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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Editorial

At the interim Conference of the International Council of Nurses two resolutions were passed which should interest nurses in New Zealand. The first one was passed by the Round Table on "Newer Developments in Private Duty Nursing," turned into the general meeting and passed by the General Council. It was as follows:—"That the nurse registries should be organised and directed only by nurses and not be a commercial proposition." This is a move in the right direction, and is a subject which might well be studied by the private nurses of New Zealand.

The other resolution was presented by the Round Table on "The Nursing Profession in Relation to Mental Hygiene." It runs: "That the Board of Directors of the International Council of Nurses be asked to appoint a Standing Committee on mental nursing and hygiene." In view of the fact that our own problems in regard to reciprocity between general and mentally trained nurses are in need of consideration, this resolution is of great interest.

Nurses' Memorial Fund

ANNUAL MEETING OF MEMBERS.

The tenth annual meeting of members of the New Zealand Nurses' Memorial Fund was held in the Town Hall, Dunedin. Sir George Fenwick (Vice-President) occupied the chair.

The annual report stated that the past year had been somewhat uneventful. The fund's income from investments had slightly increased, owing to the purchase of £500 New Zealand Government securities, and the capital now stood at £21,000, bearing interest at 5¼ per cent., yielding £1,100 per annum. But the incidental revenue—subscriptions, donations, etc.—had fallen off, while the expenditure on relief had increased, so that the balance carried forward to next year was less than that brought on from last year. Liberal donations had been received from the women's section at the late Exhibition, the Canterbury, Auckland, and Dunedin Trained Nurses' Associations, from the Wellington branch, and from private individuals. Also, since the accounts for the past year had been closed, a sum of £63 had been received from Auckland, per Mrs. Ethel A. Kidd. The calls on the fund were still increasing. There were 12 annuitants receiving relief on April 1, 1926, on March 31, 1927, there were 15, and further applications were now under consideration. Should they be granted, the fund's income from capital would all be absorbed, and in accordance with Clause 6 of the constitution no further annuity could be granted until a vacancy occurred among the present recipients. During the past 12 months one annuitant had died, one no longer needed help, and five new applications had been granted. The Committee much regretted the death, during the past year, of Mr. T. Chalmer, one of their honorary auditors, and a successor would have to be appointed at the Annual General Meeting. Their President (Sir H. Lindo Ferguson) was now absent from Dunedin, on a visit to the Old Country, and might be expected to return about the end of 1927. Miss Williams, hon. secretary, was also away for the same reason, and Mrs. M. J. Bundle had very kindly undertaken to carry on the secretarial work during Miss Williams's absence. The Committee desired to express its very sincere thanks to Mr. W. T. Monkman, F.P.A. (N.Z.), honorary auditor to the fund, for his valuable services.. The President, Vice-Presidents, Hon. Secretary, and Hon. Treasurer retired in accordance with Rule 7, and were eligible for re-election.

Sir George Fenwick, in moving the adoption of the annual report and balance sheet, said that the fund had now passed its first decade—an event in its history—and the Committee and members had every reason to be gratified at the success which it had achieved. It was not an easy matter nowadays to raise a capital of £21,000, which was a large fund, under the circumstances. When the fund had been originated there could have been no question that the people of Dunedin saw the necessity of such a movement, and not only the people of Dunedin, but those of many other parts of New Zealand, and there had not been a great deal of difficulty, fortunately, in raising very handsome sums from indviduals and bodies of people and thus have the fund established. Unfortunately, however, while the fund was of a substantial nature, he would just like to mention that their income of £1,100 was not adequate to meet what were the legitimate and urgent demands for assistance, and one would like to see the fund increased. He did not think that very much could be done just at present, because the Dominion, unfortunately, was just at present suffering from a wave of depression and there were many other calls on the community. The Committee hoped, however, some day to raise the fund to a large amount so as to enable them to grant assistance to cases that sometimes gave the Committee a good deal of thought. Probably only the Committee knew how urgently assistance was needed on occasions to help nurses who, through old age or other causes, had fallen into impoverished circum-

stances. Their needs, they all felt, should be met, and met very generously. He might add that they had a substantial sum in prospect—£1,000 from the estate of the late Miss McLean, of Timaru. It was a great satisfaction to know that their fund had thus been remembered. As regarded the operations for the year, they had brought forward last year £388 19s. 8d., and this year they were carrying forward £314 12s. 6d., which was a satisfactory state of affairs, showing that they were not spending beyond their income.

Mr. James Begg, in seconding the motion, said he thought the Committee could congratulate itself on the present position of the fund. Of the many memorials connected with the war, he did not think there was a finer memorial than theirs.

Mr. C. W. Rattray said he did not think it should go out that the fund had come to anything like the size it should reach, because those connected with it knew only too well how limited was the assistance they had been able to give. They knew after all how absolutely trifling the sum was in the great majority of cases, and he thought that point should be stressed. The fund could not be better administered than it was, as the whole cost was only 2 per cent., and he did not suppose anything cheaper or better than that could be achieved in New Zealand. They should never be satisfied that the fund was getting from the people of New Zealand or from the Government the assistance that, to his mind, was undoubtedly its due.

The motion was then put and carried.

The Chairman added that the Trained Nurses' Association had done its duty, and that it was only right that they should record that fact.

Miss Bicknell, Director of Nursing in the Health Department, Wellington, said she knew from her personal knowledge how much the nurses appreciated the work the Committee was doing—that was the nurses up north—and they were always considering means by which they themselves might add to the fund. She had several ideas on the subject, and she hoped to put them into practice when the present time of depression had passed. She thought that nurses in better circumstances should do their best to help their less fortunate fellow nurses, and she hoped that this might be brought about in the future. She extended her thanks to the Committee for the time and work they were giving to the fund.

Office-Bearers.

The following office-bearers were appointed:—Patroness, Lady Alice Fergusson; President, Sir Lindo Ferguson; Vice-Presidents, Sir George Fenwick and Dr. Wm. Young (Wellington); Hon. Secretary, Miss Williams; Hon. Treasurer, Mr. C. W. Chamberlain; Hon. Auditors, Messrs. W. F. Monkman and J. Greenfield. The local members of the Central Committee are Miss Holford, Miss Lancaster, Messrs. James Begg, C. W. Rattray, and C. Russell Smith (Otago).

A vote of thanks was passed to the honorary auditors (Messrs. W. T. Monkman and J. Greenfield). Votes of thanks were also passed to Mr. Chamberlain, Miss Williams and Mrs. Bundle (the acting secretary).

Names of subscribers:—

Miss West, Miss N. Bennett, Miss E. M. Taylor, Miss T. Butler, Mrs. Dement, Miss M. E. Gould, Miss H. E. McBeth, Mrs. Hunter, Miss G. Perrin, Miss K. E. Hanson, Miss A. Davey, Miss E. Burrell, Miss G. M. Williams, Mrs. Angell, Miss K. Gordon, Miss Newman, Miss Hetherington, Miss Barnett, Miss Dew, Miss J. Cranmer, Miss E. Wilson, Mrs. Kendall.

Glycerine for Stains

It is not generally realised that glycerine is a useful agent for the removal of stains of nearly all kinds. In some cases it may not give the desired result, but it is always worth trying, as it may be used quite safely on heavy or delicate materials. Apply a few drops of glycerine to the mark and leave it for a short while. Then rinse with plain warm water and repeat the process if necessary. For stains that prove stubborn it is a good plan to warm the glycerine. This is easily managed by putting a little glycerine into a small bottle and standing it in a cup of warm water.

Correspondence

The accompanying letters speak for themselves.

(The Editor "Kai Tiaki.")

You solicit nurses' opinions and experiences when working with young doctors. I'm afraid, if nurses cared to write all their trials on the subject, you would not have room to publish one quarter.

I hold three certificates with 10 years' constant nursing, the last two years in charge of Maternity Home.

A young English doctor, first post in New Zealand, previous two years or thereabouts at sea, was engaged for these cases.

First Case.—Multip (fourth preg.), complains of severe labour pains at 6 p.m. Doctor informed. At 8 p.m., doctor examines p.v. Says in patient's hearing: "Nothing doing, Sister. Patient may return to her room. I'm going to H—— (12 miles distant), and will return at 9.30 p.m."

At 8.30 p.m., patient in agony, begs me to send for another doctor and names him. Head appearing when he arrives, baby born at 8.45, everything normal. Patient's own doctor arrived at 9.30, astonished to find everything over; Patient in her own bed and baby clothed.

Case 2.—Multip (tenth preg.), admitted Sunday with severe cold ('flu is prevalent).

I rang doctor (same doctor as previous case) three times before I could get him, he being in M——. On Tuesday, 3 p.m., he came and examined patient's throat, ordered saline gargle; no other visits or inquiries. Ten days later labour commenced. Patient did not tell me of pains until 9 p.m., when too severe to bear. I rang doctor to be informed that he had gone to H——(12 miles distant) half an hour previous.

At 9.20 p.m. baby born, everything normal. No doctor, no chloroform, no tear. At 2.30 a.m. doctor arrived somewhat under the influence of liquor and in evening dress, demanding to know why he had not been sent for. (He had failed to inform me that he would be out of town on two other occasions.) He referred to previous case and accused me of underhand work; said it was a "put-up job." Reported me next day to Health Department for failing to call him in time for confinement. Ye gods!

I have now washed my hands of young doctors and maternity work, and am enjoying an enforced rest at a sanatorium as the result of accumulated worries, mostly due to doctors' mistakes.—Yours, etc.,

FED-UP.

A "Registered Midwife" also writes re the difficulties in connection with her work. She speaks of the need for capable midwifery, and the importance of efficiency in both doctors and nurses. She thinks sufficient food for the poorer mothers should be provided, and that they should be freed from anxiety. Antenatal treatment should be open to all everywhere, and attention paid to teeth and the eyes. Reference is also made to the difference in the rate of pay, a nurse working for a week, day and night, for a fee a doctor will take in an hour or less. The result is that maternity nurses drift away to other occupations where the salary is fixed and the hours shorter. The suggested remedies are as follows:—Both doctors and nurses should be paid a salary, the latter also being on the same footing as teachers and mental nurses; cheap laundries; lower house rents; homes for the ex-babies while the mother is in hospital; and domestic help when required. (In some towns in New Zealand these last two suggestions are already carried out by the Women's National Reserve.—Act. Ed.) Registered Midwife concludes by saying: "We raised huge sums of money for the war, to kill our men. Why can't we raise something in peace to keep our homes happier and better It is a pity we cannot all work together amicably, each helping the other according to our various abilities, for the good of the mothers of mankind. After all, it is the mothers who count."

Off the Beaten Track

MATRON'S TRIP TO INDIA. INTERESTING PLACES VISITED. STORY OF HER TRAVELS.

Off the beaten track of the average tourist, Miss Rose Macdonald, Matron of the Napier Hospital, in her eight months' trip to India and the Malay States, came across many places of beauty and interest that it is not always the luck of the ordinary traveller to see. Particularly was she fortunate in coming in close contact with the doings on an Indian tea plantation. There Miss Macdonald gained some knowledge of the conditions under which the Indian coolies worked, and from these observations was able to form the conclusion that the lot of the Indian coolie is quite a happy one. He had to work and work hard, but he received much in return.

On the Way.

Miss Macdonald's travels from New Zealand led her first to Sydney, and then around the Australian coast to Perth and on to Colombo. A brief stay was made at Madras, and then the steamer journey was made up the Hugli River to Calcutta. Miss Macdonald had now reached her base from the 600 mile journey to the tea plantation district of Cachar. It was a journey that required many modes of travelling. First a six hours' train journey to Goalanda, and then on the river steamer up the Brahmaputra, branching off on to one of its tributaries, the Barak River, towards Chaudpur.

It was time for another train journey, and then a motor drive of 20 miles before the Barak was again reached and the crossing made on a punt, a native propelling the punt across the river by means of a long bamboo. Again, the motor car was set going, but that was finally abandoned for the last few miles to the tea estate to be made up the river in a motor boat.

A Wonderful Journey.

Miss Macdonald described the 600 mile journey as wonderful, with something new and something fresh always looming up. She had the unique experience of being the only white woman among several hundred passengers who made the train journey from Calcutta to Goalanda. The stations along the route presented a wonderful sight of bright colours. Always were there hundreds of natives awaiting the train's arrival, offering fruit, cigarettes and drinks for sale.

As the train rushed on there was ever a change of picture. Four native villages they travelled through and then came the rice fields. It was just as picturesque from the river steamer, with native villages continually coming into view and mosques and temples looming up in the distance. But what capped everything on that memorable journey was the beautiful sunset on the Brahmaputra River, with the hundreds of fireflys coming above the steam just after dark.

Work of the Coolies.

"The Indian coolies, on the tea plantation at Lakhipur, my destination," continued Miss Macdonald, "are a very happy and contented lot, and are well looked after. There are about 500 of them, so that they are quite a big community. Quite comfortable huts of clay and grass, with thatched roofs, are provided for them, and the majority are keen on keeping them very clean and having gardens round about. Not only are they given a free house, but are provided with free hospitals and free medical attention. At one time the people were so scared of hospitals that they would not go near them, but now they have learned their benefits and are much more ready to receive treatment. While I was at Lakhipur a start was made with child welfare. The children are to be weighed once a month and the mothers are being helped with a view to seeing that the children are properly looked after.

Grows His Own Rice.

"Each coolie is given a piece of ground and on that he grows his own rice, usually getting enough to keep him going for

two or three months. When that is eaten up he is provided with rice from the store on the estate.

"During the free hours the coolies have plenty of amusement. Besides their pujas to celebrate a marriage or some such event, jugglers and entertainers visit the plantations and occasionally a visit is received from a travelling picture show. This is an unusually big occasion, and people from neighbouring bustees join in with the coolies from the plantation. It is an open air show, the coolies surrounding the screen. It didn't matter to them on what side of the screen they sat so long as they saw the pictures.

Work Amongst the Tea.

"I was at Lakhipur during the cool season, and owing to it being dark until almost 7 o'clock in the morning the day's work did not start until 8 o'clock. Shortly after 5 o'clock it was dark again. Each coolie always took his brass pot of rice with him out to the fields and in the middle of the day he is supplied with tea. It is the women who do the pruning of the bushes, carrying out their work similar to that of pruning rose bushes. The men's work is of a more strenuous nature. They have to do the deep holing, and repair all the drains before the rain comes. As they come in in the afternoons you will usually notice the women and children bringing in the prunings in bundles on their heads. These prunings they use for their fires. All the men bring in is what they have been working with.

"One day a week is what the workers get off, and that is almost always on the Tuesday. On that day a bazaar is generally held on the plantation garden, when everyone gets in his stores for the week. Most of the selling at these bazaars is done by Nagas and Manipuris, hill tribes of the Mongolian type. It is extraordinary how little money changes hands when these bazaars are held in the villages. Business is mostly done by bartering, goods being exchanged for others.

A Coolie and His Cow.

"On the plantation the coolies also have their own cows and there are quite a large number of them. These are driven out to the pastures in the morning, but a watch has to be kept on them all day. When they are brought back in the evening they are put in the yards or in the houses. They cannot be left out on account of the wild animals. I was highly amused when I saw the cows in the houses. Of course, a light is always kept going all night, and to look in a window and see a native sleeping in one corner and a cow in the other is a picture."

Protecting the Plant.

The tea plant, went on Miss Macdonald, began life in a nursery. She visited one of the nurseries and saw the seeds first in the germinating house, and put in the ground. They were then covered with sun grass, and as they began to sprout the sun grass was raised on a frame. This gave the plants the necessary protection from the sun, and there they remained until strong enough, and it took several months to plant out in the open. On each of the plantations there was such a nursery.

But not only did the young plants require protection from the sun. Among the tea plants on the plantation other trees were growing. In the cool weather these trees lost their leaves, letting the sun in on to the plants, but in the hot spell, with their leaves on, they formed a protection and kept the sun's rays out.

Reminded Her of New Zealand.

Miss Macdonald was attracted by the beauties of the country round about Lakhipur. Much of it reminded her of New Zealand. The trees were different, of course, but the general effect was very much the same as in the Dominion. After three and a half months in the Assam country Miss Macdonald's stay came to an end, and the journey homeward commenced, but many miles among beautiful scenery and interesting places had yet to be traversed. A return was made to Calcutta, and then on to Rangoon and Penang, the latter being one of the most beautiful places Miss Macdonald had seen.

Wonderful Roads.

She could not help but be impressed with the wonderful roads. They were almost as smooth as glass. These roads

were not confined to Penang, but were to be found all over the Malay State. Labour was so cheap that the stones were laid down by hand by the coolies, and then rolled in and tarred. It gave an almost perfect surface and made motoring a joy, there being no dust.

Rubber and Tin.

Through the States were to be seen miles and miles of rubber plantations. She was fortunate enough to see through one rubber estate, and saw the rubber being tapped from the tree and going through the different processes until it was ready for the market. On the rubber plantations the general health and life of the worker was much the same as on the tea plantations. The only difference was that the worker was of a lower class, being mostly Tamils who ship in thousands from India. Malay is quite an attraction for the coolies, for there they get higher wages than in India. Most of them come from the southern Indian States.

Highly interesting was the work in the Malay tin mines or the dredges dredging for tin. In the smelting works there was again a change in the labour, being all Chinese, even to the manager, but a peculiar fact was that the watchmen at the gates and offices were Sikhs.

The Final Stages.

That wonderful old place Malacca was reached at Easter time, where there were to be seen many old ruins of the Portuguese. But the same could be said of almost everywhere in the Malay States. Places of beauty and interesting spots were to be found at almost every place where a stop was made. Reaching Singapore the steamer for the final stages was boarded, and calls en route to New Zealand were made at Batavia, Samarang, and Surabaya. Port Darwin was the hottest place of the whole trip, added Miss Macdonald, and coming down the Queensland coast the Tasman on the reef was passed, a number of other vessels then standing by the vessel in trouble. In all Miss Macdonald spent six weeks travelling through the Malay States.

—"Hawkes Bay Herald."

A Letter of Interest

The following letter was received by the Matron of one of our training schools from a young girl, who wished to enter for training. Even education has its limitations—at 17!

The Matron,

—— Hospital.

Dear Madam,—

As I am particularly interested in the welfare of young children and am endowed with an extremely sympathetic disposition, it is my desire and ambition to become a member of the nursing profession.

I would be pleased to hear of any vacancies on your staff wherewith my services might be dispensed, failing that I would be extremely grateful if you would see that my name was referred to the waiting list.

I am a young girl nearing my eighteenth birthday, and until last year I was a pupil of the T—— District High School, where, after passing through the Primary Department, I attended for two years in the Secondary Department, the Principal of which will, on request, supply you with full particulars regarding my character and ability.

I am enclosing a snap of myself taken a few days ago, which will, I trust, give you some idea of my general personal appearance.

Any communications addressed to me, care of my parents, with whom I reside, will be appreciated.

Trusting my application will meet with your favourable consideration, and hoping to hear from you at an early date,

I remain, Madam,

Yours obediently,

———.

The Prevention of Disease in Infancy and Childhood

ARTHUR M. WILSON, D.S.O. M.D. B.S.

Lecturer in Obstetrics and Gynæcology, Melbourne University, Senior Hon. Obstetric Surgeon, Women's Hospital, Melbourne.

THE PROBLEM.

(This subject will be approached and treated from the viewpoint of the obstetrician.)

The causes of fœtal "dead-births" are intimately related to the causes of neonatal deaths and of disease in infancy and childhood. Unfortunately—except from hospital statistics—owing to the inefficient registration and notification of "dead-births," the actual causes of the "dead-births" cannot be ascertained. The position would be greatly improved if a certificate showing the cause of the "dead-birth" had to be given with all viable fœtuses.

The fœtal existence may be divided into three stages:—

(a) Ante-natal: i.e., in the quiescent uterus.
(b) Intra-natal: i.e., during labour.
(c) Post-natal: i.e., after birth before the pulmonary respiration has been established.

Pulmonary respiration is the test to apply in deciding whether the fœtus has been dead-born or not. The continance of the heart-beat is merely the extra-uterine continuance of the normal intra-uterine condition.

Fœtal Death:

This may occur during any stage of its existence:—

(a) Ante-natal death: i.e., during pregnancy. In this condition the fœtus is born in a macerated or mummified condition.
(b) Intra-natal death: i.e., during labour. In this condition the fœtus appears quite normal.
(c) Post-natal death: i.e., after labour but before the establishment of pulmonary respiration. In this condition the fœtus is born with its heart still beating.

Ante-Natal Causes of Death:

(1) Maternal; Chronic nephritis; syphilis: toxæmias, especially eclampsia —acute febrile infections; trauma; sudden shock or fright.
(2) **Placental:** Degenerative conditions of Placenta, especially if associated with ch. nephritis; premature separation of the placenta with cases of A.P.H.
(3) **Fœtal:** Very rarely is it due to fœtal conditions, but it sometimes occurs with malformations.

Chronic nephritis, syphilis and Toxæmias are by far the commonest causes. Repeated habitual ante-natal death of the fœtus has been described. Sometimes no cause can be assigned, usually one of the three above-mentioned conditions may be found. A full-time macerated fœtus in the absence of chronic nephritis, Toxæmia, or Trauma is very suggestive of syphilis.

Intra-Natal Death:

This is practically always due to asphyxia or birth injury.

Asphyxial Death: Any condition causing interference with the placental respiration will ultimately cause fœtal death. If it is not severe enough to cause death, the fœtus will be born in a condition described as asphyxia neonatorum. Owing to the disturbance of the placental respiration, there is an increase of CO_2 in the blood and the respiratory centre may be first stimulated before it becomes paralysed. As a result the fœtus makes premature attempts at inspiration and may suck into its lungs liquor amnii or blood. This stimulation of the respiratory centre is more likely to occur where the interference with the placental respiration has been rapid.

The increased intra-thoracic pressure causes venous obstruction all over the body, and if the condition persists the cardiac centre is also paralysed and the fœtus dies.

The Causes of Asphyxial death:

(1) Premature detachment of the placenta.
(2) Compression of the Cord.

(3) Compression of Placenta.
(4) Compression of Fœtus.

Deaths from Injuries:

The commonest causes are head injuries—associated with cerebral hæmorrhage. Fractures of the bones, even if depressed do not as a rule cause death, unless they are associated with cerebral hæemorrhage, the commonest accompanying lesion being a laceration of the tentorium cerebelli. One quarter of all intra and post-natal fœtal deaths is due to injury—the remaining three-quarters are due to asphyxia.

Cerebral injury and hæmorrhage are usually caused by extreme compression and moulding of the head, but occasionally they occur in apparently normal labours.

Causes:

(1) Forceps delivery, especially if much traction is used, also if forceps are applied in the wrong position on the head, and if applied too early before the head is well moulded. The tip of the blade, if it lies in the wrong situation, may actually cause a depressed fracture. A depressed fracture associated with hæmorrhage may also occur when the head is pulled past the promontory.
(2) By compression of the head, in rapid delivery of the after-coming head in ing a precipitate labour.
(3) With abnormally soft fœtal heads, especially with premature infants, and also in attempts to rotate a P.O.P.

Postal-Natal Fœtal Death:

This is due either to occlusion of the respiratory tract by mucus sucked in by premature attempts at respiration or by paralysis of the respiratory centre either by asphyxia, birth injuries, or drugs given late in labour (especially morphia).

The fœtal death rate is alarmingly high, as the following figures show:—

Place.	Confinement.	Dead Births.	Per-centage.
Victoria (1923) ..	35,876	1,056	2.9
Victoria (1924) ..	26,139	1,087	3
Women's Hospital, Melb., (1925-1926)	2,717	149	5.5

The causes of fœtal "dead-birth" have been discussed in some detail as minor degrees of the same causative conditions may cause neo-natal death and a still lesser degree may result in some disability, disease or disorder during infancy and childhood.

Neo-Natal Death:

There is some divergence of opinion as to what constitutes the neo-natal period. Some authorities reserve the term for the first fortnight after the birth of the child. On the other hand, it is much more convenient to count this period as extending over the first four weeks as undoubtedly the commonest causes of death during this period are obstetrical rather than nutritional.

It is quite obvious, however, that though many of the obstetrical causes of death are preventable, many are quite unavoidable.

In dealing with the causes of neo-natal death, the vital statistics are of some value, as in these cases the obstetrician is required to give a certificate stating the cause of death.

Causes of Neo-Natal Death:

(a) Under-development of the vital centres owing to prematurity, especially if associated with malnutrition of the infant due to some existing maternal disorder, especially Toxæmia of pregnancy, syphilis and chronic nephritis.
(b) Malnutrition and debility of the infant owing to the presence of the above constitutional disorders.
(c) Birth injuries, especially cerebral hæmorrhage.

The severity of the problem of neo-natal death may be gauged from the following figures:—

Place.	Live Births.	Noe-Natal Deaths.	Per-centage.
Victoria (1925) ..	35,922	*1,110	3.09
Victoria (1924) ..	36,139	*1,159	3.21
Women's Hospital, Melb., (1925-1926)	2,568	†72	8.8

*First month. †First two weeks.

Of the 1,159 neo-natal deaths occurring in Victoria in 1924, 751 died within the first week.

The causes of death were given as follows:—

Prematurity	568
Wasting Diseases	137
Diarrhœal Diseases	14

Bronchitis and Pneumonia ..	47
Convulsions	27
Congenital Defects	110
Violence	4
Other Causes (including Birth injuries)	246

At the Melbourne Women's Hospital, out of 152 cases of neo-natal death specially investigated, the causes of death were as follows:—

Prematury	60
Birth Injuries	35

In considering the statistics of the State, I am strongly of the opinion that the proportion of deaths from birth injuries is greater than would appear from the statistics. The classical signs and symptoms (increased tension of anterior fontanelle, head retraction, convulsions, meningeal cry), are often absent. The baby may lie perfectly quiet and flaccid refusing to suck, the anterior fontanelle may be depressed, and there may be rapid loss of weight. The cause of death in such a case is frequently given as congenital debility, heart disease, or malformation.

Here again the question of neo-natal death has been somewhat fully discussed, as it is quite evident that many infants, after surviving some neo-natal illness or disorder are condemned therefrom to various diseases and disabilities not only of childhood, but also of adult life.

The problem to be solved may be approximately stated to be as follows:— For every 100 births, there are three dead births; of the surviving infants another three die within the first month, and another two die within the next eleven months, some a result of neo-natal disturbance, others from nutritional and infectious disorders.

The prevention of the "dead-births," neo-natal deaths, and a small proportion of the deaths occurring within the 2-12 month period, are in the hands of the obstetrician — the remainder in the hands of the pedriatrician. In comparing infantile vital statistics, especially as regards dietetics, a much fairer test is the mortality in the 2-12 month period, as I believe that very few of the deaths occurring during the first month are due to improper feeding—though undoubtedly the foundation of the nutritional disorder is laid extremely frequently during this period.

The Prevention:

The three cardinal rules of obstetrics are:—

(1) Care in the ante-natal period.
(2) Care in the intra-natal period.
(3) Care in the post-natal period.

We all do not have the same operative ability, or manual dexterity, neither do we all possess in equal degree that indefinable quality known as "brains"; yet we should all have an equal capacity for being careful with our patients.

In obstetrics carefulness counts more on most occasions than skilfulness. I believe that at present the great hope of improvement in the fœtal (and also maternal) mortality rate lies in the development of a strong obstetric conscience in all practitioners and nurses, and in the education of the public to seek efficient medical and nursing attention under suitable conditions.

Ante-Natal Care:

During pregnancy the border line between the physiological and pathological is very slender; therefore all patients must be carefully watched for the appearance of the pathological.

Dame Janet Campbell's words are worth quoting:—"Until ante-natal supervision is accepted by patients and their advisers as the invariable duty of the professional attendant engaged for the confinement, we shall never make sustantial progress toward the reduction of maternal death and injury. It is the key to success in any scheme of prevention and it must be insisted on, until it is recognised as a necessary and integral part of the management of every confinement case."

The details of the routine ante-natal examinations have been so frequently discussed that it is hardly necessary to reiterate them again. However, a note of warning should be sounded. Ante-natal care should not mean increased interference on the part of the obstetrician. The early diagnosis of some pathological condition should in many cases enable the obstetrician by treatment to once again convert the case from the abnor-

mal to the normal, and thus should limit the appearance of an acute obstetrical emergency necessitating some hasty, drastic treatment.

Very briefly may be mentioned the most important conditions which should be sought for are:—Disproportion, pelvic deformity, malpresentations and malpositions, toxæmias of pregnancy, constitutional complications of pregnancy (especially chronic nephritis), cardiac and pulmonary disease, and venereal disease.

Limiting the further remarks to the constitutional disorders, I would like to

a breech. This may also occur dur-

Incidentally, Fowler and Fairley showed the almost impossibility of converting a positive test itno a negative test during pregnancy. Nevertheless, efficient treatment would undoubtedly improve the prognosis both for mother and child.

The value of ante-natal care is well exemplified by the results obtained at the Melbourne Women's Hospital last year.

Number of Cases, Maternal Deaths, Fœtal Deaths (Dead Births & Neo-Natal Deaths).

Ante-natal Cases ..	1,281	2	84	6.6%
Emergency Cases ..	1,399	26	127	10%

Intra-Natal Care:

Watchful expectancy and masterly inactivity on the part of the obstetrician will bring most cases to a successful termination. Nine cases out of ten will be perfectly normal if they are only left alone. The normal case will be much better off without a doctor than with one that interferes unnecessarily. The abuse of the obstetrical forceps leaves behind a ghastly train of dead, dying and damaged infants.

This is neither the time nor the place to enter into a dissertation upon the uses and abuses of the obstetrical forceps, yet the commonest causes of difficult forceps deliveries may be mentioned:—

(a) Premature application of forceps.
(b) Faulty application of the forceps.
(c) Unrecognised disproportion.

The Prevention:

(a) Waiting until it is apparent that no further descent of the fœtal head will occur.
(b) Correct application of forceps.
(c) Ante-natal supervision.

Too often is it assumed that because a primigravida has entered the second stage of labour that she is "ready." There is only one almost safe forceps operation, i.e., the head-on-perineum operation.

Especially should two types of fœtuses be delivered without forceps if possible —the premature fœtus, and the fœtus with the abnormally soft head.

Whilst admitting that birth injuries associated with cerebal hæmorrhage do occur in normal deliveries, nevertheless it must be admitted that the majority occur with forceps and breech deliveries. The elimination of these injuries would limit to a great degree many of the neonatal disasters and the disorders and diseases of infancy.

Post-Natal Care:

Unfortunately there is a tendency amongst some obstetricians to regard their work as finished once the infant has been safely delivered, and their subsequent attentions are devoted to the mothers whilst the infants are left to the tender mercies of the nurses.

The causes of death during the postnatal period are mainly obstetrical—this period marks the commencement of various nutritional disorders which may cause many months of disease and disorder in infancy and childhood.

The importance of breast feeding simply cannot be over-estimated. In many infants—after an exhausting and difficult labour—the sucking reflex may be weak owing to some slight cerebral hæmorrhage in œdema. Unfortunately, in many cases it is assumed that the breast secretion is at fault and the infant is promptly put on to some artificial food, whereas, with the exercise of some patience, this difficulty would be overcome.

Here also must be deprecated the indiscriminate giving of castor oil, brandy, artificial foods during the first week of the infant's life.

A few of the commoner neo-natal disorders may be mentioned. The immense death rate in premature infants calls for some comment. Undoubtedly the slender chance of survival in many of these infants is lost in the first five minutes subsequent to their birth. They are allowed

to get cold, and the greatest difficulty is then experienced in getting their temperature up again. A warmed blanket and crib should be prepared before their arrival, and immediately after birth the infant should be wrapped up in the blanket whilst the obstetrician waits for the cord to stop pulsating. It is astonishing how well these infants do—even in spite of severe syncopal attacks during the first few weeks—provided that efficient care is given to them. In my own practice I never give brandy to premature infants.

With regard to the treatment of cerebral hæmorrhage in the new-born, I have seen infants improve and survive after a lumbar puncture, but I have yet to see one that has grown up into a perfectly normal child.

The morbus hæmorrhagica neonatorum is very satisfactorily treated by muscular injections of the mother's "whole" blood. Umbilical sepsis accounts for far more deaths and ill-health during the ante-natal period than is usually supposed, and consequently in the management of the stump-cord, rigid aseptic precautions should be adopted.

In conclusion, I should like to call your attention to the following table which has been copied from Dr. Marshall Allan's interim report on maternal morbidity and mortality in Victoria.

TABLE V.—INFANT MORTALITY, VICTORIA.

Number of Deaths per Thousand Births.

Period.	Under 1 Month.	Over 1 and Under 12 Months.	Under 1 Year.
1881-1890 ..	37.2	89.4	126.6
1891-1900 ..	33.8	77.9	111.7
1900-1904 ..	34.3	63.7	98.0
1905-1909 ..	32.9	48.0	80.9
1910-1914 ..	32.6	41.2	73.8
1915-1919 ..	33.4	32.7	66.1
1920-1924 ..	33.0	32.3	65.3
1925 ..	30.9	26.1	57.0

It will be noted that the number of deaths under one month has remained practically constant, whereas the number over one and under twelve months has been considerably reduced. It has been remarked that the chief causes of death in the first month are due to syphilis and slovenly obstetrics, and in the next eleven months to food and flies.

The pedriatricians have accomplished much—the next great improvement in the infant mortality must come from the obstetricians, and this can only be obtained by the exercise of increased care during the ante-natal, intra-natal and post-natal periods.

lay great stress on the importance of chronic nephritis during pregnancy. Apart from the danger to the mother, chronic nephritis is one of the most common causes of premature labours and of dead-births.

During the year 1925-1926 at the Women's Hospital, Melbourne, out of 28 maternal deaths, 11 cases (confirmed P.M.) showed evidence of chronic nephritis or toxæmia.

With regard to the venereal diseases, the treatment of gonorrhœa during pregnancy is most unsatisfactory. However, by prophylactic treatment, the incidence of ophthalmia neonatorum should be negligible. During the puerperium, gonorrhœa, whilst being a potent cause of maternal morbidity, is not a great cause of maternal mortality. Syphilis presents a most interesting problem. Fowler and Fairley reported in the A.M.J. of December 24th, 1921, a series of 750 consecutive Wasserman tests done on patients at the Women's Hospital; 53 (7.5%) were positive.

These figures agreed closely with a smaller series taken at the Women's Hospital some years previously by Allen Robertson. The most striking fact elicited was the latency of the condition. Many of the pregnant women could give no history of infection. They had no symptoms and showed no signs, and many of the infants appeared quite healthy at birth.

There is only one solution of this problem. The Wasserman test should be made on all women attending the ante-natal clinics and also the fœtal blood obtained from the umbilical cord could be tested. The expense and the technical difficulties would be great—but the return would be far greater.

Interim Conference

International Council of Nurses—Geneva, 1927.

The College of Nursing party assembled at the Continental departure platform at St. Pancras Station on Sunday, July 24th, at 9 p.m.—the train left at 10.30 p.m. Everyone seemed to be keenly anticipating the Conference and the trip to Tilbury was an enjoyable one. We had a few hours' rest on the boat to Dunkirk, and arrived at Paris an hour earlier than schedule. Automobiles conveyed us around the city, visiting en route, Notre Dame Cathedral, the Arc de Triomphe, and Unknown Soldier's Tomb, and noting many other fine buildings. We returned to the restaurant at noon for lunch, and here Miss Till (Auckland) joined the party. After lunch the drive was continued until 3 p.m. when many members of the party who had accepted invitations to be present at a reception given by the Red Cross Society at their Headquarters Building, were driven thither. A hearty welcome was extended, and we listened to a most interesting address on the work of the League, now a world-wide humanitarian organisation. We were shown through the various sections, the work of each being explained, then were entertained at a delightful afternoon tea in the Red Cross rooms. I think we were all very tired that evening and only a few managed to secure a sleep on the train, which was crowded. Train reached Geneva just after 8 a.m., and we were driven to the various Pensions. In the afternoon, about 50 members accepted invitation to a garden party at the residence of Mme. Peyrot. Here we spent a delightful time wandering around the beautiful shady grounds, and enjoyed the afternoon tea. We were all eagerly anticipating the opening of the Interim Conference, and assembled at the Salle Centrale at 10 a.m. Wednesday, 28th, for the purpose of registration and receiving programmes, dispersing at noon. We met another New Zealander, Miss Horrell (Timaru). In the afternoon the majority of the party visited the Cantonal Hospital—a large and up-to-date institution—600 beds. We were kindly shown over in groups—languages considered.

At 8.30 p.m. the session opened, Miss N. D. Gage, President, presiding. An address of welcome was delivered by M. Turrettini, Conseiller d'Etat, Canton de Geneve, to the visiting delegates, and was responded to by Miss Gage. Mrs. Bedford Fenwick then presented a handsome bouquet to Miss Gage. An enjoyable programme of music (violin and organ) was given, then followed addresses by representatives of various societies and organisations.

Thursday, July 28th, 9.30-12 noon.—Various subjects were discussed and papers read, "Advantages and Disadvantages of Standarding Nursing Technique" proving very interesting and of great import in these modern times.

2.15-4.30 p.m. — Demonstration of "Nursing Procedures" was also very interesting (by Schools of Nursing of various countries).

From 4.30 to 6 p.m.—Visits to various institutions of Geneva. The majority visited "L'Institut International d'Etude de Material Sanitaire," inspecting the sections, and were entertained at afternoon tea.

At 9 p.m. we attended a civic reception in the Foyer of the Theatre—it was indeed a delightful evening, pleasant music, and the chatting groups made an animated scene.

Friday, July 29, 9.30-12 noon.—There were various round tables. We attended No. 5 (Ways and Means of Promoting Professional Efficiency and Personal Development of Trained Nurses working on the staffs of Hospitals and Public Health Organisations). In the afternoon we visited the Palace of Nations, and were taken in groups through the various Conference and Council rooms. In the evening a most interesting subject, "Ways and Means of Promoting the Powers of Observation and Scientific Reasoning in our Student Nurses" was submitted and discussed.

Saturday, July 30th, 10-12 noon.—Members visited the International Labour Office, where a lecture was given. The afternoon was free, an excursion on the Lake of Geneva had been planned, but took place on Monday, 1st August. In the evening the General Session resumed. Subject: "Uniforms and Equipment for Nurses," and later a demonstration of nurses' uniforms took place—what variations there are; it does make one wish for a standardised uniform. Then followed discussions, general discussion, adoption of resolutions, and closing addresses and votes of thanks.

About 250 members accepted Dr. Rollier's invitation to visit his clinic at Leysin on Sunday, 31st. We left by automobiles at 7.30 a.m.. We travelled for many miles through wondrous mountain scenery, and it was very steep and awe-inspiring in places. The visit was most interesting. To see the marvellous results of the treatment (surgical tuberculosis) cannot but convince one of the splendid work achieved. It may take a year or two in the severe cases, but the time is made very pleasant for the patients, and all appeared very contented and hopeful in their sunny surroundings. Dr. Rollier delivered a most interesting lecture, followed by a lantern demonstration. We were entertained at lunch and tea, and a group of the patients sang to us and performed some of their regular exercises. The happy smiling faces and sun-tanned bodies were worth going many miles to see.

That evening the 8-day party left for Paris, the remainder left on Tuesday evening.

About 300 attended the Conference.

Thus concluded a most interesting and inspiring Conference, and I am sure we all carried away the happiest memories. Our hosts and hostesses made the occasion a most pleasurable one, and I am sure we have all profited by the Interim Conference held in beautiful Geneva, 1927. I.L.J.C.

Annual Conference

New Zealand Trained Nurses' Association.

The Annual Conference of the Association was held from October 4th to 7th, 1927, in Wellington. The President, Miss Pengelly, was in the chair, and the delegates present were:—Mrs. Thomson, Hawkes Bay; Mrs. Kidd and Miss Bagley, Auckland; Misses Stott, Kohn, McRae and Barnitt, Wellington; Misses Every and Arnold, Nelson; Miss Buckley, Canterbury; Misses Young and Tennent, Otago; Miss Lambie, deputy delegate, Taranaki; Misses Benjamin and Preston, Wanganui; and Miss Inglis (Honorary General Secretary).

The Conference was opened by the Minister of Health (Hon. J. A. Young), who, with Dr. Valintine, was introduced by Miss Pengelly.

Mr. Young, on behalf of the Government, extended a welcome to the delegates to the Conference and hoped their deliberations would be profitable. The nursing profession, like others, had its trials, but he was sure it was the desire of its members to help the progress of their chosen calling, and he felt sure such conferences were helpful in bringing together nurses engaged in all branches of the work, private as well as institutional, and enabling all to consider their problems from every point of view. They must remember that it was one of the finest professions in the world, that of ministering to suffering humanity. There were one or two problems which he knew would receive their attention, that of the higher training of nurses and a diploma of nursing, and he hoped the Conference would consider this with regard to the difficulties of the Department. It was important that something in the nature of a post-graduate course for nurses be promoted, to enable them to keep up to

date and give those in administrative positions training to act as teachers in the larger hospitals, and he thought there should be no serious difficulty in arranging this between the Department, the hospitals, and some school of learning. Another question was that of the maternity nurse in relation to the qualification for midwifery. Difficulty had arisen through the Nurses' and Midwives' Registration Board not recognising all hospital training as midwives, that was, in taking full charge of obstetric cases, and this had given rise to dissatisfaction in some quarters. It must be remembered that the Registration Board was a statutory body created by Parliament, and not under the control of the Department. The Nurses' Association had representation on this, and it was for them to bring pressure, if they saw fit, to alter the qualification. It must be remembered, however, that in some of the smaller hospitals there was no opportunity for training midwifery nurses to take cases without a doctor, and it must be borne in mind that New Zealand had reciprocal relations with Great Britain, so that our nurses' registration was recognised there, and care must be taken not to depreciate the value of the qualifications of nurses in New Zealand. Mr. Young assured the Conference he would be pleased to hear anything they might like to lay before him at the conclusion of their meetings.

Dr. Valintine also spoke briefly and welcomed the visitors and said that in the matter of the higher training of nurses arrangements might develop in connection with the University, though it might not be Otago.

Miss Pengelly, on behalf of the Conference, thanked the Minister and Dr. Valintine for their presence.

She then welcomed the delegates to this the tenth Conference of the Trained Nurses' Association. "These meetings," she continued, "gain in importance each year. By profitable discussion many difficulties can be dealt with satisfactorily. Our chief subject for discussion at present is the question of a post-graduate course for nurses. This course was deleted from the Otago University calendar since the last conference. Our energetic secretary, Miss Inglis, has had much correspondence on the subject, and I have no doubt that it is largely due to her effort that the matter has been so well ventilated. We hope to have shortly a definite statement with reference to the post-graduate course. Correspondence has been received from the Pan-Pacific Women's Committee with reference to the Conference which is being held in Honolulu in July, 1928. This Committee is anxious that the Trained Nurses' Association should send a delegate. Some nurse taking a trip to Honolulu at that time might be pleased to act as such. If we are unable to send a delegate, it is suggested that one or more members might contribute a paper to be read at the Conference. Since our last Conference we have been honoured by Her Excellency Lady Alice Fergusson consenting to become Patroness of the Association.

We are very glad to welcome two new branches—Taranaki and Wanganui—as part of the Trained Nurses' Association.

Report for the Year 1926-1927.

Since the beginning of the year Her Excellency, Lady Alice Fergusson, has consented to become Patroness of the Association. We are very glad to have her interest and support.

Soon after the last Conference the Association received the disturbing news that the nursing course had been deleted from the calendar of the Otago University. The University Council stated that they would be prepared to reinstate it if satisfactory financial aid were obtained, but in the meantime there would be no such course at the Otago University. The Association, since then, has tried in every way to obtain the necessary assistance. The Auckland University was approached and a deputation from the Auckland Branch of the Association waited upon the Chancellor and Council. They expressed themselves as willing to institute a post-graduate course in Auckland if aid were given. The Minister of Health was then approached through Dr. Valintine, and he promised to make a recommendation to Cabinet. After wait-

ing for five months, the Minister was asked if any decision had been reached in the matter. He replied that it was under consideration. As there was evidently no hope of Government assistance in the near future, the Association decided to collect funds for the purpose, and they have met with considerable success. Last month the University Councils of Auckland and Otago were asked if they would pay the salary of one nurse lecturer if that of the other were guaranteed. No reply has so far been received.

We are very glad to welcome two new branches to the Association—Taranaki and Wanganui.

The balance sheet for the nurses' journal, "Kai Tiaki," shows a profit for the year of £18, but many subscribers are still very dilatory in sending their subscriptions. These are all due in January, and as the sum of £94 is in arrears for this year alone, that means that roughly over 300 subscribers are behind-hand with payment. Once more we appeal for prompt payment of subscriptions.

EDNA PENGELLY,
President.

H. C. INGLIS,
Hon. General Secretary.

Apologies and good wishes for the success of the Conference were received from the Presidents of the following branches:—Auckland, Mrs. Tracy Inglis; Hawkes Bay, Miss Macdonald; Wanganui, Miss McKenny.

The reading of the minutes and of correspondence received and answered, also the annual report, occupied the first day.

Remits 1 and 7 were taken together.

Remit 1.—*That all eligible nurses engaged in Public Health work and Nursing Education be urged to become members of the New Zealand Trained Nurses' Association in order to confer and promote round table discussion on points of mutual interest, thereby strengthening each other and forming one strong united organisation.*

Remit 7.—That the internal working of the Trained Nurses' Association be reconstructed so that it may meet the needs of the various branches into which the nursing profession has developed. It is recognised that the various sections of nursing each have their own problems which only relate to their special work. Consequently, it is suggested that for working purposes each branch Association should be subdivided into three groups:—Nursing Education; Private Nursing; Public Health.

Miss Lambie was asked to address the meeting about the reorganisation of the working of the Association. She stated that the nurses in Canada work the Canadian Association in this manner, dividing it into sections. The London College of Nursing had also adopted this method of dividing into sections, and found it invaluable in promoting interest in the profession.

The Canadian section, Miss Lambie continued, with which I am most familiar, has enormously strengthened its position by this method. The work is divided into three groups—Nursing Education, Private Nursing and Public Health. Each section has its own problems and deals specially with them.

As regards Nursing Education in New Zealand, those interested in this section would be Matrons and Sisters of Training Schools, either general or maternity. Private nursing comprises those engaged in private hospitals. Public Health work is a recent institution in New Zealand, and during the last ten years it has doubled in strength. This subject requires to be studied by people with a special knowledge. No one person can lay down rules for any public health conditions. Plunket nurses have a separate alumni association for studying their own problems. The Sanitary Institute is inviting public health nurses to become associated members of the institute. We are fortunate in having at present only one national Trained Nurses' Association in New Zealand, and it is essential it should remain so. Therefore, it is necessary to study without our association all aspects of nursing work. The adoption of the sectional method would assist this.

I think the dividing of the Association into sections will help to put new life into the internal working of the Association. Each section will have its own problems and discuss them among them-

selves, the private nurses talking over their difficulties with private nurses; the public health nurse with public health nurses, etc. This will tend to create more interest among the nurses in the Association.

In International Councils, where they have these sections, each section is represented in the main body. If we have these sections we will have a better understanding of the aims and details of other Associations. At present, owing to long distances, we are handicapped and have difficulty when dealing with questions sent by the International Council. I strongly urge the Association to adopt these sections and so put fresh life into the Association.

Miss Bagley, referring to the suggested sections: There is no midwifery section. I am wondering to what section they would be admitted. Should we admit them to private nursing section as members through their qualifications?

A Member: They might come under Public Health. Public Health section embraces ante-natal work and infant life protection.

Miss Lambie: Midwifery is definitely part of the Public Health programme. Midwifery nurses belong to that section, and if these nurses are on the Council it cannot effect reciprocity. One member may belong to two sections—to Public Health and Private Nursing.

Mrs. Kidd: Is each section represented on the local Council?

Miss Lambie: There is a small committee of each section of not more than three members who automatically become members of the Council, the chairman always being one. I think it best to leave it to each local branch. Of course, what suits Canada may not suit New Zealand at all. We must evolve our own system, but I do think it would be of tremendous value to have these sections.

Miss Buckley proposed that Remits 1 and 7 be passed as they stand. Miss Young seconded the proposal, with the amendment that a copy of the Otago suggestions in this connection be sent to the branches, and they be asked to deal with the matter and develop the branches accordingly.

Remit 2.—That the existence of the Nurses' Memorial Fund be brought more clearly before the medical profession, the nursing profession, and the public.

Miss Pengelly (President) said that more attention should be drawn to the Nurses' Memorial Fund, and that if the origin and reason for it were better known and discussed, more interest would be taken in the subject by nurses themselves.

Miss Buckley suggested that occasional notices in the daily papers would serve to interest the general public. Especially people who had money to leave to various funds. Wealthy people would possibly become interested in the Nurses' Memorial Fund if their attention was drawn to the matter and the purposes for which the fund is used were made known throughout New Zealand.

Miss Stott: We must interest the nurses themselves. The fund is for nurses who are in financial difficulties, but nurses generally do not seem to know about it. It was advisable that the notice of women generally should be drawn to this fund.

Mrs. Kidd proposed that the National Council of Women should be interested in the Nurses' Memorial Fund, as they could be of considerable help if approached.

The following motion was proposed by Miss Buckley and seconded by Miss Kohn: "That an account of the aims and origin of the fund be published in 'Kai Tiaki,' with an account of the financial condition, and that if possible, extracts should be copied into daily papers throughout the Dominion."

Miss Young proposed and Miss Buckley seconded: "That the Honorary Secretary write to the head of the Legal Association of New Zealand with reference to the Memorial Fund."

Miss Pengelly suggested that a short history of the Memorial Fund be written and sent to all local branches. Dunedin would be the most suitable place to do it, as all data would be to hand. She proposed that Miss Holford be asked to write it.

Miss Stott suggested that if Miss Holford was too busy or could not undertake it, Miss H. Maclean should be approached.

Miss Tennent proposed and Miss Bagley seconded: "That a short history of the Nurses' Memorial Fund be written by Miss Holford with Dr. Young's co-operation. Failing Miss Holford, that Miss H. Maclean be asked to take her place."

Miss Tennent remarked that most nurses were giving 2s. 6d. subscription annually to this fund, which was a great help. It was pointed out that the new branches had not been notified of this custom, and they were asked to send similar subscriptions to their Branch Secretary, who would forward them to Mrs. Bundle, Honorary Secretary, Nurses' Memorial Fund, 26 Tweed Street, Roslyn, Dunedin.

Remit 3.—That the Matrons of Public Hospitals be asked for their co-operation in bringing before their nurses the desirability of becoming members of the Association.

Miss Pengelly stated that although Matrons are very busy people, they can still be asked to do more, and they should be urged to do all in their power to interest their nurses in the Association and to induce them to become members. It was pointed out that not all the Matrons are members of the Association.

Miss Bagley suggested that all branches be asked to circularise the Matrons of Public Hospitals with the view to inducing them to become members of the Association, and to endeavour to interest the members of their staff and get them to join the Association. The Matrons should see that the nurses knew the origin of the Association, and bring before them the benefits they would receive as members.

Miss Pengelly: You cannot compel nurses to join the Association, but it could be suggested to Matrons that nurses looking for positions in hospitals should be asked if they are members, preference being given to applicants who are members. In this way nurses would soon see that unless they join they will have less chance of work than members, and so they will be practically made to join.

Miss Bagley proposed, and it was seconded by Miss Buckley: "That the Secretaries of the local branches be asked to circularise the Matrons of their districts, with the object of their joining the Association and persuading their staff to join also."

Miss Kohn gave notice of motion that nurses, on completing their training, should automatically become members of the Association.

Exception was taken to the word automatically.

Remit 4.—That maternity nurses who are registered on their training be eligible for membership of the Association.

Miss Pengelly: There are now two classes of maternity nurses. We have to consider what is done in other countries and what effect the admission of maternity nurses to membership would have on our position as regards the International Council of Nurses. I see no reason why a fully trained maternity nurse should not be allowed to join the Association; in fact, I think it would be imposing a great hardship on this class of nurse if they are refused membership.

Miss Tennent said that in England midwifery nurses are not admitted as members. If we admit maternity nurses to the Association, would they be recognised outside of New Zealand, and what effect would such admission have on the question of reciprocity? The standard of midwifery training in New Zealand has been raised, and is now higher than that given in England or Australia.

Miss McRae proposed that Remit No. 4 be taken as read. This was seconded by Miss Kohn, who suggested maternity nurses could belong to an auxiliary section.

Miss Lambie: I suggest that the International Council of Nurses at Geneva be approached on the matter.

Miss Kohn: Meantime, could we not make them associate members of the Association?

Miss Buckley moved as an amendment, seconded by Mrs. Thompson: "That ma-

ternity nurses be admitted as associate members of the Association until such time as the matter can be fully dealt with." This was carried.

Remit 5.—*That all branches of the Association be asked to insist on all applications for membership being accompanied by a letter from the Matron of applicant's Training School or a satisfactory equivalent.*

Mrs. Thompson stated that an application for membership had been refused, as it was unaccompanied by a letter from the Matron, the applicant being unable to obtain the said letter.

Miss Pengelly said in such a case a satisfactory equivalent was usually accepted.

It was agreed that this was the rule in most branches.

Miss Young proposed that Hawkes Bay Branch be informed that a satisfactory equivalent is accepted in place of Matron's letter when such is unobtainable.

Remit 6.—*That Hospital Boards be asked to give registered nurses free treatment in Public Hospitals.*

Miss Tennent: I do not consider the matter is one for this board to deal with.

Mrs. Kidd said that a charge was made in Auckland Hospital, but only on account of the auditor's inspection.

Miss Tennent: No person is compelled to pay who is unable to do so.

Mrs. Kidd: It is a matter which should be left to Hospital Boards to deal with, taking into consideration the merits of individual cases.

Miss Pengelly stated, on the whole nurses were generously treated by Hospital Boards, and in many cases granted a month of sick leave.

It was decided that this matter should be left to the generosity of the Hospital Boards.

SUBJECTS FOR DISCUSSION.

No. 1.—Re Subscriptions in Case of Transfer.

Miss Pengelly: The present arrangement of transfers is that if the fee is paid to her own branch a nurse may transfer to another branch and carry on for the current year.

The point was raised as to whether a further fee should be paid in case of transfer from one board to another.

Mrs. Kidd stated it was not usual to ask for any further fee in connection with transfer, provided mention was made on transfer paper of fees being paid up to date, i.e., until the end of the financial year, which was definitely fixed for all branches for the end of October.

Miss Pengelly said the fixing of one date for end of financial year for all branches had been done with a view to simplifying transfers. There was an enquiry from New Plymouth when a transfer was wanted for four months only (a member was taking Plunket training). What would happen about the fees in such a case?

A Member: They could transfer temporarily, provided they made application to the Branch.

The motion was proposed by Miss Bagley and seconded by Miss Stott: "That the Branches be asked to state the financial position of a member in the case of a transfer, and no additional fee to be asked for during the current year."

No. 2.—Re Adoption of Straight-out 12-hour Duty for Private Nurses.

Mrs. Kidd: In private nursing the actual 12-hour duty is not practical. It means a 12-hour day and night duty. We do not know at what hour a patient will be ill; there must be give and take; it must be an elastic arrangement.

Miss Lambie: It simply means two nurses must be employed, one for day, one for night. This will prevent many people being nursed in their own homes on account of the expense.

Miss Young: Or they will employ untrained nurses where they can get them at a cheaper rate.

Miss Pengelly: It is lowering the standard of nursing, bringing it down to the level of a waterside worker. We have a high standard to maintain. A nurse must use her own common sense in the treatment of individual cases. She cannot work all the time, and she should try to arrange for time off when most convenient. I do not consider the straight out 12-hour duty a practical suggestion.

Miss Buckley: With a straight-out 12-hour duty. If the patient takes a bad turn just when the nurse is going off duty and she leaves at such a time, our profession would be ruined. It is an impossible position.

Miss Tennent asked if the duty referred to private work or private hospitals.

Miss Pengelly: To them all; there is also a 10-hour duty. I dont' know how it is arranged, but it is also bringing in ideas which are lowering the standard of nursing.

Miss Bagley: This request is contrary to the spirit of nursing.

Miss McRae: It is bringing down the nursing profession to a commercial basis.

Miss Pengelly: It is impossible to give a right service with this straight-out 12-hour duty. You cannot tell when a patient is going to be ill, and you certainly do not expect, if you are employing a special nurse, that she should walk out just when she is most needed.

Miss Stott: If the case is a short one, the nurse can do day and night duty, but she cannot keep it up indefinitely.

Miss Pengelly: It is only when a patient is in extremis that a nurse is called on to do any night duty, and that does not last long. Ordinarily, a patient can spare the nurse some time off during the day. Where a long duty is necessary in the case of a busy time, the time should be made up to the nurse when less busy, and she should be prepared to carry on when required. The straight-out 12-hour duty is designed for the lowering of the nursing standard.

Miss Stott: Is it not hard for nurses going from one bad case to another? They cannot possibly get a rest.

Miss Young: It is often very hard on the nurse, but the straight-out 12-hour duty is not the remedy; she cannot leave her patient.

Mrs. Thompson proposed, and it was seconded by Miss Bagley: "That the straight-out 12-hour duty for nurses is not practicable as no hard and fast rule can be made."—Carried.

No. 3.—Re Proposal of Approaching N.Z.B.M.A. with Reference to giving Preference to Employment of Trained Nurses.

There was considerable discussion on this subject, members making a point that untrained women should not be paid at the same rate as trained nurses. It was recognised that there are many cases such as in a long convalescence, where a trained nurse is not required. It was decided that the matter be left to the branches to deal with as they think fit.

An emergency remit, with reference to the dismissal of Matrons by Hospital Boards, was discussed at length, and the following resolution was passed:—

"That a recommendation be sent from this Association to the Director-General of Health and also to the Hospital Boards' Association, that before the final dismissal of the Matron of a hospital, the reasons for such action should be laid before the Director-General of Health, for as the approval of his Department is necessary before an appointment is confirmed, this Council considers that Departmental approval of the proposed dismissal is equally desirable."

A discussion took place regarding the new Act which governs the training of midwifery and maternity nurses. Examinations twice yearly were asked for, and also that maternity nurses might be allowed to complete their training as midwives without a year's interval between the courses. It was explained that if the various training schools will be patient, things are likely to right themselves, but that the scheme should be given a fair trial.

It was decided to refer to the Nurses and Midwives' Registration Board the question of the position of untrained women who complete their maternity training, then take a full course of general training, and after that enter for a four months' midwifery course.

A resolution was passed that the fund raised for the Grace Neill Memorial should be devoted to the purpose of founding a library in connection with the post-graduate course, to be called the Grace Neill Memorial Library.

Local secretaries of the branches are asked to be responsible for sending matter for publication in "Kai Tiaki" by the advertised date.

The next Conference will be held in Dunedin.

The officers for the coming year were elected as follows:—President, Miss Young; Vice-Presidents, the Presidents-elect of the Branches; Hon. Secretary and Treasurer, Miss Inglis; Auditors, Messrs. Wilberfoss and Anderson.

Before the conclusion of the Conference, various votes of thanks were passed to the President, the Hon. Secretary, and to all those who had contributed to making the Conference a success.

Social Functions

On Wednesday, October 5th, Miss Kohn entertained the delegates at luncheon. There were also present Miss Bicknell, and Council members of the Wellington Branch.

That evening a reception was held in the Pioneer Club, the hostesses being Mrs. Valintine, Mrs. Paget and Miss Bicknell. A most enjoyable time was spent, an amusing competition adding to the pleasure.

On Thursday, the delegates were taken for a drive along the new Khandallah road, with its fine view over the harbour, and then on to Silverstream, where they were entertained by Dr. and Mrs. Elliott. Tea was served in the garden beside a flowering cherry tree, and was much enjoyed. So, also, were the flowers, the beautiful stretches of brilliant green, the walks in the bush, and the perfect weather. All were sorry that the visit was so short.

On Thursday evening an open meeting was held at the Nurses' Club, 1 Kensington Street. Her Excellency, Lady Alice Fergusson, who is now Patroness of the Association, honoured us by her presence and showed great interest in the various papers read. Later, Her Excellency asked that members should be presented to her, and charmed everyone by her interest and sympathy with nursing matters.

On Friday the members of the Council, Wellington Branch, were at home at the Nurses' Club. A pleasant afternoon was spent with plenty of conversation and a refreshing tea. Farewell to the delegates brought a profitable and happy Conference to an end.

Time Saving Hints for a Busy Nurse

To collect a urine specimen from a male child, take a piece of adhesive plaster about 1½ to 2 inches square, make hole in centre just large enough to pass a urine test tube through, attach plaster to skin, having first passed the penis into tube.

To collect a specimen from a female child a small glass cup, such as we have all seen for holding seed in a bird cage, was used: in fact, a supply of these was kept in the wards. As the glass round edge of cup was sometimes rough, the opening was always bound with a 1-inch strip of adhesive plaster, then with two more strips it is quite simple to attach this glass to the vulva and so collect the specimen required. Having vivid memories of the precious minutes spent in holding a child over a chamber when doing duty in a children's ward, I felt I must pass this method on to you all.

Plunket Nurses' Association

A little over a year ago an Association of Plunket Nurses was formed as an outcome of the need felt for some organisation which would link up Plunket Nurses in various parts of the country with one another, and with the Plunket Training Centre. There are now more than 112 Plunket Nurses employed in permanent Plunket district work, as well as 16 in Karitane Hospital staff positions—a considerable body of workers united in common interests, but widely separated by distance.

The Aims and Objects of the Association were drawn up as follows:—

(a) To promote and safeguard the aims and objects of the Royal New Zealand Society for the Health of Women and Children.

(b) To encourage and promote the interchange of such proven knowledge as is likely to be of assistance to Plunket Nurses, and through them, to the community they serve, by means of periodical meetings, correspondence, etc.

(c) To still further promote uniformity of teaching and teaching methods by affording a recognised channel of communication between the Training Centre and all nurses engaged in the work.

Membership.—Active membership is open to all nurses employed in the service of the Plunket Society; associate membership is open to Plunket trained nurses and Karitane nurses.

Branches have been formed with headquarters at the most conveniently situated centres throughout the country.

The aim has been to keep the organisation simple, with all possible flexibility to meet varying conditions in different localities.

It will be seen that the aims and objects of this small "Alumnæ" Association, if the term may be used, do not in any way overlap with those of the New Zealand Trained Nurses' Association, concerned as they are with the wider interests of trained nurses as a whole.

On July 27th an open meeting of the Dunedin Plunket Nurses' Association was held at the Medical School, when Professor Hercus kindly gave a very interesting and instructive address on "Milk." There was a good attendance of active and associate members. After the address supper was served at the Plunket Rooms.

The first four-monthly open meeting of the Christchurch Plunket Nurses Association was held at the Plunket Rooms in May, when Sister Wilson gave a very comprehensive and instructive talk on ante-natal work as carried out in the Clinics. After an interesting discussion, supper was served.

In the Plunket Rooms at afternoon tea, on July 28th, the Christchurch Plunket Nurses made Sister Wilson, of the Health Department, a small presentation as a mark of their esteem, and appreciation of her work in connection with the Plunket Ante-natal Clinics, which were about that time entirely taken over by the Plunket Society's nurses. Sister Wilson will be missed by mothers and nurses alike.

PLUNKET NURSING SERVICE.

Plunket Nurses have been appointed to positions in the Royal New Zealand Society for the Health of Women and Children as follows:—

Miss B. Clark, Matron, Truby King-Karitane Hospital, Wellington; Miss M. Hitchcock, Matron, Karitane-Harris Hospital, Dunedin; Miss V. McLean, Matron, Karitane Hospital, Auckland; Miss E. Rose, Matron, Stewart-Karitane Hospital, Wanganui; Miss H. Williams, Sister, Karitane Hospital, Christchurch; Miss A. Graham, Sister, Karitane-Harris Hospital, Dunedin; Miss S. Norris, Plunket Nurse, Levin.

The following Plunket nurses have been appointed to the temporary staff of the Society:—

As Sisters:—Misses H. Hogwood, Truby King-Karitane Hospital, Wellington; D. Harrop, Karitane-Harris Hospital, Dunedin; D. Sage, Stewart-Karitane

Hospital, Wanganui; M. Hancock, Karitane-Hunt Hospital, Invercargill.

As Plunket Nurses:—Misses M. Murphy, Timaru; E. Simpson, Waipara; J. Summers, Christchurch; G. Davy, Ngaruawahia; Mrs. B. Mason, Ohakune; Mrs. E. Lewin, Auckland; Misses C. Campbell, Auckland; S. Lusk, Auckland; M. Robinson, Wellington; E. Walsh, Balclutha; P. Cameron, Central Otago; K. Carter, Wellington.

The following resignations have been received from Plunket Nurses:—Misses A. Wade, E. Ogilvie, E. Lawer, M. McCool, E. Boyd, R. Walker, M. Lowe, D. Curtis, Mrs. N. Carmody, Misses I. McGillivray, B. Burke. Also from Miss N. Fitzgibbon, Matron, Karitane-Harris Hospital.

Miss M. McIntyre has resumed duty on the Invercargill district Plunket Nursing Staff, after being on the staff at the Karitane-Hunt Hospital since its opening last December.

Miss H. Satchell has resumed duty as Sister at the Karitane Hospital, Christchurch, after completing her midwifery training.

Miss I. McLean, who relieved her at Karitane, has resumed her district Plunket work in Christchurch.

Miss M. Hitchcock has been appointed Matron of the Plunket Training Centre, Karitane-Harris Hospital, Miss N. Fitzgibbon's resignation from that position having been accepted with much regret. Miss V. McLean, of the Wellington Plunket Nursing Staff, has been appointed Matron of the Auckland Karitane Hospital.

Nursing Treatment for Tonsilectomy in Children's Hospital, U.S.A.

Patient: Child 9 years of age; admitted to hospital morning of operation. Short time before going to operating room, Atropine grs. 1/1000th, given by hypodermic. On return to ward watched until out of anæsthetic, then lying without pillows, child is turned well on to right side; Codeine, grs. ¼, given per hypodermic, collar filled with ice chip is placed round the throat, child usually sleeps quietly for some hours. On awakening is allowed to eat ice chip ad lib. The first meal given twelve hours or less after operation, consists of small dish of ice cream. The ice collar is refilled as required and anti-septic gargles given. A gargle which comforts the patient consists of Aspirin grs. xv dissolved in half a glass of water. The free use of ice has in all cases—I have seen here—been of benefit, and there is much less bleeding than in cases treated without it.

Hints for Tonsil Day from Same Hospital

All children admitted for tonsilectomy or other minor operations are nursed in a small ward and not allowed to come in contact in any way with children resident in hospital.

I might state here that all children admitted to this hospital (other than those admitted for minor operations and leaving same day) are first admitted to an observation ward and not allowed in general wards till they have been under observation for 24 hours, and a nose and throat culture taken and pronounced satisfactory.

This method of disposal of clothing may be of help in some of our wards where space is limited on tonsil day. A pillow case was safety pinned to the top of each bed or cot, child's clothes folded and dropped into this. A supply of paper bags was kept in the ward, and boots first dropped into this if soiled. A paper bag was also pinned on to cot into which the damp cotton wool used for wiping off the blood from mouth or nose was dropped. This is a great saving in soiled dressing trays.

Auckland Post-Graduate Refresher Course

1927	Time	Subject.	Lecturer
Wed., Aug. 31:	9.45 a.m.	Opening	Dr. Chesson
	10 a.m.	The Development of Public Health Nursing	Miss Lambie
	11 a.m.	Rural Sanitation	Inspector Furness
	2 p.m.	Aspects of School Medical Inspection	Dr. Ada Paterson
	3 p.m.	History of Nursing (Lantern Lecture)	Miss Moore
	7.30 p.m.	General Meeting of Nurses: "Public Health Nursing in Auckland"	Miss Bagley (in chair)
Thur., Sept. 1:	10 a.m.	Housing Problems and Excursion	Dr. Turbott
	2 p.m.	Modern Developments in Nursing	Miss Moore
	3 p.m.	Ante-Natal Care	Dr. Walton
	8 p.m.	Veneral Diseases in Women and Children	Dr. Falconer-Brown
Fri., Sept. 2:	10 a.m.	Proper Control of a Milk Supply and Excursion	Dr. Hughes
	2 p.m.	Aspects of Nutrition	Dr. Henderson
	3 p.m.	Health Teaching	Miss Lambie
	8 p.m.	Ward Teaching	Miss Moore
Sat., Sept. 3:	2.30 p.m.	Karitane Hospital: "Natural Feeding"	
Mon., Sept. 5:	10 a.m.	Health in Industry and Excursion	Dr. Turbott
	2 p.m.	Dental Hygiene	Mr. Saunders
	3 p.m.	Prevention of Tuberculosis	Dr. Bernstein
	8 p.m.	Diseases of Disturbed Metabolism	Dr. Johnston
Tues., Sept. 6:	10 a.m.	Legal Position of the Child	Miss Spicer
	11 a.m.	Adolescent Girl	Miss Begg
	2 p.m.	Mental Hospital, Avondale	
	8 p.m.	The Development of Maternal Care in N.Z.	Dr. Tracy Inglis
Wed., Sept. 7:	10 a.m.	The Nurses Part in connection with our	
	11 a.m.	Maternal Mortality	Miss Mirams
		Vaccine Therapy. Lab., Auckland Hospital	Dr. Gilmour
	2 p.m.	District Nursing	Dr. Prins
	3 p.m.	The Control of Infectious Diseases	Miss Bagley
	8 p.m.	The Importance of Mental Hygiene	Dr. Turbott

Day Lectures will be held at University College, Symonds Street.
Evening Lectures will be held at Nurses' Lecture Room, Auckland Public Hospital.
Evening Meeting, August 31st, St. Helens Hospital, Pitt Street, Auckland.

The last of the four Refresher Courses to be held this year under the auspices of the Department of Health, took place in Auckland during the week of August 30th to September 7th.

The nature of the course, as elsewhere, was to stress the preventive aspects of medicine. All trained nurses were invited to attend such lectures as they wished and it was evident from the large attendances that this new aspect of medicine has a great attraction for many.

The nurses attending were keen and interested, some even commencing their work as early as six in the morning so as to be free later in the day to attend lectures—a fact which says volumes in itself.

The wisdom and helpfulness of such a course was very favourably commented on by several of the doctors who lectured. As they pointed out, it not only brought nurses out in the field in touch with newer developments, but perhaps what was more important, brought them together to exchange experiences.

Nurses present represented all the public health nursing organisations working in Auckland, eight of the Health Department's District Nurses working among the Maoris, and in addition many of the trained staff from the Auckland Hospital, St. Helens Hospital, and some of the private hospitals, the average attendance being 30 in the morning, 40 in the afternoon, and 80 at night.

The next question being, Will such a course be available in the future again? there is every possibility that even if it is not feasible to make a Refresher Course an annual event it will be at least repeated at occasional intervals.

The Auckland University College were kind enough to give the use of a lecture room and lantern free of charge for the lectures given during the day, and the Auckland Hospital Board placed the use of the Nurses' Lecture Room at the disposal of the Course for the evening lectures, so making it possible for many of their staff to attend who otherwise would not have been able to. These arrangements greatly facilitated the comfort and management of the lectures. During the week the nurses were entertained on several occasions. The first night at St. Helens Hospital, Miss Broadley very kindly provided a delicious supper, and as it had been one of those hectic days that St. Helens can provide in the way of work, the supper was all the more appreciated. This evening's meeting, as elsewhere, was a great success. The programme was "The Public Health Nursing Situation in Auckland." A list of the speakers is attached. In giving a review of the situation in Auckland, as compared with other centres in New Zealand, Miss Lambie pointed out that on a population basis, Auckland was very much the worst off of all the New Zealand cities as to the number of nurses employed. The need for all nurses to join the Association was stressed, and for a public health section within the Association so as to provide a means of studying ways of co-operation between the various services.

On Saturday afternoon a very interesting visit was paid to Karitane when Sister Hitchcock spoke on "Natural Feeding," showing by means of excellent charts what wonderful results were being obtained at the Mothers' Cottage. A delicious afternoon tea was served in the dining-room before the nurses left to return to town.

Dr. Prins, the Medical Superintendent, and Miss Brand, the Lady Superintendent of Mental Hospital at Avondale, invited the nurses attending the Course to visit their institution on the Tuesday afternoon. The nurses were shown round the institution by members of the staff and again a very nice afternoon tea was served in the sitting room of the Nurses' Home, the afternoon winding up with three cheers for the Mental Hospital staff for their very interesting afternoon.

A very pleasant suprise occurred the last day with the visit of Miss Bicknell, Director of Nursing, many nurses being very pleased to have the opportunity of meeting her again.

Following the last lecture of the course, Miss Bicknell spoke regarding the position of the post-graduate course at present, and of the collecting cards being issued by the Otago and Wellington Branches appealing to the nurses present to get busy in Auckland.

Everyone realised it was very good of so many busy doctors to give up their time to lecturing and to the careful preparation that many had gone to. These lectures will be long looked back on with pleasure.

GENERAL MEETING OF NURSES.
PROGRAMME.

"Public Health Nursing in Auckland."
(Miss Bagley in the Chair.)

"The Work of the Nurse Inspector"—Miss Mirams.

"The Work of St. Helens"—Miss Broadley.

"The Work of the Ante-Natal Sister"—Miss Wise.

"The Work of Plunket Nurse"—Miss Goldstone.

"The Work of Infant Life Protection Nurse"—Mrs. Masters.

"The Work of School Nurse"—Miss Cheerie.

"The Work of District Nurse"—Mrs. Saunders Jones.

"The Work of Insurance Nurse"—Miss Sutherland.

"The Work of Sanitary Inspector"—Miss Levein.

"The Work of Country District Nurse"—Miss Jarratt.

"Review"—Miss Lamb.

Christchurch Post-Graduate Refresher Course

Syllabus

Wednesday, July 13th—

Place.	Topic.	Lecturer.
10 a.m.—Health Department	Opening Address	Dr. Telford
10.30 a.m.—Health Department	Opening Address	Miss Bicknell
	Development of the School Nurse	Miss Lambie
2.30 p.m.—Ch.Ch. Hosp. Lecture Room	History of Nursing	Miss Moore
3.30 p.m.—Ch.Ch. Hosp. Lecture Room	Diet	Miss Reid

Thursday, 14th—

7.30 p.m.—Trained Nurses' Association Room	General Meeting of Nurses	
10 a.m.—Health Department	Proper Control of a Milk Supply and Excursion	Dr. Telford
2.30 p.m.—Ch.Ch. Hosp. Lecture Room	History of Nursing (continued).	Miss Moore
3.30 p.m.—Ch.Ch. Hosp. Lecture Room	Development of the Teeth	Mr. Saunders
8 p.m.—Ch.Ch. Hosp. Lecture Room	Parasite Diseases	Colonel Dawson

Friday, 15th—

10 a.m.—Health Department	School Environment	Dr. A. Paterson
2 p.m.—Sanatorium Fresh Air Home	Prevention of Tuberculosis	Dr. Blackmore
8 p.m.—	Maternal Care as a Public Health Programme	Dr. Irving

Saturday, 16th—

10 a.m.—	Karitane Hospital	

Monday, 18th—

10 a.m.—Ch.Ch. Hosp. Lecture Room	Early Detection and Prevention of Postural Defects	Dr. Will
2.30 p.m.-4.30 p.m.—Ch.Ch. Hosp. Lecture Room	Practical Ward Teaching (Hospital Sisters)	Miss Moore
2.30 p.m.—Health Department	Rural Sanitation	Mr. Kershaw
3.30 p.m.—Health Department	Health Teaching	Miss Lambie
8 p.m.—Ch.Ch. Hosp. Lecture Room	Cancer	Dr. Milligan

Tuesday, 19th—

10 a.m.—School for Deaf, Sumner	Hearing and Speech Defects	Dr. McLaglan
2.30 p.m.—Ch.Ch. Hosp. Lecture Room	Legal Position of the Child	Miss Edwards
3.30 p.m.—Ch.Ch. Hosp. Lecture Room	Adolescent Girl and Sex Education	Dr. McLaglan
8 p.m.—Ch.Ch. Hosp. Lecture Room	Venereal Diseases	Dr. A. Thomson

Wednesday, 20th—

10 a.m.—Health Department	Housing Defects and Excursion	Mr. Kershaw
3 p.m.—Ch.Ch. Hosp. Lecture Room	Control of Infectious Diseases	Dr. Telford
8 p.m.—Ch.Ch. Hosp. Lecture Room	Mental Hygiene	Dr. Russell

Notes on a Lecture given at the Refresher Course

I have been asked to speak to-night on the manner in which the V.D. Clinic is conducted at the Christchurch Hospital.

The V.D. Department for Women is conducted in the Out-Patient Department of the Hospital.

In all, there are five clinics weekly. Monday, Wednesday and Friday evenings, at which treatment for gonorrhœa is given, consisting of douching with Ac. Lactic, and plugging in some cases with ichthyol and glycerine. Tuesday evening new cases are examined. Diathermy treatment and special treatment by the Medical Officer is given, as well as injections for syphilitic patients. Friday afternoon is set aside for married women and children—children with vulvo vaginitis and congenital syphilis.

There are various types of patients.

First, the unfortunate married women infected by their husbands. Fortunately they are not numerous.

Secondly, the office and servant girl class. These comprise the majority of the patients. They are not immoral, but are really unmoral. They do not realise the gravity of their condition, or how they abuse their bodies, and often require a lot of care in handling to induce them to attend.

Thirdly, the depraved type—really bad girls who attend spasmodically, and often under coercion, and who lead an immoral life, despite their condition. They have frequent changes of address and are difficult to get hold of. This is the class who are mostly notified.

Notification, as you know, is only done when patients do not attend for treatment to the satisfaction of the medical officer.

Fourthly, the professional prostitute class. The number is not a high one, and is represented as a rule by elderly women who are thoroughly depraved and often very alcoholic.

Classes two and three may be described as the amateur prostitutes.

The average attendance for:—

V.D.G.	.. ..	270 per month
V.D.S.	.. ..	80 „ „
New cases average		12 „ „

New cases come under our care as follows:—

Firstly—Some patients come of their own accord, being worried over the appearance of a discharge and vulval irritation.

Secondly—Some are sent along by some girl friend or ex-patient, to whom they have explained their condition.

Thirdly—Some are sent along by the young man who has contracted the disease from them.

Fourthly—Occasionally some are reported from the Health Department.

The work is most interesting. Each patient has to be studied individually and treated accordingly. We do not condemn them nor do we condole with them, but aim to raise their mental outlook to such a level that they may regain their self-respect.

I appeal to the trained nurses to help always in this work for the sake of the health of the young women who are to be the future mothers of our country.

Every opportunity should be taken to teach the young people their responsibilities from the point of view of the sacredness of their bodies and the responsibility that they hold in trust for the unborn child.

In order to gain our objective we must work in unison and harmony in this branch of the Public Health work.

A memorial church to Edith Cavell is to be built in Jasper Park, in the heart of the Canadian Rockies. It will stand on the shore of Lake Beauvert, facing the snow-capped mountain which bears her name, and in design will follow Norwich Cathedral, where the nurse worshipped as a child, and in whose shadow she is buried. The proposal to build the church has grown out of the custom of holding annual memorial services on August 4th at the base of Mount Edith Cavell.—(From the "London Times.")

District Nursing is Christchurch

District Nursing in Christchurch was started by Nurse Maude in 1896, who trained in London for that purpose. The work at first was entirely supported by Lady Rhodes, who gave £100 a year and supplied a bicycle. Later on, St. Michael's and Sydenham Parishes contributed, the Rev. A. W. Averill (present Archbishop) taking a personal interest, doing all he could to further the cause. An old shop in Durham Street was rented for an office. Nurse Maude worked single handed for some years.

As time went on her work increased to such an extent it was decided to have a Committee, and appeal to the public for funds, a second nurse being required. For a short time midwifery was undertaken, but was found impracticable with general nursing.

In the course of her work Nurse Maude came across several consumptives, and was greatly troubled to know what to do with them, there being no sanatorium in those days. The late Mrs. A. J. White lent a section of land on the sandhills at New Brighton, friends and sympathisers supplied tents, the Charitable Aid Board rations, and a small camp was established. The public took the matter up with great enthusiasm, supplying funds. A larger section of land near Wainoni was obtained and twenty tents and shelters were erected for men, a marquee for a dining room, a rough shed for a cookhouse, and a small cottage for a nurse in charge, Dr. Greenwood kindly undertaking the medical supervision. The result of this work showed what could be done even in a primitive way, and it emboldened Nurse Maude to start a camp for women patients. She called a public meeting of women at the Choral Hall and made a stirring appeal for help, which was warmly responded to, money and gifts in kind being offered. A property was lent by Mrs. Florance, 20 shelters were erected by various friends, and a married nurse and her husband put in charge. Nurse Maude was assisted by Committees for both camps. Many patients benefited by the open air life and results obtained by these camps showed that the effort had been quite justified and was all a part of the District Nursing for poor patients.

To return to District Nursing proper, it might be interesting to describe what it is. It consists of daily visits to sick people in poor circumstances. The patients receive the services of a trained nurse, if necessary twice or three times a day, they are supplied with linen and all nursing requisites. The nurse has to see if there is a doctor in attendance, and leaves a form for his instructions. She sees there is sufficient food and bedding and all necessary comforts, also she inquires as to the religious denomination and puts the priest or minister in touch with them. If death takes place, the nurse prepares the body for burial.

The office is open from 9 a.m. to 9 p.m., one nurse is there in the morning and two in the afternoon to attend to minor accidents and dressings, a large proportion of the work being the treatment of ulcerated legs. Nurse Maude is in her office during the afternoon from 2 to 4 for interviews and to receive the nurses' reports, etc. A stock of nursing utensils is kept for lending and hiring out.

Another important work is to attend all cases at the Public Morgue. This has proved a great consolation to the relatives, and has done away with the primitive methods employed in old days—the terrible dread people have of being taken to the Morgue is minimised by the knowledge that the nurses attend.

There are now nine nurses, including Nurse Maude, on the staff. Each nurse has a whole day off once a week and part of Sunday, four weeks' holiday in the summer and two in the winter. This liberal amount of rest and recreation keeps the nurses fit and cheerful, bringing a bright atmosphere into many homes.

The work is supported by a Hospital grant, public subscriptions, small thank offerings from patients, Morgue fees, and jumble sales held fortnightly at the office,

a special room having been built for the purpose. The sales are managed by a number of outside helpers.

Several business men have shown their interest by serving on the Committee, Mr. W. Reece having been Chairman since 1911.

The Hospital Board is greatly helped financially by the District Nursing Association, as many chronics are kept in their own homes, who would otherwise be at the expense of the Hospital Board.

Lady Rhodes is still a very large contributor to the work, and when the new offices in Madras Street were to be built gave £500, Sir Heaton giving the land. A street collection was held, the amount raised being £973, and the building was opened free of debt.

The first Annual Report showed 1,100 visits paid during the year, and the last 1926-27, 11,619.

Two Practicial Suggestions

The need for knowledge of the proper way to shut a door, and of voice modulation to control patients, is so self-evident that I would hesitate to send the following remarks, were it not for the frequent expressions of annoyance from patients who have suffered, not always in silence, from seeming thoughtlessness on the part of the nurse.

To close a door, grasp the knob firmly, turn the latch in, holding it in this position until the door is closed. Then turn the latch out and release the knob. This method does away with slamming the door, which is such an annoyance to patients and is one of the reasons why hospitals are called "so noisy"; also fewer or no finger marks will be found on the door to be washed off later, a procedure which takes time and energy that are needed elsewhere.

An important way to control any patient is to modulate the voice by dropping the tones just below those of the patient. A voice raised to higher tones than those of the patient often causes unaccountable restlessness and irritation, while the lowered tones will not only have a soothing effect upon the sick person but will inspire greater confidence in the nurse.

N. Caryl Schooley, R.N.

Review

Advanced Methods of Massage and Medical Gymnastics.

By Ida C. Shires and Dorothy Wood, M.R.C.S., L.R.C.P.

Illustrated.

(The Scientific Press, 5/-.)

This most useful little book, as instructive for the medical student as it is for the qualified masseuse, is just what members of the massage profession have been looking for.

A special chapter on the treatment of infantile paralysis has been written with the help of Dr. Charles Mackay, and additional value has been given to this clever little book by the inclusion of a chapter on Pulley and Sling Exercises (Mrs. Guthrie Smith). The very latest methods of treating fractures, deformities well classified in different groups, muscle and joint injuries, and abnormal conditions, suitable for treatment by massage or remedial exercises of every system have all been included. The very original and clever illustrations are simple and most instructive.

No masseuse, having glanced at this book could resist having it in her little reference library.

Dunedin Post-Graduate Refresher Course

A Refresher Course for Nurses was held in Dunedin from August 3rd to the 10th inclusive, and was excellently attended, the average attendance in the morning being 20, in the afternoon 36, and in the evening 64. A very interested spirit was manifest, and frequent inquiries were made as to whether this type of course would be repeated.

A copy of the syllabus is attached.

Several of the lectures given were of outstanding interest and various excursions were planned to demonstrate special subjects.

On the Saturday afternoon a very interesting visit was paid to Karitane Harris Hospital. Miss Pattrick gave an excellent lecture on " Natural Feeding," and afternoon tea was dispensed to over seventy guests. Another very interesting visit was paid to Waikari Sanatorium. when Dr. Tythe lectured on " Prevention of Tuberculosis." The group were shown over the institution and again afternoon tea was dispensed, which added to everyone's enjoyment.

These papers were among those contributed at the general meeting of nurses during the Dunedin Refresher Course. The programme of this meeting was " The Public Health Nursing Situation in Dunedin."

As these two papers introduce fresh avenues to public health nursing work it was felt they would be of interest to " Kai Tiaki."

Syllabus

Wednesday, August 3rd.—10 a.m.: Opening Address, Dr. Crawshaw; "The Development of Public Health Nursing," Miss Lambie. 3 p.m.: "Rural Sanitation," Inspector Armour. 4 p.m.: "The History of Nursing," Miss Moore. 7.30 p.m.: General Meeting of Nurses, "The Public Health Nursing Position in Dunedin."

Thursday, August 4th.—10 a.m.: "The Administration of the Tuberculosis Problem," Dr. Crawshaw. 3 p.m.: "Health Teaching," Miss Lambie. 4 p.m.: "Modern Developments in Nursing," Miss Moore. 8 p.m.: "Orthopædics," Dr. Renfrew White.

Friday, August 5th.—10 a.m.: "Aspects of School Medical Inspection," Dr. Ada Paterson. 2 p.m.: "The Importance of the Early Detection of Mental Diseases," Dr. Gribbon. 4 p.m.: "Ward Teaching," Miss Moore. 8 p.m.: "The Development of the Teeth," Dr. Dodds.

Saturday August 6th,—2 p.m.: "Karitane," Miss Pattrick.

Monday, August 8th.—10 a.m.: "Housing Defects and Excursion," Inspector Craighead. 2 p.m.: "Industrial Diseases and Excursion to the Roslyn Mills," Dr. Crawshaw. 8 p.m.: "Control of Infectious Diseases," Dr. Maclean.

Tuesday, August 9th.—10 a.m.: Trade Defects and Excursion," Inspector Armour. 2 p.m.: "Prevention of Tuberculosis and Excursion to Waikari," Dr. Lyth. 8 p.m.: "Preventive Medicine in New Zealand," Dr. Hercus.

Wednesday, August 10th.—10 a.m.: "The Legal Position of the Child," Miss O'Shea. 2 p.m.: "Family Dietary," Miss Wells. 3 p.m.: "Tuberculosis Reactions," Dr. Champtaloup; "Class for Physical Defects," Miss Roberts. 8 p.m.: "Maternal Care," Dr. Ritchie.

The lectures were held in the Medical School Building, King Street.

A Church Nurse's Work

As I am the only Church Nurse, I have not had the privilege of arguing with another as to who should speak on this occasion about this class of work.

Knox Church is the only church in New Zealand, as far as I know, that has on its staff a trained district nurse.

The position came into being about nine years ago, through a legacy left to the church by one of its members, for the purpose of paying the salary of a trained nurse to work amongst the people of the church and the poor of the city. It was decided that the work should be largely undenominational and the nurse's services free, she to gauge the boundary and extent of her labours by time and her own discretion. The nurse was supplied with a well stocked cupboard of remedies and nursing accessories; the latter have proved invaluable for lending purposes. The Church grants money to replenish the stock and to help needy cases.

The nurse has her office in one of the church's buildings, where she keeps all that pertains to her work, and where she is to be found daily at a stated time by anyone wanting advice or nursing assistance. Her working hours are roughly from 9 a.m. to 5 p.m., but she can vary time according to patients' welfare and her own convenience.

Patients come from varied sources. The Minister or members of the Church ring up telling of homes where nursing help is needed and desired. Doctors solicit help, also private people. As a general rule the Church nurse gets her patients from among church-going people. She does not reach the down and outs as the St. John Ambulance nurses often do.

No small part of the work is giving instruction in nursing to those in the homes of the patients. Women are generally eager to learn and grateful for information.

There are invalids to be visited who cannot come to church, and there are church activities to be linked up with.

A Creche has been started on Sunday morning so that mothers with young children who wish to go to church can leave their little ones there. The nurse takes charge of this.

At the Knox Girls' Club, to which about 100 belong, she sometimes gives talks to sections of it on a nursing subject; or gives demonstrations of bed-making and bathing a patient. For this purpose she has a large doll and miniature bed and appliances. Other church clubs call on her for the same services.

In connection with the Presbyterian Church we have a Women's Missionary Training Institute, where girls are trained who wish to go as missionaries or become deaconesses. The nurse gives these students nursing lectures once a week. Sometimes they are given practical work with the patients.

Now a word about District Nursing.

In hospital life many a nurse has felt she had no time to be kind, or at least as kind as she would like to be. The scope is found in District Nursing. Nursing in district work can become a high art, because the nurse can put soul into it and take time to do her very best for the patient in detail. She gets to know to be interested in the patients as well as their maladies. They are distinctly individuals and she learns to look at life from their point of view and her own vision is widened.

A professor of medicine, in an address to nurses, said: "I do not believe there is an occupation in the world in which a woman has so many opportunities of doing good to her fellow creatures as in district nursing."

Florence Nightingale regarded district work as "The Flower of Nursing." Those are her own words. Certainly, it is a work worth while, and as the nurse goes in and out of homes helping, sympathising, relieving and educating, she finds her calling full of interest and satisfaction.

Visiting Tuberculosis in Dunedin District

A great deal is heard nowadays on the subject of tuberculosis, and to the ordinary layman so much publicity conveys the idea that the trouble is largely on the increase. From a graph recently compiled by Dr. Shore, our late Assistant Medical Officer of Health, from statistics covering the past decade, it has been proved conclusively, and this graph shows that such is by no means the case. On the contrary, the mortality rate has fallen consistently and steadily. For the benefit of those who may not already know, under the Health Act, 1920, pulmonary tuberculosis is a notifiable infectious disease, and as such, all reported cases are investigated by the Public Health Department.

On a notification being received in the office the procedure is as follows:—

The home is visited and a report on the patient first made. This is done in triplicate forms. Particulars are noted, such as patient's age, occupation, duration of disease, present condition of health, whether clinical or positive case, treatment received and treatment recommended, also the patient's past illnesses, if any, especially pleurisy and pneumonia. The history of the patient's family and antecedents is also inquired into.

The patient's bedroom is then inspected and suggestions perhaps made which may be carried out for the benefit of the patient. Even a change to a sunnier room may be advised, when such chance can conveniently be made. Much advice can be given, but the Health Department issues excellent pamphlets which contain all possible information for both patient and contacts. I shall be glad to hand these out at the end of the lecture should any present desire them. One really requires to lay stress on the most important facts only. These pamphlets give the cause of consumption and how to prevent it, also precautions to be observed by the patient and precautionary measures against pulmonary tuberculosis to be observed by the contacts. Names of all members of the family are noted, also their various occupations, and any illnesses they may have had, especially pneumonia, pleurisy, or any other chest complaint, and in the case of children, measles and whooping cough as well.

The names of school children are handed on to the school medical officer of the district, along with a short history of each child, and these children are closely watched throughout their school career.

Dealing with adult contacts is a little more difficult, as the majority are at business during the day, making it almost impossible for one to get into personal touch with them. When strongly advised that they should be examined as a precautionary measure, one invariably gets the answer that they are either quite fit or have recently been passed for a lodge, and therefore must be fit. They fail to see often the necessity for being examined periodically by a doctor, if they have no symptoms of disease. However, the public are gradually waking up to the importance of such a step, and we hope people will soon submit to a periodic examination of the body as they do now, many of them, to a periodic examination of their teeth.

The patient and contacts finished with, a survey is now made of the home. From the exterior the size, aspect, elevation, underfloor ventilation, exposure to or obstruction from the sun, etc. From the interior the number of rooms, rough dimensions of same, ventilation, number of occupants of each bedroom, whether in single beds or sharing beds, etc. As a rule, conditions are satisfactory, but one occasionally comes across cases with very poor environment. On visiting one home, which was attached to a modern shop, situated on one of our main streets in Dunedin, and passed by some of you probably every day, the patient, a girl of 17, was found in an unlined washhouse lying on a mattress supported by four boxes, with room for a chair only, apart from the copper and built-in tubs. This state of things, in spite of a large airy, unoccupied room, facing north, with fireplace and casement windows. The mother's only excuse was that her daughter was too infectious to be nursed in

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the home. Another case, a returned soldier with his wife and five children, the eldest five years, was living in one room, in a house in Filleul Street. These two cases are mentioned to emphasise the necessity for a thorough investigation when tubercular cases are reported.

When making initial visits to cases it is not possible to make many improvements right away. Suggestions can be made and advice freely given, but it is not until the confidence of the people is won that much progress is made. When the public once realise that the Health Department is striving to assist and not to interfere then much more effective work will be done.

The patients are usually well cared for, the majority transferring to the various sanatoria for treatment, and those remaining at home, looked after under suitable conditions; but it is essential that all homes be visited from time to time for more reasons than one. Apart from the contacts requiring supervision, patients are often found migratory. They are apt to move from one home to another without notifying the Department of any change of address, and it is only through constant visiting that one is able to keep in touch with them and at the same time be able to make necessary arrangements for disinfection of premises. Disinfection, of course, is done by the Department free of charge when a positive case is moved to an institution, or even if a patient be transferred from one room to another in the same house.

District visiting in connection with pulmonary tuberculosis absorbs most of my time, but I supervise and assist at Dunedin Hospital final State examination, and also inspect from time to time the premises of chiropractors, masseurs and beauty specialists.

However, to my mind, tubercular work is by far the most interesting and important, and much help is obtained by co-operation with the T.B. Out-Patients' Department, Dunedin Hospital. May I conclude with an extract from a recent address given by Sir Robert Phillip, President of the British Medical Association, in Edinburgh. It appeared in our papers a few days ago, and is as follows:—

> "I am prepared to believe that 30 years hence tuberculosis will be largely a memory of the past, and the time will come when hospitals for advanced disease and settlements for tubercular wrecks will be regarded as anachronisms."

To read such a statement is at least encouraging, and one only hopes that his prophecy may come true.

Testimonials: A Paper read at Nurses' Conference.

There is no one more dependent on recommendation (or testimonials) than a nurse.

The necessity begins with her application for training, is present when she comes forth—a graduate—and continues as long and as often as she desires to change her field of service.

Her least requirement is, of course, when newly graduated, before she has had an opportunity of nursing independently of supervision. This first testimonial is easy to give. Owing to the standardisation of the training course little is necessary beyond mention of time spent in training with remarks on the personality of the graduate.

Valuable testimonials are uncommon—even rare. Those presented by applicants for nursing positions are often of little use for evaluating fitness. Many of them contain only extravagant praise associated with no circumstances in particular, and expressions of good wishes. When such a recommendation comes from anyone in authority one is apt to be reminded of the saying, "Give a good testimonial to get her away." There is, too, the testimonial that with much use of superlatives gives a forecast, "In **any** position Miss X will give **highest** satisfaction. **Most** capable, etc., etc."

In these, if we eliminate the good wishes, expressions of personal regard (or taste) and the obvious desire to please Miss X, there is nothing left.

A request for a testimonial is apt to have a flattering effect on the authority

appealed to—and thus gets reflected on paper. No doubt this is a very human weakness—a little pleasant sense of power—a benevolence, of doing a favour that costs nothing.

Again there is the incidence of—shall we say—chivalry. The applicant may be visualised, if not as a damsel in distress, at least as in need of some help.

And there is the testimonial worded to contain no information easy to interpret.

Nevertheless, testimonials must continue to be given and received. What then to do? What **is** of value? There needs a careful evaluation of the nursing power—and of the claims of the desired service—and exercise of both charity and courage.

First in importance is the record of work a nurse (or sister, or any officer) has **done.** This includes the time spent in the position, or positions, the branch of work (re medical, pediatric, theatre, etc.), the size of institution, number of beds, etc. The writer's opinion of the quality of the work done follows.

If executive work has been done or allied, of course comment on administrative ability is included, and ethical and professional standards are indicated. Reasons for relinquishing positions, or "no reason assigned," should be stated.

No less than this will serve. Prophesying a nurse's reaction to a proposed future environment is of little value—and rather incautious. The past work is the guide to the future.

A recommendation should have the effect of stimulating a nurse to achieve better work, to justify what has been written.

A grave responsibility rests on those who must write testimonials; for them to hear the distant call of colleague for helpers—see, as in a vision afar off, the sick and dying who wait for nursing service, happy are they who, in commending the nurse, know themselves to be serving these.

The Ward Sister: A Paper read at Nurses' Conference

In submitting a paper on this subject one has in mind the very great responsibility undertaken by nurses who are appointed Ward Sisters in our hospitals, and the difficulty experienced by those in authority in securing nurses physically, mentally, morally and educationally suitable to fill such positions.

The demand for sisters with double certificates is increasing in New Zealand, and all should be encouraged to take midwifery, and where possible, child welfare, certainly those in charge of gynæcological and children's wards should have these certificates.

In the interest of patients and trainees this is very desirable, and Hospital Boards would be well advised to grant leave of absence and pay the fees enabling selected candidates to take these extra courses, it being understood that sisters availing themselves of these opportunities would be retained in the Board's service at least two years after returning to hospital.

The responsibility of Ward Sisters has increased considerably, especially in training schools, now that candidates are accepted for training much younger than hitherto and have finished at twenty-two and twenty-three years of age, instead of commencing then. It may be argued that if young women can become doctors at that age, surely they can undertake the duties and responsibility of a trained nurse. Granted, nevertheless, the responsibility of the Ward Sisters becomes greater as it is difficult to impress some of these young minds with the importance of the practical side of their training, and occasionally one meets with probationers who appear to be totally devoid of the true spirit of nursing, and they make life very difficult for the sister who is held responsible for their mistakes and neglect.

The steady advance in medical science is also a contributory factor to the extra responsibility, and calls for more skill and knowledge and powers of endurance on the part of the Ward Sister.

It has been suggested that probationers receive all their theoretical training in class rooms and practical demonstration rooms, as the Ward Sister is usually much too busy to devote any time to that work. This is a debatable point. Personally, I think that the Ward Sister must take a great part in the training of nurses, for it is her bounden duty to see that orders given by doctors for the care of their patients are attended to promptly and accurately, and that the routine treatment as laid down by the Hospital authorities, and taught in class rooms, be adhered to; otherwise, much of the valuable work of physicians and surgeons would be useless. Obviously, then, most of the practical training must be gained in wards where a capable sister must teach the real value of symptoms, treatment, etc., as applied to individual patients.

In these days of overcrowding it is difficult to carry out treatment and routine work and keep the wards clean and tidy, but a good methodical sister will maintain order where otherwise there would be chaos. Meals will be supervised and served to time, everything will be in readiness for doctors' visits; clinical lectures and doctors' visits will be over, treatment will be supervised and finished and time allowed the staff in which to clean up and tidy the ward preparatory to serving the next meal.

On visiting days the ward will be prepared, and chairs placed in position before the ward is open to visitors, who will leave promptly at the appointed hour; in fact, nothing, unless a great emergency, will be allowed to interfere with routine work.

In emergencies the Ward Sister must be prepared to formulate and carry out treatment, pending the arrival of the doctor, and the efficiency of her treatment will depend upon her knowledge of nursing principles and method of applying them.

Many of the present-day sisters were trained during the war and gained their practical experience in wards controlled by fourth-year nurses, and in some cases by nurses in training. Consequently they missed the almost constant supervision of a sister thoroughly experienced and capable of anticipating patients' wants and attending to them promptly, also of demonstrating and instructing them in ward management, e.g.:—Care of Patients, Treatment, Reports, Serving Meals, the Distribution of Duties of Nursing Staff, also Domestic Staff, Routine, Records, Hygiene, Ventilation, Heating, Method of Cleaning, Responsibility of Nursing Staff without reference to Equipment, Stores, Bedding, Linen, Lighting, etc.

This being so, they are handicapped and lack the finish and qualifications of a well-trained Ward Sister.

The subjects mentioned above are covered by lectures from medical men, matrons, and tutor sisters, and are of very great value, but practical teaching, when in actual contact with patients, from one who has the art of imparting knowledge to others, is of greater value, and no doubt inspires pupil nurses to greater effort in obeying the teachings of well ordered minds. Therefore, it will be seen that the Ward Sister must be a nurse of exceptional ability, with high ideals, refinement, understanding and common sense. She must be loyal to doctors, matron, the profession and the hospital, a good disciplinarian and organiser, observant, punctual, truthful, tactful, economical, courteous, strong-minded and dignified, capable of teaching probationers and managing a ward with the strictest attention to the well-being of the patients under her care, and it behoves nurses seeking these positions to fit themselves adequately for the arduous task by taking the extra courses available in New Zealand and making a special study of the fundamental sciences, that in time when pupil nurses pass on to hospital from the University they will be able to hold their own and command a salary that will be adequate remuneration for their services.

Symptoms of Pulmonary Tuberculosis

These depend on two factors:

1. The local effect of the disease. These are cough, sputum, hæmoptysis, pleurisy and pain.
2. Symptoms caused by a very virulent poison produced by the germs and distributed by way of the blood stream over the body, i.e., lassitude, loss of weight, loss of appetite, dyspepsia, lack of nerve tone, rapid pulse and temperature, wasting of muscle.

Cough may or may not be present in early disease of the lungs. At first the tubercles are in the lung tissue, and do not communicate with the bronchi. Any sputum at this time is merely an increase in the normal secretion of the bronchi later, when the tubercle communicates with a bronchiole, we get true infective sputum.

The dry cough is often caused by irritation in the lungs of a nerve, the vagus.

Blood-spitting or hæmoptysis may occur very early in the disease. It is then due to the rupture of very small blood vessels, and is as a rule small in amount, varying from blood-stained sputum up to a few ounces of blood.

Later, when the disease had advanced to cavity formation, the hæmorrhage is usually due to the rupture of a large blood vessel. As the lung tissue breaks down and is discharged from the cavity a vein or an artery may be left unsupported, thus allowing the walls to stretch and an aneurism or dilatation of the vessel occurs. On this bursting a very severe hæmoptysis may occur.

Pleurisy, when not associated with any other disease, is practically always tuberculous in origin. It may be of a dry type or fluid may form. At first a sharp stitch-like pain is present on taking a deep inspiration. When fluid forms the pain lessens. Various pains referred to the upper part of the chest and shoulders sometimes occur.

The symptoms due to the tubercular poison are of paramount importance, as they occur very early in the disease, and their dimunition is a sign of improvement.

Lassitude is often the first indication that the patient's health is below par. That "tired feeling" is not always due to tuberculosis, but when an ordinary energetic person finds that together with this feeling there is a loss of weight, then he or she should certainly seek medical advice.

Indigestion due to the poison affecting the digestive apparatus is very often complained of. Under suitable treatment for tuberculosis this usually clears up.

Temperature and rapid pulse rate give us an indication of the toxæmia. Very little will cause the temperature of a tuberculosis patient to rise, i.e., excitement, over-exercise, etc.

Besides the above, the toxins cause the wasting of the muscles, especially on the infected side of the chest. Naturally with this wasting there is weakness as well.

PULMONARY TUBERCULOSIS TREATMENT.

We can enumerate many measures for combating the disease, but one and all have for their object the raising of the patient's power of resistance, thus preventing further spread of the disease, and ultimately to bring about healing the lesion. The tubercle bacillus digs itself well in, in the tissue of the lung, and it is therefore safe from any antiseptic drugs given either by mouth or inhalation. Moreover, it is surrounded by a layer of fat which makes it resistant to weak antiseptics.

It is not so many years ago that consumption was looked upon as a most deadly disease—in fact, as a hopeless disease. Night air was bad, colds and draughts were most dangerous, so the poor consumptive was confined to a room with practically all fresh air excluded, and he gradually drifted downhill to his grave. Occasionally someone defied these rules, and to the surprise of all his friends began to improve. These cases were noted, and gradually what was known as the "Open-Air treatment" came into vogue. It was left to a German—Otto Walther—to realise what might be done

by combining fresh air, rest, and regulated exercise, and he founded the Sanatorium of Nordrach-Colonie in the Baden Black Forest. Success attended his efforts, and perhaps the only treatment of his that could be found fault with was his system of forced feeding. Let us now consider in detail our present-day methods of treatment in a sanatorium.

Rest.—Temperature and rapid pulse rate are symptoms of a poisoning by the disease. This poison is produced in the lungs, and passing into the blood vessels is carried all over the body, producing its deleterious effects. While this poisoning is going on, improvement is not possible, as the white corpuscles of the blood are affected, and the tissue cells of the body which produce a substance which neutralises this poison cannot act. Now, anything in the way of exercise—mental or physical—increases the pulse rate, and thus increases the amount of blood passing through the lungs, with the result that more poison is picked up. Lying quietly in bed reduces this pulse rate, and leads to quieter breathing; less poison is distributed, some of the tissue cells begin to produce this anti-body substance, and the poisoning begins to lessen, the temperature to come down. The time necessary for this varies greatly—it may be from a few days to even a year, or more—but no real progress towards cure can be made until the temperature is normal. Sometimes ordinary rest in bed is sufficient; at other times absolute rest is essential.

With temperature and pulse rate normal for some time, we can begin on a little exercise. To keep on resting indefinitely would not cure the disease, because the tissue cells will not produce the anti-body substance unless stimulated to do so by the presence of some toxins in the blood. We therefore try to keep on liberating successively increasing amount of poison by increasing the amount of exercise, but always trying to avoid an overdose. An overdose will immediately cause a rise in temperature and other toxic conditions. Hence the reason why we allow one hour or more up, and gradually increase. This brings us to treatment by regulated exercise and work.

We wish to fill up the blood with anti-bodies, and we therefore graduate the exercise, each patient doing more and more, always being guided by the thermometer and weight chart. Of exercises, hill-climbing is perhaps one of the best, any exercise throwing too severe a strain on the arms being avoided.

In our last lecture we dealt with Rest and Graduated Exercise. It is necessary if the disease is to make steady progress towards healing that nothing may happen to lower the resistance for even a short time. Now it is possible to do this with over-exercise. Nature knows this, and so responds by creating fatigue.

A consumptive with active disease should never tire himself; he may do so once or twice with impunity, but to persist will eventually cause a further breaking down of the tissues. He may risk an overload once or twice without actually causing an extension of the disease, but undoubtedly for the time healing is at a standstill.

When you are put on work do not attempt more than you are allotted. Work in a sanatorium is just as much part of the treatment as rest, but if that work causes fatigue then it must be reduced. Again, if you shirk your work you are hindering your own cure. It is difficult to judge exactly the amount of work necessary in each individual case; some are used to harder work than others, and feel the effect less, and it is only by exercising a careful look-out on the weight, pulse, temperature and lung changes that danger can be avoided. It is not practical or necessary to examine everyone daily, for fortunately symptoms appear before and give warning.

The result of exercise mentioned in a previous article is to cause an outpouring of toxins from the seat of the disease. We call this Auto-Inoculation.

If a patient is steadily getting better the amount of toxins begins to decrease, and when the disease becomes quiescent, practically no toxin is given off. We have noted that the presence of toxin causes an anti-toxin to be produced by the tissue cells of the body, and our ob-

ject is to produce these anti-bodies in excess.

Unfortunately, the tissue cells will not produce them, unless stimulated to do so by the presence of the toxins, so to get this excess we fall back on Tuberculin.

Tuberculin corresponds to these toxins, and we are able to inject increasing doses, and to bring about the desirable effect of loading the body up with anti-toxin substances.—From "The Journal" of the Waipiata Sanatorium.

An Epidemic in C.M.S. Victoria Home and Orphanage, Kowloon City, Hong-kong

(By "Not-a-Nurse.")

"Ku Neung (title for addressing a foreign lady), please look at A. Fung" (one of the orphans).

We looked—and there was no mistake about it—A Fung had the measles.

Picture to yourself an L-shaped dormitory with beds—boards on trestles, you would say—six feet long, packed in a double row right down the length on one side, and in a single row on the other side, with a narrow passage-way in the middle. Some beds joined, but in no case more than a foot's space separated them. A. Fung was one of the hundred and forty who slept on these beds. Have any of the others been infected, we wondered, as we sent her off to Kwong Wah Hospital. A few days passed with a few weary little folk lying on their beds too tired to go into school, and then out came the crimson rashes. It was no use trying to avoid the fact—measles had come to stay.

We have a tiny dormitory about twelve feet square, and there we tried to isolate our paients. One little girl, more sleepy than the rest, seemed to be breathing too quickly. Oh! how we longed for a nurse to tell us what to do and how to care for them all! "We must call the doctor," we said, and he came—a thin, tall man with a tired looking face, but kindly blue eye. "She's got double pneumonia," he said, "and must go at once to hospital, but there isn't any hope for her." This sounded bad; but as he himself called the ambulance and took her to hospital we knew all that could be done would be done. She was only eight years old—had been sold by her parents to be a slave—was treated cruelly by her purchasers, and finally, being thrown out of a window, was left for dead. The Christian Hospital doctor in Yunnan chanced to pass by and picked her up. In the hospital, after months of patient nursing, she recovered, and her purchasers, hearing of her whereabouts, wanted her back. Fearing they might steal her, the Christian doctor sent her over a week's journey by land and sea to us, and still pays for her support.

Each day brought more patients; each day the doctor came. "We don't know why the rash does not come out on this one, doctor." After a minute or two of examination we were told this one had pneumonia in one lung, and not measles. "Leave her where she is, put a blanket under her, and give her only milk to drink" (a beverage she detested).

Next day two very sleepy folk were waiting the doctor's visit, attended by their respective grandmothers, for their mothers were dead. "They are both very ill. Can you isolate them?" So they were carried into our own quarters to our tiny guest room. That night one put forth long worms, and the other liver fluke worms. Next day the former was better, but the latter—the little one—was worse, and the doctor said he would come again in the evening. After seeing his patient he asked us to prepare to keep a steam kettle going all night while he returned to hospital for drugs. We rigged up one in the only fashion we knew and were hardly finished when he came back with the ambulance. No risks must be run with the little life; so she

went to Kwong Wah, and according to Chinese custom, her relations went with her. She was given the usual drugs to make her sleep, which the Chinese grandmother could not understand. In the absence of the doctor and against the wishes of the Chinese nurse, she would pick the child up in her arms and try to make her talk. The matter was reported and she was warned of the consequences, but she persisted in her devotion, and the little life departed.

So the days passed with some quite simple cases; others very perplexing, till at the end of three weeks the doctor said drastic measures must be taken to stamp out the disease. He came with the ambulance, and in two trips carried away our last eight patients—the last of twenty-eight cases.

It was amusing afterwards to hear Dr. Ip's version of the telephone call and the request to take in immediately eight patients with measles, but Dr. Ip, the Chinese doctor in charge of Kwong Wah Hospital, is not the man to be daunted by any request for help. He passed through St. Paul's College, carrying off all the honours, was a brilliant University student, speaking English as fluently as Chinese, and now is noted for his resourcefulness and his skill in the use of medicine. He is, moreover, a true Christian gentleman, winning love and respect from all. Kwong Wah is far too big a hospital to be supervised by one person. There are no foreign nurses to see that the Chinese nurses are trained to be scrupulously clean, and the consequence is that skin diseases are easily caught. We were very anxious when we saw our eight go there, for our previous visits had taught us they might come back with something worse than measles.

The day after our eight left was beautifully fine, and everything that could be taken outside went out to be sunned. Everything inside was scoured with Jeyes fluid, much to the disgust of the Chinese, who seem to have an innate dislike to this kind of cleanser.

Worse was to follow, for in a few days the sanitary authorities arrived with formalin, and in a very short time the whole place was sprayed and floors were washed with "the offensive stuff." Bed covers, mosquito nets, etc., were taken away to be steamed, and we felt sure not a single microbe could be left alive.

Daily visits had to be paid at Kwong Wah, for our eight were so hungry that we had to supply a mid-day meal. Poor Chinese eat only twice daily, and this is the custom at Kwong Wah.

After two weeks the doctor gave his consent to our eight returning! Amid great rejoicing we brought them back. One was discovered to have brought back chicken pox, and we feared another epidemic; but only a few mild cases eventuated.

Would you believe it—two days later was a big girl with a home in a village another case of measles appeared! She not far distant, so we sent here there.

Now, in accordance with new Government regulations, we are reducing our numbers so that each bed may have eighteen inches space around it, and we hope never again to have another case of measles in Victoria Home.

New Zealand Nurses' Christian Union

On July the 20th a pleasing function took place at "Chequers," Napier, when Mrs. Marett and Sister Goldsmith gave an "At Home" to introduce Mrs. Tythe-Brown, the new Travelling Secretary for the N.Z.N.C.U. It was a beautiful afternoon and punctually at 3 p.m. the large drawing-room was practically filled by the arrival of over thirty guests, the Public Hospital being well represented by the Matron, several Sisters and Nurses. Altogether it was a very encouraging audience for the new Secretary's first public meeting. Sister Goldsmith introduced Mrs. Tythe-Brown, who gave a very interesting address on the object and aims of the Union. Deaconess Saunders also gave a short address. During afternoon tea Mrs. Tythe-Brown took the opportunity of distributing Prayer leaflets and

enrolling new members. At 4.30, the guests departed, all expressing hearty appreciation of the little gathering and wishing Mrs. Tythe-Brown great success, and the Union many new members as the result of her tour throughout New Zealand. Apologies were received from many nurses who were unable to attend, thus proving that the interest in the N.Z.N.C.U. is growing.

A very enjoyable re-union took place one sunny afternoon, during March, at "Chequers" lawn, which is situated high up on the Napier hill overlooking the sparkling blue sea, Marine Parade and Public Swimming Baths. The occasion was a tennis tea, given by Mrs. Marett and Sister Goldsmith to the returned N.Z.A.N. Sisters and overseas workers. Those present were: Sisters Millar, Grant, Walker (2), McBeth, Childs, Sheridan, Wetheral, and McLean, and overseas workers, Mesdames Land, Large, Brown, Miss Thompson and the late Secretary of the Napier Plunket Society, Mrs. Peter Ashcroft. Apologies were received from Sisters Hodges, Hastie, Davy, Gilmour, Eagle, Brown and Miss Spencer.

Obituary

SISTER CATHERINE BELCHER.

There are many who will regret the untimely death of Sister Catherine Belcher. A native of Oamaru, where she had a brilliant school career, the deceased lady was beloved by all who knew her. In Invercargill her sphere of influence lay in the Southland Hospital, where she was Sub-Matron when compelled to relinquish her duties on account of ill-health. She became known to the members of the St. John Nursing Division through instructing them in Home Nursing last October. Her ability as a teacher, her tact and skill as a nurse, her gentleness and sympathy as a woman, won for her the respect and love of all who knew her. Possessed of a bright nature and a charming personality, Sister Belcher was one who never spared herself in her devotion to the lifework of her choice—the alleviation of the pain of suffering humanity. When she was laid to rest in Oamaru the St. John Ambulance Association of Invercargill sent a wreath in token of the high esteem in which she was held here, the Superintendent of the Oamaru St. John Ambulance Association placing it on the grave.

Though her life was short, her memory will never lose its fragrance in the hearts of her friends, for hers was a beautiful life of service cheerfully and whole-heartedly rendered.

IN MEMORIAM.

The "Pale Rider's" stolen a march on the ranks
Of the Nursing Brigade—What does it mean?
Why are the flowers that are fairest and rarest
Plucked, while the hybrids stay healthy and green?

Another's just gone her reward to inherit,
Leaving a gap that t'will be hard to fill;
No one who knew her but honoured and loved her,
Her loving deeds cling to our memory still.

Gone where the shadows of life cannot come;
Where every stranger may find a sweet home;
Severed the chains that have bound her to earth,
Gone to the land where the soul hath new birth.

Where every stranger is gathered to God,
Soul to its maker and dust to its sod;
Weep not to miss one on earth's weary shore,
Earth has an angel less—Heaven one more.

—By one of her Patients.

The Ward Sister: A Paper Read at Nurses' Conference.

A thorough knowledge of nursing is only one out of many qualifications that are considered indispensable before the satisfactory discharge of a Sister's duties becomes a possibility. People who are unacquainted with the actual practical work of a Hospital suppose that when a Probationer has learnt to be a Nurse, she is fit to be a Sister; they imagine that the satisfactory fulfilment of the duties appertaining to one position ensures the same result in the other. A better understanding of the qualifications required for a Sister, would at once show that this is a very inadequate view of the subject. All the qualities needed to make a good head of a household are essential for a good head of a ward.

The same constant thought for others, the same method in the arrangement of work, the same forethought to meet the expected as well as the unexpected incidents of the day, and to bear the brunt of them and make the best of circumstances, the same cheerfulness and sweet temper to allay the friction which may arise among workers and the same unfailing courtesy to stray visitors of all kinds, however inopportune their visits may be—all these qualities and many more, are indispensable in a Hospital Sister. The character of the Sister in Charge of a Ward will not only affect the comfort and well-being of the sick, but will exert a distinct influence over her Nursing Staff, who look to her for instruction and guidance.

The first act on the part of a new Sister should be the careful study of the Standing Orders. If she is to control others and set a good example of obedience to rule, she must first ascertain carefully what her own rules are. She must make herself acquainted with the regulations which apply to nurses as well as those drawn up for her own guidance. It becomes a portion of her duty as Sister to enforce the due observance of all Standing Orders that apply to members of the Nursing Staff.

Everything in the wards, literally from the floor to the ceiling, is the Sister's business, and the responsibility for the good condition and for the superintendence of every detail of the work rests with her. Good results must be maintained and only constant supervision will keep her nurses and wardsmaids up to the mark.

The Sister must not be content to pass over indifferent work as good enough, and to listen too readily to the explanation of why work that should have been well done has been badly done; other people will accept a second-rate standard with surprising rapidity. If we remember that it is these subordinates who are the means by which the Sister chiefly gets the actual nursing carried out and at the same time they are the links which will extend the chain of her influence in various directions later on.

The perfect order, cleanliness and smartness of her ward, as well as the neatness of her nurses and wardsmaids are also due to her supervision.

Those who cannot learn how to impart their knowledge may be capable of very good work, but should consider themselves unfitted for the part of a Sister. The nursing of the patients is undoubtedly the first consideration, but that is only a portion of a Sister's duty. There is a great variety in the teaching power of many good sisters, and the fact of imparting knowledge with faculty is a specially useful qualification for anyone desirous of filling these posts.

If a knowledge of nursing came by instinct there would be no need of Sisters as teachers, for we all know that the technical training of nurses must be given and acquired in the wards of a Hospital, and that this is a very important part of a Sister's duty.

There can scarcely be a nobler incentive to make ourselves worthy of such a great trust that our fitness is a matter of grave importance to others. The opportunity for usefulness is almost unlimited.

The Doctors are quick to feel that their patients are being left in capable hands as far as the nursing is concerned, and whether the Sister has the personal qualifications which alone can inspire confidence.

Patients are almost entirely dependent upon the Sister's kindly management and upon the tone that she maintains in her wards. It is not easy to define how much

the patients are always seeking at her hands, mentally, morally and physically Nurses and Probationers are looking to her for constant guidance, and learning by everything she does.

As also it is a Sister's duty to give each new patient admitted to her ward a kindly welcome, few Sisters attach sufficient importance to this detail. It must be remembered that they are not only strange, but ill, and often in pain, so that they are not in a normal condition for going through the orders of being consigned to strange hands and the way they are spoken to on their first arrival will make a wonderful difference to them: just a little individual interest for the moment will meet with a quick response.

In addition to these claims the Sister owes to the authorities of the institution in which she is working that conscientious discharge of duties entrusted to her, which they have a right to expect.

A Visit to the Avondale Mental Hospital

The visit of the Auckland Refresher Group to the Avondale Mental Hospital will long last in our memory. The day was dull, and rain showers fell, but a comfortable corporation bus had been commissioned to convey us to the institution. The grounds were bright with rich coloured beds of anemones which gave a brightness the sunshine denied.

We assembled in the large reception hall, where the Medical Superintendent and Matron introduced us to the staff and were then divided into groups and escorted through the institution. The wards were bright, fresh, clean and gay with flowers, and the day rooms had an air of calm rest and quiet so necessary for such cases. Many of the inmates were busy at sewing and fancy work, and apart from an occasional utterance one might have been passing through a hotel lounge.

Next, the sick wards—these are in charge of general trained Sisters, and the patients looked exceedingly comfortable and well cared for. The ward equipment, with high beds, rubber castors, white-topped lockers, with neat curtains with scarlet bands across the front, gave a neatness and brightness to the ward; there was plenty of light and a delightful view. These wards were quite equal to any in our general hospitals.

The refractory wards were spotlessly clean, and well arranged for the care and protection of the patients.

The kitchen where food is cooked for 1,200 patients was very good of its type; many of the inmates assist in this department. One patient present came forward when requested by the Medical Superintendent and willingly chatted with the group. She was quite proud of her age—71 years—and that she was the mother of 13 children.

The laundry and sewing rooms were each reviewed in turn and presented the same well-managed appearance.

After a survey of the well-kept grounds and gardens we visited the Nurses' Home. This has just been opened—not an elaborate structure, but each nurse is given the comfort of a bedroom to herself, plenty of bath and shower appointments, and a well fitted up kitchenette.

The Sisters' sitting room is comfortably furnished and has a very nice outlook. The nurses' sitting room is large, attractive rugs on the floor, plenty of bright covered easy chairs and restful chesterfields. There were pretty flowers and the welcome of a bright fire. This room has a very bright, cheerful outlook, which is very necessary with this type of nursing.

The Medical Superintendent, Matron and Staff kindly dispensed a most refreshing afternoon tea, which all present greatly appreciated. Afterwards the Matron, Miss Brand, took the opportunity of speaking to the group. She expressed her pleasure at so many coming on such a wet afternoon, she emphasised the great need for affiliation between the General Hospital and Mental Hospital, and appealed for recognition by the New Zealand Trained Nurses' Association of the fine group of women it had been her pleasure to work with in her own institu-

tion. She spoke feelingly of their superior qualities and loyalty to their work which we well know they must possess by the slight experience we receive in General Hospital with these cases.

These steps for affiliation have been taken in Great Britain and many other countries. It would be a step in the right direction if the General Hospital could send its students for four months' special training in handling and nursing the mentally sick patient.

Miss Bicknell then thanked Miss Brand and her staff for the interesting afternoon they had given the group, and mentioned how it had dispelled many misunderstandings about such institutions. We all took away happy recollections of our visit to the Avondale Mental Hospital. J.A.M.

A Case of Streptococcic Haemolytic Infection of the Middle Ear following Tonsillar Infection

Jas. Hardie Neil, M.B., N.Z., F.C.S.A.., F.A.C.S., Aural Surgeon, Auckland Hospital.

On May 31st, 1927, Dr. Derrick kindly asked me to see a lady aged 29, who had been admitted to a private hospital three days previously, with severe tonsilitis.

The history was, that for six days prior to admission she had suffered from acute sore throat, general malaise, and aching limbs. Her temperature was 99.4, pulse 96, respiration 24. The tonsils were enlarged and acutely inflamed without the cryptic spots usually seen. The right side was the more painful. The gland beneath the angle of the jaw was slightly tender on both sides. She was given gargles of Milton, and hot foments to the neck in front of the ear. Her dentures were removed.

The urine was examined and found normal. Shortly after admission the left side became the more painful, and at the consultation examination a left side quinzy was located and opened. She was more comfortable during the next few hours, but twenty-four hours later the temperature went up to 104deg. and she complained of pain in the left ear. She was not certain that it had not been present to some extent prior to this, but masked by the predominant throat pain. Previous to this illness she never had any ear trouble.

She had had a restless night, was flushed and bright-eyed and her mind wandered at times. In the morning the drum had perforated, as a quantity of mucoid fluid like saliva appeared at the orifice of the meatus. This was sent up at once to the Hospital Laboratory, and Dr. Gilmour subsequently reported that it gave a pure culture of Hæmolytic Streptococcus. Movement of the outer ear was objected to, and severe tenderness complained of, on pressure over the antrum, front of the tip and behind the mastoid. The drum could only be seen with difficulty. In the posterior inferior quadrant could be seen a large perforation through which a mucoid like fluid was pulsing. There was no sagging of the posterior superior wall of the canal, nor was there any noticed in the frequent examinations subsequently made. A slit flap dressing was placed over the outer ear and the discharge wiped away four-hourly. The patient presented a marked toxic appearance with confused and dulled sensorium. For a week the temperature swung up to between 103 and 104. Head pains and constant throbbing were consistently complained of. The tongue was dry, glazed, and fissured, and with the marked accumulation of sordes, demanded the constant care of the nursing sister, who realised that any addition to the residual tonsillar sepsis would be a menace to the lungs. She made constant use of lemon juice to clean the mouth and necks of the teeth. Consistent efforts were necessary to counteract the effects of the rapid bodily wasting on the skin and to administer nourishment to the patient who was more anxious for fluids. Three doses of scarlet fever antitoxin (P.D. & Co.) of 500,000 units were administered at two-day intervals. These were each followed by a drop of three or four degrees on the following morning; otherwise the fluctua-

tion was two degrees. None of the characteristic chills or sweats of Lateral Sinus infection were noticed.

The mental condition persisted, except that slowness of response to questions increased. Eleven days after the commencement of the discharges from the ear, the nursing sister reported that there was albumin in the urine to the extent of 12 on the Esbach scale, and as the patient showed resentment on moving the head, Dr. T. W. Johnson was called in consultation. He made a careful examination and excluded meningitis, and superintended the medical side of the case, ordering a diet non-irritant to the kidneys.

The result of the bacteriological examination and the onset of the case recalled a comprehensive article by Ballinger, in the "Archives of Laryngology," August, 1926. He recounted an epidemic of 56 cases of acute otitis media, secondary to an acute infection of the throat. He drew attention to the fact that many cases simulated the up and down temperature of lateral sinus thrombosis, and that the temperature was uninfluenced by the free drainage obtained from an early and wide opening of the drum. He pointed out that many cases of mastoidectomy in the first week were reported in the literature ,and that when the Hæmolytic Streptococcus was the offending organism, an almost equal number of grave blood borne complications were reported. He thought it logical to assume that with this organism present, these symptoms and complications were accounted for by the entrance of the bacteria (not necessarily a thrombus) into the blood stream. In the secondary infected area (the middle ear and mastoid) too early an interference would greatly increase the bacteremia by opening up new channels before the area was walled off by nature's protective measures, and so overwhelm the general immunising mechanism. He stated that the vast majority recovered without surgical interference and without lateral sinus thrombosis. As regards our patient it may be advisable to state the reasoning that guided us in the handling of this case that naturally caused us great anxiety.

Clinically she presented a picture of acute suppurative otitis media with toxic symptoms compatible with virulent mastoid infection involving the Lateral Sinus.

In acute mastoiditis the cases can be grouped into the coalescent and the hæmorrhagic types. The former, usually with an exacerbation of symptoms, follows some days after an otitis from nasopharyngeal infection, and may be painful, or more rarely, painless. There is stagnation of pus in the mastoid cells with decalcification and necrosis of the inter-cellular bone. With the profuse purulent discharge, there is sinking or sagging of the posterior superior wall of the canal, and narrowing of the inner part of the lumen. With variations, pain in and behind the ear, tenderness over the mastoid, head pains, pulsing noises, restless nights and the general signs of septic absorption form a typical picture.

The hæmorrhagic type is usually influenzal in origin, and is not a preliminary to the coalescent type. It is comparatively rare in this district. It is accompanied by symptoms of acute otitis. An incision of the drum lets out only thin blood-stained discharge. The other signs of mastoiditis are present, but there is no sagging of the canal wall, and the temperature remains constantly about 100deg. from the outset. The cases all present clinical manifestations of severe sepsis, the course is stormy and prostration is marked from the outset. The principal lesion is confined to the small veins in the mucosa lining the mastoid cells. When the mastoid is opened the cells are free from pus and not broken down. Excessive bleeding is encountered with every disturbance of the mastoid substance. The frequency of Lateral Sinus infection in this type is well known. It occurs about four times more frequently than in the coalescent type, and is due to direct extension of the infection through the tributary veins from the mucosa.

The well-known authority, Kopetzky, who named the condition, sets down its complications and terminations as: Resolution rarely, Lateral Sinus thrombosis, Acute Brain abscess, meningitis and metastatic lesions. He states that this type of case requires early surgical intervention, operation in the first week will usually clear up the case. We were thus con-

fronted with the necessity of making a diagnosis between acute Hæmolytic Streptococcis Infection mainly confined to the middle ear, where early intervention would in general increase the gravity of the prognosis, and acute hæmorrhagic mastoiditis that demanded early surgery to save the patient from the most serious complications.

The discharge from the ear was profuse and was never blood-stained. The spontaneous perforation was adequate for drainage. The Sister, to whom we must pay tribute for skilful observation and meticulous nursing care, reported that the patient appeared to be more hyperæsthetic when we were making our regular examinations, than when she was doing the dressings.

The patient maintained her blood colour comparatively well. Circumstances made it impossible for us to seek frequent help from the Laboratory, but signs were absent of marked destruction of the hæmoglobin so characteristic of local Hæmolytic Streptococcal infection of the Lateral Sinus by direct extension into that vessel. The absence of chills (or even transient coldness of the extremities), the absence of rapid rises in the pulse and respiration rates to correspond with the height of temperature rises—the non-appearance of nausea and vomiting on being roused or on the head being moved, or on partaking of fluids, and the constancy of the mental condition all tended to show that the Lateral Sinus was not involved. The X-ray, taken with a portable apparatus, was not convincing. The cloudiness stated to be present was not sufficiently definite. Our diagnosis was Bacteremia, in which the ear condition was a secondary focus, the infection being confined to the middle ear. The mastoid involvement we deemed to be that usually concomitant in the antrum in acute otitis media. The nephritis was very disturbing. Ballenger did not mention this as a complication in his series. Dr. Johnson has kindly supplied a memo. on the subject:

"On account of its initial severity, microscopic examination of the centrifuged deposit showed the field crowded with epithelial cell casts, epithelial cells and red blood cells. It was obvious that the excretory organs were feeling the effect of their attempt to reduce the Bacteremia, and were giving way to the attack of the virulent streptococci. An acute tubular nephritis had thus arisen. This helped to increase the severity of the general symptoms.

"Fortunately, within a few days, the resistance of the patient began to gain ascendancy over the Bacteremia. The kidneys immediately responded to the lessened attack, and the acute nephritis began to subside. The cell casts rapidly disappeared, and the urinary output rose to normal. The albuminuria persisted to the same degree, but at the end of a week it was decreasing, and in three weeks it had almost completely gone. Estimation of the urinary functions at the end of six weeks showed that the kidneys had completely recovered, and the possibility of a chronic nephritis supervening was removed.

"The kidney lesion was interesting in that it demonstrated the bacterial cause of acute nephritis and also the complete recovery that is possible in a severe lesion."

In another four days the evening temperature began to hover about the normal line, and convalescence after the typhoid type set in. The tongue cleared slowly, and the mentality became acute and bright. The ear discharge which became purulent in the first week gradually diminished and dried up in another two weeks.

We must express our thanks to Miss Wilson, the Matron of Huia Private Hospital, to Sister Curtis and the staff, whose efforts in no small way contributed to the recovery of the patient.

The two following Papers on the Spirit of Nursing were read at the Nurses' Conference. I.

It is rather amazing that in recent years there has been not a little discontent in connection with duty and time off amongst some of our young student nurses, and still more amazing that this discontent should have been made public through the Press. It appears that the trouble has arisen owing to nurses in training having at times been called upon to extend hours of duty and forego days off when their respective hospitals have been pressed by stress of work, sickness amongst the staff, and other unforeseen emergencies. A spirit of this kind is hopelessly incongruous when associated with a profession. If work is to be done and the sick to be nursed, then women who call themselves nurses should willingly answer the call. If not, how can they be regarded as women faithfully serving the sick, loyally supporting their respective hospitals, and upholding the ideals of the profession. It is most disappointing that even a few should take up such an attitude. Indeed it is not the action of women of education studying a profession. Those possessing such a spirit should join the ranks of unskilled labour, for there they would find themselves in the right atmosphere with every opportunity of airing grievances without blotting the ideals of the profession.

During the last few decades nursing has evolved enormously, and the women directly responsible for this great advance are those who have worked long hours, given time graciously, and have never stopped to consider the hours or the days off they have not had. If they had, a great many of our nurses to-day in training would not be surrounded with such comfort, neither would they enjoy such happy and convenient working conditions. It is devoted service and time faithfully given that forces progress. If this progress is to continue, then our students must carry on in the face of seeming adversity with a cheerful and willing spirit, and be proud that by so doing suffering humanity will benefit. Nothing can be said in favour of any nurse who opposes the administration of her school, for while in training she is not qualified, therefore not in the position to criticise. Moreover, she will never join in the march of progress and success. In short, the profession would be better without her.

Chronic nursing is a subject that is much in need of thought and consideration, for it is rather a regrettable fact that it has been known for nurses to regard this work as something that should not exist. So apparent has the disinterest been that even trained nurses have been known to refuse work of chronic nature. It can only be brought home to those possessing such a spirit if they realise that they themselves may some day be so afflicted. How, then, would they care to be nursed by someone who regarded such work as a trouble? In this particular branch we could well take example from women nursing in the various religious orders, for no doubt very excellent work is done by them. They possess wonderful patience and charm of manner, and are devoted to the work. Moreover, their work is done with a silence that brings rest to the patient.

Quietness is an art that has a tendency to be forgotten—outside interests and pleasures may be responsible with a result that duty suffers, and in consequence many nurses become noisy, hurrying and rather irresponsible young women. In these days it is difficult to hold on to the true nursing spirit as Miss Florence Nightingale meant it to be. Our profession is fast developing along two very definite lines, in that much times is given to encouraging better scientific teaching, and that we have an organised association founded on a very definite business and financial basis. These factors were not prominent 20 years ago, and although they have brought greatly improved conditions and helped tremendously financially, the fact remains that they have to some extent overshadowed the true nursing spirit, or, perhaps it may be said that the combined efforts in support of the nursing spirit have not been so strong as those supporting the financial benefits.

In conclusion, it can only be said that unless students possess a true desire to nurse the sick and loyally serve their schools with a very high sense of duty they will fail in maintaining the ideals as they should stand.

II.

There has been so much said against the present-day nursing spirit that I should like to say a word in its defence.

Not because I rather tend to champion forlorn hopes, but because I do not think this a forlorn hope. I believe the nursing spirit is very much alive, but that it is rather hopelessly smothered under its new clothing at present.

We acquire the habit of blaming the spirit of the age rather carelessly without stopping to realise the spirit of the age as it applies to nursing.

The growth of preventive medicine, and treatment to a much greater extent on psychological lines, rather tends to make the average woman much more intolerant of illness generally.

The tendency to rush cases through in big hospitals to clear the way for more, takes the place of the old leisurely treatment. Added to this is the fact that few women are content in these days to give all their youth and strength so tirelessly and to be cast aside when spent and worn. In the nursing profession a good nurse spends herself as in no other walk in life. We are trying to remedy this, but there is still much to be done for the private nurse. Nurses now must keep closely in touch with new movements; there is too much at stake not to, and in attempting to keep up, they sometimes appear to be not closely in touch with their work, and to treat it lightly.

Most people who think are learning a wider, finer philosophy of life, and I believe the future nurses will posses this and learn to apply it in their work as part of the care of humanity. The quiet but sure working for the common cause —humanity—the Y.W.C.A., Y.M.C.A., Ambulance Corps, Girl Guides, etc., are all more or less imbued with the nursing spirit; they prove that it is alive, and I must believe that a large percentage of the women who take up nursing do so for the work's sake, not just because it is an honourable profession.

Having taken it up the best nurses learn to love it, and from these we chose our responsible people.

Few people agree with me when I say I prefer to train the idealists before the very practical people. The idealists will go on through anything, even after the wholly practical person will finish up. The idealist never believes "it" is finished.

The truest nursing spirt is found in the idealist, and these nurses go quietly on, do what they have to do, and are not much in evidence generally. Only when an outstanding nurse combines idealism with a practical nature is she noticed.

Do not let us grow into the habit of overlooking these quiet people in the weariness of having the others always before us.

When I see the tired faces of the sisters who stay on after a long day to do just a little more for an almost hopeless case; or see nurses' faces light up because a tiny premature baby (which only by the most constant and loving care has held on to life at all) has learn to "really cry," when almost all the staff rejoices because a very ill man or woman has recovered enough to be put out on the balcony for the first time, then I do not despair of the nursing spirit.

I know we must battle hard in the years to come to hold and foster it. In all the changes and readjustments it will not be easy to fight through, but the old spirit of the founder is still extent, and something as definite as that cannot be lost.

We know thoughts are concrete, so do not let us even think the nursing spirit is dead, it is only temporarily more or less smothered under all its new clothing.

The Genito-Urinary System

By Dr. Kendrick Christie.

The genito-urinary system comprises two groups of organs, the **Generative** and the **Urinary organs.**

The former group forms and liberates the products of the sex glands; the latter group elaborates and excretes the urine.

In the lowest verebrate animals these two groups of organs are inseparably united, so that the excretory duct of their primitive kidney may also transmit sex cells.

In the higher vertebrates this union obtains only in the early embryo. In the adult the urinary and generative organs are quite independent apparatuses except at their terminal segment, where the uretha of higher animals may conduct either urine, or sex cells occasionally.

In considering the diseases, treatment, and nursing of Genito urinary cases, we deal with the following organs:—

1. **The Urinary Organs,** i.e., the kidneys, ureters, bladder and urethra.

2. **The Generative Organs,** i.e., in the male: Generative glands (testes) the vas deferens, or generative duct, seminal vesicles, the external organs, the accessory glands, i.e., prostrate. In the female: Generative glands (ovaries), fallopian tubes, uterus or womb, vagina, external parts, accessory glands (glands of Cowper and Bartholin).

Our main concern is to grasp the rational basis for treatment, and especially nursing treatment, in diseases of these organs. In order to have clear ideas of the why and wherefore, we must have definite working views of the anatomy and physiology of these systems. I propose to deal with each organ in turn, under the headings of Anatomy and Physiology, diseases, treatment and the essential points for the nurse. The importance of each point in the anatomy will be shown in its relation to disease and treatment, so that the origin of the disease will itself suggest the treatment of it.

The Urinary System.

Urine is a waste product of the body, and the essential waste substance it contains is **urea.** How does this arise in the first place?

Origin of Urea: Part comes from the protein of foods, and part from the breaking down of the tissues. Proteins are foodstuffs containing nitrogen. In digestion, amino-acids are formed, and are absorbed to build the tissues. But some ammonia is also formed as a waste product, and this with waste ammonia from the tissues, is carried to the liver as carbonate of ammonia. The liver transforms the carbonate of ammonia into urea in the blood. The kidneys thus excrete urea, but do not manufacture it.

The urinary organs get rid not only of urea, but also of other waste substances, and of poisons which enter the system.

In order to carry out this function we must have an active filter, the kidney which separates the urine, a duct, the ureter, which conveys it to the bladder where it is temporarily stored, and eventually passed out through the urethra and got rid of. These organs are in the pelvis, except the kidney, which is abdominal, and the ureters which are abdomino-pelvic.

1. **The Kidneys.**

Are two flattened bean-shaped organs, one on each side of the spine opposite the xiith dorsal and first two lumbar vertebræ. Each kidney has a supra-renal body placed like a cap on top of it. Each kidney is enclosed in a thin smooth fibrous capsule, and lies outside the peritoneum, surrounded by loose connective tissue containing fat. Most of the fat is placed around the lower and outer pole of the kidney (vide, in sheep).

The kidney has a reddish brown colour, is 4½ inches long, and weighs 4½ ounces. It is so placed behind the peritoneum that its front surface is in contact with the viscera in the abdomen, and its back surface in contact with the muscles of the posterior abdominal wall.

Hence, at operations the kidney may be reached either from in front or from behind. It is usually approached through the muscles from behind, in order to avoid opening the peritoneum. Many of the operations performed on the kidneys are for septic conditions, such as stone, and by not opening the peritoneum the risk of peritonitis is avoided.

Position: As stated, opposite 12 Dorsal and first two lumbar vertebræ. Notice that the kidney is not vertical, the upper end of each being nearer the spine than the lower end. The upper poles are covered by the 12th rib. The lower poles project below the 12th rib, are further out from the spine, and reach usually to 1½ inches from the crest of the Iliac bones. Hence in the operation of exposing the kidney from behind (Lumbar Nephrotomy) it is the lower pole that is exposed. When this is grasped the kidney can be drawn out of the wound in virtue of its loose connective tissue surroundings, and the elasticity of the renal artery and vein.

We may regard the kidney as being packed into its place by the surrounding fat, and by the pressure of the abdominal viscera. The outer layers of the kidney fat are condensed into a definite fibrous layer which slings the kidney on to the diaphragm. Being attached to the diaphragm, the normal kidney moves down about an inch in full inspiration. This fact is important in connection with movable kidney, and also in connection with tumours of the kidney. In normal persons the kidney cannot be felt through the abdominal walls, even in inspiration. If it can be so felt, we have the condition of dropped kidney or "Movable Kidney." This occurs in thin women, where there is loss of the fat which should be packed around the kidney. They have also loss of tone in the abdominal walls, and hence lack of support to the kidney.

Again, in growths, if these have caused the kidney to be fixed they are certain to be malignant. The kidney is X-rayed in expiration, and again in inspiration, and the degree of movement thus noted.

That surface of the kidney which looks towards the spine is indented, to receive the renal artery from the aorta and sympathetic nerves, and to give exit to the Renal Vein passing to the Inferior Vena Cava, and the ureter passing down to the bladder. The Renal Artery is derived directly from the Aorta, so that a large amount of blood reached the kidney. This amount is equal to its own weight every minute. Hence the secretion of urine is free, and wounds of the kidney bleed very freely. Before the artery enters the kidney it breaks up into branches.

The large number of Sympathetic Nerves entering the kidney account for the terrible pain of renal colic, which may be the worst of all pains. Many other diseases of the kidney are associated with severe pains also.

The ureter commences in this indented part of the kidney, as an expanded portion about an inch long, called the renall pelvis, which tapers to form the ureter. Between the arteries, veins, nerves, and renal pelvis there is packed fatty connective tissue.

Relations of the Kidneys to other Organs.

The upper end of each kidney lies on the diaphragm, which separates it from the pleural cavity. This explains why sometimes an abcess of the kidney bursts into the pleural cavity. Suprarenal body is placed on top of each kidney. The kidneys lie one on each Psoas Muscle, which explains why pain or colic in the kidney causes the thigh to be drawn up. On the right side of the liver comes down over the front of the upper part of the kidney. For this reason, the right kidney lies a little lower than the left, and a "Movable Kidney" is nearly always the right one. In each case the Colon is in close relation to the kidney; on the right side it is the ascending colon (Hepatic Flexure); on the left side it is the descending colon (Splenic Flexure). The colon is passing up or down just outside the kidney, and has to be avoided at operations. Sometimes it is wounded, and a fæcal fistula results. These usually heal by granulation without a further operation.

In place of the liver, we have on the left side the spleen in front of the upper pole of the left kindney.

The duodenum is in front of that part of the right kidney where the vessels enter. In operations on the right kidney from in front, the duodenum has to be pulled inwards, and the liver upwards. In the same way the stomach and pancreas are related to the left kidney and in both cases, coils of small intestine are also in front of the kidneys. Hence it can be seen that the easiest way to expose the kidney is from behind. The chief dangers in the operation from behind are of wounding the peritoneum, the colon, or the pleura.

Internal Structures of the Kidneys:

(Studied on a Sheep's Kidney).

When split lengthwise the kidney is seen to contain the upper expanded end of the ureter. This is the renal pelvis. (Pelvis, a basin.) The kidney substance projects into this renal pelvis as a number of little projections or papillæ. Each papilla is made up of from two to four little pyramids of kidney tissue. They appear radially striated, since they contain numerous minute tubules all running towards the apex of the papilla, with blood-vessels sandwiched between them. Urine is thus discharged from the apex of each pyramid into the renal pelvis. In order to collect it the renal pelvis sends out a number of short finger-like tubes, each of which embraces one papilla by means of an expanded cup-shaped end known as a Calyx (calyx, a cup).

Each Calyx embraces from two to four pyramids which together form one papilla.

Between these calyces are passing in and out, as the case may be, the arteries, nerves, and veins.

The structure of the kidney is much simplified if we remember that in the unborn child it consists of a number of separate lobules. Each is a gland with its papilla and calyx, and hence the blood-vessels and nerves must run between them. Later, these lobules become compressed together into one kidney, so that the blood-vessels are still found running between the calyces, or their papillæ. The whole is covered with a smooth capsule, and in the adult but little trace of the lobulation remains.

Diagram 2.

The section of the kidney shows two zones, which together form the main substances of the organ.

1. The Cortex, or outer zone.
2. The Medulla, or inner zone.

In the brown cortex are minute red dots, the Glomeruli.

In the Medulla are the pyramids, consisting of excretory tubules. Between cortex and Medulla the blood-vessels break up into smaller arteries, forming loops from which the final branches run out to end in the cortex. These do not anastomose with any other arteries, and are known as "end-arteries". Their importance as such will be referred to later.

The kidney, like other compound glands, is composed of a vast number of minute glands. Each of these small elements requires three essential parts:

1. To extract the fluid, urea, and salts from the blood, we have a "Glomerulus" (tuft), or twisted capillary, derived directly from the Aorta.

2. A tubule lined with secretory epithelium, which can re-absorb some of the water.

3. A duct, or drain, to convey away the now concentrated residue of urine.

Diagram 3.

The Glomeruli and the Tubules are in the Cortex. The ducts are in the pyramids of the medulla, and they join to open as one duct on the apex of the papilla, discharging into the calyx. These ducts with the small blood-vessels between them, give the radial striation to the pyramids.

The whole of these structures are supported in connective tissue.

Practical Application of these Facts.

(a) **The Arteries:** From the arterial loops between cortex and medulla run out the end arteries which do not anastomose. Hence, if a small clot or other embolus, such as a mass of bacteria (germs) gets into and blocks one of these end-arteries the whole segment of kidney cortex supplied loses its blood supply and dies. This gives rise to a depressed scar on the kidney surface. If the embolus is a septic one (bacteria) an abcess is formed in the cortex.

Again, where the blood-vessels break up (between cortex and medulla) into their smaller branches, it follows that there must be a slowing down of the rate of flow. This affords an opportunity for tubercle bacilli, which may be travelling in the blood stream from tonsils or tuberculous glands, to effect a lodgment; and we find that this zone between cortex and medulla is the usual starting place for tuberculous infection in the kidney. With further reference to the arteries, we find in Bright's Disease

(chronic interstitial nephritis), that the inflamed connective tissue in the kidney becomes excessive in amount, and blots out many of the arteries, and tubules, by its pressure. It follows that less urine can be formed and these patients may die ultimately of Uræmia (retention of urea in the blood).

(b) The Tubules and Ducts.

In **acute Nephritis,** the kidney cortex is inflamed, and the tubules may be blocked either by blood getting into them or by their own epithelium being shed off into them. The blockage is aggravated by the general swelling of the kidney. Again, the urine is diminished and the patient becomes uræmic. Some of the tubules may get rid of their contents, however, and then microscopic examination of the urine shows casts retaining the shape of the tubules. These, when seen, are proof positive of nephritis.

Moreover, the damaged tubules now allow serum-albumen from the blood to pass through, and we have albuminuria. The casts prove that it is derived from the kidney, not the bladder. The albumen is in solution, and cannot be seen on looking at the urine. It is tested for by two tests:

(1) The heat test. A white cloud on heating with a few drops of asetic acid.

(2) The cold test. A white ring on adding commercial strong nitric acid.

In the healthy kidney, the tubule is being continually flushed out by the fluid urine secreted by the glomerulus. The amount of urine depends upon the amount of blood passing through glomerulus, the amount of fluid this blood can spare, and the amount of foreign substance to be got rid of.

Thus more urine is secreted during excitement, due to the more rapid circulation, more in cold weather, due to diminished loss of fluid perspiration, and more after certain drugs called di-uretics.

In heart disease the circulation is slow, and the system gets water-logged (dropsy). Heart tonics are given)digitalis and mercury, etc.), the circulation goes faster, and all the dropsical fluid is passed out as urine and disappears. Hence the practical importance of measuring and recording a 24 hours' specimen of urine.

The kidney structure explains certain other diseases and medical tests, e.g.:

Tests for Renal Efficiency: The glomerulus excretes not only urea, but also certain other substances as well, and poisons from the system. In testing the kidney, the **"Urea test"** consists in giving a weighed amount of urea, and finding what proportion of this is excreted in the urine in a given time.

"Colour tests" consist in injecting into a vein a known quantity of an aniline dye (methylene blue or indigo-carmine), passing the cystoscope, and noting how long it takes each kidney to excrete the dye through the ureter.

De Witt's pills contain Methylene blue, and this is excreted into the urine. We all know that blue and yellow mixed make green. The blue in the pill mixed with the yellow of the urine forms green, a colour most impressive to the patient. In Jaundice, **bile** is excreted by the kidney. The tests for bile in the urine are:

1. Test for **Bile Pigments:** Addition of commercial nitric acid to the urine, producing a play of colours, especially green at the point of junction of urine and acid.

2. Test for **Bile Salts:** Flowers of sulphur will sink in urine containing bile, because the latter diminishes the surface tension.

In **Diabetes Mellitus,** the kidney excretes glucose. The blood should contain 1% only of glucose. The excess due to the failure of the tissues to burn it, is excreted by the kidney. The test for sugar in urine is Fehling's. A red precipitate got on heating to boiling point a mixture of urine and Fehling's solution.

In this disease also, the kidney excretes di-acetic acid, the test for which is to add to the urine a crystal of soda nitroprusside, and a few drops of caustic potash, when a red colour is got, which remains on boiling. Acetone, which is also excreted in diabetes, is tested by adding a few drops of tincture ferri perchlor,

filtering off the precipitate, and adding a few more drops, when a red colour is got.

In diabetes insipidus, too much urine escapes through the kidney, and the patient, whilst having great thirst, passes large amounts of urine. This disease is either hereditary, or in some cases due to disease of the pituitary gland.

Nephritis.

In acute nephritis, nurses are often puzzled because different physicians order different treatment. This refers especially to the question of giving fluids. Two schools of opinion have existed in regard to this.

1. Those who have regard to the kidney.
2. Those having regard to the renal œdema, or dropsy.

It is obvious from the structure of the kidney as considered in the previous lecture, that fluids will flush out the tubules, thus helping them to get rid of their unusual contents (casts). On the other hand, the second school contends that fluids will increase the dropsy. This also cannot be denied.

The most logical attitude to adopt seems to be to give fluids freely, in order to get the kidney tubules cleared as soon as possible. The restored kidney will then deal with any temporary increase in the dropsy.

Diet in Acute and Chronic Nephritis.

The milk is gradually thickened with arrowroot, and later gruel, so that light diet is reached as the temperature becomes normal and œdema disappears. Light diet may include eggs, rabbit, or chicken, fish. Red meat is not added for 14 days, and then cautiously.

Avoid: Meat extracts, which stimulate the kidney too much. Alcohol, which irritates it, and salt, which attracts water into the tissues and makes excretion more difficult.

This treatment is combined with hot packs, hot air baths to help elimination of urea by the skin, and with purgation by means of jalap or magnesium sulphate to get rid of fluid.

Mercury is said to be harmful, since some is excreted by the kidney.

Chronic Stage: Diet as in later stages of acute attack.

Diet, etc., in Bright's Disease.

We have adopted the view that the damage to the kidney here results from a disease with overgrowth of the connective tissue in the organ. The excreting parts of the kidney suffer as a result. Early and suspicious symptoms are:— Headache and giddiness, dyspepsia and palpitation, general weakness, getting up at night to pass large quantities of pale urine with low specific gravity (1005-1010). Defective sight from retina being affected.

Treatment: We can relieve, but not cure. Treatment comes under three headings:

1. **General:** Regular action of the bowels every morning by giving fruit salts. Avoid chills; warm climate preferred. Avoid worry. Moderate exercise. Baths, fluids (hot water every morning), no alcohol.

2. **Diet:** Give a light, mixed, plain diet. Plenty of fluids. Red meats are to be reduced in amount.

3. **Symptoms:** Treatment may be required for high blood pressure, dyspepsia, or uræmic symptoms.

Surgical Conditions of the Kidney.

These can be reviewed briefly as follows:—

1. **Congenital Conditions:** Abnormalities of shape, size, number, and position. When one kidney is absent or very small, it is not permissible to remove the other. In a recorded case where this was done, the patient lived 13 days, the first symptom being nausea and vomiting, and the cause of death being uræmic coma. More usually death would take place in about seven days.

Sometimes the kidneys are fused at their lower ends into a horse-shoe shape. Naturally such a kidney could not be removed.

Malpositions usually occur in fused kidneys, and the kidney has been found in the hollow of the sacrum. A misplaced kidney might give rise to mistake in diagnosing an abdominal swelling.

2. **Moveable Kidney** has been referred to. 80% of the cases occur in women, and usually it is the right kidney that is unduly mobile. It may cause pain, vomiting and neurasthenia by dragging on the sympahetic nerves; it may cause indigestion by pulling on the duodenum, congestion of the kidney by stretching its own vessels, or a hydronephrosis by kinking of the ureter.

3. **Injuries:** A blow may cause bruising or tearing of the kidney, and the kidney punch was barred from amateur boxing. There may be signs of internal hæmorrhage, and blood may appear in the urine. After abdominal injuries this is one of the things that the nurse watches for. A penetrating wound gives rise to bleeding, and if pelvis of the kidney has been punctured, to the discharge of urine. Infection is liable to follow since the fatty tissue round the kidney has poor resistance to infection. The result is an abscess, and sinus. Injuries of the kidney occasionally give rise to reflex suppression of the urine.

4. **Blockage of the ureter,** if sudden and complete, causes pain and atrophy of the kidney. If gradual and incomplete, it gives rise to hydronephrosis, a condition of distension of the renal pelvis by the accumulated urine. This will gradually destroy the kidney, or in some cases it becomes infected and turns to a pyonephrosis where the renal pelvis is full of pus.

A hydronephrosis is diagnosed by forming a swelling which is fluid, and by a pyelogram, which shows it under the X-rays. An opaque solution is injected through a fine tube passed up the ureter, and an X-ray taken then shows the outline of the renal pelvis. It is treated by an operation to restore the continuity of the pelvis and ureters—a plastic operation.

A pyonephrosis requires nephrectomy (removal of the kidney).

5. **Inflammation of the Kidney.** May be acute or chronic.

Acute nephritis is a medical disease; but in chronic nephritis, with dropsy, which will not clear up, an operation to strip the capsule from the kidney is sometimes done.

Acute pyelitis, or inflammation of the renal pelvis, may recover, or pass into the chronic form. When the disease spreads to the kidney substance also, it is called pyelo-nephritis. This is indicated by rigors, and the general condition getting much worse.

Pyelitis may have its origin from the blood stream, B. coli travelling to the kidney via the blood from the bowel. Sometimes it is an ascending tuberculous infection, forming small ulcers on the apices of the pyramids. Another form is known as "surgical kidney" and occurs during "catheter life," where the patient is passing his own catheter with insufficient aseptic precautions. Cystitis first arises, and the B. coli ascend from the infected bladder to the renal pelvis.

In the acute form, only one kidney is usually affected. The onset is always sudden, with fever, sweats, and rigors. The temperature is important, as if it becomes swinging, pyelo-nephritis has occurred. The acute form may subside or become chronic, or may as noted become pyelo-nephritis, with abcesses in the kidney, requiring operation at once. If the ureter gets blocked, it may become a case of pyo-nephrosis, or pus in the renal pelvis, requiring operation.

Chronic Pyelitis may be seen in persons leading "Catheter life," and they have pus in the urine, irregular attacks of fever, and septic symptoms, such as loss of weight, anæmia, and irritability. The kidney region in the loin is usually tender.

In pregnancy it is important to relieve constipation, which is a cause of pyelitis in such cases.

The chronic form is treated by vaccines and drugs, and sometimes by washing out the renal pelvis through a catheter passed up the ureter. It may also occur in children, particularly girls, and is a cause of screaming in children.

Chronic: Includes chronic pyelitis, syphilis, and tuberculosis.

Chronic pyelitis has been considered.

Syphilis is treated medically with mercury, iodies and arsenic.

Tuberculosis commonly becomes a surgical disease, since if tuberculin fails to cure, an operation has to be performed.

T.B. of the kidney usually occurs in young men, and often in red-headed persons. Nearly all the cases are infected through the blood stream, as noted. A few may get an ascending infection along the ureter from tuberculosis in bladder or epididymis of testis. Generally, only one kidney is infected, and the other remains healthy in most of the cases. Infection via the blood stream lodges between cortex and medulla. Infection coming up the lymphatics of the ureter causes small ulcers on the apices of the pyramids. The result is an illness, with pain, frequency and pyuria, and often hæmaturia. Healing may take place; but more often the disease progresses, and the bladder is infected, and occasionally the other kidney. One sequel of a tubercular infection, in the kidney is a similar infection of the ureter with blockage, and pyonephrosis. (Pus in the renal pelvis.)

The treatment is first to test the other kidney, and then to remove the tuberculous one. (Nephrectomy.) Then feed the patient.

Pus in the urine is tested for by adding liquor potassæ (caustic potash). The urine becomes gelatinous, and can be poured from one vessel into another with an audible "plop."

Tumours of the Kidney.

A congenital condition is the pressure of cysts in the kidney, which gradually grow and form a large tumour, known as a congenital cystic kidney. The disease affects both kidneys, and neither must be removed.

In children, sarcoma is the malignant growth. In adults, carcinoma (cancer), or a papilloma (benign growth).

These tumours cause bleeding, pain and swelling. The treatment is early nephrectomy. This must be done before the kidney has become fixed.

Growths in the kidney have a tendency to form secondary deposits in bones. In children a secondary deposit occurs in the orbit. In adults with carcinoma (called hypernephroma) a secondary deposit may form in the long bones, e.g., the Tibia.

Stone in the Kidney.

Symptoms are due to the pain of the stone, and to infection setting in. Thus we get shooting pains, colic from clots passing, frequency, and pus in the urine. X-rays show the stone. These stones are due to insoluble substances in the urine, substances which are soluble in blood serum but not in the watery urine. They crystallise out. Stones are formed of urates of ammonia and soda, due to uric acid, and oxalates and to salts of lime. The treatment is to remove a small stone by nephrotomy, either through the kidney substance or through the renal pelvis. A large stone may necessitate removal of the kidney (nephrectomy). The stone may be in the renal pelvis, or in the calyces, or in the cortex. Sometimes a stone in the right kidney is mistaken for appendicitis.

When a stone becomes stuck at the entrance of the ureter, an attack of renal colic results. Hence the small stones are those which produce colic. Those which are too large to move produce dragging pains and pus in the urine.

The Treatment of a Case of Acute Renal Colic.

The nurse might be confronted with such a case in a country place. There is agonising pain, which shoots down into the loin, along the course of the ureter. There is cold sweat, and subnormal temperature. After the attack, there will be a little hæmaturia. Between attacks there is variable pain in the kidney region.

Treatment **during the attack** must aim at reducing the pain. Hot poultices and bottles are applied over the kidney. Rest in bed, and hot drinks are prescribed. Morphia and atropin will be required. When attack is over, patient to watch for any stone that may be passed. **Between the attacks:** Medicinal treatment can be given. It must be remembered that no drug will dissolve a calculus. The bowels must be attended to regularly. Give

sodium bicarbonate three times a day. Test the urine with litmus until it is alkaline, and keep it so.

Diet: Avoid red meats, which might produce uric acid. Avoid acid vegetables such as rhubarb, spinach, strawberries, tomatoes, because these produce oxalates contained in calculi. Give plenty of other vegetables, which are alkaline. Whey is good to promote excretion, and fluids are indicated. Apart from these measures, give an ordinary simple diet.

A stone in the kidney, of course, should be removed surgically at the first favourable opportunity, unless it passes naturally.

Hæmorrhage from the Kidney.

Occurs in acute nephritis, in T.B., in stones, in growths, and in a condition called "essential hæmaturia," which is due to small patches of nephritis.

Emergency Operations on the Kidney.

1. **Calculus Anuria.** One kidney is absent or not functional. The other becomes blocked by a stone. No urine can be passed, and the operation must be done at once. Either the stone is removed or a temporary urinary fistula is made from the renal pelvis to the surface.

2. **Injuries:** A blow over the kidney, with signs of internal hæmorrhage, or a penetrating wound of the kidney. Kidney is either stitched up, or removed, according to its condition.

3. **Abscesses** (Pyelo-nephritis). Must be opened and drained.

Female urethra—Length 1½ inches.

Operations on the Kidney: General.

Exploration: Exposing and examining the kidney.

Nephropexy: Fixing up a movable kidney.

Nephrotomy: Exposing and opening the renal pelvis.

Nephrectomy: Removal of the kidney.

Before operating on the kidney we require to know the nature and situation of the diseases, and whether one or both kidneys is affected; also the efficiency of the other kidney. For example, a stone in the kidney has been mistaken for appendicitis. When the diagnosis has been made, the efficiency tests are carried out on the other kidney, and the operation proceeded with.

Preparation of the Patient for a Kidney Operation.

(a) **The Bowels.** Must be well emptied, since a common complication is distension of the colon. Hence give a purge 36 hours before operation. It should be castor oil or a vegetable pill. Avoid salts, which are uncertain and produce flatulence.

A small enema is given on the morning of the operation.

b. **Diet.** Give moderate diet for the last 36 hours. Avoid starchy food, potatoes or bread, which form gas. Give toast instead of bread. Avoid green vegetables and salads, which leave too much residue.

It is an advantage to give liquid paraffin regularly where possible for some weeks before operation.

(c) **Urinary antiseptics** are always given before operations on the kidney or bladder.

Position on the Operating Table.

For lumbar nephrectomy, use the "kidney position." Lying on the sound side, with an air cushion or sandbag under the sound loin to open out the space between the last rib and the crest of the ilium. The upper arm is supported on an arm rest out of the way. This allows freedom to the chest in breathing. Lower arm drawn forward out of the way of the sandbag. Upper leg is straight. Lower limb is fully flexed at knee and hip, and this with the use of a sandbag in front of the upper knee, and behind the lower buttock, prevents the patient rolling out of position.

The Operation.

A curved incision is made starting from between the last rib and the erector spinæ muscle, and extending down towards the anterior superior spine of the ilium. The thick muscles are partly cut and partly retracted. Free hæmorrhage is stopped with artery forceps or pack. The kidney is behind the peritoneum, and this must not be opened accidentally.

Other dangers to avoid are the colon, to outer side, and the pleura and diaphragm above.

The kidney is brought outside and dealt with.

Drainage is not done except after nephrotomy to allow any escaping urine to get away, or after opening an abscess. In the former case, the tube is left in for from two to four days, the lesser time if no urine escapes. It is best covered with a gauze eusol pack to prevent entry of infection to the poorly resisting perirenal fat.

After opening an abscess, drain until there is no more pus.

After the Operation.

Nurse the patient on the bad side if there is a drain in place. He should remain in bed for three weeks to get a firm scar, and avoid any tendency to hernia through it.

The immediate dangers of the operation are:—

Shock: Treated in the usual fashion.

Hæmorrhage: Which may be internal or external.

Infection: Requiring wet dressings, or evacuation of pus.

Flatulence: Treated by turpentine enema, and eserine or pituitrin. Give a dose of castor oil daily: on the second day.

Uræmia is a rare complication with modern methods of preliminary testing of the sound kidney. It requires hot packs and purgation, etc.

Retention of Urine: Hot pack to bladder. Catheter if other means fail.

The Ureters or Renal Ducts.

Originally the kidney arose in two parts:

1. The cortex or essential part was developed in situ.

2. The renal duct grew upwards from the bladder into the cortex or secreting part.

This renal duct formed the ureter, renal pelvis, calyces, and the excretory duct in the pyramids of the kidney.

The renal pelvis has two main parts, upper and lower, each of which gives out its group of 4 to 6 calyces, making a total of 8 to 12 calyces.

The renal pelvis and ureter are placed behind the blood-vessels to the kidney. Hence, at operations, the kidney is turned forwards, and the renal pelvis opened from behind. This avoids danger to the renal vessels. In contact with it on the right side is the duodenum, and on the left side the pancreas. Before it has reached the lower pole of the kidney, the renal pelvis has narrowed down to form the ureter.

The ureter, from kidney to bladder is 10 inches long. It lies outside or behind the peritoneum, surrounded by fat. Its average diameter is 5 millimeters (1/5th inch).

It has three **narrow parts:**

1. Where it joins the renal pelvis.
2. Where it crosses the pelvic brim.
3. Where it enters the bladder.

A stone passing down tends to be arrested at one or other of these three points.

Structure of the Ureter.

1. Mucous membrane lines it, and is thrown into folds to allow of expansion. It has no glands, because the urine keeps it wet, and it thus requires none.

2. Muscular coat, of three layers, two longitudinal with a strong circular layer between. The muscle coat is present also in the renal pelvis.

3. Fibrous coat, which in the last inch above the bladder contains strong longitudinal muscle bundles.

The Blood Supply.

1. The upper part is supplied by branches from the renal artery.

2. Middle part by branches from the ovarian (female), or spermatic (male).

3. Lower part by ureteric artery from internal iliac; and

4. By branches from the middle hæmorroidal (rectal) or inferior vesical (bladder) arteries.

These arteries anastomose, forming a network around the ureter. It follows that the ureter can be extensively stripped up from its bed and still preserve enough blood supply to keep it alive. **The veins** run into the spermatic or ovarian veins, and into the internal iliac.

The lymphatics drain into the glands along the aorta.

The Nerves: Supplied by sympathetic nerves. Minute ganglia lie within the fibrous coat of the ureter. This explains the automatic contractions of the ureter in expelling urine, and also the fact that violent contractions in renal colic cause great pain.

Abnormal Ureters.

One or both ureters may be double in part or the whole of its length. The upper end, or renal pelvis, may have various shapes and subdivisions which are important to recognise in pyelograms.

Occasionally one ureter may open into the prostatic urethra or into the vagina. In the first case this causes blockage of the ureter and hydronephrosis. In the second (vaginal opening) it causes leakage of urine.

Stones in the Ureter.

These occur in cases with acid urine. The commonest is composed of a mixture of oxalate and phosphate of lime, and throws a shadow in X-rays. A stone composed of uric acid only sometimes occurs, and does not throw a shadow in X-rays.

A stone must be small to enter the ureter at all. Its diameter is only 1/5th of an inch. When one enters, it becomes stuck at one of the three narrow places mentioned. In 75% of cases this impaction is only temporary, and the stone will pass on to the bladder after a time. It may have to be helped by passing instruments, or the injection of novocain. Some stick at the lower end projecting into the bladder, and can be removed by passing special scissors through the cystocope and splitting the opening. The remainder will require an operation for removal.

The nurses' treatment of a case of ureteric calculus would be the same as that given under renal calculus.

A stone in the ureter causes colic, slight hæmaturia, and irritability with frequency of the bladder. X-rays will usually show it. The lower part of the ureter can be palpated by the finger through the vagina in the female. It cannot be reached per rectum in males unless a stone is lodged in it, and not always then. In each case there would be tenderness on feeling the lower end if a stone were present.

The ureter is deeply placed and well protected, especially in the pelvis. Hence it is not often injured. Occasionally it is accidentally cut at an operation for growths in the pelvis, especially in complete hysterectomy. The ureter is running forwards and inwards to the bladder, and one lies on each side of the cervix uteri. If a ureter is so cut, it may be repaired, or implanted into the bladder higher up, or simply tied. Usually it will be simply tied, because the patient has already had a big operation and may not stand the extra time required to repair it. The effect on the kidney would be to cause atrophy.

Operations on the Ureter.

These may be part of an operation on the kidney, as for hydronephrosis or part of another operation as for injury during hysterectomy. The ureter itself may be operated upon for an injury or stricture or for tuberculosis. Growths are very rare in the ureter, but it may suffer from growths of other organs pressing upon it, as in carcinomas in the pelvis, or in the kidney, or colon.

Before operating, there are several methods of diagnosis for the ureter. Much information may be gained by cystoscopy, or catheterising or sounding the ureters, and by X-rays, pyelograms, or ureterograms. These procedures require much practice to be of any value. The diagnosis must be accurate before any operation is undertaken.

The ureter may be reached either through the abdomen (trans-peritoneal route), or by the extra-peritoneal route, or occasionally the lower end through the bladder itself.

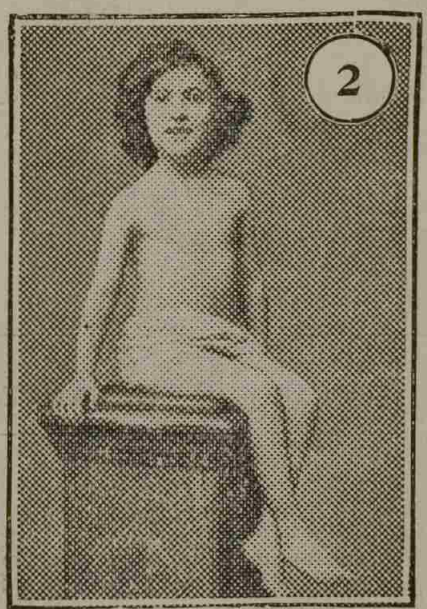
As a rule the trans-peritoneal route is avoided, as, though it is rapid and easy, the disadvantages are that the peritoneum may be infected, and that drainage is not possible. In this method the ureter is found at the brim of the pelvis and

BUILDS *FOR LIFE!*

MRS. BAKER
and her new baby
TO-DAY

MRS. BAKER WHEN A CHILD

Age 5 yrs. 7 mths. Weight 1 st. 7 lb. 2zo
BEFORE TAKING VIROL



Age 6 yrs. Weight 3 st. 2 lb. 2 oz.
AFTER 5 MONTHS ON VIROL

Pre-Natal Feeding

Fifteen years ago Mrs. Baker (then a child of six) was at death's door. Virol saved her life and laid the foundations of her own permanent good health and that of her child.

Read what Mrs. Baker says herself:—

Dear Sirs, *January, 1927.*

"I feel sure that the enclosed photograph (printed above) of two generations of Virol children will interest you. As you already know, my life was saved by Virol during a severe illness, when I had been given up by the doctors, between 5 and 6 years of age. My baby boy is now ten months old, and is a splendid boy with fine strong limbs. He is full of life and very good-tempered. He has 8 teeth and is beginning to walk. I have breast fed him entirely till now, with the addition of Virol the whole time.

"I find Virol-and-Milk very valuable for myself."

(Signed) MRS. E. BAKER.

VIROL

A building up food for all ages.

VIROL LTD., HANGER LANE, EALING, W.5, ENGLAND.

These are guaranteed to be genuine photographs and accurate particulars of Mrs. Baker. This and every other case published by Virol Ltd. are open to the strictest investigation by any Doctor interested.

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traced up or down. On the right side the colon overlaps it, and on the left, the sigmoid. The method is chiefly used for repair after injuries during uterine operations. The trendelenberg position is used.

The usual causes for removing a ureter are either in kidney growths, in tuberculosis, or pyo-utereritis (distension of the ureter with pus).

The extra-peritoneal operation is done from in front also; but the peritoneum is stripped inwards instead of being opened.

Ureters may be transplanted, for various reasons. Temporary transplants are done into the vagina. Permanent transplants are done into the bladder or the other ureter. If transplanted into the colon, there is too great a risk of infection (colon bacillus), and of stenosis.

Plastic operations are done on the ureter in cases of hydro-nephrosis. Sometimes this is caused by an additional artery which runs to the lower pole of the kidney, and over which the ureter has become kinked. Such an artery has to be tied and cut.

It is thus evident that a good many operations are done on the ureters. Those for stone, or where the ureter is opened, require drainage tubes, in case of escape of urine from the spot opened. Such tubes are usually left in for from two to four days.

In all operations on the kidney, bladder or ureter, catgut only should be used for ligatures, because sutures, which are not absorbed, are likely to form the nucleus of later calculi, lime salts being deposited around the ligature.

(To be Continued.)

"KAI TIAKI"

RECEIPTS AND PAYMENTS ACCOUNT, YEAR ENDED 31st AUGUST, 1927.

RECEIPTS.	£ s. d.	PAYMENTS.	£ s. d.
To Balance, 31/8/26	16 7 5	By Printing and Publishing Journal	246 0 8
Subscriptions	238 1 7	Postages	18 0 4
Advertisements	91 4 10	General Expenses	8 2 6
		Editor's Fee	52 0 0
		Bonus	10 10 0
		Balance	11 0 4
	£345 13 10		£345 13 10

BALANCE SHEET AS AT 31st AUGUST, 1927.

LIABILITIES.	£ s d.	£ s. d.	ASSETS.	£ s. d.
Sundry Creditors		20 9 2	Subscriptions in Arrears	94 1 0
Subscriptions in Advance..		19 16 0	Bank of New Zealand	11 0 4
Accumulated Fund—				
Balance, 31/8/26 ..	4 3 5			
for this year ..	18 12 9			
Add Excess of Income				
		64 16 2		
		£105 1 4		£105 1 4

Audited and found correct.
A. MAURICE ANDERSON,
Auditor.

Wellington, N.Z.,
22nd September, 1927.

Notes from the Hospitals and Personal Items

Births

DODDS.—At Dunedin, on July 31st, to Dr. and Mrs. Dodds (née Rosamund Punter)—a son (Peter).

PATERSON.—On July 21st, at Livingstone Street, Patea, to Mr. and Mrs. W. Paterson (Sister E. Fraser, trained at Timaru Hospital)—a daughter (Janet).

McIVER.—On September 11th, 1927, at 31 St. Leonard's Road, Epsom, to Mr. and Mrs. P. McIver—a daughter.

Marriages and Engagements

The engagement is announced of Nurse A. M. Rowe, only daughter of the late Mr. and Mrs. T. J. Rowe, of Dunedin, to Mr. S. W. Richardson, third son of the late Hon. E. and Mrs. Richardson, of Christchurch and Wellington.

Nurse Eva E. Smith, trained at Auckland Hospital, recently married Mr. Lemming, and will make her home in Auckland.

Miss Winifred L. Eves, trained at Nelson Hospital, married Mr. T. A. Hyland, and will make her home at Takaka, Nelson.

Personals

Miss Maclean, who has been spending an enjoyable holiday in Australia, is returning to Wellington on October 25th.

Miss Ewart, late Matron Southland Hospital, writes from London. She was much impressed during the voyage by the Panama Canal. Shortly before reaching Southampton they struck bad weather and during the tossing about Miss Ewart had the misfortune to fracture a rib and injure her thumb severely, but was well again when she wrote, and was able to enjoy, among other things, the "Trooping of the Colours" and a military tournament.

Miss Cornish, formerly Sister at the Palmerston North Hospital, writes from Rome, which she had reached from Geneva and Lucerne by way of Milan, Venice, and Florence. She had been intensely interested by the cathedrals, sculpture and mosaics and paintings. In Rome she had visited the Colosseum and the Catacombs, which she describes as very weird. Miss Cornish is returning to England, via Switzerland, France and Belgium, and later hopes to visit Scotland.

Nurse K. Redmond, trained at Picton Hospital, and recently a member of the Palmerston North Hospital staff, has joined the staff of the Pukeora Sanatorium, Waipukurau.

Miss R. Fanning has joined the staff of the Lady Buxton Home (Karitane), Claremont, South Africa, to help Miss Mitchell, the Matron, who is also a New Zealander.

Miss Theresa Butler, who accompanied Miss Fanning to South Africa, is returning to New Zealand in July. She had a most interesting trip up to the Victoria Falls, and stayed with Mrs. Murray Wilson (Sister Emily Curtis) at Bulawayo.

Miss E. M. Taylor has accepted a position as Sister on the staff of the Wanganui Hospital.

The Misses Z. and K. Grimstone left New Zealand for a trip to Canada in the second week in June.

Miss E. Bishop, formerly Matron of the Apia Hospital, Samoa, and now of British East Africa, near the Kenza Country, recently spent an enoyable holiday in New Zealand, returning to South Africa in June.

Miss T. Butler, who, with Miss Rosa Fanning, visited South Africa in the latter part of 1926, returned to New Zealand early in August. Miss Butler and Miss Fanning spent a delightful holiday with Mrs. Murray Wilson (Sister Curtis) at Bulawayo, on their way up to the

Victoria Falls, and afterwards did some private nursing in Durban and Capetown.

Miss Rosa Fanning has joined the staff of the Lady Buxton Home, Claremont, to help Miss Mitchell for a time, and will therefore not be returning to New Zealand at present.

Sister Grace Spencer, who was trained in Napier Hospital, and for the last six years has been a sister there, has left to be married. On the eve of her departure she was presented with a large brass jardinere and a pyrex dish by members of the nursing staff, and afterwards entertained at supper by the sisters and charge nurses.

Nurses George, Culling, and Taylor, trained at Dunedin Hospital, who have been private nursing in Sydney for some time past, have left by the Aorangi for a holiday trip to Honolulu. On their return to New Zealand they will visit places of interest in the Dominion, and then expect to return to their nursing duties in Sydney.

Miss Janet M. McGhie, trained at Naseby Hospital, has been appointed Matron of the Palmerston North Hospital. For the past two years Miss McGhie held the post of Sister Tutor at King George V. Hospital, Rotorua.

Miss Letitia Lindsay, trained at Dunedin Hospital, and formerly Acting Matron, and Matron of Waimate Hospital, has been appointed Matron of Timaru Hospital.

Sister Samson, for some years Home Sister at the Pukeora Sanatorium, Waipukurau, has been appointed Matron of Flock House, Marton.

Miss M. King, for many years Sister of King George V. Hospital, Rotorua, has been appointed Matron of Whangaroa Hospital.

Sister Ellen Axup, who was for many years Sister on the staff of the Pukeora Sanatorium, has resigned to take up a position at an orphanage at the Upper Hutt.

Miss A. I. Johnston, trained at Wanganui Hospital, has recently been appointed to the staff of the Pukeora Sanatorium, Waipukurau.

Miss V. McLean, R.R.C., who has been Sister in Charge of the Ante-Natal Clinic of the Plunket Society, Wellington, is taking a refresher course at the Karitane Harris Hospital, Dunedin, and will then proceed to Auckland to take charge of the Karitane Hospital there.

Miss D. Robinson has been appointed Sister in Charge of the Ante-Natal Clinic at the Plunket Society, Wellington.

Notes from Pukeora Sanatorium, Waipukurau.

Sister T. Butler, late N.Z.A.N.S., has recently joined the staff at Pukeroa Sanatorium.

Sister M. Newman, late of Waikato Hospital, has been appointed to the staff at Pukeora Sanatorium.

Sister E. Axup, who has been on the staff at Pukeora Sanatorium for the last 5½ years, has retired from nursing, and is about to enjoy a well-earned rest. Before her departure on 30th September, she was presented by members of the nursing staff with an 8-day clock, suitably inscribed; also a very nice silver teapot, from her patients in Ward 2.

Sister Samson, who has been Home Sister at Pukeora Sanatorium for some years, has been appointed Matron at Flock House, Bulls. On the occasion of her departure, she was presented with a royal Doulton tea set from members of the nursing staff.

Personal Notes—Auckland District.

Miss Margarita King, late Sister King George V. Hospital, Rotorua, is now Matron, Cottage Hospital, Whangaroa, North Auckland.

Miss Ethel Swayne, late Matron Huntly Cottage Hospital, has been transferred to Te Kuiti Hospital, as Matron, in place of Miss Fricker, who has returned to Waikato Hospital.

Miss E. E. Hilditch has been appointed Matron at Huntly Hospital, in place of Miss Swayne.

Miss P. A. Rolfe has been appointed Matron at Whitianga Hospital, Mercury Bay.

Miss Jamieson, late Sister, Pukeroa Sanatorium, has been transferred to Te Kaha as District Nurse, to replace Miss L. Kennair, who has returned to the Auckland district.

Miss L. Hill is on temporary duty in Auckland district, while Miss Kennair has extended leave.

Miss Olive Drewett, well known to Christchurch nurses, who was for some time District Nurse at Mokai, after two years spent on her apple orchard at Waimauku, North Auckland, has now leased her orchard, and left last week for Kenya County, East Africa. Miss Drewett intends to join Miss Emily Bishop, Tabora, Tanganyika, East Africa, in managing a coffee plantation, and has every hope of making a success of the enterprise. Miss Drewett is an expert agriculturist, and believes it will be possible to produce vegetables and fruit, as the plantation is situated on very high country, household fires being necessary there in the winter season. We hope later to publish some items of interest about these enterprising ladies, as Miss Drewett has promised to keep in touch with her friends in New Zealand.

Miss Norah Sullivan has been appointed Matron of the new Cottage Hospital at Kaitaia, Bay of Islands.

Miss Gladys Swears and Miss Dorothy Wright have taken over Miss Vivienne Montgomery's private hospital, "Cairnhill."

Miss Lilian White has given up her private hospital at Bryce Street, Hamilton, and has accepted the position of Superintendent of St. John Ambulance Women's Home, Nursing Division.

The following District Nurses under the Health Department attended the Refresher Course at Auckland during the week, August 31st to September 8th:—Nurse Jarrett, Thames; Nurse Blackie, Rotorua; Nurse Cameron, Opotiki; Nurse Vos, Dargaville; Nurse Leslie, Hokianga; Nurse Jewiss, Kaitaia.

Ichabod

Mysterious silence broods upon the air,
A sense of loss—a haunting wraith of grief,
As Autumn's radiant robe falls, leaf by leaf,
And incense of dead flowers floats everywhere.

O stately trees, your vesture stript away,
Do ye not need it most in wintertide?
Why could ye not remain thus glorified
To gladden earth when skies were dread and grey?

Beautiful leaves, falling without a sound,
Circling and fluttering, floating slowly down,
Rich hues of purple, crimson, gold and brown,—
A wealth of beauty wasted on the ground!

With ye, the hopes that made sweet summer bright—
Thoughts, friendships, joys, are withered now and gone—
Ah! Earth was very fair to look upon
Till sunset splendour faded into night!

The Tree of Life is not an evergreen;
Its leaves must fall and die and bud again
When winter's snow melts in the spring's warm rain
Whate'er has been, will be, or might have been!

—L. M. Macdonald.

Business Notices

SUBSCRIPTION TO JOURNAL.—**The subscription to the journal is 6/- per annum for members of the N.Z.T.N.A., for non-members 7/6 per annum. It is published quarterly, and any money remaining after actual expenses of printing and posting are paid will be put towards the future enlargement and improvement of the paper. Subscribers are requested to send addresses to which the journal may be sent, to Miss Todd, Secretary, Wellington Branch, N.Z.T.N.A., 1 Kensington Street, Wellington.**

Single copies can be obtained for two shillings each.

(Canterbury members may, if they desire, pay their subscriptions to **Miss Buckley, District Health Office, Christchurch.**)

All communications regarding Advertisements should be addressed to the Publishers: **The Tolan Printing Co., 22-24 Blair Street, Wellington.**

We beg the co-operation of the Nurses who read the Journal in keeping up its interest by sending news for insertion from all parts of the Dominion. An item of news or personal paragraph from the most distant place where there is a hospital or a nurse, is of as much interest as that which can be gleaned in the centres.

Matrons and nurses are invited to send letters, or articles, on any subject that interests them, to open up discussions on nursing or ethical points. To send any personal items of news, to make any inquiries.

Accounts of holiday trips, especially to other countries, extracts from letters from nursing friends abroad will all be welcome and help to make the journal interesting. All matter for printing should be written on one side of the paper only.

The Matrons of Hospitals are asked to send news each quarter by the 1st of January, April, July, and October, of any changes in their staffs, resignations, promotions, marriages and births among the former nurses, obituary notices with any little biographical notes of interest to nurses, alterations and additions to the hospitals, new equipment, accounts of any festivities, presentations and so on.

All literary communications, articles contributed, items of news, and other matter for printing in the journal should be addressed to: **Miss Maclean, 32 Upper Watt Street, Wadestown, Wellington.**

Small Casual Advertisements from Nursing Homes, Maternity Hospitals, etc. The cost of these advertisements is 10s. for a two-inch space and 7s. 6d. for one inch for one insertion. The copy and postal note should be forwarded direct to the Tolan Printing Co., 22-24 Blair Street, Wellington.

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