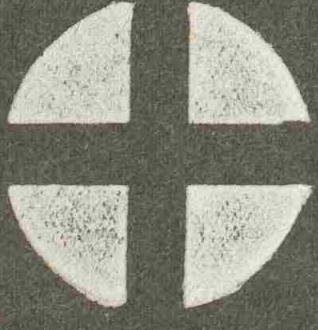
Kai Tiaki:

The Journal of the Nurses of New Zealand



Kai Tiaki

(THE WATCHER—THE GUARDIAN)

The Journal of the Nurses of New Zealand

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Contents

Training in Small Hospitals

THE frequently discussed point of the advisability or not of allowing nurses to be trained in small hospitals is one which very largely affects a country such as New Zealand, which has for a very limited time been settled and provided with nurses and training schools at all. As you all know, the Act for the Registration of Nurses does not debar the smaller hospitals from training and sending up pupils for the State Examination, and it has not infrequently happened that the nurse who heads the list of successful candidates for her term, has been a graduate from one of these small hospitals. While freely acknowledging that our opinion is in favour of small hospitals not attempting to turn out fully qualified nurses, except under the difficult conditions of a young country, justice compels us to admit that given favourable circumstances, nurses may have some advantages in those hospitals which they lack in larger training schools. The favourable circumstances are first of all a medical officer and matron who are capable, keen in their work, and willing to make the fullest use of the material at their command. The doctor who is up-to-date and able, will have patients in his hospital who would otherwise go to one of the larger centres for treatment in serious disease, or for grave operations; and a well trained matron, who is also head nurse, will be able in nursing these cases to give instruction to her pupils in a practical and detailed way impossible in the rush of a large place, where administrative work is all she can undertake.

We must not forget also, that to an individual probationer in a large hospital, the work outside her own ward of sixteen or twenty or more beds, does not concern her; so that

she has only to do at one time with about the same number of patients as a nurse in a smaller hospital. Moreover, as there are more nurses, the available practical work is divided between more pupils. Therefore, perhaps in a hospital of twenty beds, a nurse may have had during the term of her training to do with as many patients as the nurse in a hospital of 200 or more, and she will have been able to watch each patient during the full course of treatment.

We are not advocating training in small hospitals; but, being obliged to accept the conditions in this country as they are at present, it is well to recognise all the possible advantages as well as the disadvantages, and to point out the best way of utilising those advantages.

We must remember that hospitals are not established merely for training nurses; if so they could be placed in large centres only. They are principally for the benefit of the sick, who are to be found in larger or smaller numbers everywhere. Here, where our towns are scattered, and some many miles from railways, it is necessary to have hospitals for quite small numbers of sick, and it is necessary for those hospitals to be staffed. There are not enough trained nurses to do all the work of these hospitals, even if the money could be provided to give them adequate payment, and it is hard for a girl to spend three or four years learning all she can, and getting much good practical experience, and at the end of that time being no further advanced in her professional career.

The ideal manner of staffing these small hospitals would be to have certain districts, with one main hospital; the outlying small ones to be staffed from this centre with a sister in charge, the staff nurse and so many probationers being sent from the main hospital every three months or so; just as they are in the different wards and departments of a large training school. This would ensure uniformity of training and be of great advantage to nurses, whose ideas would be much broadened by the variety of work and surroundings, and who would still have the privilege of belonging to a large training school. Nurses may think that time would be lost by being away from the more important hospital, but that need not be so; a probationer in a small hospital is called upon to do many things, which in a large place are reserved for the more experienced staff nurse, medical student, or even resident surgeon. For instance: we recently visited a country hospital where the operation of apendicectomy had been performed in the morning. The medical officer had done the operation, which had been a particularly difficult one, with the matron as his assistant, one of the pupil nurses as anaesthetist (of course under his direction), and the other pupil attending to the sponges, and so on. The third pupil would have charge of the patient at night. Now in a large hospital the probationer nurses have no chance of such close association with a major operation until well on in their training, or as post-graduate nurses, therefore, although the number of operations is very much larger, yet each individual nurse in the large staff cannot have much more practical experience.

Then in small hospitals the pupils may, if they take an interest in their work, know, and help to carry out, the full treatment in every case. There is ample time for them to observe, and for the matron to point out to them, all important symptoms of diseases and results of treatment. They get a chance of assisting in the dispensary, and learning a great deal about drugs, and last but not least, they have the major part of the invalid cookery to do.

Another point apt to be lost sight of, is that in a small place with a limited staff it is impossible to adhere closely to any systematic time on duty, and that the off times of the nurses has to be made subordinate to the needs of the patients. This fact alone is of advantage, as it is more calculated to promote unselfishness and the true spirit of nursing, than any set, eight-hour system of duty.

The chief disadvantages of training entirely in a small hospital are largely caused

by the indifference of the teachers, who do not think it necessary to put forth their best for the benefit of two or three pupils (and it certainly is difficult to deliver formal lectures to so few), and the carelessness of the pupils, who have not the same incentive to study as in a larger class. It is necessary for the teachers, doctors and matron to be the more earnest in their efforts, and to seize every opportunity for demonstrating and teaching all the proper methods of nursing, with the material at their command; also to keep themselves up-to-date in lines of treatment both medical and surgical. As we said before: given an up-to-date medical officer, and a well trained matron, there is no reason why the pupils should not become valuable members of their profession.

Discipline is a part of the training which is more difficult to enforce among small numbers, but that also rests largely with those in charge. It cannot be as strictly carried out as in a large training school; but nevertheless, the ethics of nursing can be well taught by precept and example.

The Progress of State Registration in Great Britain.

The Nurses' Registration Bill, promoted by the Society for the State Registration of Trained Nurses, was introduced into the House of Commons by Mr. R. C. Munro-Ferguson, on Tuesday, 2nd March. The Bill is identical with that so ably piloted through the House of Lords last session by Lord Ampthill, and which had the full support of the Government and of the Marquess of Lansdowne, Leader of the Opposition, on the third reading. We hear that: "Petitions in support of the Bill are being forwarded to members of Parliament." From the *British Journal of Nursing*.

We shall await with deep interest the news of the progress of this Bill, and sympathise with its promoters in their hard fight against opposition. Quite a new difficulty has been placed in their way now that success is almost in view, by a section of the medical and nursing world in Scotland, which advocates a separate Bill for Scottish nurses, eliminating the great principle of a central and uniform qualifying examination.

Let us hope that this opposition which has been presented at the last moment may be overcome, and may not delay the long-desired consummation.

Nursing in Outlying Districts

It is under contemplation by the Inspector-General of Hospitals to recommend the appointment of nurses to positions in some of the outlying Islands and districts where there are no medical men, and not sufficient practice for one, but where a nurses' services would be invaluable in attending maternity cases, and any cases of illness which would come within her scope.

She would be paid a salary of £100 per annum, and allowed to receive fees up to two guineas a week from patients able to pay. While the very poor she would attend without payment, or she could visit patients daily for moderate fees. A well qualified nurse, trained both in general work and midwifery would have splendid opportunities of doing good work in these isolated places.

The Inspector-General would be glad to have the names of nurses who would be ready to take such positions if occasion should arise, and such nurses are requested to write to Miss Maclean for any further details they wish to ascertain.

Wellington Trained Nurses' Association

A general meeting of nurses was held in the Club-room on Monday, 23rd January. There were 28 members present, Mrs. Gibbs occupied the chair.

The rules of the Association were passed. A scale of fees and rules for general and midwifery nurses, which were drawn up by the Council, were passed by the nurses.

Names of lecturers and subjects for the session were suggested by the members present.

The syllabus has since been arranged and printed, and two of the lectures have already been given. These were well attended and thoroughly appreciated.

A general meeting of nurses was held in the Club-room on Tuesday, March 23rd. Mrs. Kendall presided, and there were 36 members present. The president explained that the meeting had been called to discuss the subject of affiliation.

Miss Maclean, who was present, gave a short address, in which she pointed out the advantages of affiliation.

Dunedin and Canterbury Associations have already held meetings, and had decided in favour of affiliation.

The result of the meeting was that the members present voted unanimously for affiliation, and nominations of office bearers on Central Council were as follows :—

President, Mrs. Grace Neill; Vice-President, Miss Maclean; Hon. Secretary, Miss Bicknell; Vice-President from Branch, Mrs. Gibbs; delegates from Branch, Mrs. Kendall, Miss Berry, Dr. Young.

By Miss Berry's appointment to the position of Matron at Napier Hospital, we have been deprived of the services of yet another member of our Council. As representative of Wellington Hospital Miss Berry has always striven to act in the best interests of the nurses. Her friends wish her every comfort and success in her new appointment.

Nurse Atkins, who resigned three months ago from the position of visiting nurse to the Association, was married on the 15th April to Mr. James Stephens. Nurse Attkins did good work as visiting nurse, and she takes with her the best wishes of the Association for her happiness in her new life.

That there is need in Wellington for a visiting nurse is quite evident from the fact that the work of the visiting nurse still continues to grow. Our newly-appointed nurse, Nurse Dencker, has as much work as she can cope with. Nurse Dencker was trained in Wellington Hospital, and is well known and much liked by the medical men in the city.

Nurse Stewart has been appointed Matron of our Nurses' Home, and under her rule we are confident that nurses will find the Home a pleasant place to live in. Nurses who have difficulty in finding rooms, or who are not happy in their surroundings, we would advise to give the Home a trial. Nurses visiting Wellington will be welcome.

A dance is to be held in St. Peter's School-room on Friday, May 7th. Proceeds of the dance will go towards paying off the small debt on the furnishing of the Home. We are finding the Home as a centre for the work of the Association, almost invaluable, and members of the Association are earnestly asked to give the Home all the support they can. Eighty members have paid annual subscriptions up to date. Nurses who have not paid their subscriptions by the end of June cannot be enrolled on this year's list of Association members.

SYLLABUS OF LECTURES.

SESSION 1909.

March 11, "Diphtheria," Dr. Herbert.

April 8, "Suprapubic Lithotomy," Dr. McGavin.

May 13, "Obstetric Nursing—As it is and as it was," Dr. Agnes Bennett.

June 10, "Eclampsia and Post-partum Hæmorrhage," Dr. Holmes.

July 8, "Opthalmic Nursing," Dr. Harty.

August 12, "Nursing in Diseases of the Heart," Dr. Gibbs.

Sept. 9, "Gastro-enterostomy," Dr. Young.

Lectures will be given in the Club Room, 237 Willis St., at 8 p.m.

Otago Trained Nurses' Association

December and January being holiday months, no lectures were given. Two very enjoyable social afternoons were given, one in each month, and another in February.

On February 27th a general meeting was called, when we were fortunate in having Miss Maclean with us. The subject of amalgamation was discussed, and a resolution was passed deciding that "this Association do all in its power to forward the movement." Miss Maclean pointed out it would be necessary to form a central council, composed of a certain number of representatives from each centre, suggesting that each of the four Associations should be represented on the council by a vice-president, and three councillors, with a general secretary resident in Wellington. She expressed the hope the matter would be definitely settled in time for the General Secretary to write to the International Council of Nurses, which will meet in London in July, asking for recognition as a branch of that Council. It was proposed that Mrs. Grace Neill be asked to accept the position of President; which was carried unanimously by our Association.

It was proposed, and also carried unanimously, that Miss Maclean be elected Vice-President of the N.Z. Association. Both these proposals are subject, of course, to the approval of the other centres. Letters have been written to the Secretaries of each centre asking for the co-operation of their councils in this matter. Miss Holford, one of our Vice-Presidents, who is away north, has been asked to interview, where possible, the councils of the other Associations, and hear their views, and place ours before them.

Our members elected four representatives whom they wish to act on the Central Council, in the event of this method of forming it meeting with the approval of the other Associations.

A letter and pamphlets have been received from the Secretary of the Royal National Pension Fund for Nurses, which is an excellent way for nurses to provide for sickness or old age. It is open to certificated nurses throughout the world.

A letter was read, which will be published in another column, from Miss Dock, Hon. Secretary of the International Council of Nurses, conveying a cordial invitation to the nurses of New Zealand, to attend the meeting in July.

Members elected as representatives for the Otago branch on the Central Council of the N.Z.T.N.A.—Vice-President, Miss Jeffreys; Councillors: Dr. Will, Miss Holford, Mrs. Milne.

On Tuesday afternoon, 23rd March, the members of the Association were the guests of the President, and Mrs. Will at a garden party, held in their picturesque grounds at Abbotsford.

The President had arranged some original outdoor games for competition which were much enjoyed by the guests. Nurse Eidelberg was the winner of the croquet competition. During the afternoon much amusement was caused by the arranging of a group of the guests by the photographer, who found it a somewhat difficult undertaking to group so many. Later on, those of the Executive Council who were present were photographed together, and two interesting pictures should be the result.

On March 25th Mr. W. Trimble gave a most delightful address to the members of the Association. The subject chosen by him was: "The Thread of Literature," and everyone was intensely interested. About 36 nurses were present. We hope to publish the lecture later.

Owing to the loss of her mother on April 4th, Miss Jeffreys, who has been Hon. Secretary of the Association since its inception, will probably resume her nursing work, and will not be able to continue her work as Secretary. This announcement will be received with the greatest regret by all the members, to whom she has been so helpful, and not the less so from the sad cause.

Miss Holford, while away from Dunedin for her holidays, was able to meet some members of the Council of the Wellington Association, and to attend a general meeting of the Canterbury Association, at which the matter discussed was the question of affiliation, and formation of the New Zealand Nurses' Association.

Canterbury Trained Nurses' Association

On Thursday evening, 18th March, the Canterbury Trained Nurses' Association held its monthly general meeting in the Board Room of the Christchurch Hospital.

By great good fortune, Miss Maclean and Dr. Valentine happened to be in Christchurch at the time, and they both promised to be present and speak to the nurses. Needless to say, with this promise in view, there was a very large gathering of members of the Association. After the business part of the meeting was concluded, the President (Mrs. Irving) said a few words of welcome to Miss Maclean, who then proceeded to give a most interesting address on the subject of amalgamation of the various local nurses' associations, and the formation of a New Zealand Nurses' Association.

At the conclusion of the address, a motion conveying approval of Miss Maclean's suggestions with regard to amalgamation was unanimously passed by a show of hands.

The President then called upon Miss Holford (vice-president of the Dunedin Trained Nurses' Association), who kindly gave an account of how the question of amalgamation had been dealt with in that city.

It was then proposed and seconded, "that should the four Associations amalgamate, and one central Council be formed for New Zealand, Mrs Grace Neill should be asked to be the first President, Miss Maclean General Vice-President, as in virtue of her official positions whose duties carry her all over New Zealand, and bring her in touch with nurses in all parts, she would be able to do much to forward the movement." It was also decided to ask Miss Bicknell to act as Hon. Secretary to the Central Council, her official position also giving her special facilities for usefulness.

The delegates from Canterbury to the proposed Central Council were next nominated and elected by ballot, Mrs. Irving being elected as Vice-President representing that branch and three other delegates—Miss Turner, Mrs. Lester and Miss. Beck.

Dr. Valentine next spoke to the nurses, and gave a most inspiring and helpful address on the subjects of "Hospital Economics," and "The Loyalty of Nurses." We should like to take this opportunity of thanking Dr. Valentine very earnestly for his most excellent and practical remarks.

An animated discussion took place on the eight-hour system at a meeting of the Association on 16th April.

The discussion was opened by Dr. Acland, and was carried on with much spirit for and against the system which is so largely in vogue in New Zealand hospitals.

Five of the medical profession were present, and joined in the debate, and the meeting came to the conclusion that some change was necessary.

We hope to receive a more detailed account of this discussion on a most important question for our July issue.

Some very interesting and instructive lectures are being arranged for the Canterbury Nurses' Association.

Auckland Trained Nurses' Association

Since the last issue of KAI TAIKI this Association has commenced a course of very interesting lectures, which will continue until October.

Already there have been given by Drs. Bedford, MacKellar and Roberton, at the General Hospital, in the Board Room, kindly lent for the purpose until the Association is able to procure a suitable club-room.

A very fair number of nurses have been able to attend these lectures. We were pleased to have Miss Maclean present at the second lecture, during her short visit to Auckland.

A social committee has been formed in connection with the Association. Mr. Alfred Kidd being president, and Mrs. Hughes-Jones hon. secretary.

An afternoon tea was given by Mrs. Kidd at her residence, "Houston," Epsom, to welcome Miss Maclean, who addressed the nurses upon the subject of amalgamation. The

Hon. Mr. and Mrs. Fowlds were also present. The former spoke of the valuable work accomplished by trained nurses, and expressed himself as pleased to be present at such a happy gathering.

Miss Cottman, a member of the Association, has left Auckland on a visit to England, and while there she has promised to visit the chief nursing centres, and obtain any information which might help on our work here. Miss Cottman does not intend returning before October or November.

COURSE OF LECTURES.

Dr. Bedford, "Some causes of Diseases," March 9th; Dr. E. D. MacKellar, "Vaccination," March 30th; Dr. E. Roberton, "The Origin of Antiseptic Methods: The Work of Pasteur and Lister," April 20th; Canon G. MacMurray, "Egypt," May 11th; Dr. T. R. Inglis, "The Treatment of inflammation by Mechanical Hyperæmia," June 1st; Mrs. Leo Myers, "A Wider Outlook for Women's Work," June 22nd; Dr. Pabst, "The Eye," July 13th; Mr. C. H. Hinman, "Palestine," August 3rd; Dr. McDowell, "Typhoid Carriers," August 24th; Dr. P. Buck, "The Maoris," September 14th; Dr. J. S. Purdy, "Flies and Other Germ Carriers," October 5th. Members to be in their seats by 7.45 p.m.

Trained Nurses' Home, Christchurch

On Saturday last a very successful garden party was given by the Matron and Nurses of the Trained Nurses' Home, Salisbury St., about 100 guests being present.

Music was very generously contributed by Mrs. Gower-Burns, Dr. Crooke and Mrs. Collins' Ladies Quintette, which played a selection from "The Prince of Pilsen," and several other numbers, which were much enjoyed by those present.

An amusing feature of the afternoon was a nail-driving competition for ladies, won by Miss Ford; and a hat-trimming competition for gentlemen, in which the first prizes went to Mr. Barrett, second prize to Mr. Cunningham.

A mystic Egyptian Seer, rejoicing in the name of "Ziara" attracted a great deal of attention, especially from the ladies.

A few of those present were Mrs. Julius, Miss A. Julius, Archdeacon and Mrs. Averill, Mrs. and Miss Gower-Burns, Dr. and Mrs. D. Anderson, Dr. Eleanor Baker, Mrs. Bean and daughters, Mrs. Orchard, Rev. and Mrs. Haggit, Mr. and Mrs. Hunter, Mr. and Mrs. Barrett, Dr. Crooke, Dr. Moorhouse, Dr. Nedwill, Dr. Courteney Nedwill, Mrs. LeLievre, the former Matron, Mrs. Moon, Miss Wood, Miss Grant, Mrs. C. J. Hart, Mr. T. D. Harman, Mr. W. T. D. Harman, Miss Collins (Rangatira), Miss Morgan, Miss Wall, Miss Dunsford, Miss Lonagan, and numerous representatives from the various nursing institutions, and private nurses.

The nurses belonging to the Home who were able to be present, wore white uniforms, and assisted in handing round refreshments, and seemed to enjoy the relaxation of being "off duty."

The guests expressed surprise and pleasure at the admirable provision made by the Home for the comfort of the nurses, and for the facilities it provides for those of the public requiring nurses in time of illness.

The Home has been taken over by Miss Hood, who hopes to maintain its efficiency and increase its usefulness to the members of the medical profession and the public; who can rely upon obtaining the services of fully qualified and reliable nurses at short notice, and to the nurses, who will find a comfortable and economical home between their cases. An advertisement is inserted in another page.

Treatment of Headache.

In that type of headache which depends for its existence chiefly upon nervous exhaustion, rest in bed with massage, the administration of tonics, and the support of a tired heart by small doses of digitalis, are usually advantageous. In many of these, patients as soon as they become strong enough to react, hydrotherapeutic measures are exceedingly advantageous. In the early stages, if these is cerebral congestion, a general hot pack, and an ice-bag applied to the head, may be useful. Afterward a cold drip-sheet may be thrown around patient for a moment.

District Nursing in New Zealand

[BY A " COUNTY NURSE."]

The post of " County Nurse," is one of the new openings for nurses in this country, designed to make efficient nursing available for the dwellers in scattered country districts. As these posts are likely to be multiplied, readers of the journal may be interested in the experiences of a " County Nurse."

The appointment, in this instance, is made by the County Council, who guarantee a retaining fee of £1 per week, and also decide the place of residence. The condition is that patients shall not be charged more than a fee of £2 2s. per week, with travelling expenses. Beyond this the Council does not interfere, and the arrangement works smoothly.

The amount of work varies, but expenses are light, and at the end of the year the balance-sheet compares well with that of the city nurse.

The disadvantages of country life are more imaginary than real. The nurse who can forego the stir and excitement of the city for the simpler pleasures of the country, will find ample compensation. I have the good fortune to be stationed at one of the loveliest of seaside resorts. A call to a case usually involves a trip across the bay, very pleasant if the day is fine. Frequently this is followed by a railway journey, and a ride or drive, to reach my destination. There is variety, too, in the homes I visit ; but everywhere I meet with kindness, and solicitude for my comfort, and a very genuine appreciation of the services I am able to render.

The chief drawback to the life is the risk of growing " rusty." The best preventive would be to alternate district, with hospital work. I think, too, that the district nurse should cultivate a hobby in her leisure hours. It will prove a prophylactic against *ennui*, should the health of the district be, at any time abnormally high.

[EDITOR'S NOTE—We should like to draw attention to the advertisement which has been in the papers for a " County Nurse," for the Whangaroa district, in the Bay of Islands. The above account of her work, by Nurse Hames, who is stationed at Russell, also in the Bay of Islands, should assure nurses that they might do much worse, than to accept such a post both from a monetary point of view and from that of an interesting and agreeable life. A letter to the secretary of Whangaroa County Council would obtain details.]

An intimation has been forwarded by Mr. Reeves to the Prime Minister forwarding an invitation from the Liverpool Queen Victoria District Nursing Association for a delegate from New Zealand to attend a Congress, having for its object the commemoration of the Jubilee of the founding of district nursing by the late Mr. Wm. Rathbone.

This congress will be held in Liverpool, to extend over three days, during May next, and invitations are being sent to all kindred nursing associations in Great Britain and the Colonies. How interesting such a meeting will be ! It is to be hoped that New Zealand may be represented, and fortunately a most suitable and able representative will probably be in England at that time, in the person of Nurse Maude, so well known in Christchurch as the founder, together with Mrs. Heaton Rhodes, of the work there.

The other district nursing associations of Dunedin and Wellington arose afterwards, and on similar lines.

We hope steps will be taken to enable Nurse Maude to act as the delegate from New Zealand to this Congress, and that we shall have the benefit of her account of the work and views of the many experieneed nurses who will be present.

Knowing ourselves, our world—our task so great,
Our time so brief—'tis clear if we refuse
The means so limited, the tools so rude
To execute our purpose, life will fleet,
And we shall fade, and leave our task undone.

—*Robert Browning*

Examination for the State Registration of Trained Nurses

In our last issue we gave the results of the December final State Examinations. Below will be found the questions and some of the answers given in the medical and surgical papers, together with the comments of the examiners.

We are sorry we have none of the answers given by the midwifery candidates, as they were especially good; but hope after the next examinations to be able to print some.

Anatomy and Physiology.

1st December, 1908.

TIME: THREE HOURS.

[N.B.—Candidates are expected to answer every question. Answers should be brief and to the point.]

1. Describe a rib, and give the attachments before and behind of (*a*) fifth rib, (*b*) ninth rib, (*c*) eleventh rib.

2. Name the different kinds of joints met with in the body, giving an example of each. Describe carefully the knee joint.

3. Give a short sketch of the systemic and pulmonary circulation. At what points in the circulation do important changes in the character of the blood occur, and what is, briefly, the nature of these changes?

4. What are the chief ferments met with in the alimentary canal? Name the regions where found, and state shortly the part each plays in the process of digestion.

5. Give a short account of the excretion of urine. What amount of urine is excreted in twenty-four hours by an adult, and what are the circumstances which lead to a variation in the amount excreted?

Medical Nursing.

QUESTIONS.

TIME: TWO HOURS AND A HALF.

1. What are the causes of coma? Describe briefly the symptoms and nursing of a case of apoplexy.

2. Describe the symptoms and nursing of typhoid fever. What are the chief complications?

3. Give particulars as to the preparation and administration of nutrient enemata. In what cases are they usually required?

4. Describe the symptoms and nursing of a case of pneumonia. Mention the complications.

5. Enumerate the most common hypnotics, giving doses for an adult.

6. What do you understand by paraplegia, thrombosis, empyæma pneumothorax?

EXAMINERS'S NOTES.

The best replies were undoubtedly given to question II.: "The Symptoms, Nursing, and Complications of Typhoid Fever." Candidates had evidently been well grounded in this subject. Few gross mistakes were made, and the average percentage of marks was high.

The question on Pneumonia was productive of suggestions which, if carried out, might be an evidence of the zeal of the nurse, but would not conduce to the comfort and safety of the patient. Among the recommendations were the following:—That the temperature of the room be from 70 deg. to 75 deg.; that the patient be placed in a steam tent; that the mouth and teeth be cleaned two-hourly, and that the patient be fed on an exclusively milk diet.

Question III., on the preparation and administration of nutrient enemata, met with very indifferent treatment. Few candidates gave any details as to the peptonisation of nutrient enemata; though almost without exception it was recommended that the milk should be peptonised. Still fewer made any mention of lavage of the rectum as a preliminary to the administration of a nutrient enema: most candidates were content with a soap and water enema every twenty-four hours.

Remarkable lengths of rubber tubing—four or five feet—would, in the opinion of more than one, be requisite for a four-ounce nutrient enema.

One candidate would give a four-ounce enema every two or three hours; another would not object to administering four ounces of brandy per rectum in one act—happy patient!

On the whole the replies to this question were very disappointing. Candidates did fairly well as regards hypnotics, though some drugs were mentioned: such as phenacetin, spirits of ether, tinc. camph. co., which certainly are not usually classed under that category.

BEST ANSWERS.

No. 1.

Coma is caused by: (1) Drugs; as alcohol, opium, and other poisons; (2) Fits; apoplexy, epilepsy, also hysteria (*similates*) fainting: (3) Head injuries or diseases; compression, concussion, tumour, etc.: (4) Sunstroke: (5) Suffocation; by water, gas or smoke: (6) Shock; electric, etc.; (7) Anaesthetics: (8) Diabetes: (9) Uræmia.

Apoplexy: The patient, usually past middle life, falls suddenly, the face becomes congested and flushed, the eyes are unequally dilated, one only reacting to light. Temperature will be raised, pulse full and bounding. Respiration: Slow, stertorous. Breath may possibly smell of alcohol, the patient having previously taken some, and very often it has been administered by the first person who saw him. One side of the patient's body will be paralysed, also one side of the face, and should the hæmorrhage be on the left side of the brain, the power of speech will be lost.

Put patient in bed in a warm room, give him plenty of fresh air. Raise the head slightly, turning it on one side to prevent suffocation and to relieve stertor. Protect from falling out of bed. Administer croton oil, m.i, or m.ii if so ordered.

Remove false teeth and examine for and treat any injuries sustained by the fall. Make and keep patient thoroughly clean, as urine and fæces will probably be passed unconsciously, necessitating extreme care of the back, and perhaps constant changing of the bed, which must be well protected by long macintosh. Draw macintosh and sheet while patient is unconscious, avoid giving nourishment by mouth, and later, when he can swallow, restrict him for some time to liquids.

Take and record temperature, pulse, and respiration regularly, four-hourly at first, and keep bowels well opened each day. Attend to general health and comfort of patient, guarding carefully against bed-sores, especially in affected parts. Later, massage and other treatment may be resorted to to restore the affected muscles. Heat must be applied with extreme care (hot tins to feet, etc.), as there is extreme danger of burning. Avoid stimulants.

No. 2.—Typhoid Fever.

Symptoms: First the patient complains of listlessness, drowsiness (especially during the day), headache, anorexia, and general malaise. The temperature and pulse may be slightly above normal. As the attack comes on the temperature is noticed to go up two degrees at night, falling one degree in the morning. Pulse and respiration also become accelerated.

Position: Flat on back. Epistaxis, bronchitis, indigestion, constipation, and possibly retention of urine, are often present. Later, constipation gives place to diarrhœa, stools being the typical "pea-soup" consistency. Delirium comes on. Spots appear in successive crops on the abdomen or back. The tongue becomes dry and brown, sores form on the teeth and lips, and unless improvement sets in, the patient falls into the "typhoid" state: when he picks at the bedclothes, sinks down in bed, passes urine and fæces under him, pulse becomes rapid and weak, and respiration may be "Cheyne-Stokes."

Nursing treatment: Keep patient at perfect rest in bed, forbidding any movement, all of which must be done for him extremely carefully. Atmosphere warm, fresh air but not draughts. Windows and doors must be guarded if patient delirious.

The bed should be narrow and accessible, the mattress fairly firm, and it is desirable to have a second bed or couch in the room.

Patient's clothes (light and warm) are best opened right down the back.

Diet: This is a point about which there is a great difference of opinion; but a nurse's duty consists in carrying out, conscientiously and exactly the doctor's orders. Probably liquid diet—milk (z5), diluted with barley, soda, or plain boiled water (z3), strained beef tea—will be given two-hourly during the acute stage. Chicken broth, custard, beaten eggs, arrowroot, leading gradually on to light diet, according to state of patient. General treatment comprises attention to the general health and cleanliness of patient; guarding against bed-sores by thorough cleanliness of back and bed, and constant slight alteration of position, which decreases tendency to hypostatic pneumonia.

Extreme care in handling patient, especially abdomen. Care of mouth and tongue—glycerine and borax, etc. Thorough disinfection of everything connected with patient: urine, fæces, soiled linen, etc.; also nurse's hands, for which purpose a basin of disinfectant should be kept by the bed.

Take and record temperature, pulse, and respiration four-hourly, reporting any suspicious changes at once. Sponging four-hourly, or even cold packs or cold baths may be ordered to reduce temperature, allay delirium, and promote sleep, or remove perspiration.

Alcohol is administered only under doctor's orders; usually given towards the end of the illness. Watch for, and withhold if symptoms of internal hæmorrhage appear. Drugs, too, are given as ordered, for relief of symptoms, or perhaps to act as disinfectants of the alimentary track. Watch for undigested curd in stools, or blood. Complications: (1) hæmorrhage, (2) relapse, (3) retention, (4) perforation and peritonitis, (5) hypostatic pneumonia, (6) thrombosis.

No. 4—Pneumonia.

Symptoms: Rigor, or feeling of chilliness, followed by sudden rise in temperature (103 deg. 105 deg.). Rapid increase in pulse, which may go up to 120 deg. per minute. Very rapid respiration (40-60 per minute) is one of the most marked symptoms. Anorexia, malaise, listlessness, flushed face, bright eyes, working nostrils, dry brown tongue, and excessive thirst, scanty concentrated urine, constipation, perhaps sickness, sordes on lips and teeth, cough dry and hard at first, then followed by rusty-coloured—or prune-juice—blood-stained expectoration.

Nursing Treatment: Keep at rest in bed, head and shoulders raised, in a very well-ventilated room, protecting from actual draughts. Flannel nightdress and singlet, open down back. Fresh air and oxygen, the last obtained naturally or artificially, are of the greatest importance in treating pneumonia.

Prevent movement, especially sitting or rising up suddenly, on part of patient, as there is great danger of heart failure. Pay attention to general cleanliness and health of patient. Back to be well washed and rubbed to prevent bed-sores. Teeth and tongue to be swabbed with glycerine and borax, lemon, etc. Constantly keep bowels well open, and watch state and quantity of urine. Take and record temperature, pulse, and respiration four-hourly till temp. normal at least a week. Sponge four-hourly if temperature over 102 deg. (as ordered). This also promotes sleep and lessens delirium.

Alcohol, administered by doctor's orders when the state of the pulse indicates its use, is used more freely during this illness on account of its short duration. Drugs may be ordered to relieve symptoms, when it will be the nurse's duty to see that they are administered exactly when, and as, ordered. Watch patient carefully if delirious; also watch for symptoms of overdose alcohol, heart failure, cyanosis, etc.; also false and true crisis, night sweats.

Diet: Liquid during acute stage. About 3pts. milk and 1pt. beef tea in the 24 hours. Administer milk 5oz., water 3oz., two-hourly; beef tea half-pint, twice daily. Give plenty of water to relieve thirst, lemon water, etc. Increase gradually, with doctor's orders, to light diet, as temperature remains normal.

Complications: Heart failure, pleurisy and empyæma, bronchitis, tympanitis, jaundice, gangrene of lung.

Surgical Nursing.

QUESTIONS.

TIME: TWO HOURS AND A HALF.

1. How would you prepare a patient for the removal of a stone in the bladder by suprapubic cystotomy? Describe the nursing for the first week.
2. What instruments are required in an operation for appendicitis? How would you prepare yourself in order to assist?
3. Describe the treatment and nursing of a case of compound fracture of the tibia. What symptoms would make you suspect sepsis?
4. What is meant by "shock"? Describe the symptoms, nursing and treatment.
5. Enumerate the various degrees of burns. Describe nursing and symptoms of a severe case of scald in a young child.
6. How would you prepare (1), saline for transfusion (2), turpentine enema?

COMMENTS BY EXAMINER.

The answers to this paper were, with few exceptions, very satisfactory. The instructions that "answers should be brief and to the point" were, on the whole, consistently

carried out, though a good many candidates erred in the direction of too much padding. In all examinations it is a serious mistake to add extraneous details, in the hope of obtaining extra marks for a comprehensive display of knowledge. Answers must be to the point. Any unnecessary padding only results in the trial of the examiner's patience without any benefit to the candidate.

Care must, however, be taken not to omit necessary details. One candidate, in answer to question I, stated that she would "sterilise the parts in the usual manner." That is carrying brevity to excess for she gives no indication of her knowledge of the subject, and she may, or may not, know the proper procedure.

Generally speaking, the answers to questions I and II were the best, and those to questions IV and V the worst.

The instruments selected for the operation for appendicitis were many and varied. Some of the candidates were evidently prepared for more than usual emergencies.

It would be well for nurses to familiarise themselves with the strength of lotions used in surgical nursing, and not to depend on stock solutions used in the hospitals. One candidate remarks that she would use "boracic lotion, strength half and half," while another recommends for a saline, half an ounce of the concentrated solution to a pint of sterilised water. Such replies are too indefinite to score any marks.

Lastly, mistakes in spelling were so numerous in both papers, that it is necessary to advise candidates to pay a little more attention to correct orthography.

BEST ANSWERS

No. 1.

The patient should have daily hot baths for some days previous to the operation, if he is able, if not daily spongings in bed. Especial attention be given to the lower part of abdomen. The bladder should be syphoned out with boracic lotion two or three times a day, for some days previous to operation. Bowels should be regulated, and given a light, generous diet, and put under as good hygienic conditions as possible. On the afternoon before the day of operation, the patient should have an aperient. The lower part of abdomen, pubes, and perinæum should be shaved.

The part is now prepared for operation. Have ready on tray beside patient: hot sterile water, biniodide of mercury lotion, aseptic dabs, lint, gutta-percha tissue, ethereal soap, turpentine and bandage, sterile guards.

Sterilise your own hands. Get someone to turn down blankets, and to expose operation area. Surround with guards. Wash well with ethereal soap and sterile water. Wash off soap with sterile water. Rub quickly with turpentine, taking care not to burn the skin. Wash off with sterile water and soap. Re-sterilise your own hands. Rub well with ethereal soap. Wash off with sterile water.

Wash with 1-500 biniodide of mercury solution. Wash with sterile water. Cover prepared parts with sterile lint wrung out of 1-2,000 biniodide of mercury. Cover with the gutta percha tissue and bandage on.

The skin of abdomen perinæum, and all surrounding parts, must be cleansed for this operation.

After this preparation put clean nightshirt on patient and leave for the night. Try to secure him a good night's rest if possible. About four hours before operation an enema of soap and water should be given, and not less than three hours before, a cup of beef tea or other easily digested fluid should be given. No solid food should be taken if the operation takes place in the morning; if operation later in the day, a light breakfast might be given, bread and milk, etc. A good plan to give a nutrient enema half hour before operation to keep up strength. About three hours before operation the preparation of parts is repeated. Some surgeons prefer the moist aseptic pad to be now replaced by a dry sterile towel. Before going to the theatre the patient is warmly clad. The nurse sees that the clothing is loose, and that any false teeth are removed.

After treatment.—The patient should be brought back carefully from theatre, avoid jolting. Watch breathing and pulse. Have bed warmed with hot bottles. Lift him carefully into bed. If any vomiting, turn head to one side. Do not leave him until he is out of anaesthetic. If breathing should stop, pull out tongue and apply artificial respiration. Send for the doctor. If the patient suffers from shock, saline enemata will be given. If vomiting is very severe, drinks of hot water (about half a pint at a time) may be given, or soda bi-carb. gr. 15

given with it. Essence of peppermint, 20 drops on a lump of sugar, slowly sucked, gives relief sometimes. Strong coffee, or lumps of ice swallowed whole, sometimes given. If none of these arrest the vomiting the doctor may order the stomach to be washed out by means of a stomach tube; or mustard leaf may be applied to the epigastorum.

The patient must be kept dry. Dressings changed frequently as required. The bladder will probably be drained by glass and india-rubber tubing into a basin by bedside. Bladder may be syphoned out once or twice daily, more often if tubing becomes blocked. Towards end of week tube may be removed. Record of temperature, pulse, and respiration must be kept. Fluid diet for first few days; light food, as milk puddings, etc. later. Doctor's orders carefully carried out. Complications, as cellulitis and uraemia, looked for.

No. 2.

"Instruments required for operation for appendicitis"—

Two scapels, one pair angular scissors, one pair curved scissors, one needle-holder, six needles of various sizes, two retractors, two blunt hooks, one probe, one director, three aneurism needles, one blunt dissector, twelve Spencer-Wells artery forceps, one sinus, one pair toothed dissecting forceps, one pair plain dissecting forceps, four sponge holders, bladder sound and catheter, pedicle needle, intestinal clamps, intestinal needles, two pairs large hæmostatic forceps, eye curette, hernia needle often useful.

No. 3.

Have bed ready, with fracture board and fracture mattress. Put patient on to bed, moving the injured limbs as little as possible. Remove clothes from broken leg: first by splitting the trousers along the seam, and slipping them from under the leg; cut off the boot and sock if not able to remove them easily.

Arrest hæmorrhage, if any present, by pressure; ligature, etc. Sterilise wound and surroundings by washing round wound with ethereal soap. The doctor would probably flush out the wound with some strong antiseptic—1-1000 perchloride of mercury, or 1-2000 biniodide of mercury—then dressing would be applied to wound. Some sutures might be required, or drainage tube inserted if wound large.

While this was being done the leg must be held in position by assistant, to prevent the ends of the bone doing further damage. The doctor would now set the fracture, probably using back and side splints with foot piece; or box splint might be used. The leg would then be supported by a pillow, and steadied by sandbags on either side. Care must be taken to see that the splints are properly padded, and that there is no pressure on the heel or mallioli, or splint sores will result. The splints and bandages are so arranged that the wound can be easily inspected. If the wound can be made aseptic, it will heal about as quickly as a simple fracture.

The bandages must be watched for the first few days to see that they are not too tight, afterwards to see that they are not too loose.

Care must be exercised when examining the leg, during bed-making and use of bed-pan, that leg is not disturbed by too much movement. Bed-sores must be watched for and avoided, also splint sores.

In about three weeks to a month, if the bone has united satisfactorily, the leg may be put up in plaster of Paris, and the patient allowed to get about on crutches. Usually well united by end of two months; but patient must take care of it for some time. Wasting of muscle treated by electricity massage and stimulating liniments.

If the wound becomes septic boracic fomentations will be applied frequently; doctor may order wound to be syringed with some antiseptic: as peroxide of hydrogen. Symptoms of sepsis: Rise of temperature about second or third day, with pain and throbbing in wound. Inflamed appearance of edges on wound itself.

No. 4.

Shock is a severe depression, or lowering of the vital powers, due to excessive nerve energy, and is more severe when the sympathetic nerve system is affected. The depression is chiefly caused by exhaustion of the vaso motor nerves centre.

Symptoms of Shock: Increasing pallor of face, cold perspiration, extremities cold, pupils dilated, pulse and respirations rapid and feeble. The senses are dulled, or there may be unconsciousness.

Nursing and Treatment: Place in warm bed. Hot bottles. Foot of bed raised on blocks, no pillow under head. Saline enemata 1dr. to a pint of sterile water at a tem-

perature of 103 deg. Fah. to 105 deg. Fah. 4oz. given half-hourly. Brandy or strong coffee may be combined with these. Surgeon sometimes injects saline solution at temp. of 105 deg. Fah., either into vein or intercellular tissues. Digitalin, 1-100th gr., and strychnine sulph. 1-60th gr. may be given. If the pain is very severe and prolonging the shock, morphia may be ordered and combined with atrophine 1-100th gr. Stimulants may be given by mouth if the patient can take them; but care must be taken not to carry stimulation too far, as more harm may be done than good when reaction sets in. If patient can take nourishment, give fluids; otherwise nutrient enemata must be resorted to if shock is prolonged. Sometimes the legs are elevated, or bandaged spirally upwards, from foot to thigh.

Midwifery Nursing.

The following are the questions set for the last examination of midwives. The examiner has kindly promised to send some comments, and also select for publication some of the best answers :—

QUESTIONS.

DECEMBER, 1908.

(N.B.—Candidates are expected to answer every question. Answers should be brief and to the point.)

1. What do you understand by the terms "Antiseptic," "Aseptic?" What antiseptic lotions are ordinarily used in obstretric practice, and how do you prepare them?

2. Describe the management of the third stage of labour. If bleeding, follow this stage to what may it be due, and what treatment would you employ in each case?

3. What conditions present in the mother would justify you in deciding that she must not, or is unable to, nurse her baby? If she do not nurse what steps would you take to prevent or suppress the secretion of milk?

4. How would you recognise a breech presentation? Describe the conduction of delivery in these cases.

5. Describe in detail the technique (*a*) of making a vaginal examination; (*b*) of administering a vaginal douche; (*c*) of passing a catheter.

6. By what signs would you recognise that labour had commenced, and in a normal case when would you send for the doctor?

7. What is "Eclampsia"? What symptoms would lead you to suspect that this condition might occur, and in such a case what instructions would you give to the patient?

8. What do you understand by the term "Asphyxia neonatorum?" Describe fully the treatment of this condition.

Royal Heroines

Dealing with the bravery so often exhibited by royal personages in great emergencies, an English paper says :—"The Empress Eugenie atoned for many of the shortcomings laid at her door by the manner in which, on the occasion of the great cholera outbreak in France, in 1866, she visited all the hospitals in Rouen, where the disease was raging with the greatest intensity; while, on another occasion, during a particularly violent epidemic of small-pox, she did not hesitate to go through the hospitals in Paris to encourage the doctors and nurses to remain at their post of duty, although by so doing she risked those good looks, and that beauty, which constituted her principal if not indeed, her only claim to sovereignty.

"Nor would any reference to European monarchs in this connection be complete without a brief mention of the widowed Queen Amelie of Portugal, who, having rendered herself immune from diphtheria by inoculation, with the object of removing the popular prejudice against this form of vaccination, was wont, until the murder of her husband and her eldest son, a year ago, to visit the diphtheria wards of the Lisbon hospitals each week. She showed an even still greater bravery at the time of the last outbreak of the bubonic plague in Portugal. While it lasted she appeared daily in the hospitals, and herself acted as the nurse, and attended the deathbed of a young physician who succumbed to the malady while ministering to the stricken. She is a trained nurse and a full-fledged physician, being the only occupant of a throne who is entitled to add the letters "M.D." to the list of her dignities."—From the *Dominion*.

King Edward has given the decoration of the Royal Red Cross to Her Majesty Queen Elena in recognition of her services in Messina after the late terrible disaster.

A Talk About Tolstoy

(A lecture delivered before the Dunedin Trained Nurses' Association, by A. H. Grinling.)

Invited to talk to you about Tolstoy, I am faced with the fact that to the members of this Association, accustomed to discuss subjects of a more or less technical character, my selected topic is outside your usual range; and yet perhaps, not so far divided from the world in which you live and move, and have your being, as at first sight appears. For the relation of literature to life is exceedingly intimate; indeed, literature, in more senses than one, is the reflection of life itself. Many of the most notable reforms which the world has seen were pioneered in literature.

As a popular example of such pioneering, permit me to claim Charles Dickens as the virtual founder of the Trained Nurses Associations; for he it was who set the forces in motion which evolved from the "Sairey Gamps" and "Betsey Prigs" of sixty years ago, with their odious vices and criminal incompetence, which rendered the very name of nurse a by-word and a scandal, the scientifically trained and well disciplined ladies of the nursing profession to-day. For as Dickens declares in his preface to "Martin Chuzzlewit," in the year 1884: "Mrs. Sarah Gamp was a fair representation of the hired attendant on the poor in sickness, while Mrs. Betsey Prig was a fair specimen of a hospital nurse." Foster tells us, in his "Life," that the original of Mrs. Gamp was in reality a person hired by a most distinguished friend of Dickens' to take charge of an invalid very dear to her, and the common habit of his nurse in the sick room, was to rub her nose along the top of the tall fender.

It is one of the triumphs of the humour of Dickens, that while on the one hand he has immortalised Mrs. Gamp, on the other, by his gentle satire, he virtually put an end to her existence. Could there be a greater contrast than the neatly-uniformed, well trained, and sympathetic nurse of to-day, and, what Foster dubs, "the portentous Mrs. Gamp, with her grim grotesqueness, her filthy habits, and foul enjoyments; her thick, and damp, but most amazing utterances, her moist, clammy functions, her pattens, her bonnet, her bundle and her umbrella." Yet Charles Dickens was the men who set rolling the ball of public opinion, which within the last half century has brought into being this and its kindred Associations, and who is therefore fully entitled to be styled the patron saint of the nursing profession. Should there be anyone present not sufficiently grateful for the proud position at present occupied in the community by the members of the medical profession, and for the respect in which they are now universally held, I would advise them to turn again the pages of "Martin Chuzzlewit," and peruse that delightful chapter in which the reader is brought into communication with some professional persons to wit, "Sairey Gamp," and her friend and acquaintance "Betsey Prig," to say nothing of her "alter ego," the mysterious Harris.

This digression into the realm of Dickens and his characters gives birth to the thought of what a delightful study it would prove to introduce you to the nurses of fiction, commencing at the heights of world literature, with the great Shakespeare, who created Dame Quickly, and Juliet's nurse; right down past Sterne's Dr. Slop and the nurse, and Susannah Tristram Shandy, to the nurses of the present day. But this takes me away from my first point, which is that the seed of every great reform which the world has known, has been sown by one or other of the great writers of the world. Charles Dickens is responsible for many of the reforms which, during the last half century, have blessed the people of England. Count Leo Tolstoy for the past 30 years at least, has been actively engaged in sowing the seed of great and sweeping reforms, which must ultimately bring forth a mighty harvest of happiness in Russia, freeing the people of that vast empire from the bonds of oppression and the fetters of tyranny by which they are at present so grievously bound.

There is another reason why a study of the life and work of Tolstoy should prove helpful and inspiring to the members of the nursing profession. I have lately been reading a most fascinating book called "Confessi Medici," written by a doctor, and manifestly a modern version of old Sir Thomas Browne's

quaint and famous treatise, " Religo Medici." In his opening chapter this doctor remarks on the difference between profession and vocation, that the doctor has a profession, while the priest has a vocation. And he then proceeds : " It is certain that some men are indeed called to be doctors, and so are some women. They are, as we say, born doctors ; they were shapen in medicine. So apt are they to their work, and it to them, that they almost persuade me to hold the opinion with Pythagoras, and to believe that in some previous existence they were in general practice. Or their ability may be the result of inheritance ; but we know next to nothing about inheritance, neither is it imaginable by what physical processes the babe unborn is predisposed for one profession. Still, there are men and women, not a great number, created for the service of medicine, who were called to be doctors while they were not yet called to be babies."

Certainly these remarks, if true, concerning the medical profession, are doubly true of the nursing profession—which is yet another digression. But in the following chapter of the same book, there is an essay on " Hospital Life," in which the writer remarks that " sickness shows us things as they are, the mask is torn off, the facts remain. That is the spiritual method of the hospital, it makes use of sickness to show us things as they are." It seems to me that it is impossible for any thoughtful men and women to be engaged in a profession which brings them into such close and continuous contact with sickness, without over and over again asking themselves the question : " What is the meaning of life, why did we come into this world, to what purpose and for what end ?"

Now, the reason why Tolstoy differs from his fellow-men is, because, almost as soon as he began to think, he asked himself this question concerning life ; and, not content with the self-inquiry, he has endeavoured to inspire others to ask themselves. And so far as his own country and his own countrymen are concerned, the future of Russia depends largely upon the extent to which adequate reply is forthcoming to the question.

In order to understand Tolstoy, and obtain a grasp of his meaning and ambitions, it will be well to take a preliminary glance at his environment, his country, and his times. Professor Weinen, whose " Anthology of Russian Literature," is one of the best authorities on the subject, points out that the peculiar conditions of Russian literary life are the result of the whole social structure of the country. The literate class of the people of Russia is, at the present time, but a small part of the total population, and the cultured elements of society form but a small percentage of all those who can read and write Russian. Thus literature has been in Russia the field in which all the battles of progress have been fought. As there does not exist a representative government where political opinions may struggle for recognition, and as there cannot exist a public opinion based on tradition and class interests, literature alone appears as the medium for advancing social and political ideas ; and, since scientific treatises reach but a vanishing proportion of the nation in Russia, the main means of inculcating and propagating great truths has been literature, notably stories and preferably the short story. In the telling of these latter Tolstoy pre-emintly shines. Some good examples of these stories will be found in a small shilling volume in the World's Classics entitled, " Twenty-three Tales by Tolstoy," and the gem of the collection is undoubtedly the story entitled " Where love is, there God is also."

Although still living, Tolstoy certainly belongs to a group of writers and thinkers who have stamped their names indelibly upon the record of the latter half of the nineteenth century. Balzac has said that there are three classes of men in the world : Those who revolt, those who struggle, and those who accept," and the pages of history represent the successive cycles of revolution, struggle, and acceptance on the part of nations and individuals. But, whilst struggle and acceptance may be carried on in the mass, the action of rebellion necessarily implies a leader. Thus the prelude to revolution in any department of life or section of society is the uprising of men of genius, leaders of thought, avenues of expression for the mutterings of the multitude. Thus in the latter half of last century arose a notable quartette, whose attitude of revolt against custom and convention has paved the way for the social revolution now in active manifestation amongst us. And curiously enough each of the four represented in his own person, one of the four forms of popular expression : viz., philosophy, the drama, music, and literature. Thus it is no figure of speech to dub Leo Tolstoy the foremost living man of letters ; he is that and much more. He

represents the only survivor of the remarkable quartette who dominated European literature during the latter half of the nineteenth century. With Frederich Wilhelm Nietzsche, the German moralist (1844-1900); Emil Zola, the French novelist (1840-1902); and Henrik Ibsen, the Norwegian dramatist (1828-1907): Leo Tolstoy, the Russian reformer, constitutes the four presidents of dying nineteenth century literature. And Tolstoy has this in common with the other three that, although his fame as a novelist has gone out to the ends of the earth, he is far from being a mere professional story-teller. He is an original thinker; he is the leading man of his race; he is a social reformer, and he is an interpreter of religion. He has written a number of novels, a multitude of short stories, sketches, social, religious, and art studies, chapters of biography, and tracts dealing with almost every subject under the sun. Roaming over every field of human life, he has discussed in turn such all-embracing topics as the authenticity and harmony of the gospels, the evils of militarism, and nationalisation of the land; the relation of the sexes, the ideals of education, the mistake of patriotism, and the limits of government, social organisation, art, industry, wealth and poverty. The list of publications and translations which bear his name fill more than 40 pages of the catalogue in the British Museum. He is a good linguist, reading English with facility, and speaking it well, besides having a full command of Russian, French, and German. He also has a knowledge of Italian, and a good grounding in Greek, besides a smattering of Latin and Hebrew. He belives in learning languages because such knowledge promotes the brotherhood of man, or rather that closer intercourse which must eventually bring brotherhood about. He is a personage of such world-wide significance that he is, in a sense, above government, for he has secured for himself freedom of speech and immunity from imprisonment or banishment by sheer moral and intellectual ascendancy. The wonderful extent to which Tolstoy has freed himself from the hampering and injurious effect of an untoward environment may best be gauged by glancing for a moment at the conditions of life in Russia, and by calling to mind the fate which overtook many of the novelists' predecessors, friends, and contemporaries. Here is the tragic tale condensed into a sentence by a writer in a recent issue of the "Edinburgh Review"—"Rykeief was hanged as a conspirator; Gogol committed suicide at 43; Pushkin was killed in a duel at 38; Lermotnoff, twice in exile, died in the same way at 30; Shevtchenko, beaten, tortured and robbed by imprisonment of half his life, died at 47; Venevitinof succumbed to insult and outrage at 22; Koltzof died at 23 of a broken heart; Belinsky perished of starvation and consumption at 38; Chernishevski, after two years imprisonment, was sentenced to the mines at 35; Herzen was imprisoned, twice exiled, and finally banished; Dostoyevski, led out to be shot at 27, was only released from Siberia ten years' later, broken in mind and spirit." Yet, as Professor Wiener remarks: "Nor can Governmental policy, nor severity of citizenship be made accountable for the short-lived literary influence of each individual Russian author, nor for the early maturity of genius, and the wide chasm between the author's sunny youth and his old age in the same instances when he has lived beyond his fifties. At 40 years of age, rather earlier than later, all Russian writers have reached their apogee. Most authors have gained their reputation long before that, and their old age passes by unnoticed, or in mystic abstractions, and in nearly all cases out of tune with the realities of the day.

Thus, in striking contrast to the pathetic passing at an early age of so many of his contemporaries, we see Tolstoy, more than 80 years of age, and possessed of comparative vigour of body and full vigour of mind, it may be said of him in a very real sense, that he has found the truth, and the truth has made him free. As uncompromisingly and impossibly individualistic as Ibsen, albeit in a radically different way, his name has become the watchword of a cult, and the battle-cry of an unorganised body of disciples, to whom he has been a voice in the wilderness rather than a leader to a definite reconstruction of society. To quote Loliee, "The influence of Tolstoyism, like the Darwinism of another branch of letters, has been one of the most powerful factors of modern thought." One of Tolstoy's outstanding characteristics is transparency allied to an intense sincerity. He despises concealments and compromises of every kind. Thus his writings are human documents in which his own personality figures prominently; his real biography is to be found in his novels.

Manifestly, it will not be possible, in the brief time at my disposal, to give more than a bare outline of the remarkable career of a remarkable man. Leo Tolstoy was born on 28th August, 1828, at Yasmaya, Polyana the now world-renowned estate, situated about 150 miles south of Moscow. His ancestry is highly aristocratic, he being descended at several removes from St. Michael, Prince of Montenegro ; his father was Count Nicolai Tolstoy, and his mother Princess Volonskaya. The family of Tolstoy's father had rendered great service to the Russian Government, and had held high official positions. When Tolstoy was two years of age his mother died, and he, with his brothers and sisters, was handed over to the care of a distant relative, a maiden lady—Tatyana Yergotskaya. Seven years later, in 1837, Count Nickolai removed to Moscow to give his eldest son the opportunity to enter the university. But in that very year the Count died suddenly. In 1843, when he was fifteen years of age, Leo entered Kazan University, but rebelling under its discipline, he left suddenly three years later, having spent one year at oriental languages, and two at law, and returned to Yasnaya Polyana, which he inherited under his father's will. To rightly understand Tolstoy's character, and the impulses and environments which went to make him what he is to-day, a careful study of "Childhood, Boyhood, and Youth," is essentail. The first of these three stories, "Childhood," to be shortly followed by "Boyhood," was contributed by Tolstoy in 1852, when he was but 24 years of age. This marked the commencement of Tolstoy's career as a writer. The stories were a great success. They were essentially biographical, and in them the reader may gather the remarkable evolution of a remarkable temperament,

Young Tolstoy's type of mind was a strange mixture of passion, intimidity and idealism. Instances of all three qualities are to be found in abundance in the self revealing pages of this book. His childhood was a tragedy, consequent upon his introspectiveness and compunction, and he was particularly sensitive in regard to his personal appearance. This comes out in almost all his novels, for every character which claims to be autobiographical is depicted as uncouth, ungainly, and awkward in the extreme. He was unhappy because he was misunderstood, he chafed against his artificial environment, and yearned for a life of freedom. Especially did he rebel under the discipline of school and university, since his instincts demanded that he should follow his own desultory fashion of picking up learning. Each and all of these characteristics may be traced in their fuller evolution in the subsequent phases of his after life. His almost uncontrollable passion, with its inevitable reaction, led him to indite a violent protest against modern love and marriage ; his morbidity and introspection caused him to explore the sphere of religion and ask, and endeavour to answer the question : "What is Life ?" His dissatisfaction with existing educational methods impelled him to experiment with school teaching among the peasants ; his love of nature caused him eventually to adopt the cult of the simple life.

The dominant note of "Childhood, Boyhood, and Youth," is its severe simplicity. The following brief extracts instance this, and, in addition, reveal something of Tolstoy's sensitiveness and morbidity :—"I remember very well how once—I was six years old at the time—they were discussing my looks at dinner, and mamma was trying to discover something handsome about my face. She said I had intelligent eyes, an agreeable smile, and, at last yielding to papa's arguments and to ocular evidence, she was forced to confess that I was homely ; and then, when I thanked her for the dinner, she tapped my cheek and said : 'You know, Nikolinka, that no one will love you for your face ; therefore you must endeavour to be a good and sensible boy.' These words not only convinced me that I was not a beauty, but also that I should without fail become a good, sensible boy. In spite of this, moments of despair often visited me. I fancied there was no happiness on earth for a person with such a wide nose, such thick lips, and such small, grey eyes as I had. I besought God to work a miracle to turn me into a beauty, and all I had in the present or might have in the future I would give in exchange for a handsome face."

The boy's mind was full of fancies, his imagination was a vivid one. He had been punished for some slight offence by his French tutor, St. Jerome, and the iron of the disgrace had entered into the sensitive soul. Under the heading of "Fancies," Tolstoy indulges in the following strange soliliquy :—"It occurs to me that there must exist some cause for the general dislike and even hatred

of me. (At that time I was firmly convinced that everybody, beginning with grandmamma and down to Philip, the coachman, hated me, and found pleasure in my sufferings). It must be that I am not the son of my father and mother, not Volodya's brother, but an unhappy orphan, a foundling, adopted out of charity, I say to myself; and this absurd idea not only affords me a certain melancholy comfort, but even appears extremely probable. It pleases me to think that I am unhappy, not because I am myself to blame, but because such has been my fate since my very birth, and that my lot is similar to that of the unfortunate Karl Ivanitch."

For the next four or five years Tolstoy alternated between Yasnaya Polyana, and Moscow and St. Petersburg. Externally, while in the cities, he led the life of most young men of the Russian aristocracy, but internally he experienced a continual reaction against the dissipated life he was leading.

Thus his carouses and orgies at Moscow and St. Petersburg were followed by seasons of sincere repentance at Yasnaya Polyana. An insight into his riotous course of life—possibly somewhat exaggerated and dramatised—is given in his "Notes of a Billiard Marker," translated into English as, "The recollections of a Scorer." The same atmosphere and environment is also reflected in "Albert," and "Lucerne."

In 1851 his eldest brother, Nikolai, fresh from the Caucasus, came to stay at Yasnaya Polyana, and Leo Tolstoy eagerly embraced the opportunity to escape from his distasteful surroundings, more especially as he had become financially embarassed owing to the contraction of considerable gambling debts. Thus, renouncing the life of an ideal aristocratic youth, he volunteered for the Caucasus, and entered the military service, and received as a non-commissioned officer, or yunker, he went to serve in a Cossack village on the banks of the Terek. His experiences at this time are vividly recorded in "The Cossacks." Here, amid the beautiful mountain scenery of the Caucasus, the literary instinct which had lain dormant in Tolstoy's mind began to awake. It was while here with his regiment that he sent to "The Contemporary" his first literary experiment—"Childhood."

(To be continued.)

Scarlet Fever

The *Journal of the American Medical Association* says: "The advantage of hot, or at least warm, water bathing in scarlet fever is well set forth by D. H. W. Rover, of Denver, in *Colorado Medicine*. He premises the discussion of the hot water treatment of this disease by the statement that "what the cold bath is to typhoid fever, the hot bath is to scarlet fever." The advantages of hot baths in this disease are that they hasten the completion of the eruption; quiet restlessness, and prevent cerebral excitation; dilate the perepteral blood vessels and increase heat radiation and diaphocesis, which is often absent in this disease; tend to prevent itching; relieve the congestion of the kidneys due to dry skin; make disquamation more rapid, and tend to remove, daily, the dry epsichemis that, if not prevented by oily applications, will fly about and supposedly spread the contagion.

With a warm room and a bathroom handy there is no question that hot or warm bathing in scarlet fever is an advance in the treatment of that disease. If a hot bath is not available, hot water sponging should be done daily. If, during the disquannative stage, much itching or irritation is present, or the skin is dry; rubbing in some clean olive oil, or some clean, diluted wool fat preparation is advisable.

While the patient may be sponged finally before he leaves the sick room with some mild antiseptic solution, there should be no daily application of germicide, lest absorption and poisoning take place.

While there is some doubt whether the epidermal scales of scarlatina are the cause of the spread of the disease, until there is proof that such is not a means of propagation, the patient should be isolated until scaling is complete, and, as Rover has emphasised, hot baths and inunction of oil will hasten the completion of the disquannation."—*American Journal of Nursing.*

Nursing Journals from Abroad

There has been so much of interest in many of the recent nursing publications that we have been tempted to make large excerpts and reprints of whole articles ; but our space has forbidden this indulgence, and we can only advise nurses to read as many of the different journals as they can. It will now be possible, when so many nurses clubs and residential homes are being started, for members to see these papers regularly.

In a recent *Nursing Times* there is a very good article on the establishment and equipment of a nursing home ; different sections of the article are written by members of the medical profession, and by trained nurses who have had experience in this class of work. The requirements as regards staffing are quite out of the question in this country, it would not be possible here to carry on an establishment as described, where the fees expected from patients reach so high as twelve guineas, and the salaries given to trained nurse are as low as £36 or £30 per annum. The exact reverse is the case—Patients rarely pay more than three, four, or in a few cases, five guineas, and the salaries paid to trained nurses are from £52 to £100 a year. It is therefore necessary to limit the number of trained nurses, and to employ a certain number of probationers, who will receive £25 per annum and upwards, for any but special nursing duties. Then the problem of whether or no training can be given in a private hospital is a very live question here. It is absolutely necessary if the proprietress of a private hospital is to cover expenses and make any profit at all, to have a certain amount of untrained assistance, and in a well-equipped private hospital of about twelve beds, to which patients are sent by up-to-date surgeons and physicians, the probationers get very valuable instruction and experience in the course of a few years. The Government regulation is that there must be a registered nurse for every six patients.

We would much like to receive an article from a nurse conducting a private hospital here, describing her experiences.

The *British Journal of Nursing* is, as usual full of interesting matter ; not least being the latest news concerning State registration. Nurses should all read this journal, as by it they are kept up to the details of nursing progress in varied directions all over the world. We would like to copy much, but then KAI TAIKI would no longer be the New Zealand Nurse's own journal.

La Garde Malade Hospitaliere, in its January number, has an interesting account of a hospital in Algiers, the conditions of which take one far back. There is also translated an account of the Army Nursing Reserve in New Zealand, which was given some time ago in the *British Journal of Nursing.* We regret that we have no further progress to report of this movement.

The American journals are also full of interest. We have received copies of the American *Journal of Nursing,* the *John Hopkins Almanac Magazine,* and the *Canadian Nurse.* In the March number of the latter, there is an article which we shall reprint, the conditions described being so similar to our own, and the article containing many useful hints for us :—

"NURSING IN THE BACK-BLOCKS."

In connection with the little paper sent by a nurse working under a County Council in a distant country place, it may be interesting for the nurses of New Zealand to learn how the same difficult problem of providing nursing care for those far away from the large centres is exercising the minds of members of their profession in Canada. In a recent number of the *Canadian Nurse,* is a most interesting article dealing with this matter. A great difficulty has been propounded by the Inspector-General of Hospitals, who has on several occasions spoken to various assemblages of nurses, and appealed to them for help in carrying out his idea. It is, as you have read in previous numbers, a system of district nursing in the back-blocks under the various Hospital Boards. Steps are already being taken to institute the system, and it is hoped during this year, to establish nurses in many parts to carry out the work. The plan described by the Russell County nurse is a little different, and inasmuch as the nurse is at more personal risk, perhaps not so good moreover the very poorest are not catered for. Do not let it come to pass that there are no volunteers for this most necessary work and that, as recently happened, a nurse who is not fully trained, or a registered nurse

of New Zealand has, for default of one of you, been appointed County nurse. What will have to be done if this is the case will be to get nurses sent out by the Colonial Nursing Association, which supplies Nurses from the training schools in England for many of the British colonies.

Here let us quote from the *Canadian Nurse*, and you will see how like our conditions are.

"Miss Laut spoke of the dearth of nursing care for poor women in the more thinly settled parts of the West. She took the point of view (and most justly) that every child has the right to be "born well"—that is to say, that the best of nursing care should be afforded both to the mother and child at that critical time when their whole future is at stake, whether they are able to afford to pay for it or not. Miss Laut regarded this matter as of national importance, and who can assert that it is not? She asserted boldly that these women are not given a fair chance, that they do not, and under present conditions, cannot receive anything approaching adequate care and assistance.

Those of us who have worked in the gynæcological wards of any large Western hospital need no further argument to convince us that women are not cared for as they should be from an abstretrical point of view. Nurses in small Western hospitals can also give some experiences at first-hand which are tolerably ugly. To take one instance in the writer's personal experience: A woman, thirty years of age, English by birth, and possessing both education and refinement, was brought into the hospital (the usual type of small Western Hospital) lying on straw on a waggon box, twenty-five miles over an unspeakable trial. She had been confined three days previously. No doctor had been present. They had no neighbours within ten miles. Her husband had cared for her as best he could, had done the necessary housework, and looked after two children under seven years of age. On the second day she had attempted to rescue the youngest child who was crawling about too near the hot stove. The result was a severe hæmorrhage. It is not necessary to go into further details other than to say that on the seventh day she died at the hospital, crying out with her last breath against this cruel lonely West. This object lesson left an ineffaceable impression on the writer's mind, the more so because her particular hospital refused to take obstetrical cases unless they could afford to pay.

It will, of course, be said that the woman's husband was to some extent responsible. But, was he? They were living on a shack on their own homestead. They had been out from England for a year. They were struggling against debt and homesickness. The crop had been a bad one. In other words, they had the bare necessities of life and no more. They could no more afford to pay for a doctor and nurse than they could fly. And the hospital did not take free obstetric cases. There you have the matter in a nutshell. It cannot be said that cases like the above are by any means rare. Any country doctor can match it from his own experience time and time again."

We know that cases such as this occur in the sparsely settled parts of New Zealand also. The writer goes on to propose schemes by which hospitals may be established to take such cases, but

"By no means all women can or will leave their homes for the hospital at this time. Here is the crux of the situation. The problem now is double. The domestic side intrudes itself here as it does in all phases of nursing. Private nurses in the West know to their cost that a case in a farmhouse of the poorer sort usually entails not only the care of the patient night and day, but the responsibility of the domestic menage as well. With all due deference to our literary critics, this is too heavy a load for the average woman to bear. We bear no malice either to Mrs. Cran or Miss Laut, but we must express an earnest desire to see them attempt this dual role in their own proper persons for the short space of one week. At the end of that time we feel sure that these ladies would acknowledge the fact that no one human being can conduct a maternity case with one hand, as it were, and get the children ready for school and put out the washing with the other. It is not a matter of a nurse being above housework. Tasks fall to the lot of every nurse beside which the most menial domestic drudgery might be deemed æsthetic. This is simply a matter of physical incapacity.

It seems to the writer that this question of nursing these women in their homes will be met in the long run by an extension of the sphere of the Victorian Order of Nurses (District or Visiting Nurses). The domestic side of the question should not be shouldered upon the nursing profession entirely. They have sufficient responsibility already.

The scope of the smaller hospital must be increased, and the work of the Victorian Order, or some other order along its lines, must be greatly extended. This means volunteers, and it means money. Both surely will be forthcoming. Whatever scheme is adopted will require considerable outlay at the beginning, but in time, if properly conducted, the enterprise might be partly self-supporting.

Pioneer work is beset at best—hard enough for the men, and cruelly, sometimes unbearably, hard for the women. Still hard as it may be, there are now, and will be for many years to come, women who having set their hands to the plough in this last work, will not turn them away until the

furrow be completed. New country is opened up every year. One task only grows the more difficult for being put off. One's critics notwithstanding, we have done much. The Victorian Order has done much. All honour to them both. Most of all, the private nurses deserve every praise. Many of them take their cases as they come, and go as cheerfully to a desolate farmhouse as to a rich Winnipeg home. But it is not fair to thrust the burden on individuals. We should take counsel together, East and West, and find out how best we can answer, and quickly, the exceeding bitter cry of our pioneer sisters of the West for help and succour."

How true all this is, how applicable to our new country here, and to the work our nurses have to do for those who are struggling to make a living away in the back-blocks—in the roadless North. When called for to assist with the institution of the back-blocks district nursing system, let us hope many volunteers may come forward and may leave the towns, where, though they are needed, the need is not so urgent.

Insurance for Nurses.

I should like to draw the attention of nurses to the advantages of making some provision for their future. For some years I had thought of insuring my life, but I had always put it off because I was again and again confronted with the thought, What should I do about the payments if I could not nurse any more, or was out of work for a time through some illness? Then I heard of an Insurance Company in which it is possible to take out a policy payable in a certain number of years with an accident policy attached in which one can insure against septic fingers, sprained ankle, appendicitis, pleurisy, scarlet fever, in fact any accident and almost any illness that would prevent a nurse carrying on her work. Say one insured for £500, payable at 50 or 60, if totally permanently disabled the Company undertakes to pay the policy holder £500 down, and the policy is still carried on by yearly payments, and £500 with bonuses is again paid at the age agreed upon. If totally temporarily disabled a nurse would receive £3 weekly for not more than 26 weeks. If permanently partially disabled, £250 down; if temporarily partially disabled 15s. weekly.

In any case a nurse gets good interest on her money, and the oftener she has accidents or illnesses the more she gets out of her insurance.

A probationer recently fell and hurt her knee, and was in consequence off duty for five weeks; if she had been insured in this Company for £250 she would have received 30s. a week during the whole of that time.

I blistered my hand one day against the steriliser; if I had scrubbed that hand I would have taken the skin off and run the risk of getting it infected. I was therefore temporarily partially disabled for a few days, and I got 10s. for that blister.

For example: A nurse aged say, 30, insuring for £250 payable at 55, would pay a yearly premium of £11 8s. 2d., or under 5s. per week. For that she gets 30s. per week for any accident or almost any illness which totally disables her.

The Australian Widows Fund Life Assurance Society issues such a policy, and full particulars can be obtained from the resident secretary at Wellington, or from any of the district inspectors in the Dominion.

H. Inglis.

The Interstate Medical Journal says Nobecourt and Merklen (*Revs. Mens des Mal de L'Enf.*) have studied a series of cases to determine she normal temperature curve in nurslings. They find that the infant does not present the line of variation commonly seen in the adult, even in health. The infant has a monothermal temperature, with little variation in the morning and evening. This monothermal temperature is constantly found in normal infants at least up to the fifth month in life. Interference with this regular line betokens always a pathological condition.

Insanity and the Nursing of the Insane

(BY T. J W. BURGESS, M.D., in the *Canadian Nurse.*)

During the early dawn of human history, insanity was regarded as of divine origin, and its treatment was confided to the priests, who, as a rule, treated those so afflicted with kindness and consideration.

In the fifth century, B.C., for a period known as the Hippocratic period, there were enlightened views of insanity, owing to the wise and advanced teaching of Hippocrates, justly designated "The Father of Medicine." He first recognised the true nature of mental disorder, *viz.*, that it is only a manifestation of actual bodily disease, the brain being the part affected, and laid down rules for the humane and rational treatment of those mentally afflicted.

The world, however, was entirely unprepared to follow the course advocated by Hippocrates, and from the commencement of the Christian era down to nearly the beginning of the past century, there was a return to primitive superstition, but with this great difference--insanity was no longer looked upon as of divine origin, but regarded as due to demoniacal possession. In consequence, lunatics were almost universally treated in the most brutal and barbarous way.

It is only during the last century that insanity has again come to be recognised as a bodily disease, or that rational treatment of it has been practised. In fact, during the past 70 years the advance in the care and treatment of the insane has been greater than for two thousand years previously.

Among the advances made in recent times, not the least has been the nursing of the insane, or, as it is now often termed, mental nursing. The problem of the proper nursing of this deeply afflicted class arose with Pinel and Tuke in 1791. For many years after their time, however, it was doubted by the majority of alienists whether the humane and sympathetic service required for the insane would ever be gained unless it were prompted by a purely religious spirit.

Mental nursing proper, though said to date back over 70 years, that is, even prior to the development of the nursing of phyiscal ailments, nevertheless received no great attention until the period from 1880 to 1885, during which years the movement to establish training schools for mental nurses, as well as emphasize the general hospital idea in asylum work, was successfully inaugurated by Dr. Edward Cowles, of the McLean Asylum, at Somerville, Mass. Since then the movement has grown so largely that to-day, the mental nurse differs as much from the "keeper" of 50 years ago, as does the sick nurse of the present time from the "Sairy Gamp" of the immortal Dickens.

As a rule the nurse trained only in general hospital work does not take kindly to the care of the insane. There seems to her to be little to do for a patient who has no appreciable bodily ailment, and so she is prone to think that the work is not calculated to call into activity the highest qualities of the nursing profession. Never was greater mistake. In the whole category of ills that flesh is heir to, there is no disease that requires more skilful and careful nursing than mental disease. Patience, tact, watchfulness, courage, fertility of resource, forbearance under the severest provocation, ability to assert authority without violence, and to command the affection as well as the respect of a patient, presence of mind and judgment in emergencies, capacity to carry out intelligently the details of treatment as directed by the physician—all these qualities are required for the proper treatment of the insane in even a much higher degree than for those afflicted only physically.

Some of you may feel disposed to dispute this. Take however, for example, the matter of nutrition, and you will see at once how much greater an importance it assumes, when the object of your care is insane instead of sane. In the case of the latter, your patient is anxious to assist your efforts for his comfort, to meet you half way in all measures for his care—lack or capriciousness of appetite is all you will have to contend against. In other words, the sane patient, as a general rule appreciates his condition, is anxious to get well, and helps all he can in any treatment that may be prescribed for him. Not so with the insane. Here, while there may still be lack or capriciousness of appetite, we

may have added thereto absolute refusal of food, or even actual opposition to all efforts to induce the patient to eat. This, mayhap, from fear of being poisoned; an idea that he does not need to eat to sustain life; or a desire to commit suicide by starving himself to death. But, whatever the reason for the refusal of food, there is no disposition on his part to meet you half way, no effort to assist in any measures devised for his comfort or cure.

There is thus, as you can easily see, a vast difference between the two forms of nursing, a difference thus aptly illustrated by Dr. Cowles in one of his reports on the McLean Training School:—"A nurse of large experience in mental nursing, after a term of service in a general hospital, was asked what the difference was between the two kinds of nursing. She answered: 'In a general hospital, the patient must please the nurse; with the insane the nurse must please the patient.'"

Were I asked what, in my opinion, would constitute the ideal trained nurse, I would, without hesitation say: A thorough course of training in a hospital for the insane, followed by the regular hospital course.

As a rule, the insane can be much better cared for in institutions devoted exclusively to the treatment of mental disorders, than at home; but there are times when removal to such an establishment is for some reason deemed inadvisable. Consequently cases of insanity are liable, now and again, to be amongst those of which the ordinary sick nurse is asked to take charge. For this reason it is advisable that she should add at least some knowledge of mental nursing to her *repertoire* of accomplishments, a task in which I feel honoured by having been asked to assist you.

To render intelligible what I have to say about the nursing of the insane, let me first devote a brief space to telling you something about what insanity is, and the forms of the disease most frequently met with.

The fundamental principle of a mental nurse's education must be the fact that insanity is a disease; that insane acts and ideas as surely spring from a morbid condition of the brain as a bilious attack springs from a morbid condition of the liver. It is hard to realise that it is possible for a person seemingly well and strong, able to eat three square meals a day, and capable of moving vigorously about, to be sick, as is really the case with the insane, and yet it is all-important that this fact should never be lost sight of. Very often the victims of disordered mind imagine that their best friends are their worst enemies, and frequently, under the influence of insanity, the most kindly and refined ladies become notoriously obscene lewd, and irritating. Not rarely, too, we come across patients who, let the nurse be ever so kind, will persist in formulating charges of neglect, inattention, and even cruelty against her. To bear such charges with equanimity, knowing them to be utterly baseless, is one of the hardest tasks imposed upon the clinical nurse. It is only by the full recognition of the fact that such patients are sick, and not answerable for what they say, that this can be done. It takes a hard struggle, I grant you, to keep down the "old Adam," innate in us all, under such circumstances. It must be done, however, if you are to have any success in the care of the insane. Perhaps it may help you in the struggle if you will put it to yourselves in this light: I would never dream of taking to heart any of the absurd things said by a delirious fever patient, why then should I feel aggrieved at the remarks of an unfortunate lunatic, who is equally sick, and equally irresponsible for what he may say?

The general term "insanity" embraces a number of forms of mental disorder, and the question of an accurate definition of it has been much puzzled over. Even yet, alienists are not agreed upon one that will embrace all those who are insane, and exclude all those who are sane. Perhaps the simplest definition, and one as good as any, is that which defines it to be a prolonged departure from an individual's normal standard of thinking, feeling and acting.

As to the forms of the disease, I need only say that it will commonly present itself to you in one of four aspects. There will be a departure from the normal condition, either in the direction of depression, of exaltation, of enfeeblement, or of perversion. These constitute the four great forms of mental disorder to which the technical names melancholia, mania, dementia, and paranoia have been applied.

That a nurse's duty must differ greatly in the different forms of insanity will be obvious. If the patient should be depressed her manner should be brisk, and her conversation lively and pleasant, though not flippant. If, on the other hand, the patient be

maniacal, it will be her duty to soothe, moderate and restrain, for which purpose her demeanour should be quiet and deliberate, her speech subdued. Even the most apparently demented patient must be treated with friendliness and politeness, because stupidity is often only an appearance, and experience shows that such patients are sometimes receptive of impressions and influences from minds stronger and clearer than their own, as well as from the surroundings which such minds create for them. Remember too, that although they do not always show it, the insane have likes and dislikes, often very strong ones, the same as the sane. They are often extremely sensitive to rude or unkind treatment, and, on the other hand, they are very grateful for favours or kindness. The nurse who has the patience and tact to take advantage of these facts can obtain a great influence over a patient—an influence which may be a powerful factor in his restoration to health. In all cases, her main object should be to gain the confidence of her charge. Let her do this, and she will have much more comfort and ease in her attendance upon him, and much more success in carrying out any indicated line of treatment.

Among the insane just as among the sane, the mental condition is very greatly affected by the state of the body, and anything that tends to promote the bodily welfare has a beneficial influence in promoting mental health. Hence, in all cases, but especially in those where the mental condition is such that the patient cannot take proper care of himself, everything possible should be done by the nurse to preserve and improve the bodily health. Your hospital training will have taught you the necessity for good ventilation, cleanliness, warmth, nourishing food, and attention to the proper discharge of the various bodily functions. I shall, therefore, pass over these points, merely warning you that sanitary surroundings are very apt to be neglected in the case of the insane, though they are just as necessary to their well-being as to that of any other sick patient.

In the care of the insane, the nurse is an even more important agent than in the care of those only physically ill; not only because she is the immediate agent to carry into effect the prescribed treatment, but because she is the one upon whom the doctor must depend for the bulk of his information. Her relations with the patient are of the most intimate nature, and, having him under constant observation, she, better than anyone else, can learn all the subtleties of his mental state, and so, if observant, can add much to the physicians' knowledge of the case, and in this way do much to help toward a cure.

As regards a patient's delusions, and your behaviour with reference to them. My advice to you is to avoid them as much as possible, but never to admit their truth. One is apt to think that to humour a patient by acquiescence in them will help to make things go along easily. This is very far from being the case. To appear to admit, either specifically or by your conduct, that delusion is truth, will eventually lead to your confusion. Let us suppose, for example, that the patient imagines himself to possess superhuman strength, and you humour him by assenting. Shortly after you have to give him a dose of medicine, and he objects to taking it. Inspired by his delusion that he is stronger than you, in which you have coincided, he will resist taking the dose, and your trouble will begin. Nor is it wise, on the other hand, to ridicule or needlessly contradict his erroneous ideas, for neither ridicule, contradiction nor argument will convince him of his error. Ignore delusions if possible; but, if they are forced upon you, say kindly, but plainly and firmly, that you cannot agree with him, and you think the patient must be mistaken. Let the matter rest there, and on no account allow yourself to be drawn into an argument. Instead, try to divert your patient's mind with other thoughts by getting him, if possible, to engage in some amusement or occupation.

Patients with delusions of suspicion demand special care, and with such, a nurse must be doubly careful as regards her manner and conduct. If these be frank and open, natural and unembarassed, they will go far towards allaying suspicion. If, on the contrary, the nurse has an insincere look, avoids her patient's eyes, is given to whisperings aside, or mysterious movements, she need not wonder if the distrust of her charge be excited, and he sets her down as a fellow-conspirator against his life or property. With such a patient, always be sure that it is made perfectly plain to him at the outset, that you are a nurse, and he is a patient; that you are there because he is sick, and you have been engaged to take care of him; let there be no deceptions as to your

relations one to the other, or as to the meaning of your presence.

An important point in the management of the insane is never to manifest fear of a patient. If you have any such, you should carefully conceal it in his presence. Lunatics are very quick to detect evidences of such weakness, and to take advantage of it whilst for one who, though always kind is cool and self-possessed, showing no signs of timidity, they have a very wholesome respect.

It is a common characteristic of insanity to show itself most prominently in an entire change of the natural feelings and affections. Those whom a man has loved and trusted most dearly, whilst he was in good health, are the very ones towards whom he shows the greatest dislike and distrust when his reason is overthrown. This peculiarity forms one of the strongest reasons for sending insane patients to asylums, because continued contact with relatives or friends who have become objects of suspicion or dislike is not conducive to recovery. If a patient is to be treated at home, the physician should make it a condition that his friends shall abstain from seeing him, and the wisdom of withholding from his sight all those who might excite or irritate him, would seem evident to the common-sesne of anyone. Unfortunately, however, the relatives of insane persons do not appear to be blessed with much of this quality, and, consequently, one of a nurse's duties, and one of her hardest tasks, may be to enforce the doctor's orders in this respect. Friends will appeal to you, coax you, even try to bribe you to ignore your instructions and let them see the patient. Of course, you must, for both your own and your patient's sake, refuse them courteously, but with a firmness that will admit of no appeal. Baffled in this, they may want you to speak to the patient on some subject for them, or to ask him some question. In this also your refusal should be definite but polite. Make your reports to the family as regards the patient's condition as encouraging as you fairly can, but avoid descriptions of his behaviour or repetitons of his remarks. Above all, never let the patient's friends tempt you to express an opinion as to the prospects of recovery ; refer them to the doctor, in whose province alone it is to answer such questions.

When friends are admitted to see a patient, regulate their conduct, as far as you can, by precept and example, deprecating any display of emotion, or aught that is calculated to excite or depress him. Be careful that nothing is said, even in the case of the dullest of patients, that it is not advisable that he should hear. If anything has to be said about him,let it be said aloud,not in a whisper, because all lunatics are prone to be suspicious. It is far better, however, that anything of the kind should be communicated outside the sick room.

Another thing that the nurse should always bear in mind is this—the insane utterances of her patient, no matter how droll or strange they may be, must be regarded as confidential disclosures, and never repeated. The skeleton that is said to exist in every household is very apt to be unveiled in the ravings of madness, and it is quite possible that secrets may be revealed which your charge, while in health, saw fit to keep from those nearest and dearest to him. In such cases, the thoughtless repetition of what may have appeared to you to be only a senseless fancy, might be the cause of grave annoyance, or worse, to the patient's family and friends, or to the patient himself should he recover. The law which forbids a doctor to disclose any information gained whilst acting in a professional capacity, applies with equal force to the nurse. The only exception to your silence, which your position of nurse imposes on you, must be in favour of the attending physician. To him the patient's sayings should be freely known, because in them he may find some clue to the mental trouble, or some warning of a danger, such as suicide, to be guarded against.

(To be continued.)

Dr. Leo B. Meyer, in an article in the "*New York Medical Journal,*" urges a greater care in the application of even weak solutions of carbolic acid where continuous action is required. It should never be applied to terminal parts, such as fingers or toes, when the amount of tissue between skin and bone is small. Gangrene, dermatitis, or burns, more or less severe, may result from its use. Weak bichloride of mercury, or boric acid solution, is recommended instead.

Notes from the Hospitals, and Personal Items

BIRTHS.

Mrs. Graham Connell (formerly Nurse Guthrie, of Thames Hospital), has a son.

MARRIAGES.

Nurse Pattimore was married to Mr. Ernest Galpin, of Marton, on 17th March.

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Nurse Atkins, late visiting nurse at Wellington, was married to Mr. Stevens early in April.

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Nurse Elizabeth Crawford was married on 20th March, to Mr. Lionel Brealy, of Otorohanga, King Country.

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Sister Lyons, late of Auckland Hospital, was married to Dr. Walsh, Superintendent of the Thames Hospital, on 21st April.

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Nurse Elizabeth McLean, late of Auckland Hospital, and recently sister at Hamilton Hospital, was married recently to Mr. Cowen from Edinburgh, and has left for Scotland.

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Nurse Lane, also late of Auckland Hospital, was married in March to Mr. Hawle, of Auckland.

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Sister Brodie, late of Auckland Hospital, was married on 12th April to Dr. Casement Aichen, late Medical Superintendent. They are leaving for a visit to England by the *Oswestry Grange.*

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The marriage of Miss Sims (ex Matron of Hokitika Hospital) to Mr. Skeet, took place on the 25th of February, at All Saints Church, in Hokitika. The crowded church was prettily decorated. The day was a perfect summer day, and the bride looked as happy and handsome as a bride should. Her dress (of some rich white material), was trimmed with exquisite lace, and she wore the customary veil. The bridesmaids also looked charming in their pretty frocks. Miss Sims' sister and Miss Nesta Lambert, of Wellington, were the bridesmaids, and Mr. Seddon, M.P., the best man. Dr. Trickleman gave the bride away. After the ceremony Mr. and Mrs. Skeet drove to Mrs. Tait's residence, where the reception was held. There the usual toasts were honoured, the wedding party were photographed, and finally the bride and bridegroom drove off. It was pleasing to note the genuine good-feeling of everyone who had come in contact with Miss Sims, and many warm wishes for her future welfare from friends and patients followed her on her entrance into "that new world which is the old." The presents were numerous and costly, and the large assembly of guests spent a most enjoyable afternoon in the pretty house and grounds. Mr. and Mrs. Skeet spent their honeymoon in Christchurch.

DEATHS.

We record with deep regret that Nurse Helen Robertson, of Maori Hill, Dunedin, trained at the Dunedin Hospital, died from an attack of virulent scarlet fever on 17th April. She contracted the disease from a family whom she was nursing, and who were afterwards sent to the Fever Hospital. The youngest of her patients and she herself died the same day.

Miss Purcell has left New Zealand for a visit to England.

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Nurse Winifred B. Norman is doing private nursing at Marton.

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Sister Simpson is engaged to Dr. Falconar, of the Dunedin Hospital.

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Also Nurse Barron, late of Timaru Hospital, to Dr. Burns of Timaru. Dr. Rogers to Miss Gwen. O'Callaghan.

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Miss Cora Anderson has just returned from a trip to Hobart and Sydney.

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Nurse Wilson, from Thames is also away visiting various parts of the North Island.

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Miss Annie Rochfort has been appointed staff nurse at the Sanitorium at Hanmer.

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Mrs. Desmond, 21 years Matron of the Oamaru Hospital, resigned her position in February. Miss Dick, trained in Chorlton Union Hospital, Manchester, was appointed Matron in her place.

Nurse C. Smith, trained at St. Helens, Auckland, has gone to Dunedin to live.

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Nurse E. E. Beattie has also gone to our Southern City.

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Miss Hay recently resigned the matronship of the Forth Street Maternity Hospital.

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Nurse Rose Macdonald, trained in the Dunedin Hospital, and in Forth Street Maternity, has been appointed Matron.

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Sister Gumbley, from Wanganui, has been appointed Sister in the Auckland Hospital.

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Miss Edwards has resigned her position of Matron of Napier Hospital, and intends taking a long holiday in Sydney.

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Miss Berry, Sub-Matron in charge of the Nurses' Home in Wellington, has been appointed Matron.

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Nurse Millard is at present visiting Dunedin from Australia, and while here is doing private nursing.

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Mrs. Wooten, Matron of Auckland Hospital, recently spent her holiday at Rotorua and Wellington.

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Miss Spellman is moving from her private hospital to the house lately used for Dr. Hosking's Hospital.

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Nurse Law, from Christchurch Hospital, is now undergoing her maternity training in St. Helens, Dunedin.

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Nurse Bilton, from Napier Hospital, is going through her course of midwifery training at St. Helens, Dunedin.

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Nurse Gertrude Mason, of the Wellington Hospital, has been appointed Sister on the staff of the Hamilton Hospital.

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Miss Dixon, Matron of Whangarei Hospital, has also been away for her annual holiday, and was relieved by Nurse Wilson of Auckland.

Nurse Mildred Ellis, of the Wellington Hospital, has been appointed Matron of the Karitane Hospital for Babies.

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Nurse Ellis, late of Wellington, has commenced visiting nursing in Christchurch, and is living at Miss Lonergan's Home.

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Nurse Sexton, of the Private Hospital, Feilding, is going through her midwifery training at St. Helens, Wellington.

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Nurses Rose and Lamb, of Thames, have been doing temporary duty in Gisborne Hospital during an epidemic of typhoid.

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Nurse Eaddy has resigned from the staff of the Gisborne Hospital, and after a holiday intends to take up private nursing in Auckland.

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Miss Clyne, who has been in charge of Dr. Barclay's private hospital, in Waimate for some years, has resigned, and is private nursing.

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Sister Marion Little, of Christchurch, and late Sister of Ashburton Hospital, has been appointed Matron of Westland Hospital, Hokitika.

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Miss Beetham, Matron of Wanganui Hospital, has been away for a holiday of six weeks, during which time Miss Lamb, from Auckland, relieved her.

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Sister Paul, Sub-Matron of St. Helens, Auckland, has lately returned from a holiday spent at Rotorua, and is enchanted with the sights of Wonderland.

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Miss Keath, late of Dr. Hosking's Private Hospital, Masterton, is leaving New Zealand next month with her sister, Mrs. Mason, for a long visit to England.

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Miss Cruden resigned her position of Matron of Waimate Hospital, and is now private nursing in that district. A presentation was made her on leaving the hospital, an account of which is given. Miss Shanks, who has been staff nurse at Riverton Hospital for some time, was appointed Matron.

Sisters Bell and Williams have just returned from spending an enjoyable though quiet time in the Waitakerei Bush ; a place little known but very beautiful.

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Nurse W. Lamb has resigned her position on the staff of the Thames Hospital, and is doing private nursing for six months. After which she is to be married to Mr. S. West, Waikino.

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Miss Gosling, for some years Matron of Reefton Hospital, was appointed Matron of Nelson Hospital, that position having been vacated recently by Miss Field owing to family reasons.

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Nurse Walsh, from Victoria, who has been housekeeping for her brother, Dr. Walsh, at Thames, has now returned to her nursing work, and taken a position on the staff of the Christchurch Hospital.

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Sister Margetts, late Matron of the Auckland Hospital, has resigned her position, in order to join her sisters in their private hospital for maternity cases, which they have recently greatly enlarged.

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Miss M. E. Brooke-Smith is now in Dunedin, and has been ordered several months rest by her doctor ; so she is obliged to give up nursing for the present.

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Nurses White and King, trainees of St. Helens Hospital, Dunedin, are going to open a private maternity hospital in Timaru in June next. Their fellow pupils wish them every success in their new undertaking.

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Miss Stewart was appointed Matron of the Nurses' Home, Wellington, and Miss Dencker was appointed visiting nurse to the Association in place of Nurse Atkins.

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Miss Stewart has resigned her position of Matron of Gisborne Hospital, after the long term of nineteen years. She will be much missed by her nurses, by whom she was much beloved, and to whom she endeavoured to impart the true spirit of nursing. A presentation is being got up for Miss Stewart by the residents of Gisborne, of which we hope to receive details.

Miss Godfrey, Matron of Dannevirke Hospital, has been appointed Matron of the Gisborne Hospital.

Nurse Cruden's Farewell

On the eve of her departure for Christchurch, Nurse Cruden, Matron of the Waimate Hospital, was entertained by the staff of the Hospital at a social on Friday evening, (29th January).

The orchestra was present, Father Aubrey being conductor. The selections were interspersed with songs, cornet, and violin solos. From the main corridor where the concert took place, an adjournment was made to the largest ward, where all present were assembled. Miss Watt (one of the probationers) presented Miss Cruden with a bag fitted out with nursing pharaphernalia, on behalf of the staff ; also a framed picture of the nursing staff.

Miss Watt paid a warm tribute to the parting guest. She had sympathised with the younger nurses in their troubles, and helped them in their studies, and they felt parting with her very keenly.

Dr. Barclay (Medical Superintendent) said Nurse Cruden had been Matron two and a half years. During the twenty years he had been Medical Superintendent, Nurse Cruden was the only Matron they had been able to farewell as they were then doing. He then paid a warm tribute to Mrs. Chapman, the late Matron, who had "died in harness." Nurse Cruden came as trained nurse, it had been quite unnecessary to issue orders to her at all, it was only requisite to express a wish, and it was realised at once, and that was how things should be. Personally, he felt the parting very much, and he could only wish her long life and prosperity.

Mr. Hayman, in a neat little speech, then presented Miss Cruden with a watch on behalf of the patients in hospital.

Mr. Miller Atwill, representing the Hospital Trustees, also made reference to Miss Cruden's abilities, and expressed good wishes for her future.

Father Aubrey, on behalf of the Clergy, thanked Miss Cruden for her kindness to the clergy in their ministrations for the sick. Her traditions would be an ideal to those following her.

Mr. Atwill, a member of the Trustees, returned thanks on behalf of Miss Cruden. The guests were then regaled at supper, and the function ended.

Letter to the Editor

MY DEAR MISS MACLEAN,—Your delightful letter of September was the greatest kind of pleasure; it is so refreshing to feel the links of interest in mutual work with our members across these great seas. I do hope some day I can visit New Zealand, that wonderful country which many advanced thinkers in this one regard as the most elevated of all in social justice. I hope the nurses will never forget to realise their great privileges in being citizens of such a country; they should feel such a pride in its economic and social democracy, and rejoice in being able to take a part in its legislation for social betterment. If you could realise, for instance, the heart breaking struggle in this big, rich land to obtain shorter hours for working women; more protection for children; more consideration for the young. It is like pulling teeth to get the smallest crumb, and I feel sure that until women gain the ballot here we shall have nothing but a cruel rule of exploitation of the workers by the rich and powerful classes. I have been busy all this winter in helping to gather material, from German and French sources, on the evil results to health of overwork, long hours, premature toil, and all the things that any sensible, decent person ought to know; whilst others are getting the same things from all English (language) sources, so that our National Consumers' League may make another attempt in favour of legislative restriction of overwork. However, I sat down to write you of the coming International Council meeting next summer. How very delightful it would be if you could come.

You will, of course, have seen in the British Journal all the announcements and communications, so I need only urge upon you the great pleasure it would give us all to have some of the New Zealand sisterhood on hand. As you see, besides the business meetings there will be a Congress with varied papers and discussions, in which all will have equal share. I would be so glad if you would insert parts of this letter into KAI TIAKI, so that all the nurses may know that anyone who can come to England next summer, whether as a visitor, or as a representative of organisations, will be most warmly welcomed. We would like to hear at first-hand about your registration. We must bring up all the facts on this subject in order to help the English nurses in their great fight. But maybe they will have won it by next summer—I hope so. Hoping that we may see some of you, Believe me to be,

Always very sincerely yours,

LAVINIA L. DOCK,
Hon. Secretary.

27th December, 1908.

Nursing Notes

Infirmary Nurses Learn Cooking

An interesting experiment has recently been inaugurated at the Hammersmith Infirmary, Wormwood Scrubs. It appears that Miss Ward, Matron of the Infirmary, considers cooking a very essential part of a nurse's training, and has been devoting a great deal of care and attention to the matter with regard to her own nurses. At first she had intended including special cookery classes in her own lectures to nurses; but hearing of the excellent teaching by the L.C.C., and other schools of cookery, decided it would be better for them to acquire their knowledge away from the infirmary. Therefore it has been arranged that 27 of the nurses go to cookery classes at two L.C.C. centres and the Camden Institute. As may be realised, by matrons especially, it was no easy matter to arrange these classes, and the work generally, so as to allow as many as 27 nurses to get away, although they are divided up into batches of five, seven and fifteen. One important point which facilitates matters in this respect, is the fact that all the nurses go in their evening off duty hours; and, another important point, pay their own fees. Whilst, of course, it is quite obvious that the arrangement can be to the

nurses' own advantage only, there is room for commendation when it is remembered that these girls have done a hard day's work. As a matter of fact, the innovation is extremely popular ; the nurses go off duty at 7 p.m., and have three-quarters of an hour for changing and reaching Portobello Road, which is the L.C.C. centre, getting back at 10 p.m. The L.C.C. fees are 1s for the whole term, lasting twelve weeks.

A special class has been arranged for them alone, which means that sick cookery is made a speciality. At present the L.C.C. have no examinations, but it is hoped to arrange for one, in which case nurses would pay their own fees. This is an important point, as it quite prevents the guardians, or anyone else, complaining about expense. To drive home, in actual practice, lessons learnt during cookery hours, Miss Ward has instituted the very wise rule that "special" diets, chops, fish, custard (boiled and baked), and so on, shall be cooked in the ward kitchens instead of being sent up on trolleys from the big kitchen. This involves no waste, as only those who have really learnt to cook are allowed to do this ; but it serves as an excellent reminder of things learnt, and, moreover, patients are likely to get food extra hot and dainty. Several other infirmaries are watching the experiment before they follow suit, and if it is successful the Hammersmith nurses may justly claim to be pioneers of a very practical and sensible idea.

Editor's Note—The subject of invalid cookery has been given special prominence to in the recently revised regulations under the Nurses' Registration Act. The subject was always included in the syllabus, and for the last two or three years an attempt was made, during the practical portion of the Final State Examination, to give some test of preparing invalid diets. As this necessarily took up some time, and was rather difficult to arrange for a number of candidates, a certificate of having attended a course of lessons in the subject both practical and theoretical, and of having passed a satisfactory examination will in future be required from each candidate before she sits for the examination. The course can be taken at any time during the term of training. Many of the hospital Boards have risen generously to the occasion, and are arranging for the instruction of their nurses at the technical schools in their districts. Where this cannot be obtained, the matrons will be allowed to give the necessary instruction.

Invalid Cookery

BEEF-TEA CUSTARD.

One gill of beef-tea, 2 eggs and taste of salt. Put the yolks of two eggs and the while of one into a basin. Pour on them a gill of cold beef-tea, and whisk all well together. Pour the mixture into a buttered cup or jar, tie a piece of paper over it, put it to stand in a saucepan of boiling water ; but do not let the water come over the paper. Let it simmer ¼ of an hour, the water must not keep boiling or the custard will be spoiled. Take the cups out of the saucepan, remove the paper, dip a knife into boiling water, slip round the edge of jar, and turn the whole out on to soup plate. Chicken broth or clear soup can be used in this way equally as well. The writer has succeeded in getting a patient to take eggs this way, when they couldn't otherwise.

BEEF-TEA WITH OATMEAL.

Two tablespoonsful oatmeal well mixed with 3 tablespoonsful of cold water. Add 1 pint of strong, boiling beef-tea ; boil all for 5 minutes stirring well, and strain through a hair-sieve.

SOLID TEA.

One tablespoonful of gelatine, 1 pint of milk, 2 tablespoonsful strong tea, 1 tablespoonful sugar. Melt the gelatine in the milk over the fire. Add the sugar, mix all together, then strain, and pour into moulds. To be eaten cold. Coffee or cocoa may be used in the same way.

MINCED CHOP.

One mutton chop, 1 tablespoonful bread crumbs, 2 tablespoonsful water, salt and pepper, small piece of butter. Method : Shred the lean part of the chop, put it into a small pan with the water, breadcrumbs, butter and seasonings. Simmer for ten minutes, stirring all the time. Serve on toast. If liked, ½ teaspoonful of mushroom ketchup or sauce may be added.

PEPTONISED OYSTERS.

Take half a doz. large oysters with their juice, and ½ pint of water. Heat in saucepan until they have boiled briskly for a few minutes. Pour off broth and set aside. Mince oysters finely and reduce to paste

with a potato masher in wooden bowl. Now put the oysters in a glass jar with the broth and add: Liq. pancreaticas, 2 teaspoonsful; soda bicarb., 15 grains. Let the jar stand in hot water or a warm place, temp. 115 deg., for 1½ hours. Pour into saucepan, add ½ pint of milk. Heat to boiling point slowly. Flavour with salt and pepper, serve hot. A very few pieces of oyster will be undigested, but will not be found unacceptable to the stomach except in rare cases. The milk will be sufficiently digested if heated gradually.

BROILED CHICKEN.

One small chicken, 1 oz. butter, pepper and salt. Prepare a young chicken for roasting, split it down the back and lay it open. Take only half at a time. Rub the piece of chicken over with a little butter to keep its skin from cracking, and season with pepper and salt. Grease the gridiron, and make it thoroughly hot. Lay the chicken on it, with the cut side down to begin with, Broil either on the iron or before a clear fire for half an hour. When cooked, lift on to hot plate and rub the rest of the butter over it. Serve with rolls of bacon.

CHICKEN SOUFFLE.

Breast of chicken, 1 gill cream, 1 egg, ½ oz. flour, salt and pepper. Skin the breast, chop finely, and pound well in mortar. Melt the butter, stir into the flour and a tablespoonful of cream. Let it come to the boil. Pour it over the pounded chicken; and seasoning; pound together, and rub through wire sieve. Switch rest of cream till stiff; mix gently with other ingredients. Butter some cups; half fill with mixture; cover with kitchen paper, and set in stewpan half full of boiling water. Steam for 15 minutes. Serve with white sauce.

The following course of instruction has been arranged by the Auckland Hospital Board for the training of that school. The sisters and staff nurses are also to take advantage of the course, which will be most valuable for them in their after work. The classes have already commenced:—

INSTRUCTION IN COOKERY FOR NURSES OF THE AUCKLAND DISTRICT HOSPITAL.

The course should consist of at least eighteen lessons, each of two and a-half hours duration. The number of nurses to attend at each lesson should be not less than six, nor more than fourteen.

The cost to the Board for eighteen lessons would be £18.

The classes would be held at the cookery kitchen of the Newton Manual Training School, Upper Queen St., on Wednesday or Friday evenings, from 7 to 9.30. It would thus be possible at the present time to hold not more than two classes per week.

SYLLABUS.

The course would include lectures, demonstrations and practical work. Food, and its functions; the preparation of food; its five principles; nutrition; digestion.

Invalid Drinks: Such as toast-water, barley water, milk, lemonade, egg-flip, rice-water, sterilised milk, etc. Beef juice, beef-tea, and various broths.

Jellies: Such as wine, lemon, orange, chicken, coffee, restorative, etc.

Toast: Such as milk, cream, egg, vermicelli, sippets, croutons, etc.

Soups: Such as oyster, chicken, potato, cream of celery, cream of rice, beef, tapioca, chicken ponada, consomme, apple, etc.

Fish: Preparation when is season; broiled, boiled, steamed, fried.

Poultry: Various methods of boiling and roasting.

Sweetbreads: Brains, chops, steaks, etc.

Custards, creams, puddings, blanc-manges, etc.

Eggs: Various methods of cooking omellettes, etc.

Cooked fruits, bread, cakes, etc.

The feeding of children and infants; humanised milk, etc. Diet lists for the sick; liquid diet, and convalescent's diet. Serving of food for invalids; tray decoration; intervals of feeding.

NOTICE TO SUBSCRIBERS!

Subscribers for 1908 desiring to continue their subscriptions for "Kai Tiaki" for this year, are reminded that although copies of the January number were sent to all 1908 Subscribers, those who have not sent in their fees will not receive copies of the April number until they have intimated their desire to continue their subscription.

Copies are available on early application.

EDITOR.

Why Cannot Babies Digest Mother's Milk ?

(BY ADA E. CHAPPELL.)

In my work as the Plunket Nurse at Auckland, it has distressed me to see how many babies do not seem to thrive on their mothers' milk.

In a number of cases the nurses and mother have battled bravely through the difficulties of undeveloped, inverted, or sore nipples. In other cases there is sufficient milk for the baby, but it does not agree. The motions are curdy, and then followed by green, and very frequent. The baby is fretful, unsatisfied, and sleeps little night or day, and always seems ravenously hungry no matter how much or how often it is fed. The babies are just unhappy, suffering little atoms of humanity, and as unlike the babies our grandmothers used to tell us about (who used to sleep most of their time) as it is possible to be. As there is a cause for every effect, I have tried to discover the cause. I tried to think what I would do if these babies were on humanised milk. For indigestion, then, I would reduce the strength. One might even peptonise the humanised milk if the stomach was too weak to digest milk of a required strength unpeptonised. We cannot, however, do this with mother's milk.

It is usually supposed when a baby cannot digest mother's milk that there is too much proteid in the milk. To overcome this difficulty (unless able to regulate the mother's exercise, etc.), we could give the baby boiled water previous to a feed from the mother. This would dilute the milk in the baby's stomach by mixing with the water ; but there are disadvantages even with this. Supposing the baby is new born and you give a bottle with water in prior to giving it a drink from the breast, baby will not readily take the breast milk, especially if the nipple is small. If you spoonfeed with the water the baby becomes so impatient that by the time you get it to the breast it will scream instead of sucking.

Then I thought : " Is there no way ? Eventually I decided to reduce the length of time a baby feeds from the mother. I was called to one baby a few weeks old, looking old and careworn, in a home where every need could be supplied. The nurse said the milk did not agree, and the motions were curdy and green. They had sent for me to show them how to make humanised milk for the baby. I inquired why the mother was not nursing the baby entirely. I was told she had not sufficient milk. I found upon inquiry that the baby was allowed to drink until she stopped of her own accord. I asked for the drinks to be limited to fifteen minutes, and the breast last nursed from to be massaged gently (not the full one, as that would waste the milk). I then gave baby three feeds per day of graded humanised milk. I got the mother to take milk-forming food. The milk supply improved, and as the baby was unable to digest a feed of fifteen minutes, I reduced that to ten minutes. Then the mother found she had sufficient milk to nurse the baby entirely. The mother still made the humanised in case her milk should fail, and drank it herself to transform to human the humanised milk. In the meantime the baby's motions had become nearly normal —it was sleeping better and gaining in flesh. " Now," I thought, " I can advance," and I gave permission for the feed to be extended to twelve and a half minutes. This brought a return of indigestion, shown by the curdy motion, followed by the green, colicy pains, sleeplessness and crying. We reduced the time to ten minutes again, and the indigestion disappeared. We let the baby remain at that for some days ; then thought we might again increase, but more carefully, so only increased one minute. Again a return of indigestion, but not so bad as before, as shown by the smallness of the curd, which was not followed by green colour this time. Back we had to go to ten minutes, and once more there was a contented baby, sleeping a normal amount. I know this is only one case ; but in every case where I have tried it, the effect has been the same.

Another case : A lady came to my office to see me. She wanted me to supply her with humanised milk as she had not enough, and the baby was always crying. " It used to be such a good baby," she said. I found the motions were curdy and green. The mother said, " I feel the draught of milk come and when it stops the baby cries and I have to put it to the other breast." I found it was two hours since the baby was fed, so I got her to feed the baby then. " I can feel

the draught coming," she said. Then the baby cried, and the mother said it had stopped. "That is not a long enough feed, is it ?" she asked "Are you sure there is no more ?" I asked. "Yes, quite sure." "Let me see," I said. In pressure a good supply of milk flowed from that breast, showing that the mother's feelings and impressions about there not being any more milk are often misleading. It was amusing to see her look of astonishment.

"Now," I said, "you came for my advice, will you do as I ask you ?" Go home and nurse the baby for fifteen minutes, every two and a half hours during the day, and once between 10 p.m. and 6 a.m., and come and see me in three days' time, and if I find you have not enough milk when you have not given the baby more than baby could digest, then I will order humanised milk for you." This she promised to do.

At the end of the three days she returned with a smiling face. "Well, how is baby," I said. "Oh ! baby is splendid. I did as you said and I have plenty of milk, and baby's motions are all right, and she sleeps, and coos, and we have got our good little baby back again. Someone told me I can be a member of the Society for 5s, so here is my subscription."

I could go on citing cases, but this, I think, is sufficient to show that reducing the quantity enables babies to digest their mother's milk. I have not yet found a baby unable to digest its mother's milk when the quantity has been reduced to its digestive capabilities.

I do not mean to imply that all mothers' milk will sufficiently nourish a baby. There may be some of the necessary constituents missing, or be not in proper proportion. There are cases where babies suffer from malnutrition and marasmus, though fed on mothers' milk, but they are the exception, and the cases I have named are the rule so far as my experience has gone.

This seems to point to the fact that it is the overfeeding in breast-fed infants which has done the mischief. Also, I think we have let the idea get too great a hold upon us that anxieties and work upset the milk for the babies. We think if women lived as native women used to do, that mothers could still nurse their babies as they did. Yet when we think of the wars between the different tribes, and how the men they loved and the fathers of their babies had to go and fight, and might never return alive, we cannot say those women were free from anxieties, seeing womens' hearts in all ages have ever been the same ; yet they were able to nurse their babies successfully.

It seems to me that this great question as to mothers nursing their babies or not, depends mostly upon us nurses. The doctor only sees the baby a few minutes a day, or every other day. If the nurse says the milk does not agree, or is not sufficient, the doctor must either take the nurses' word for it, or practically act as if the nurse does not know her work. With the fact before us, as stated by those in a position to know, that malnutrition in infants tends to the imperfect development of the brain, which in later life may develop insanity, and with the important fact also before us that the brain grows more in the first twelve months of life than in the whole of the after life, surely we can realise the importance of babies being nursed by their mothers, when we remember that in mothers' milk there is special provision made to supply the materials for the growth and development of the brain. Dr. Gow says : "An infant's brain grows faster than a calf's, and science has not yet been able to extract from the cow's milk the brain feed that is necessary for the growth of an infant's intellect." If science has not yet been able to extract from cow's milk the brain food necessary for the growth of an infant's brain, how infinitely less likely is it to be extracted from patent food. There never were so many artificially-fed babies in the world's history, and we know insanity is on the increase. Have these two things any connection with the other ? One hears a great deal about the unnatural mothers who could, and yet will not, for selfish reasons, nurse their babies. I am pleased to say I have not met them yet ; but I have met many who ceased to nurse their babies because of the curdy green motions, which made them think their milk did not agree, whereas I have proved to my own satisfaction that it was the over-feeding that did not agree. Personally, I think the indigestion is started by the very first feed. I think if the baby was allowed to drink for five minutes only the first feed, and within six hours of its birth (if the mother was in a fit condition) it would be better, the length of time being increased according to the digestion of the baby. Sometimes the baby is not put to the breast until the third day, because "the milk has not come in." Yet nature has provided a weaker milk those

first three days to help prepare the little stomach for the harder work which it will have on the third day. How sad one feels for the little thing when one hears the old saying: "Oh, he will stop when he has had enough." So the wee stomach is loaded with a feed, often lasting half an hour, or three-quarters. We expect a new-born infant to know what is good for him better than some adults, who do not know when to stop. Perhaps we think the babies are so near to Heaven that they have brought this wisdom with them. It seems to me we nurses have a great work before us in pointing out all the advantages of natural feeding, and all the dangers and disadvantages of artificial feeding, not forgetting the danger of rickets through lack of fresh milk direct from the mother. We should keep before us the fact that it is only the amount of food digested (whether mothers' milk or humanised) that nourishes the baby. If it were otherwise, why are the over-fed children the most like skeletons? What an immense gain we have given to each infant when we have secured the natural food for its use, and have taught the mother the A B C of feeding according to the digestion of the individual infant.

While in one case I mentioned ten minutes is all the baby could digest at present, yet in other cases fifteen minutes and half an hour may be needed. When once the amount that the individual baby can digest has been discovered—by reducing the time until there in no curd in the motion, etc.—give the baby a few days at that amount, and then advance by a minute or minutes until you see signs of indigestion, then shorten the time just enough to allow the digestive organs to do their work, and continue at that amount. The saving to the nursing mother is great, seeing nature tries to meet the demand. Nature in the mother has been trying to make enough milk to feed a baby for thirty minutes when that baby is only able to digest a feed of ten minutes, in some cases, and the other twenty minutes feed has not only been utter waste, but injurious often to both mother and baby—particularly to the baby.

Is not this one great cause why mothers do not nurse their babies? They think they have not sufficient milk unless they have enough to feed the baby for half or three-quarters of an hour.

In conclusion let me say that the result of my experiment has cheered me much; because I no longer feel the God-given food for infants has all gone wrong (as in the great majority of cases it appeared), but it shows that the fault is that somehow we have lost sight of the need of being guided in natural feeding by what a baby can digest. This amount is not a matter to be estimated by rule of thumb; but in cases outside the average depends on the digestive capacity of each child. Thus each child must be a special subject of study to the nurse, especially in cases where nature's nurse—the mother—calls in the aid of those whose duty it is to benefit by the experience gained by observation.

Mrs. Grace Neill

Nurses will be pleased to hear that Mrs. Grace Neill has returned to New Zealand from America, where she has been for the last two years. The climate of Montana unfortunately tried her greatly, and since her return she has not been at all well, but her friends hope before long she will be among them.

The various members of nursing associations which have been formed during the last few years in the chief centres, are hoping that when she is well enough she will identify herself with their interests, and become the first president of the New Zealand Nurses' Association. They do not forget that it is to her they largely owe the fact that their profession is recognised by the Governmen.. Thus giving them a high status in the nursing world.

The trouble so often experienced in getting the new baby to nurse is suddenly overcome by first pumping a little milk from the breast. Have ready a little of the milk in a medicine dropper, and as the nipple is put into the infant's mouth, drop some milk into his mouth, and what he has tasted will be an incentive to work hard to obtain more, and he will go at his task with a will.—From "Practical Suggestions," *American Journal of Nursing.*