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President's Address

ON

HOSPITAL PROBLEMS

BY

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The late Sir Richard Stawell would have given a characteristic address on this unique occasion, a monument of industry and penetrating thought. Had it been possible to ascertain what subject in the vast range of the science of medicine he had selected it would have been my privilege to follow the lead he had given. But as there is, I regret to say, no indication obtainable, it only remains for me to deal with the subject with which I am daily engaged and best described as "Hospital Problems," though they would really be more accurately described as "Studies in Human Nature." It is owing to the absence of consideration of this factor that many failures occur. The failures are sometimes surprising and remarkable.

I propose, with as much brevity as may be possible, to indicate the various phases of the hospital problem which have forced themselves upon my notice during a lifetime spent in hospital work. Prior to the war I had been an assistant surgeon to the Ophthalmic Hospital in London and clinical assistant to another, also a surgeon on the staff of the Eye and Ear Hospital, Melbourne, and ophthalmologist to the Melbourne Hospital, and I occupied similar posts in several ophthalmic organizations in Victoria. I knew, of course, what I wanted for my work, and as a member of the Committee of Management of the Eye and Ear Hospital I had some knowledge of administration. But when the war broke out and I reached Egypt in January, 1915, in a short time I found myself actively concerned with the administration of a 1,000-bed hospital, and soon after in general supervision of hospitals containing about 11,000 beds and also of a fleet of ambulances. All sorts of problems of which I was ignorant made their appearance, and a process of forced education was imposed on me.

On returning to Australia in 1919, where I again took up the work of the Victorian Bush Nursing Association (initiated in February, 1911, and of which I have been honorary secretary from its inception) and ordinary hospital work, my attitude was naturally modified by the experience gained in strenuous circumstances when serving in the Australian Army Medical Corps in February, 1916, and in the Royal Army Medical Corps thereafter to the end of the war.

Six Related Problems

I propose to-day to deal with six related problems:

1. The Victorian Bush Nursing Association.
2. The hospital system of Victoria.
3. The hospital system of Great Britain.
4. The hospital system of New Zealand.
5. The optimum size of a hospital.
6. The nature of the nursing services in hospitals.

May I, however, again indicate that I should have preferred to call this address a study in human nature, for that is the all-important factor which is usually overlooked in these varied systems. The Latin poet reminded us that if we chase Nature away with a pitchfork she always comes home again, and I think the late Professor Huxley also indicated another essential feature of social life. If one attempts to alter social arrangements two results are certain. When the effort has been made we shall not be in the position we occupied, nor shall we obtain exactly the result we expected; human nature asserts itself. With these elementary facts in mind let us turn to the practical issues.

The Victorian Bush Nursing Association

Owing to the initiative of the Countess of Dudley, wife of the then Governor-General of Australia, and Sir Thomas Gibson (afterwards Lord) Carmichael—Governor of Victoria—and Lady Carmichael, in the year 1911 one trained nurse was established with much difficulty at Beech Forest, the residents undertaking to pay her salary. In two years' time there were thirteen such nurses, and many troubles became apparent. At first the salary was raised by subscription, and the varying amounts contributed by residents caused criticism and feeling. The centres ended this conflict by making the contribution uniform and determining that those who paid were entitled to the nurse's services without charge—a decision which led to a remarkable result, though not foreseen at the time.

Next came the problem of housing. Hotels, boarding houses, and private houses interfered with the privacy of the patients, and both patients and nurses preferred small cottages, which were rented. In the natural course of events some of these cottages developed into hospitals. Visiting thirteen centres in remote places to ascertain how they were developing became impossible as an honorary service, and a superintendent was appointed with the aid of the Walter and Eliza Hall Trust. Unless someone visits the centres and ascertains how they are progressing the system would soon become unworkable.

The movement grew until in 1931 there were thirty-three centres. Then one small cottage hospital was established by the State Rivers and Water Commission, followed by another set up as a soldiers' memorial, and a third, in 1923, at Phillip Island—a gift from two generous citizens. The hospital created by the Commission adjoined a large camp, really a town developed by the building of a dam on the Goulburn River. So it came about that in 1925 there were forty-four purely nursing centres and three hospitals. The appearance of the hospitals was followed by the transference to them of the contributory scheme applied to nursing centres, with the arrangement that those who contributed could obtain unlimited hospital and nursing attention for themselves and dependants up to a certain age at the cost of approximately £2 2s. per week. But all patients are required to make their own arrangements with their medical attendant, a system which, being essentially human, has worked exceedingly well. Throughout, the nurses give service in the adjacent schools.

In 1926 the Edward Wilson (of *The Argus*) Trust decided to establish an ambulance service for the State on the same basis as the Bush nursing movement—namely, that the ambulance service, apart from the initial gift, must be self-supporting. The table now shown indicates the subsequent growth of these movements.

Table Indicating the History of the Victorian Bush Nursing Association

Date Founded	No. of Centres	No. of Hospitals Built and Building	No. of Ambulances	Administration
1910				Founded by the Countess of Dudley with the support of Lord and Lady Carmichael
1911	4			
1913	13			First superintendent appointed (Miss E. M. Greer)
1914	20			
1915	21			
1916	24			
1917 to 1920	28			
1921	33	1		Miss E. M. Greer resigned. Miss E. C. Cameron, A.R.R.C., appointed
1922	39	2		
1923	47	3	Country ambulance founded	Miss M. Mathieson appointed as assistant
1924	47	3	6	
1925	47	3	11	
1926	52	8	18	Miss E. C. Cameron resigned. Miss M. L. Gillis appointed
1927	55	9	19	
1928	59	14	21	
1929	62	17	21	Miss M. L. Gillis resigned. Reorganization of administration; office of superintendent abolished. Office and nursing supervisor and a travelling inspector appointed owing to magnitude of work
June, 1930	68	25	22	Miss M. Mathieson, office and nursing supervisor; Miss M. Edwards, travelling inspector
June 1931	66	28	22	
1932	63	29	21	
1933	68	38	21	
1934	67	40	21	
1935	69	45	22	There are twenty-four purely nursing centres

A survey of the State was made in 1924, and thirty-one ambulances were estimated as the requisite number to serve the country. Sixty-eight first-aid outfits were also provided by the Edward Wilson (of *The Argus*) Trust for remote places where wheeled vehicles might not be easily employed. This ambulance development owes much to the initiative of the Countess of Stradbroke, wife of the then Governor of Victoria.

Sources of Capital and Revenue

So far as the hospitals are concerned they receive and request nothing from the Government for construction, and, except in six instances of special and really historical interest, nothing for maintenance. They must maintain themselves or close. So far none have closed, and the present position is that these hospitals, staffed by doubly and trebly certified nurses and not by trainees, and who are the best-paid nurses in the State, provide the cheapest hospital accommodation in the State. Of the quality of the service you can judge for yourselves.

The hospitals are, in addition to their usual functions, health centres, centres for school work, and baby health centres; they afford accommodation at what, so far as I can learn, are the lowest rates in the world. But it must be remembered that the success of these forty-five hospitals, with an aggregate accommodation of about 416 beds, depends on the fact that the contributory system invented by the purely nursing centres was naturally transferred to the hospitals when they came into existence.

The cost of construction, but not of maintenance, has been borne by the Edward Wilson (of *The Argus*) Trust and the H. V. McKay Trust to the extent of one-sixth to one-third of the cost. The balance has been provided by the districts which own them. The cost of the economical administrative central service has been borne by the following trusts: the Walter and Eliza Hall Trust, the Edward Wilson (of *The Argus*) Trust, the David Syme Charitable Trust, the Felton and Sumner Trusts, the H. V. McKay Trust, the Henry Gyles Turner Samaritan Fund, the L. Henty Estate, the J. R. McPherson Fund, the Joseph Kronheimer Estate, the Alfred Edments Trust, and the Mrs. C. H. Opie Estate.

To such a gathering it is unnecessary to indicate the great improvement in medical practice which has resulted from the provision of suitable buildings and very highly trained nurses in country districts. The Bush nursing principle consists in the clear recognition of the fact that in private and intermediate hospitals, and to some extent in public hospitals, the sick and injured must defray the cost of their treatment. The sick and injured in these institutions do not come into the picture until they are sick or injured. In the Bush nursing system so many people pay, say, £1 10s. a year. As only a percentage require the hospital the fees can be lowered by the utilization of this basic income for hospital purposes.

A factor which has profoundly influenced the development of the Bush nursing hospitals is the rule that the medical practitioners who treat patients in these hospitals become *ex officio* members of the committee of management. This system has worked smoothly and efficiently. It is obvious that the association is really a hospital insurance system.

The Victorian Public Hospitals

If we turn now to the system of public hospitals in Melbourne and in Victoria there is much to be learnt from the foregoing. The public hospitals are maintained by

voluntary contributions, by Government subsidy, and by patients' contributions, but are not under direct Government control, being administered by honorary committees containing many eminent citizens. They are theoretically existent for the benefit of the sick and injured poor. Between these institutions and the expensive private hospitals there are a number of intermediate hospitals, mostly organized by religious bodies, at which the charges, though in my opinion too high, are less than those of the private hospitals. Of the taxpayers in Victoria 85.6 per cent. receive £300 per annum or less, and 14.4 per cent. receive more than £300 a year. It is obvious that the hospital problem resolves itself into making proper provision for many of the 85.6 per cent. by giving them the necessary hospital and nursing attention at rates within their means. Up to about the year 1900 the public hospital system worked tolerably well, but since then a great change has taken place.

In 1900 the contributions (in round figures) from the public amounted to £101,500, and from Government and municipalities £66,500, making a total of £168,000. In 1934 the contributions from the public were £451,500, and from the Government and municipalities £254,000, making a total of £705,500 ; but the population had only increased by 53.6 per cent. The details are set out in the following table.

TABLE I.—*Public Hospital Income for Maintenance (in round figures)*

	Govt. Grant	Municipal Grant	Charit. Contrib.	Patients' Contrib.	Other Sources	Totals	
	£	£	£	£	£	£	£
1900:							
Melbourne ...	24 000	2,000	35,500	9,000	25,000	95,500	168,000
Country ...	31,500*	9,000	24,000	8,000	†	72,500	
1914:							
Melbourne ...	29,500	3,500	36,000	21 500	27,000	117,500	184,500
Country ...	20,000	4,500	23,500	8,000	11,000	67,000	
1924:							
Melbourne ...	56,000	6,000	97,000	67,500	107,000	333,500	472,000
Country ...	24,500	7,000	53,000	31,000	23,000	138,500	
1934:							
Melbourne ...	161,500	8,500	90,500	106,000	134,000	500,500	705,500
Country ...	54,500	29,500	43,000	53,000	25,000	205,000	

* Includes country benevolent cases.
† Amounts not separately shown for metropolis and country.

But in the meantime the number of patients in public hospitals increased to an extraordinary extent, as the following table indicates.

TABLE II.—*Public Hospital Patients*

	1900	1914	1924	1934
Out-patients:				
Melbourne ...	46,665	69,450	103,760	213,098
Country *	15,235	8,525	25,894	25,135
In-patients:				
Melbourne ...	11,432	20,745	28,279	48,611
Country	13,086	12,889	16,495	34,413

* Includes country benevolent cases.

And hospital expenditure had increased enormously, as shown below.

TABLE III.—*Public Hospital Expenditure on Maintenance Account*

	1900	1914	1924	1934
	£	£	£	£
Melbourne	75,211	116,442	303,149	432,767
Country	59,682	71,863	138,216	192,448
	134,893	188,305	441,365	625,215

TABLE IV.—*Public Hospital Position in the State of Victoria in 1934 as Compared with 1900*

Population has increased by ... ... 53.6 per cent.
Number of in-patients has increased by ... ... 238.5 ,,
Number of out-patients ,, ,, ... 264.9 ,,

In 1900 the number of persons treated at public hospitals was 7.2 per cent. of the population; in 1934 it was 17.4 per cent.

TABLE V.—*Contributing Sources per cent. to Public Hospital Revenue for Maintenance Purposes for the Years 1900 and 1934*

	1900		1934	
Charitable contributions	35.6	per cent.	18.9	per cent.
Patients' contributions	10.2	,,	22.6	,,
Government grant	33.3	,,	30.6	,,
Municipal grant...	6.5	,,	5.4	,,
Other sources (legacies, endowments, etc.)	14.4	,,	22.5	,,
	100.0	,,	100.0	,,

If a shorter period is taken—namely, from 1920 to 1934—the change is even more marked, as the following figures show.

TABLE VI

In the fourteen years 1920 to 1934 the population of the State has increased by 20.3 per cent., whereas the number of public hospital in-patients has increased by 86.5 per cent., and the number of out-patients by 176.7 per cent.
In 1920 the proportion of public hospital patients to population was 8.5 per cent.; in 1934 it had increased to 17.4 per cent.

But people can find money to spend in other things:

TABLE VII

Expenditure in Victoria on tobacco 1929-30 £4,926,800 or £2 15s. 5d. per head
,, ,, ,, 1931-32 £3,922,962 or £2 3s. 6d. ,,
,, ,, beer 1930-31 £7,441,200 or £4 3s. 1d. ,,
(The cost of the public hospitals is less than 8s. per capita.)

A Changed Attitude

From these facts definite conclusions can be drawn. The hospital problem is, in Victoria, essentially a city problem. In the country the change has been much less marked. But we have people who advocate the cessation of the charitable system and who would throw the burden on to rates and taxes as New Zealand did, and they must be made to face the basic facts.

The contributions from patients and public amount to £450,000—that is, 64 per cent. of the income, or, if you deduct patients' payments, about £340,000. This would certainly disappear almost completely when the change was made, and the patients' payments might also decrease substantially. The New Zealand figures are eloquent, as you will see directly. There is no mistake about the forecast. If people are taxed for hospital purposes why should they make voluntary contributions? Why should they pay when they enter a public hospital for which they are in many cases already taxed? Thus, before the hospitals benefited, between £350,000 and £400,000 must be provided by taxation to make good the deficiency caused by the certain loss of voluntary gifts. The public cannot have the advantages of both systems. They must choose the one or the other.

Summarizing, then, the sole cause of the hospital problem is not want of money, but simply that tens of thousands of people now resort to the public hospitals who did not do so formerly. A great change of attitude has taken place, and with that we must alter our ideas and outlook and meet the difficulties arising from the change. The enormous increase in the demands on the public hospitals of Victoria is not materially due to the depression. You will note that the change has been continuous since 1900.

As regards the increasing cost of hospitals, some qualifications are necessary: (1) the value of money has diminished, though that is less marked in its internal than in its external purchasing power ; (2) the remuneration of the paid non-medical staff has increased ; (3) *x*-ray plants and various pathological services add to the cost, though

not to the extent usually imagined. But after making due allowance for these factors it is obvious that in serious illness some hospital service is now required by the public—I think rightly—whereas formerly people were treated in their own homes. But it is also obvious that this does not explain the enormous growth of the out-patient service, even if we allow for some duplication. Is it not a little remarkable that in calculating the basic wage in Victoria nothing is allowed for medical expenses? Ninepence a week, or about £2 a year, would make all the difference if the money were so applied. But this profound change in attitude has been accompanied by the tacit assumption that medical experts will continue to give honorary service just as if they were officers of a charitable institution.

The English System

Of the English hospital and medical system in general I have nowadays no direct knowledge such as that possessed by many members of this audience. But I shall quote from an address given by the late Sir Basil Blackett, a director of the Bank of England, and who spoke with great breadth and insight on July 5th, 1932, in a lecture entitled "A Layman's Plea for a Positive Health Policy." Realizing, as many people do, that there is a danger of all State social services breaking down by their own weight, he put the questions: What do health services cost? Is the nation getting full value for them? The following table shows the estimate of cost, which the compiler thinks is a large understatement.

TABLE VIII

	Treatment of Disease	Prevention of Disease	Other Health Services and Expenses Incidental to the Cost of Disease	Total
	£	£	£	£
Local authorities	21,464,653	28,910,370	29,840,107	80,215,130
Central administration (Ministry of Health and Board of Control)	—	—	1,150,000	1,150,000
National Health Insurance	9,051,500	—	24,687,700	33,739,200
Friendly societies	762,000	—	5,238,000	6,000,000
Workmen's compensation (applicable to England and Wales)	—	—	6,000,000	6,000,000
Voluntary hospitals ...	8,699,450	—	—	8,699,450
Voluntary societies and institutions	1,641,896	—	4,941,415	6,583,311
Medical schools	—	—	400,000	400,000
Private practice of medicine, dentists, drugs and appliances, and subordinate medical service	53,000,000	—	—	53,000,000
	94,619,499	28,910,370	72,257,222	195,787,091
	48%	15%	37%	100%

The cost of poor relief is not included above. The sum involved is £27,889,049.

Expenditure on health services met by public funds increased from 1900–1 to 1927–8 by 360 per cent., or per capita 279 per cent.—that is, from 14s. 5d. to £2 14s. 9d. per head. The proportion of total national expenditure on health spent directly on prevention in 1927–8 was only 15 per cent. Has the health of the nation improved by 279 per cent.? Discounting the increased expenditure owing to the altered value of money, he has no difficulty in showing that a claim of health improvement of 279 per cent. is out of the question. He proceeds to point out that the steady rise in the numbers of in- and out-patients at the voluntary—or as we call them in Victoria, public—hospitals, and the habit of sending panel patients to the out-patient departments, has become a serious problem. It would almost seem that an expenditure of some £39,000,000 a year on health insurance has proved merely a means by which both sickness and payments for it have increased in volume.

He makes allusion to the insufficiency of scientific domiciliary treatment in many cases. He discusses, but with sympathy, the fact that the medical practitioner cannot refuse a certificate under the national health insurance scheme, or he would lose his livelihood. The applicant says, in effect. "There is a fund; why should I not benefit?" Time does not permit of further examination of this broad-visioned and illuminating document.

I will conclude this part of the survey by expressing my opinion of the British Army Medical Service, of which I was a member for three years. I estimated that the work of the Service could be roughly apportioned as one-third prevention, one-third treatment (which was admirable), and one-third devoted to finding occupation for the partially disabled, which was part of my occupation towards the end of the war. In civil life, as there cannot be Army discipline, such results can only be obtained by popular education and voluntary action With one observation of Sir Basil Blackett I am in complete accord. If we can offer the average working man a service within his possible means he will pay for it. The Bush Nursing Association has taught me that the spirit of independence is still part of the life of the country dweller if this condition is complied with.

The New Zealand System

If we turn now to New Zealand we find a system which has been definitely nationalized since 1909. The official figures relating to the working of this system are difficult to disentangle from other State charitable enterprises, but they have been separated, as far as possible, owing to the kindness of Dr. Watt, Director-General of Health.

A Royal Commission on National Expenditure was appointed, and reported finally in 1932, and the statements made by that body have not, so far as I am aware, been publicly challenged, though there may be considerable private disagreement. At all events the Government has not accepted many of its recommendations.

The people of New Zealand, like some Victorians, thought it better definitely to nationalize the hospital service, and did so in 1909. The financial responsibility was thrown on to the ratepayer and taxpayer on a definite ratio between them. Anyone could obtain admission to a public hospital, but could not be charged more than £3 3s. a week, and while in the cities the honorary system of medical officers was retained, in many places permanent salaried medical officers were appointed. The resultant financial effect may be followed.

TABLE IX.—*Hospital Maintenance and Hospital Board Capital Expenditure*

Year	Number of Institutions	Average Number of Occupied Beds per Diem	Hospital Maintenance Expenditure	Capital Expenditure
			£	£
1909–10	59	1,749	174,288	58,259
1914–15	74	2,564	270,179	115,294
1924–25	105	4,392	855,104	425,066
1933–34	123	5,370	936,224	48,859

TABLE X.—*Hospital Receipts*

Year	Hospital Fees Received	Gifts and Legacies	Year	Hospital Fees Received	Gifts and Legacies
	£	£		£	£
1909–10	35,135	20,833	1924–25	250,954	24,181
1914–15	71,701	20,379	1933–34	331,081	13,465

The figures are approximate.

TABLE XI.—*Cost to Government and Local Authorities*

Year	Hospital Maintenance		Year	Capital	
	Cost to Government	Cost to Local Authorities		Cost to Government	Cost to Local Authorities
	£	£		£	£
1909–10	69,046	49,273	1909–10	29,129	29,129
1914–15	94,239	73,860	1914–15	57,647	57,647
1924–25	302,075	277,894	1924–25	212,533	212,533
1933–34	295,839	295,839	1933–34	24,429	24,429

The figures are approximate.

It will be noted that the expenditure on hospital maintenance in New Zealand is even now considerably greater than it is in Victoria, which has a much larger population—namely, New Zealand, £935,000 ; Victoria, £705,000. Population: Victoria, 1,840,000 ; New Zealand, 1,560,000.

The Commission appointed in 1932 recommended:

1. That for financial reasons, if no other, the hospital system should be reorganized.
2. That it could not discover any instances in which the full cost of treatment was charged to a patient whatever his circumstances, and, consequently, the burden on rates and taxes had continued to increase.
3. That reorganization would enable the Governmental subsidy to be reduced by 10s. in the £, and the burden on local authorities could be reduced.

Since then considerable economies have been effected. But in 1933–4 the total voluntary contributions to hospitals and other governmental institutions was only £13,500 and the total fees collected £331,000, while the levy on Government and local authorities for maintenance still remained as high as £592,000 (£296,000 each) ; the fees receivable amount to £954,000 (accumulated debt), but apparently cannot be collected. In Victoria the Government contribution is £216,000 and the municipal contribution £38,000.

Into the consideration of the nature of the medical service and the obvious and serious political implications of the administration I am not competent to enter, but the facts warrant the definite conclusions: (1) nationalization inevitably puts an end practically to charitable contributions ; (2) the collection of fees payable by those who use the hospitals is extremely difficult in a nationalized system ; (3) and consequently a nationalized system must be expensive to Government and local authorities. Australian taxes are the second highest in the world, and the foregoing conclusions have a direct bearing on our policy. Dr. Malcolm McEachern of the American Medical Association made an investigation of the New Zealand system in 1927. He is reported to have made the following significant observation:

"I hope voluntary effort and voluntary control will never be replaced in New Zealand wholly by governmental or national effort and control, for, if it does, the hospitals of this great Dominion will never come into their own under a wholly taxation system. A voluntary-giving people makes for better citizenship and tends to keep the hospital human.

"Goldwater, the superintendent of that great hospital Mount Sinai, New York City, and the world's greatest hospital authority in my opinion, uttered immortal words recently when he said: 'The voluntary hospital gifts come as expressions of love, gratitude, friendship, memory, good fellowship, pride of the family, and pride of the race. Under a purely public or State system the hospitals may be able to spend as much money as they are spending to-day, but the joy of spontaneous giving will be gone. One shudders to think of the day when hospitals, transformed into soulless standardized State institutions, will be compelled to haul down the flag of human brotherhood. May that day be far off, and may American hospitals contrive for generations to be supported by voluntary contributions.'"

The Size of Hospital

What is the optimum size of a hospital? It is evident that a very small hospital cannot provide all the necessary specialized equipment for the treatment of disease, though the staff of one Bush nursing hospital of about thirty beds informed me that not more than 4 per cent. of the patients require a pathologist or *x*-ray therapeutic equipment. (Many of the hospitals contain *x*-ray diagnostic plant and have access to a pathologist.) On the other hand, a hospital of 4,000 beds, such as Bellevue, New York, is reported to contain, is obviously unwieldly. The Vancouver Hospital of 1,100 beds occupies about three city blocks, and the mere effort of transportation from one place to another is severe. The Military Hospital near Honolulu, with only 400 beds, almost requires small motor cars on the corridors. Between the two extremes there must be an optimum size. The administrative expenses of a hospital are a very small part of the total running cost—about 3 to 5 per cent. But as the hospital grows more nurses and attendants become necessary ; certified engineers are wanted, and so on. At the Melbourne Hospital, with 400 beds, excluding the honorary medical staff, there are 1.1 employees to each bed ; at the Alfred Hospital, with 320 beds, there are 1.2 employees to each bed.

The medical superintendents of two Canadian hospitals informed me that in their opinion 300 beds should be the maximum size, and then only with vertical extension of the building and different floors devoted to special purposes and self-contained. Some senior American surgeons fixed the limit at 250 beds. By general consent about 500 beds is the extreme outside limit. It would surely be better where more accommodation is wanted in a fair-sized hospital to cease any effort for extension and to build a new hospital somewhere else.

May I, however, submit a conundrum which I have found it difficult to answer in accurate technical fashion? To-day there are built and building forty-five Bush nursing hospitals ; there are forty-five kitchens, forty-five laundries, forty-five staff quarters, and forty-five reception rooms, thirty-one properly equipped operating rooms, and sixty bathrooms. If this system, containing in the aggregate 416 beds, were placed in one building with one kitchen, one laundry, one reception room, and one set of staff quarters with, say, four operating theatres, and ten or more bathrooms, the natural assumption would be that it would be cheaper to build and administer. The cost of indoor beds in the Bush nursing buildings is £400 a bed, or with the veranda beds about £120 a bed, for superb accommodation, which, I think you will agree after inspection, is far superior to anything the public hospitals can provide. Yet as a matter of fact the cost of hospitals in Melbourne has never been less than £500 a bed and, it is reported, has reached £2,000 a bed. What is it that is wrong with the centralization? And so,

finally, I put the question, if a hospital of 300 to 400 beds is becoming insufficient to meet requirements why seek to extend it? Why not build another hospital somewhere else?

Nursing Services in Hospitals

As most of us are aware, in Canada there are at least three types of nurses: (1) the bedside nurse; (2) the bedside nurse with sufficient pre- or post-graduate training to enable her to become better qualified or become a public health nurse; and (3) the graduate in science in nursing, who, after matriculation, becomes a graduate after a five-years university course.

In Victoria we have bedside nurses who, in many cases, especially in the Bush Nursing Service, hold a general, an obstetric, and often a baby health certificate, and we have made a sound commencement in developing post-graduate work, largely owing to the energy and leadership of Mrs. Herbert Brookes. But to obtain the three certificates and to follow post-graduate study involves five or six years of work. The question arises whether our administration of public hospitals by trainees and a limited staff of trained nurses is sound in principle or just to the trainees. For example, the Melbourne and Alfred Hospitals, containing 750 beds, are staffed by eighty-two sisters and staff nurses and 326 trainees. Should we not train nurses as we do medical students, and so shorten the length of training? There is no sense, from the educational point of view, of a trainee repeating something she has learnt to do efficiently. On the one hand, five or six years of preparation and partially paid work should ensure an adequate remuneration; on the other, is it right that public hospitals should be maintained largely at the expense of the trainees? The financial difficulty is obvious, but sooner or later the issue must be faced. Any change would perforce be gradual.

Conclusion

Thus there has been sketched:

1. A completely self-supporting system, the Victorian Bush Nursing Association.
2. A system at the parting of the ways, the Victorian public hospital system.
3. A partially nationalized system, the complicated English hospital system.
4. A system almost completely nationalized, that of New Zealand.

In bringing this sketch to a conclusion the questions I wish to submit for consideration are as follows:

1. Are we to abandon our voluntary charitable system and nationalize (that soothing word) our hospital service? If so, we shall lose the humane feelings of public and profession which brought the hospitals into existence and have ensured their continuance. The medical staff must then cease to be honorary. Unless the experience of other countries misleads us, the cost will be great if efficiency is to be maintained. But the choice must be made. It is obvious that the public have decided one factor—namely, they intend, unless checked, to enter hospitals, where they do not, or cannot, pay even the cost of their keep. But the other essential factor has not been faced. It is quietly assumed that the medical expert will continue to act as if the system were a charitable one so far as he is concerned. If nationalized hospitals make their appearance the medical officers must be adequately paid if efficiency is desired.
2. As regards the intermediate hospitals, which, as I have stated, are not cheap enough, why should the contributory Bush nursing principle not be applied and the cost to the patients substantially reduced?
3. Why should there not be hospitals of the Bush nursing type placed in the suburbs and maintained in the same fashion as the Bush Nursing Association?
4. What is the optimum size of a hospital, whether regarded from the point of view of efficiency or economy?
5. Are we to continue practically to staff hospitals with nursing trainees, or are we to staff them with fully qualified nurses and to train nurses as we train students of medicine?
6. To what extent should the pre- and post-graduate training of nurses be developed?

It is, however, obvious that the main question is *whether hospitals are to be nationalized or not*. If they are, the whole medical profession will inevitably be nationalized sooner or later. The choice must be made, or we may drift by indecision into a position difficult to justify or to alter.

The only positive statement I feel justified in making while occupying such a position is as follows. The fault of the present hospital system is that the economic gap between the public hospitals and the so-called intermediate hospitals and the private hospitals is too great, and should be bridged by a contributory system such as Bush nursing, in which case the hospital charges for intermediate cases can be made very small. If such a contributory system is adopted by the profession they will, as in the Bush Nursing Association, exercise their just influence in managing it. If, on the other hand, it is supplied by the State or other organizations, and they do not play an active part in its establishment, then their control and influence will probably be negligible. Now is the time to decide, and to choose which system is preferable. But some provision of the kind is essential and inevitable.

I have done my best to present these difficult questions in broad outline. It is now for a body of trained and thoughtful medical practitioners to reach positive conclusions. There is only one thing worse than a wrong decision, and that is indecision. Finally, may I make the most ample acknowledgement of the assistance received in obtaining data from the Director-General of Health, New Zealand, Dr. Watt, and from the assistant secretary of the Victorian Branch of the British Medical Association, Mr. Ward; without the generous help given the task would have been difficult.

V. Schilling (*Med. Welt*, July 27th, 1935, p. 1075) describes an outbreak of infection by the meningococcus at the University Clinic of which he is director at Münster. The source was a patient with meningitis in whom the first lumbar puncture, owing to a faulty Gram solution, was thought to show pneumococci; later meningococci were identified microscopically and by culture and serological tests. He was admitted on March 17th. On March 26th one of his nurses began with meningitis. On March 29th no fewer than twenty-four of forty-five contacts working in the unit were found to give positive nasal cultures, including all the nurses, two doctors, and two students; two days later ten more contacts were positive. The infection, judged by cultures, spread rapidly through adjacent and distant wards: in all, thirty-one of the personnel (out of sixty-eight) and sixty-two patients (out of 161) were found to harbour meningococci. No further case of meningitis occurred, however, but there were six instances of febrile rhinopharyngitis and many more of nasopharyngeal catarrh. In other reported epidemics cultures from contacts have shown twelve to forty times as many carriers as clinical cases of meningitis. Powers of compulsory isolation, in certain circumstances, of meningococcus carriers do not exist, but have been demanded in Germany; but the practical difficulties are so great that a counter-suggestion would prohibit the swabbing of contacts.

ever, is abundantly justified in the public interest. People who have experienced benefit from homoeopathy, or have witnessed what it has done to others, have a right to know where they can obtain this treatment. So long as this valuable therapeutic method is unrepresented in the voluntary and public assistance hospitals of this country homoeopathic hospitals must remain homoeopathic hospitals. There is no need to label any famous London hospital "allopathic." No patient runs the slightest risk of being treated homoeopathically there!

No, Sir, I do not think that we can be accused of unethical conduct. I wish I could say the same of our critics. Every member of our society has been the victim of conduct on the part of his professional brethren which violates the canons of ordinary decency, and I myself have had more than one occasion for instituting libel proceedings against medical men, a course which would be repugnant to me. Perhaps if medical students were given an outline of the principle of homoeopathy during their materia medica course, instead of hearing their professors hold it up to ridicule by way of enlivening an extremely dull set of lectures, we should be spared some of the many rather stupid letters which are written on the subject.—I am, etc.,

Liverpool, Sept. 7th. F. B. JULIAN.

Medico-Legal

TREATMENT BY OSTEOPATH: CORONER'S COMMENTS

At an inquest held at Camberwell on September 4th the coroner, Mr. Douglas Cowburn, made some indignant references to the treatment given by an osteopath in the case. It was stated that the deceased, a woman named Adams, aged 32, had suffered from diabetes for several years. She was recommended to a Mr. William Mellor, an osteopath, of Balham Park Road, S.W., and first visited him a week before her death. A few days later, when she was very ill, he was called in, but she became worse, and on being sent for again Mellor recommended that she should see her insurance doctor.

Mellor, in evidence, after being cautioned by the coroner, said that he carried on business at Peckham Rye as an osteopath and homoeopath. A plate outside his surgery bore the words: "Dr. William Mellor, Osteopath, U.S.A., Homoeopath, India." He obtained the degree of osteopathy at the First National University, Washington, N.J., and he was an associate of the Western University, Kapurthala, India. It was put to him by the coroner that there was no Western University, Kapurthala, nor any college, but only a place which issued diplomas on payment of a fee. The witness said that he was surprised to hear that; he had sat for an examination in homoeopathy in London under the Indian Education Scheme. He called himself a doctor because he held a doctorate of osteopathy. He did not practise as a physician, nor was he a surgeon or a general practitioner. He held a degree of doctor of medicine from the American Academy of Medicine and Surgery, Washington, and he was a member of the British Homoeopathic Association.

Dr. D. P. McGrath said that he was called to the deceased a few hours before her death; she was then in a state of coma. A relative told him that she had been under treatment by an unqualified person, and accordingly he refused a death certificate. Sir Bernard Spilsbury testified that death was due to diabetes. The treatment given by Mellor, which was an old one for diabetes, would not have shortened her life, but it would have been perfectly useless.

The coroner, in summing up, described Mellor as a "quack," and his treatment as "arrant rubbish."

A verdict of "Death from natural causes" was accordingly returned.

Obituary

The death took place at Aberdeen on September 1st of Dr. GEORGE ROSE, who had been for many years medical officer to the education authority of Aberdeen. Dr. Rose was born in Aberdeenshire in 1855, and prior to taking a medical course had worked as a mason and granite merchant in America. He graduated M.B. at Aberdeen University at the age of 33, and after some years in private practice became surgeon to the Sick Children's Hospital at Aberdeen, and later full-time medical officer for the schools of the city, a post which he held for twenty years until his retirement in 1930 on the transference of educational affairs from the education authority to the town council. Dr. Rose is survived by a widow, one son, Major Gilbert W. Rose, R.A.M.C., and one daughter.

The following well-known foreign medical men have recently died: Professor FONZES-DIACON, dean of the Montpellier faculty of pharmacy, aged 67; Dr. FERNANDEZ PEREZ, formerly Ambassador of the Argentine Republic in Rome, aged 70; Dr. BRAEMER, formerly dean of the faculty of pharmacy at Strasbourg and corresponding member of the Académie de Médecine; Dr. STANY E. RISACHER, professor of clinical obstetrics and gynaecology at Beirut; Dr. ERNEST LACKNER, an eminent Chicago paediatrist, aged 83; Professor GEORGE BENNO SCHMIDT, for many years director of the surgical department of the University Children's Clinic at Heidelberg, aged 75; Professor ALOEF, director of the medical institute at Kazan; and Baron GUGLIELMO ASCIONE, professor of bacteriology at the Institute of Hygiene at Naples, aged 48.

Medical News

ANNUAL MEETING AT MELBOURNE

According to a press message 1,500 medical men took part in the opening ceremony of the British Medical Association which was held at the Town Hall, Melbourne, on September 10th. The following reply to a loyal telegram sent to the King was received by the President, Sir James Barrett:

> "Please convey to the members my sincere thanks for the assurance of loyalty and devotion. I am convinced that the interchange of ideas on these vital matters among the nations of the Empire must benefit mankind. As Patron of the Association I send best wishes for the successful issue of your deliberations."

It is intimated that the King has been pleased, on the recommendation of the Secretary of State for Scotland, to appoint Professor Duncan MacCallum Blair to be Regius Professor of Anatomy in the University of Glasgow in succession to Professor T. H. Bryce, who has resigned as from September 30th, 1935. In 1927 he was appointed to the chair of anatomy at King's College, London, a post which he still holds, being also Dean of the Medical Faculty.

The King has appointed Mr. J. R. Learmonth, Ch.M., F.R.C.S.Ed., to be one of the Honorary Surgeons to His Majesty in Scotland in the place of Sir John Marnoch, K.C.V.O., C.M., who has been appointed Extra Surgeon to His Majesty in Scotland.

In connexion with the opening of the new session in October next, the Faculty of Medicine, Birmingham University, has arranged to hold a series of post-graduate lectures at the General, Queen's, and Children's Hospitals for old students of the school on October 11th and 12th. There will also be an address by Sir Walter Langdon-Brown, on October 11th, in the Medical Theatre, Edmund Street, and the annual dinner will be held at the Grand Hotel at 8.15 the same evening. Further particulars may be had on application to the dean.

Middlesex Hospital Medical School will hold its annual dinner for past and present students and their friends on Tuesday, October 1st, at the Savoy Hotel, at 7 for 7.30 p.m. Dr. H. Campbell Thomson will take the chair.

The annual dinner of past and present students of King's College Hospital Medical School will be held on Saturday, October 5th, at 8 p.m., at the May Fair Hotel, with Sir Charlton Briscoe, Bt., in the chair. An intensive post-graduate course will be held on Saturday, October 5th, 11 a.m. to 6 p.m., and on Sunday morning, October 6th, to which members of the school and other practitioners are invited. A series of post-graduate lectures on tuberculosis, free to all practitioners, will be delivered in the lecture theatre on Thursdays at 9 p.m., from October 3rd to December 12th, inclusive. The inaugural lecture of the winter session will be given on October 10th, at 4.30 p.m., by Professor G. F. Still.

University College Hospital Medical School has arranged a programme of post-graduate demonstrations for the benefit of old students on Thursday and Friday, October 10th and 11th, from 10 a.m. to 4 p.m. At 4.15 p.m. on October 11th the annual general meeting of the Old Students' Club will be held in the Medical School, under the chairmanship of the president, Dr. F. J. Poynton. At 7 for 7.30 p.m. the same day the annual dinner (12s. 6d. exclusive of wines) will be held in the library of the Medical School. The annual dinner of the University College Hospital Medical Women's Association will be held at the Piccadilly Hotel on Friday, October 11th, at 7.30 for 8 p.m. The chair will be taken by the president, Dr. Annis Gillie.

The annual refresher course for former students of Middlesex Hospital Medical School will begin on Saturday, September 28th, at 2.15 p.m., and continue up to the evening of October 1st.

The Institute of Medical Psychology announces that five seminars on fundamental psychological conceptions, by Professor C. G. Jung (Zurich), will be given on Monday, September 30th, to Friday, October 4th, inclusive, at 7.45 p.m., and will be followed by a discussion for medical graduates only at 9.15 p.m. The fee for the course is £1 1s., and tickets may only be obtained in advance, from the Educational Secretary, Institute of Medical Psychology, Malet Place, W.C.1.

The Fellowship of Medicine (1, Wimpole Street, W.) announces the following courses: medicine and surgery, at Westminster Hospital, September 16th to 28th (men post-graduates only); chest diseases, at Brompton Hospital, September 23rd to 28th; week-end course in ophthalmology, at Royal Westminster Ophthalmic Hospital, Saturday and Sunday, September 28th and 29th; proctology, at Gordon Hospital, September 30th to October 5th; dermatology, at St. John's Hospital, afternoons, September 30th to October 31st; primary F.R.C.S. lecture-demonstrations in the lecture theatre of Infants Hospital, on Monday, Wednesday, and Friday evenings, at 8 p.m., from October 7th to November 29th; *x*-ray interpretation, at Medical Society of London lecture room, September 30th to October 4th at 5 p.m.; endocrinology lectures, at National Temperance Hospital, Tuesday and Thursday evenings at 8.30 p.m., October 8th to 24th; gynaecology (advanced) lectures at Medical Society of London lecture room, Thursdays, 4 p.m., October 10th to November 7th; week-end course in fevers, at Park Hospital, Hither Green, Saturday and Sunday, October 5th and 6th; medicine and surgery "refresher" course, at Metropolitan Hospital, October 7th to 19th. Application for detailed syllabuses should be made to the Fellowship of Medicine. Courses, etc., are open only to members.

The following lectures will be given under the auspices of the London and Southern Counties Branch of the Incorporated Dental Society and the Metropolitan Branch of the Public Dental Service Association, at the London School of Hygiene and Tropical Medicine, Keppel Street, W.C.: Wednesday, October 2nd, Dr. D. A. Imrie, "Dental Skiagrams, Difficulties in Interpretation"; Thursday, November 7th, Mr. G. F. Cale-Matthews, "The Importance of Early Recognition of Developing Malformation, Causes and Treatment"; Wednesday, December 4th, Mr. J. H. Badcock, "Useful Hints in Everyday Practice"; Thursday, February 6th, 1936, Dr. J. B. Parfitt, "Surgical Cleanliness and the Present-day Practice of Dental Surgery"; Wednesday, March 4th, Dr. E. W. Fish, "The Pathology and Treatment of Pyorrhoea"; Thursday, April 2nd, Mr. W. Stewart Ross, "The Treatment of Pulpless Teeth and Apicectomy." The lectures commence at 8 p.m., and medical practitioners are invited to attend.

A course of lectures and demonstrations for the diploma of public health on clinical practice and in hospital administration will be given at the North-Western Hospital, Lawn Road, Hampstead, N.W., by the medical superintendent, Dr. A. Joe, on Mondays and Wednesdays at 9.30 a.m., and alternate Saturdays at a time to be arranged, beginning Monday, September 30th, for three months. Medical men and women desiring to take the course of instruction are required, before attending at the hospital, to pay the requisite fee to the medical officer of health, London County Council, Public Health Department (Special Hospitals), the County Hall, S.E., giving their full name and address.

A course of lectures and demonstrations for the diploma of public health on clinical practice and in hospital administration will be given at the Brook Hospital, Shooter's Hill, Woolwich, S.E., by the medical superintendent, Dr. J. V. Armstrong, on Mondays and Wednesdays at 9.30 a.m. and alternate Saturdays at a time to be arranged, beginning Monday, October 7th, for three months. Medical men and women desiring to take the course of instruction are required, before attending at the hospital, to pay the requisite fee to the medical officer of health, London County Council, Public Health Department (Special Hospitals), the County Hall, S.E., giving their full name and address.

The annual meeting of the International Society of Medical Hydrology will be held in Belgium from October 12th to 17th. The following discussions are taking place: "The Action of Carbon Dioxide Baths on the Peripheral Circulation," with introductory papers by Drs. E. Guilleaume and M. Wybauw, jointly, Drs. P. N. Deschamps, and R. Wachter; "The Therapeutic Action of Peloids," with introductory papers by Professors Scherbakov, S. Pisani, and Dr. F. Lenoch; "Therapeutic Agencies of the Sea Coast," with introductory papers by Professor I. Gunzburg and Dr. W. G. Willoughby. These discussions are being held on the mornings of Sunday, October 13th, and Monday, October 14th, in Brussels, and Thursday, October 17th, in Ostend. On the afternoon of Monday, October 14th, there are visits to the Department of Physical Medicine of the Brugmann Hospital, and to the Universal Exhibition, and in the evening there is a banquet in one of the restaurants of the Exhibition. On Tuesday, October 15th, there is arranged a visit to Luxembourg, with lunch at Mondorf, and a clinical meeting and visit to the spa establishments, and on Wednesday, October 16th, a visit to Spa and a lunch and reception by invitation of the municipality and the Société Spa Monopole. On the last day, Thursday, October 17th, there is a visit to the new spa establishment in Ostend and lunch at the Palais Thermal. Papers on the newly discovered waters at Ostend will be read by Drs. Reynaerts and De Roo. Non-member's fee is 100 Belgian francs, and the inclusive charge for accommodation, board, and travelling in Belgium is 1,125 Belgian francs. All information from I.S.M.H., 109, Kingsway, W.C.2.

The sixth Italian Congress of Legal Medicine will be held at Milan from September 26th to 29th, under the presidency of Professor A. Cazzaniga, director of the Institute of Legal Medicine of Milan University. Further information can be obtained from the Secretary, Via Mangiagalli 37, Milan.

The meeting of the Continental Anglo-American Medical Society, arranged for October 5th in Paris, is postponed indefinitely.