the direction of preventive medicine?"

The trend of modern medicine is strongly in the direction of prevention, and the hospital, reflecting as it does the progress of medicine, must follow this trend. A hospital is not fulfilling its duty to its patients unless it combines with the curative work of its wards sufficient preventive work of a clinical nature to minimize the chance of recurrence of disease. A large proportion of patients are able to leave the ward when they are not able to return to work or to family life without endangering their return to health. If the patient is from a well-to-do home, the family and the family physician provide this after-care. If the patient is not from such a home, the hospital must provide it or else fail to do a thorough job for that patient.

How shall the hospital provide this after-care as a part of the required preventive work? In three ways:

1. Through the out-patient department.
2. Through a convalescent home.
3. Through a social service department working in cooperation with other medical,

charitable and educational agencies in the community.

At this point we may divide hospitals into three classes:

- (A) The large general hospital in the large city.
- (B) The small semi-private or special hospital in the large city.
- (C) The hospital of small or moderate size in the small city or town.

(A) Large general hospitals in large communities have, in many cases, out-patient departments. Every such hospital needs one. The out-patient departments that now exist are often not systematically used as a means of follow-up work for patients discharged from the wards. One frequent defect is that out-patient clinics are overcrowded; another is loose organization. The out-patient department should be medically organized in the most intimate relation with the hospital, and should be under the personal administrative supervision of one of the assistant superintendents.

Every large hospital needs a convalescent home, or access to such a home or homes supported by their agencies. A convalescent home is a direct financial as well as a medical economy to a hospital.

Every hospital in this class needs a social service department. Proper after-care cannot be provided without the aid of such a department. Through the same means the assistance of charitable agencies is secured for patients or families who need such aid. It is most important that, in establishing social service, a properly trained worker be secured. Adequate salaries must be paid. On the other hand, social service is generally found to awaken new interest in the hospital and to attract financial support more readily.

The work of the social service department should be planned so as not to duplicate the work of charity organizations and municipal departments already covering their special

*Read at the sixteenth annual conference of the American Hospital Association, St. Paul, August 25-28, 1914.

The Trained Nurse and Hospital Review

VOL. LV

NEW YORK, DECEMBER, 1915

No. 6

The Possibilities of Future Development in the Service Rendered by a Hospital to a Community*

ANDREW R. WARNER, M.D.

Superintendent of Lakeside Hospital, Cleveland

FUNDAMENTALLY, hospitals are one type of institutions created by society for service to society. Their existence implies a need, for the service and their future growth depends upon the degree of usefulness that can be developed. Beyond and above a hospital's service to the individual sick in its beds, to the medical profession, to the cause of medical education, and to the growth of human knowledge, stands that hospital's final, resultant, real service to society as the ultimate measure of excellence. It is the whole of which all of the many other functions of a hospital are parts, important—essential, but only parts. There is yet, occasionally, a hospital performing only the first elementary function of a hospital—the furnishing of bed and board to individual sick; but there are now many at the other end of the scale giving service which is the product of hands skilled in many ways and the work of several professions, at least of the nursing, the medical, the ecclesiastic, and the sociologic. These hospitals can render the greatest service to society; it is therefore these that society will in the end elect to preserve and support.

* Read before the Convention of American Hospital Association, in San Francisco, June, 1915.

In a single paper one could not discuss all the possibilities of future development in the service rendered by such hospitals to society; there are too many now clearly in sight and of these but few can be selected.

PREVENTION OF DISEASE AND PUBLIC HEALTH

The era of prophylactic medicine is no longer a hope; it has come, a reality in fact, though it will develop in degree. The health centers established, the more frequent routine periodic physical examinations, the work of the factory physician and social service department and the frequent use of the visiting nurse by insurance companies indicates that individuals and corporations are becoming convinced that it already pays in days of health and productive labor better than its cost. There is now a general recognition that it is better charity to keep a man from the need of a hospital bed than to care for him when in one.

The composition of the average hospital ward is a public disgrace and a reproach. Here are found typhoids because we drink our sewerage; visceral and brain syphilis, because doctors, dispensaries or hospitals have been too careless about letting patients slip away half cured, a menace to others

and a prospective public burden; here is sometimes tuberculosis, but never chicken-pox, because the community calls chicken-pox contagious and isolates it, but not as yet tuberculosis; here are men sick because they worked in a danger of which they knew nothing; here is a long line of men useless from the primary and secondary effects of alcohol. Hospitals see the needlessness, the ridiculousness of it all even better than others, and although it often means hard work to raise the money to pay the cost, they generally endure it in a silence and with a degree of inaction, that does not indicate patience or any other virtue.

If a factory begins to send to a hospital, cases of lead poisoning or other industrial disease to fill the spare beds, there is a sacred duty, a trust, to be fulfilled—not to appeal to the trustees for more beds for these poor sufferers, but to tell the facts, all the facts, to the local authorities, to the State board, and to the public. What the authorities cannot do to force a correction of the faulty working conditions, public opinion can, and it will be done. Then the extra beds will not be needed. It is not always a compliment to a hospital when some factories elect to patronize that hospital, and if a hospital's collective conscience and regard for duty can be kept dormant by the prompt payment of ward rates, it is thereby classified if not standardized. The public has long talked about cemeteries as the burying ground for the results of medical incompetence, and the public is beginning to talk about the hospital record room as the burying ground for the responsibility for human lives carelessly, needlessly, wrongfully damaged or lost. A policy of silence, inaction, disregard toward industrial carelessness and other causes of needless suffering and death, makes the hospital an accessory to the crime. The working conditions of some manufacturing plants are wrong entirely through ignorance, and not with wilful carelessness. But this does

not lessen—it increases rather the hospital's responsibility to make the effort to relieve the detrimental working conditions; for the hospital's story told direct to the managers will in such cases promptly bring the desired results.

The preservation of public health in all its forms is a major work for every hospital. No contribution of facts pertaining to public health problems can in any way equal that collected by hospitals. This is due to the fact that the records are written, that both the primary and secondary diagnoses are collected together in the indexes, and that large series are rapidly collected. The poor, the people reached best by hospitals, are affected first and most by community conditions unfavorable to health. The out-patient department by its numbers is extremely sensitive to changing conditions. The diagnoses made in a day or a week are a fairly accurate picture of the state of the public health of the locality, a fact just beginning to be put to any use. We are the keepers of public health more than we sometimes realize. In these days cities have epidemics of small-pox only when some dispensary misses that first case from the crowded foreign settlement.

Dispensaries will not always be departments or adjuncts of hospitals' "poor relations," as they have been called. The public interest will follow the profession to the newer fields. Although the man with tuberculosis, brass poisoning, or typhoid will continue to get the most careful attention, the keen interest and the higher regard will be placed in the work of preventing others from getting the same troubles. The primary philanthropic institution will then be the one in the closest contact with the people, the dispensaries, and the one which writes daily in its records the danger signals and the forecasts of the health of the community, now so little considered. Financial support always fol-

lows interest. Around the dispensary will be grouped the acute wards, the convalescent hospital, the hospital farm, the departments to train the maimed and handicapped back to usefulness, and other departments. Such an institution will be equipped to mend the accident or misfortune in the best way possible at the same time that it is promptly preventing more from the same source.

Sometimes even our routine work and records can be used quite effectively. When the Social Betterment Committee of the Federated Churches of Cleveland decided to attempt to secure the closing of the segregated vice district, the ministers counted the men and boys who visited this district, and asked what the harvest must be. The two hospital superintendents who were members of the Committee counted the cases of disease coming to our clinics. We questioned every man as to the source of his infection and were soon able to demonstrate that 40 per cent. of the fresh infections with venereal disease was acquired in this small isolated vice district, although only 10 per cent. of the prostitutes, street walkers, and other habitually immoral women known to the police, were inmates of this district. We brought the Mayor and Chief of Police of the city to our clinics to show them the constant stream of needless human suffering that came from this district to overwhelm the offenders and the innocent of this and succeeding generations—not to point out the wealth of our clinical material. We opened our hospital records to them that they might realize the aftermath. The result of it all was the addition to the plans of our City Hospital of a pavilion of 150 beds for the isolation of the venereal disease together with an increase in the beds now available, and recently, too recently to count our gain, the complete permanent closing of the district by a forceful, sincere Mayor and an efficient Chief of Police, equally deter-

mined to rid Cleveland of all traces of commercialized vice. The crowding in our dermatological clinic will, I believe, soon become a little less troublesome.

The fields for service to public health and preventative medicine open to hospitals are as yet mostly possibilities for future development, but the proper use of our records and opportunities already promises to prevent more disease than our beds could possibly relieve with treatment. Incidentally the record-room work gets results cheaper than the ward. Is the "summum bonum" the medical profession or is it public health?

BROADER FIELD

The present also reveals to us the beginnings of a recognition of our broader responsibility to a patient. Usefulness is the measure of life and life's happiness. It may be lessened or abolished by disease and thereby bring not only dire misfortune to the individual, but a problem to society. Such a problem begins when full usefulness ends; it is solved only when usefulness is again restored. To hospitals society assigns the solving of these problems when the individual's resources are inadequate. The limits of the hospital field are therefore from the ending of usefulness to the restoration of usefulness. Social service, as we now know it, is but the beginning of the reorganization of hospitals to assume the full responsibility for the assigned problem and a promise of farther development, not a finished product. The hospital social service worker recognizes these broader limits of the hospital field in the daily task of getting someone a job and back to work, to normal life. The interval between the discharge from the hospital after an acute illness and the day the man can return to work is usually—at least a dangerous risk, if not a serious damage to a working man. Supervision of convalescence saves too many chronic conditions, too many

overstrains, and too many lives not to eventually become general. Hospitals must make the use of convalescent departments a routine, the longer stay in the wards at high cost can never stand against the far cheaper and better farm life, the open air, the sunshine, and the graded schedule of work in the garden to bring a man back to working condition. This and much more will come when the hospital's work no longer ends when the patient is "able to go home," but when he is "fit to go to work." The responsibility to furnish the most effective and the broadest service cannot now be abrogated by any hospital: it can be ignored only.

RESEARCH AND EDUCATIONAL

In the last few decades many medical schools have established chairs of Experimental Medicine and provided ample laboratory facilities for borderline work with good and sufficient results. Notwithstanding the work of these university research posts, there has come to hospitals a feeling of direct responsibility to increase the store and use of medical knowledge by actively encouraging the study of problems presented by its patients instead of passively permitting this to be done. Animal experiments done in hospitals and laboratory work to prove and to check the theories, explanations, and observations of the staff are becoming more common. It is in the hospitals that the practical clinical problems actually present themselves, and there is a growing belief that it is in the hospital that most of these will not only be solved for the day by a shrewd guess, or keen logic, but be so proven by animal experiments and other means that the work will reach and be of value to others, and a benefit to posterity.

There is another benefit from the cost of experimental work often, if not always, worth more than the knowledge gained. Hospitals are becoming progressively more

and more interested in the training of young medical men for their own future use and for others. Without experimental work they are trained to depend on the say of others; with it they are trained to think and to prove. Surely the latter will produce better men. To the local dwellers, a hospital is a building of brick or stone, built to care for the sick; to the world—to society, it is a group of men of a certain caliber and results of a certain worth. It pays to train men right. Lakeside has recently backed this belief by adding five men to the resident staff, and equipped a new laboratory, that thoughtful observation, study and demonstration, or "research work" as it is often called, may be increased among them to the extent of five men's full time. By no means does this make us the leader in this particular; rather a follower in a line that is content to look to the future for even moderate results. The clinical clerk is another evidence that hospitals are taking an active interest in medical education.

COOPERATION AND MUTUAL HELPFULNESS

The idea of mutual cooperation between hospitals as it is developing is hopeful and prophetic. The very idea of active competition between hospitals, of a bitterness of feeling, and of any rivalry that is not simply altruistic eagerness to serve better and absolutely free from thought of gain to self, is unreservedly repulsive; it is entirely foreign to the purpose of all endowments, grants or expressed tenets of purpose of any hospital. The public servant, institutional or individual, who reveals for an instant a selfish aim is instantly discredited. Honor and gratefulness are but the acknowledgment of debt for uncompensated service. The union of hospitals to increase the ultimate service to the community is broadening in scope. New York hospitals united to lessen waste

in buying. Philadelphia hospitals united in an effort to increase the individual efficiency of the institutions. The New York dispensaries and the Cleveland hospitals have each united for the primary purpose of increasing the combined contribution of all the local institutions to the public welfare of the community, helping each to fit its work to the others and to the existing needs, eliminating overlapping and wasted energy. Surely we may look forward to the day when all hospitals shall present to society harmonious united service, adapted with the greatest care and in absolute unselfishness to the needs of the time.

REAL RESULTS

What are days and weeks spent in a hospital worth to patients and what do the "cured" and the "improved" in the discharge notes of medical and surgical histories mean? Dr. Codman of Boston has been asking these questions for some years. A few hospitals are now really trying to find out by thorough follow-up systems how beneficial the average cure proves to be, and to appreciate the later influence and the final effect of particular treatments. We are entering on the stage of the collection of the actual results as fundamental facts. From these there will come comparisons, deductions, lessons learned, and based upon these, future progress in many ways. Known results can be compared with the cost; one method with another, and society will be able to buy its health more intelligently.

To many who have thought about the

growth and development of the medical sciences, the shifting of the professional aim from treatment alone to individual prophylaxis, the expansion of this to the community, and who have then realized that this was simply intensified public health work, have reasoned from this conclusion and from the growing recognition that all is for service to society, that in the end the medical profession and all institutions contributing to the preservation of health "must become a function of the State." But society has other professions and other institutions existing to protect and advance itself, and the same principles of greater, broader service pervade many such. All that render good service cannot become "functions of the State" as we now understand that term. There would be nothing to do worth the while outside the State. Such a condition can be only when the State and society become synonyms, when Statecraft and the science of society are one. This may come, but it will come through the socialization of the State, and its elevation to almost perfection in grasping and enacting a wiser public will, not by the extension of political control of the present type to and over the professions and institutions. Active participation by the profession and by hospitals in the solution of public health problems and the acknowledgment that the logical test of excellence is the ultimate value of the service to society will bring no crisis, no conflict, with the State. Ideals and service will guarantee respect and position tomorrow just as they do today.





POST-GRADUATE CLASS IN LEATHER WORK

Occupational Therapy

REBA G. CAMERON, R.N.

Superintendent of Nurses and Occupational Instructor, Taunton State Hospital, Taunton, Mass.

NOWADAYS we hear a good deal said about the occupational nurse. One of our post-graduate pupils, on being asked the meaning of the above term, replied as follows: "An occupational nurse is a woman who can nurse a man with a double fracture of the femur during the acute stage and who can also nurse him through convalescence without having him break the commandment which says, 'Thou shalt not swear.'" This is, perhaps, a crude definition, yet it is expressive. An occupational nurse not only knows how to nurse her patient during the critical stage, but also during the long, trying days when convalescence is established.

General Hospital graduates are beginning to realize more and more the necessity of this branch of work, and in a number of large General Hospitals throughout the country occupation is being taught to the nurses in training. From Maine to California we get inquiries from nurses regarding our post-graduate course which includes occupational therapy, and I think I am safe in saying that three-fourths of the applicants say they desire to take up the course solely for the industrial training, which would go to prove that some nurses at least are seriously considering this line of work.

The economic value of occupational

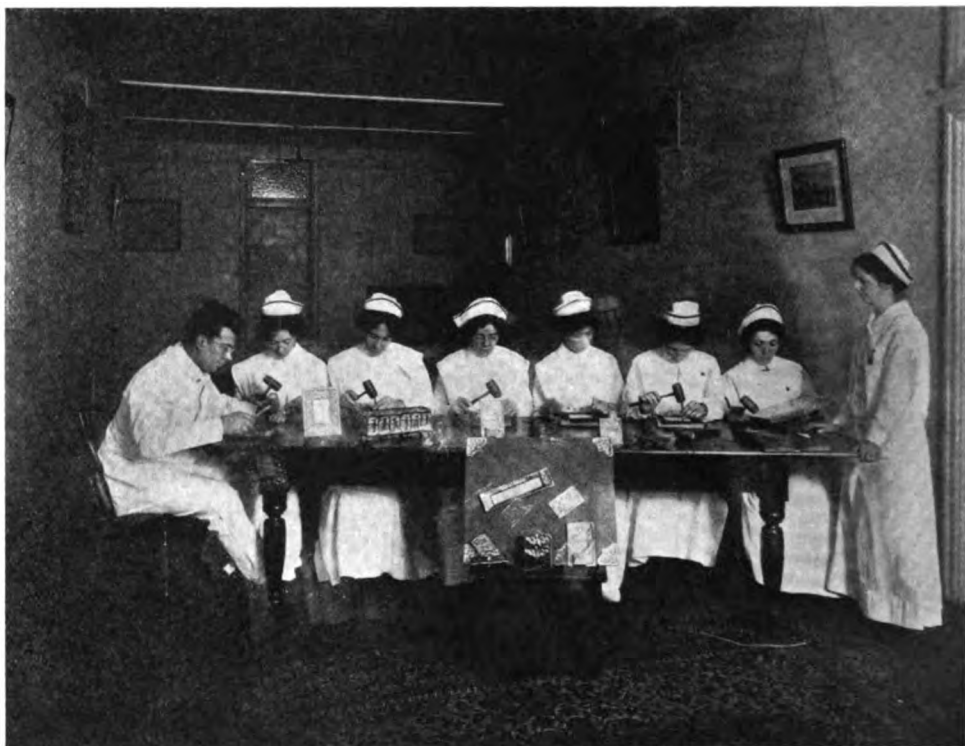
therapy is a subject in itself, and the benefit to be derived from it to the hospital, the physician, the nurse and, most of all, to the patient, cannot be estimated. The tax-payer groans and grumbles over his high taxes and well he may for they are not decreasing. A large part of this money goes to support our hospitals. These institutions must, of course, be supported, but if hospital authorities all realized the economic value of occupational therapy it would not take so much money to support our institutions as it does today. For example: Here is a mechanic who, perhaps, has both legs crushed which renders him unfit the remainder of his days to pursue his former occupation. What can he do? He has no other trade; therefore, in a good many cases, he becomes a public charge, and the tax-payer helps in his support. But if occupational therapy plays a part

this same man can be taught some line of work whereby he can earn a respectable living, and by so doing he lessens the rate of taxes by one less public charge, and he is also able to hold up his head with his fellow workmen and say, "I, too, although crippled, can earn my bread without the aid of charity."

Again, a short time ago I was approached by the mother of a young man who had tuberculosis. He was her only support when he contracted the disease and she had to assume the responsibility with the assistance of the Tubercular Society. She said, "If he could only do something he would not find the time so long. Is there anything he could do with a commercial value?" I recommended colonial mats, old-fashioned yet attractive, and also saleable, and I have found them one of the most valuable industries for tubercular



MAKING COLONIAL MATS FOR HOT DISHES



A LESSON IN BRASS WORK

patients, as they can easily be sterilized when completed. They are made of ordinary white darning cotton or twine and are made on wooden frames (see cut), tied off with white or colored silkateen, and then cut from the frames. If any one doubts the commercial value of these old-time, table mats I must say that at a sale last December in Taunton one thousand of these mats were sold in less than ten days. The experiment was tried with this young man (with the consent of the Tubercular Society), and was found successful both as a means of passing the long hours more pleasantly and also of value in a commercial way.

Occupation is one of the best therapeutic agents that we have. It can act as a stimulant, a sedative, or a tonic in the hands of one who understands its use. So many nurses seem to think that occupational

therapy consists in knowing how to make a basket out of reeds and a three-cornered purse of leather, with, perhaps, a knowledge of card games and the making of paper flowers. These are good things to know but a woman so endowed could not be called an occupational nurse in the true sense of the word.

Of what use is occupational therapy to the hospital? Let us take the common subject of toweling. All hospitals use towels. In this institution about one thousand yards toweling is woven every month at a very moderate cost, and that means that the cost to the institution of toweling is reduced to the minimum degree, whereas if the toweling were not woven here we would have to buy it elsewhere and pay the usual price. Yes; but you say, "What has the weaving of toweling to do with the physician and patient?"

Simply this: the physician has a patient who is a constant care to him, sleepless, irritable, nervous. "Get him interested," the physician says. "Get him to do something; then, perhaps, he will sleep." We try him at basketry. He doesn't care for baskets; brass-work, "only fit for children," he says. Finally, he is put at weaving, simply for a test, and behold the scene

changes. He is interested; he works at the loom and when night comes he sleeps. Is not that better than a dose of trional?

Do not be misled by the use of the term "Occupational Therapy." It is more than knowing how to amuse a convalescent patient. As yet it may be likened to a very young child who, with proper care and treatment, will develop rapidly.

Vegetable Growths in the Throat*

CECIL CHARLES

OCCASIONALLY a patient presents himself in his physician's office, saying in a puzzled tone.

"My throat is queer, doctor. It isn't sore, but it has some funny spots all over it. No, I have no fever, but I do feel a little run down."

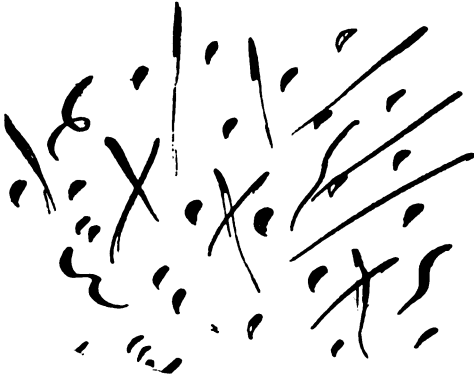
Possibly on examination the doctor will see a large number of yellow spots on the fauces, the uvula, or even the base of the tongue.

A case is on record where one such patient, a woman teacher, submitted herself to heroic treatment the very night she discovered the condition. Probably throat strain was the contributory cause, but she felt she could not afford to stop work, and bravely endured having every visible spot punched out. It took hours. She slept none that night, but she had a spontaneous cure. It was just the end of the term, when her vitality was much lowered, but a long vacation, taken in a same way, with a good

bracing tonic restored her completely.

The second case, the subject of these sketches, was a young student also suffering from depleted strength, due to long hard study, anxiety, hasty meals, and vacations spent at work under conditions not entirely favorable to rebuilding a constitution. He had a very persistent growth of these strange plants, which yielded only after frequent applications of the electric cautery. The fungoid growth, or plant, is named the "leptothrix," and the disease is called "Mycosis of the tonsils or fauces." Under the microscope, the leptothrix looks like a hard yellow icicle. It is a sort of rod, not always straight, sometimes curled or twisted. It is a benign growth of the vegetable kingdom, a little lower than the moulds, a little higher than the bacteria. In and around the colonies of slender leptothrix filaments gather the usual germs found in the mouth, staphylococci, pneumococci, and many bacilli of non-pathogenic origin. The whole mass resembles the accompanying illustration:

* This article is the first of a series of three, on a very unusual case of throat trouble, which came under the author's observation.



This is not "fox and the goose." The dots are cocci, the rods are the fungoid leptothrix growths, being many times larger than any bacilli. It is the fungoid growths that give color to the mass, a dirty yellow. Under the microscope, on careful inspection, the mass is found to resemble a spray of cauliflower or coral.

When a patient, who is laboring under the disadvantages of this unpleasant condition, has to go from town to town in the performance of his work, he should bear a letter of reference from his physician, to whom it might concern in each of those towns which it is impossible for him to leave in time to get home for his treatments,

definitely outlining what is being done for him.

This condition is of a benign nature. The patient does not suffer from it. But it needs persistent radical treatment. While the most strenuous part is purely local, consisting of cocainization, curetment and cauterization, yet a discreet combination of tonics, exercise, rest, diet, and change of air are also imperative.

At first the patient dreads the cautery, but after finding that he can tolerate it easily, he willingly goes for his treatments. In the interim, local applications of iodine or silver nitrate are used.

Women suffer from this condition more frequently than men, *smokers* rarely.

How things dawn on one, years after they are first seen, in their true significance! Six years ago, an enthusiastic old physician presented a case to a crowd of doctors and nurses, one rainy Sunday afternoon, in a big suburban hospital, when they all looked or expressed their wonderment at seeing a man "with hair on his tongue." Dollars to doughnuts, that it was a case of leptothrix mycosis of the tongue. It had the yellow color, the usual absence of discomfort, and the long sprays of delicate filaments that are found on the tonsils or fauces.

HOLY NIGHT

Silent night, Holy night,
All is calm, all is bright;
Round yon Virgin Mother and Child,
Holy Infant so tender and mild,
Sleep in heavenly peace!
Sleep in heavenly peace!

Silent night, Holy night,
Shepherds quake at the sight;
Glories stream from heaven afar,
Heavenly hosts sing alleluia.
Christ, the Saviour, is born!
Christ, the Saviour, is born!

Eye Nursing

HENRY GLOVER LANGWORTHY, M.D.
Dubuque, Iowa

WORKING OR DIOPTRIC SYSTEM OF EYE

PART V

DIRECTION FOR USE OF ATROPINE IN REFRACTION CASES

The proper fitting of glasses to be worn in cases of eye-strain or for poor sight cannot be done intelligently without special training. Ophthalmologists, who have given ample time and the most careful study to this work, should be given preference over less qualified individuals. In fitting glasses it may or may not be necessary to employ a so-called cycloplegic (paralyzer of ciliary muscle) such as atropine sulphate, one per cent. solution, or homatropine hydrobromate one per cent. solution. The eye specialist, in the nature of things, however, can be the only competent judge as to when and where atropine should be used for refractive purposes. The following routine is usually followed in large and busy eye clinics: All children under fourteen years of age are fitted under drops containing atropine sulphate, one per cent. solution. A solution of atropine sulphate one per cent. is ordinarily given to the parents with instructions to put one drop in each eye three times daily for four days. On the fifth day the pupils will be widely dilated, the muscle of accommodation fully paralyzed, and glasses can then be accurately fitted without further trouble. Glasses are usually ordered direct from the atropine examination. Vision will be blurred for from eight to twelve days after using drops containing atropine sulphate. Tinted glasses (London-smoked, blue or amber) are usually worn until the effects of the atropine have nearly disappeared, as the dilation of the pupil allows

a large amount of light to enter the eye and bright light may produce a bothersome dazzling or glare.

In adults under thirty-five years of age the eyes are also frequently fitted for glasses under the influence of homatropine hydrobromate, one per cent. solution. The patient is instructed to drop one drop of a solution of homatropine hydrobromate, one per cent. in each eye every ten minutes for six doses. At the end of an hour the eyes will be ready for fitting. Vision will be blurred for thirty-six to forty-eight hours after using homatropine. Homatropine dilates the pupil and paralyzes the muscle of accommodation. The patients are unable to read even large print when fully under its effects. Distant vision, as a rule, is not much affected by either atropine or homatropine.

In adults over forty years of age (presbyopes) the eye is fitted without using drops. Occasionally, in difficult cases, a drop of four per cent. cocaine solution is ordered dropped in the eye every five minutes for three or four doses merely to dilate the pupil so that a rough retinoscopy may be performed or the interior of the eye more easily inspected by the specialist. The effect of cocaine (eye dilatation) usually passes away in an hour or two and has practically no great effect on reading power.

GLASS FITTING IN ILLITERATES AND THE DEAF AND DUMB

In the fitting of glasses in the "dark room" the oculist uses an instrument called a retinoscope, the examination being known

as retinoscopy. A retinoscope is a plane mirror somewhat similar to the ophthalmoscope but without the revolving disc. Rays of light are reflected into the patient's eye with this instrument. By tilting the mirrored part of the instrument to and fro, and up and down, the examiner carefully observes the movement of the retinal illumination (shadow) in the patient's pupil, and in this way gathers a correct idea of the glass to be worn. In far-sightedness the shadow moves opposite to the tilting of the mirror, while in near-sightedness the shadow moves with the movement of the mirror. By the aid of this instrument the eyes of small children or children unable to talk can also be accurately fitted for glasses without having to depend upon the patient's answers.

NOTE—While most general nurses will probably not serve additional time in eye and ear infirmaries, eye clinics or oculists' offices, where special training is readily learned, nevertheless they should know something about certain phases of refraction work as they are very apt to be questioned by the laity about the fitting of glasses and particularly as to the use of atropine drops in the eye. For this reason nurses should be able to assure such patients who have used atropine in the fitting of glasses, that the sudden dilatation of the pupil and inability to see close objects (read) are the expected effects of the drops, will wear away in due time and need occasion no alarm. This question quite often comes up in busy eye clinics where the effects of atropine drops have not been clearly explained to the patient when prescribed.

MEDICAL INSPECTION BY THE SCHOOL NURSE

These few paragraphs have been prepared for the benefit of nurses who desire a working idea of the routine problems which come up with reference to school inspection and of the few simple eye and ear tests which have to be carried out in order to fill

out the physical record card of the school. As a preliminary preparation the nurse should read up on the following: Common symptoms of eye-strain, early symptoms of contagious diseases and especially those referable to the mouth and throat as seen in measles, scarlet fever, chicken pox, etc., symptoms of spinal curvature and flat-foot which are amenable to orthopedic treatment, adenoids and tonsils, epilepsy, and finally habits and effects of masturbation. Usually a great deal of stress is laid on sore throats, discharging ears, nasal obstruction, deafness, bad teeth, eye-strain and poor sight. It is important to remember that many children suffer severely with eye-strain who have good enough distant vision so that the test of sight is a test for sight only and not necessarily for eye-strain. Besides the foregoing, as the nurse becomes acquainted with the work she will naturally be expected to give the children lectures

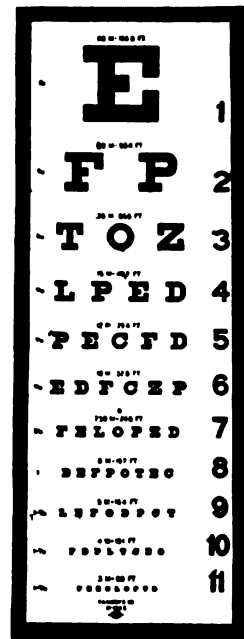


Fig 31—Standard Snellen Test Chart for testing sight in school children.

Line 8, or the fourth from the bottom (marked 6 meters—19.7 feet) is the line which should be read normally at a distance of twenty feet on this chart.

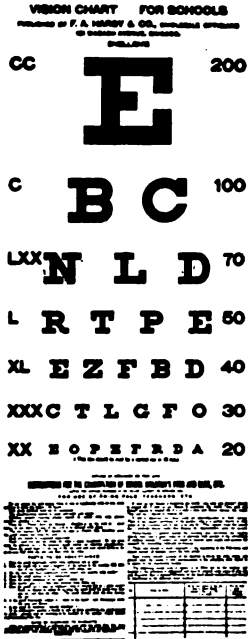


Fig. 32—Allport's modification of Snellen Vision Testing Chart with teacher's detachable questions for easy examination of school children.

The bottom line, marked XX or 20/20, are the letters which should be read (each eye tested separately) at a distance of twenty feet. It is important to remember that many children suffer severely from eye strain who have good enough vision, so that this test is a test for distant sight only and does not necessarily rule out eye strain.

on such necessary subjects as personal hygiene, bathing, cleaning the teeth, etc., as well as advising and addressing mothers on such important matters as proper food and diet for the younger children. Usually the nurse contrives to spend anywhere from one-half to one day at each school getting the names of special pupils to be seen from the teacher's or principal's office and while in the rooms making such observations as are possible, besides instituting at times actual class inspection of the hair, ears, nose, mouth and eyes.

With this preliminary explanation the matter of recording the sight is in order. This last is best determined by means of the Snellen Test Chart (Fig. 31) or some of its modifications. A most excellent vision chart for the systematic examination of school children has been devised by Allport

(Fig. 32), conveniently including a series of supplemental questions (detachable) which when answered will easily disclose most any serious eye, ear, nose or throat disease. The test chart printed in the Snellen standard test type is hung on the wall in a good clear light at about the level of the child's eyes and exactly twenty feet distant (six meters). Each eye is tested separately, the other eye being covered for the time being with a bit of cardboard held against the nose without, however, actually pressing on the covered eye. The normal eye (child reading aloud) should see distinctly the 20/20 line (last line) marked on the chart (each letter of which equals roughly a letter $\frac{3}{8}$ of an inch square). After a record of the sight has been made the other facts to be ascertained (by the questions) are roughly as follows:

1. Does the pupil habitually suffer from inflamed lids or eyes?
2. Does the pupil fail to read a majority of the letters in the number XX (20/20) line of the Snellen's Test Type, with either eye (children if already wearing glasses should be tested with the glasses on).
3. Do the eyes and head habitually grow weary and painful after study?
4. Does the pupil appear to be cross-eyed?
5. Does the pupil complain of ear ache in either ear?
6. Does matter (pus) or a foul odor proceed from either ear?
7. Does the pupil fail to hear an ordinary whisper at twenty feet distant in a quiet room? (Each ear should be tested by having the pupil hold his hand over first one ear and then the other. The pupil should close his eyes during the test and repeat aloud what he hears.)
8. Is the pupil frequently subject to "colds in the head" and discharges from the nose or throat?
9. Is the pupil an habitual "mouth breather"?

The above serve as excellent illustrations of some of the things sought for and together with the printed blanks of the school (which must also be followed) further complete any and all necessary data centering about the physical or mental well-being of the child.

If an affirmative answer is found to some of the more important questions a record of same is made and the pupil given a printed card of warning to be handed to the parent. The notification card to the parent simply states that the child is believed to have some eye or ear trouble, etc., which impedes its progress in school and urges the parent to at once consult a reputable doctor about the matter. Each school should have at least one of these testing

vision charts on hand ready for use. They are made of very inexpensive strips of white cardboard with black printed letters and may be obtained at any of the large optical houses. As individual permanent records are the important feature in our present day system of medical inspection, the card chart of the school at once becomes "an integral part of the child's educational accounting and must be always available." According to Gulick-Ayres in the average city school system about 65 per cent. of the children have physical defects serious enough to warrant treatment by a physician, oculist or dentist and nearly 85 per cent. of all these defects are those of teeth, throat, eyes and nose.

The End



IN THE CHILDREN'S WARD

Christmas for the Shut-Ins

AMY ARMOUR SMITH, R.N.

IN the Health Inns, or hospitals, there should be such a joyous yule-tide spirit, beginning, say, about the time that the average small boy gears up his Sunday-school attendance a little tighter in hope of a present—that everyone in town would want to come in. The staff of attending doctors, and the nurses should vie in their efforts to entertain the sick folks, no matter how lonely they themselves may feel. Giving other people pleasure is a panacea for every heartache. It is well to have the entertainment, dinner and decorations carefully thought out beforehand, and the previous year's trimmings brought out and pressed or dusted, so as to know exactly how much new to request and from whom to request it. It is, indeed, difficult in the constant shifting of hospital officials and employees, to meet a day like Christmas, unless there is a sort of "family" record kept, of who gives the nurses theatre or concert tickets, who sends the turkeys, etc., etc. If you haven't such a record of personal data in your hospital, start one now. Not the least responsible part of the occasion is receiving and acknowledging donations, because, you know, many people are not going to have any secrets between their right and left hands.

It is desirable that all gifts coming for the nurses should be held up by the main office, and registered as to stamp, date and other information available on the wrapper, a card of receipt being given each recipient, so that they may know the things they expected from certain persons have come, but that the pleasurable excitement of anticipation is prolonged till the holiday.

For the first weeks of December, twice a week, the nurses should practise a few of the best carols, to sing on Christmas

morning. If one can play the violin it is all the more effective. Then on Christmas morning they gather in the main hall, at six sharp, and begin to sing softly "Holy Night, Silent Night" in perfect unison. On the last verse they march quietly through the building, no farther than the door of each ward, and only where no patient becomes agitated by any sentiments the songs arouse. The songs should be chosen with a view to close resemblance in pitch and suitability for marching. Patients who have heard nurses sing in this way, after hearing the melody rise and fall in long waves, as they threaded their way up and down stairs and corridors, thought they had died and waked up in heaven.

These carols can be typed for each, and only a few copies of the music bought for practice, for the leaders. Other suitable songs for dear old yule-tide are Stephen Adams' "Holy Night," with the grand sweep of its refrain, "Fall on your Knees, O Hear the Angel Voices!" "O Tannenbaum!" sung by every German family around their tree, "The first Nowell," an old air, "Good King Wenceslas," an old air, "I Saw Three Ships," an ancient carol, and "I Hear Along the Street," by Hatton. But best of all, if any one nurse has a high pure soprano for an obligato, or if any friends of the hospital know some choir boy, whose clear, sexless voice sounds so heavenly, by all means have them learn with him, "It Came Upon the Midnight Clear," by Sir Arthur Sullivan.

Every town and every city has its own special customs, schools, society and legends. The traditions of each place give it its individuality and its genius. In some suburban towns there are fine private schools where growing girls can have a

seed of philanthropy planted in their minds by inviting them to come and sing, or play games and otherwise entertain the sick. There are not any *very* ill patients as a rule in the hospitals at this time, since all operations that are not urgent are postponed.

Soldiers from a nearby garrison, a quartette from the colored church or from the "swellest" tabernacle in town will all willingly consent to sing at intervals.

Pillars can be twined with ground pine, or less expensively, with dark green paper, mixed with red; the latter must be rather scant, or the effect will be harsh. All protuberances, telephones, electric lights and other stationary objects can be covered with green, crinkled paper to make the whole look like a dark, evergreen forest.

In decorating the tree, it should be kept screened from prying eyes till the last moment. Bear in mind that it will have



A WARD SITTING-ROOM DECORATED FOR CHRISTMAS

The scheme for decoration must be sufficiently uniform to cause no clash, but each ward can have special features in friendly rivalry, and the nurses planning this have more fun than in any Christmas they ever had at home. If, by any chance, the children's ward has a high ceiling with a Gothic arch, it makes a beautiful decoration to paper the end of the room in pale blue, studding it with silver stars, a moon, and two angels with long, golden trumpets announcing the coming of the Christ-child.

more weight to carry than its comrades in happy down-town homes. The box in which it stands needs to be weighted heavily, besides being quite wide. Secure a tree with a good peak, that just escapes the ceiling, and set thereon a silver star. The local dealers in electrical supplies will give strings of tiny lights, which hide in the interior of the tree. The silver filigree, (never gold) should be strung on the *under* side of the stems of the branches, tied here and there to be firm. Never drape it in

festoons. It looks more mysterious, like silver moonlight or frosty snow, when strung straight on the underside. For the distribution of the gifts, all the patients who can be moved should be brought on cots, beds or wheel-chairs, wrapped in the gay, red hospital blankets, to be within sight and smell of the balsamic odor of the tree. Somebody will lend a victrola to play between the songs of the nurses. The women patients all look much gayer by wearing their own boudoir caps, or a pleasant uniformity can be secured by the nurses' making each one a pretty white or pink one of tissue paper. Santa Claus arrives with red coat, cotton snow, and a string of bells heralding him, to prepare all to receive their gifts.

For the day of the dinner, all the up-patients can be seated at a real table, and eat like well people, so that they may help each other, and feel more at home, especially if the table has the usual decorations. A pretty cheery way to usher in the morning is to have a Christmas card and a spray of holly on each tray. The hospital should be open to all visitors during the Christmas week so that all the shut-ins may feel a little of the expansive good cheer of yuletide.

Nothing is too good for the nurses at this time. Their parents are lonely without them, and they are apt to be more homesick at this time than any other. But by having them assist, each assigned a definite duty, they can learn how to conduct these festivities in hospitals of their own some day. Buy a barrel of mistletoe, and let it *mature*. See that the Christmas pudding is burned in brandy, with a stick of holly. Do not send all the legs and wings of the turkeys to the nurses' tables, keeping the breasts for the staff table. In some of our minds so many of those did we see during our training, that we imagined that these birds

were a sort of winged centipede. Build fires in all the fireplaces, and let the nurses talk around them till half after one; dances, supper and friends invited hither, of course, go without saying. Don't fail to arrange a similar function for the servants in their hall, with formal invitations and supper just the same. In one very handsome building in New York City, the servants were so largely of Finnish or other European peasant origin, that the clever housekeeper had abundant material to arrange a complete program of their folk-dances, which drew a larger crowd than the nurses' party the night previous.

One excellent feature of entertainment for the nurses' evening is Shadowgraphs, where persons behind a white screen stretched tightly across the hall, with movable lights again behind them, throw funny shadows. These are very easily prepared, and no people can get together and think up in a minute more fun that is truly original, than a group of pupil nurses.

It is just as imperative to acknowledge in polite notes the services of any singers, violinists or pianists, as to write a note of thanks for a table donation. This depends largely on the personality of the officials. No matter how philanthropic a Board of Governors may be, they will always remain, in the eyes of the patients, a most abstract, metaphysical creation. To the patients, the nurses, internes and superintendent symbolize everything in hospital administration. Let this season in the hospital be flavored then with a goodly leaven of unselfishness and labor. Merchants, private patients and their relatives, the clergy, teachers in the schools who cannot go home themselves, all such people will give goods, money and work, to make the hospital bright and cheery, if approached in a simple, direct, homely way.

The Christmas Culinary Treat in the Hospital

KATHERINE E. MEGEE

OF all places, it is surely in the hospital, where suffering and sorrow is the daily portion, that Christmas should be made much of. From the patient luxuriating in all that money can do to ease pain down to the very scullions, each should be made to feel that this is in reality the day of good will and cheer. The wards should be brave in the season's greens intertwined with the glistening red of the holly berry—

social barriers should be, so to put it, thrown down and all be included.

Above all, because of the inseparable association of certain dishes with Christmas, the *motif* of the day should be reflected in the food served. Indeed, so universal and thoroughly established is this feature of the festival, that all will agree that Christmas is no Christmas at all and the note of cheerfulness is lacking from cheer,



EACH TABLE WITH ITS OWN CHRISTMAS TREE

or holy berry as it was anciently called because of its intimate association with Christmas—and the creamy mistletoe, formerly supposed to possess magical virtues because it was found on the sacred oaks of the Druids. The Christmas trays should each boast a bit of holly or other emblem of the “day we celebrate.” The nurses’ dining-rooms and tables, also those of all other employees of the hospital, however menial their positions, should be in gala trim. It is on this Day of Days that the

unless there are plenty of good things to eat. While, of course, in a hospital certain foods must be eliminated from the dietary of the sick, there is no reason why the convalescents and the numbers of well people in the house should not have a Christmas culinary treat. Even the food of the special diet patients should be given the “Christmasy” touch, if no more than a sprig of richly-berried holly on the tray, to help keep down the home longings which this day always fosters when separated



JUST A SPRIG OF HOLLY

from home and loved ones, even under the most favorable conditions.

While it goes without saying, the main interest in the culinary department will be centered upon the dinner, the real feast of the day, yet it should by no means be limited to this. In one large hospital, where much is made of every holiday, the Christmas breakfast, while simple in so far as the food is concerned, is always marked by some distinctive feature, and thus the day is started off merrily. To begin with, in addition to the holly wreaths in the windows, each table in the dining-rooms boasts its own miniature Christmas tree, gay with tinsel. Everybody belonging in any capacity to the hospital, also the erstwhile paying guests, all receive some little gift at breakfast time. Invariably these gifts are of a mirth-provoking nature and never fail to put everybody in a good humor. Fresh fruit is generously served to everyone, which in a big institution is, of necessity, a luxury. Then, too, some special dish or an out-of-the-usual way of cooking one of the accustomed foods announces the beginning of the Culinary Canticle of the day.

Appropriately decorated Christmas dinner menus is another established custom and adds not a little to the attractiveness of the meal.

Anyone at all familiar with the work of a big kitchen knows that when cooking is done on such a wholesale scale, as it must be when several hundred people are to be

served, it is impossible to introduce the culinary frills and furbelows and the tasty "made" dishes which contribute so largely to the appealingness of home cooking. Even so, the plainest food can be well cooked and seasoned, and so attractively served—provided a little personal equation and effort be expended—that these omissions are lost sight of.

By way of suggestion, menus for the hospital Christmas dinner are appended, all of them have been put to the practical test.

In the diet kitchens many little finishing touches were added to the food before sending it out on the trays. For example, the mashed potatoes were pressed into individual ramekins, glazed over with white of egg and browned in a quick oven; the plum pudding was served in individual pudding dishes, each encased in a pudding "collar" of paper; the ice cream for the wards was, at a slight additional expense, frozen in individual molds simulating Christmas bells; all the dishes were attractively garnished with bits of parsley and other pretty garnishings, all of which meant, of course, a little extra work, but brought rich returns in the way of expressions of delight from the patients.

The Christmas supper, in view of the heavy mid-day meal, should be most simple in character. Eggs in some form, bread and butter, jelly or preserves, baked potatoes, milk and cocoa are quite sufficient. Such a supper can be easily and quickly prepared and served.



CHRISTMAS BREAKFAST TRAY

MENU I

JULIENNE SOUP
CRACKERS
CELERY INDIA RELISH
ROAST TURKEY WITH OYSTER STUFFING
CRANBERRY SAUCE
MASHED POTATOES CORN PUDDING
PLUM PUDDING WITH WINE SAUCE
NUTS ICE CREAM RAISINS
COFFEE

MENU II

CREAM OF ASPARAGUS
CRACKERS
CELERY OLIVES
ROAST TURKEY WITH CRANBERRY SAUCE
MASHED POTATOES SAUER KRAUT
PLUM PUDDING WITH WINE SAUCE
NUTS RAISINS
COFFEE

MENU III

CONSOMME CROUTONS
OYSTERS IN THE HALF SHELL
CELERY CRACKERS
ROAST TURKEY WITH PLAIN STUFFING
CRANBERRY JELLY
BROWNED SWEET POTATOES CREAMED ONIONS
PLUM PUDDING WITH HARD SAUCE
NUTS ORANGE ICE MALAGA GRAPES
COFFEE

MENU IV

CLEAR SOUP
CELERY CROUTONS OLIVES
ESCALLOPED OYSTERS
ROAST TURKEY WITH CHESTNUT STUFFING
CRANBERRY SAUCE
CREAMED POTATOES SUCCOTASH
MINCE PIE CHEESE
BISQUE ICE CREAM FRUIT CAKE
COFFEE

MENU V

OYSTER SOUP
CELERY CRACKERS
ROAST TURKEY CRANBERRY SAUCE
BROWNED SWEET POTATOES
CREAMED CAULIFLOWER
PINEAPPLE AND LETTUCE SALAD
CHEESE
PLUM PUDDING WITH HARD SAUCE
NUTS RAISINS
COFFEE MINTS

Standardization of Standing Orders

AT THE hospital convention in San Francisco one of the exhibits which aroused a good deal of interest was a loose-leaf book of standing orders brought by Miss Florence Potts, superintendent of the Hospital for Sick Children, Toronto. After being tested for some time, Miss Potts had the standing orders printed. A considerable number of requests came to her while at the convention for copies of these standing orders—requests which she finds herself unable to fulfil. But she has sent a copy to this magazine.

Miss Potts wishes it understood that the credit for the standing orders she has been able to work out belongs largely to Miss Lauder Sutherland, principal of the Training School Hartford Hospital, Hartford, Conn., who furnished her with a specimen set which helped greatly in working out the standardization in the Hospital for Sick Children. We publish this month some of these standing orders and others will follow.

INSTRUCTIONS FOR NIGHT NURSES

WHAT A NIGHT NURSE SHOULD LEARN FROM NURSE IN CHARGE

New Patients—Name, physician, diagnosis, treatment, general condition, something of history, if possible.

General condition of all patients, change in treatment of patients, operations, etc., where supplies are kept.

WHAT A NIGHT NURSE SHOULD KNOW AND DO

How to be quiet—to walk, talk, handle dishes, close doors, etc., quietly. Where ward supplies are kept and their use. The preparation and post-operative treatment of general surgical cases; antiseptic precautions for caring for open wounds, the danger of infection, if exposed. Report if she is

not sleeping well during the day. Report if she feels that she cannot keep awake at night.

WHAT A NURSE MAY DO BEFORE CALLING THE DOCTOR

Give ice cap for headache, give hot water bottle to feet, give hot drinks for sleeplessness, rub patient with alcohol for pain or general restlessness, change any dressing after she has been instructed and has done it once with permission.

THE COMPLICATIONS AFTER OPERATIONS

For hemorrhage—watch pulse, watch dressing, elevate extremities, report.

For Shock—watch pulse, watch general condition, report, hot water bottles and blankets, elevate foot of bed, have hypodermic syringe ready.

Intestinal paralysis—tympanites, vomiting, eructations of gas; report.

MEDICAL CASES

Watch carefully—temperature, pulse, respiration. Pain—cause, character.

Typhoid precautions—Common complications: hemorrhage, stool, rapid pulse, report; perforation, sudden pain, drop in temperature, give nothing by mouth; delirium, keep in bed, report.

Pneumonia—Delirium report; heart complication, report, keep quiet; crisis, sudden drop in temperature, hot water bottles, blankets, report.

Stomach cases—save vomitus, note pain; chill, hot water bottles, blankets, report, hot drink; have hypodermic syringe ready.

ROUTINE ORDERS FOR CONTAGIOUS DUTY

Nurse's Equipment—When a nurse is sent on duty in the contagious ward, she must take with her two complete uniforms, an outdoor costume, preferably an old one that can be fumigated when she leaves the ward, and such toilet articles as are absolutely

necessary. Nothing must be taken that cannot be disinfected in some way.

Nurses on 24-hour duty are to wear the special cotton dressing gown, provided for them on night duty.

All articles of nurse's clothing that cannot be sent to laundry must be properly disinfected before being taken back to the residence.

While on duty nurses are not allowed to go to the homes of their friends, nor where there are children. They are allowed to go on the street cars and shopping, provided their outside clothing has been completely changed and their hair washed. This does not apply to daily outdoor exercise, in which case the hair may be rubbed with alcohol.

Upon the nurse in charge of the Infectious Ward devolve the same duties and responsibilities as upon a head nurse in a ward, and in addition she is responsible for the conduct and discipline of the nurse on and off duty. Any refusal of a nurse to obey orders must be reported immediately to the superintendent or her assistant.

She is responsible for—1. The conscientious carrying out of the prophylactic measures prescribed, as well as the patients' treatment.

2. The order, discipline and cleanliness of the place.

3. The ordering, careful and economical use of supplies and equipment.

It is expected that those nurses on 24-hour duty, whose rest is likely to be disturbed, will have made all preparations for the night and be in bed at 9 p. m.

Reports—The nurse in charge of the In-

fectious Ward shall give the ward report to the superintendent by telephone at 9 a. m. and between 5 and 6 p. m. For the ward report see general instructions, and in addition *report* immediately any serious change in the condition of a patient; the delirium or restlessness of a patient. *Report* promptly the illness of a nurse.

Precautions for Nurses—It is of vital importance when nursing infectious or contagious diseases that the general health be cared for, therefore, the nurses are advised to pay special attention to the following:

1. It is important that the nurses acquire regularity in going to meals, eating good wholesome food and spending at least fifteen minutes daily in the open air.

2. Avoid using handkerchief and touching face and hair while waiting on patients.

3. Any abrasion of the skin must receive immediate attention.

4. Always disinfect the hands a second time before going to meals.

5. When nursing scarlet fever and diphtheria patients, the nurse must gargle her throat four times in 24 hours with salt solution.

6. In erysipelas cases gloves must always be worn when doing dressings.

7. In diphtheria cases and scarlet fever cases, when giving throat treatment, the nurses must protect their faces with a mask.

8. Gowns and caps must always be provided for the doctors.

9. When a nurse leaves the infectious ward she must take the same precautions as ordered for patients when discharged.



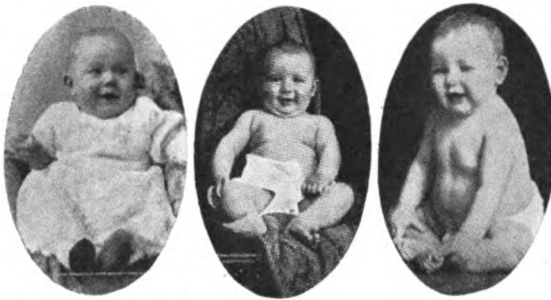
Infant Feeding

B. M. PENNEWILL

IT might be said that too much has been written on the subject of infant feeding. One hardly picks up a magazine or a daily paper but he is confronted with an article on infant feeding. Some are written by pediatricians, some by nurses, and some by laymen, and all contain more or less valuable information, but the subject fails

by any possible chance, he might not want, or more important still, that he might not need to be fed.

To Lakeside Hospital, Cleveland, Ohio, I am indebted for the régime, which experience has proven to me to be sensible, practical and humane, that of feeding the baby every four hours from birth. The



"SOME BABY"

to impress, because it has become commonplace and nothing new is ever ventured upon, hence half the articles that are written are never read.

As a graduate nurse I have made a special study of babies, having seen born and taken actual care of many dozens of them, and I know whereof I speak. As the result of my experience I unhesitatingly state that *babies are fed too frequently*. It has been only in the last few years that physicians and nurses have learned this, and when we consider that the baby has been the victim for so many years, we should all grasp at the first opportunity of alleviating the suffering we have, unthinkingly, thrust upon him by overfeeding him. Heretofore almost every text-book and almost every physician has advocated the feeding of the baby every two hours, never once thinking that,

following report shows the results in two cases where this schedule was used:

INFANT I	BORN	WEIGHT
July 30th		7 $\frac{1}{4}$ lbs.
Aug. 6th		7 $\frac{1}{2}$ "
" 12th		8 "
" 19th		8 $\frac{1}{2}$ "
" 28th		9 $\frac{1}{4}$ "
Sept. 2d		10 lbs. and 1 oz.
" 9th		10 $\frac{1}{2}$ lbs.
" 17th		11 lbs. and 2 ozs.
" 24th		11 lbs. and 12 ozs.
" 30th		12 lbs.

This baby slept almost the entire time, never vomited, and was so contented and happy that she was a perfect joy.

INFANT II	BORN	WEIGHT
March 16th		9 lbs.
March 23d		9 "
April 1st		9 "
" 7th		9 $\frac{1}{2}$ "
" 13th		10 "
" 20th		10 $\frac{1}{2}$ "

This baby, as you see, did not gain at all for the first two weeks, but his gain was

above the average after that time. He slept, like Infant I, almost all the time and had always to be waked for nourishment, and would lie awake afterwards apparently looking around and never a sound from him.

To my mind the advantages of this method of feeding are many. The baby's rest is not disturbed as in the two-hour method. It is small wonder that babies become nervous and cry a great deal, when they are taken from a sound sleep every two hours during the day and most of the night. In four hours he has time to digest and assimilate his food, consequently he is not continually spitting up and does not have colic.

The mother in the meantime is accumulating good rich milk. The quantity the baby would get in nine or ten feedings by the former method he now gets in quality in six.

It also gives the mother time to rest and relax and attend to her duties without hurry. The mental strain under which a nursing mother exists invariably manifests itself in the baby. I would like to say a few words in regard to the mother's feeding. There is no reason why the diet of a perfectly normal, healthy mother should be restricted. Her food should be nourishing and plentiful, remembering always that she has two to feed. It would, of course, be fool-hardy for the mother to eat anything that she knows disagrees with her, but I contend that the baby's body requires the same kind of tissue-building material as the mother's, and gets it in minimum doses relative to its demand. I begin immediately after birth to give fruits of all kinds, plenty of eggs and milk, very little

meat till after the third or fourth day, a reasonable quantity of tea and coffee, and most all vegetables. I can truthfully say that I have never had, in my hundreds of cases, a baby with colic, or one whose cries I could in any way attribute to the mother's feeding.

Here are a few *don'ts* to follow which I think are necessary to baby's comfort.

Don't pick him up because he cries, change his position and he will often go to sleep at once.

Don't feed him off scheduled hours, and not longer than twenty minutes, if he nurses vigorously for that time.

Don't put him to sleep on anything but a firm mattress (*never feathers*) and don't give him a pillow.

Don't fail to give him a drink of water daily, using for this a bottle, which accustoms him to its use for his transfer to artificial feeding.

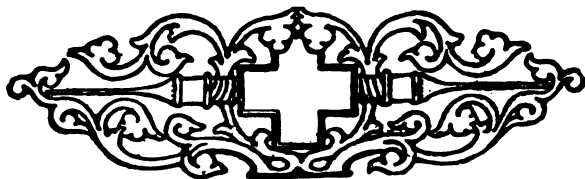
Don't disturb him while asleep except for feeding. I find it advisable to take him up at five P. M. and prepare him for the night. This gives him a change of position and brings muscles into play which are not used in a recumbent position.

Don't cater too much to his nervous system. Noises and lights in moderation should not disturb an infant. It is a mistake to tiptoe around in darkness in baby's room. If he is accustomed to these in reason when he is small, he will not object to them when he is older.

Don't give him drugs without explicit directions from a physician.

Don't allow him to use a pacifier.

Don't let flies near him, as they collect, breed and promiscuously distribute germs.



Surgery in the Present War

THE work of the American Red Cross in the present war has commanded the admiration of the whole world, and the announcement that its forces are soon to be withdrawn because of exhaustion of funds, while causing general regret serves to emphasize the fact that it has been through great sacrifice that this service to the warring nations has been rendered. How great this sacrifice has been in many cases is illustrated in the following letter written to his brother by Dr. Ernest P. Magruder of Washington, D. C., three days before he acquired the fatal Serbia typhus fever infection which resulted in his death. Dr. Magruder is only one of a number of brilliant American physicians who have given up their lives to alleviate the sufferings caused by this, the bloodiest war in all history.

Dr. Magruder was serving at Gevgeliga, Servia, and the letter which follows was written from that place. It is reprinted from the *American Journal of Surgery*.
DEAR—:

I have wished to write to you ever since we got started here, but the work has been so heavy altogether—converting buildings into hospitals, organization of the whole plant, sanitation, care of the wounded and sick (we began with thirteen hundred patients, mostly surgical)—that when night came one could only topple into bed and hope that the work of the morrow would be less exhausting.

Until lately, when the medical cases exceed the surgical, we had, among other things, an endless variety of compound fractures, gun-shot wounds of the skull, chest, abdomen, arms and forearms, thighs, legs and feet; amputations, single and double; aneurisms, of the common carotid, subclavian, axillary, brachial and femoral arteries; fecal fistulae; the extraction of

the greatest variety of shot and shell, huge bullets, shrapnel, grenade and dum-dum; and one hernia of the brain of great interest to me. On the whole, the work has been wonderfully interesting.

This great war is quite educational in its influence upon medical science, because of the new and special nature of its aspects, especially with reference to shell fire. Formerly the surgeon had to treat wounds caused for the most part by rifle bullets. Today his special attention is called to the frightful casualties of grenade and shrapnel. The dynamite grenade was first used at the siege of Mafeking. In the Russo-Japanese War, the Japs used this modern high explosive very effectively. It is cylindrical in form, filled with shimose powder and fitted with a time fuse and percussion cap. It bursts into many fragments and emits a gas which is very painful to the eyes and air passages.

The shrapnel is a projectile fired from a gun and carrying a large number of bullets. At the point of bursting the bullets are charged with an added energy over a wide area. It is the main reliance in the present war's field artillery. It is most effective against large bodies of troops in masses, in mountain and siege artillery, as well as in repelling attacks against sea coast fortifications. Its casing is a steel tube with a solid base. The 3-inch field gun shrapnel weighs 15 pounds, its length is 10 inches and its muzzle velocity 1,700 foot seconds. It contains 252 round bullets made of hardened lead. It is referred to as a man killer at 6,500 yards. But it has even then on bursting a remaining velocity to the bullets of 865 foot seconds. The fuse is gauged to make the projectile explode at the fractional part of a second in its flight. The preponderance, therefore, of artillery in the present war is a new order

of things from the viewpoint of the modern surgeon.

Additional interest centers in the complications of those exposed to the terrifying effects of the high bursting charge of shrapnel, to aerial arrows and to the various types of flying machines. The new genius of man at war has been challenged by the old maxim, "familiarity breeds con-

machines of death turned loose from hell to execute his purposes. Hence the moral and mental nervous wrecks we meet and those suffering functional effects from the near-by explosion of a large shell, as seen in the temporary loss of speech and hearing. Added to these are the terribly mutilating wounds of flesh and bone further complicated by infection.



CONVALESCENT SOLDIER BIDDING GOOD-BYE TO HIS NURSES

tempt," and he has accepted the challenge knowing full well that man's nervous system is found at last not made of adamant, that there is an end to nerve power, nerve endurance. Truly, nerve-racking as well as death-dealing mechanisms have been the greatest study of the day. Nerve tension, from waiting for and dreading an attack, extreme excitement and mental confusion, aggravated by fatigue of mind and body and the ever-present menace of exhaustion—these have been calculated by man with mathematical precision and embodied in

These shrapnel wounds also give rise to the most virulent forms of sepsis. The present-day rifle bullet travels so fast that it is often sterilized by the heat generated by the friction caused by the velocity of its flight. A wound by such a bullet, if it carry in no clothing or other septic matter, may heal promptly; whereas, the bullets carried within the shell of shrapnel frequently give rise to a most virulent form of infection, known as "spreading gangrene." This requires quick amputation of the member, and isolation to prevent its

spread to other wounded soldiers in the ward. Modern treatment is powerless to control this form of blood poisoning in a badly infected case and I am now testing some of the latest discoveries in antiseptics in the hope of finding an effective remedy against this old scourge of war which the immortal Lister buried and which the modern shrapnel, curiously enough, has brought back to life.

I have only time to mention a number of cases of frostbite, requiring amputation of one or both feet, sometimes of one or of both legs; several cases of lock-jaw; and a large hernia of the brain, following a compound shrapnel wound of the skull. The recovery of this patient, following operation, has been to me perhaps the most interesting and gratifying of all my cases.

There are many things of which I should like to write, but the censorship here in the war zone, of course, prevents.

Normally the town has about 7,000 inhabitants. It is a part of old Macedonia, held by the Turks for 500 years, and won by Serbia in the late Balkan War. The surroundings are beautiful, especially as one views the rising sun reflected from the snow-capped mountain tops. Saloniki (old Thessalonica, Greece, upon the Aegean Sea) is only four hours' run by train. So that we do not feel cut off entirely from the outside world.

On the whole, the work of the mission has been very hard, but the consciousness of the relief it has given to awful suffering in its manifold manifestations, has greatly lightened our labors. . . .



COURTESY OF BOSTON HERALD

TRAINED NURSES WHO ACCOMPANIED THE SECOND HARVARD UNIT WHICH SAILED FROM NEW YORK, NOVEMBER 17th, ON THE NOORDAM, OF THE HOLLAND-AMERICAN LINE

Upper Row, Left to Right—Miss H. S. Peterson, Miss I. S. Harkom, Miss G. E. B. Gilbert, Miss Helen Tolman, Miss C. B. Akeley, Miss Isabel Kelso, Miss M. C. Fallon, Miss C. M. Sinclair, Miss N. M. Logue, Miss F. M. Hocken, Miss L. L. Edwards. Centre Row—Miss I. S. Watson, Miss K. J. Wiseman, Miss H. G. Fyfe, Miss Ella Sinclair, Miss C. C. Johnston, Miss Eva A. McBride, Miss A. B. Shepherd, Miss E. E. B. Shepherd, Miss Edith Hamblin, Miss N. M. Aschah, Miss M. F. Copeland, Miss Dorothy Foster. Front Row—Mrs. S. C. Kazanjian, Miss Minnie Goodnow (Matron), Miss Calisia Goss, Miss M. S. Marr, Miss A. C. Birtles, Miss M. L. Linscott, Miss M. F. Malley, Miss C. F. Gardner, Miss V. L. Benjamin

The Unit is in charge of Dr. David Cheever, who has a staff of thirty physicians and surgeons. The Unit will serve under the British Government

Department of Public Welfare

THE VISITING NURSE AND HER INFLUENCE

EMILY HARRISON BANCE, R.N.

(Continued from November)

THAT dread enemy to society, tuberculosis, should have strict attention in tenements where isolation is impossible.

In many cities the law for the removal to places where proper care can be given, and spread of this disease stopped, is not compulsory. It is a common thing to find a poor man or woman lingering on amid uncleanly and crowded surroundings, and often in poverty, contaminating the house and spreading the disease broadcast. Personal antipathy to a sanitarium and objections of the family should have no weight in cases of this kind. The law regarding their removal should be compulsory, more so as many of these cases are very ignorant and utterly ignore the precautions suggested and taught by the nurses of tubercular agencies. Until such a tenement-house law is made and enforced this dread disease will continue to spread and flourish and take its toll in new victims year by year.

I wonder how many people, except those who have been brought in close proximity to it, realize the dreadful discomfort which accompanies tuberculosis in its advanced stage. Night after night the prolonged agony of wracking cough and disturbed fitful rest, followed by a day of lassitude and general fear of the next night and many nights to come, of endless exacting coughing. Many of its victims are among the wealthy where every comfort that money can procure affords relief but, in the tenements where there are no comforts and often

the bare necessities of life are wanting, how wretched and how pitiful is their condition. Let us use all our influence to stamp out and prevent this curse upon mankind.

The "Sunday Liquor Law" and the closing of saloons on that day has in many cities caused much discussion. One hears the remark that the saloon is the "poor man's club." How about the hard-working wife and the children to whom he returns at night in a condition worse than that of any beast. Go to the various societies for the prevention of cruelty to children and find out how many children are kicked and injured and, in too many cases, hopelessly deformed, the result of a day's entertainment at the "poor man's club."

I will never forget the haunting eyes of the little six-year-old boy who died from the effects of a kick given him by his drunken father.

The young girl of seventeen who returns home from a hard day spent in a factory, has little to influence her for good when the whole atmosphere of the little railroad flat is dominated by a drunken brute to whom, by all the laws of the home, she should look up to for guidance and protection.

How many lives are influenced by drink and how far-reaching is the misery of a drunkard's home.

In most of our large cities the appropria-

tion of land to be used as city playgrounds is becoming more general. People are gradually learning that in congested districts children must have some place to play besides the streets. In our Juvenile courts we hear daily the shocking evidences of immorality among little children, some of them scarcely more than babies. Everyday little girls and young boys are sent away to reform schools to be taught decency and morality.

These unnatural conditions are the results of crowded tenement existence and the influence of the street. Is it not pitiful to see babies of two years turned out into the thoroughfare to play, thus beginning a career of filth and vice?

How soon they learn to swear and how quickly they become initiated in evil of mind and body. Do we not see them out at late hours of the night when they should be in bed.

The little girls grow up to prostitution and the boys to drunkenness and gambling.

No, we cannot have too many playgrounds where the short childhood of these tenement children can perhaps be influenced and molded by protected, decent play and the natural happy games of childhood.

I think that in every large city a great effort should be made to teach the boys of the tenements a good trade or occupation, even if it is only that of mending shoes, so that when they reach manhood they will have a sure means of support and not be always out of a job and looking for another, and their families dependent on the city for support.

It should be part of their school training, and these children receive very little training except that which they receive in school, that a man's duty is to support his wife and family. He should be taught the responsibility of home support.

In our cities are many visiting nurses and it is our privilege to see clearly and

understand so many conditions of which many people do not realize the existence. Is it not our duty to use our influence to remedy these conditions?

It is quite true that we may not be able to do very much but we can at least speak of these conditions and make them known.

Let us ask ourselves these questions.

Are there enough parks and playgrounds in our city and, if not, what can we do to obtain more?

Are all the saloons in the city open on Sunday and, if so, what can we do to close and restrict them?

Is there a tuberculosis agency in the city and if not what can we do to start one?

What are the tenement-house laws of the city?

Are they enforced and can they be improved upon?

Is there a babies' milk station in the city?

You only need one baby to start with.

In all cities, however small, there are charitable organizations and civic betterment clubs of various kinds and the district nurse should cooperate with these societies, for in cooperation there is the strength and advantage of united force.

Every nurse should belong to and give her support to some church and have a moral standing in her community.

In well-organized districts we find hundreds of children growing up in physical and spiritual cleanliness with every chance to become good citizens. In the same city are being reared as many more poor little victims of vice and environment. When they grow older they will meet and the poor tenement child retaliates upon society and often his influence is powerful and far-reaching like the tentacles of a foul octopus.

Let us all, not only as visiting nurses, but as Christian women, use our influence toward the moral uplift and betterment of the many little children of our crowded tenements.

The Hospital Council

Items of Interest, Annual Reports, Publicity Literature and Material Descriptive of Newer Methods and Plans in Any Department of Hospital Work Are Solicited

Hospital Records and Their Value in Preventive Work

It has now been stated in public what the far-seeing minority has been saying in private for years—that instead of citing yearly the increase in the number of patients treated over last year, as the basis of an appeal for more beds, hospitals have a duty to perform in keeping people out of hospital beds, and of calling attention to conditions in their own locality which are causing an unnecessary demand for hospital beds. Dr. Warner's paper in this number will not add to the feeling of satisfaction which is felt by those whose enthusiasm for larger and larger hospitals and larger figures each year in the number of sick treated, leads them to accept numerous patients from preventable diseases each year without a thought or inquiry as to why conditions were allowed to exist which caused the diseases.

Some of the things which he says are neither complimentary nor comforting. For instance, the following extract does not make really pleasant reading though we cannot readily dispute that "the composition of the average hospital ward is a public disgrace and reproach. Here are found typhoids because we drink our sewerage; visceral and brain syphilis, because doctors, dispensaries or hospitals have been too careless about letting patients slip away half cured, a menace to others and a prospective burden. Here is sometimes tuberculosis but never chicken-pox because the community calls chicken-pox contagious and isolates it, but not as yet,

tuberculosis. Here are men sick because they worked in a danger of which they knew nothing. Here is a long line of men useless from the primary and secondary effects of alcohol. Hospitals see the needlessness, the ridiculousness of it all, better than others, and although it often means hard work to raise the money to pay the cost they generally endure it in a silence and with a degree of inaction that does not indicate patience or any other virtue."

It will take many years of effort in creating sentiment that hospitals, in general, have a duty of preventive work to do before much change in conditions is apparent, but the task has been begun—when even a few of the men and women in the hospital field get a vision of the value of their records in preventive work and the practical use that can be made of them in this direction.



Cutting Cost in Ward Dressings

It is a trite saying that you never know what you can do till you really try. An illuminating experience of this has come to the London Hospital as a result of the war. Shortly after the war began, the hospital was notified by the firms supplying surgical dressings to the hospital, that the claims of the Government came first and that they might be unable, at least temporarily, to fulfil their contract. The stock of dressings on hand would, in normal times, have been exhausted in a few weeks. Strict economy was demanded and every possible effort had to be put forth to make the supply on hand last as long as possible. To

supplement the supply the superintendent issued requests to friends of the hospital for contributions of old linen. The head nurses were appealed to to exercise the strictest sort of supervision to prevent too lavish use of surgical dressings throughout the hospital. New gauze was reserved for the operating room as far as possible. Old linen sterilized was to be added to the gauze when possible. The results achieved showed a saving during the year of over \$2,300 over the year before—this in spite of the fact that the surgical cases were greatly increased—several hundred wounded soldiers being treated.



Should Every Pupil Nurse Have Operating-Room Training?

A correspondent asks for an opinion on the above subject. Doubtless the desire to mete out justice to all, led to the effort to provide for every nurse to have a term in the operating room, yet there is probably no hospital which has not been embarrassed by such a rule and no superintendent who has not dreaded the approach of the time when some certain nurses' "turn" would come to be put on operating-room duty. This "turn" is sometimes determined in one way and sometimes in another, according to conditions that arise. That many pupils who have no aptitude for surgical work are kept for weeks on operating-room duty, goes without saying. That the safety of patients is frequently risked because of such a procedure cannot be denied.

Should *every* pupil nurse have operating-room training? If the principle of providing for *all* nurses to have operating-room service and training is not followed how should the selection be made or what conditions should determine it?

We have today this anomalous condition: Not one nurse in ten expects to become an operating-room nurse yet such

training, and experience, is rigidly prescribed in many hospitals. Probably nine out of ten nurses graduating will do private nursing in homes for a longer or shorter period after graduation, but opportunity to secure experience in nursing in private homes so that pupils can go into such work with some idea of conditions and how to meet them is religiously forbidden.

Replies to the question asked by our correspondent are requested. She especially asks to know how to do justly by all the nurses in a school numbering thirty, if all are not given the operating-room training. What other service or experience in a small hospital would seem to be equal in value to a pupil nurse? She has three or four nurses who are faithful workers but slow, and whom she is dreading placing on duty in the operating room.



Explaining the Treatment

A writer in an English magazine makes a very sensible plea for a little more explanation to be given to patients in hospitals in regard to their ailments. She cites an incident which is suggestive, and which, no doubt, is true, in its main outlines, of many similar cases. We talk of preventive medicine and of educating the public in regard to health matters, yet our rules or our stupidity or carelessness keep us many times from enlightening our patients as to their own condition, or of giving any reason why they are placed on a rigid diet system.

The incident is as follows:

"I am what is known in the laundry trade as 'an ironing-room examiner,' and while at work I recently overheard the following remark from one of the ironers: 'I went up the 'ospital yesterday, and they told me I'd have to go in. Well, I ain't a-goin' in. If they can't do me no good outside I stays as I am.' I could not refrain from asking the speaker why she would not go in. 'It's like

this, Miss,' was the reply: 'Our Lizzie—a fine, strappin' girl she were—was took bad and went up the 'ospital. They said she'd got gastritis and kept her in. She was using the gas-irons at the time. Well, what do you think? If they didn't try to starve her! I suppose they were payin' 'er out because she give 'em a lot of trouble. Well, Liz wasn't goin' to stand it, so after four days she came out.' (I knew that the poor girl died shortly after her return home.) I took the opportunity to explain that gastritis had not the connection with 'gas-irons' which the speaker believed, but meant ulcers of the stomach, demonstrating as well as I could that when the stomach is covered with ulcers and you put food in, it breaks and tears them open. 'So you see,' I concluded, 'that is why they refused to give Lizzie any food.' I cannot tell you how I felt when the poor mother exclaimed that if she had known that was so Lizzie might have been living now. Several of the other ironers had listened to my explanation. I found later that another one had smuggled in two small meat pies to a sister-in-law in hospital under similar food restrictions. These poor women have strange ideas about hospitals. Some would rather, as they say, 'die in the street' than go into one, while others speak of them very highly. What I should like to suggest is that any nurse who reads my letter might try now and again to give a few homely reasons to the patients for the treatment which is being carried out. It surely cannot be wrong to do so judiciously. I find that these women learn a great deal from a simple illustration, and they most certainly pass it on to many others. I feel glad to realize that the simple explanation I gave these women answered the purpose, and that Mrs. A. is going into the hospital feeling rather hopeful."

If this patient had been visited by a nurse in her home, probably she would have been told the why and wherefore of her rigid diet. Then why not in a hospital?

Hospital Costs on Paper and in Real Life

An effort is being made to form an organization in Jacksonville, Florida, which will work to secure a municipally owned hospital, which it is stated is much needed in that city.

Dr. M. B. Herlong has been appointed chairman of a temporary organization, to work toward this end and in the effort to create sentiment for the proposed new hospital he submits some interesting figures which will doubtless be read with surprise by those who have personal acquaintance with the cost of operating a hospital in 1915. Dr. Herlong proposes to treat 100 patients a day at a per capita cost of 67 cents. The figures submitted by Dr. Herlong to the *Times-Union* newspaper of that city are as follows:

Capacity of proposed hospital, 100 bed patients and 100 outdoor clinic patients. Cost of proposed city hospital, four stories and basement, fireproof.....	\$50,000
Equipment and furnishings complete....	10,500
Maintenance for one year, full capacity..	24,000
Cost per patient (bed) per day in proposed hospital.....	.67

The cost of 67 cents per bed patient per day covers all cost on 100 outdoor clinic patients per day and this is making no allowance for the tremendous quantity of farm products that can be produced on the city prison farm of 649 acres, which would probably reduce the figure to 50 cents per patient per day.

MONTHLY EXPENSES

According to Dr. Herlong the following figures show what the monthly expenses of the proposed city hospital would be:

One superintendent.....	\$ 75.00
One superintendent nurse.....	50.00
One night supervisor.....	50.00
Four orderlies.....	80.00
One chief cook.....	25.00
One druggist.....	50.00
One janitor assistant.....	20.00
Groceries for attaches.....	250.00
Laundry.....	45.00
Gasoline.....	50.00
Total.....	\$695.00

One assistant cook.....	\$ 20.00
Three internes.....	15.00
One elevator man.....	20.00
Twelve nurses.....	60.00
One ambulance driver.....	40.00
One janitor.....	50.00
Groceries for 100 patients.....	810.00
Drugs and supplies.....	200.00
Fuel.....	75.00
Gas for plates.....	15.00
Total.....	\$1,305.00

Grand total cost per month to operate hospital, full capacity, \$2,000. With this hospital the city could then treat 100 bed patients every day in the year and 100 outdoor clinic patients, also, for a total cost of \$24,000, whereas the city paid St. Luke's hospital last year, including clinic patients, \$29,252.37 for the care of only thirty-six patients per day throughout the year, thus showing a loss to the city of \$5,252.37 in one year. For twelve years this amounts to \$63,028.44, or enough to pay for the hospital and equip it. The city also lost the treatment of sixty-four patients per day throughout the year (bed patients), and the city also lost the treatment of fully fifty outdoor clinical patients per day; the result is that many of these patients who should have been treated are now either dead or helpless invalids looking to the city for support. With treatment, many of them would today be well and self-sustaining.

Evidently from the above figures the new organization is not expecting to overpay its working force.



Economy in Caring for Convalescents

In his paper before the hospital convention in San Francisco Howell Wright, superintendent of the City Hospital, Cleveland, emphasizes particularly the pressing need of more accommodation for convalescent patients, especially where municipal institutions are concerned, and the economies which might be effected thereby. Mr. Wright claims that if convenient cottages were available on their Warrensville Farm, it would be possible to care for

patients for fifty cents a day, and restore them more quickly to their homes than is possible by keeping them in beds for acute sick in the City Hospital, where the cost is \$1.50 per day.

Illustrating the cases that the convalescent home could be used for the writer says:

All of the mental patients sent to us for observation should be sent to the Warrensville Farm, where they may have opportunities for work and recreation and a chance to forget their troubles. As our accommodations for convalescents develop the term "convalescent" can be made more and more elastic. In time it would include a patient who has been operated upon for appendicitis and could not go back to his regular work for two or three weeks but could go to Warrensville in a week; a maternity case that ought not to go home for three weeks but could go to Warrensville on the ninth or tenth day; and patients with communicable diseases could go to isolation wards at Warrensville as soon as the fever period is over. Children suffering from nephritis and certain diseases of childhood that mean months or years for recovery, if they recover at all, and from chronic bone diseases of childhood, should be included eventually.



Iowa Industrial Hospital

The old Drake University Medical Building in Des Moines is to be remodeled for a hospital. The present plans are for an ultimate bed capacity of 200.

The hospital will be known as the Iowa Industrial hospital of Des Moines. It will extend the privileges of hospital, medical and surgical attention to organized labor and industrial workers of Des Moines on the same plan as is carried on for United Mine Workers in other places. A dispensary will be operated in connection with the hospital. The hospital will be open to any reputable physician.

The Dietary Question-Box

BY E. GRACE MCCULLOUGH

Dietitian, Peter Bent Brigham Hospital, Boston, Mass.

THE HOSPITAL-DIETITIAN

THE hospital-dietitian, as such, has a life history of about twenty-five years, dating back to 1890. The first diet kitchen opened for the dual benefit of patients and nurses was at the Johns Hopkins Hospital, Baltimore, when Miss Isabel Hampton (Mrs. Robb) was superintendent of nurses. It was her thought and influence in the hospital which made the position possible. Miss Mary A. Boland (now Mrs. George Pequignot) was selected to organize the new department. It was during her service there that she wrote and published her book on "Invalid Cookery," which was almost exclusively used as a text-book for nurses during fifteen years.

The title and official ranking of the person who is the head of the new profession in hospitals, has always been uncertain, and continues to be a problem. The prominence of the hospital, and the dietitian herself, are really the determining factors. The hospital-dietitian works out her own salvation.

At the Lake Placid Conference in 1906, the controversy waxed strong and fiery as to whether she should be called a dietist, a dietician or a dietitian, plus a hyphenated prefix, to determine in which class to place her. It was left an open question, and custom has given the preference to the title of this preamble.

As to the official ranking in the hospital, which one hears about at all meetings, I feel it is always determined by the amount of dignity and confidence the dietitian maintains, the amount of exact knowledge and executive ability she puts into the work. We attract the conditions of our daily life

to us, by our own attributes of mind, under seemingly purposeless acts; there is always the strong current of personal inclination.

The hospital-dietitian must be equal to organizing a simple, yet systematized dietary department. It requires tact, executive ability, adaptability, eternal vigilance and excellent health to produce results. She must keep ahead of demand, creating opportunities. The evolution of the dietitian in every institution has not been by ways of pleasantness, where all the paths are peace.

The profession of Dietetics is not popular; only 2 per cent. of the domestic science graduates of reputable technical colleges elect Dietetics. For the past few years the effort has been made to find the why! There are few positions which offer board, lodging, laundry, fair salary positions frequently carrying the dignity of an officer of the institution, that are not overrun with applicants. Some of the conclusions reached are that the work, in many ways, is unattractive. It is nerve-racking, there is very little leisure; nine hours is the minimum for duty; while the maximum may cover the entire twenty-four. The working hours are most strenuous, hands, feet and brain go by leaps and bounds from one thing to another. The old stigma continues to cling to anything which approaches what might be considered domestic drudgery, to the kitchen in particular—and though we have advanced, and may feed the hungry to the glory of God, the devil usually blows the odors into the nostrils of the shocked public. It takes character to ignore public opinion in the selection of a profession. The woman

specially gifted and suitable can often find more congenial work at larger salary, with more leisure.

At her best, the hospital-dietitian is but a small part of huge institutional machinery. To be paradoxical she must lose herself in the work and, at the same time, find herself the recognized head of her department. The dietary work differs from all others, in that she must care for the sick as for the well. The ill fed up to health and the well kept there; if possible, all contented and happy—this is her task. There must be a steady advance in the entire field. The standard should be continuously raised, by the best practical methods, which mean good financing, frictionless institutional machinery and an open mind, ever alert for the advances in medical research applicable to her work. If she is in a large hospital, the horizon will be wider, her duties more complex, with insistent demands on her time and strength. The small hospital, in proportion, needs the lesser requirements. The trouble, however, does not rest entirely with the applicant. The hospital frequently does not know the type to select, has not an outline of duties, and the medical staff too often follows the course of least resistance and dietetics until too late.

It is exceedingly difficult to formulate routine duties. Hospitals differ greatly in character, but all demand good food, clean food, and suitable food for each member of the household. A hospital-dietitian should never be selected immediately after graduation. She should be required to serve an internship in a hospital where practice has rounded out theory. The majority of technical schools are affiliated with the large hospitals, who take students as pupil dietitians for a period of three, four or six months where they are brought in touch with the various phases of life and work of an institution.

Briefly summarizing from the foregoing

—we find dietitians facing a very new profession in a state of evolution, not overcrowded. To be truthful, the supply in no sense is equal to the demand eminently within "woman's domain." There is yet much that is unsatisfactory on both sides—that of the employer and employee—much that can be remedied by definite knowledge of both hospital and applicant on the subject of requirements. Realizing that it is a work the world needs, that it is of great importance and has a broad outlook for the future, both sides may wisely give serious attention to its requirements and problems.

This brings us to the matter of the questions grouped in the Introduction to the Question Box of the October number, showing how important the dietitian is to the hospital, and that she is a real problem.

I. What salary should a small hospital pay a dietitian?

Ans. A dietitian having completed the four years' technical course and pupil dietitian's internship receives \$60 per month, with promise of increase at the expiration of one or two years.

II. If a small hospital cannot afford a thoroughly trained dietitian, yet has a visiting doctor and resident interne, demanding weighed and calculated diets, how can they meet the requirements?*

Ans. The hospital must be willing to pay from \$50 to \$100 to an expert dietitian, as is required by an auditor or engineer, to work out a series of diets with the possible varying amounts of fats, carbohydrates protein and salts to suit the diseases. Turn these calculations over and over into menus and arrange in a card catalogue. Then send one of your brightest nurses for a dozen lessons in the preparation of the food selected; if possible, plan six weeks' service in a diet laboratory and then con-

*This question was answered in a paper before the American Hospital Association at San Francisco, June 21, 1915.

tinue along the same lines in your own hospital.

III. Why do so many college graduates fail as practical dietitians?

Ans. They are too young; their vision is not broad enough; they do not grasp the entire situation; they give their personal time to the *doing* of details, rather than to supervising them. Through lack of experience they make changes too abruptly and in quick succession which creates friction. They are uncertain in the handling of help; unsystematic in dealing with large quantities; physically unable to bear the strain of long hours with the nervous wear and tear, and they too often refuse to consider the unwritten laws of the institution.

IV. What are the duties of a dietitian?

Ans. The duties of the dietitian vary somewhat with the size and scope of the hospital, but always is she expected to control the food and feeding of the hospital family, to have oversight of all places where food is prepared and served, plus the cleanliness of the same, be responsible

for the help of her department, their work and their time. If she does not purchase the food; she should supervise the receipt and condition of the raw food material, and be consulted in the ordering, care and distribution of it, as she is responsible for the per capita cost. She should visit the wards daily, come in touch with the patients as far as possible, be open-minded as to complaints and idiosyncrasies, go from one place to another during the rush of meal hours, to be sure things are as they should be. She will teach the pupil nurses in dietetics by lectures, practical lessons and service in the diet kitchen or laboratory. She must cooperate with the medical staff when required and, by continually studying, be ready for the emergencies.

V. Genesee Pure Food Co., Le Roy, N. Y.?

Ans. The two books can be purchased directly from the publishers or the Lakeside Publishing Co.: "The Principles of Human Nutrition," by Whitman H. Jordan; "Nutrition and Dietetics," by Winfield S. Hall.

An International Hospital in Tokio

Dr. R. B. Tensler, formerly of Virginia, who is promoting the establishment of a great international hospital—St. Luke's—at Tokio, Japan, is now in America. Previous to his leaving Japan he was the guest of honor at a farewell dinner given by Count Okuma, Premier of Japan, at which the American physicians who are sent by the Rockefeller foundation to promote the establishment of a modern system of medical education in China—Dr. William H. Welch, Dr. Simon Flexner, Dr. Wallace Buttrick and Dr. F. L. Gates were present. The new St. Luke's Hospital in Tokio will have about 150 beds, a complete dispensary and a social service department.

Memorial Nurses' Homes

The year 1915, in spite of the adverse effects of the war on hospital finance, has been notable in the United States for the large number of nurses' homes which are being planned and built as memorials or as gifts from some devoted friend of hospitals and nurses. Within the past month news of at least a dozen such memorials which are under construction has reached this office. What this means in increased comfort and convenience can hardly be estimated. Without question the popularity of this form of memorial is growing. What is needed now for many of them is an endowment that will make possible many advances along educational lines.

Editorially Speaking

"We Can Make Our Lives Sublime"

Stories of heroism in this war are common. We read and quickly forget, but now and again, as we scan the papers for any news that will give hope that the war may soon close, there comes to us from across the seas a story of heroism so great, so striking, that men and women instinctively pause in admiration. A few weeks ago few outside the circle of her friends and associates had even heard the name of Edith Cavell. Today all over the civilized world her name and the story of her victorious death are known. Men and women of all races and nations have paid their tribute of admiration to the spirit of the indomitable woman who, because she had hold of the things which endure, was able to make death glorious, and through her death was able to inspire millions of others with the courage and faith that strengthens.

Out of the gloom of night in a prison yard in Brussels, this woman in a nurse's uniform appears before the world, a sublime figure, whose name will endure as long as the history of this war endures.

What has she done? Hall Caine puts it beautifully when he says, "*She taught us how to die.*" Her name will stand for different things to different people. She had broken the laws of a Government in order to obey the higher laws of humanity, of mercy, and of God, and she paid the price with her life. This is a fact that will deeply impress itself on hospital workers and nurses. Hall Caine's tribute to the memory of this great nurse, after the memorial service in St. Paul's Cathedral, has in it some lessons of wonderful beauty, and is well



EDITH CAVELL

worth preserving as a literary gem. He was about to write a word of pity—to say "poor Edith Cavell" when he checks himself and says "no, not poor—great, heroic, immortal, everlasting—victorious—one of the sentinels on the hilltops of eternity, who have won the right to stand by the beacon fires of hope and sacrifice which light up the destinies of mankind."

Put her story in your scrapbooks. Tell it to the nurses of today and of the future—how this nurse, this great heroic soul, met her death. Placed on trial in the afternoon and executed before the dawn of another morning—her courage failed not. Her life had always been so busy and so

full of difficulties that she said she thanked God for a little rest before the end—the rest secured by ten weeks in prison. No bitterness, no hatred entered into her closing hours—just the calm, unfaltering courage of a dauntless soul whose faith in the Infinite One upheld her till the supreme sacrifice of her life was made.

Her spirit calls to nurses all over the world to be strong, to meet adversity with a courage that will not fail to keep our faces toward the light that illuminated her closing hours.

It will be given to few to meet death as she did, let us hope, but all of us can "make our lives sublime."



The Christmas Spirit

Another anniversary of the coming of the Prince of Peace is approaching. The dark war cloud still hovers over the world and in many thousands of homes the day will be one of sorrow because of "the vacant chair"—because of calamities of all kinds due to the great devastation.

In America there is abundant reason to be grateful because of the blessings of peace that are ours—and because we have been privileged to have such a large part in lessening the suffering of those who are fighting for their country or for their honor.

Some writer has suggested that "Christmas is not a season—it's a feeling!" and most of us are ready to agree that the feeling has a lot to do with Christmas. Nurses and hospital workers can do much to brighten the day in their own little corner. We are glad to be able to present in this number a variety of suggestions from the facile pens of Mrs. Amy Armour Smith and Katherine Megee for making the season in the hospital one to be long-remembered by those having a part in it.

To those of our readers who are serving in isolated sections far from home and

friends our hearts go out in sympathy, yet we know that to them much real joy is possible by giving pleasure to others.

To one and all our readers, we wish abundant joy and peace in this approaching yule-tide season. We would be glad to have from our readers brief letters on the way in which Christmas was spent—especially where the circumstances were unusual or unexpected. The best time to write such letters is during Christmas week, while the impressions are still fresh in mind.



The Nurses' Convention in China

The story of the meeting of the Nurses' Association of China, found elsewhere in this number, is a story of pioneer work that fills one with a sense of pride in the part which nurses are playing in the evolution of that country, now just awakening to its need of skilled care in illness, and to the need of proper methods of preventing illness. When the history of nursing in China is written, one hundred years hence, the names mentioned in this report will stand out with a luster which none of them today have time to dream of.

In a letter to the editor one nurse at work trying to get a new building in condition for work and to train native nurses expresses the wish that she were made of iron so that she could go on working without getting so tired—there is so much to do. Doubtless every one of the dauntless band of nurses at work in China has often expressed the same wish.

One reading the report is struck with the similarity of the subjects to those occupying the thought of hospital and training school workers at home, such subjects as "The Social Life Recreation, and Care of Nurses in Training," "Discipline," "A Scheme for District Workers," "Hospital Economies and the Prevention of Waste," "Hospital Social Service"—sound strangely familiar.

Not so familiar however sounds the following: "*After the reading of each paper or giving of an address, an open discussion was held, this often being quite as helpful as the address itself;*" or this, "*fifty-three heads contributed to the topic under discussion.*" Imagine, if you can, our American Nurses' Association, with time for full discussion of each paper, or fifty-three nurses taking part in the discussion!

We would again remind our readers that they can have a part in the work this pioneer band of nurses in China are doing, by cooperating with their friends in providing for a scholarship at about \$40 a year, which provides for the support of a native Chinese pupil nurse. Here and there individual nurses and alumnæ societies are doing this and without depriving themselves of one thing really needful. American nurses could provide for hundreds of such scholarships.



The Nurse-Anesthetist Again

The medical profession still remains divided on the question of whether nurses should or should not be allowed to administer anesthetics in hospitals, as the following editorial from the *American Journal of Surgery* indicates.

"The drastic attitude of the American College of Surgeons toward *fee-splitting* loses much of its force in view of the fact that the organization permits some of its most prominent members to continue the routine employment of unlicensed anesthetists.

"If anything can be such the administration of an anesthetic is certainly a medical act, and as such should be duly limited to licensed practitioners of medicine and dentistry. Any other course of procedure is in direct violation of the letter and spirit of all *Medical Practice Acts*.

"That a question of sex is not at the root of the antipathy toward the nurse-anesthetist is evidenced by the number of women physicians who are members of the various associations of anesthetists in this country and England. The nurse-anesthetist must go because she is unlicensed, and because her employment is as much an economic crime against the profession and public as *fee-splitting*.

"It is up to the American College of Surgeons, during its forthcoming meeting in Frisco, to take action in this matter, or stand convicted of playing favorites, violating medical ethics and alienating a certain proportion of licensed practitioners from a legitimate source of financial support. Meantime, the demand for nurse-anesthetists shows no sign of lessening but, on the contrary, appears to be growing."

In this connection it is interesting to note that the Georgia Board of Medical Examiners has put a stop to this practice.



Occupational Therapy

Probably no articles which have appeared in this magazine in recent years have attracted such widespread attention as those of Miss Reba G. Cameron, and Mr. George Edward Barton, on occupational therapy. We have heard from these articles, and are continuing to hear from all parts of the globe. It is therefore not only a pleasure but we feel it a privilege to be able to present in this issue another article from the pen of Miss Cameron. Miss Cameron feels that the subject is as yet little understood, many believing that occupational therapy is simply play, or something to amuse. Like Mr. Barton, Miss Cameron is an enthusiast on the subject, and has an unbounded faith that this new therapy will "prove its case" and rise triumphant.

Gleanings

Nitrous-Oxide Gas in Obstetrics

In the Journal of A. M. A. J. C., Webster describes his use of nitrous-oxide gas in certain complicated obstetric cases. The technique is simple. Usually the administration is begun when the patient complains of second stage pains, though it may also be used during the first stage. In the majority of cases, however, gas is not necessary during the greater portion of this period. It has been found best to use a small nasal inhaler, the mouth of the patient being uncovered. The gas-bag attached to the tank is kept under low pressure and, as the pain begins, the patient is instructed to breathe quietly, keeping her mouth closed. Ordinarily, light inhalation suffices to produce the analgesic effect. It is not necessary to cause asphyxiation or jactitation, which are due to the inhalation of large quantities of gas. Expulsive efforts on the part of the patient are not interfered with, to any appreciable extent. As soon as the uterine contraction begins to subside the inhaler is removed and the patient is again conscious. This procedure may be kept up for hours if necessary. A nurse or assistant may be instructed so as to carry out the administration satisfactorily. Pure nitrous-oxide gas or gas with oxygen (3 per cent.) may be employed. The former is, perhaps, the most universally applicable. It may be used in private houses as well as in hospitals, the necessary apparatus being small, compact and easily transported. The amount of gas varies according to the duration of painful contractions, and the cost is therefore a variable factor. In the Presbyterian Hospital the ordinary small gas-tanks have chiefly been used, the expense

of administration being comparatively small. In hospitals where large tanks may be employed, the cost may be reduced about one-half. This method is recommended as the safest and simplest method of conducting painless labor. Its advantages are as follows: The apparatus is simple, easily transported, and may be used by any practitioner. Deep anesthesia is not necessary. There are no ill-effects to mother or child. The strength of uterine contractions is not diminished, no matter how long the administration of the nitrous-oxide gas is continued. The administration is under control all the time, and can be stopped at any moment. This is a very decided advantage which is not possessed by any method which necessitates placing a patient under the influence of drugs administered internally.

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Diet After Abdominal Operations

A. Carless, surgeon to Kings College Hospital, London, in a paper in *Medical Press* and circular, states that methods in regard to feeding after abdominal operations have undergone great modifications in recent years, as a result of increasing confidence in aseptic technique. Formerly patients were starved for nearly a week; now the surgeon's desire is to restore the normal activities of the intestinal canal at the earliest date, and where there has been no interference with the continuity of the bowel there is not the slightest reason why the patient, if he desires and feels capable of taking it, should not be given his ordinary food the next day. As for the quenching of thirst, this is best relieved by

the administration of saline solution by the bowel, either continuously or in doses of a pint at a time at six-hourly intervals. In enteroanastomosis a little more care has to be taken with the administration of food, but even in gastroenterostomy the present-day methods of suture are so perfect that the risk of leakage need hardly be taken into consideration. Carless recommends as purgative measures that a turpentine enema be given on the day after operation when the patient generally suffers from distention and some colicky pains. On the second or third day an ordinary routine purgative is necessary in most instances, and the patient may be given castor oil or calomel. Subsequently the bowels are kept acting daily by senna, cascara or some other mild laxative.

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Therapeutic Measures in Typhoid Fever

The surgeons are not the only ones who are applying their resourcefulness in trying to solve the many important problems arising in the present war. The internists are also profiting by the vast amount of material at their disposal in the various military hospitals. Typhoid fever is the disease which as usual is engaging most attention in this respect. In the *Presse Médicale*, January 14, 1915, there appear two papers in which are reported new routine methods of treating typhoid fever. M. E. de Massary advocates the use of continuous refrigeration of the abdomen by means of an ice-bag, the skin being protected by a thick layer of talcum powder and a piece of light flannel. In conjunction with this measure there is enforced absolute rest, and the patient is given a large amount of water to drink. This includes boiled milk well diluted with tea or coffee. After each drink the mouth is rinsed with an alkaline solution and a mouthful is swallowed. This method was employed in 140 patients with a mortality of 8.5 per cent. In the second

paper, E. Weil extols the use of the Murphy drip as an efficient procedure in combating typhoid fever. The solution used is a liter of water at 40° C., containing 50 grams of glucose. It has both nutritive and diuretic properties, reduces the temperature of the patient, and in other respects improves his condition. The nervous manifestations particularly are said to be relieved.

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The Comforter

Is the use of the dummy or comforter on the increase in this country? Certainly its use does not seem to be decreasing. A writer in an English magazine suggests that notwithstanding the propaganda against the comforter it seems to be on the increase in England. She advocates the usual method, "pass a law against it," and believes that when the law against the manufacture or sale of the disgusting things is passed, there will be a great improvement in the digestion of infants. She suggests that there is a close connection between the "dummy comforter" and delicate digestion.

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Posture After Labor

It is now the consensus of opinion that it is not always the wise thing to keep the parturient woman "flat on her back" for nine days or longer. If there are no pronounced contraindications for so doing, the woman should assume a sitting posture for micturition and defecation. Drainage is thereby better effected and retained clots and debris expelled with greater facility. Many physicians even favor this procedure in septic peritonitis following labor. Drainage as a preventive of sepsis is one essential factor, and whatever measures accomplish this end without otherwise proving detrimental to the patient is commendable practice.—*Med. Summary*

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 History of Nursing

To the Editor of The Trained Nurse:

One of the greatest needs of our system of nurse education is more teaching of the "History of Nursing."

If it is important that our normal schools teach "History of Education" to imbue teachers with the high ideals of Pestalozzi, Arnold, of Rugby, and Horace Mann, does not the nurse need, in fully as large a degree, the inspiration and ideals to be gained from a knowledge of that noble woman of the Society of Friends Elizabeth Fry; Florence Nightingale the angel of Crimea, and our own Clara Barton?

Many pupil nurses become dissatisfied as soon as they are put on night duty and many drop out of training about that time. May it not be that night duty would not seem so "hard" if those young nurses had their first enthusiasm sustained in the early trying experiences of hospital life by the vision of Florence Nightingale, as she quietly ministered to those uncounted thousands in Crimea?

Let us make our nurses familiar with Longfellow's poem, "The Lady of the Lamp," early in their course of training, at that impressionable period when their highest ideals take form. We should teach them, perhaps later on in their course, something of the history of the Red Cross, not only in times of war but in times of pestilence, famine, earthquake, flood and fire.

There seems to be need of a "History of Nursing," brief enough to be used as a text-book and inclusive enough to give the nurse a realization that she is part of a noble band of the world's workers, and that her calling has a dignity which she will want to help uphold.

I would not urge the "over-education" of nurses, but I wonder if we do not sometimes put too much stress on non-essentials and forever miss instilling into our pupils the larger world-vision that will enable them to realize the import of the words of the peerless Servant when he said: "For even the son of man came not to be ministered unto but to minister."

H. J. C., R.N.

Ownership of the Clinical Record

To the Editor of The Trained Nurse:

I have been reading with considerable interest an article in July number of *THE TRAINED NURSE*, "The relation of the nurse to the ownership of clinical records."

I can easily see why a nurse leaving a case, should leave the record to her successor, but after the patient has recovered, or otherwise, as the case may be, I cannot see wherein it belongs to any one but herself, or her physician, if he asks her for it, for rather that it being like unto a servant leaving her employer's own property where she found it. A clinical record, as I understand, is a private conversation between physician and nurse, and a nurse who is so unwomanly and indiscreet as to publish her patient's private affairs can do so without the aid of a record. In fact, my experience has proven that a record is far more private in the hands of an honorable nurse, than in that of the patients themselves. And again let me say that no honorable nurse has any desire to cover up her mistakes.

Am anxious to hear other comments on this question.

ADELAIDE B. PICKELL, R.N.



An Answer to "The Observer"

To the Editor of The Trained Nurse:

"The Observer" who wrote an article for the October number of *THE TRAINED NURSE* reminds one of the story of the old colored gentleman who put a fine fat 'possum roasting for his dinner, and then soothed by the warmth of the fire and the delicious fragrance of the cooking 'possum fell in a sound sleep. The savor of the 'possum attracted the attention of a mischievous young negro passing Uncle Jerry's cabin. He stepped close to the window and peered in. Uncle Jerry sat deep in his chair, sleeping audibly, beside his little set table.

Quickly and stealthily the young man entered the cabin and soon the 'possum, now cooked just

right, was reduced to a heap of bones on Uncle Jerry's plate, and as a parting gift the young man put a bone in the hand of the sleeping old man. Then the perpetrator of the joke hastily retreated and took up a point of observation outside the window.

Soon Uncle Jerry awakened with a wide yawn and sniffs of pleasurable anticipation. Then beholding the wreck of the 'possum, a look of surprise and perplexity overspread his face, and he shook himself thinking he must be dreaming. But he found himself awake and as the terrible conviction came to him he expressed himself thus:

"Yes, suh! Ah suah ate dat 'possum in moh sleep—but it suttinly leaves a mighty empty feelin' in de stummack."

Having attended the inspiring meetings at San Francisco, I feel convinced "The Observer" occupied much the same position and condition as did Uncle Jerry, and while others enjoyed the feast, she slept.

That was her privilege. But now when the meetings are past history and "The Observer" finds all she gleaned from the feast was bones, which give no satisfying feeling to the mind, we think it is not fair that she should use one of our prominent nursing journals to pass those bones to the nurses throughout the country, as the feast served at San Francisco.

A MONTANA OBSERVER.



The Problems of the Practical Nurse

To the Editor of The Trained Nurse:

Will you permit me a word to the contributors and readers of your magazine?

Certain articles in late numbers concerning registration and practical nursing I have found amusing and others amazing.

Sifted down to real fact the argument seems to be the supply of trained nurses exceeds the demand, therefore, practical nursing must be eliminated.

Of course, if the good of the trained nurse only is to be considered, there is nothing to be said, but if to the sick in families of moderate means, or less, the salary of a trained nurse is prohibitive, and the continuous service of a practical nurse is of more benefit than the intermittent work of a district trained nurse, possibly, the greatest good to the sufferer is worthy of being taken into account. And surely the employer has a right to decide what he can afford to pay and, having consulted with his physician, what grade of service he requires.

The objection to the term "Nurse" as applied to any but those who have received hospital training seems funny. People who cared for the sick, for babies and young children, were called nurses before ever there was a nurses' training school. It seems to me the prefix, apparently looked upon by trained nurses as a decoration only, a badge of honor, should be sufficiently distinctive as well as dignifying. But I believe there would be no objection by practical nurses to the adoption of the term "attendant," indefinite as it is, or to any more suitable one, to indicate the nature and limitations of their work, leaving to the trained nurses the title about which they seem so sensitive.

I have done practical nursing for sixteen years. I may at least say that I never have let a patient die from neglect, given the wrong medicine, nor burned her with a hot-water bottle. I proudly number among my friends five trained nurses. They are so good as to endorse my work, frequently referring calls for a nurse to me.

One such case was that of a 22-months' old child with measles, double pneumonia, and an intestinal infection, and in a home where dirt and vermin abounded. The child recovered.

I am always glad to be taught better methods of work by a trained nurse, and as glad to tell her of those I have discovered to be of value. And I believe this to be true of other practical nurses. But I am sure none of us will ever submit to have a trained nurse fix our salaries, nor dictate to us as to what kind of a case we shall engage for. The first is a matter which concerns ourselves only, the other one to be decided by the patient, the doctor, and the nurse herself.

I do not belittle nurses' training. No knowledge of the details of any avocation can be too thorough, certainly no amount of preparedness for the care of the sick can be too great. And I recognize the fact that hospital training develops self-control, self-denial, tact, cheerfulness and other virtues to a marked degree. But surely it is not altogether from lectures and text-books, nor wholly from example, that these things are learned. It is quite possible that some skill and the same qualities may be begotten in the practical nurse during the long and trying hours and months and years she spends by the bedside of the sick, giving to them of her very best, sometimes life itself, in the effort to bring to them health of body and peace to mind and soul.

You seem to me, trained nurses, to be needlessly disturbed. Sooner or later things properly adjust themselves. "The old order changeth"—if the new be better. But no real and lasting

reform is brought about by intolerance and arbitrariness.

Put aside your prejudices, learn really to know us, to do our work justice, and so prove to us that your training has also made you wise enough and broad-minded enough to recognize merit wherever found. For at present we are inclined to say, with Job, "No doubt but ye are the people, and wisdom shall die with you." L. M. P.

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Again "The Grouch"

To the Editor of The Trained Nurse:

I have received a copy of the October number of the TRAINED NURSE AND HOSPITAL REVIEW with A. E. C.'s reply to my letter in the August issue. I quite agree with her that my question is "Absurd." It was indeed a disbelief that anything so utterly absurd could really exist in a serious profession, which led me to write my August letter. Nevertheless, I must point out that A. E. C. has evaded a very real question, which, it seems, does lie beneath the absurdity. A. E. C. says, "I believe it is entirely within the jurisdiction of the nurse to use or not to use salt to season food." My question was one not of "belief" but of law. I wrote to THE TRAINED NURSE AND HOSPITAL REVIEW hoping that my question might be easily answered and because I am not sufficiently interested to employ my attorney in looking into the legal question involved.

If, however, the doctor has succeeded in so concentrating the nurse's attention upon "taking off her cap" to him, as A. E. C. says, it may well be that the public of the future (considering all the other things it has to pay for), will cease to regard this exhibition of charming manners as "absurd," and it may be forced for the sake of suffering humanity to take sufficient interest in the situation, not only to employ an attorney to go into the question of the legal standing of the nurse, but also to have the laws so changed as to include a benefit for the sick man even regardless of the doctor's desire for the nurse's subjection and abasement.

THE GROUCH.

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Is it the Usual Custom?

To the Editor of The Trained Nurse:

It has been my custom when engaged on an obstetrical case, to call on the physician in charge, who has always expressed his opinion as to whether he is expecting anything out of the ordinary in labor, or if he is looking forward to an easy confinement.

The doctor has always both looked and expressed his pleasure by voice at my call and has

invited me to return and report on case at a later date if I am in the home of patient.

My sister has engaged me for her confinement, which is barely ten weeks in the future.

This is her first child.

She only lately visited her physician, who informed her her pelvis was small and gave her to understand her measurements were not satisfactory. I called on him at his office at which my sister, who is a trained nurse, also took offense. Are other nurses in the habit of visiting the physician before labor begins. If not, why not?

R. S. S.

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What Is Your Opinion

To the Editor of The Trained Nurse:

I would like to have nurses express through THE TRAINED NURSE AND HOSPITAL REVIEW, their opinions on this question. What is your opinion of a woman who after one year's training, leaves the hospital, poses as a graduate, and demands \$25 a week. Has she any right to accept \$25 per week because people are willing to pay her that? She says it is no one's business. Is it or is it not any one's business to look after cases of this kind?

P. S. M.

✦

A Klondike Bed

To the Editor of The Trained Nurse:

Will some one of your readers send, as soon as possible, directions for making a klondike bed?

B. M. R.

✦

Miss Smith

To the Editor of The Trained Nurse:

We read the article in a recent issue of *McClure's Magazine*, Miss Smith, of Bellevue, and were much impressed by its injustice to the nursing profession. Miss McLean's letter, "We Protest," in October issue, will we know be appreciated by all readers of THE TRAINED NURSE, and will give to the public a higher regard for the nursing profession. We wish to express our gratitude to Miss McLean for her loyalty to the profession and hope that all nurses are equally loyal.

We resent the paragraph in the article on the removal of an eye, as an injustice to the medical profession. We also resent being criticized by the public for not being musical nor an artist. As nurses we believe that there are many things which should hold a higher and more sacred place in our minds than music or art.

NORA K. CANTWELL, R.N.

NINA B. WALES, R.N.

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

An American Nurse in Mexico

The friends of Miss Anna Hanbury will be interested to know that she has recovered from an attack of typhus fever which she contracted while assisting the Red Cross Society in its humanitarian work among the starving Mexicans.

She says that in the month of August, 30,000 people were subsisted, by that society, in Mexico.

Miss Hanbury has lived in Mexico City nearly ten years. In February, 1906, she went to Mexico City to assist Miss Mary J. McCloud in supervising the training of Mexican nurses at the Mexican General Hospital (the largest hospital in Mexico), which accommodates 1,500 patients and has a staff of 112 Mexican nurses.

She has seen many changes in the government and conditions of the country but is not discouraged, hoping that under the present régime better times may come.



Army Nurse Corps

APPOINTMENTS—Loie L. Compton, graduate of Woman's Hospital, Philadelphia, Pa.; Marion A. Himes, Memorial Hospital, Worcester, Mass.; assigned to duty at the Walter Reed General Hospital, Takoma Park, D. C.

TRANSFERS—To the Walter Reed General Hospital, Takoma Park, D. C.: Bessie S. Bell, assigned to duty as chief nurse. To Letterman General Hospital, San Francisco, California: Ella Kirkpatrick, Rose Pegler, Edna M. Rockafellow, Bessie P. Seger. To Department Hospital, Honolulu, H. T.: M. Estelle Hine, with assignment to duty as chief nurse. To Department Hospital, Manila, P. I.: Carolyn Milligan. To Post Hospital, Fort Wm. McKinley, Rizal, P. I.: Clara G. Calderwood.

DISCHARGE—Auber M. Kepler.

DORA E. THOMPSON,
Superintendent, Army Nurse Corps.



The Conference of the Nurses' Association of China

Reported by "Missionary Nurse."

The 1915 conference of the Nurses' Association of China was held September 1 to 6, at the national capital, Peking. Over fifty nurses attended, coming from eleven provinces, and representing well-nigh every denomination and



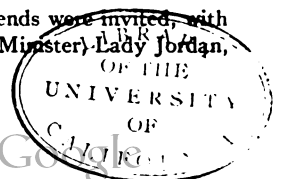
MINNIE GOODNOW, R.N.

Matron of the nurses of the Harvard Unit which sailed from New York, November 17, for war service. Miss Goodnow is well known to the readers of this magazine, being one of the regular staff of contributors. She is also the author of several nursing books, "First Year Nursing," "Ten Lessons in Chemistry," "The Nursing of Children," etc.

nationality engaged in such work in the empire. With such representation the conference could not fail to be most helpful, full of inspiration and encouragement to all who attended.

On Wednesday, at the Union Medical College, the conference opened with Miss Hope Bell, president, in the chair. Dr. Cormack, principal of the college, conducted the devotional service, giving a deeply spiritual address, the keynote of which was, "Steady! Keep Cool! Pray!" "These are three vital necessities in the life of a Christian nurse."

Miss Powell, of the Peking Methodist Hospital for Women, gave a cordial address of welcome. A reception followed to which all delegates, physicians, and friends were invited, with Sir John Jordan, British Minister-Lady Jordan,



Surgeon-General Ch'uan, of Tientsin, Mr. Greene, representative of the Rockefeller Foundation, and Dr. Wu Lien Te, as guests of honor. A letter of welcome was read from the American Minister, expressing his regret at being unable to attend. Dr. Wu spoke most appreciatively of the progress along medical lines in China during recent years, the reward of much faith and patience on the part of the pioneer workers. He urged the importance of getting in readiness fully trained Chinese nurses who would be competent to staff the new hospitals now going up in all parts of China—laying great stress on the need for *real nurses*, not "half nurse, half doctor." Mr. Greene gave a rapid sketch of the purpose of the Rockefeller Foundation Movement, especially with regard to China, revealing at the same time his own keen personal interest and appreciation of the part which trained nurses, foreign and native, are to play in the establishment, staffing, and carrying on of adequate hospital aid for China's needy millions.

Thursday morning was given to the hearing of three papers. The first was on "Social life, recreation, and care of nurses in training." Miss Powell, the writer, is one of the "veteran" nurses in Peking, to quote her own words, though by no means ancient in years. Superintendents were urged to see to it that the pupils had opportunity for active out-of-door play, and that they took advantage of such; not always the easiest end of the bargain.

Throughout the conference, after the reading of each paper or giving of an address, an open discussion was held, this often being quite, if not fully, as helpful as the address itself.

The second paper dealt with the "Discipline for Women Nurses" by Miss Baldwin, of Foochow. The status of our work today over that of fourteen years ago was vividly portrayed. Miss Baldwin urges that superintendents give themselves utterly to working personally side by side with the new nurses, during their first six months, the crucial and important period in their training. "Their standard of work during these first six months will determine it for life." "Let your first lecture to them be on the requirements for a good nurse, and then live it, and teach it day by day, from a physical, moral and spiritual standpoint. From your second- and third-year nurses you yourself may learn much, but your first-year nurses should learn your way of doing things first. Beware of understaffing your hospital, lest you be forced to lower the grade of your work, since the press of the sick about us is so great that it is difficult to control the number

of inpatients." Miss Tomlinson's paper on "Discipline of Men Nurses" was exceedingly practical and helpful.

The Chinese graduate and pupil nurses of the city were the guests of the afternoon on the second, and all papers, addresses and discussions were in the native tongue. Dr. Liu, of the Methodist Women's Hospital, presided with gracious dignity. He made a few preliminary remarks in explanation of the Nurses' Association of China, its purpose, its growth in these four years (the membership now reaching to more than one hundred), and also for the benefit of the non-members present, giving the official titles in Chinese, as conferred by the association, for graduate and pupil nurses. The graduate nurse to be known as "hu shih," and the pupil nurse as "hu sheng."

In the next address given by Surgeon General Ch'uan of Tientsin, ever a warm and loyal friend of our profession, he stated "that there were those who said that the nursing profession could not grow in China, but that day has passed. The nurse has proven her worth in this land, and has come to stay and to multiply. Keep your ideals high. A nurse worthy of the name must have education and refinement, and a character above reproach. Go forth with love, faith and purity of heart—your hope for the future is bright."

Miss Tippet, of P'ingyangfu, followed with one of the most spirited and spiritual appeals that nurses were ever privileged to hear. She said in part: "The Chinese have a saying, which being translated reads, 'With three of one mind, even earth's dust turns to gold.' Important everywhere, it is doubly so in hospital life that harmony and singleness of purpose reign. If we hitch two animals to a cart, and one goes east, and one goes west, we are not likely to make very rapid progress. You nurses who are located in the large cities in this land are opening up a new road to the Chinese, the profession of nursing. It is you who pave the way for them to follow. Take care that you build well!"

Thursday evening from eight to ten the conference met in a united session with the Peking Medical Association, with Dr. Gray, of the British Legation, in the chair. The officers of the association had hoped to be able to arrange for an audience with the president at some time during the conference, but illness preventing, his representative, Admiral Ts'ai, was the guest of honor for this evening.

A paper by Mrs. Lyon, of Tientsin, followed on "A Scheme for District Nursing," full of interest to the listeners. This phase of nursing

work at present, however, is possible only in the large cities and ports of the empire. The interior hospitals, owing to the rigidity of social laws and customs, must needs advance more slowly, even though all are heartily in sympathy with such work, and long for the time when it will be possible to put our nurses out into the homes of the people to a greater degree.

The final paper of the evening was by Miss Hope Bell, of Hankow, on the "Teaching of Men Nurses," a topic of keen interest to the many engaged in that work. "There are those who think the training of male nurses in China but a temporary expedient until social laws permit women nurses to care for both sexes, but it is hard for some of us who are teaching the boys to feel convinced on that point. Many of them are proving themselves as gentle and capable as their sisters. It is evident, of course, that for the present in many localities men nurses must be used for the male wards. In the port cities where the customs have been broken over women nurses are caring for men in some instances, but this phase can come about but gradually, if at all, in the far interior. The foreign woman superintendent in the interior often finds herself looked upon as a decided innovation, and she has to move cautiously ere she can command the respect of her men nurses and other native co-workers, and

thus gain entrance to the wards. It is easy enough to give the male nurses lessons in theory, but practical work must be taught and still meet the ethical requirements." Miss Hope Bell finds her "sawdust man" of the greatest value in giving demonstrations. "The dummy lends himself to all manner of treatments with perfect good nature, and much can be taught of routine ward work with his aid. A copper or two will secure a small boy patient as a willing victim for massage or an occasional bath. Specimens of heart, eyes, bones, and the like may be gotten from the friendly butcher, and these object lessons are not easily forgotten. The danger of teaching too much materia medica to the men nurses was warned against, lest they go out and pose for doctors. But there is much to encourage one in the progress made by the male pupils in recent years, and certainly "it is a comfort that so many of them choose to make it their life work, and not lay plans to marry as soon as they get their certificate."

Friday morning's papers were on very practical subjects. The first on "Hospital Economies and Prevention of Waste," by Miss Booth, of Hankow, was a delight to the hearts of all the hospital housekeepers who listened. Miss Booth in helpful detail told just how, when, and what to buy in kitchen commodities, fuel, linen, dress-



GROUP OF MISSIONARY NURSES, DELEGATES TO THE CONVENTION

ings, disinfectants, etc., and though location governs to some extent certain of these details, everyone found much that was helpful and suggestive.

Next came "Nursing Requisites as Made on the Native Street," Miss Sawyer, of Tehchow, had this topic, and had prepared an exhibit of articles or their photos. A lively hour was spent in which many of the members shared, giving as they were called on, descriptions, prices, and their personal experience in making or buying the article under discussion. "Necessity is the Mother of Invention," especially in interior hospitals, where practical substitutes for expensive and impossible equipment must be had. This was one of the occasions when fifty-three heads contributed to the topic under discussion, and it could but be an interesting and profitable hour for all.

After tiffin everybody piled into rikshas and the party was off for the Temple of Heaven, where the afternoon session was held. As one listened to the devotional service, and the address that followed, one forgot that this spot, so rich in the beauties of Nature, was steeped in centuries of heathen rites and adoration. Miss Tippet, of P'ingyangfu, gave a forceful talk on "Evangelistic opportunities of the Superintendent."

Miss Clark, of Shanghai, followed with "Humor and Pathos in Nursing in China." She chose to turn the tables and tell of the pathos first that the happier memories might linger. First of the horrors of child labor. "There is abundant child labor in China everywhere, but it is at its worst in the treaty ports. Child labor in the factories is far more to be deplored than that which takes them out into the sun and air. The accident cases among these mites from machinery are too sickening for description, a disgrace to civilization. Then from the social customs arise much pathos. A patient suffering from inoperable cancer is doomed to live apart from husband and children, a veritable outcast, though wealthy. Small wonder she begs for something to make her sleep forever. A girl of thirteen is brought in frightfully mutilated. Her baby is born soon, happily dead, and the child-mother soon follows. Her brother finding *she* had disgraced the family, takes revenge on the child. What of the man, one can but ask? A baby slave girl is beaten so cruelly that paralysis results. Here I would pay a thankful tribute to the Shanghai municipal police who always aid us in protecting the children's cause." Time will not permit the repeating of the tales told of that uni-

versal curse, white-slave traffic, rife in this port city, or of the sufferings of the riksha coolies, or of the unknown thousands of suffering women who have no chance to lay down the cares of the home and children, and come to the hospitals for treatment, even if grandmother, neighbors, husband, and countless other factors approved of Western methods, which is doubtful. But to the humorous side of the work, for there is one. From the husband who, dissolved in tears that his wife must remain in the hospital for two weeks because there was no one left to take care of *him*, to the mites who came to the dispensary one day, and on being asked what their sickness was, replied, 'We aren't sick, we've come to see the fun.' A child of a hospital worker is suddenly seized with convulsions and hurried to the hospital. On undressing the baby we find such a pretty suit of underwear made from pink *boracic lint*, but perhaps to the hospital housekeeper that was not so funny."

"Obedience is what we all strive for in our schools, and we had an instance of it recently when one of our doctors sent a nurse to wash his hands after dressing a pus case, instructing him to 'continue washing till I come for you.' Other duties cropped up and the nurse was forgotten till some time later the doctor had occasion to return and the lad was still washing."

Business over, the nurses went across to the Temple of Agriculture grounds, and enjoyed a picnic supper, for the foreigners were not permitted to eat in the Temple of Heaven's sacred precincts.

Saturday morning an interesting paper on "Hospital Social Service," and its possible use in China, by Miss Gage, of Ch'angsha, was read. Room does not permit reviewing the comprehensive sketch of social service as it has been carried on in America in recent years, but many helpful suggestions were given as to its adaptations to our own work in this land. "Must China wait all the tens of years which Western lands have waited for what has been proven an economic necessity rather than a charity? Social service in some form should stand at the door of the hospital to welcome every patient.

The question box was then opened, and the meeting thrown open to discussions of the various topics thus introduced. All manner of problems were brought up from the building and equipping of hospital kitchens and how to make a home-made incinerator, to the proper term for our hospital matrons (tsung kuan).

The program for the afternoon was a treat to all, but especially to those coming from the in-

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terior. Immediately after tiffin eight big touring cars took the party for a ten-mile ride through fields and woodsy roads, terminating at the summer palace of the ruler of the empire. The chief points of interest were visited, including a boat ride on the lake, and a stop at the marble boat built for the Empress Dowager (but which, needless to say, is not navigable). The picturesque scenery was enjoyed to the full and then came the home ride which took us via the grounds of the Ching Hua Indemnity College. It was a memorable closing for the busy week, and but one of the evidences of the thoughtful interest of our hostesses for our pleasure.

Sunday was a day of rest with friends in the city, new or old, with a helpful sermon at Union Church, by Dr. Fenn, at eventide.



Massachusetts

The Taunton State Hospital has been splendidly active in relief work for the Allies. Since December 5, 1914, until October 22, it has made and shipped 1,741 garments, 500 bandages, 400 slings, 247 amputation dressings, and 2,000 gauze sponges. All contributed by the employees.

Dr. Worcester has resigned the presidency of the Waltham Training School for Nurses, a position he has held since the school first opened. Dr. Worcester has meant much to the school and its development, and his loss will be keenly felt. The school is very fortunate in having as his successor Dr. Fuller, who has been for a number of years in close touch with it, and who understands and sympathizes with its principles and aims. Dr. Fuller has the good wishes of all in his new duties.

The State Infirmary Training School for Nurses, at Tewksbury, Mass., held commencement exercises in the chapel on September 28, for the 1915 class, of which there were twenty-six members. First came the procession, which numbered nearly two hundred, marching from nurse's home to chapel. The exercises were opened with prayer by Rev. F. X. McGann. The address of welcome was given by Madeleine L. Hartley. There were addresses by Dr. John H. Nichols, superintendent of the Infirmary and Mr. John B. Tivnay, chairman of the board of trustees. Hazel M. Daye delivered the valedictory. Mrs. Nellie M. Talbot, a member of the board of trustees, presented the diplomas. School pins were presented by Laura E. McEachern, R.N., superintendent of nurses. Class ode was com-

posed by Bertha J. Robinson. Class motto, "Be Thou Ever Faithful." Class colors, blue and gold. Class flower, roses. The exercises were followed by a reception and dance.

The annual meeting of the Massachusetts State Hospital Alumnae Society, was held August 28. Thirty-nine members present. The following officers were elected for the ensuing year: President, Miss Etta Handley; vice-president, Mrs. A. G. McDonald; corresponding secretary, Miss C. Germain; recording secretary, Miss B. Baillie; treasurer, Miss S. Holden.



Connecticut

The regular monthly meeting of the Nurses' Alumnae Association of the Connecticut Training School for Nurses, New Haven, was held on November 4, meeting at the usual time and place.

Miss Barron presided and all officers were present and a fairly large attendance. After routine business and adjournment, an interesting talk on origin and work of free dispensary, was given by Dr. Comfort, after which a social hour was held, with refreshments.

Miss Coonan, a former secretary of this Alumnae Association, who has been several years in the navy service, has retired and is now doing post-graduate work in Johns Hopkins, to prepare for obstetrical teaching in the University of California, in San Francisco.

Miss Stannard, the matron of the Nurses' Home, has completed a very satisfactory ten years this last October, congratulations, tokens of esteem and best wishes for the future are expressed on all sides.



New York

The New York State League of Nursing Education, met October 19 at the Hotel McAlpin, New York City, and listened to papers and addresses in which various phases of nurse training were discussed.

Officers elected for the coming year are: President, Miss Julia Littlefield, Homeopathic Hospital, Albany; vice-president, Miss A. M. Hilliard, State Inspector of training schools; secretary, Miss Louise Arnold, Samaritan Hospital, Troy; treasurer, Miss Emma Smith, Rochester General Hospital.

The fourteenth annual meeting of the New York State Nurses' Association was held at the Hotel McAlpin, New York City, October 20-22. Among the subjects discussed were "Progress in

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the Department of Nursing and Health," "The Possibility of Introducing Student Government in Training Schools," "The Value of Social Service Instruction to Pupil Nurses," "A Sounder Economic Basis for Schools of Nursing." Many prominent speakers were heard during the convention.

The graduating exercises of the City Hospital School of Nursing, Blackwells Island, were held on Thursday, October 28, at 4 P. M. in the Nurses' Home. Twenty-three students received diplomas.

A reunion of the alumni of the New York City Training School for Nurses was held at the Hotel Savoy, on the evening of November 4, and was celebrated with a banquet; on this occasion the members of the class of 1915 were entertained.

Miss Irene Yocum acted as toastmistress, and among the speakers were Miss Jane Pindell, and Miss Croft, former superintendents of the school, Miss Carolyne Gray, present superintendent and Miss Dora Thompson, superintendent of the United States Army Nurse Corps. Also at the speakers' table were Mrs. Harriet Clute, and Dr. F. S. White, the only members of the class of 1877 present; also Mrs. Charles Stevenson, and Miss M. E. Bollerman. A number of physicians of the staff of the hospital, past and present, and internes, were present for the dancing which followed the banquet.

The Nurses' Alumnae Association of the Kingston City Hospital held a meeting at the hospital, November 1. Owing to the small attendance (a number of the members being on cases), it was considered best not to transact any business, but a social hour was enjoyed by those present.

Miss Lucy A. Hall, R.N., New York Infirmary Training School, class '96, for several years night supervisor at the House of the Holy Comforter, New York City, received the State appointment of nurse, at the State Custodial Asylum, Newark, N. Y.



New Jersey

The commencement exercises of the Homeopathic Hospital Training School for Nurses, Newark, N. J., were held at the Masonic Temple on Friday evening, October 22. Eleven young women received diplomas: Myrtle Stirton, Marion Clark, Minnie Ringgold, Marion Crawford, Myrtle Raub, Sadie Tolen, Alice Nesslage and Theodora Foote. The superintendent of the

hospital is Miss Helen Bare. Reception and dancing followed the exercises.

On Wednesday, October 27, the graduating class and supervising nurses of the hospital were entertained by the Alumnae Association, at a luncheon at Davis' banquet hall. Miss Emilie Willms is president of the association.

The annual meeting of the Mountainside Hospital Alumni Association was held at the Nurses' Club, 39 South Willow Street, Montclair, N. J., October 19.

Among the reports read two of particular interest might be mentioned:

First—Report of the commission appointed to interview Mrs. F. H. Hooper, president of the board of governors of the Mountainside Hospital, regarding the use of a room in the new hospital for sick graduate nurses. Mrs. Hooper graciously received the committee and plans of the new building were submitted, showing where it would be possible to locate such a room as suggested, and this was subsequently endorsed and the request granted by the board of governors.

The second report was from Sivas, Turkey. Mrs. Leon Sewny, formerly Miss Lillian Cole, graduate of the Mountainside Hospital, 1894, recently lost her husband, who died of typhus fever, and later in a massacre of Christians of that place, was given an opportunity to escape, being an American. She refused to desert her husband's people, however, and is now a refugee in the desert, her exact location being unknown.

The election of officers for the ensuing year resulted as follows: Executive officers—President, Miss Ida Stitt; first vice-president, Miss Mae Willer; second vice-president, Miss Alice Guthrie; recording secretary, Miss Ann Speichery; corresponding secretary, Miss Josephine Trippett; treasurer, Mrs. Margaret Wilson.



Pennsylvania

The thirteenth annual meeting of the Graduate Nurses' Association of the State of Pennsylvania was held November 8, 9, and 10, 1915, at Thomson Hall, College of Physicians, Philadelphia, Pa. The morning of November 8 was devoted to the reports of officers and committees. The program for the other sessions follows: Invocation, Carl E. Grammer, D.D.; Address of welcome, Joshua H. Penniman, Ph.D. LL.D.; response, Roberta M. West, R.N.; president's address, Susan C. Francis, R.N.; report of proceedings of the convention of the American Nurses' Association; discussion, "Affiliation of Training

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Schools." Evening session held at the Medico-Chirurgical Hospital, demonstrations by student nurses of Philadelphia hospitals.

Tuesday, November 9, 1915, invocation, Monsignor Kiernan; the curriculum of the Training School for Nurses, Miss Isabel M. Stuart, Teachers College; nurse's alumnae sections. Reports from the different alumnae associations; private nursing section, "The Progress of Central Registries;" "Why Private Nurses Need an Association;" "The Nurse and Her Opportunities to Aid in the Prevention of Cancer," John G. Clarke, M.D.; Red Cross nursing section, report of work done by local committees; report of delegate to National Red Cross Association. Evening, banquet at the Aldine Hotel.

Wednesday, November 10, 1915, report of tellers; "The Opportunities, Responsibilities and Relations One to the Other of the State Association, The Board of Examiners, and the State Inspector of Training Schools," Annie W. Goodrich, Teachers College; Public health nursing section, "Settlement Work from a Nurse's Standpoint," Anna B. Heldman, R.N.; "Some Recent Developments in Public Health Nursing," Ella Philips Crandall, R.N.; "The Public Health Nurse," Charles E. A. Winslow, M.S.; "The Nurse as a Collector of Statistics," Carol Aronovici, Ph.D.; "Red Cross Town and Country Nursing," Florence D. Fuller, R.N.; reports of committees, unfinished business, introduction of officers. Announcement, time and place of next meeting. Adjournment.

The senior class of the Norristown State Hospital Training School has formed a club for social purposes. The club meets every Thursday evening and, after a short business session, thirty minutes is devoted to talks on various nursing methods and the rest of the evening is devoted to card playing, music, etc. The senior class will also entertain the junior class and will also take charge of all visiting nurses who visit the institution.

The following officers were elected: Mr. David Hopkins, president; Miss Maude Strine, vice-president; Mr. Melvin Green, treasurer; Miss Elizabeth Cook, secretary.

The following comprise the social committee: Mr. Eugene Bonniwell and Miss Jessie K. Iles.

The regular monthly meeting of the Alumnae Association of the Philadelphia Lying-in Charity Hospital was held at the hospital on Thursday afternoon, November 4, at 3 o'clock. The president, Miss C. B. Steinmetz, presiding, the roll call showed twenty-two members present.

The Friend's Hospital Alumnae of Frankford, Philadelphia, Pa., held a special meeting October 18, 1915, at the hospital, in which they established a registry for the graduates of Friend's Hospital.

All nurses, members of the alumnae, were notified to register, all present had their names put on the board, which had just been purchased. Physicians can obtain nurses especially trained in mental and nervous diseases at any time. The secretary, Miss R. Kerstan, R.N., would be pleased to hear from any graduate of Friend's Hospital, who is not yet a member of the alumnae.



Delaware

The Delaware State Association of Nurses held its fall meeting at the home of Mrs. Allen Speakman, at Claymont. About twenty members were present at the meeting and five new members were added to the association. The reading of papers and discussions was the order of the meeting.

Miss Turner, superintendent of the Homeopathic Hospital Training School for Nurses, gave a report of the convention of the Associated Charities which was held early in the fall in Baltimore.

Mrs. Ralph I. Flinn, who was the delegate to the convention, sent by the Delaware State Association of Nurses, also gave a report of the convention. General discussions on the need of the work in Delaware followed the reports of Miss Turner and Mrs. Flinn. Mrs. Curry, of Chester, read an interesting paper on "Twilight Sleep."

Miss Jeannette F. Duncan, superintendent of the Delaware Hospital, who has recently returned from hospital duty in the war zone, gave an interesting talk concerning some of her experiences during her absence from the city.

Mrs. John Bancroft read a paper on the Red Cross relief work. Luncheon was served at 2 o'clock and a social time prevailed. Mrs. Charles F. Robinson, of Claymont, played several selections.



Ohio

On Tuesday evening, October 5, a reception and banquet was given by the alumnae of St. Vincent's Charity Hospital, Cleveland, Ohio, to the war nurses from Cleveland and vicinity, who had returned home after service in the Red Cross Society in Europe. Sixty nurses were present, including the Charity Hospital graduating class of 1915, and nine war nurses. Sister Marcelline, directress of nurses, in a few well-

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chosen words, welcomed all the nurses from the different hospitals, assuring them, that within the hospitable doors of Charity Hospital they would always find a warm welcome. Miss Margaret McGuire, in behalf of the *alumnæ*, extended a greeting to the war nurses, and Miss Grace Bentley gave the response.

Miss Rachel Morgan commended the courage of the efficient young women who left home and kindred to engage in the noble work of alleviating the suffering of the victims of war on foreign battlefields.

Miss Margaret Doyle welcomed the graduating class of 1915 into the *alumnæ*. Fine musical selections were given by Mrs. E. G. Lloyd.

After the banquet, the delightful evening, long to be remembered, came to a close.

The following young ladies served as war nurse in France and Austria-Hungary: Margaret McGuire, Katherine Volk, Rosina Volk, Grace Bentley, Mollie McKenney, Minnie J. Bowman, Nettie Eisenheim, Clara Reynolds, Claribel Schofield, Eva Mantner.



Georgia

The Georgia State Board of Medical Examiners, in executive session October 13 at the Kimball House, Atlanta, put a stop to the practice said to obtain in many of the hospitals of the State of allowing trained nurses to administer anesthetics.

It having been brought to the attention of the members of the board that in many hospitals of the State trained nurses were allowed to administer anesthetics, and that some physicians in their private practice were accustomed to have nurses administer chloroform to patients. The board adopted resolutions declaring that the administration of an anesthetic came under the head and within the province of the practice of medicine and that only licensed practicing physicians should be considered as qualified to perform this work.

The secretary of the board was directed to mail copies of the resolutions to the hospitals and physicians said to be the offenders.



Mississippi

The Mississippi Association of Graduate Nurses held a two-day session at Jackson the last week in October.

During the convention the association heard some interesting papers and discussions from members.

Mrs. J. H. Fox was present and invited the

nurses to join the Federation of Clubs, which was accepted.

The nurses adopted resolutions thanking the people of Jackson, the press and local association for courtesies extended.

The association was the guest of the Hinds County Association at the Mississippi State Fair, taking supper at the Episcopal restaurant.

Forty-two nurses were in attendance on the meeting and all present joined in declaring it a most successful event.

The following officers were elected: President, Miss Mary H. Trigg, Greenville; first vice-president, Miss Leola Steele, Natchez; second vice-president, Miss Kate James, Grenada; third vice-president, Miss Brit Sutton, Meridian; fourth vice-president, Miss Rose Keating, Jackson; secretary, Miss Jane Cox, Natchez; treasurer, Miss Irma Lee O'Mara, Hattiesburg.

The State Board of Examiners of Graduate Nurses met at the Capitol November 1. At this session Miss Jennie M. Quin, of Hattiesburg, was re-elected president and Miss Mary H. Trigg, of Greenwood, secretary-treasurer.



Texas

Miss Carrie Knox Williams, graduate of Austin Presbyterian Sanitarium, '15, sails January 1 for Sutsien, North Kiangsu, China, to accept a position.

Miss Mattie Summers, R.N., class '09, Charleston General Hospital, Charleston, W. Va., has accepted the superintendency of nurses at Austin Sanitarium, Austin, Texas.



Marriages

On October 14, 1915, at Torrington, Conn., Mary Esther Holden, of Stamford, to John Francis Brady, of New York City.

On October 30, 1915, at St. Paul's Lutheran Church, Hartford, Conn., Ingrid M. Carlson, to Frank N. Crane.

On October 29, 1915, at Flushing, L. I., Catherine MacDougall, graduate nurse of Flushing Hospital, to Dr. Walter Steffens, of College Point.

On October 28, 1915, at Mendham, N. J., Edna M. Hann, to Grover C. Apgar.

On October 29, 1915, Nina E. Wyman, formerly superintendent of nurses at Lynn Hospital, Lynn, Mass., to Dr. Wilfred G. Funnell, of Boston.

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(Name of Chemist
on request)

Colgate's Baby Talc is prepared on exactly the same formula as the other Colgate Talcs.

On October 20, 1915, at Lawrence, Mass., Emily Briggs, graduate nurse of Lawrence General Hospital, to Dr. Harold N. Allen, of Norway, Me.

On October 14, 1915, at Springfield, Mass., Blanche E. Holliday, formerly assistant superintendent of Wesson Memorial Hospital Training School, to Richard T. Carrier.

Recently at St. Louis, Mo., Janet Luke, graduate nurse of Rebekah Hospital, St. Louis, to John Grant.

On July 27, 1915, at Dallas, Texas, Lillian Stella Shaw, R.N., graduate nurse of Texas Christian University Hospital, Fort Worth, class of 1913, to Roscoe Conklin Maxwell. Mr. and Mrs. Maxwell will reside in Ft. Worth.

On June 15, at New York City, Miss Marion Clark, Ingersoll, Canada, class of 1915, Homeopathic Hospital, Newark, N. J., to John F. Katz. Mr. and Mrs. Katz will live in East Orange.

On September 14, at New York City, Alice Nesslage, class of 1915, Homeopathic Hospital, Newark, N. J., to George W. Herrington. Mr. and Mrs. Herrington will live in New York.

On September 18, at Glen Ridge, N. J., Lillian Simmons, class of 1914, Homeopathic Hospital, Newark, N. J., to Harry Whelan. Mr. and Mrs. Whelan will live in Newark.

On October 2, 1915, at Washington, D. C. Ida E. Tinsley, to Whithers Whitehead, of Roseland, Virginia. Mr. and Mrs. Whitehead will make their home in Roseland.

On September 30, 1915, at Sacred Heart Church, Evansville, Ind., Ida F. Crowds, a graduate nurse of St. Mary's Hospital, Evansville, Ind., to Mr. F. C. Bradley, of Pensacola, Florida.

On September 22, 1915, at the Rectory, Welland, Ont., Can., by the Rev. James Thompson, M.A., Emily May Sauve, of Cleveland, Ohio, to George Alpha Hanna, of Welland.

In October, 1915, at Paterson, N. J., Kate E. Golding, formerly supervising nurse at the Paterson Isolation Hospital, to Aldrich Harvie Moore, of New York.

On Tuesday, November 8th, 1915, Imogene Smith, graduate nurse of the Homeopathic Hospital, Newark, N. J., to Mr. B. R. Roome, of Arlington, N. J. Mr. and Mrs. Roome, will make their home in Staten Island, N. Y.

Births

On October 20, 1915, to Mr. and Mrs. W. C. Hussey, a daughter, Anna Elizabeth. Mrs. Hussey was Miss Anna Bell, graduate nurse of the City of Kingston Hospital.

Deaths

On November 1, 1915, at Sag Harbor, Long Island, Julia Fordham, of heart disease.

A cablegram received November 1 from Etables, France, reports the death of Sarah Hamilton, from meningitis. Miss Hamilton was attached to the Chicago Nurses' Unit, in charge of Dr. J. M. Knapp.

In October, Mabel Gertrude Thompson, nurse in training at Waldo County Hospital, Belfast, Maine. Miss Thompson was operated on for appendicitis from the effects of which she did not recover.

On October 7, 1915, Isabella Hackett, graduate of St. Joseph's Hospital, Paterson, N. J., and cousin of Rev. Father Hackett, of Massachusetts. Miss Hackett will be greatly missed by her family and many friends.

Many Canadian-born nurses, trained in the United States, have volunteered for service under Canadian organizations sending nurses to the war regions. The *Nursing Times* (London, England), of October 16, records the death of two Canadian-born nurses—Mrs. Jessie B. Jaggard, a graduate of Massachusetts General Hospital and later employed as an executive in the Morristown State Hospital and the University Hospital, Philadelphia, and Miss Mary E. F. Munro, a graduate of the City Hospital, Boston.

Mrs. Jaggard, it appears, was matron of a hospital unit first ordered to Shorncliffe, England, and later to the Mediterranean. Miss Munro served at Rouen, France, and later was sent to join the unit of which Mrs. Jaggard was matron. Miss Munro died of dysentery September 7 and Mrs. Jaggard's death occurred September 25.

The war takes its sad toll from workers of all classes. Our sympathies go out to the friends and relatives of these two who gave up even life itself in the service of the country of their birth.

(Continued on Page 404)

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Book Reviews

T. B.—Playing the Lone Game Consumption. By Thomas Crawford Galbreath, author of "Chasing the Cure in Colorado," Journal of the Outdoor Life Publishing Co., New York City. Price, \$1.00.

This is the story of Mr. Galbreath's own inner life. The book is filled from cover to cover with helpful suggestions to those taking the cure for tuberculosis and others interested in the fight against the disease. At the same time, the inspiration, optimism and hope that breathe from every page enhance its value a hundred fold. Here are the chapter headings which give one an idea of the scope of the book: "My Early Life: I get it; I go away;" "Early Mistakes—My own and others—which you should avoid;" "In the matter of seeking climate;" "If not climate, then what?" "Staying Home—You have your office—What next?" "The place of the Sanitarium;" "Phthisiophobia: Intelligence, its cure for it;" "Later Mistakes: Conclusion."

The late Dr. Edward L. Trudeau, Saranac Lake, N. Y., founder of the American Anti-Tuberculosis Movement said:

"I have read Mr. Galbreath's book 'T. B.' with utmost pleasure. It is admirably written and presented and should be the means of saving many lives."



A Text-Book of Chemistry and Chemical Urinalysis for Nurses. By Harold L. Amoss, S.B., S.M., M.D., Dr.P.H., formerly Chemist, Hygienic Laboratory, U. S. Public Health Service; Physiological Chemist, U. S. Bureau of Chemistry; Instructor in Physiological Chemistry, George Washington University Medical School; Assistant in Preventive Medicine, Harvard Medical School. 12mo, 268 pages. Cloth, \$1.50 net. Lea & Febiger, Publishers. Philadelphia and New York, 1915.

Dr. Amoss has made a careful but very concise survey of the whole subject, making clear the terminology of the science, afforded definitions of unusual lucidity and selected for more detailed consideration those points, an understanding of which must increase the capacity of the nurse

for intelligent service. To this end stress is laid on the chemistry of foods, of metabolism and of digestion, and on urinalysis and allied subjects. A clear grasp of the requirements of the nurse has enabled him to avoid the two extremes of superficiality and of too minute attention to detail and the more complicated aspects of his subject. Technical terms are elucidated and laboratory procedures explained. A useful feature is a brief and most enlightening summary, at the end of each chapter, of the information the author has endeavored to impart. The nurse who devotes serious attention to this volume will have an intelligent working knowledge of general chemistry and a useful, well grounded understanding of the science as it bears on her work.



First Aid in Nursery Ailments. By Emelyn Lincoln Coolidge, M.D., author of the *Mothers Manual*. Physician in charge of the babies' class of the Society of the Lying-in Hospital, N. Y. City. Sturgis & Walton Company, N. Y. Price, 50 cents net.

The aim of this little book is to assist young mothers in caring for their children, when any of the simple ailments of the nursery arise, and to teach them how to act in an emergency. It is not for a mother to treat her own child when he is seriously ill; such is the province of the physician. But, in the absence of a doctor, reference to this volume may save a baby's life.



A Manual of the Practice of Medicine. By A. A. Stevens, A.M., M.D., Professor of Therapeutics and Clinical Medicine in the Woman's Medical College of Pennsylvania, Lecturer on Medicine in the University of Pennsylvania. Tenth edition. Revised. 12mo of 629 pages, illustrated. Philadelphia. W. B. Saunders Company, 1915. Flexible leather, \$2.50 net.

The special features of the tenth edition include the careful revision of all the chapters, and the addition of new ones. Important modifications will be found in the sections relating to leukemia, chronic nephritis, pyelonephritis, cardiac ar-

(Continued in Publisher's Desk)

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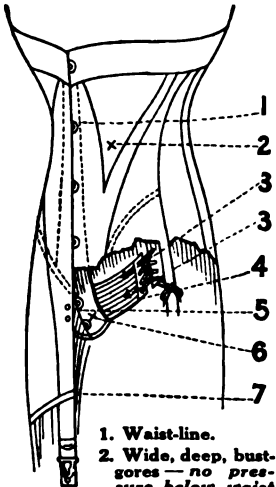
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Graduation Report

Among the students graduated at the end of the summer term, 1915, from the Pennsylvania Orthopædic Institute and School of Mechano-Therapy, 1709-1711 Green Street, Philadelphia, Pa., were the following:

Mrs. F. I. Coutant, R.N., Lincoln, Nebraska; Dr. Benjamin F. Bailey, Training School for Nurses, Lincoln, Nebr.; Miss Agnes McL. Martin, Augusta, Ga., London Hospital, London, England; Mrs. Louise M. Schuler, Philadelphia, Pa.; Miss Enid G. Finley, Montreal, Canada; Miss Maude V. Kinnier, Philadelphia, Pa.; Miss Louise Jetter, Collingswood, N. J.; Mr. F. I. Coutant, R.N., Lincoln, Nebraska; Dr. Benjamin F. Bailey, Training School for Nurses, Lincoln, Nebraska; Mr. Thomas U. Brink, Philadelphia, Pa.



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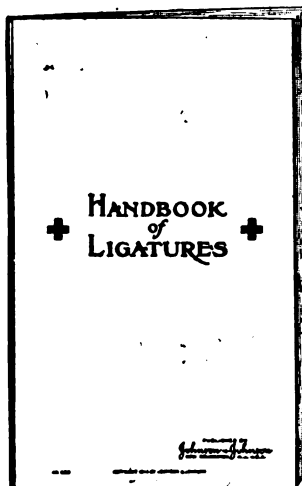
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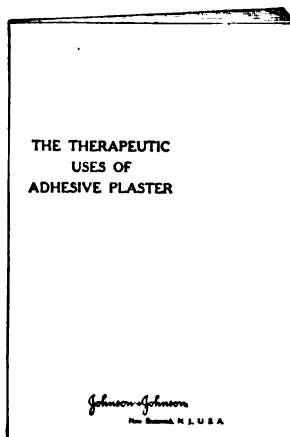
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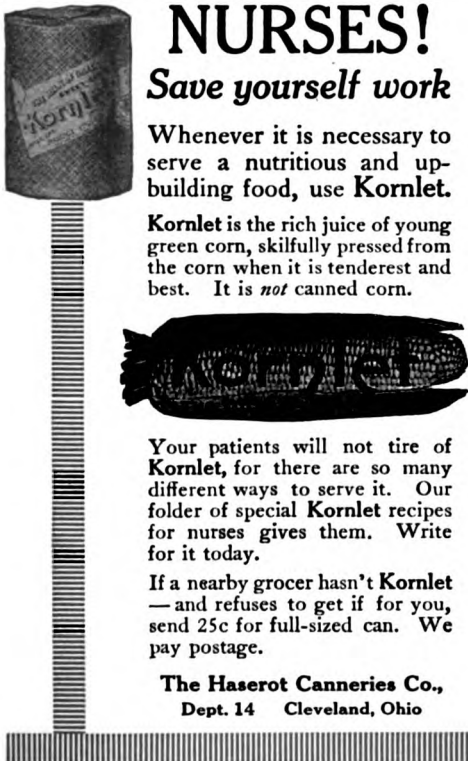
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THE TRAINED NURSE AND HOSPITAL REVIEW

is a magazine of practical nursing and progress—not an organ. It is the magazine for the nurse who desires open-minded, free discussion of all nursing questions, and who expects to keep abreast of the times in regard to practical methods in the nursing field. The magazine with the courage of its conviction, which numbers among its contributors the cleverest writers in the hospital and nursing world.

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Book Reviews—Continued

hythmia, pulmonary tuberculosis, typhus fever, malaria, pyogenic infections, bacillary dysentery, diabetes mellitus, tetany, locomotor ataxia, heat stroke, and dermatitis exfoliativa. Also articles relating to Vincent's angina, diverticula of the esophagus, acholuric jaundice, embolism and thrombosis of mesenteric vessels, alkaptouria, albumosuria, tests of the functional capacity of the kidneys, polycystic disease and malignant disease of the kidney, chronic enlargements of the spleen, hypopituitarism, infantilism, glandular fever, Rocky Mountain spotted fever, and Weil's disease, Kala-azar, have been added.

✦

Fever Nursing. Designed for the use of professional and other nurses, and especially as a textbook for nurses in training. By J. C. Wilson, A.M., M.D. Eighth edition. Revised and enlarged. J. B. Lippincott Co., Philadelphia, Pa. Price, \$1.00.

As each new edition of this popular work has appeared, it has been reviewed in these columns, and it, therefore, needs no introduction to our readers. In the eighth edition the work has been revised and enlarged to keep pace with the growing requirements of the training of the nurse, and brought fully up to date. The nurse engaged in public welfare work will find this book of special value.

✦

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Nursing World—Continued

New York

The annual general meeting of the New York County Chapter of the American Red Cross, was held in the Astor Gallery of the Hotel Waldorf-Astoria, New York City, on the afternoon of October 28, 1915. Mr. Robert W. de Forest, chairman of the chapter, presided. The speaker of the occasion was Dr. Richard P. Strong, of the Serbian Sanitary Commission. Dr. Strong told of the successful fight to stamp out the typhus epidemic in that country.

More than 150,000 Serbians succumbed to the disease within the space of a few months. Dr. Strong said conditions in Serbia before the commission took charge of the situation were appalling. He paid a high tribute to the work of Sir Ralph Paget, formerly British Minister to Serbia, and to Lady Paget, who became ill of typhus while conducting a hospital in Serbia. To Sir Thomas Lipton, Dr. Strong also gave praise for the assistance he rendered in aiding to combat the disease.

Dr. Strong said the best-equipped hospital in Serbia was the American Hospital in Belgrade, under the direction of Dr. Ryan. He used lantern slides to illustrate the methods used by the commission in disinfecting plague-infested spots and in distributing supplies.

Mr. Jacob H. Schiff, treasurer of the New York State Board of the American Red Cross, said the amount collected in this State for war relief during this year amounted to \$215,838 and that the total collected in this State since the war began is \$532,370.89.

Mrs. William K. Draper, secretary of the chapter, expressed gratitude to the Russell Sage Foundation, the Bush Terminal Company, Mr. Cleveland H. Dodge, Miss Anna Pavlowa and others who have aided the cause. Since September 7, 1914, she said, there have been 140 shipments of hospital supplies, valued at \$850,922, to the countries affected by the war. All the officers of the chapter were reelected.



Ohio

The twelfth annual meeting of the Ohio State Association of Graduate Nurses was held at Columbus October 20 and 21.

The meeting was called to order by Miss Marie A. Lawson, of Akron, president of the association.

George W. Gillette, secretary of the Chamber of Commerce, delivered the address of welcome, and this was responded to by Miss Mary Roberts, of Cincinnati.

Dr. George Matson, secretary of the State

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Medical Board, in an address outlined the provisions of the new nurses' registration law. Miss Maude Bernard, of Eaton, will address the meeting on "The Welfare Work Done in Connection With the District Tubercular Hospital."

The following officers were elected: Miss Mary Roberts, president; Grace E. Allison, Cleveland, first vice-president; Jennie Tuttle, Columbus, second vice-president; Rose Steinmetz, Akron, third vice-president; Merry C. Echols, Massillon, fourth vice-president; Mary H. Greenwood, Cincinnati, fifth vice-president; Lora A. Logan, Cincinnati, corresponding secretary; Mabel Morrison, Toledo, recording secretary, and Mary Jamieson, Columbus, treasurer.



Iowa

Des Moines nurses are again agitating the question of a club house. It has been suggested that nurses contribute \$25 each for the purpose. Such sum to entitle them to life membership, and to all the privileges of the club for life.

Miss Edith Countryman, R.N., of Sioux City, has recently accepted a position as superintendent of the Whitefish Hospital at Whitefish, Mont. Miss Countryman has been nursing in the West for the past six years and is a graduate of St. Joseph's Mercy Hospital of Sioux City.



Alabama

The second annual convention of the Alabama State Association of Graduate Nurses was held in Montgomery, October 5, at the Exchange Hotel. Convention was called to order by the president, Miss L. H. Denny. After reports from local associations, there was an adjournment for luncheon, which was given by the Graduate Nurses' Association of Montgomery, to the officers, delegates and guests of the State Association.

Three P. M.—Convention called to order, Miss Margaret Hutton, presiding. Election of officers. Unfinished business. Adjournment at four o'clock.

Eight P. M.—Miss Phares, presiding. Invocation, Dr. R. H. McCaslin, of Montgomery. Addresses of welcome on behalf of the city, Honorable W. A. Gunter; on behalf of the Graduate Nurses' Association of Montgomery, Miss Margaret Hutton. Response—Miss L. H. Denny, of Birmingham. Addresses, Dr. R. S. Hill, of Montgomery; Dr. C. S. Yarbrough, of Auburn; "The Trained Nurse, Past, Present and Future," Dr. J. N. Baker, of Montgomery. Adjournment.

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Arkansas

The annual convention of the Arkansas State Nurses' Association was held at the Hotel Marion, Little Rock, October 27 to 29. At the opening session, Governor Hays made the opening address, which was responded to by Mrs. Bella McKnight. Addresses were made by Dr. Ida Joe Brooks, George B. Cook, Dr. W. F. Smith and Menia S. Tye.

Other features of the program were: "The Relation of the Nurse to the Local Registry," by Mrs. Oscar Deubler; "The Tuberculosis Nurse," Mrs. E. D. Bryan; "Nursing Ethics," by Sister Bernard; "Private Duty Nurse," by Miss Annie Bremeyer; "Value of Post-Graduate Work," by Miss Ruth Riley; "Some of My Experiences," by Miss Carlee Swindle; "Hydrotherapy in Fever," by Mrs. L. F. Hansen; "Vital Statistics," Mrs. F. W. Aydlett.

The legislative committee recommended that the next committee appointed prepare a bill regulating the practice of nursing for presentation to the next legislature. The report said the advance in the profession required the amendment of the law.

Miss Frankie Hutchinson, of Little Rock, was elected president.

Other officers elected were: Miss Ruth Riley, of Fayetteville, first vice-president; Mrs. Bella McKnight, of Pine Bluff, second vice-president; Mrs. Agnes McDougal, of Booneville, third vice-president; Miss Cora B. Hoy, corresponding secretary (re-elected); Miss Gertrude Grobin, of Little Rock, recording secretary; Mrs. W. C. Green, of Little Rock, treasurer (re-elected).

Hot Springs was chosen for the next meeting place.

The social features included an automobile ride over the city, followed by a luncheon at the Country Club, and a banquet at the Hotel Marion, tendered by St. Vincents Alumnae Association.



Missouri

The Missouri State Nurses' Association held its tenth annual convention at the American Annex, St. Louis, October 20-22. The convention was divided in six sessions: legislative session, private duty nurses' session, superintendents' session, public health nurses' session and Red Cross session. The last session was a Round Table conference.

Some of the subjects discussed were "Infectious Nursing in the Home," "Ethics and Adaptability," "Twelve-Hour Duty in the Hospital," "Baby Welfare," "Red Cross Town and Country Nursing," and many more of equal interest.

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The legislative committee will draft amendments to the State nurses' law, asking for a higher standard—that the qualifications be at least one year in the high school or its equivalent; that there be an inspector of training schools, and that the registration fee be increased from \$5 to \$10.

The officers elected were: Miss Sallie J. Bryant, St. Joseph, Mo., president (re-elected); Miss Mary Baird, St. Louis, first vice-president; Miss Anna Barr, Kansas City, second vice-president; Miss Elizabeth A. Doran, St. Joseph, secretary; Miss Janette Flanagan, St. Louis, treas.

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Colorado

Colorado State Board of Nurse Examiners will hold an examination for the registration of nurses according to the law, at the Capitol Building, Denver, Colorado, December 29th and 30th. For further information address Louise Perrin, Secretary, Capitol Bldg., Denver.

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Nebraska

The annual meeting of the Nebraska State Association of Graduate Nurses opened October 19 in the Assembly Hall at the Y. M. C. A. About one hundred were present at the opening session, Miss Minerva Ryley, vice-president, occupying the chair.

Following addresses of welcome and response, a short business session was held, including election of officers for the next year. They are: President, Miss Allison, head nurse of the Methodist Hospital; vice-president, Mrs. Jennie Gillespie, Omaha; treasurer, Bessie Iowa Ryan; secretary, Miss Deane, Omaha. Members of the Board of Directors, Miss Higgins, Lincoln; Miss Keating, Nebraska City.

In the afternoon, following a luncheon at the Commercial Club, the nurses listened to the report of the delegates to the National Association meeting, and heard three papers read, two by physicians, Drs. T. D. Boler and D. T. Quigley on "The Nurse in Contagious Diseases" and "Uses of Radium" and a third by Miss Gertrude Keating on "The New Law," a statute recently placed on the books regulating the registration of nurses in this State and making it compulsory.

In the evening the nurses witnessed demonstrations in practical nursing at the Methodist Hospital.

The closing session was held at the Y. W. C. A. and included papers by Judge Howard Kennedy on "What Nebraska Is Doing for Her Dependents," Dr. C. W. Pollard on "Twilight Sleep," and "The Nurse in a Small Town," by Miss Grace V. Bradley.

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